Derbyshire
Safeguarding Children
Board

An assurance report reflecting on the current multi-agency safeguarding arrangements within Derbyshire, with reference to Aston Hall Hospital

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Contents

Number	Subject	Page
1	Introduction	4
2	Background	5
3	Assurance Review Methodology	10
4	About the Author	12
5	The support provided to victims/survivors	12
6	The standards against which non-recent practice should be compared	13
7	National safeguarding and child protection developments and arrangements	13
8	Current arrangements in partner agencies:	
	Derbyshire County Council's Children's Services	21
	Derbyshire Constabulary	24
	Clinical Commissioning Groups	26
	Derbyshire Healthcare NHS Foundation Trust	31
	Other healthcare providers	41
	Derbyshire County Council Adult Social Care	43
9	Derbyshire Safeguarding Children Board	45
10	Conclusions	46
11	Recommended Measures for Ongoing Assurance	51
Appendix 1	Roles and responsibilities of agencies involved in the review	53

FOREWORD

The Independent Report being published today was commissioned by the Derbyshire Safeguarding Children Board in 2017. It concerns allegations of abuses committed against children and young people resident in Aston Hall, located in Derbyshire but the provider of a service across the country, over 40 years ago. The report was commissioned to find out whether and take action to ensure that, if such abuses were committed today, there are systems, practices and processes in place, including the sharing of information, which would identify them at an early stage and take necessary and urgent steps to deal with them.

Prior to the commissioning of this report, consultation with the Department for Education confirmed that a Serious Case Review was not appropriate or required; hence this is an Assurance Report, which does not seek to describe or analyse past events. It seeks to provide assurance and give advice as to the effectiveness of what is happening now. As this report was being compiled, it has become increasingly apparent that its conclusions and the associated recommendations for ongoing assurance will be of great relevance to safeguarding agencies operating across the country and the report will be made available to them as a basis for their own assurances.

It is important that I make it very clear that Derbyshire Safeguarding Children Board accepts as genuine the allegations of abuse which have been made and is highly sensitive to the significant distress the victims/survivors have experienced over a long period of time. We are committed to ensuring that victims/survivors receive all necessary and appropriate ongoing support. However, we cannot pass judgement on what actually happened or what was done by whom. That is not within the remit of this report and there are very practical legal reasons why the report can not make such judgments, as stated in the separate report by Derbyshire Constabulary. Nevertheless, we must ensure as far as we can that any such abuse is, if not wholly prevented, reported/identified and necessary action taken with all speed.

It has been most helpful and encouraging that, despite their natural feelings of great distress, the victims/survivors have felt able to recount their experiences of some years ago. They have acted with great courage and it is our hope that any others facing similar experiences will be encouraged to come forward at an earlier time. I thank them most sincerely for what they have done.

As our knowledge, awareness and understanding of the impact of child abuse has increased over many years, we must still acknowledge the unpalatable truth that such abuse is often caused by those whom children regard as protectors and carers, family and friends. As a society, we have begun to understand the need for systems and processes to be in place to

afford protection to our most vulnerable members of society and have developed these over the years since the Children Act 1989.

Most recently, the national Independent Inquiry into Child Sexual Abuse (IICSA) is a response to the need to understand what happened within institutional care in the past and how this occured. Therefore, this is not the focus of this report. The Derbyshire Safeguarding Children Board response to historical abuse allegations by those in positions of trust is to focus on the availability, adherence to and effectiveness of the current protection afforded to children who are in need of professional intervention from the agencies identified as being central to this service provision.

The Derbyshire Safeguarding Children Board commissioned Glenys Johnston OBE to research and prepare a report looking critically at these processes and to identify any improvements which could be made. I wish to thank Glenys Johnston for a thorough review, which challenges all agencies – and the Derbyshire Safeguarding Children Board – to maintain their vigilance and not to become in any way complacent. The report has been informed by and in part initiated in response to the accounts of victims/survivors of the regime at Aston Hall hospital. Their accounts have been accepted in full as it was not the place of this process to test the veracity of this information; but rather to ensure that support was available to the victims/ survivors and that measures were in place to respond promptly to any future concerns of a similar nature.

The report now being published confirms that the practices and procedures which are currently in place are effective in ensuring the safety of children and young people in Derbyshire. However, whilst such reassurance is important and welcome, the Derbyshire Safeguarding Children Board acknowledges that we should never be complacent and, consequently, we accept also, without reservation, and will implement the measures recommended to continue to strengthen what is already in place.

I am grateful to those agencies who have contributed information regarding their current procedures and processes. I appreciate the determination of all involved to ensure that there is a more rigorous and effective regime of safeguarding which protects children. National Guidance on ensuring the Safeguarding of Children will alter local arrangements across the country by September 2019. We will take steps in Derbyshire to ensure that any successor body maintains that determination and commitment.

STEVE ATKINSON
INDEPENDENT CHAIR
DERBYSHIRE SAFEGUARDING CHILDREN BOARD

1. Introduction

1.1. This Assurance Report, commissioned by Chris Cook, Independent Chair of Derbyshire Safeguarding Children Board, in 2017, and subsequently overseen by his successor Steve Atkinson, concerns allegations of child abuse being committed in Aston Hall during the 1960s and 1970s. Under the care of Dr Kenneth Milner children were restrained and then injected with sodium amytal and while sedated by it, they state that they were sexually abused.

1.2. Derbyshire Safeguarding Children Board accepts as genuine the allegations of abuse made by people who, as children and young people, were resident at Aston Hall. Neither the Board nor the author of this report can pass judgement on what actually happened, for reasons stated in the separate report by Derbyshire Constabulary. In any case, such judgements are not within the remit of this report. However, in order to provide assurance and make appropriate recommendations, such an assumption must be made and the report is written on that basis.

1.3. The assurance process which informs this report utilises the review methodology from HM Government's Working Together to Safeguard Children[1]. It is <u>not</u> a serious case review, a position agreed at the outset by the Department of Education; nor is it an 'investigation' of what happened at Aston Hall, as has been reported by some sections of the press and media. The Safeguarding Board, nevertheless, felt it important that there should be a transparent review of the responses of all relevant agencies to assure children and young people, and which could be of use to relevant agencies operating across the country.

1.4. Whilst the trauma and long-term impact of the abuse that occurred cannot be undone, this report provides assurance that whilst child abuse will never be eradicated, there are now in place, in all relevant agencies in Derbyshire, measures, arrangements, procedures, and effective scrutiny that provide the best safeguarding for children, in line with current knowledge, understanding and best practice.

1.5. **Children can be confident that, if a similar situation, such as occurred at Aston Hall, arose again, there is a clear and transparent route for them to raise their concerns and that those concerns would be taken seriously. Furthermore there are robust and effective processes in place to identify concerns that are not reported by children.**

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1 HM Government Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children, March 2015

2. Background

2.1 Aston Hall Hospital

2.1.1. Aston Hall was initially a Red Cross hospital for wounded soldiers during the World War 1, becoming a 'colony' for people with Learning Disabilities, detained under the Mental Deficiency Act 1913, in 1924. Aston Hall was designated as a hospital with a Medical Superintendent on establishment of the National Health Service. Two special wards were opened for children who were described as 'delinquent' and it is known that by 1956 there was a school to provide education for children on the wards. Derbyshire County Council also operated a special school on the site between 1965 and 1985. Aston Hall achieved a reputation as a treatment centre for children who came to be placed there and in the 1960s and 1970s.

2.1.2. Aston Hall was opened as an institution on the 6th April 1926 by Nottingham Corporation, under the provisions of the Mental Deficiency Act 1913. It ceased to be managed by Nottingham Corporation when it became part of the National Health Service in 1948. From 1948-1974 it was administered locally by the Sheffield Regional Health Board. In 1974 control of the hospital passed to South Derbyshire District Health Authority. During the period covered by this report, whilst located in Derbyshire, it provided a service for children placed there by agencies from across the country.

2.1.3. It was known as Aston Hall Hospital from the early 1950s and eventually closed in 2004. Prior to its eventual closure in 2004, it became a facility solely used for the accommodation of adults with learning and behavioural difficulties.

2.1.4. Aston Hall had its own education facility which dated from at least 1956, although it could have existed before this time. Derbyshire County Council operated a special school on the Aston Hall site from 1965 – 1985, which is known from committee records that are archived at the Derbyshire Record Office. These records also indicate that the County Council employed at least 67 members of staff at the school, although there are no known existing files for any of the individuals identified as these were destroyed in accordance with retention and destruction policies.

2.1.5. The Derbyshire Record office holds archives of Aston Hall which identify names of hospital residents and staff. These records include admission / discharge records, committee minutes and assorted nursing records. Information pertaining to these records has been shared with the police who have subsequently viewed them. It appears that some children were admitted for weekend care whereas others may have been placed there on a longer-term basis.

2.1.6. Due to the significant historical nature of the events concerned, compounded by the contextual information in respect of record-keeping and record retention, it is difficult

to determine the absolute facts of how children became patients in Aston Hall hospital, either on a long term or respite basis, or how the responsible local authority monitored their care.

2.1.7. Between 1926 and 2004 the management of Aston Hall sat with various public bodies as changes took place across health and social care organisations. It closed in 2004, the closure being led by the now dissolved organisation, Derbyshire Mental Health Services NHS Trust. In terms of legacy issues pertaining to Aston Hall, responsibility now lies with the Department of Health and the Secretary of State for Health and Social Care.

2.2. Dr Milner

2.2.1. Dr Milner was employed at Aston Hall between 1947 and 1975. This period is of primary interest to this assurance report as this is when the abuse took place.

2.2.2. Dr Milner was the Medical Superintendent, which meant he had full authority and control over all aspects of the hospital. For example, as the final signatory he could have ordered medications and equipment independently. In his role his practice would have been largely unmonitored and unchallenged at the time.

2.2.3. Furthermore, it is reported that Dr Milner was seen by many as a kind and caring professional, innovative in his practice and providing solutions that would improve the lives of children; positive reputations and perceptions are recognised as powerful influences and can affect people's confidence to challenge.

2.2.4. Since Dr Milner's tenure there have been high profile cases of significant abuse by senior professionals within the NHS such as those described in '*Safeguarding Patients*[2]*.* Crucially this report outlined changes relating to the monitoring and local discipline of health professionals and the handling of complaints and concerns.

2.2.5. In addition, there was also the White Paper – '*Trust, assurance and safety*'[3]*,* which outlined proposals for fundamental change to the regulation of health professionals in the UK. These documents are key to understanding the development of the NHS current regulatory arrangements, on which assurance of robust current practice can be based.

2.2.6. In terms of timing, the abuse to which this report refers coincided with the development of the phenothiazine group of antipsychotic drugs in the 1970s e.g. chlorpromazine, fluphenazine, thioridazine and the more difficult to manage behaviours that people exhibited were able to be reduced. A corresponding sea-change was taking place as

[2] Safeguarding Patients - The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, February 2007

[3] White Paper - Trust, assurance and safety – the regulation of health professionals in the 21st century (Department of Health, February 2007)

to the care and treatment of some of society's most vulnerable members with changes to clinical models.

2.2.7. Dr Milner had experience of working with adults in Special Hospitals, which were linked with the criminal justice system and were managed under the Ministry of Health. Dr Milner was registered within the 1975 Medical Register which indicated he was registered as "MRCS England, LRCP Lon 1933, MB ChB 1933, MD 1939 Leeds."

2.3. Treatment

2.3.1. Aston Hall had several wards. The allegations centre on two wards opened in 1956, called Laburnum (which housed adolescent female patients until 1978) and Beech (which housed adolescent boys until 1981). Of the files that have been researched by the Local Authority's Complex Inquiry Team, reference has been made to narcoanalysis being the form of treatment practised at Aston Hall for adolescents with behavioural problems. It is understood that this involved Dr Milner injecting children with narcotics (sodium amytal) to 'unlock' previous abuse and trauma which would assist in understanding and addressing their behavioural difficulties (see Naples and Hackett 1978[4]). This type of procedure would not be acceptable under today's medical standards and it was not standard practice during the period in question, according to medical expert Dr Michael Rutter, who has been consulted on this opinion; in particular, it was not standard practice in the treatment of young people and children.

2.3.2. The limited record keeping means that this review's findings are inconclusive as to the full nature of the treatment, whether the treatment was covert or in plain view and whether it was sanctioned by a social worker .

2.3.3. Furthermore, in evidence from Dr Milner's written work, he expressly recommends limited record keeping. (In notes from a Milner talk in 1953 entitled 'Psychotherapy with high grade mental defectives', it quotes Dr Milner as saying: "*The barrier of distrust and suspicion and a trust between a patient and a person representing authority had to be broken down and the patient convinced that whatever he told in confidence would never be put on his official record or used against him. Often it was better to take no notes at the time.")*

2.3.4. This practice would be unacceptable in terms of professional standards of conduct and record keeping in 2018.

2.3.5. It is understood that the allegations of abuse may relate to the administration of inappropriate drugs but also to sexual abuse carried out whilst under the influence of those drugs. Many people have reported that they do not remember what happened

[4] The Amytal interview: History and current uses, (Naples and Hackett, 1978)

to them during the drug administration, but some said that when they 'came to' they noticed some wetness/ bleeding in their genital area and were unable to explain this. Others have reported recalling being raped or sexually assaulted. Many survivors report having to agree, because of the pressure exerted on them by Dr Milner during this procedure, which they were terrified of and wanted to stop, that they were sexually abused by members their family although this was not true.

2.4. Victims/Survivors

2.4.1. Most of the complainants of Aston Hall were under 18 years of age at the time they were victims/survivors of Dr Milner and his medical staff; a number of allegations have also been linked to other staff members who were working under the direction of Dr Milner at the time. Most complainants are now between 50-73 years of age. They live across the United Kingdom and internationally, as far afield as Australia.

2.4.2. The most frequent route of admission to Aston Hall would appear to be from Children's Homes. Children were also transferred from their own homes, from court, remand homes and foster homes; referrals were also made from schools and the courts.

2.4.3. Children went to Aston Hall from over 50 local authorities in the 1960s and 1970s. The Complex Inquiry Team wrote to those authorities or their potential successors to alert them to the possibility of patients who were placed there still being potentially in the area of origin and possibly requiring support. To date thirty authorities have responded to the alert and have been given specific information of individuals from their area.

2.4.4. The record of children's admissions and discharges held by Derbyshire County Council show that it had 158 care episodes for Aston Hall, of which 30 were re-admissions. There are suggestions that the facility may, at the time, have been used as a form of respite care and that siblings may also have been accommodated in an undocumented and haphazard fashion.

2.4.5. Due to the significant historical nature of the events, compounded by the contextual information in respect of record-keeping and record retention, and the preference of Dr Milner for limited record-keeping, it is very difficult to analyse and assess the clinical care at this time. In addition, there is insufficient evidence to determine the absolute facts of how children became patients in Aston Hall hospital, either on a long term or respite basis, or whether and if so how, the responsible local authority monitored their care.

2.4.6. Initial concerns relating to the treatment of children at Aston Hall were first passed by Suffolk Police to Derbyshire Constabulary in June 2011. Whilst it is recognised that earlier disclosures may have been attempted by victims/survivors to agencies, these do not fall within the scope of this report. Investigation of the concerns reported by one

woman concluded that they related to the nature of treatment rather than allegations of abuse and/or criminal offence. There was no mention of sexual abuse in the statements. At this point this individual was advised to contact the Primary Care Trust and the police case was closed. Following contact from Nottinghamshire Police regarding another investigation of non- recent abuse, she raised further concerns about her treatment at Aston Hall, including abuse, in September 2014.

2.4.7. In July 2015 a second woman raised concerns about her treatment while at Aston Hall including allegations that she was raped. Derbyshire Constabulary asked her local force to conduct a video interview to obtain an initial disclosure. Derbyshire Constabulary investigated the allegations and concluded that as the suspected abuser was deceased and that no others were identified, the case be filed as 'undetected'. Around the same time, three further women reported concerns about their treatment at Aston Hall, two directly to Derbyshire and one to Hampshire Constabulary. The first complainant (2011) also asked for her allegations to be reconsidered. A sixth woman contacted Derbyshire Constabulary in December 2015 after seeing information on a Facebook site about allegations about care at Aston Hall. She described similar treatment about care and use of medication as the other women and specific allegations of sexual abuse.

2.4.8. On 16 November 2015 an officer of Derbyshire Healthcare NHS Foundation Trust called an interagency strategy planning meeting following a small number of requests for access to medical records. The Derbyshire Healthcare NHS officer commenced enquiries into why individuals were asking for records and learned they had expressed distress with regard to what happened to them at Aston Hall. This triggered a formal request to Police, the Clinical Commissioning Group and Social Care to share information and work together, to explore why individuals were asking for medical records and to enquire whether this was a non-recent abuse enquiry pertinent to all key partners. In addition, Safeguarding Children and Adult Boards were contacted to raise this concern and issue. Derbyshire Healthcare NHS Foundation Trust commenced a study of accounts on social media, made enquiries about the General Medical Council status of Dr Milner and sourced a literature review of any publications or historical information related to Dr Milner to understand his position and scope of role. All information gathered was shared with named partners.

2.4.9. Due to their clinical expertise, Derbyshire Healthcare NHS Foundation Trust's Family Liaison and Safeguarding teams were requested to provide initial telephone support to any person coming forward to request access to their medical records and to offer support. This telephone support was supplemented with a Clinical Nurse Specialist and a Clinical Psychologist.

2.4.10. By March 2016 there were over 40 individuals in contact with partners discussing concerns and partial memories of experiences at Aston Hall.

2.4.11. Operation Thalia was launched by Derbyshire Constabulary on 25th February 2016, in response to continuing concerns and the increasing number of allegations about the experiences of children while placed at Aston Hall. A Gold Command, originally chaired by Jim Connelly, Chief Nurse of Hardwick Clinical Commissioning Group then Chris Cook, the Independent Chair of the Derbyshire Safeguarding Children Board, was established in partnership with Derbyshire County Council, Derbyshire Clinical Commissioning Group, Derbyshire Healthcare NHS Foundation Trust and NHS England.

3. Assurance Review Methodology

3.1. HM Government's Working Together to Safeguard Children[5]' is clear that 'professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others'. Having consulted with the Department for Education, it was established that the most appropriate means of reflection would be through an Assurance Review, guided but not constrained by, the HMG methodology.

3.2. Scope of the review

3.2.1 The key question for this review is – Could such abuse happen again and, if it did, would it be identified and addressed with sufficient vigour and speed? To provide the information needed to answer this question Derbyshire Safeguarding Children Board asked partner agencies to:

- evidence that the circumstances that occurred at Aston Hall could not exist today to compromise the safety of children and young people in NHS and Local Authority provision.
- clarify the areas of historical concern in relation to clinical practice and management of children and young people with behavioural issues and mental health difficulties
- consider the historical perspective of development and implementation of clinical research in respect of direct patient care

5 HM Government Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children, March 2015

- consider the roles and responsibility of professionals to safeguard children, taking account of the statutory framework for safeguarding children both historically and to compare with current statutory regulation
- review current practices to ensure these are evidence based and that children and young people are safeguarded, and their wellbeing is being promoted
- consider current service provision regarding children and young people with behavioural issues, to ensure their needs can be addressed through safe clinical practice and in a safe environment.

In responding to the above questions, partners were asked to work on the basis that the allegations which have been made regarding Aston Hall are true.

3.2.2 The following agencies have provided independent management reviews of their involvement in Aston Hall, these include the practice and arrangements during the period covered by this review, the arrangements that are in now in place and identified learning for further improvement.

- Derbyshire County Council Children's Social Care
- Derbyshire Constabulary
- NHS North Derbyshire, Southern Derbyshire, Hardwick and Erewash Clinical Commissioning Groups
- Derbyshire Healthcare NHS Foundation Trust
- Derbyshire County Council Adult Social Care

3.2.3 In undertaking their management reviews partner agencies were directed by Derbyshire Safeguarding Children Board to appoint a reviewer independent of the practice at Aston Hall and to consider the following;

- the arrangements that are in place within the NHS or local authority organisation to promote good practice, facilitate whistleblowing and take complaints about children seriously.
- how Derbyshire Safeguarding Children Board can be assured that they have a full understanding of the role, function and services which commissioned organisations provide. That there is assurance that they support whistle-blowing by staff and complaints by children and ensure that they are taken seriously and agencies demonstrate how the procurement process effectively safeguards children and young people.
- how the police take complaints in relation to children seriously

- how the organisation works effectively with other child protection agencies to ensure the safety and wellbeing of young people.
- demonstrate how the organisation address the risks posed by senior and powerful figures. For example, those who are perceived to know best and to be doing good work, but whose status renders them sacrosanct;
- how the provision of medical treatment would involve informed consent being obtained from children and young people and their carers as appropriate;
- whether the provision of medical treatment has inherent safeguards to ensure that patients would not be vulnerable to abuse.

4. About the Author

4.1. Glenys Johnston OBE is the author of this report. She is an independent social work consultant of many years' experience and has previously undertaken work for Derbyshire Safeguarding Children Board and Derbyshire County Council in terms of practice reviews, serious case reviews and a domestic homicide review. She has never been involved in operational management or practice at Derbyshire County Council and had no previous involvement in Aston Hall.

5. The support provided to victims/survivors

5.1. As the local specialist provider of mental health services it was deemed appropriate for Derbyshire Healthcare NHS Foundation Trust to provide appropriate support to victims in respect of their emotional health and wellbeing.

5.2. NHS England funded Derbyshire Healthcare NHS Foundation Trust to establish a telephone helpline, which commenced after the first interagency strategy meeting in November 2015. Derbyshire Healthcare NHS Foundation Trust staff have also provided direct support for people looking to access their medical records and have provided direct psychological support to several individuals. This support has included home visits or visits to local health centres across the UK and telephone contact internationally. In addition, Derbyshire Healthcare NHS Foundation Trust has supported individuals in reliving their accounts when sharing with the Police and has provided information to health professionals and family members, where appropriate.

5.3. In 2018, Derby/Derbyshire Safeguarding Children and Adults Boards signed off a Derbyshire and Derby City Strategy for the management of non-recent abuse in child hood and Practice Guidance for the management of survivors of non-recent abuse in childhood., led by the Designated Nurse from Derbyshire Clinical Commissioning Groups, involving a number of partners.

5.4. The passage of time does not decry the psychological needs of the people who have been affected by Aston Hall and this has been further reinforced by NHS England's commitment in 2018 to revisit the commissioning of these support services in the future, based on the direction set by Strategic Direction for sexual assault and abuse services lifelong care for victims and survivors 2018-2023[6].

6. The standards against which non-recent practices should be compared

6.1. This assurance process considered matters that took place in the 1960s and 1970s. Some date back almost 60 years ago. As the following section illustrates, over that period there have been changes in what is regarded as acceptable or unacceptable behaviour towards children, and in what are regarded as proper standards of accommodation and childcare for children in residential care. If this review judged what happened many years ago, by the standards of today that would mean imposing today's standards on the past with the advantage of hindsight. It is not denied that abuse and unacceptable care took place and should not have done, but this review is not an investigation into these issues. This review looks at current arrangements only.

7. National safeguarding and child protection developments and arrangements

7.1.1 Our understanding of, and response to, child abuse has evolved over time. Child sexual abuse was highlighted through the Cleveland Inquiry 1987[7], and Orkney Inquiry 1991[8]. Also during the 1990s concerns grew about the abuse of children in care – Child Abuse[9], and the 'Pindown Inquiry'[10] which highlighted child abuse in care.

7.1.2. Revelations of historical abuse emerged nationally during 2011, creating a paradigm shift in safeguarding and in particular in relation to historical child sexual abuse, and have resulted in the on-going extensive public inquiries; the concept of historical abuse or Non-Recent Abuse[11] (NSPCC, 2018) has become a recognised concept.

7.1.3. The number of current or recent historic abuse inquiries, e.g. the national Independent Inquiry into Child Sexual Abuse[12], the Report of the Historical Institutional Abuse

[6] Strategic Direction for sexual assault and abuse services lifelong care for victims and survivors 2018-20236 – NHS England 2018

[7] Inquiry into child abuse in Cleveland 1987 (Butler-Sloss 1988)

[8] The report of the Inquiry into the Removal of Children from Orkney in February 1991(Clyde, 1992).

[9] Child Abuse, Towards a knowledge base (Corby B, 2006) 3rd Ed.

[10] The Pindown Experience and the Protection of Children: The Report of the Staffordshire Child Care Inquiry 1990 Stafford (Levy & Kahan, 1991; Deker, 2006)

[11] Non-Recent Abuse (NSPCC, 2018)

[12] Interim Report: A Summary: Independent Inquiry into Child Sexual Abuse, (Jay A, April 2018)

Inquiry Northern Ireland [13], the Report of the Independent Jersey Care Inquiry[14] , the North Wales Inquiry[15] indicate the seriousness with which this issue has been and is being addressed.

7.1.4. It should be acknowledged that the context in which services were provided to all children, particularly those with additional needs, was very different between 1947 and 1974 to that in which all safeguarding services, both nationally and locally, operate now. This section provides a brief summary of the relevant legislation and statutory guidance which set the culture and framework in which organisations, including the local authority and the police, provided services to children. It also identifies the relevant legislative powers available to Derbyshire Constabulary in responding to the allegations pertinent to Aston Hall.

7.1.5. The legislative framework sets the tone for the changing purpose of care and, in some respects, society's attitude towards children and their care. The Children and Young People Act 1933 and the Children Act 1948 provided for children whose parents did not have the resources to care for them and shaped provision for much of the period relevant to the investigation into care provided at Aston Hall. The 1969 Children and Young People Act was implemented towards the end of the relevant period and saw a change to children who were "beyond the control" of their parents. Throughout this period, children could be placed in care and related settings by courts and educationalists without the involvement of social care. It was only the Children Act 1989 (and subsequent iterations) that shifted the focus to 'promoting the welfare' and safeguarding of children, along with residential provisions place in meeting those purposes.

7.1.6. There were some regulatory requirements i.e. 1949 Approved Schools Rules and 1951 Administration of Children's Homes which set out requirements for monthly reporting to a board of managers and a team of inspectors monitored by the Home Office. The 1972 Regulations set out the regime for managing all children's homes. None of these applied to care provided in hospital settings. They remained in place until 1991 Children's Homes Regulations.

7.1.7. Also of relevance is the development of statutory guidance relating to child protection and wider safeguarding. The first real processes were not developed until the 1970s, following the death of Maria Colwell, and were aimed at investigating concerns about

[13] Report of the Historical Institutional Abuse Inquiry Northern Ireland, (The Inquiry into Historical Institutional Abuse 1922 to 1995 and The Executive Office, January 2017)

[14] The Report of the Independent Jersey Care Inquiry (Independent Jersey Care Inquiry R59 July, 2017)

[15] Lost in care, report of the tribunal of inquiry into the abuse of children in care in the former county council areas of Gwynedd and Clwyd since 1974 The Honourable Sir Ronald Waterhouse(Chairman), Margaret Clough, Morris le Fleming DL February 2000

physical abuse and neglect in family homes and protecting children from their family members. The first edition of "Working Together"[16], setting out all agencies' responsibilities and how they should work together was not published until 1988. It was at this point that sexual abuse was included for the first time along with the acknowledgement that "responding to sexual abuse is a new area of work for many staff…". The guidance and related procedures applied to children at risk of abuse within their own families and did not apply to allegations against staff. Such concerns remained the responsibility of the police to investigate whether an offence was committed and was influenced by the requirement of burden of proof and concerns about the credibility of witnesses. It was the Children Act 1989 and the 2001 Residential Care Regulations that required that all children had the right to be protected including those in care. Revisions to "Working Together[17]" in 2001 emphasised the need for children in care to be afforded the same protection as children living at home and included guidance for allegations against staff and whistle blowing.

7.1.8. Requirements for record-keeping and record retention were minimal. It was the 1991 Children's Homes Regulations that set out the requirements for Local Authorities to keep specified records including daily logs, staff on duty, visitors, significant events and records on individual children. Prior to this records on individual children were required to be destroyed after their 18th birthday or three months after their last period in 'short term' care.

7.1.9. The voice of the child was not embedded in regulation, policy or working practices until after the adoption of the 1989 Convention on Children's Rights and its incorporation into Child Protection Procedures and Children's Homes Regulations.

7.1.10. A statement by the Association of Directors of Children's Services in 2006 recognised that significant records of children's lives prior to 2000 were missing because of the legislative framework and previous practice.

7.1.11. All Children's Services provided by the local authority are now subject to routine and regular internal and external scrutiny. Focused inspections such as for Children with Special Educational Needs and Disability (SEND) ensure added vulnerabilities are responded to across services. Residential care homes are heavily regulated, whether directly provided by the local authority or private/independent providers and are overseen and inspected by OFSTED. Care within a hospital setting is inspected by the Care Quality Commission (CQC). The way in which local authorities carry out their duties in respect of assessment of children who need additional services and/or safeguarding, including the implementation of policy and procedures, timeliness of

[16] Working Together (DHSS, 1988)
[17] Working Together (DH, 2001).

activity and achievement of outcomes, is also inspected by OFSTED. This oversight provides independent scrutiny and rigor to enforcing standards of care and practice.

7.1.12. It is of relevance that the primary legislation available to Derbyshire Constabulary when investigating the allegations of abuse at Aston Hall is the Offences Against the Person Act 1861 and the Sexual Offences Act 1956.

7.2. National developments and arrangements in the regulation of health services

7.2.1. The first white paper regarding people with learning disabilities, or mental handicap as it was then referred to, *Better Services for the Mentally Handicapped*[18] was published in 1971 and questioned care provision for people with learning disabilities. It prompted the move away from institutional-based care to care in the community. In the mid-1980s the Government funded several schemes designed to resettle people from institutions into homes of their own, with support, in the community. The 'Derby Scheme' was established as a health, social care, and housing association partnership. The target was to move 100 people from Aston Hall into Derby City over a five-year period. The target was met, and people had in fact been leaving the hospital for homes of their own for some time before this.

7.2.2. Correspondingly, professional training was also changing quite dramatically. Learning Disability Nursing was, and remains to this day, to be the only professional registration route for a qualification specific to this population. The 1980s marked the changing era, nurses were encouraged within their training to challenge the institutional model at every level and a more individualised approach, Individual Programme Planning [IPP] led the way for the later development of the Care Programme Approach [CPA].

7.2.3. Commissioning and purchaser provider relationships were to be further developed with the NHS and Community Care Act 1990, a pivotal piece of legislation to bring together and reform a significant amount of health, especially primary care, and local authority-related legislation and, as a result, more stringent monitoring, governance and oversight was established.

7.2.4. The training of health and social care professionals also began to become increasingly more academic, with 50% of training remaining practice-based, and how certain professional groups had been regarded in previous decades began to change with the establishment of multi-agency multi-disciplinary teams across health and social care.

7.2.5. Overall, there are significant changes in NHS organisational structure, professional culture and governance processes and regulation which provide more safeguards against professional misuses of power. We shall outline some of these in what follows.

[18] The 1971 White Paper Better Services for the Mentally Handicapped (Department of Health and Social Security, 1971a)

7.3. Organisational Structure

7.3.1. There are differences in the structure of NHS organisations that would mitigate against any one individual today having the extent of power and control that Dr Milner had during his tenure at Aston Hall.

7.3.2. The structure of NHS and hospital management was already beginning to change during Dr Milner's tenure. For example:

- The *Cogwheel Report*[19] in 1967 encouraged the involvement of clinicians. Hospital Activity Analysis was introduced to provide better patient-based information and in the hospitals 'divisions' were created to group medical staff by specialty to look at clinical/managerial problems.
- The *Salmon Report*[20] in 1967 encouraged the development of a senior nursing staff structure and raised the profile of the profession in hospital management.
- The National Health Service Reorganisation Act (1973) was intended to unify the health service through facilitating better co-operation between health and Local Authorities. It also aimed to achieve better management through clarifying functions between each tier of the system.

7.4. Clinical governance

7.4.1. The concept of 'clinical governance' was first introduced in '*The new NHS – modern, dependable*[21]*'* and described more fully in '*A first class service: Quality in the new NHS*'[22]' and later publications. Before this, clinical quality was largely dependent on the individual professionalism of senior clinicians and their teams.

7.4.2. It describes both an overall approach to improving the quality of care and a set of specific systems processes. At the most general level, clinical governance asserts that healthcare organisations have a corporate responsibility, over and above the responsibility of individual health professionals working in the organisation, to provide safe and high-quality care and to strive for continuous quality improvement.

7.4.3. Clinical governance seeks to embed the culture and systems needed to promote quality improvement and patient safety into the everyday routines of every clinical team.

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[19] www.nhshistory.net/cogwheel.doc Cogwheel Report First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals (LONDON HSMO 1967)

[20] The Salmon Report, Janet T. Locke May, 1967

[21] The new NHS modern dependable (Department of Health Command Paper December, 1997)

[22] A first class service: Quality in the new NHS (Department of Health July, 1998)

7.5. Regulation – safeguarding people's interests

7.5.1. There are several different bodies in the NHS who now share responsibility for monitoring and regulating services against quality standards and clinical governance implementation. These include:

- The regulator for Health and Social Care, the Care Quality Commission (CQC).
- NHS Improvement – which brought together Monitor the NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams, individual professional regulatory bodies, such as the Nursing and Midwifery Council, General Medical Council, and the Health and Care Professions Council.

7.6. Codes of practice and professional governance

7.6.1. The code of practice for Psychiatrists is the 'Duties of a Doctor' from the General Medical Council, the governing body. This entails ensuring that the patient is the first concern, keeping skills up to date, working within limits of competence, safety domains, and taking prompt action if safety is compromised.

7.6.2. There is a code of practice regarding provision of treatment, which is clear that treatment must be based on best evidence.

7.7. Therapeutic practice

7.7.1. The use of Narcoanalysis by Dr Milner with the children and adults in his care and the way this was performed was clearly outside of mainstream practice at the time. For example, with reference to an article by Naples and Hackett[23] (The Amytal Interview, 1978) this procedure was not typically used with children and only used with adults in relation to certain mental health diagnoses.

7.7.2. Therapeutic practice in the NHS is now subject to more scrutiny under the auspices of clinical governance and there are more safeguards around the introduction and use of innovative or experimental methods. There is also national best practice guidance published by the National Institute of Clinical Excellence ("NICE").

7.7.3. The Kerr/Haslam Inquiry[24] set out a key set of recommendations relating to therapeutic practice in the NHS.

[23] The Amytal interview: History and current uses. Psychosomatics 19(2), 98-105: Journal of Consultation and Liaison Psychiatry, Naples, M., & Hackett, T. P. (1978)

[24] Kerr/Haslam Inquiry Report: Command Paper: July, 2005

7.8. NHS monitoring of individual doctors

7.8.1. With reference to the monitoring of individual doctors there are a number of specific monitoring processes in place nationally and within organisations:

7.9. General Medical Council

7.9.1. The General Medical Council is an independent organisation which regulates British doctors through the Medical Act 1983. The General Medical Council registers doctors for UK practice, sets professional standards, regulates basic medical education, and manages doctors' fitness to practise. (General Medical Council, 2017)

7.10. Registration

7.10.1. The General Medical Council registers doctors to practise in the UK. The General Medical Council has the powers to issue a warning to a doctor, suspend or place conditions on their registration or remove a doctor from the register. Patients, doctors and other health professionals who have concerns about a doctor can make a complaint to the General Medical Council about said doctor.

7.10.2. There is a Specialist Register, which is a register of doctors who are eligible for appointment as "substantive, fixed term or honorary consultants in the health service in the UK" (General Medical Council 2017.) This register was introduced on 1st January 1997. The General Medical Council is required by law to maintain this register.

7.10.3. From 1st January 1997 a doctor may not commence appointment to any post as a consultant in the National Health Service (NHS) unless they are on the Specialist Register. Doctors may also be members of specialist organisations such as the Royal College of Psychiatrists.

7.11. Licensing and Revalidation

7.11.1. The General Medical Council introduced licensing in November 2009 and revalidation in December 2012. All doctors with a licence to practise regularly have to demonstrate to the General Medical Council that they are up to date and fit to practise medicine. Each designated body (e.g. NHS Trust) has a Responsible Officer (usually the Medical Director) who oversees the process, making recommendations to the regulator.

7.12. Appraisal

7.12.1. Medical appraisal has been a requirement for consultants since 2001 and for General Practitioners (GPs) since 2002. Medical appraisal is the appraisal of a doctor by a trained appraiser, informed by supporting information defined by the General Medical Council (including details and outcomes of any complaint or serious investigation), in which the doctor demonstrates that they are practising in accordance with the General

Medical Council “Good Medical Practice for Appraisal and Revalidation” across the whole of their scope of practice. The NHS Revalidation Support Team has published a piloted and tested model of medical appraisal, the “Medical Appraisal Guide”, which complies with the needs of revalidation.

7.13. Use of Physical Interventions / Restraint

7.13.1. Mental Health and Learning Disability Services have a history of staff members using physical interventions and aversive techniques, often outside of agreed guidelines and procedures. Legislation, changing philosophies of care and professional training programmes have, particularly over the last 30 years, changed and developed to challenge what had become custom and practice in many long-stay institutions.

7.14. Child and Adolescent Mental Health Services Inpatient Admissions

7.14.1. All admissions of young people to Child and Adolescent Mental Health Services Tier 4 Inpatient Units are managed by a process overseen by NHS England that has been in place for several years. NHS England commissions all Tier 4 Child and Adolescent Mental Health Services beds. The aim is to ensure admission is appropriate and for the minimum time required with active care planning to ensure at discharge appropriate services are in place to reduce the risk of readmission and support recovery.

7.14.2. NHS England monitors inpatient admissions and there are tight links with local Child and Adolescent Mental Health Services and Commissioners to ensure inpatient stays are purposeful and do not drift. Should an assessment indicate a Child and Adolescent Mental Health Services admission may be of benefit a referral form is completed and the Tier 4 case manager reviews this to ensure the request is appropriate. They complete their own assessment regarding the pros and cons of admission and the type of unit required.

7.14.3. If a child has Autism Spectrum Disorder and or an intellectual difficulty,’ there are additional safeguards in place via a Care, Education and Treatment Review (CETR). This is a process to consider all resources that could be put in place to prevent or reduce the length of admission as many young people with these conditions are placed in Tier 4 Units when in crisis due to lack of appropriate, educational and social care support.

7.14.4. This process is overseen by NHS England with young people already in hospital and the local Clinical Commissioning Group, should the young person in the community be felt to be at risk of admission. In emergencies a Blue Light CETR can be conducted. Failure to comply with the CETR policy may lead to a fine to the Mental Health Service involved.

8. Current arrangements in partner agencies

8.1 Derbyshire County Council's Children's Services

8.1.1 The current legislative and regulatory framework sets out clear duties and expectations on the local authority in respect of responsibility, decision making, planning, reviewing and quality assurance regarding the provision of care for children including that for children who have suffered abuse and/or with special needs due to behaviour or health issues. This is also the case in respect of promoting the welfare, the broader safeguarding and protection of children, whether these children remain with the family or are looked after by the local authority. There are also clear statutory duties and requirements for the way agencies, including the local authority, work together to safeguard children, including the identification and investigation of those who are at risk of harm through abuse and neglect. Internal audit, and external scrutiny through Ofsted inspections, provide robust monitoring and quality assurance.

8.1.2 Derbyshire County Council's Children's Services have clear policies, procedures and operating processes that are compliant with legislation and regulation. Compliance is scrutinised as part of the Ofsted inspection framework. These apply to assessment and decision-making in respect of individual children who need care provision outside of their own families. There are robust expectations in respect of multi-agency decision-making, planning, and reviewing for children who need care, chaired by Independent Reviewing Officers who take a proactive role in the services for individual children including visiting them in placement and in neutral, private settings where they are seen alone.

The findings of the most recent Ofsted and Care Quality Commission inspections of Children's Services:

- The Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board 2013 judged the services to be good, the judgement of the Derbyshire Safeguarding Children Board was that it required improvement – all the recommendations from this inspection were implemented.
- The joint Ofsted and Care Quality Commission local area SEND inspection of Derbyshire in 2016, to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014, found some areas of strength and areas for further improvement.

- In February 2018 Ofsted undertook a 'focused visit' to Derbyshire County Council Children's Services on 27 and 28 February 2018. There were no areas for priority action and no children were found to be unsafe.
- Derbyshire County Council has 11 children's homes and the standard in Derbyshire is 'good'.

8.1.3 Processes are in place to identify the best placement for children, including those with additional needs because of behaviour and/or disabilities/ health problems. Arrangements for commissioning placements and monitoring their effectiveness, where the local authority cannot provide them, are in place.

8.1.4 These arrangements operate concurrently and are complementary with the arrangements for planning and decision making in respect of individual children. Finding appropriate placements for children with complex needs will continue to present a challenge, particularly when needed at short notice. It is noted that the council is paying attention to this to ensure placement finding in this challenging environment does not compromise standards. All residential care establishments are subject to internal and external inspection. The Council has a robust process for ensuring visits are conducted in compliance with Regulation 44 and all establishments, both internal and commissioned, are subject to Ofsted inspection. Private residential establishments are subject to the same regulatory and inspection framework as Local Authority settings

8.1.5 The Transitions Panel which involves managers in children's and adult social care services and ensures that children who move from childhood to adulthood have appropriate continuous care and support, was re-established in early 2018 to provide a renewed focus on the related issues of early identification and effective planning. The Care Leavers' Service is also under review and includes the transition arrangements for children who are looked after.

8.1.6 Derbyshire Children's Services have a clear and well-embedded supervision policy for all staff with a requirement that all staff have supervision with a manager at least once a month. These supervision sessions address issues in relation to individual cases, the member of staff's adherence to the performance framework and their personal development. Attention is also paid to policies and procedures for example, the section on tracking individual cases is currently under review and will result in an updated policy.

8.1.7 They have participated in Derbyshire Safeguarding Children Board's recent review of the child protection processes and have been proactive in scrutinising their internal child protection practice with a commitment to continuous learning and development.

8.1.8 All policies and procedures require evidence that the voice of the child is sought and heard as an integral part of assessments, decision-making, planning, and reviewing

8.1.9 Derbyshire County Council is compliant with the statutory requirement to have a Local Authority Designated Officer (LOCAL AUTHORITY DESIGNATED OFFICER) with responsibility to manage all allegations against members of staff in any organisation and any foster carers. Children's Services are a key partner in these arrangements. They employ the Child Protection Manager who acts as the Local Authority Designated Officer and have robust processes that are compliant with the multi-agency procedures to ensure that all concerns or allegations of abuse or neglect are thoroughly investigated, that children are protected and that where necessary the person against whom the allegation was made is subject to criminal and/or disciplinary processes and notification to their professional body and the Disclosure and Barring Service, so that if they move to another employer the record would be available.

8.1.10 During the period from 1st April 2017 to 31st March 2018, 544 enquiries/referrals about concerns regarding staff working across a range of agencies in Derbyshire had been considered and completed. Of these, 255 required no further action by the Local Authority Designated Officer, 15 people were dismissed and 15 were referred to the national Disclosure and Barring Service.

8.1.11 The Council has a clear whistleblowing policy that is accessible to all staff. There were no whistle blowing reports under the Council's arrangements in relation to Children's Social Care in 2017-18

8.1.12 Children's Services have an accessible complaints procedure for children which is brought to their attention by a range of professionals, for looked after children this would include their social worker, foster carers, residential staff, and the Independent Review Officers.

8.1.13 Specific advocacy services for vulnerable children and young people began to develop in the 1980s and have since grown with the development of statutory guidance and legislation. Derbyshire Children's Services provides an advocacy service for children in care and other vulnerable children, including children with special educational needs and disabilities, who wish to make a complaint or need help to ensure that their voice is heard. The Derbyshire Advocacy Service is delivered in line with national standards for advocacy. During 2017/18, Derbyshire advocates worked with 71 children and young people to help them communicate their wishes and feelings across a range of issues.

8.2 Derbyshire Constabulary

8.2.1 There is no information to indicate that any concerns were raised with Derbyshire Constabulary about the care or treatment of children while at Aston Hall prior to 2011.

However, there is evidence to indicate that concerns were raised by one of the victims with their local police force in another part of the country in 2003; a report of the Constabulary's investigation will be published.

8.2.2 The records relating to the first five women who contacted Derbyshire Constabulary, either directly or via another police force, evidence that their concerns were taken seriously and that appropriate investigations were conducted. All the women were given information about support services. Decisions made in respect of the initial concerns were appropriate and, based on the nature of the information given at the time and/or that the alleged perpetrator was confirmed as deceased, further investigation was not possible. Information available would indicate that all victims, male and female, who have subsequently made allegations have been responded to in the same manner.

8.2.3 The nature of the investigation was appropriately escalated, with the establishment of Operation Thalia, in response to the continuing, and increasing, concerns. An experienced Senior Investigating Officer (SIO), at PIP (Professional Investigation Procedures) 2 level, was identified to lead the investigation. A PIP3 SIO later took over the case. A Gold Command was set up in accordance with the Derbyshire Safeguarding Children Board multi-agency procedures and chaired by Jim Connelly Chief Nurse Hardwick Clinical Commissioning Group.

8.2.4 The PIP3 SIO commissioned Professor Sir Michael Rutter a Professor of Developmental Psychopathology at the Institute of Psychiatry at The Maudsley, to provide expert opinion in respect of the nature of treatment and use of drugs as reported at Aston Hall. This has been valuable and informative to the investigation and decision-making**.**

8.2.5 The PIP 3 SIO made a policy decision to record allegations describing sedation and sore genitals on waking as rape, using the threshold of a 'balance of probability' rather than that of 'beyond reasonable doubt'. The latter, required for a criminal conviction, would be impossible to achieve in view of the historical nature of the allegations and that the perpetrator is deceased. It is reported that this decision has been significant to the survivors and in their journey to recovery. The investigations as part of Operation Thalia have been reviewed by an independent barrister to ensure that all viable lines of enquiry have been pursued.

The current arrangements within Derbyshire Constabulary

8.2.6 It is evident that Derbyshire Constabulary take all allegations of non-recent child abuse seriously and have a robust organisational structure to support an appropriate response. The Public Protection Unit/Major Investigation Team now investigate all such allegations. The Detective Sergeants and Detective Constables are accredited

child abuse investigators with a number being qualified to tier 3 (enhanced) level for witness and victim support. A Detective Inspector and Detective Chief Inspector oversee this team.

8.2.7 All allegations of child abuse, current and non-recent, against senior and political figures, are investigated by the Public Protection Unit/Major Investigation Team.

8.2.8 Derbyshire Constabulary was inspected in 2017, and in March 2018 Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) conducted an inspection of Derbyshire Constabulary as part of the PEEL inspection process.

8.2.9 One of the findings of that inspection reported that Derbyshire Constabulary was graded as 'GOOD' under the category of Protecting the Vulnerable.

8.2.10 Derbyshire Constabulary is an active partner in the Derbyshire Safeguarding Children Board and is appropriately represented at Board and sub-group level.

8.3 The Changing NHS Landscape

8.3.1 The NHS landscape between 2006-2013 was changeable. This included progression from Primary Care Groups (PCGs) to Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs), which currently remain in place (Turner & Powell, 2016)[25]. Initially PCTs undertook a dual role of both commissioning services and providing services – often community services. In 2010, the NHS change was for PCTs to separate their provider and commissioning functions by April 2011.

8.3.2 NHS services at local level were monitored at regional level through Strategic Health Authorities (SHAs). Further NHS reforms abolished SHAs in April 2012, and the PCTs in 2013.

8.3.3 The Clinical Commissioning Groups did not exist between 1954 and 1979 and therefore have not been directly involved with the commissioning of Aston Hall Hospital, nor did they directly or otherwise employ Dr Milner for his role at Aston Hall Hospital.

8.3.4 Derbyshire Mental Health Services NHS Trust was created in 2002 and was the organisation that closed Aston Hall Hospital in 2004. Derbyshire Healthcare NHS Foundation Trust was established as an NHS Foundation Trust in 2011, at which point Derbyshire Mental Health Services NHS Trust ceased to exist. Any reference to that organisation in this report is purely for historical context.

8.3.5 There is no existing NHS body that was responsible for the management of Aston Hall Hospital at the time Dr Milner was in post. No current NHS organisation ever employed Dr Milner.

[25] NHS Commissioning before April 2013, House of Commons Briefing Paaper (Turner & Powell, 2016)

8.4 Clinical Commissioning Groups and former Primary Care Trusts

Current arrangements in place within Derbyshire Clinical Commissioning Groups

8.4.1 The Clinical Commissioning Groups have employed Designated Nurses and Doctors and Named GPs, who provide support, training and guidance to practitioners to ensure that robust safeguarding practice is embedded within all staff teams.

8.4.2 The above arrangements are in line with statutory guidance Working Together to Safeguard Children[26] , the Intercollegiate Document[27] on roles and responsibilities, and the NHS England Safeguarding Vulnerable People in the NHS-Accountability and Assurance Framework[28].The Designated professionals have statutory responsibility for providing leadership for safeguarding children and for ensuring that services are commissioned with due regard to promoting the wellbeing and safeguarding of children and their families in conjunction with the Clinical Commissioning Group Chief Nurse.

8.4.3 The Designated professionals have a role in providing assurance to the Governing Body of the Clinical Commissioning Groups and Derbyshire Safeguarding Children Board, for example, by undertaking an annual Safeguarding visit of all Health Trusts to ensure compliance with section 11 of the Children Act 2004.

8.4.4 Every licensed doctor who practices medicine in the UK must be revalidated to show they are up to date and fit to practice, and there are sound arrangements in place to ensure this takes place in Derbyshire.

8.4.5 The Clinical Commissioning Groups, in partnership with the local authority, commission the arrangements for Looked after Children (children in the care of Derbyshire County Council). The Designated Doctor and Nurse for looked after children have a statutory responsibility to supervise and support the statutory arrangements "Promoting the Health of Looked After Children[29]"

8.4.6 Additional Health Services are provided in Derbyshire through the 0-19 Service which is commissioned by the Public Health Department of the Local Authority. This means that all children in Derbyshire who are under the age of five and are looked after have a heath visitor. Those over this age have a named LAC nurse and all children have an

[26] HM Government Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children, March 2015

[27] Safeguarding Children and Young people: Roles and Competences for Healthcare Staff: Intercollegiate Document published by the Royal College of Paediatrics and Child Health: Third edition, March 2014

[28] Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, NHS England 2nd July 2015

[29] Promoting the health and well-being of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England: Department of Health: March 2015

Initial Health Review by a paediatrician. From this first review a Healthcare Plan is developed to improve the health of the child. Following this there is an annual examination of the child's health care needs and review of the health care plan which is carried out by the named nurse. Children under 5 years are considered under the same process twice a year by their health visitor.

8.4.7 Young people can contact their named nurse for looked after children if they require health advice or have concerns about their wellbeing.

8.4.8 This health assessment process includes face to face contact with the nurse and an opportunity to consider the child's feelings and views in relation to their placement and to capture the child's level of happiness and emotional wellbeing with their placement.

Interagency working

8.4.9 Designated Professionals attend Safeguarding Children Board meetings and sub groups and Head of Safeguarding Adults attends the Safeguarding Adult Board meetings and subgroups. Named GPs attend some Derbyshire Safeguarding Children Board and the Safeguarding Adults Board sub-groups. The above professionals all have a key role in co-ordinating and disseminating new information and ensuring that relevant Clinical Commissioning Group matters are shared appropriately.

Policies and Procedures

8.4.10 Clinical Commissioning Group safeguarding policies and procedures are up to date and in line with Derby and Derbyshire Safeguarding Children Board policies and procedures and statutory guidance. These were approved by the Clinical Commissioning Groups' Governing Bodies in 2017.

Training

8.4.11 There are effective training arrangements in place which include learning from latest guidance, best practice, and national and local learning.

8.4.12 GP safeguarding children training is conducted at level 3 as set in the Intercollegiate Document 2014[30] and presented by the named GPs. eLearning is also available. Compliance with safeguarding adults and children training is part of GP revalidation.

8.4.13 All Clinical Commissioning Group staff are trained by the Designated Nurses in line with Intercollegiate Document[31].

[30] Safeguarding Children and Young people: Roles and Competences for Healthcare Staff: Intercollegiate Document published by the Royal College of Paediatrics and Child Health: Third edition, March 2014

[31] Ibid

8.4.14 The Safeguarding Adult and Children Training sessions are developed to contain topics as advised by the Intercollegiate Document[32] 2014 and The Care Act 2014, such as what constitutes maltreatment, best practice for safeguarding children, information sharing, making a referral, escalating areas of concern and lessons learned from serious case reviews and other learning reviews.

Assurance of safeguarding compliance

8.4.15 In 2017 the Clinical Commissioning Group underwent the following assurance processes:

- 360Assurance – independent safeguarding assurance inspection – the outcome being that the Clinical Commissioning Group gained full compliance
- NHS England – safeguarding assurance tool (SAT) - there is an action plan to draw together full compliance with adult and children safeguarding and looked after children (LAC) arrangements.
- Derby and Derbyshire Safeguarding Children Board – section 11 assurance tool – the Clinical Commissioning Group gained full compliance.
- All Clinical Commissioning Groups adhere to the Recommendations by Kate Lampard in her report "Themes and lessons learned from NHS investigations into matter relating to Jimmy Savile"[33].

8.4.16 The Designated Nurses review serious incidents reports relating to adults or children provided by relevant health service, for any safeguarding issues.

8.4.17 The Designated Professionals review service specifications for new and maintained services to ensure that the service takes due regard to promoting the well-being of children.

8.4.18 All contracts and service specifications produced by the Clinical Commissioning Group contain a safeguarding element which is required to contain key performance indicators (KPI) for monitoring purposes.

Whistleblowing Policy

8.4.19 The Clinical Commissioning Group has a whistleblowing policy which is linked to the Derbyshire Safeguarding Children Board procedures and is in line with the Public

[32] Ibid

[33] Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile: Independent report for the Secretary of State for Health: Lampard K & Marsden E, February 2015:

Interest Disclosure Act 1998 which provides worker rights to protection in set circumstances where there is qualifying disclosure.

8.4.20 There is evidence that all providers have a whistleblowing policy, and this has been included in staff training. Several providers now have whistleblowing champions within the Trust to enable staff to speak out more freely when they have health and safety concerns. There were no whistleblowing incidents across the Clinical Commissioning Groups for 2017-18

Complaints Policy

8.4.21 The Clinical Commissioning Group and all its commissioned NHS Trusts, GP practices and services have clear lines of complaint for the general public and these are available on their websites. The patient advice and liaison service (PALS) staff have mandatory safeguarding children and adults training. Complaints are monitored via the Clinical Commissioning Group Quality Assurance Groups and must be resolved with 12 months.

Serious Incidents

8.4.22 The Clinical Commissioning Group and all its commissioned NHS Trusts, GP practices and services have a Serious Incident Policy in line with NHS England who published a revised Serious Incident Framework in 2015, together with an updated Never Events Policy and Framework. The purpose of patient safety investigations is to learn from incidents.

8.4.23 Action Plans for serious incidents and "never events" are monitored by the Clinical Commissioning Group via the Clinical Commissioning Group Quality Assurance Group, Learning from Serious Incidents is shared across providers and there is a Regional North Midlands network where learning from serious incidents is discussed. There are plans to produce a thematic review to better understand the context and nature of serious incidents in the NHS.

Managing risk posed by senior powerful figures

8.4.24 The Clinical Commissioning Group has considered and implemented learning from The Dame Janet Smith Review[34] into the culture and practice of the BBC during the years Jimmy Savile worked and which the report found:

[34] The Jimmy Savile Investigation Report: Dame Janet Smith, February 2016

- ***The lack of an effective complaints process*** – the Clinical Commissioning Group has a robust complaints policy (as previously discussed), whistleblowing policy.
- ***The need for stronger lateral relationships encouraging the sharing of information*** – the Clinical Commissioning Group has good information sharing both across the health economy and upwards to NHS England. This is supported by Information Sharing protocol and professional codes.
- ***The lack of an effective investigations process*** – the Clinical Commissioning Group has robust investigation arrangements through the Serious Incident Protocol.
- ***The need for stronger audience controls and Protection*** – the Clinical Commissioning Group has ensured that all NHS Trusts have a robust visiting policy for the children and celebrities visiting NHS premises and Health Providers have also implemented a policy for chaperoning children. NHS Trusts were required to ensure they complied with the themes and lessons learnt from the NHS investigations into matters relating to Jimmy Savile (Lampard & Marsden 2015[35])
- ***The need for an effective human resources department providing proper support to employees as well as the employer*** – the Clinical Commissioning Group has a Humans Resources Department which is free for all to visit and is currently provided by Arden and Greater East Midlands Commissioning Support Unit.

Medical treatment and consent

8.4.25 The Clinical Commissioning Group has robust medicines management structures in place for the monitoring and funding of medication in primary care. There are standards of practice and there are prescribing and administration of medication policies in place which cover both children and adults. Guidance states that *'it is important to discuss treatment options carefully with the child and the child's carer. In particular, the child and the child's carer should be helped to distinguish the adverse effects of prescribed drugs from the effects of the medical disorder. Medicines should be given to children only when they are necessary, and in all cases the potential benefit of administering the medicine should be considered in relation to the risk involved'.* When the beneficial effects of the medicine are likely to be delayed, this should be highlighted.

[35] Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile: Independent report for the Secretary of State for Health: Lampard K & Marsden E, February 2015

8.5 Derbyshire Healthcare NHS Foundation Trust

8.5.1 The predecessor organisations of Derbyshire Healthcare NHS Foundation Trust date back to 1992, with the establishment of South Derbyshire Mental Health Trust. Management for Aston Hall (which at the time was an in-patient facility for adults with learning disabilities) passed to Derbyshire Mental Health Services NHS Trust on its formation in 2002, from Southern Derbyshire Community and Mental Health Services Trust. This included responsibility for patient records. Derbyshire Mental Health Services NHS Trust formally closed Aston Hall in 2004, in line with the national move to support people with learning disabilities in the community. The Trust never provided any mental health services from the facility.

8.5.2 Derbyshire Healthcare NHS Foundation Trust is not the legacy organisation for the services provided by Aston Hall Hospital during the 1960s/70s. Neither the Trust nor any of its legacy organisations ever employed Dr Milner.

8.5.3 Derbyshire Healthcare NHS Foundation Trust participates in a thorough regulation regime via the Care Quality Commission. The Trust had a full CQC inspection in June 2016 and achieved a 'good' rating for the "Safe" dimension of the inspection framework in its learning disabilities adult service and outstanding in its Child and Adolescent Mental Health Services service.

8.5.4 The Trust Board demands assurance on key issues of quality and performance, holding the Executive Officers to account. The work of the Board is in turn assessed by the regulators, with professional bodies such as the General Medical Council applying additional scrutiny and safeguards.

8.5.5 In 2015 Derbyshire Healthcare NHS Foundation Trust was contacted by one of the victims/survivors of Aston Hall through its patient experience team. This contact was then escalated to an executive director of Derbyshire Healthcare NHS Foundation Trust who escalated this issue and called a multi-agency meeting for further exploration. This process latterly led to a Police inquiry and the establishment of the Gold Group, outlined earlier in this report.

Quality assurance processes

8.5.6 Derbyshire Healthcare NHS Foundation Trust operates a standard model of clinical governance, with scrutiny of clinical practice and a full research and audit monitoring model, which has oversight of all research trials or evaluations of non-typical practices. Doctors practicing today do not undertake any treatments on children without significant scrutiny from a variety of internal committees and external regulators, including but not limited to, the Trusts Serious Incident Group, Quality Committee, Freedom to Speak Up Policy and appraisal system.

8.5.7 All medical complaints are reviewed for patterns and issues and are screened for safeguarding concerns by the internal safeguarding teams for Children's and Adults Services.

8.5.8 In addition, Derbyshire Healthcare NHS Foundation Trust has a Board level safeguarding committee and checks are undertaken on staff over 1, 3, and 5 years for an overview any patterns of complaints of doctors or any practitioners in the Trust.

8.5.9 Freedom of information requests and/or medical record requests demonstrating a pattern or concern would be escalated by the Medical Records team to the Trust Safeguarding leads and advice would be sought from the Executive lead for safeguarding, as it was in 2015. This is all undertaken by the Executive Lead for Safeguarding, the Director of Nursing and Patient Experience.

8.5.10 A further layer of governance is audit. There are internal and multi-agency safeguarding audit processes that the Trust undertake/contribute to.

Safeguarding Children Audit

8.5.11 Audit programmes are in place and designed to monitor improvement and effective change in practice to improve outcomes for children, young people, and their families. Derbyshire Healthcare NHS Foundation Trust Safeguarding Children develops an audit plan each year with audits that are based on the findings of the various case reviews and serious incident reviews undertaken.

8.5.12 Recommendations are made from audit and implemented both internally and externally as necessary via action plans.

Codes of Practice and Professional Governance

8.5.13 Codes of practice are required for all Trust professional staff groups. The Health and Care Professionals Council (HCPC) provide all the regulating codes of practice for the following professions:

- Psychologists (also covered by the British Psychological Society (BPS))
- Psychiatrists
- Occupational Therapists
- Physiotherapists
- Speech and Language Therapists
- Nurses
- Pharmacists
- Dieticians
- Unregistered staff including Health Care Assistants, Assistant Practitioners and AHP Assistants.

Therapeutic practice

8.5.14 Partly as a response to Kerr/Haslam Inquiry[36] in 2005, Derbyshire Healthcare NHS Foundation Trust developed a Protocol for the Governance of Approved Therapies/Treatments to ensure sound governance of therapeutic practice in the Trust through a rigorous Assurance Framework.

8.5.15 A central component of this Assurance Framework is a Trust Register of Approved Therapies/Treatments. The protocol provides processes and procedures for managing the Register, including mechanisms for determining those therapies/treatments that will be placed on the Register and how a regular review of therapies/treatments on the Register will take place.

8.5.16 During 2008 and 2009 the Multi Professional Leadership Council developed a Trust Register of Approved Therapies. This Register was recommended to the Quality Governance Committee where it was agreed for implementation.

8.5.17 In May 2010 the Trust's Quality Governance Committee agreed the Protocol for the maintenance of the Trust's Register of Approved Therapies/Treatments, and the process for its implementation.

Medicines Management

8.5.18 All medicines-related practice within Derbyshire Healthcare NHS Foundation Trust is guided by the Trust Medicines Code and approved by the Drugs and Therapeutics committee with input from the Trust's Medicines Safety Committee.

8.5.19 Relevant sections of the Trust's Medicines code are shown below, and are available via Derbyshire Healthcare NHS Foundation Trust's intranet.

The range of medicines to be prescribed

8.5.20 The only medicines which may be prescribed (and thus used) in routine care are those approved by Derbyshire Healthcare NHS Foundation Trust and the Joint Area Prescribing Committee.

8.5.21 These formularies, that guide medicines choice, take into account both the national evidence base, including patient safety considerations (e.g. NICE guidance), and local guidance (e.g. the Derbyshire-wide formulary – oversight is via the Derbyshire Joint Area Prescribing Committee).

8.5.22 The system mentioned above involves a formal request being made by the clinician / prescriber via the completion of a Trust 'Non-Formulary Medicine Form' or 'Unlicensed Use form' (available via a link within the Medicines Code), to gain approval for use

[36] Kerr/Haslam Inquiry Report: Command Paper: July 2005

from the Drugs and Therapeutics Committee. The onus is on the clinician / prescriber to state the rationale for use of the medicine over other medicine choices.

8.5.23 Multi-disciplinary decisions are made at Derbyshire Healthcare NHS Foundation Trust Drugs and Therapeutics Committee, with the Committee including experts such as psychiatrists, pharmacists, nurse specialists/ consultants, clinical and nurse managers. Advice is also taken from the Trust's patient safety lead and practising clinicians working within specific specialist areas. Any guidance including medicines may also be reviewed by other committees as required, for example, the Physical Healthcare Committee, Infection Control Committee, and Medicines Safety Committee etc.

8.5.24 Derbyshire Healthcare NHS Foundation Trust Drugs and Therapeutics committee retains oversight of all non-formulary or unlicensed medicines requests made and actions taken, on a Trust-Wide basis.

8.5.25 The Ward/Department/Team Stock Medicines policy includes an agreed list of medicines that are regularly prescribed for administration within a specific area. These lists of medicines will be agreed by a senior pharmacist, in conjunction with the pharmacy technician and the local clinical lead. All named patient medicines ordered will be checked clinically for appropriateness by a Derbyshire Healthcare NHS Foundation Trust pharmacist, before being dispensed.

Monitoring of doctors

8.5.26 As of 9th March 2018, Derbyshire Healthcare NHS Foundation Trust has 100% compliance with General Medical Council doctor revalidation.

Appraisal

8.5.27 In Derbyshire Healthcare NHS Foundation Trust there is a robust medical management system in place which ensures all doctors are aware of their responsibilities and have clear and direct access to clinical directors and operational managers if concerns are to be raised.

8.5.28 Regarding supervision, consultants are expected to attend peer supervision, this can be as frequent as monthly, but the minimum is quarterly. For Child and Adolescent Mental Health Services and Community Paediatricians, safeguarding supervision is more formal, provided by a Safeguarding Professional. For all other consultants, safeguarding would be part of the peer supervision.

8.5.29 There is a supervision register which is completed for all consultants. The levels of Safeguarding supervision are not currently formally in place for non-child consultants.

Supervision

8.5.30 The Trust has a Supervision Policy and Procedure to ensure the work of individual health professionals is overseen and supported.

8.5.31 Supervision is an essential component of sound governance and is central to the Trust's governance processes - operational governance, clinical governance, and professional governance. Supervision has a crucial role in enhancing a member of staff's competence and effectiveness. It promotes high standards in its services and protects the best interests of service users and carers. Supervision is the cornerstone of staff care and underpins the NHS Constitution pledges.

Disclosure and Barring

8.5.32 Derbyshire Healthcare NHS Foundation Trust operates a Disclosure and Barring Service Policy and Procedures, led by the People Services directorate who are responsible for monitoring, oversight and compliance, working collaboratively with Operational Managers and Safeguarding Leads.

8.5.33 Unsatisfactory Disclosure and Barring Scheme disclosures are subject to a Disclosure and Barring risk assessment which is discussed with appointing officer and the appropriate executive director.

Safeguarding

8.5.34 Derbyshire Healthcare NHS Foundation Trust applies and adheres to Derbyshire Safeguarding Board's (Children & Adult) Policies and Procedures. The Trust made a strong commitment to safeguarding by reviewing its Safeguarding Governance structures in line with the "Safeguarding Children: 'Roles & Competences for Healthcare Staff, Intercollegiate Document [37]."

8.5.35 Safeguarding Leads, Named Nurses and Doctors directly report to the Executive Lead for Safeguarding Children. The 'Safeguarding Adults at Risk and Children Committee' now directly reports to the 'Trust Board'. This has been a very constructive move and has resulted in improved scrutiny, quality, and assurance of the importance of that safeguarding.

Multi-agency working

8.5.36 Multi-disciplinary and multi-agency working is fundamental to both Children and Adults Safeguarding Policies, Procedures and Practice Guidance. The duty to report

[37] Safeguarding Children and Young people: Roles and Competences for Healthcare Staff: Intercollegiate Document published by the Royal College of Paediatrics and Child Health: Third edition, March 2014

concerns sits with every individual staff member and volunteer in each and every organisation that is signed up to the policies and procedures in Derbyshire. Staff training, supervision and appraisals reinforce this duty and responsibility.

8.5.37 Once reported, agencies work together through Starting Point, which is Derbyshire's Contact and Referral Service for children. Call Derbyshire operates a single point of access for safeguarding concerns for adults in the county.

8.5.38 The policies and procedures speak for themselves in terms of processes and the sub groups of the Safeguarding Children and Adult Boards provide scrutiny and assurance of practice in the partner organisations.

Markers of Good Practice & Section 11 Audit/Safeguarding Assurance process

8.5.39 'The Markers of Good Practice' Assurance Framework that has been undertaken over previous years has shown Derbyshire Healthcare NHS Foundation Trust continued commitment to safeguarding children and adults and how the organisation has provided assurance to meet the seven areas of compliance successfully.

8.5.40 The Section 11 assurance document 2015/2016 and previous year's assurance framework has been presented to the 'Adults at Risk and Children's Safeguarding Committee' and the Trust Board and the results of the frontline audit the 'Traffic Light Summary' completed by the Clinical Commissioning Group. There were no challenges, as a result of the last Quality Visit; an action plan has been developed and all the recommendations were completed.

Promotion of good practice

Training framework and the training framework policy

8.5.41 Derbyshire Healthcare NHS Foundation Trust set out a structure for all staff to undertake learning and development for compulsory and role specific training through the Training framework and the training framework policy. This was ratified in 2016.

8.5.42 It is intended to provide clarity for planning, implementing, monitoring compliance as well as the development of Trust staff. The Trust aim to work in line with the Skills for Health UK Core Skills Training Framework to ensure that training adheres (where applicable) in core subjects to minimum national standards.

8.5.43 The Learning & Development team are responsible for overseeing compulsory and role specific training. It works in partnership with the Children & Adult Safeguarding Boards to provide a blend of agency specific and multi-agency training within the annual training framework.

8.5.44 As an example of mandatory training, Derbyshire Healthcare NHS Foundation Trust requires all new Healthcare Support Workers to complete The Care Certificate as part

of a common induction process. The Care Certificate is an outcome from the Francis Report[38] and has been a national requirement since April 2015 and includes safeguarding. Its purpose is to ensure that health and social care support workers in clinical roles have the required values, behaviours, competencies and skills to provide high quality compassionate care.

Use of Physical Interventions / Restraint

8.5.45 Derbyshire Healthcare NHS Foundation Trust has updated its Positive and Safe Strategy to align with the Mental Health Act Code of Practice.

8.5.46 This policy takes account of the Department of Health guidance, health and safety legislation, guidance from the NHS Security Management Service, and follows the template of the Health and Safety Executive HSG65. It has been revised to ensure policy and practice meets the requirements of the Mental Health Act 1983: Code of Practice.

8.5.47 The policy outlines the operational aspects of the Trust's Positive and Safe Strategy in line with the MHA Code of Practice and should be followed in conjunction with the Trust's Safety Needs Assessment and Management of Safety Needs Policy and Procedure/clinical risk policies, which address the assessment and management of risk factors for individual clients.

8.5.48 The Trust's Positive and Safe Strategy details its restrictive intervention reduction programmes. This policy encompasses six key principles:

- Complying with the European Convention on Human Rights.
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- Involving people, their families, carers and advocates in decisions about their care wherever practicable and subject to the person's wishes and confidentiality obligations.
- Treating people with compassion, dignity and kindness
- Supporting people to balance safety from harm and freedom of choice.
- Protecting and preserving positive relationships between the people who deliver services and the people they support.

[38] Freedom to Speak Up - an independent review into creating an open and honest reporting culture: Sir Robert Francis QC: February 2015

Child and Adolescent Mental Health Services

8.5.49 Derbyshire Healthcare NHS Foundation Trust provides Child and Adolescent Mental Health Services across Derby and South Derbyshire, the service received an outstanding rating in the Trust's 2016 Care Quality Commission. Derbyshire Healthcare NHS Foundation Trust is not commissioned to provide inpatient Child and Adolescent Mental Health Services beds.

8.5.50 Southern Derbyshire and City Child and Adolescent Mental Health Services are within their 6th year of 'Children and Young People - Improving Access to Psychological Therapies'. This is a service transformation that embeds evidenced based therapy, participation, supervision and the use of clinically relevant outcome measures at the heart of clinical practice. This is in line with the current NICE and best practice guidance. Over the last six years, Derbyshire Healthcare NHS Foundation Trust have trained over 20 percent of its work force and have trained 30+ members of staff within its partner agencies in evidenced based therapies, some to the position of therapist.

8.5.51 The Trust's use of outcomes measures, which are electronically recorded and submitted to the Department of Health, show the consistent use of clinically based outcome measures and show consistent improvement within session by session ratings with children and young people.

8.5.52 Derbyshire Healthcare NHS Foundation Trust has recently moved to a new service delivery model which is a clinically-led service, promoting care-coordination as the 'therapeutic glue' for which all other interventions are integrated with. Care-coordination sits within a competency framework that ensures safeguarding at all levels of intervention. This is further ensured by on-going reviews at session 5 and 10 by the clinical pathways leads and the senior MDT.

Child and Adolescent Mental Health Services Service provision for children and young people with behavioural difficulties

8.5.53 Children and young people with behavioural issues need a detailed assessment; behaviours can represent many things, however namely it is a form of communication that the child or young person cannot articulate verbally. Child and Adolescent Mental Health Services and Children's Services have a Single Point of Access referral system within the Derby City and Southern Derbyshire. This enables all Derbyshire Healthcare NHS Foundation Trust specialist teams and professionals to come together on a weekly basis to discuss the appropriateness of referrals of the previous week, enabling the most appropriate team to accept the referral for assessment. This reduces the possibility of children and young people being passed around the different agencies before they are offered a service.

8.5.54 As behaviour can present as so many possibilities, it is important that a good understanding of the function of that behaviour can be assessed and the right service offered to them. Behaviour by itself would not necessarily mean direct referral to Child and Adolescent Mental Health Services. However, for children aged 12 years and under the evidence base suggest that for children with behavioural issues, parenting therapy is the first line intervention.

Assessment of capacity and consent

8.5.55 There is more emphasis on placing the child at the centre of care and ensuring that where possible consent is given from the child in all available circumstances, no matter what their age, for all medical interventions – including exploratory research. Research has progressed significantly in developing direct clinical care on many levels. This is supported through training staff in evidenced-based therapies and developing both interpersonal skills within the therapeutic relationship and also the skill set for the interventions. The research governance frameworks in 2018 are highly sensitive and developed compared to the lack of governance systems that the incident took place.

8.5.56 Derbyshire Healthcare NHS Foundation Trust have both a Mental Capacity Policy (Overarching) and a Capacity Manual for Doctors.

8.5.57 With respect to Child and Adolescent Mental Health Services the Trust has several ways in which consent and capacity are assessed and gained from both children and parents. This is documented on both paper and electronic notes. More recently there has been significant improvement in ensuring the collection of consent and ensuring that this is appropriately documented. This would be for a specific intervention, the sharing of information between agencies and the uploading of outcome measures to the department. Further discussions with the child or young person will also be undertaken to ensure that the child's views and/or wishes are understood and facilitated where possible in relation to their care provision.

Chaperoning

8.5.58 Within Derbyshire Healthcare, a Trust-wide Chaperone Policy and Procedure was issued in November 2016. Key principles from this are:

- Patients have a right to a chaperone.
- It is mandatory for healthcare professionals to have a formal chaperone present when performing intimate examinations or procedures.
- No child or young person should be seen or examined without a chaperon being present.

- The need for emergency care will take precedence over the request for and /or the requirement for a chaperone.
- Any concerns about the conduct of healthcare practitioners should be raised immediately.

8.5.59 The policy also covers how adequate information and explanation as to why an intimate examination or procedure is required should be provided in a format that the patient can understand. It also includes other guidance and instruction about how staff are to conduct procedures for intimate care.

8.5.60 Following the abuse committed by Myles Bradbury[39] at Cambridge University Hospital NHS (Addenbrookes) Trust revealed that their Chaperone Policy arrangements were inadequate. This learning was shared across the NHS to enable Trusts to review their polices and make them more robust.

Raising compliments and concerns

8.5.61 In March 2016 Derbyshire Healthcare NHS Foundation Trust issued the Policy and Procedure for Handling Patient Feedback 2016-2019 – The 4 Cs: Comments, Concerns, Complaints and Compliments.

8.5.62 In the reporting Quarter 3 2017/18 (October, November & December 2017), the main concerns expressed in the complaints received by the Trust related to:

- availability of services/activities
- appointments e.g. delay and cancellations
- abruptness, rudeness & unprofessionalism of staff

Raising Concerns (Whistleblowing)

8.5.63 Derbyshire Healthcare NHS Foundation Trust has policies and procedures in place to support staff to raise concerns regarding a colleague or service.

8.5.64 The Trust developed its first whistleblowing policy in 2007. Since then, there has been increased national profile of whistleblowing in the Health and Social Care sector; the Freedom to Speak Up report[40] and its associated recommendations have heightened awareness amongst workers of the need to raise workplace concerns. In May 2015 the Trust issued its 'Raising Concerns at Work ("Whistleblowing") Policy and Procedures'. Furthermore, organisations have acted to support the workforce to raise

[39] Independent investigation into governance arrangements in the paediatric haematology and oncology service at Cambridge University Hospitals NHS Foundation Trust following the Myles Bradbury case: Lucy Scott-Moncrieff & Barry Morris: October, 2015

[40] Freedom to Speak Up - an independent review into creating an open and honest reporting culture: Sir Robert Francis QC: February 2015

concerns ("whistleblowing"), and to effectively address concerns raised by support service users, family, and carers.

8.5.65 The Trust has several processes in place to facilitate the reporting of concerns by staff, service users, families, and members of the public; these are scrutinised by the Health Regulator during inspections.

8.5.66 From 1 January 2018 to the date of this report there have been four whistleblowing concerns, one of which pertains to Child and Adolescent Mental Health Services, reported under the Public Interest Disclosure Act (1998) regulations.

8.6 Other healthcare providers

8.6.1 The national drive for patient safety has strengthened the culture and emphasis within health organisations, to provide a safe environment for patients. This has been reinforced by, for example the Care Quality Commission inspectorate, the Lampard report[41], events at Mid Staffordshire and the subsequent Francis report[42] and a number of other high profile reports. There is a much greater focus on transparency within health providers.

8.6.2 From 1st April 2015, all registered providers of both NHS and Independent Healthcare bodies, as well as providers of social care ,have been required to have regard to a Duty of Candour, in accordance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to be open with patients and to apologise when things go wrong, fostering a culture of openness and transparency.

8.6.3 No single professional (including doctors) has the autonomy and power that was previously invested in doctors. Care is now multidisciplinary in nature and staff are empowered and encouraged to challenge where they have a concern about practice.

8.6.4 All NHS Trusts are required to have whistle blowing policy in place, which provides clarity about how to do this if staff are uncertain.

8.6.5 Since October 2016, the standard NHS contract requires all NHS Trusts to have a Freedom to Speak Up Guardian following the Francis report[43]. Their remit is to lead culture change within NHS organisations so that speaking up becomes business as usual; an independent National Guardian's office provides advice, support and guidance to Guardians across the country.

[41] Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile: Independent report for the Secretary of State for Health: Lampard K & Marsden E, February 2015:

[42] Freedom to Speak Up - an independent review into creating an open and honest reporting culture: Sir Robert Francis QC: February 2015

[43] Freedom to Speak Up - an independent review into creating an open and honest reporting culture: Sir Robert Francis QC: February 2015

8.6.6. Many Health Trusts recognise the need for innovation and the introduction of new techniques and procedures is a vital part of practice to improve patient care and enhance the patient experience – but Trusts balance this with the corporate responsibility for ensuring the safety of patients by having a policy about the introduction of such techniques and procedures to ensure that they are safe, appropriate and effective and that all staff undertaking or involved in the procedure are trained.

8.6.7 Medicines Management Policy and oversight of prescribing by pharmacists within organisations supports safe prescribing of medicines.

8.6.8 Increased public and professional awareness of abuse and an emphasis on listening to patients has enabled a culture where patients feel more able to raise concerns about professional practice.

8.6.9 All Trusts have a Patient Advice and Liaison Service (PALS) to provide advice and support for patients, including those who have a concern or complaint. Trusts are required to have readily accessible complaints procedures and to listen and respond to patients concerns. If patients are unsatisfied with the response, they have recourse to other avenues for complaint, for example the health ombudsman or the General Medical Council.

8.6.10 Informed consent processes have been greatly strengthened, with health professionals being required to explain procedures and risks in great detail to patients and or carers.

8.6.11 Research is overseen by Clinical Research Networks. All projects have to go through a rigorous and detailed process of ethics approval. International ethical, scientific and practical standards in research have been developed (Good Clinical Practice (GCP)) to which all clinical research is conducted. Compliance with GCP provides public assurance that the rights, safety and wellbeing of research participants are protected and that research data are reliable.

8.6.12 General Medical Council guidance on chaperoning was introduced in 2013 and Trusts are expected to have a chaperone policy in place.

8.6.13 Working Together guidance requires all health providers to have a Named Nurse and Doctor and, if they provide midwifery services, a Named Midwife for safeguarding children, whose role is to support organisational leadership, governance and training and to advise organisations and the staff within them on safeguarding matters. In the community, Named GPs support primary care in a similar manner.

8.6.14 The Intercollegiate document “Safeguarding Roles and Responsibilities for Healthcare Staff” 2014 covers both clinical and non-clinical staff and makes clear recommendations for training against which all organisations are monitored.

Assurance

8.6.15 Assurance with regards to the above points have been provided in other sections of this report – for example, within individual organisations own governance arrangements, through commissioning arrangements and contracts, through quality assurance mechanisms, including Markers of Good Practice, Section 11 audits, Peer Review audits and CQC inspections.

8.7 Derbyshire County Council Adult Social Care

Social Care Safeguarding Responsibilities.

8.7.1 Adult care's responsibilities to Safeguarding vulnerable people has been evolving over many years since the publication of 'No Secrets[44]' in 2000, when the Department of Health published the guidance for local authorities and relevant partners.

8.7.2 'No Secrets[45]' did not give local authorities a legal framework in which to work like that of Children's Services, but shared policy and procedures were developed with partners to try to protect the most vulnerable people in Derbyshire, with NHS and police colleagues signed up to work together.

8.7.3 Derbyshire had a shared Adult Protection Board with Derby City for many years involving local partners including the voluntary sector.

Current arrangements

8.7.4 The Adult Care service in the districts is divided into two arms: a provider service and a Prevention and Personalisation Service (Field social workers and assessment teams) reporting to the Service Director. The provision of services is more joined up and co-ordinated as set out below.

8.7.5 There is an agreed Policy and Procedure for 'Transitions' of children into adult care services.

8.7.6 Dialogue between Adult Care and Children's Services senior and middle management teams is now more robust and there is a commitment to work together to improve the lives of local people. Within Adult Care there is a lead senior manager who works directly with his counterpart in Children's Disability Services to discuss the needs of all of Derbyshire's Children in transition. There had previously been a North and South Derbyshire Transitions Board which had worked reasonably well but with changing personnel had ceased to operate. This Board is now being re-instated and early conversations will be had about local children in need of future care and services.

[44] No Secrets: guidance on protecting vulnerable adults in care: Department of Health: March 2000
[45] No Secrets: guidance on protecting vulnerable adults in care: Departmetnt of Health: March 2000

8.7.7 There is an 'episode' (section) within Mosaic, the department's information and recording system for children's social workers to initiate an area adult care response. It is expected that the re-instatement of the Transitions Board will assist and monitor adult and children's social care workers activity to ensure timely transfer of cases. With this monitoring there should be no surprises to adult care when a child is reaching 18 years and needs ongoing assessments and monitoring of care provision.

8.7.8 The Care Act 2014 has established the local authorities' responsibilities for Safeguarding Adults with a legal requirement for Safeguarding Adults Boards to be established. The board must have three statutory partners from the NHS Local Authority and Clinical Commissioning Groups.

8.7.9 The Board has a shared Safeguarding Policy and Procedure with Derby City that reflects the requirements outlined within the Care Act.

8.7.10 In order to receive a Safeguarding response there are clear eligibility criteria set out within S42 of the Care Act. The duties apply to an adult who: -

- Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- Is experiencing, or at risk of, abuse or neglect and;
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect.

8.7.11 With the introduction of the Care Act the response to vulnerable people and the awareness of professionals has increased dramatically and Derbyshire Adult Care referrals has increased by 188% to date.

8.7.12 Nationally following major safeguarding issues with the 'Winterbourne' hospital all local authorities and the NHS are involved in the Transforming Care programmes for assessing and providing local personalised responses to people with a Learning Disability. Derbyshire in conjunction with Derby City have completed the external cohorts but continue with the programme in having a more responsive service to people with a Learning Disability.

8.7.13 Alongside this programme there is also the Learning Disability Mortality Review programme which is a national initiative designed to review all deaths of people with a Learning Disability to examine whether there is evidence that agencies have provided the appropriate level of care and/or agencies have worked together to ensure the individual received the best possible care.

8.7.14 Whilst the eligibility for a safeguarding intervention is clear there is a legal responsibility for the partners within Adult Safeguarding to ensure there is a personalised response and professionals work with people and not 'do' to people. Individuals who have

mental capacity under the terms of the Mental Capacity Act [2005] have the right to refuse to engage with formal services and this can be a tricky area where people suffer from a mental illness or their mental health is variable or questionable at times. It is this group of people which is maybe the more susceptible group for abuse of the nature currently in question.

8.7.15 The Adult Care services in Derbyshire have the structure and frameworks in place to be able to respond to the needs of vulnerable people with a professional personal centred focus.

8.7.16 Senior managers within both children and adult social care are working more closely together in developing a strategic response to the needs of young people.

8.7.17 The two Safeguarding Boards Independent Chairs and Board Managers meet bi-annually to discuss the interface between Children and Adult responsibilities

8.7.18 The major challenge for both departments is to continue working with front line staff to ensure the transitions protocol is responded to and all staff remain alert to the safeguarding needs of all local people.

9 Derbyshire Safeguarding Children Board

9.1.1 All agencies involved in this assurance review confirmed their commitment to and engagement in the Board and its work. They described how the Board has robust multi-agency policies and procedures that clearly set out the role of each agency and how they should work together to: identify children who may be at risk of abuse and neglect; investigate concerns, allegations, and disclosures; make decisions and effectively plan to protect children and review such plans. The procedures are applicable and implemented wherever there is concern that a child is at risk of or has been abused, irrespective of the source of the information or the role, position and standing of the alleged perpetrator.

9.1.2 Derbyshire Safeguarding Children Board is a statutory body, established in accordance with the Children Act 2004 and Working Together to Safeguard Children 2010[46].

9.1.3 Its role is to co-ordinate and monitor the effectiveness of the safeguarding work of agencies and bodies represented on the board.

9.1.4 The Board includes representatives from a wide range of statutory, public and third sector/voluntary organisations. See http://www.derbyshirescb.org.uk.

9.1.5 The Board's aim is to work together to protect children and young people from harm, abuse, and neglect.

[46] Working Together to Safeguard Children (HM Government, 2010)

9.1.6 *'Working Together to Safeguard Children 2015*[47]*'* contains more information about the Board's range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.

9.1.7 The role of the Board is to co-ordinate what is done by each agency represented on the board for the purpose of safeguarding and promoting the welfare of children in the area and to ensure the effectiveness of what is done by such agency for those purposes.

9.1.8 Summary of functions:

- developing policies and procedures for safeguarding and promoting the welfare of children and young people.
- ensuring all organisations are aware of their responsibilities to safeguard and promote the welfare of children.
- monitor the work of board partners to keep children safe and advise on ways to improve.
- be involved in the planning of services for children.
- undertake serious case reviews to advise board members of lessons to be learned.
- provision of training programmes for persons who work with children or in services affecting the safety and welfare of children.

9.1.9. Of particular relevance is the Derbyshire and Derby City Strategy for management of survivors of non-recent abuse in childhood 2018 and the Derbyshire and Derby City Practice Guidance for management of survivors of non-recent abuse in childhood.

9.1.9 The Board is chaired by an Independent Chair, Steve Atkinson.

9.1.10 The Children and Social Work Act 2017 requires changes in the local arrangements for ensuring effective safeguarding of children. Revised National Guidance - Working Together 2018 - was issued early in July 2018 and this will form the framework for the future.

9.1.11 It will be vital that whatever local arrangements replace the existing statutory Board ensure that the current policies, procedures and practices are maintained, at minimum, and that the recommendations in this report are fully implemented.

10 Conclusions

10.1 Derbyshire Safeguarding Children Board and the Gold Command Group, originally chaired by Jim Connelly, Hardwick Clinical Commissioning Group, then Chris Cook and currently by Steve Atkinson, the former and current Independent Chair of

[47] Working Together to Safeguard Children(HM Government, 2015)

Derbyshire Safeguarding Children Board, accept that allegations of abuse described by those people who lived at Aston Hall during their childhoods and, as adults, have shared their concerns, are genuine.

10.2 This report is not an investigation into what took place, it is an assurance report as to the current safeguarding arrangements in place in relevant organisations in Derbyshire, but it is appropriate to include some of the reasons why the abuse could have taken place.

10.3 Our society's view of children and their care has changed. Children being 'seen but not heard', 'Sparing the rod and spoiling the child' have not been widely accepted for some time, though some people do retain these views and it was only in 1986 and 1998 that corporal punishment (caning) was made illegal in state and independent schools respectively.

10.4 Children's behavioural difficulties were not understood in terms of the reasons for it. Instead it was seen as deliberate and wilful and the symptoms, rather than the causes, treated.

10.5 Sex was less talked about and even today, as the Interim Report of the National Inquiry into Child Sexual Abuse[48], April 2018, chaired by Professor Alexis Jay, says. *"Child sexual abuse is talked about and understood in different ways. Groups in society – including professionals working with children, the media, the law and in Government – have different ways of thinking about child sexual abuse. Their views are informed by their own experiences and perspectives and the debates that take place about child sexual abuse. These ways of thinking include how and why child sexual abuse takes place, who perpetrates child sexual abuse, and what effect child sexual abuse has on victims and survivors. In turn, these ways of thinking influence how people respond to child sexual abuse, including how to prevent it. It also has a direct impact on the responses institutions have to child sexual abuse."*

10.6 Children's rights as a concept was not recognised and even today the above Inquiry has noted that '*the UK Government is still to ratify the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse128[49] (also known as the 'Lanzarote Convention') that it signed in 2008. The UK is one of 42 countries that signed the Convention but is now one of only five signatory countries still to ratify it.*

10.7 *The Lanzarote Convention[50] sets out the wide range of measures that must be in place to protect children from sexual abuse. These include: introducing preventive measures*

[48] Interim Report: A Summary: Independent Inquiry into Child Sexual Abuse, (Jay A, April 2018)
[49] Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse 2007
[50] Ibid

(such as the screening, recruitment and training of people working with children, and making children aware of the risks of child sexual abuse); establishing programmes to support victims and survivors, encourage the reporting of suspected child sexual abuse, and set up telephone and internet helplines for children.'

10.8 Perpetrators in professions or positions of trust may use their authority and position to create opportunities to be alone with children and to shield themselves from suspicion.

10.9 They know that their reputation and authority can be used as a shield to deflect and discredit accusations if concerns are raised.

10.10 Dr Milner was a respected experienced consultant psychiatrist. He had great power, control and influence at Aston Hall and his methods and instructions went unchallenged as far as can be ascertained. There is evidence in papers written by Dr Milner of his working practices which would indicate that his records were not always maintained.

10.11 The difficulty of challenging such people of power and influence has only become better understood in recent years for example in relation to Jimmy Savile known as a children's entertainer and for his charitable work.

10.12 As the National Inquiry into Child Sexual Abuse[51] states *'In recent years, a significant number of NHS organisations have been investigated following incidents of child sexual abuse. Most notably, a series of reports found that the famous media personality, Jimmy Savile, had sexually abused adults and children over many years in NHS hospitals and, in 2014, Dr Myles Bradbury was convicted of sexual offences against children who were his patients. The Inquiry was told that education and training tend to focus on equipping healthcare workers to recognise signs of abuse and neglect in the children they treat. Respondents to the request for written submissions and seminar participants suggested that training should be improved to help workers detect and respond to child sexual abuse that takes place within healthcare services, including child sexual abuse by colleagues. Written submissions covered the responsibilities of healthcare workers to take action when they are concerned that a child is being sexually abused or is at risk of sexual abuse. It was suggested that various factors may prevent workers from raising concerns or reporting sexual abuse. These included an unwillingness to challenge the actions of senior workers and fears of an unsupportive response from managers and colleagues. These factors were also cited during seminar discussions about barriers that might prevent workers from raising concerns.*

[51] Interim Report: A Summary: Independent Inquiry into Child Sexual Abuse, (Jay A, April 2018)

10.13 *The Inquiry sought information in writing from around 50 health sector organisations about the measures that are in place to prevent child sexual abuse within healthcare settings, such as hospitals, GP practices and clinics. The issues raised in written submissions were subsequently discussed at a two-day seminar that took place in September 2017. Views were drawn from England and Wales to ensure that discussions recognised the structural differences between the health sectors in both countries. Responsibility for healthcare in England and Wales England The Department of Health and Social Care is responsible for health and adult social care policy and legislation in England. The Department is supported by 28 agencies and public bodies, including NHS England, which leads the NHS in England. Wales The Welsh Government's Department of Health and Social Services is responsible for health and social services policy and legislation in Wales. The NHS in Wales delivers services through seven local health boards and three NHS Trusts. The written submissions raised several issues about how current arrangements to protect children from sexual abuse within healthcare services could be improved.'*

10.14 There were few checks and balances, regulatory bodies, external scrutiny or inspection or reflective organisational practice. Given a reluctance to accept that children could be abused outside their family and in an institution that was staffed by experts who knew how to care for children this is, sadly, unsurprising and is reflective of a time when abuse of this nature was poorly understood

10.15 The importance of sharing information about concerns was not understood or practiced, and even today lack of so doing is one of the most common findings of serious case reviews.

10.16 Health regulators would not have existed at the time of Dr Milner's tenure and the culture of health regulation was not as robust as it is today, nor did it enable practitioners to challenge where a health professional may have harmed a child.

10.17 In 2018, as detailed above, there are several mechanisms and governance arrangements which, should a health professional be alleged to have harmed a child, facilitate robust scrutiny, and provide disclosure opportunities to enable prompt and timely action.

Could such abuse take place again?

10.18 The Inquiry mentioned above looked at 211 public reviews and reports about child abuse, containing 3,004 recommendations. This demonstrated that the recommendations in order of prevalence were:

- Staffing (including practice, supervision and recruitment) 826 recommendations (27.5%).

- Records management systems and processes (including information sharing) 501 (16.7%).
- Failures, issues and attitudes in working or supporting children and/or victims and survivors 413 recommendations (13.7%).
- Leadership and oversight 396 recommendations (13.2%).
- Inter-agency working 318 recommendations (10.6%).
- Other recommendations (including operational policy and procedure, and complaints) 55 recommendations (18.3%).

10.19 The information provided to the Derbyshire Safeguarding Children Board's assurance review and contained in this report, evidences consistent improvement and a willingness to continue to improve, in all the aspects of safeguarding listed above.

10.20 All relevant organisations in Derbyshire are compliant with statutory and other national guidance and standards, they have safe structures, they have learned and continue to learn from national, local, and internal reviews and serious incidents; they are externally inspected and implement the recommendations and learning from these and most importantly they are committed to ensure that as far as possible nothing like the abuse at Aston Hall, described in this report happens again.

10.21 They have policies and practice, which are commensurate with Derbyshire Safeguarding Children Board's inter-agency procedures that together help to keep children safe from abuse.

10.22 There is evidence that national and local learning has informed this improvement, that there is external and internal scrutiny, clear senior management accountabilities, policies and procedures, safe recruitment, supervision, professional training, and the means by which challenge, concerns and complaints can be raised by service users and staff.

10.23 The information provided to the review evidences that organisations operated in accordance with the knowledge, understanding, practice and arrangements in existence at the time. These would not be acceptable today.

10.24 The assurance review is unable to establish whether Dr Milner had had any previous allegations made about his practice in other institutions, as there is no existing organisation that was his employer, and governance at that time was not as rigorous as it is today. Assurances can be given that robust processes are in place in 2018 and these have been reviewed by Health regulators

10.25 I appreciate that those people who suffered abuse at Aston Hall may be understandably sceptical that improvements are embedded, their trust in those who were responsible for them was shattered many years ago. However, I hope they can

take a modicum of comfort from this report and the evident commitment of people working in safeguarding in Derbyshire today.

10.26 It would be unwise, inappropriate, and incorrect to state categorically that child sexual abuse could not happen in our society today, perpetrators will always strive to have unfettered access to children. A significant risk to safeguarding and protecting children is a complacent view that there is no more to be done. Organisations must continue to think the unthinkable, suspend their disbelief and continue to improve processes and systems and inter-agency working, the information contained in this report gives significant confidence that organisations in Derbyshire will continue to do so.

11 Recommended Measures for Ongoing Assurance

11.1 Central to this report is the finding that children and young people in Derbyshire can be confident that, if similar circumstances were to recur, they and others have a clear and transparent route for them to raise concerns, that their concerns would be taken seriously and acted upon vigorously. However, the issues raised and addressed in this report, and the recommended measures below, have relevance and application to safeguarding agencies across the country. and should be widely circulated for their use. Accordingly, it is recommended that Derbyshire Safeguarding Board should both oversee the local implementation of the ongoing measures (below), but also disseminate and share the learning and Assurance measures with Boards and agencies across the country Derbyshire Partner Agencies should consider learning from the individuals affected by this case and give feedback on how Derbyshire Safeguarding Children Board can learn from their experiences and improve practice.

11.2 Derbyshire Safeguarding Children Board should:

1. Disseminate the learning from this assurance report.
2. Consider the findings of the Interim Report of the National Inquiry into Child Sexual Abuse[52] to ensure their policies and procedures reflect the recommendations of the review.
3. Review the NHS England requirements 'Strategic Direction for Sexual Assault Services and Abuse services: Lifelong care for victims and survivors for 2018 -2023[53] and ensure that local arrangements taken into account the new requirements.

[52] Interim Report: A Summary: Independent Inquiry into Child Sexual Abuse, (Jay A, April 2018)
[53] Strategic direction for sexual assault and abuse services - Lifelong care for victims and survivors: 2018 – 2023, NHS England April, 2018

4. Continue to raise awareness within all organisations in relation to escalation, whistle-blowing and complaints procedures, within staff induction and training and assure itself that staff are confident in using them.
5. Review the policies and guidance to which practitioners are expected to adhere when they are in legitimate one to one interactions with children, to ensure that the safety of the child is paramount.
6. Derbyshire Safeguarding Children Board, through its agencies, should explore and develop all opportunities to support and amplify the voice of the child, enabling them to speak out and be heard in relation to potential and actual abuse against them.
7. Review all policies which relate to managing historical allegations so that, in all cases, a risk-based review is undertaken about known factors in situations where the alleged perpetrator is deceased, to determine the best course of action, including convening a gold, silver or bronze group where appropriate.
8. Where reports of historical offences are reported where the offender is deceased, appropriate sharing of information between police forces should ensure that any potential wider safeguarding implications are addressed.
9. The three main local partners as defined by Working Together 2018 – Derbyshire County Council, Derbyshire Constabulary and Derbyshire Clinical Commissioning Groups - must ensure that any local arrangements for the oversight and coordination of safeguarding activity, implemented to replace existing statutory arrangements, in response to the Children and Social Work Act 2017 maintain a strong focus on developing and working to effective policies, procedures and practices.
10. In order to inform national knowledge and policy, Derbyshire Safeguarding Children Board should share this report with the Department for Education and other relevant bodies and recommend that the assurance measures contained within it are shared across the country.

Appendix 1

Roles and responsibilities of agencies involved in the review

Children's Social Care

Derbyshire Children's Social Care services are made up of an integrated structure for Early Help and Safeguarding which has been in place since 2015. Services are delivered via 25 Multi-Agency Teams (MATs) and 26 Social Care teams, organised within the 6 geographical localities and a specialist service for disabled children. The service provides support to families across the spectrum of need from early help, child in need, child in need of protection, children in care and aftercare in accordance with the duties outlined the Children Act 1989 and 2004 amended in the Children and Social Work Act 2017.

Partnership working is key to the delivery of good outcomes for children and the recently published Working Together 2018 strengthens the relationship between the key partners of Health, Police and Social Care to ensure the welfare of children remains of paramount concern. Derbyshire is undertaking a review of the Local Safeguarding Board arrangements to respond to this key change.

Children's services have a framework of audit activity and external scrutiny through OFSTED inspection providing robust monitoring and quality assurance. There is robust leadership which seeks to strengthen and improve services in the best interests of children and young people in Derbyshire. The learning from this review has afforded additional opportunity to rereinforce our partnership working in particular around transitional arrangements for children moving to adulthood.

Adult Social Care

In 2010 the Adult care department undertook a radical review where it was recognised as part of that review that by having specialist divisions within Adult care there were significant numbers of vulnerable people including young people who were not receiving services from social care because of the need for people to fall within the 'silos' that had been created.

In 2010 the Adult Care department became a generic adult care service, bringing together the previously specialist teams into one service. The learning from this in relation to the context of this report was that there was significant work to be undertaken with the Local Authority's

response to those children who were transitioning from Children Services to Adult Care Services.

The Adult Care service in the Districts is divided into two arms a provider service and a Prevention and Personalisation Service [Field social workers and assessment teams] reporting to the Service Director. The provision of services is more joined up and co-ordinated as above.

There is an agreed Policy and Procedure for 'Transitions' of children into adult care services

Derbyshire Constabulary

Protecting the most vulnerable is threaded throughout the strategic priorities of the Derbyshire Police and Crime Commissioners, Police and Crime Plan. It also stands firm within Derbyshire Constabulary's commitment. Children and young people can become vulnerable through a range of situations.

Safeguarding children is described by the government as "the action taken to promote the welfare of children and protect them from harms and is everyone's responsibility". It is clearly defined within Working Together to Safeguard Children 2015 and Derbyshire Constabulary works with statutory and non-statutory partners to ensure children are kept safe.

Child Abuse investigations both recent and non-recent cover a range of offences. By their very nature they are complex enquiries requiring an active multi-agency investigation, utilising specialist skills from across all agencies. Derbyshire Constabulary is committed to multi-agency working and has strong well established relationship with all partners.

Derbyshire Clinical Commissioning Groups (Clinical Commissioning Groups)

Changing structure of the Clinical Commissioning Groups

Derbyshire Clinical Commissioning Groups are in the process of change across the Derby City and Derbyshire footprint. The current position is that there are four Clinical Commissioning Group's (North Derbyshire Clinical Commissioning Group, Hardwick Clinical Commissioning Group, Erewash Clinical Commissioning Group and Southern Derbyshire Clinical Commissioning Group) which have statutory functions and arrangements whilst moving towards a more integrated approach with one strategic management structure providing the overall leadership.

The Clinical Commissioning Groups are made up of a number of personnel including GPs, nurses, safeguarding professionals, commissioners, contractors, accountants, project

managers, pharmacists, managers and administrators. There are approximately 388 staff across the four Clinical Commissioning Groups and a number of lay representatives and GPs doing sessional work in specialist areas on behalf of the Clinical Commissioning Groups.

The four Derbyshire Clinical Commissioning Groups came into existence in 2014 following the deregulation of the Derby & Derbyshire Primary Care Trusts (PCT). Prior to this there were two PCTs one for the City and one for Derbyshire. Historically, in the early 2000s there had been six Community Primary Care Trusts who were co-terminus with the Local Authorities. At this stage the county was split North and South with a focus around the two lead NHS Providers of Chesterfield Royal Hospital and Derby Teaching Hospitals.

There has been a Designated Doctor and Nurse for Safeguarding Children to advise and support Health Trusts since the Children Act 1989. The role was originally based in a community provider Trust until 2008 when it moved to a commissioning role within the PCT.

The Head of Safeguarding Adults role also came into the PCT in 2008 following recommendations from “No Secrets” guidance.

The Designated Nurse for looked after children role was established in 2015, prior to this the role had been located with the Designated Nurse for Safeguarding Children since 2011. There has been a Designated Doctor of Looked afer Children since 2008 following statutory guidance on promoting the health of Looked after Children.

The Clinical Commissioning Groups cover the Derby City and Derbyshire footprint excluding Glossop who are part of the Health economy of Tameside and Glossop Clinical Commissioning Group. Derbyshire as a whole is made up of rural and urban areas which present both a mixed social economy and cultural diversity. The Clinical Commissioning Groups has a total population of 1,050,000 and a child population of 165,000. Budgetary constraints are in place as is the case with the whole NHS system.

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust is a specialist provider of children’s, learning disability, substance misuse and mental health services – across community, inpatient and specialist settings. The Trust employs over 2,400 staff based in over 60 locations across Derby and Derbyshire.