Derbyshire
Safeguarding Children
Board

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

Executive Summary

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1. Executive Summary

1.1 Introduction

1.1.1. 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.

1.1.2. 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.

1.1.3. The assurance process which informs this report utilises the review methodology from Her Majesty's Government's "Working Together to Safeguard Children 2015" (Working Together). 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 Derbyshire Safeguarding Children 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.

1.1.4. Whilst the trauma and long-term impact of such abuse 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.

1.1.5 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.

1.2. Conclusion

1.2.1. 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 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.

1.2.2. 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.

1.2.3. 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.

1.2.4. 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, were treated.

1.2.5. 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.

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

1.2.7. 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.

1.2.8. 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.

1.2.9. 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.

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

1.2.11. 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.

1.2.12. In 2018, as detailed above, there now 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.

How would agencies respond now?

1.2.13. 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 aspects of safeguarding

1.2.14. All relevant organisations in Derbyshire are compliant with statutory and 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.

1.2.15. 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.

1.2.16. 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 means by which challenge, concerns and complaints can be raised by service users and staff.

1.2.17. 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.

1.2.18. 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.

1.2.19. 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.

1.2.20. 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.

1.3. Recommended measures for ongoing assurance

1.3.1 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 Children 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.

1.3.2 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 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 and ensure that local arrangements taken into account the new requirements.
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.