1 Wednesday, 23 March 2022
2 (10.00 am)
3 Round-table discussion
4 MR MACAULAY: Good morning to you all, welcome back to this
5 round-table. We have four discrete topics on our agenda
6 for today and I'm reasonably confident that we will be
7 able to explore them and deal with them in the course of
8 the day.
9 The first topic that we're looking at is headed
10 "Victims and attachment", and that's attachment to
11 abusers. That's an unhealthy form of attachment as
12 opposed to safe attachment.
13 The first limb of the question that you were asked
14 to ask is why different children within care settings
15 may be treated differently by caregivers, some favoured
16 and well cared for whilst others are abused. That
17 really turns upon how victims for abuse might be
18 selected by prospective abusers.
19 Lorraine, I think you say in your response that
20 abusers can be particularly skilful in selecting their
21 victims. Can you elaborate upon that?
22 DR JOHNSTONE: I think Liz touched on this yesterday as
23 well. Sometimes abusers will select people who perhaps
24 are viewed as not particularly credible or reliable, so
25 they tell lots of stories. Children with disorganised

1 attachment disorders, for example, often struggle to
2 tell the difference between fact and fiction, sometimes
3 their accounts can be challenged and questioned.
4 That gives an opportunity for someone to disbelieve
5 or select a victim that will be disbelieved.
6 Other children and young people just cannot give
7 a coherent account. The prevalence of undiagnosed
8 neuro-developmental disorders and communication
9 disorders, language disorders, all sorts of cognitive
10 impairment is exceptionally high in looked-after and
11 accommodated children, so even just the ability to
12 provide a consistent narrative is difficult.
13 But there are also issues in attunement, so
14 perpetrators and children can become connected to each
15 other in different ways because they meet each other's
16 needs and they can form an attachment, you know, with,
17 for example, a girl who has not had nurture or love or
18 attention or kudos before and that need is met and that
19 need supersedes every other need, including to be safe.
20 Again, just reiterating I think the themes, that
21 there are lots and lots of different victim groups'
22 vulnerabilities and for whatever reasons, deliberate or
23 subconscious, dynamics can evolve and connect victims
24 with their perpetrators.
25 MR MACAULAY: Morag, you also mentioned the way that

1 an abuser engages in careful selection of their targets.
2 Can you elaborate upon that?
3 MS SLESSER: Yes, I think from my experience of working with
4 abusers, it's not incidental who they choose.
5 MR MACAULAY: No.
6 MS SLESSER: I can give a case of a man who basically became
7 the -- he lived in quite a poor place and he basically
8 became the babysitter for the community and the
9 children -- you know, the parents were really relieved
10 to have a bit of space and so he was -- I don't know why
11 he ended up in that community, but that was useful for
12 him and that's how he chose his victims.
13 I think in care situations what I've heard is that
14 the children who are more vulnerable, who are less
15 popular, who are shy, not good at speaking out, who
16 don't have anyone coming to visit them, you know, those
17 kind of situations make them more vulnerable.
18 MR MACAULAY: You mentioned not having visitors. Are
19 children who lack that sort of support then more
20 vulnerable to abuse?
21 MS SLESSER: It depends on their personality, I suppose, but
22 if they have nobody they can tell, I suppose that
23 makes -- or they have no frames of reference, I think
24 that would make it harder, but I'm talking -- my
25 experience is adults, either adults who abuse or adults

1 who have talked to me about that situation and it's
2 difficult to know exactly what they were like as
3 children. But they sound vulnerable children to me.
4 MR MACAULAY: Michele, you do focus on those children in
5 care who either have no external or internal support as
6 being potential targets for abuse.
7 MS GILLULEY: Yes. I would say generally children, unlike
8 many of us sitting around the tables today, don't
9 understand the characteristics of people who may make
10 them more vulnerable, who may abuse them, and children
11 don't know who to turn to, and when somebody does show
12 them what may be perceived as love and care and
13 affection that they've maybe not had in a family or home
14 environment, that they do begin to trust that person and
15 they may go to that person for that support and become
16 more vulnerable, because they don't understand the
17 characteristics of somebody who can cause them harm.
18 MR MACAULAY: Stuart, you broaden this, I think, because you
19 say this isn't unique to organisational settings and you
20 also focus on it happens within families and among
21 siblings. Can you just elaborate upon that?
22 MR ALLARDYCE: The point I was making was that when we think
23 about interfamilial abuse, what we will often find is
24 that not all children are abused in the same way, and
25 indeed there may be some children who are abused and

1 other children who are not. I was saying that I was
2 involved with writing a report recently around sibling
3 sexual abuse and what evidence we have around child
4 protection and safeguarding of when sibling sexual abuse
5 takes place, which is actually the most common form of
6 interfamilial sexual abuse, shockingly enough. You
7 know, often what happens is you'll have an adolescent
8 who sexually abuses one younger child in the family but
9 not necessarily others, although sometimes they will
10 abuse more than one victim.
11 So what's going on there? I think there are
12 a number of kind of dynamics about what's going on in
13 families, about closeness, about intimacy, but actually
14 at the end of the day a lot of it is opportunistic as
15 well. I absolutely take the point that's been made
16 about the kind of careful selection of victims that can
17 take place in organisational settings and I can think of
18 many situations like that, but I think this is what we
19 learn in particular from those who are serial abusers
20 and therefore have built up skills and knowledge in this
21 kind of particular area.
22 I think the first time somebody sexually abuses
23 a child, there often is quite an opportunistic element
24 to that and they're kind of creating a dependency with
25 a child who -- going back to Finkelhor's model about

1 four pre-conditions, who meet that final condition: who
2 will provide the least resistance and will be most
3 easily silenced.
4 It's often kind of -- we kind of think about this as
5 a very kind of planned, concerted kind of strategy on
6 the part of the abuser, but sometimes it can be a bit
7 more unconscious or subconscious and opportunistic in
8 nature.
9 MR MACAULAY: We're going to talk about grooming later and
10 that's more of a process rather than an opportunistic
11 event as you've been describing.
12 MR ALLARDYCE: (Nodded)
13 LADY SMITH: Stuart, what you say certainly fits with
14 evidence I've heard in a number of case studies of
15 I think a young priest who had the opportunity when he
16 was in charge of children camping, it hadn't been
17 created by him. Just one example. There were others of
18 a similar nature and I've heard some of a similar nature
19 just recently in the last case study hearings we were
20 doing, and that fits.
21 These people are operating from a different
22 psychology or psychological process, are they, from the
23 ones who plan?
24 MR ALLARDYCE: Well, if you look at the emerging literature
25 about abuse within organisations, it would suggest that

1 there is a typology and the typology includes those who
2 are preferential, often serial, offenders, and then
3 those who are opportunistic in nature and those who are
4 situationally orientated, so those individuals who --
5 and let's be clear, this is abuse, but will say, "Look,
6 I've never had sexual thoughts about children, but
7 actually just something happened in my life and I had
8 feelings for this particular child", so something that's
9 very contextually specific.
10 The complexity, I think, is that although that
11 typology is useful, those who are serial offenders will
12 usually have started being some of those other kinds of
13 offenders at some stage, not always, but sometimes.
14 LADY SMITH: That makes sense. Thank you.
15 MR MACAULAY: Judi, although I think you do say in your
16 response that you have limited experience of clinical
17 work with victims directly, you do get an insight into
18 why victims become victims from the offenders that
19 you've dealt with. Can you give us some insight into
20 that?
21 DR BOLTON: I think it's building on Stuart's point that you
22 notice with abusers they sort of build up their skills,
23 so there's a refinement of their skills, and actually
24 probably some of the risk to them becomes then
25 complacency and actually that is often at the point of

1 when they get caught.
2 I think it's what Stuart's saying about the
3 refinement of their skills.
4 I would also say that I think, related to what
5 Lorraine said in terms of risk of victims that you gain
6 from abusers, there's something about the -- I suppose
7 in summary the relationships that the children have or
8 the lack of protective relationships, and those
9 relationships are amongst their peers and families or
10 external agencies as well. It's a lack of protection in
11 their interpersonal relationships that probably
12 contributes to their -- I don't think the right word is
13 selection, but that's the only one I can think of.
14 MR MACAULAY: That it's what makes them particularly
15 vulnerable?
16 DR BOLTON: Vulnerable, yes.
17 MR MACAULAY: Liz, do you have any comments to make on this
18 topic? Do you agree or disagree with what's been said?
19 PROFESSOR GILCHRIST: I agree with what's been said.
20 I supervised some research about grooming of children
21 back in the late 1990s and we spoke to victim/survivors
22 of a range of different child sexual abuse, more in the
23 community than in care, but some who were affected by
24 religious leaders. One of the things that sticks in my
25 mind is young people saying that they expected their

1 parents or their carers to know what was happening, and
2 because they didn't have a developed theory of mind, so
3 what was happening to me, my parents would obviously
4 know, even if they weren't present.
5 So being in the room then with their abuser and
6 their parents and their parents not challenging that
7 abuser very much supported the abuser's, "Nobody's going
8 to do anything". It was not even, "Nobody's going to
9 believe you". So they actually were reporting that they
10 had thought, "I must be wrong, because my parents are
11 accepting this, they're not challenging this, they're
12 sending me off to be with this person and supporting me
13 going, so it must be right". So they really got quite
14 confused about what was accepted and what wasn't. That
15 was about trust in authority and trust in a priest and
16 actually the parents not knowing what was happening and
17 not colluding with it but it being portrayed that way by
18 their abuser.
19 That lack of theory of mind and belief that adults
20 knew and that actually because they didn't challenge it
21 was okay then really confused the issue and confirmed
22 their victim status.
23 MR MACAULAY: Can I ask, do children who perhaps have
24 physical disabilities or indeed psychological
25 disabilities, are they almost by definition more

1 vulnerable to be targeted?
2 PROFESSOR GILCHRIST: Yes, sadly across the vulnerabilities
3 in terms of victims again in domestic abuse, family
4 violence and broader victim, you know, those additional
5 physical vulnerabilities where people are more
6 dependent, so they're less -- so they lose more by
7 telling, but they're also more dependent, so they don't
8 actually have physical access to go and talk to people
9 or to get places or to go somewhere means that they are
10 actually less able to report things. Very much more
11 vulnerable, much more easily exploited. You see it in
12 elder adult abuse as well, that those additional
13 vulnerabilities really mean that people are much more in
14 control, they're easier victims, it's much harder to
15 report. Sadly that exploitation also means that to
16 an extent they could be seen as lesser human beings. If
17 you imagine children with Down Syndrome, children with
18 intellectual disabilities, children with physical
19 disabilities who are put somewhere for their own safety
20 and protection and then they're exploited, again
21 sometimes by peers, so within institutions, that lack of
22 ability to manage sexual relationships between, say,
23 teenage children who are being housed together, to look
24 after themselves -- I mean, I'm aware of a relatively
25 recent particular case where a young woman was raped

1 within a care situation by a peer and nobody had done
2 a risk assessment to manage -- nobody had thought about
3 it, really, or they certainly hadn't done good risk
4 assessment.
5 MR MACAULAY: Martin, I've left you here to be tail-end
6 Charlie because I think you're going to give us
7 a different slant on those who may be targeted for
8 abuse, having regard to your experience as the chair of
9 the Independent Review into Sexual Abuse in Scottish
10 Football?
11 MR HENRY: Yes, indeed. As my colleagues were talking
12 there, it resonates very strongly with me that it's very
13 difficult as a society and sometimes professionally to
14 identify exactly what we mean by "vulnerability". There
15 are factors, there are vulnerabilities that are
16 well-documented and researched and these are the kind of
17 fixed ones we've talked about: intellectual
18 disabilities, physical disabilities, social isolation,
19 all of these kind of things.
20 But, of course for all of us as human beings
21 vulnerability is more dynamic than that. We find
22 ourselves vulnerable in different contexts, at different
23 times in our lives, just depending on circumstances and
24 how life is treating us we are more or less vulnerable.
25 No different for children or young people.

1 I think by doing the Football Inquiry our
2 expectation was that what we would normally see would
3 be -- I have to stress this, they were mostly boys who
4 came to us. There were very few girls, because of the
5 nature of the sport at that time. Let's just be clear,
6 it was mostly adult men who were coming, talking to us
7 about their experiences as young men.
8 Our expectation was that what we would see is a lot
9 of men who would describe their childhoods and their
10 adolescence as being where they were lonely, they were
11 down at heel, they were needy, they were isolated,
12 friendless, bullied or whatever. Actually what we found
13 was it wasn't always like that. There were lots of
14 these men who actually when they were adolescents were
15 socially competent, skilled, confident, outgoing young
16 men, unsurprisingly participating in sport, who actually
17 were vulnerable.
18 What we felt what was quite important to get
19 a message across to institutions dealing with
20 adolescence is vulnerability doesn't always look like
21 what you think it's going to look like.
22 The surprise for us was of course, when we stood
23 back, we thought actually it makes sense, because these
24 kind of boys had more to lose by talking about what's
25 happening to them. So the trade-off by the people who

1 were targeting and abusing them was: if you start to
2 tell anything about this, the sorts of aspirations and
3 goals you have in life are at stake. That would be
4 success in a sport which is possibly for some of these
5 young men it has to be said was the most important thing
6 not only in their life but in their family's life, it
7 was about achievement. The trade-off was: I'd better
8 keep quiet about this because that's something that
9 I might have to sacrifice if I start to talk.
10 Actually, to be fair, some of these young men did
11 talk and they did sacrifice their careers in football,
12 so it was actually true.
13 They also have at risk the opinion, reputation,
14 their well standing with their peers. We all know from
15 adolescence that what your peers think about you is
16 actually crucially important.
17 For a lot of young men that was their vulnerability.
18 It wasn't about a sign of weakness. Their vulnerability
19 was almost -- it was the sign of strength that was their
20 vulnerability.
21 The message I would send out to people is be
22 cautious about how you define vulnerability as
23 professionals and start to be more open-minded about how
24 you receive information about how young people are and
25 how they experience their world, because it's sometimes

1 very different to that that we as adults expect but also
2 we as professionals expect.
3 If I can just come on to my final point about it,
4 for many young people who have deficits in their lives
5 and of course many young people do as many of us did as
6 young people, some abusers are very good at identifying
7 what these deficits are and meeting these unmet needs.
8 In other words, constructing a relationship that can
9 meet some of the unmet needs that young people have,
10 whether it's in institutional care or elsewhere.
11 The problem with that is a good relationship that's
12 meeting an unmet need is exactly what we want from
13 adults to do with young people, but for those young
14 people it was a site of risk and dangerousness.
15 To unpick that is quite difficult for colleagues who
16 are working alongside people, who are actually
17 apparently doing a really good job by getting close to
18 young people and constructing good relationships. What
19 they can't actually pick up is that actually it's about
20 something else and not about doing a good job.
21 MR MACAULAY: Yes, Morag?
22 MS SLESSER: I just want to add one thing which resonates
23 when you were speaking is that children in boarding
24 schools and one of my jobs I've had is I saw a lot of
25 people who were coming for psychological therapy and

1 their stories were about having -- being abused, not
2 necessarily sexually but definitely physically and
3 emotionally while they were in boarding schools. That
4 is a care situation and the same thing that you're
5 talking about there just immediately resonated with me
6 because I thought they couldn't say anything because
7 they were at a public school and these were powerful
8 people and also they were at a public school to do well
9 academically and that's what they were getting out of
10 it, so it's a similar situation. I'd forgotten about
11 that group of people.
12 LADY SMITH: Lorraine, I heard a lot of evidence about abuse
13 in boarding schools across a wide range, mainly seven of
14 them, but some others as well, some prep schools.
15 A common theme was the theme of no cliping, you don't
16 tell. That was the culture across the board that
17 I heard again and again and again.
18 Is that part of what was going on in football,
19 Martin, that you just wouldn't tell? You keep it to
20 yourself?
21 MR HENRY: I absolutely think that was going on across the
22 board, but it was particularly the case in football not
23 divulging information that made you a subject of
24 particular interest to your peers was something that
25 kept a lot of these young men quiet for a long time.

1 You know, like this Inquiry, for the Football
2 Inquiry we had exactly the same experience. People were
3 coming to us talking about stuff that happened to them
4 for the first time. This wasn't something that they had
5 been casually sharing with people and then coming to
6 give evidence about. This was, for many of them, their
7 first opportunity to talk through aspects of their
8 growing up that they'd never yielded before, and
9 particularly not to those closest to them, because they
10 thought that what would happen is the people closest to
11 them would suddenly see them differently and see them as
12 damaged or in fact for some parents blame themselves or
13 see themselves as somehow being responsible for allowing
14 this to happen to their kids.
15 There's a whole complexity there that keeps people
16 quiet and I'm sure we'll discuss that as the day goes
17 on.
18 I think peer relationships was a very powerful
19 message to us about young men, how they operate in
20 groups and what's at stake if you start to reveal
21 anything that looks like an unusual experience,
22 a weakness, a fragility or indeed anything that
23 constituted same sex behaviour at that time also carried
24 a huge stigma.
25 LADY SMITH: I can think of one witness in a boarding school

1 set of evidence who was sexually abused his first night
2 in the school by an older boy and other people got to
3 know pretty quickly. They called him "Willingness"
4 after that. He was known as "Will", "Willy",
5 "Willingness", and teachers even called him Willingness.
6 The way he talked, that was one of the hardest things to
7 take of the whole abusive situation.
8 I've heard accounts like that again and again.
9 Allied with that, accounts from people who may be in
10 their 70s talking about the abuse they suffered as
11 children, not just boarding schools, any institutional
12 care, for the first time to us, never having talked to
13 anybody else about it before, some of them not even
14 having told their families they were in care before.
15 I'm sure Colin remembers some people in that situation.
16 MR MACAULAY: Yes.
17 LADY SMITH: I don't want to dominate this, but can I just
18 inject one other factor that -- it arose yesterday and
19 I'm hearing it a bit this morning.
20 I think from what I've heard we have to be very
21 careful about assuming that there's a default position
22 that children would speak up if only it wasn't a clever
23 abuser or whatever. I have the clear impression that
24 children generally, from my witnesses, were not going to
25 speak up. I had a wonderful witness who once said,

1 "Well, you see, I didn't have the lexicon for it", and
2 others have spoken similarly about:
3 "How could I explain? I was a child. I couldn't
4 find the words to tell people what was happening."
5 Going back to what you can help us with, do abusers,
6 do you think, ever pick that up and realising that this
7 is a child who not only won't speak up because of the
8 pressures on them, but they don't know how to tell
9 what's going on here, I can take advantage of that?
10 MR HENRY: Well, if I can just finish off before Lorraine
11 comes in, I think that that's absolutely hitting the
12 nail on the head. I think for a lot of non-abused young
13 people growing up, it's very hard to actually find the
14 words to describe what you're going through and how you
15 feel. For a lot of adults it's quite hard to find the
16 words to describe how you feel and what you're going
17 through.
18 For many people it's so hard that you just don't
19 bother because it takes too much time and energy to try
20 and find ... that doesn't make things worse.
21 So there was an aspect in terms of the young people,
22 the men, who were coming forward to us and talking about
23 their experiences as young people, many of them were
24 saying, "I wouldn't really know how to have found the
25 words to talk about this", and as professionals I think

1 sometimes we try and give them a step ahead by helping
2 them over that bridge by offering them some kind of
3 vocabulary to describe their experience but it's not
4 always the vocabulary that matches the experience,
5 that's the problem.
6 Yeah, I think it's a difficulty we struggle with
7 probably every day of our -- in clinical practice it's
8 something you struggle with all the time, about framing
9 things in a way that actually matches the experiences.
10 It's not easy.
11 MR MACAULAY: I think a number of green cards have been
12 flashed. Lorraine, did you want to come in?
13 DR JOHNSTONE: There's a couple of strands to my thinking.
14 Absolutely, developmentally children do not have the
15 language, framework, theory of body or experience to
16 label what has happened to them. I think the default
17 position is probably better to assume that they won't
18 tell, can't tell. They simply don't have the language.
19 I do training for the police in joint investigative
20 interviewing and one of my slides is just the various
21 colloquialisms and terms I've heard throughout my career
22 children using and there's all sorts of language that
23 children use, so unless you're tuned into developmental
24 age and stage you could easily miss the narrative.
25 I think the other issue around -- so there's

1 a couple of things. I think even when children do
2 disclose, the consequences of disclosure and the journey
3 from disclosure to whatever the destination is, is not
4 one that can feel protective. So children will -- you
5 know, if they make a complaint or a concern about
6 a caregiver, whether that's a foster carer,
7 a residential worker, they will be subject to
8 an investigative process, which in itself is a very
9 unusual experience.
10 We bring up children to say, "Don't speak to
11 strangers, don't tell strangers anything", and then,
12 "But, oh, these two strangers that come into the room,
13 tell them everything about all your trauma". And, "By
14 the way, we'll video record you just while you're doing
15 that".
16 I do a lot of work around that.
17 Then you have: What does it mean to disclose?
18 Invariably it means a move of placement. Invariably it
19 means more disruption, more trauma. Invariably all the
20 things that you were protected from that resulted in you
21 being in someone else's care happened to you again.
22 I think there are real reality checks that need to
23 be put in around about the process and how we respond to
24 abuse, but similarly, you know, from my experiences of
25 working in CAMHS and with very high-risk youth, the care

1 setting is harmful on many levels. So a child may be
2 removed from care because a parent has substance misuse
3 difficulties, but otherwise would love to care for them
4 but they can't. Then they go into residential childcare
5 and they are sexually assaulted by an adolescent that
6 lives next door.
7 So there is a really traumatising process on
8 different levels.
9 I think that was my thinking around the sexual
10 elements around it.
11 Also there are very different dynamics at play when
12 it comes to physical abuse and emotional abuse. Again,
13 at the severe end when you're working with children who
14 are extremely dysregulated and aggressive -- colleagues
15 of mine have had broken bones, broken ribs, multiple
16 bites, they've been off work with all sorts of injuries.
17 It can be an extremely difficult environment to work in.
18 There is an element of control that can be used around
19 physical abuse as well.
20 A trend that I've seen is that obviously adults may
21 not use physical control, but one of the things that
22 does happen is the group dynamic does. If a young
23 person, for example, attacks a staff member, then they
24 become targeted for assault by the group. That isn't
25 always protected.

1 I do think it's really important to be mindful that
2 different types of abuse have different trajectories and
3 dynamics and needs and processes, so the physical abuse,
4 the sexual abuse that's around in relationship crossing,
5 sexual abuse that's around control, collusion with abuse
6 and control in a group dynamic. There also other forms
7 of psychological abuse that are far more nuanced and
8 what one person experiences as psychological abuse,
9 someone else might think it's funny.
10 You have these horrendous group dynamics and you're
11 trying to manage that with staff who sometimes come in
12 traumatised, who in all honesty come in frightened
13 because, you know, the incidence of assaults in
14 residential care settings and secure care settings is
15 amongst some of the highest.
16 I've worked in prisons, I've worked in secure
17 hospitals, forensic hospitals. The only time I've ever
18 had to resort to intervention is when I've been working
19 with children.
20 MR MACAULAY: Stuart, you had your green card up a little
21 while ago. I don't know ...
22 MR ALLARDYCE: A couple of points. Let me amplify something
23 Lorraine's been saying, because I do actually think
24 a kind of culture of children's rights within
25 organisations goes some way to mitigate against abuse.

1 You know, making sure that professionals know that the
2 children are autonomous individuals that have rights and
3 a right to be protected and a right to be listened to.
4 These kind of things are really important and need to be
5 baked into the training of all professionals.
6 I think the problem is when child protection
7 colleagues assume that that will be the only solution to
8 abuse within organisations. The Children's Commissioner
9 in England and Wales produced a report about five or six
10 years ago which looked at disclosures, and I think the
11 report looked at a fairly large cohort of adult
12 survivors. It found that only one in eight children who
13 had experienced sexual abuse were known to police or
14 social work at the time in relation to their abuse.
15 They may have been known to social work for other
16 reasons, but only one in eight were known because of
17 their abuse.
18 Some of them may have disclosed, they may have
19 disclosed to a parent, some of them may have disclosed
20 to a peer. Let's not forget that the person that
21 children most commonly disclose to are peers. But
22 actually, with a figure of one in eight, if you doubled
23 that, if you tripled it, you're not -- in terms of
24 children coming forward and talking about their
25 experiences, you're still not touching the sides of the

1 problem.

2 I think the reasons for that are the reasons that

3 Lorraine has laid out. I think there are complex

4 developmental reasons why children often won't come

5 forward and also things around particular contexts and

6 drivers.

7 So we need to make it easier for children to come

8 forward, but it won't be the solution.

9 The other thing very briefly I wanted to say,

10 picking up on a point that Martin made, Martin, you

11 talked about same-sex behaviour within institutions and

12 I think that's a really important one to bring out in

13 terms of vulnerability. One of the things that was very

14 clear from the review that Martin led was that the

15 homophobic cultures within football just gave an extra

16 dynamic to how abusers could keep things secret.

17 I think there's something interesting about gender

18 to hold onto here as well as sexuality. If you look at

19 abuse in family settings, you're normally -- we're

20 talking about abuse of girls, so you're much more likely

21 to be abused as a girl in a family situation in

22 comparison to being abused as a boy, in terms of sexual

23 abuse.

24 But, actually, that shifts a little bit in

25 organisational settings where we do see lots more boys

1 that have been abused. It might be because there are
2 lots more boys in organisations, that could be
3 a demographic thing, but actually I do wonder whether
4 there's stuff around homophobia that's a key factor in
5 this.
6 MR MACAULAY: Did you have your card up a moment ago?
7 PROFESSOR GILCHRIST: It kind of fits now, but we've gone
8 away and come back again. I was going to pick up on
9 that fear as being judged as homosexual was really
10 important.
11 In addition to that, what we found when we were
12 interviewing some of the young people was that they were
13 confused about their physical reaction and what that
14 meant about whether they had consented and have they
15 enjoyed it, and were they hearing that what their abuser
16 was saying was you enjoyed it, you were involved, it was
17 consensual, and it is like, "I don't think it was, was
18 it? I don't know". And actually that real confusion
19 about whether it was their fault, so picking up on
20 victim blaming and that, "I think I must have agreed,
21 did I? Did I not?" You know, it was that confusion.
22 And actually then thinking if they were to disclose,
23 then it would come back to being: it was your choice.
24 MR MACAULAY: Martin.
25 MR HENRY: If I could just say something further about that,

1 Liz has reminded me of it, that not being able to
2 determine what is sexual, for example, is quite
3 a challenge for a lot of people, including young people.
4 I was reminded of cases that came forward to us in the
5 Football Inquiry of young men who had been physically
6 punished by people, and that meant removing an item of
7 clothing and being physically chastised. Of course at
8 the time they thought it was because they'd done
9 something wrong and that's all that it was, was physical
10 chastisement, but looking back on it and talking through
11 the narratives, it's very clear that there was a very
12 strong sexual element to that, not just a control
13 element but an arousal element to it.
14 I think that was for us quite an interesting thing
15 to unpick a bit, because back particularly at that
16 period of time, so we're talking about the 1970s and
17 1980s, the physical chastisement of children didn't
18 quite carry with it the same stigma as it would now, so
19 it was something that was kind of permitted and very
20 often young people thought they might have deserved it,
21 but actually what was going on was breaking down young
22 people's resistance in relation to further sexual acts
23 that might be subsequent to it.
24 Actually, when we talked through the physical
25 punishment, it's very clear that that was a sexual act

1 as well and it wasn't a physical punishment.

2 MR MACAULAY: Yes, Liz, you want to come back in?

3 PROFESSOR GILCHRIST: Yes, I was going to say what I'd
4 written down was normalising that touch and normalising
5 everything, those steps towards, "No, no, that is fine,
6 this is a normal ... this is a massage, this is
7 a whatever".

8 But also, I think we haven't said this yet, but some
9 abusers would use either implicit or explicit threats
10 about disclosure and actually people would say bad
11 things will happen, either to you and your reputation,
12 picking up on what you were talking about, other people
13 will think that you're gay, harm will come to your
14 parents. There's been quite explicit threats, "you
15 can't tell, people will take away our relationship,
16 I won't be able to look after you the same, I won't be
17 able to give you whatever". But that either really
18 explicit or implicit is there.

19 MR MACAULAY: Michele?

20 MS GILLULEY: I wanted to come back to the discussion that
21 Martin and Lorraine were having about almost the
22 inability to speak about what's happening, the loss of
23 words. We need to be very careful really not to put
24 that in the context of thinking somebody, a child, is
25 just not articulate.

1 There is actually known a condition called
2 Alexithymia, which is related to trauma, which will
3 prevent people, young people particularly and even young
4 adults when they try to talk about what's happened,
5 where they just literally cannot tell you what has
6 happened, they cannot find the words, they're unable to
7 do it. There's a whole body of research literature and
8 my experience of working with younger adults who have
9 come through quite serious abuse where -- and there's
10 often a telltale sign with young people where when you
11 try to ascertain how they are and how they're coping and
12 the phrase is, "I'm fine", and it is a tell because they
13 will often say, "I'm fine".
14 But I think you need to be very careful not to
15 assume that they're just not articulate because they're
16 young, but there actually is something that's related to
17 the trauma. I think that then leads to -- it kind of
18 leaps a little bit, but it leads to sometimes how we
19 work with people when they have been traumatised,
20 because that trauma is affecting their adaptive
21 information processing. So what happens when the abuse
22 is taking place, it's stuck, it's frozen, and then they
23 can't deal with that, they don't know how to deal with
24 it, they don't know how to tell you, they don't know how
25 to explain, and often why we talk now about -- that for

1 people who are abused, it's not always the words, but
2 the body knows the score, because it's internalised
3 somewhere else and why we often see -- not for all
4 people -- issues of self-harm and suicidal behaviours,
5 where people cannot find those words, they're too
6 traumatised to be able to say what's really going on.
7 MR MACAULAY: I'll pick you up in a moment, but can I just
8 say what's been wonderful about the last ten minutes is
9 you've been completely off-piste, which is one of the
10 purposes of this type of environment, but being
11 off-piste in a situation where what's being said is
12 highly relevant to the work of the Inquiry. I mean, the
13 question, I think, was why an abuser would target
14 people, but we've gone completely beyond that, which is
15 excellent.
16 Lorraine, you wanted to say something?
17 DR JOHNSTONE: So you have multiple parallel thoughts going
18 on as usual, but absolutely what Michele says is so
19 incredibly important and what we know is if you have
20 a prior history of victimisation, you're more likely to
21 be victimised again, because we talked about attachment
22 yesterday. Basically, you get an imprinting of what is
23 normal, and quite often in one of the things
24 I experience a lot with young people is they will seek
25 what's familiar, not necessarily what's safe. So you

1 seek a familiar environment and a dynamic if that's
2 highly traumatising, it's something that you recognise,
3 not necessarily what's good for you, and that parallels
4 multiple things in human behaviour.
5 I suppose there is a real importance about being
6 really measured about trauma and sexual abuse and
7 violence as well, because as rare as it is, there are
8 occasions when a person may have a coherent memory of
9 abuse that hasn't actually happened. That is one of the
10 real difficulties that we have when we are trying to
11 make recommendations, when we're trying to work in this
12 context.
13 There's several very high-profile case studies and
14 there's lots of research around how you speak about
15 abuse, how you question abuse, how you infer the meaning
16 of a behaviour. For example, childhood self-stimulation
17 and masturbation, obviously if you use the term
18 "masturbation" it carries sexual connotations, if you
19 use "self-stimulation" it could be a sensory need. We
20 all have to be really, really mindful in this minefield
21 that we're highly competent when we're pulling
22 information around, because I've certainly worked in
23 cases where children who do have neuro-developmental
24 issues or difficulties will be exhibiting behaviour that
25 on the face of it looks very worrying and if you were to

1 question them in a particular way you may therefore get
2 a narrative that would point to abuse or harm, but
3 actually it's something different.
4 I think that's one of the big challenges in how we
5 go forward, that we create safe environments that are
6 very rights informed and it's trauma and attachment
7 informed, but it's like everything, it has to be done
8 with a high degree of skill and competency.
9 They used to use anatomically correct dolls and say,
10 "Point here and point there", and even just that can
11 implant a memory of harm.
12 I think we have this terrible challenge where we
13 have developmentally limited individuals, we have
14 traumatised people with impaired memories and
15 cognitions, but we also have an approach that sometimes
16 can do more harm than good, so we really need to know
17 how to respond, I think is what I'm trying to say in
18 a long-winded way.
19 MR MACAULAY: Okay. Thank you all for that input over the
20 last 10, 15 minutes.
21 Can I just look at the second part of this topic and
22 that's how a strong attachment may be formed between
23 a child and his abuser. I think you're being asked how
24 can that be? Can you provide explanations for that?
25 Judi, I think essentially what you and others say in

1 fact is that this happens because the child gets special
2 treatment, at least is part of the picture.
3 DR BOLTON: Yeah, I think we've touched on that in terms of
4 the different variations in the relationship between the
5 perpetrator and the victim and the setting, so those are
6 the kind of two -- and I think a lot of the discussions
7 have focused around those areas.
8 I think we've also talked about vulnerability that
9 would link to this in terms of again coming back to the
10 kind of setting that the person's in and the individual.
11 I suppose I was also struck by thinking earlier
12 about attachment and from the work that I do with
13 perpetrators, and maybe it muddies the water, I'm not
14 sure, but thinking about if we take an assumption of one
15 sort of causality -- maybe that's not the right word --
16 that we're in difficult territory. I was thinking that
17 say, for example, in the last month I've had in
18 treatment a priest in treatment and a teacher, and if
19 you infer the same psychological processes about those
20 two people, you would come to a very different
21 conclusion, I think.
22 For example, the first person you would think that
23 their knowledge of children and sexual processes and
24 healthy sexual behaviour is poor.
25 The second person, their knowledge and relationship

1 with children -- it links back to Martin's comment --
2 and the skills they have with children would be high.
3 So, yeah, I think -- maybe that's not really
4 answering the question, but you're going to struggle to
5 get a definite kind of causality and one size fits all,
6 I suppose is going to be a very difficult conversation
7 to have, I think.
8 MR MACAULAY: I think Liz, Lorraine, and I think Stuart as
9 well, you describe how a traumatic bond can be formed
10 between the abuser and the victim.
11 Lorraine, perhaps can you pick that ball up for the
12 moment?
13 DR JOHNSTONE: Yeah. So relationships generally -- I call
14 it the good, the bad and the ugly a little bit. Where
15 you get lots of good, it can compensate for the bad in
16 relationships. For example, you might find many
17 endearing qualities about your caregiver, that they are
18 nice to you, they spend time with you, they make sure
19 that you're cared for, they share the same sense of
20 humour, they show you attention. It's almost like a bit
21 of a trade-off, there is this bad stuff, but I'll put up
22 with it because the good stuff compensates for it. So
23 a bond develops where the trauma doesn't dictate or
24 determine or become sufficiently strong enough to enable
25 you to see the relationship objectively and you bypass

1 it.

2 It's also a little bit the way we learn, if we put
3 a learning schedule on an intermittent schedule, so, for
4 example, sometimes we're traumatising but most of the
5 time we're nice. The way our brains learn is we tend to
6 condition to what we think we will get, so we have
7 a bias towards seeing and wanting that.

8 But also generally the trauma bond, relationships
9 are usually dynamic, they're reciprocal in some way, and
10 victims can love their abusers.

11 MR MACAULAY: This links into grooming, which we're going to
12 be looking at in a moment, but it is a process; is that
13 correct?

14 DR JOHNSTONE: It is a process, yes.

15 MR MACAULAY: Is there any way that the process, as it's
16 ongoing, can be identified by another person --

17 DR JOHNSTONE: Yes.

18 MR MACAULAY: -- and indeed stopped?

19 DR JOHNSTONE: Yes, I think so. If people know what
20 a trauma bond looks like, then absolutely.

21 So some people, if you look at trauma literature, if
22 you have a discrete -- what we call acute trauma,
23 discrete acute trauma, that's a one-off event, it's
24 really unexpected, it's out of character with what your
25 life is like, recovery from that can be far easier than

1 if you have multiple small -- we call it little t
2 traumas, multiple little t traumas that basically chip
3 away at your sense of the world, your view of self, your
4 view of others. It really distorts how you view what is
5 healthy. So that is much more difficult to recover
6 from.
7 Also, arguably, it allows you, if you have people
8 around you who are informed about how that bond
9 develops, that should give you opportunities to
10 intervene.
11 But also how we help children identify when they may
12 be being groomed as well, because people generally
13 don't -- well, they don't recognise that actually, well,
14 the reason he gave you, you know, this bouquet of
15 flowers, the reason he bought you the trainers that you
16 really wanted is not really because he wants to make you
17 feel good. It's for a secondary gain. That, for
18 a child, who is very egocentric, they don't really care.
19 They want the trainers and it's worth it.
20 LADY SMITH: Lorraine, I just looked back at some of my
21 notes from a witness, who is now very much an older
22 adult, looking back on his relationship with a man who
23 abused him sexually when he was in care and he said:
24 "It was done in a very caressing and loving way.
25 The reality of it was that it [that was the abuse] was

1 probably 20 or 25 per cent of the relationship I had
2 with that man. The other percentage was amazing."
3 DR JOHNSTONE: Yes.
4 LADY SMITH: He could see this breakdown in the quantity of
5 the relationship that was bad, but as you were
6 explaining that, I could see exactly this man, picture
7 him in the witness box. He was doing a trade-off as
8 a child.
9 DR JOHNSTONE: Another thing that I've seen, because the
10 attachment, the trauma bond, becomes really strong, it's
11 almost there's an investment. Some victims I've worked
12 with have talked about how they become ferociously
13 possessive and protective over their perpetrator.
14 There was one case that was particularly distressing
15 recently when the perpetrator and abuser started to give
16 another young person attention, the victim physically
17 attacked the other girl because she was so jealous.
18 I've certainly worked with people who say, "I'll
19 tell you, but they won't get into trouble, will they?"
20 Or, "Can you make them come home, can you make them come
21 back?" Because they're so tremendously attached.
22 So the trauma bond is a very real phenomenon and in
23 my view it's one of the things that makes abuse from
24 a caregiver so damaging, because it's so pervasive in
25 the person's development and life. Whereas, as I say,

1 the discrete trauma, you can externalise that. That was
2 a really bad thing that happened, but my life is quite
3 stable otherwise, I'm surrounded by care. But when the
4 trauma bond is there, you're literally powerless.
5 MR MACAULAY: Liz, you also mentioned, I think, the
6 traumatic bond. Do you have anything further to add --
7 PROFESSOR GILCHRIST: Various different things, I'm just
8 trying to work out where to start.
9 Yes, one of the things I'll pick up on is that in
10 the research that we did, one of the things that
11 Samantha Craven identified was the notion of a "grooming
12 shadow" and actually that the process of becoming
13 identified as special and agreeing to boundary
14 violations and being involved in abusive contact
15 actually was the thing that lived with people, more than
16 the discrete incidents of physical abuse or sexual abuse
17 or whatever. It was that sense of eroding themselves
18 and eroding their sense of safety and sense of security
19 in who they were and the choices they'd made and
20 certainty in all sorts of other ways.
21 I think that concept of the grooming shadow is
22 really important because that's the psychological needs
23 that people have to recover from those experiences.
24 In terms of actually a slightly less benign
25 experience in terms of the trauma bonding, where there's

1 been more maybe explicit threat or more physical
2 violence, actually bonding and trying to predict your
3 abuser's mood or need, pre-empt that threat, it's
4 a survival mechanism, and very much that learned
5 helplessness that you get where actually what happens to
6 you is nothing to do with how you are presenting, it's
7 how the abuser turns up and what mood they are in. Are
8 they in a caring mood? Are they in an angry mood? Are
9 you going to be a punchbag today, are you going to be
10 a partner today? It's nothing to do with you, it's how
11 the abuser is turning up.
12 Actually, when you put that together, as somebody
13 experiencing that where the victim has no actual control
14 over that, they'll be desperately trying to read the
15 cues and the signs to try and make themselves safe, to
16 try and appease, to try and do what is needed to keep me
17 as safe as possible, and that trade-off isn't
18 necessarily just about goods, it's maybe just about
19 safety or not physical -- you know, it didn't hurt, it's
20 like it's easier to do it this way than that way, it's
21 going to happen anyway. Sometimes it might even look
22 like provocative behaviour. You know, I'll do something
23 now.
24 I think in addition, I had certainly a case, one of
25 the reported cases, was where a young person -- where

1 their abuser was quite fixated on younger children. As
2 they grew out of being that age group and then were no
3 longer of sexual interest, felt abandoned and actually
4 found it really difficult that the abuser had moved on
5 to some other person who was younger and then was
6 starting to doubt their attractiveness and things and
7 then trying really to regain that attention.
8 There's a lot of sensible mechanisms involved in
9 actually putting yourself forward and almost offering to
10 be involved in those relationships.
11 MR MACAULAY: Stuart, you also talk about a strong bond
12 being formed. I think really in the context of
13 a grooming process, is that how you see it?
14 MR ALLARDYCE: Yes. I think in the evidence we submitted we
15 suggested that actually often abuses -- the strong bond
16 is a pre-condition of the abuse.
17 MR MACAULAY: Yes.
18 MR ALLARDYCE: It's almost a kind of necessary reality to
19 make sure that the child can be silenced, that
20 opportunities are made for the child to be abused.
21 I am going to say something else maybe a little bit
22 controversial, so I'm sure most of us at this
23 round-table discussion have been involved with providing
24 training to professionals about what grooming looks
25 like. We'll talk about grooming as that quite kind of

1 concerted conscious strategy used by abusers, which then
2 often, as Lorraine and Liz have said, can create this
3 trauma bond. Indeed Liz articulated this really well,
4 that actually it can sometimes even be almost like
5 a Stockholm syndrome when there are kind of threats of
6 violence and rejection that exists within the
7 relationship as well.
8 A few years ago I was really struck by hearing
9 a very experienced treatment provider called
10 Bill Marshall, who is a writer in our field as well,
11 where he was kind of reflecting on his life of working
12 with offenders. He was saying that one of the problems
13 in the discussions around grooming is there's a question
14 of positionality and where we hear the information about
15 the grooming process, which is usually after
16 an individual has been convicted.
17 One of the things that Bill was saying was that, you
18 know, actually, we often as professionals then assume
19 that any positive interaction that took place between
20 the adult and the child was leading towards the act of
21 abuse in some way and we don't allow the possibility
22 that there actually just might have been some nice
23 interactions between the adult and the child.
24 When you get to the lived experience of survivors,
25 or certainly some survivors and some abusers, that

1 really comes to the fore, I think, that that there was
2 an abusive part of it. But going back to the stuff that
3 Liz was talking about yesterday, abusers often -- you
4 know, meeting quite natural human needs through highly
5 abusive and harmful practices. So maybe it's not too
6 surprising that there are often kind of nice moments
7 that take place in that care-giving process, which
8 I think over time absolutely become only defined by the
9 grooming process, but we should keep open the
10 possibility that sometimes there are other explanations
11 as well about why adults are nice to children.
12 MR MACAULAY: I think somebody said yesterday that it's not
13 easy to distinguish sometimes between affection and
14 exploitation.
15 Martin, you also I think talk about strong
16 attachments and how these are formed.
17 MR HENRY: Yes, indeed, and I'm glad Stuart said what he
18 said actually because it resonated strongly with my own
19 experience, both in terms of practice but also in terms
20 of the review that I've just concluded.
21 One of the ways that I arranged my report when
22 I made my recommendations was thematically, so what we
23 did was kind of raise the themes that came up by people
24 who were reporting to us and one of those was loyalty.
25 It was a very strong theme.

1 You would expect that in a world where sport was
2 involved, because it's kind of deliberately constructed
3 a sense of loyalty, because that's how teams operate.
4 You know you have to kind of have that cohesion and that
5 allows you to be successful, but of course that also
6 means loyalty towards individuals and that loyalty needs
7 to be so well bonded that it doesn't risk the success of
8 the group or the team.
9 That sense of a bond between peers and indeed adults
10 is constructed so strongly and so firmly that it needs
11 to become almost impenetrable. Your individual
12 responsibility as a member of that group is very clear,
13 you have to maintain loyalty at all costs.
14 Of course, that can actually literally be at all
15 costs. I was put in mind when Stuart was talking of one
16 man who came along and reported to us and he had been
17 part of a group of boys who were being abused by this
18 particular man and at the time some of these boys
19 started to talk, and he quite powerfully took against
20 the other boys who were starting to disclose. He was
21 also being abused, but he wasn't disclosing that he'd
22 been abused and his sense of -- the vehemence of his
23 reaction to what these boys were doing by disclosing
24 that this man was perpetrating abuse against them was
25 really, really strong. So strong had his sense of

1 loyalty become to this man that he was not even prepared
2 to say that he had a shared experience with these other
3 boys at that time.
4 As an adult man he's come on to be able to do that.
5 What he attempted to frame to us was an experience --
6 and I'm trying not to paraphrase -- I will paraphrase
7 what he was saying, I won't quote what he was saying,
8 but it was something along the lines of, "It wasn't the
9 fact that I was abused that became a central aspect of
10 my identity, it was the fact that I belonged that was
11 a central aspect of my identity".
12 What we took from that was actually lots of bad
13 stuff was happening to this guy, but lots of good stuff
14 was happening at the same time, and how as an adult and
15 as a young person can he make a distinction between
16 these when we at times are struggling to make
17 a distinction, without stealing from him the strong
18 aspects of his adult life that that relationship had
19 left him with? You can't take it all away from people.
20 There is some good that comes of that terrible -- well,
21 not good, but there are some parts of that relationship
22 that are not all bad and, you know, in our process to
23 try and free people from their heritage of abuse and to
24 help them to feel freer from it, we have to be very
25 careful that we don't then start to run roughshod over

1 some of the good stuff that has happened through their
2 experience of relationships growing up.
3 MR MACAULAY: Yes, Morag?
4 MS SLESSER: I just want to say the extreme consequences of
5 abuse, which is probably the people that I see, and
6 I think one of the things that goes on is extreme
7 disassociation from what's happening and I think people
8 are talking about that.
9 One of the ways children cope, and this is probably
10 quite normal as you're growing up, if something bad
11 happens to you, you can just simply shut it off as
12 though it didn't happen. You can sort of see -- we see
13 it in our own children. We see the good mum and the bad
14 mum. If you're cross with your small child they go away
15 crying, but then when they see you again 30 seconds
16 later they want a cuddle. There is that kind of
17 disassociation that can happen normally, but if that
18 carries on and if you're having to shut off a very bad
19 experience, and I've seen some very troubled, severely
20 mentally disordered individuals. When you start to talk
21 to them about abuse, they literally fall asleep in front
22 of you. It's very, very powerful when it happens and
23 you're trying to talk to them about what's happened and
24 you can see them shut down physically.
25 This is just to counteract what you're saying. You

1 know, it can -- and working in high-secure hospitals,
2 I've seen a few people like that who report
3 horrendous -- one of them who was reporting being
4 a victim of a paedophile ring, that's how serious it
5 was.
6 Then I think there is evidence -- again the
7 academics might know the detail of this -- where people
8 who experience severe psychosis very often report abuse
9 and also people who present with what we would call
10 borderline personality disorder. They've often
11 become -- that bit of them is completely inaccessible
12 and shut off and has led to experience psychosis.
13 When you're talking about how would we know that
14 process was happening as a child, I'm not sure.
15 I suppose it's going back what maybe Michele is saying,
16 "I'm fine", "Well you can't be fine, look what's
17 happening to you, how come you're fine?"
18 I guess that's getting into early intervention
19 there, how you would do that. Because with the people
20 I'm seeing the damage is very much done and then they
21 are at risk of serious self-harm. The man I told you
22 about who was the victim of a paedophile ring is now
23 dead from suicide, so .... you're.
24 MR MACAULAY: Lorraine, you wanted to come back in on this?
25 DR JOHNSTONE: Yes. Similarly shared experiences clinically

1 and I certainly see people in who the process of abuse
2 has been so destructive that it is lethal, really.
3 I did have an experience recently where I was doing
4 some training around about trauma and the effects of
5 abuse and I was very humbled at the end when somebody in
6 the audience approached me and said, "You were
7 describing my childhood there, but I'm absolutely fine,
8 I have a great career, I've grown from it". It's really
9 important that we get into the field the notion of
10 post-traumatic growth.
11 Again, I think it is around about balance and
12 recovery and resilience. Obviously there are horrific
13 effects of maltreatment and abuse and it can be
14 lifelong, persistent and severe, but it's another bias
15 in our literature sometimes that we focus on that, and
16 obviously that galvanises effort and energy, but there
17 is post-traumatic growth as well and I think that is --
18 you know, moving forward, absolutely as Morag says,
19 early recognition, early intervention and having the
20 right responses to that so that we don't compound abuse.
21 Because one of the things you'll often see, especially
22 in children, they're somatised, they come with
23 constipation, headaches, they get all these medical
24 investigations but actually it's trauma and abuse. What
25 we do is we compound it by not hearing or giving them

1 a language, whereas some people do recover.
2 MR MACAULAY: I think, and Lady Smith will confirm, that the
3 Inquiry has heard from witnesses who were seriously
4 abused in childhood and yet have gone on to lead
5 positive and fruitful lives.
6 Conversely, of course, there are many who have
7 suffered impact upon their mental health and functioning
8 that's long lasting, so there are these different
9 categories.
10 Very well -- oh, I'm sorry, Judi.
11 DR BOLTON: I just wanted to say, taking Stuart's point,
12 really, that I think it's interesting to describe
13 something as controversial, but you have to reflect it
14 on society more broadly, that we want to see people as
15 all bad or all good or -- you know, and the most common
16 question I'm asked is: how can you work people who have
17 done bad things? And that is because I would probably
18 say, you know, all bad doesn't exist. But actually we
19 have to extrapolate from that argument to how society
20 wants to see the world and that is because human beings
21 are driven towards certainty and therefore we want to
22 see people as good/bad, because that makes us feel safe
23 and have an understanding of our world to the point that
24 we describe it as controversial that people are one
25 thing or another. So I think, yeah, we need to think

1 about taking it broadly to how society wants to view the
2 world.
3 MR MACAULAY: Yes, Liz? Please.
4 PROFESSOR GILCHRIST: It was literally just to pick up on
5 what you were saying and suggest that we might think
6 about behaviours and interactions as being bad and
7 people as being people, you know, so not ascribe it to
8 identity but more about behaviours that we want to
9 manage.
10 MR MACAULAY: Thank you.
11 Yes?
12 MR ALLARDYCE: Just one sentence on that. In the sex
13 offending field there is a shift going on at the moment
14 around person-first language, so instead of talking
15 about abusers or perpetrators where you're only
16 identifying that individual by that characteristic, we
17 talk about people who abuse or people who have harmed
18 children, recognising that is not the only part of their
19 identity.
20 MR MACAULAY: I see.
21 MR ALLARDYCE: It's maybe something that can be thought
22 about by the Inquiry.
23 MR MACAULAY: Yes.
24 In a sense, we have been looking at grooming
25 already, but one of the specific topics that we have

1 also identified for today and in relation to which
2 you've provided us with responses is how you define
3 grooming, and I'll come back to that, and how do abusers
4 groom children and indeed their families. We've touched
5 quite a bit on aspects of that.
6 Beginning with the first point, if one is looking
7 for a working definition of grooming, my impression from
8 the responses is that you really are more or less all on
9 the same page on that, in that it seems to be a process
10 whereby an adult builds up a relationship with a child
11 or a young person or another adult actually in
12 a familial context, with the aim of exploitation and
13 compliance and silence.
14 But I think, Stuart, you draw attention to the
15 definition of grooming that was provided by Professor
16 Anne-Marie McAlinden, which is a more sophisticated
17 definition than the one I've summarised. Are you able
18 to take us through that?
19 MR ALLARDYCE: I think it has all the components that you're
20 talking about, Colin. Anne-Marie McAlinden, based in
21 Belfast, has done a lot of work in this area. Her
22 definition of grooming is:
23 "The use of a variety of manipulative and
24 controlling techniques with a vulnerable subject in
25 a range of interpersonal and social settings in order to

1 establish trust or normalise sexually harmful behaviour
2 with the overall aim of facilitating exploitation and/or
3 prohibiting exposure."
4 I just think it's quite a neat encapsulation of
5 this.
6 MR MACAULAY: Any other thoughts on that before I move on?
7 Yes, Morag?
8 MS SLESSER: Yes, I was thinking about that definition but
9 that sort of seems to imply consciousness and I'm not
10 sure how many offenders I've seen who cynically set
11 out -- I have seen a few -- to abuse children. It's
12 much more sort of -- I don't know what the word is, kind
13 of insipid than that. They may have been abused
14 themselves so they confuse sex and love and, you know,
15 things that have happened to them as being confused, so
16 their attachments are awry. They may be convincing
17 themselves that this is just them, you know, doing the
18 right thing by a child.
19 Then I think people have talked about they may find
20 themselves in a situation where they are sexually
21 aroused and then they allow themselves to become
22 disinhibited by alcohol or they convince themselves
23 they're just giving them a cuddle. So I'm not sure --
24 I don't think what you think about that, but I'm not
25 sure it's as conscious as that, I think it's rarely as

1 conscious as that.

2 MR MACAULAY: You're suggesting it's something that develops

3 in a particular context rather than someone going out to

4 target a particular --

5 MS SLESSER: It still is grooming, because whether they

6 cynically are doing the grooming -- I have met people

7 who cynically have taken a child and know fine well what

8 they're going to do in the end.

9 MR MACAULAY: I'll go to you, Lorraine, and I think Liz is

10 waiting in the wings.

11 DR JOHNSTONE: I think, it's reflecting the theme it can be

12 both, it can be a mix, it can be either, it can be or,

13 it can be both.

14 I think it is a really good definition, the only

15 thing that jars with me slightly is referring to people

16 as a vulnerable subject, because it almost has a tone

17 around it. You can be vulnerable for 15 minutes of your

18 life or vulnerable for 15 years, so it might be that it

19 exploits an opportunity. There's another way, I think,

20 to word that.

21 I think it links back to the point I made earlier,

22 because even that definition is quite disempowering and

23 we want to be really mindful that it's not a weakness or

24 a deficit in the victim per se. It's a deficit or

25 an issue with the dynamic, so that at the can broadly

1 capture all the different spectrum.

2 MR MACAULAY: Liz?

3 PROFESSOR GILCHRIST: One of the things I wanted to

4 highlight is that grooming isn't just of an individual

5 child. There's a model that suggests that there's

6 a grooming that takes place with the person who abuses,

7 so that they are overcoming their own internal barriers.

8 There's grooming an environment, so sort of creating

9 an environment where abuses can happen. Grooming

10 a family, perhaps, and then grooming an individual or

11 grooming an individual within a care context. So

12 there's a range of grooming.

13 It might well be -- one of the things that really

14 strikes me and some of the sex offender treatment

15 programmes talk about seemingly irrelevant decisions,

16 where somebody might give themselves permission to go to

17 a park where they know vulnerable children are, or

18 I certainly have heard a number of stories where people

19 would tend to go to fish in areas near young people

20 where there wasn't a lot of surveillance, and then

21 a young person would be there and then there would be

22 an interaction and then there would be horseplay and

23 these seemingly irrelevant decisions at each point the

24 person was sort of stepping towards actually an outcome

25 that was almost inevitable.

1 However, until that was actually pointed out -- and
2 I'm fairly cynical myself, but until that was really
3 pointed out, it wasn't inevitable to them. It was
4 almost the inevitable outcome but they were making kind
5 of steps. I'll just go here, I'll just move here, I'll
6 just do this. And that outcome then happens.
7 So that whole kind of: Is it deliberate? Is it
8 knowing? Is it conscious choice? I think it's not
9 dichotomous.
10 MR MACAULAY: Right.
11 MS SLESSER: I have a really good example I'll just tell
12 here. This was in a psychiatric ward I was on and
13 I became aware that the nurses as part of this man's
14 outings he would get once a week, that they were going
15 to the shop, buying a cheap loaf of bread, and then he
16 would go to the park where he would feed the ducks.
17 This was described as: "Oh, this is nice, he likes to go
18 feed the ducks". I had an uncomfortable feeling about
19 it, so I decided to go one day myself on the outing
20 I took him on the outing.
21 Of course, the minute you start feeding the ducks,
22 all the children around in the park that day come
23 around, because 40-year-old men don't feed the ducks.
24 They feed the ducks with their children or their
25 grandchildren, and it was utterly astonishing. But

1 nurses had been going out with him. That was the thing
2 that he liked to do without that being discussed at all.
3 After I'd been, he didn't go out any more to feed
4 the ducks, but it took quite a lot -- it took me to be
5 there to realise that's what was going on. I think
6 that's the kind of thing that looks like an ordinary
7 activity, and he may even have thought it was
8 an ordinary activity, but he got very excited when the
9 children started coming around and he was a sex offender
10 who was in hospital.
11 MR MACAULAY: I think we have to touch upon this, as to how
12 one can identify that grooming is taking place. I think
13 you have said that the health professionals should be
14 able to identify.
15 MS SLESSER: Yes, should be.
16 MR MACAULAY: Does training/education come into this then?
17 MS SLESSER: It must do, and I'm sure we're going to talk
18 about that. But none of the staff on the ward,
19 including the psychiatrists and everybody who was giving
20 permission for that outing, really thought he was doing
21 any harm. Superficially, he wasn't doing any harm,
22 actually. He was always accompanied, so there was no
23 harm could have happened in that situation. But he was
24 perpetuating his thoughts, excitement. You know, it was
25 obvious he was enjoying that. I don't know what was

1 happening in his head when he went to his room at night.
2 I don't know how often the same children would be in the
3 park on a Tuesday morning with their childminders,
4 maybe. You know. So the childminders might have seen
5 something like -- who knows how many adults were
6 involved in that situation who didn't see it as
7 problematic.
8 MR MACAULAY: Yes, Lorraine?
9 DR JOHNSTONE: I think it is really important when you have
10 someone who you know has a particular difficulty, you
11 have a lens to interpret behaviour through, so it's
12 offence parallelling behaviour. It's very different,
13 I think, you know, as Stuart was saying, we want to see
14 positive interactions, if there's no reason for concern,
15 that's perhaps a bit more difficult.
16 I think in terms of the broader how you train
17 people, it's not necessarily about grooming per se, it's
18 about boundaries, it's about what is appropriate
19 relationships in a much bigger context.
20 Again, I think if you just focus on a narrow lens,
21 then you potentially miss opportunities or misinterpret
22 really benign behaviours as well, or you become so
23 concerned that you're rugby tackling your colleague when
24 you see them giving a child a cuddle. You don't want to
25 overreact, it has to be informed and proportionate.

1 I think there is a huge amount of work still to be
2 done around boundaries and relationship boundaries and
3 not -- I don't think it's helpful to necessarily think,
4 well, we'll look for this type of dynamic and focus on
5 that, because I think that would miss opportunities.
6 As I say, being preventive, how do you address --
7 unless it's really explicit and overt, then you might
8 actually be undermining a relationship that's really
9 benign, helpful and positive.
10 MR MACAULAY: Again, we've touched upon how you
11 differentiate between affection and something more
12 sinister. What you're saying is that somehow you have
13 to put in appropriate boundaries.
14 DR JOHNSTONE: Absolutely, there has to be an expectation,
15 boundaries and guidance.
16 One of the things I use on the secure unit I work in
17 down south is we talk about the boundary see-saw model.
18 We just have a diagram of red, amber and green, and
19 there's fuzzy bits in the middle. It's this is
20 definitely not okay, this definitely is okay, this stuff
21 you need to think about and have supervision, think
22 about the context, how you apply that.
23 Again, it's with supervision and an objective
24 observer on a ward or with some advice, so it's
25 important to have team discussion as well.

1 I think it's definitely about relational boundaries
2 much more broadly than focusing on a potential grooming
3 behaviour and identifying them to dealing with that.
4 MR MACAULAY: Yes, Liz?
5 PROFESSOR GILCHRIST: Just sort of picking up on that.
6 Without trying to be glib about it, I think the
7 intention behind the behaviours and the impact of the
8 behaviours are really important to think about. This
9 isn't preventive, but early identification. If you see
10 a special relationship having a negative impact on
11 a child so that they seem more withdrawn, more isolated,
12 you see changes in interactions or a fear or isolation
13 or a lack of space for action, not being able to make
14 choices and seeming different, then early identification
15 is possible.
16 But that sense of looking at intentions of behaviour
17 is from the person who might be abusing or -- you know,
18 what needs are they trying to meet within that
19 relationship with the child and getting those needs met
20 elsewhere. So that's supervision, the space for
21 reflection.
22 Actually, if you have adequate resources to meet
23 your adult needs somewhere else, then you would be less
24 likely and less at risk to be trying to meet needs in
25 a relationship with a child.

1 MR MACAULAY: Can I ask, would you see secure attachment
2 then as an important factor to counteract grooming?
3 PROFESSOR GILCHRIST: Yes, I think secure attachment. There
4 is evidence from way back from the Farrington Cambridge
5 study et cetera that a secure attachment with
6 a caregiver provides a real interrupt, is a significant
7 protective factor for many, many negative outcomes and
8 that secure attachment, it's not just about attachment
9 to a person. It gives you a stable sense of self and
10 a stable sense of the world. So that you have a model
11 and a way of thinking about what attachment looks like,
12 what relationships should look like, that reciprocity,
13 that what is good, normal and healthy, it's there, but
14 it's also that sense of who I am independent of other
15 people, so I'm not as needy in relationships. I don't
16 need the relationships to have an independent sense of
17 self.
18 MR MACAULAY: Is the notion of secure attachment taught into
19 those who work in the care system?
20 PROFESSOR GILCHRIST: As far as I understand, attachment
21 developmental processes are taught with nursing and
22 caregivers and certainly in psychology it's something
23 that we would focus on.
24 MR MACAULAY: Lorraine?
25 DR JOHNSTONE: That's not my experience.

1 MR MACAULAY: What's not your experience?
2 DR JOHNSTONE: Secure attachment isn't taught. I have done
3 quite a lot of work with residential workers, foster
4 carers, professionals and people who have been in this
5 sector for 20, 30 years. My training is the first
6 training they've had on attachment. My view is that
7 I think even across the mental health profession people
8 don't understand what attachment is. We don't have
9 a common definition of attachment, different models of
10 attachment.
11 One real concern I do have as well is the overlap
12 between trauma and attachment. These are very distinct
13 constructs of processes and even some of the training
14 that has been rolled out conflates these constructs.
15 I think that there is a huge gap around people's
16 understanding about what attachment is and how it's
17 formed.
18 It's also extremely -- there is a biological
19 vulnerability primacy to attachment and how it forms.
20 There's also critical period of attachment as well, the
21 first 90 days of a baby's life.
22 For me the original question is: does secure
23 attachment mitigate? Absolutely, I think I said
24 yesterday that if you have a secure attachment, pretty
25 much your resilience will be as good as it's going to

1 be. But teachers don't get taught what attachment is.
2 MR MACAULAY: Those who care for children, particularly in
3 the care system, are you saying they're not really
4 taught about secure attachment?
5 DR JOHNSTONE: They do not get taught on attachment. It's
6 just not there. They get taught a bit about trauma, but
7 the actual constructs of attachment and the processes
8 and developmental processes and also how to recover from
9 disorganised attachments or insecure attachments,
10 I don't see it at all.
11 MR MACAULAY: Michele, you had your card up?
12 MS GILLULEY: I have a number of things, so can I go through
13 them one by one.
14 Morag was talking about her experience on
15 a psychiatric environment. I would wholeheartedly agree
16 with that, that you can have whole staff groups. When
17 we are talking about grooming behaviours, one of the
18 aspects we talked about is loyalty, sometimes when staff
19 groups begin to work with individual offenders, if that
20 offender is generally doing well and working well and
21 looks as though they are trying to address maybe some of
22 the challenges that they have in life, you can have
23 a staff group -- I don't know if you agree with me,
24 Morag -- that almost go with that and develop a loyalty
25 to that person and then don't see some of like the

1 behaviours you were talking about there, where actually
2 that one would have been quite clear to you, to me,
3 especially if you were actually involved in -- and as
4 you said you actually went out to see what was
5 happening, but the staff group can't see that.
6 That then made me think if we have trained people,
7 experienced staff groups working with offenders who can
8 still miss some of those red flags, critical points,
9 make somebody else vulnerable. Then if you think about
10 a family -- I can think about somebody I have worked
11 with in the past where the grooming behaviours started
12 generationally quite far back and went through each
13 generation of their family on the female side, and
14 nobody would have considered that that behaviour was
15 going on and that the abuse was happening generationally
16 one after the other, unfortunately until this person was
17 deceased.
18 I'm thinking if we can't get very experienced
19 trained staff within environments to always be able to
20 see what's happening, because they can become -- the
21 kind of old terms that we used to call, Morag --
22 conditioned to particular behaviours from offenders,
23 then how challenging is it for families who are not
24 operating in that way, thinking that they should be
25 looking at abuse every day of their life, should be

1 trying to look at specific behaviours.
2 They may see a simple family activity as exactly
3 that, a simple family activity and it's safe, but not
4 seeing the markers that professionals would see. So how
5 do you protect families from that, where it may be going
6 on intergenerationally?
7 I also wanted to pick up on Lorraine's point about
8 training, and training on attachment. I deliver
9 personality disorder training to staff on a regular
10 basis. A huge part of it devotes itself to
11 understanding of attachment and how do people make
12 themselves safe, working with people who abuse, who are
13 challenging, who have personality issues that can impact
14 on staff groups themselves.
15 One of the things that was coming to my mind when
16 you were talking is it's quite difficult because you're
17 talking about front-line staff who may be very motivated
18 to learn, very motivated to integrate learning as
19 they're given it through training, but we all know as
20 professionals as well that sometimes training only has
21 a short-lived impact before people don't recall what it
22 was they were trained in, don't understand what they
23 were trained in, and it's not through any specific
24 purposeful or meaningful way of not using their
25 training, but they do forget and sometimes then we have

1 an ongoing need to constantly train people.
2 Especially if, you know, many people sitting here
3 today as professionals, as experts in their own areas,
4 have spent many, many years being able to understand
5 everything they know and how to apply it and there's
6 maybe the word: application of learning. Yet we're
7 trying to almost drag other members of staff, and
8 everybody has a critical part in a team, don't they, but
9 dragging people with us to try and make sure that we can
10 create those safe environments.
11 Sorry, that was a bit long-winded, wasn't it?
12 MR MACAULAY: That's taken us nicely up to 11.30. We shall
13 have our break and come back in about 15 minutes or so.
14 (11.32 am)
15 (A short break)
16 (11.47 am)
17 MR MACAULAY: I think one of the important messages that
18 came out this morning, and indeed also yesterday,
19 I think, is the importance of secure attachment in the
20 protection of children in care, and I think, Lorraine,
21 you were a bit quizzical as to whether or not care
22 workers are trained, but I think Michele pointed out, if
23 they are, how long does the message persist?
24 What I want to ask at this point before moving onto
25 the next topic is: how does a system that has children

1 in care and that these children are moved on a regular
2 basis, how can we reconcile that process with the
3 fundamental need to build secure relationships for child
4 protection?
5 Can you answer that, Lorraine?
6 DR JOHNSTONE: There's a simple answer to that: you can't.
7 It's really simple.
8 MR MACAULAY: Because I think we know, and this may come out
9 particularly in the foster care case study, that,
10 really, children are moved from pillar to post on
11 a regular basis in the care system.
12 DR JOHNSTONE: The best opportunity, I think, and I think
13 this is where a lot of The Promise thinking and
14 Lifelink's thinking comes from is if there is someone
15 that you can have longevity in your relationship with,
16 whether that's a teacher, a social worker. Some social
17 workers I've worked with will commit to children. They
18 routinely go above and beyond, and the relationship
19 would be longstanding. But usually, or often, that is
20 on top of the case load and it's a real vocational
21 exercise. So that does afford, from the professional
22 side.
23 Other things, though, that are really important are
24 things like sibling relationships, extended family
25 relationships and really trying to promote identities

1 and links with people who will have an input or have
2 a higher potential to have a lifelong relationship.
3 Constant caregiver disruption is really detrimental
4 to children, as is being in a placement that is poorly
5 attuned or responsive to your needs as well. So it is
6 an extremely difficult issue to try and address.
7 I do think that children who come into the care
8 system are so disadvantaged anyway by virtue of their
9 vulnerabilities, but also I said yesterday, certainly in
10 the work I do through parenting assessments, the process
11 that it takes before a child can have a stable family,
12 be adopted, you know, where they go for attempts
13 rehabilitation, sometimes it's five, six years before
14 a child is adopted, even though they've been on the
15 child protection register pre-birth.
16 I've certainly worked with children, too, whose
17 foster placements have broken down, adoption placements
18 have broken down. I've seen some of the work I do on
19 attachment training, poor people have adopted children,
20 or after long-term fostering, they generally don't
21 understand what that is. So there's a real reactive
22 reaction as opposed to prevention.
23 Yes, it's an extremely difficult set of
24 circumstances to address and people often come into it
25 well intentioned, but some of the children can be in

1 a range of spectrums from fairly benign and avoidant --
2 if you think about avoidant attachments, the kids come
3 in, they are gleaming, their school shirt is perfect,
4 they're doing really well at school, but they're
5 completely disconnected from their emotion, all the way
6 to the high drama, high-expressed emotion, every risk
7 taking you could imagine and then everything in between.
8 So it's not surprising that placements fall and you
9 move.
10 MR MACAULAY: No doubt that will be explored again when we
11 look at foster care in particular.
12 Liz, you wanted to come in?
13 PROFESSOR GILCHRIST: Just to pick up on this, and it's
14 unhelpful in some ways, but that idea that we could
15 potentially work with families of origin in a more
16 coherent way to manage risks that are emerging in
17 families of origin and not move to foster care and other
18 types of care if at all possible might be one way of
19 promoting that kind of -- you know, so good enough
20 parenting, if it's possible. But there's something
21 about actually if it's at all possible to keep children
22 in families of origin with support and oversight,
23 et cetera. That's one way of promoting the positives.
24 DR JOHNSTONE: My experience -- the social workers are
25 definitely well placed to answer this -- is the

1 threshold for removing is extremely high, and if
2 anything, I think there is an argument to be a bit more
3 proactive.
4 For example, I have parents who are on baby number
5 14, 15, 17, and their babies are all in care. They've
6 been born with neonatal abstinence syndrome, but there's
7 still an attempt at rehabilitation.
8 I think it can go the other way, but generally
9 I think there's procontact with birth families and
10 I think there definitely is, wherever possible, children
11 will remain with their birth families. In Scotland,
12 anyway.
13 I think there's a lot of work to be done around
14 that.
15 It's very rare in my experience for permanence to go
16 ahead or a child to come into the looked-after system
17 when nothing has been tried. It's usually when
18 everything has been tried.
19 Yeah, I think things like the family nurse project
20 are really helpful. They've certainly had some positive
21 effects where it's a teenage pregnancy, there's
22 vulnerabilities due to immaturity and lack of
23 experience. But at the harsher end, I think, the system
24 itself is not particularly helpful.
25 MR MACAULAY: I'll come back to you in a moment, Liz, but

1 Morag, I think you had your card up a minute ago?
2 MS SLESSER: Yes, picking up both those points and also what
3 Michele was talking about before the break.
4 The attachment training -- this is what we tried at
5 The State Hospital, and I'm interested to see what
6 Lorraine thinks about how transferable this is. We had
7 exactly the things that Michele's talking about,
8 people -- not only did they not understand the impact
9 about the trauma that our patients would have had, but
10 also the impact of that trauma and the attachment styles
11 our patients had.
12 Apart from doing the training, we tried to make each
13 patient's needs in that respect explicit to the staff
14 and ourselves, and also to have strategies for each
15 behaviour that we might see for that patient. Because
16 there's a real risk that you sort of perpetuate the
17 negative attachment that's gone on. You know, the
18 classic thing would be a patient pushes you away when
19 you try and show some care or kindness because they have
20 an avoidant attachment style so they can't handle you
21 being like that, so you have to try and work out what
22 their attachment style is and then figure out how you're
23 going to approach that in a way that doesn't perpetuate
24 that. Which is quite hard to do, so certainly at the
25 front of it you need staff who are competent to come up

1 with strategies and understand what's going on with the
2 patient, but then you need to get everyone else to do
3 the right thing when they see the bit of behaviour
4 that's problematic.
5 It's a kind of long-term process, and then you need
6 good supervision of the staff. You quite often see just
7 little negative things with staff who look after
8 difficult people that kind of perpetuates the problem,
9 but it's very minor. I'm trying to think of -- I mean
10 the obvious thing with people in psychiatric hospitals
11 is there's a lot of paranoia, especially in the high
12 secure, so just making little jokes about paranoid
13 symptoms.
14 The one that comes to my mind is we had a patient
15 who thought there when people were clearing their
16 throat, that meant something in their head, that they
17 had a negative thought about him. So some of the staff
18 would just wind him up by sort of clearing their throat
19 and making a joke about it. In some ways you can think
20 that's him seeing we can do that a lot and he won't come
21 to any harm, but it's quite an unpleasant and uncaring
22 way to go about it.
23 Just trying to sort of explain to staff things --
24 give them a kind of menu of things you need to do, maybe
25 that's the way to put it, with this individual, and

1 especially things you need to not do.

2 I don't know if that fits with children in care

3 models.

4 DR JOHNSTONE: Can I --

5 MR MACAULAY: Yes. Liz, I know you're waiting in the wings,

6 as is Martin.

7 DR JOHNSTONE: One of the things I do with children in care

8 is develop something called the 6D model. It's

9 basically to give the care team strategies on how to

10 work with the complexity of what children present with.

11 The 6D model is basically strategies to respond to the

12 unmet needs.

13 So behaviour can be aggression, but that might be

14 because the child has an attachment need, a behavioural

15 need, they are confused.

16 If a child is showing an attachment need they become

17 regressed and need nurture then.

18 If there's a behavioural need, you give them clear

19 directions and expectations.

20 If it's a communication need, you simplify

21 instructions, you don't overload them.

22 If it's a trauma need, you use all sorts of

23 trauma-based strategies, you ground them, you're

24 compassionate.

25 Also in that approach we have an emotional and

1 mental health need, because it can be symptomatic of
2 a disorder.
3 Then we also have a category of don't know, so when
4 you just don't know.
5 It's linked into what Morag says. We use something
6 called the PACE mould and it's an approach with
7 traumatised -- anyone, it's a fantastic approach to use
8 to deal with people with difficult behaviours and a PACE
9 model means you do no harm. So you're allowed to not
10 know and when you respond you do it in a way that
11 doesn't cause harm, but then we spend a lot of time
12 mapping out what a child may look like when the unmet
13 need is attachment behaviour cognition.
14 The thing that has been very helpful about that
15 approach, the staff really like it, it's on an acronym,
16 it's easy to remember, but also it helps protect what is
17 a very common trend in health and social care where
18 things become popular. So ADHD was popular for a while,
19 then autism, then attachment and then trauma. This
20 formulation is holistic, but also meaningful and it's so
21 simplified that it enables residential workers and care
22 staff -- I mean we literally train them to put it on
23 their fingers as an acronym to know what to do.
24 That sounds very good. It's actually quite hard in
25 practice to train it, so --

1 LADY SMITH: PACE stands for what?
2 DR JOHNSTONE: Playful, acceptance, curiosity and empathy.
3 LADY SMITH: Thank you.
4 MR MACAULAY: We have that in the transcript now, thank you.
5 We have a queue over here.
6 Liz, were you first in the queue? Then I think
7 Michele and perhaps Martin.
8 PROFESSOR GILCHRIST: Almost to go back to the conversation
9 that Lorraine and I were having, but picking up actually
10 on where you ended up. One of the things that I think
11 is changing and should be changing is the models of
12 actually dealing with families where there has been
13 abuse, very much about responding to the
14 intergenerational transmissions.
15 Edinburgh, for example, has very much bought into
16 a model which is the safe and together model. In the
17 past, where there has been difficult physical, sexual
18 abuse, neglect in families, quite often the non-abusing
19 parent was demonised, there was separation, there was
20 removal, people met a threshold for various different
21 reasons and actually that failure to protect model of
22 mothering, often, was very difficult and may well have
23 then ended up with young people ending up entering
24 a system where there might have been opportunities to do
25 it differently, because we really didn't know how to

1 work with uncertainty, and that uncertainty of risk
2 promoted people -- mothers leaving, where we actually
3 made the risks worse and actually we wanted to finish
4 the risk quite early but we didn't, because actually
5 separated parents end up with still ongoing abuse.
6 Actually the safe and together model where the idea
7 is about parenting or linking with the non-abusing
8 parent and profiling the risk to really understand it
9 and to see what is possible in terms of is it possible
10 to maintain that familial bonding in an ongoing way to
11 avoid all the other disruptions is potentially going to
12 have an impact down the line.
13 I think everyone was being trained around -- no, it
14 was at the start of Covid, so it was only being
15 introduced then, it's an American model, but it's quite
16 positive in some senses but it's very much about
17 training staff to respond as a model that is helpful but
18 not ignoring risk, but managing it and working with it.
19 So I don't know, we'll see if that has an impact in
20 terms of shifting some of the removals.
21 MR MACAULAY: Michele, you had your green card up a little
22 while ago?
23 MS GILLULEY: Yeah. A couple of points.
24 We were talking about with parents and one of the
25 things -- my experience is mostly actually in England

1 and working with the children and families courts. One
2 of the things that always resonated with me was exactly
3 what Lorraine has said, because that's my experience as
4 well, that children are often removed there's such
5 a risk, but what then happens is the parents are not
6 worked with, and unfortunately those parents will often
7 then go on to have more children, and they're
8 subsequently removed, and more children, and they're
9 subsequently removed, but the parents are still there
10 and they go on to have more and more children and the
11 abuse will continue. I think probably several of the
12 experiences I have, more an assessment process, but
13 I have assessed individuals for what we call good enough
14 parenting, and been very concerned about the amount of
15 damage that goes on and is continually perpetuated in
16 every subsequent child who is unfortunately born into
17 a family who cannot cope, don't know how to cope, are
18 not educated, are not worked with, because they don't
19 work with them because they remove the child and then
20 don't do anything with the family. I think that is
21 a significant problem.
22 The other thing that I had just very quickly with
23 the point that you were making again about how we work
24 with staff and working with staff all the time in
25 a closed environment, very aware that staff aren't

1 always aware that on occasion -- and not obviously with
2 sexual abuse, I very much hope not, but in terms of the
3 potential for it being perceived similarly to somebody
4 who's been victimised in neglect, that staff can almost
5 reinforce and be seen to, I suppose, demonstrate very
6 similar behaviours that victims have already experienced
7 in family environments, where it's almost like
8 a self-fulfilling prophecy:
9 "I know this is how I'll be treated, so I'm now
10 looking to confirm that that is exactly what you will
11 do."
12 In a staff group who work very much on the floor, on
13 the ground, front-facing, with individuals who have been
14 victimised, because that will confirm to them that this
15 is the world and this is how people treat you.
16 MR MACAULAY: Martin?
17 MR HENRY: Yes. I suppose Stuart and I have something in
18 common here as the social workers around the table, and
19 certainly in my not-so-distant professional past I have
20 been a social worker who has removed children from home,
21 I've been a social worker who has placed children in
22 residential care, and placed them in foster care, and
23 I've sometimes left children at home, knowing that it's
24 far from ideal, in fact knowing that it's risky and
25 knowing that I bear a burden of responsibility to ensure

1 their safety, in circumstances where I know that safety
2 is going to be in very short supply.
3 I'm not wanting to revisit that professional history
4 and I'm not being defensive about it, but until we can
5 untangle the challenges that some professionals are
6 facing on a day-to-day basis and have an honest
7 conversation about what that's about and how to resolve
8 it, instead of staggering from one problem to another,
9 we're going to find probably in 20 or 30 -- long after
10 I'm cold in the grave, there will be these conversations
11 going on sadly in Scotland.
12 However, what I wanted to do was come back to the
13 point, Colin, that you made earlier on about secure
14 attachment, because for me secure attachment, the
15 important part of that phrase is the word "security".
16 It's not just about the attachment, it's about the
17 nature of that attachment. Of course you can't assume
18 that the longevity of a placement necessarily indicates
19 that the attachment that has been formed is secure,
20 particularly when children and young people have
21 a history of insecurity that may well be relived by
22 expecting to be moved at any point in time.
23 Lorraine's absolutely right that the answer to your
24 question is the more you move kids, the less the chances
25 of a secure attachment you're going to have. Even

1 building some kind of secure attachment later on in life
2 can undo some of the damage that's been done.
3 So people often say, oh, well, is it something --
4 can you really give people secure attachments long
5 after -- has that ship not sailed once they're after
6 five years old or whatever? You say no, there are all
7 kinds of opportunities to put together relationships
8 that are truly secure, and that includes for children in
9 the looked-after system.
10 I suppose where that's taking me is to again ask the
11 question, which seems a bit perennial really, is
12 family-based care, for example, really the gold standard
13 for us in Scotland? Is that what we aspire to or are
14 there other ways of giving young people, whose
15 experiences of growing up have been difficult and
16 damaged and problematic, these kinds of attachments that
17 are not always dependent on family-based care being the
18 gold standard?
19 MR MACAULAY: If a child has established a secure attachment
20 in a particular location and then is moved on, so that's
21 broken, how easy is it to build another secure
22 attachment?
23 MR HENRY: I would have thought it would be a major
24 challenge. It's a major challenge when you're operating
25 within a system where moving children has become a norm.

1 Where culturally that is -- it's seen as something you
2 would rather not have, but it's not seen as necessarily
3 something that is perpetuating damage to children until
4 the damage is done.
5 What happens is when you start to look at young
6 adults in terms of outcomes, you think, "Oh my God, what
7 have we done here?" But while you're doing that, you're
8 not thinking that through. I think that's part of the
9 problem. Partly to do with our looked-after system,
10 which I haven't worked in for quite a while so I don't
11 want to get people being hostile, oh, Martin hasn't
12 worked in that system for so long, but I'm just
13 commenting as an outsider on how it seems.
14 In terms of outcomes, we don't do too well when we
15 bring children into public care. There's a multiplicity
16 of reasons for that, but it's still the case that we
17 don't do as well as we should.
18 So state-based care, for example, state care doesn't
19 really tend to do what it ought to do, but there's
20 an expectation that moving children is just something
21 that kind of still happens. My expectation when I was
22 a practitioner in social work was: oh, that will be long
23 gone by the 21st century. Kids won't -- we won't --
24 because in the 1980s, for example, adoption at all costs
25 was really in fashion, that was a thing. Put kids into

1 care and you were working towards adoption and from
2 a policy point of view that was the end game.
3 That's been rethought, of course. When I was
4 a social worker in the 1980s, I was thinking about what
5 about the 21st century, there'll be all kind of options,
6 there will be sustainable family care for kids and we
7 won't be in this position of moving kids about and yet
8 we still are.
9 Going back to the point that Liz made, which I think
10 is still as important now as it was for me as a young
11 social worker in the early 1970s, working with the
12 families of origin is still something that we have to
13 try and put investment and money into, and time and
14 effort and commitment and training. Not something
15 that's just a passing interest, but the longer we have
16 social workers who are becoming more and more case
17 managers rather than people who are capable of working
18 with families, then the more difficult it's going to
19 get.
20 Particularly if you're going to commit to working
21 with a family of origin, you have to know how to deal
22 with and effectively change the effects of trauma on the
23 parents. Instead of -- you know, this child-centred
24 thing is all very well, but if you actually start to
25 look holistically again -- I said this back in the

1 1970s -- looking at families as systems more
2 systemically and look at what parents have been through
3 and understand what that's about, you might start to get
4 somewhere. But the more we have social workers that are
5 case managers, the further away from that we're getting.
6 MR MACAULAY: I know we still have a queue --
7 LADY SMITH: Can I just follow up on one thing so I can
8 understand it, Martin? Earlier on when you were talking
9 about secure attachment, I think I heard you in effect
10 saying it shouldn't be assumed that just because a child
11 has been in a particular placement for a significant
12 period, they will have formed a secure attachment in
13 that place.
14 MR HENRY: (Nodded)
15 LADY SMITH: Two questions.
16 Does that mean that you think the greater likelihood
17 of any child being able to form a secure attachment is
18 that they do it within the family setting? Is it more
19 likely that a child will form a secure attachment in
20 a family setting?
21 MR HENRY: I think in general I'd be very tempted to say yes
22 to that, but I think it depends on the child and it
23 depends on what they've been through.
24 LADY SMITH: Okay --
25 MR HENRY: I'm sorry to interrupt you. But if a child sees

1 the family as a site of danger and risk and you put them
2 in another family, there's a lot of work to be done to
3 help that child adapt to that model of care.
4 LADY SMITH: Right.
5 The second question is, okay, taking it that you're
6 not to assume a period in a particular placement means
7 that a child will have formed a secure attachment, how
8 do you tell whether they've formed a secure attachment
9 or not, if that's a factor you should take into account
10 before you move them again?
11 MR HENRY: Without wanting to spend the rest of the day
12 talking about it, I would have thought from
13 a professional point of view is you start with the kid
14 and you start with the child and ask them what their
15 experience of living there is actually about. Not just
16 ask them, hear them, listen to them, be with them and
17 evaluate how that is changing who they are and how they
18 experience the wider world.
19 Because secure attachments aren't something that you
20 can just measure in a jar. It's something that's
21 qualitative rather than quantitative, so you really need
22 to have very good skills of communicating with and
23 understanding young people.
24 I think the more we have a kind of machinery of
25 care, an industry of care, the less some of these skills

1 perhaps are available in the places where they're needed
2 most.
3 MR MACAULAY: I think an issue that you said in this
4 response, that you should listen to children.
5 MR HENRY: (Nodded)
6 MR MACAULAY: There's a queue.
7 I think, Judi, you were first in the queue.
8 DR BOLTON: That's unusual.
9 I just wanted to pick up on the training point about
10 attachment, which I think is a really important one.
11 I think we're very familiar with talking about it in
12 terms of -- I say patients just because I work in
13 a hospital, or young people, but I think there's
14 extrapolation of training from direct training about the
15 people that we're working with to the staffing group.
16 Therefore that's why we use things like reflective
17 practice and things, which is about self-awareness and
18 insight in the staffing group. Part of attachment
19 training is about self-reflection and understanding our
20 own attachment systems, and particularly in working with
21 people about how we recover from disorganised
22 attachment.
23 The training has to be -- it can't exist in a silo
24 around just the direct interventional work with young
25 People. That was one of my points, that I think we need

1 to catch on in training.

2 The second thing I was going to say -- well, I'll
3 always have opinions, but I've left opinion on the birth
4 family and care because I work with adult services
5 predominantly, but I would say, according to the
6 recommendations on how far you want to take them, by far
7 and away what I hear from adults is that you have to
8 extrapolate not just from the family situation to the
9 problems beyond the family and society and the addiction
10 problem. So the impact of addiction services is
11 enormous on family, which is my tenuous link to the role
12 of whether or not you keep children in families, because
13 by far and away the thing I hear, you know, 90 per cent
14 of the experience from adults is about problems of
15 addiction in families.

16 MR MACAULAY: Thank you.

17 I think Morag and then perhaps, Lorraine, you had
18 your card up as well.

19 MS SLESSER: Judi's brought up exactly the point I wanted to
20 make about addiction. In terms of services for people
21 with addictions, somebody was saying you need to
22 intervene with the family. The major way you need to
23 intervene with the family is address the alcohol and
24 drug problem. The services for that are absolutely
25 woeful. I mean, I can't explain to you how bad they

1 are.

2 So we have offenders -- I mean, most of the people
3 in prison have some kind of addiction problem.
4 Curiously, the ones that have the least addiction
5 problem are generally the sexual offenders. The
6 services are all about the person being motivated to get
7 help. So, you know, you can get methadone -- you can
8 get methadone to help you, there are services, you know,
9 you can attend groups, there are drug and alcohol
10 services around the country that you can go to and see
11 them once a week, you can get drug testing.

12 But in terms of the families, the way I hear
13 about -- I hear it from the point of view of people's
14 children being taken into care. If you're intoxicated
15 either with alcohol or substances, especially substances
16 like cannabis, which are not in and out your system
17 quickly, it can be there for 28 days, and then if you're
18 continually topping up, you're just emotionally removed
19 from what's going on around you and you are not capable
20 of meeting your own emotional needs, let alone anyone
21 else's. You just don't see things. And your
22 decision-making is hugely impaired and your next most
23 important desire is to find out where you're going to
24 get your next drink from, how you're going to get the
25 money to get your next drink, how you're going to pay

1 your drug dealer for the amount of cannabis you want to
2 smoke, or heroin, worse.
3 What those individuals need is to be in hospital or
4 to be in some kind of situation so that they are not
5 taking drugs. Then you might be able to work with them
6 so you can completely -- I don't know what your
7 experience is, but if you can remove all alcohol and
8 drugs from their system, you might actually have
9 a chance of working with somebody. But if you're
10 expecting the person to go, "Oh, hello, I have a drug
11 problem, can you help me", you know, I don't know how
12 effective that is, if you've got evidence of that, but
13 what I observe is it's not effective at all and it's
14 hugely damaging to our society and definitely to our
15 children.
16 MR MACAULAY: Thank you.
17 Lorraine, you had your card up a moment ago.
18 DR JOHNSTONE: I would agree with Morag's point. I would
19 broaden that out far further than addiction services,
20 I think it goes across the whole entire health and
21 social care arena.
22 As I said yesterday, having worked in CAMHS and
23 adult services, they're entirely divorced, entirely
24 divorced. I suppose before I get cold in the ground,
25 I would quite like to see family mental health services,

1 that is about family, everyone in the family. We need
2 to get it right for families, not a child, not an adult,
3 we need to get it right for systems-based work, and we
4 are so, so, so far away from that.
5 The other thing that there is -- I have absolute
6 reality with resources. There are lots of families that
7 can be kept together with family support workers, with
8 people turning up, being there in the morning when
9 they're trying to get children out to school, just that
10 level of support. Those resources are -- to say they're
11 scarce on the ground is probably being optimistic.
12 There are absolutely numerous things that you can
13 do, things that did work very well years ago, and
14 because of resource constraints are no longer there.
15 I think the more fundamental point that I think is
16 necessary to make is of course going into care is not
17 the optimum for children, but it's what happens in care.
18 I think that gets confused hugely, because some children
19 absolutely require to be looked after and accommodated,
20 absolutely. In and of itself, the act of being removed
21 from an abusive environment you can recover from. It's
22 the quality of the care services that you experience
23 therein.
24 You're put in a placement that you may never choose
25 to be in, with people you would have no attachment or

1 connection to, revolving staff, staff that move. You
2 know, you might move from an inner city area to
3 somewhere like Dumfries and it's wilderness and it's
4 completely alien to you and these children get
5 completely dysregulated and before you know it, they
6 find a railway line to walk along.
7 I think it's really important what Martin says.
8 It's completely perplexing that we've come so far and
9 still don't have a menu of options for children, because
10 if you look at other cultures, for example where girls
11 maybe aren't valued and families will relinquish the
12 care of a female child, you know, some of the Asian
13 countries, they generally don't have as poor outcomes,
14 so we need to be really mindful. And the Scandinavian
15 countries have really good outcomes for looked-after and
16 accommodated -- well, comparatively speaking.
17 I think there's a lot we can do. Unregulated
18 placements, placements that are high staff turnover,
19 placements where you're with children who are moving, so
20 even trying to form a sort of pseudo-sibling attachment
21 is disrupted.
22 So going into care and what happens to you in care
23 are two completely different things.
24 MR MACAULAY: Liz, you were also waiting there patiently.
25 PROFESSOR GILCHRIST: This goes back to what Morag was

1 saying, but I think does very much link with what
2 Lorraine's been saying. I've spent the last five years
3 trying to develop integrated models of working with
4 abusive behaviour and substance use and families, so
5 meeting the needs of a range of different people, so the
6 people who abuse, the people who experience abuse, both
7 adult and children, and the services are there but
8 they're patchy and they're really unstable in terms of
9 funding. So there's something about actual stability of
10 funding. Integrated models of understanding the role
11 substance use plays, not necessarily requiring
12 abstinence-based models. Offering a range of options in
13 terms of how to work with somebody, and very much trying
14 to move away from hard-to-reach clients. You know,
15 often substance-using adults will be seen as ones who
16 don't turn up, who are too chaotic, who are unmotivated,
17 who fail to attend appointments so they won't be offered
18 any more.
19 Actually shifting the services to say that we're
20 hard-to-reach services because we're not meeting the
21 needs of our group and actually providing the input and
22 the interventions in such a way that it can be delivered
23 to those groups. And linking to that, it's like not
24 separating the children and the adults. It's the
25 holistic intervention where the agencies talk to one

1 another about risk and need and absolutely some people
2 will require a residential and separation accommodation,
3 but it's sort of somehow or other, if we can manage to
4 do the integration of the models and the thinking and
5 get support and resource, long-term resource so people
6 aren't constantly every six months bidding against each
7 other to deliver substance abuse services, which is
8 meant to sit within health and social care but it seems
9 pretty patchy, that would be really helpful.
10 MR MACAULAY: Yes, Lorraine?
11 DR JOHNSTONE: I think it is important to also
12 acknowledge -- having worked in mental health services,
13 a CAMHS service that I was a head of service for had as
14 an exclusion criteria attachment difficulties. That
15 changed, but they had as an exclusion criteria
16 attachment difficulties.
17 Exam stress, not to diminish it, but if you were
18 really anxious that you weren't getting five A stars in
19 your highers, that got in the door. Attachment and
20 trauma didn't get in the door. So that's for us maybe
21 to reflect on.
22 The other thing is there's a reality about how
23 services are measured and how they are adjudged as being
24 performing. You perform well if you see 17 and a half
25 patients a week as a clinician, and those 17 and a half

1 patients may be mild to moderate in severity. You're
2 not performing well if you see three patients a week and
3 you manage to stabilise their placements, keep their
4 family together, give them longevity of placement and
5 address their trauma.
6 There is a real issue with that, that is
7 undermining, I think -- maybe I'm speaking completely
8 for myself -- very much what most of us come into this
9 field to do, but also what we know what we should be
10 doing.
11 As I said yesterday, a girl that will stay in my
12 mind forever, I spent time playing cards because it was
13 the only way I could get near her. I had at that time
14 a fantastic manager when I went and said:
15 "What have you been doing?"
16 "I've been playing cards."
17 "What about the CBT? What about the therapy?"
18 I wasn't doing that, I was stabilising.
19 It would be incredibly helpful, I think, as part of
20 the recommendation is to talk about not the old concept
21 of realistic medicine or care, but really realistic
22 medicine and care. It's not about quantifying
23 a person's journey into 10 or 20 sessions, it's about
24 giving them what they need when they need it and how
25 they need it. Even if that means assertive of outreach.

1 There's a team in I think Manchester and the
2 clinicians basically go around the streets linking in
3 with the adolescents who are homeless. They go and find
4 the adolescents who are too intoxicated to come to
5 appointments, too chaotic. They go and find them,
6 rather than waiting for them to get the bus along to
7 their appointments.
8 MR MACAULAY: This has been a very interesting discussion on
9 the back of grooming. Perhaps I can try and wrap up the
10 grooming topic and ask generally now how rare is
11 grooming in practice? Is it something you come across
12 on a regular basis?
13 Yes, Judi?
14 DR BOLTON: I think -- I've just realised I'm answering
15 a bit like a psychologist -- it would depend on the
16 context of the work you're doing.
17 In a specific sexually offending group you would
18 mark that as very high, if you took the broad
19 definition.
20 In terms of physical violence or perhaps there still
21 might be some elements, but the variation would be huge
22 by population and definition I think.
23 MR MACAULAY: Did you want to --
24 PROFESSOR GILCHRIST: I was just going to say, one of the
25 moves in family violence is actually I think we're

1 recognising more that vulnerable families can be groomed
2 in the same way, that actually it's a concept not just
3 in child sexual abuse but intimate partner abuse, there
4 are abusers who specifically join groups, go to
5 substance abuse groups, to access victims who will make
6 really poor witnesses in court, who won't be easy to
7 leave and will accept maybe quite transactional
8 relationships where they have a tendency and their
9 partner does not.
10 Actually the concept of it not being by chance that
11 vulnerable people become exploited and continue to be
12 exploited so revictimisation and repeat victimisation is
13 something we're recognising more.
14 MR MACAULAY: Can I say just again, it has been very helpful
15 having had the discussion, really what is the converse
16 of insecure attachment, and that is secure attachment,
17 that's been very helpful, I think a very fruitful
18 discussion.
19 Can I then move on -- I'm sorry, Stuart. You've
20 been very quiet up there, Stuart.
21 MR ALLARDYCE: Sorry about being very quiet.
22 I just wanted to kind of note -- we don't need to go
23 into this because I'm sure that there's evidence that's
24 been provided, but we've not talked about the grooming
25 of adults in all of this, so the grooming of parents.

1 Which was a key thing that came in the Scottish Football
2 Inquiry where it looked like there was more grooming
3 going on of parents than there was of children in many
4 situations, but also the grooming of other professionals
5 in professional contexts as well, which is something
6 that we need to recognise.
7 Just to put that flag there and say that's
8 an important subject.
9 MR MACAULAY: Yes. You give the example, I think, Stuart,
10 the example of how befriending a single mother in order
11 to access the child would be a form of grooming that
12 could take place.
13 MR ALLARDYCE: I saw a terrific piece of work from Australia
14 a few weeks ago, which I don't think has been launched
15 yet, but it's a video for parents about grooming and in
16 the video -- it's actually a kind of sporting football
17 context, it's an animation where the coach says to the
18 mum of a child:
19 "Your child is really gifted, you know, and actually
20 with a bit of extra support, he could really get
21 somewhere in his sporting career, so can I make an offer
22 to you? Why doesn't he stay back for a couple of extra
23 classes every week? And I know that you're working, so
24 why don't I drop him home as well so you're not being
25 put out in any way?"

1 Then the question there for those that are watching
2 the video is: what are the red flags here? Should you
3 be concerned in this situation?
4 Because I don't think we've had a public kind of
5 conversation about the grooming of adults.
6 LADY SMITH: I mentioned yesterday having read the review of
7 abuse by John Smyth QC at Winchester College and I think
8 he did both, he groomed children, he groomed parents,
9 and he was in effect grooming other professionals at the
10 college because he worked in this area that other people
11 didn't really dare go to.
12 He was an evangelical Christian, he was keeping the
13 Christian group going and everyone thought he was the
14 best thing since sliced bread because of that, he must
15 be doing good, and he built up that reputation and
16 played on that, I think, to have the freedom to
17 perpetrate the abuse that he perpetrated on these
18 children. He wasn't even employed by the college. He
19 was an outsider, but managed to get in there and get so
20 accepted by everybody in the way he groomed them.
21 MR MACAULAY: We'll move on to the next topic, and that's
22 generally the topic of victim-to-perpetrator journey,
23 and that was one of the issues that you were all asked
24 to consider. Can I just ask the question: is there
25 a clear correlation between early victimhood and

1 engagement in abusive behaviour later in life?

2 I put it to you, Liz, I think you say certainly in

3 a sexual abuse context there is not a simple

4 correlation.

5 PROFESSOR GILCHRIST: One of the difficulties in answering

6 that question is the way that you would research it, in

7 the sense that if you go to perpetrators of abuse, then

8 you might find a fairly high percentage have abuse in

9 their backgrounds. However, that's really quite flawed

10 kind of retrospective, prospective analysis.

11 If you go to a population basis and actually look at

12 how many people in that population who then go on to

13 abuse, then there are all sorts of different interrupts

14 in the journey. There are things about personal

15 resilience and situational context and, you know, just

16 the context then of that opportunity to abuse makes

17 a huge difference.

18 I think in terms of those who have -- there's many

19 studies, but I think in general two-thirds of people who

20 go on to perform child sexual abuse, two-thirds, maybe

21 have -- this is convicted population, so again it's

22 flawed -- abuse in their backgrounds. It's not

23 necessarily sexual abuse.

24 MR MACAULAY: I think that's what I was going to ask you.

25 PROFESSOR GILCHRIST: It's not sexual abuse necessarily. So

1 neglect, physical abuse, the alcohol, so absent
2 parenting, lax parenting, abusive strategies,
3 authoritarian parenting, so overly rigid rules, it has
4 a very different impact.
5 What you might see is actually those who have been
6 sexually abused might go on to be more physical abuse.
7 Those who have had neglect and that attachment style not
8 met may end up being more sexually abusive. But it's
9 different studies in different patterns, so there's no
10 direct correlations through.
11 It's what we're learning, what we experience, what
12 other protective factors can be put in place so that
13 positive adult who is there kind of offering another
14 alternative to the stability in your life, so that could
15 be an aunt, it could be a positive coach, it could be
16 a teacher, can change that entirely.
17 MR MACAULAY: Morag, I think you say in your response that
18 people who are abused as children may develop
19 emotionally and psychologically in distorted ways and
20 that has an impact upon what may happen in adulthood, in
21 that they internalise their experiences and that becomes
22 part of how they see themselves.
23 MS SLESSER: I would say that much more often turns into not
24 being abusive of other people, that much more often
25 turns into depression, anxiety, mental health problems.

1 That's where it more often goes to, especially amongst
2 women, who we haven't talked much about female abusers,
3 I don't have that experience of that, but that's what
4 you more often see.
5 As Liz is saying, when you see the population of
6 individuals who abuse children, they have often
7 experienced all those problems with attachment and poor
8 models of behaviour, watching pornography as a child,
9 not being looked after, and confusing sex and love in
10 the same way.
11 There is this, and it must be a very small, minority
12 of people who go on to actually sexually abuse. Of
13 course we don't know, because how do we research it?
14 When you were asking that question, I was thinking
15 what is it about those who go on to abuse, and I don't
16 know definitely what we can say about this, but thinking
17 from my experience, there's usually something else about
18 them that allows them to indulge their sexual interests
19 in a negative way.
20 It could be things like a mental disorder and it
21 could be things like severe personality disorder, like
22 being very narcissistic or having psychopathic features
23 where you just want what you want and you don't care how
24 you get it, and that may not be specific to children,
25 that might be people who have high sexual arousal and

1 don't care about other people. You see that pattern in
2 offenders. You quite often see the kind of -- they have
3 sexually abused children, or maybe not young children
4 but adolescents or they'll sexually abuse their
5 partners, but sometimes you see things like cognitive
6 impairment can lead to that. Definitely substance
7 misuse can be very disinhibiting.
8 You often hear a story where they say, "Oh, I was
9 really drunk and I sort of fancied her a bit and then
10 I ended up having sex with her", and it seems like it's
11 all a kind of muddle in their heads.
12 Also, I think -- we haven't talked about this much,
13 but there are some people who have phenomenally high sex
14 drives and are very addicted to sex and almost ...
15 I don't want to say can't, because obviously they can
16 stop themselves, but that level of addiction where it's
17 in their heads all the time and they're the ones who
18 will be spending four or five hours of the day on the
19 internet, who struggle to get to work because of it,
20 staying up all night late because of it, and then, you
21 know, that kind of potentiates contact abuse.
22 I don't know what the research says recently about
23 who out of that tiny minority of those people turn into
24 abusers, but those are the kind of things you see when
25 you're reading their case histories or when you're in

1 front of them.

2 MR MACAULAY: I think you do say in your response under

3 reference to your own experience that violent men almost

4 always give accounts of being victims of violence as

5 children.

6 MS SLESSER: That, I think, is probably more straightforward

7 psychologically because they just haven't learned how

8 not to be violent. If you're living in a hugely

9 stressful situation where you're surrounded by people

10 who can be violent with very small triggers, you learn

11 how to respond with violence. Your emotional arousal

12 leads to violence, because it's actually quite a good

13 resolution of your anxiety, being violent. If you're

14 very -- I'm sure you're all heard of the flight or

15 fight. If you're very aroused and then you actually hit

16 somebody or you're very aggressive and angry, that can

17 make you feel better quite quickly and you get that sort

18 of sense of relief. So it's very reinforcing.

19 One of the things we would do with people who are

20 violent is to teach them to (a) recognise that they're

21 becoming angry, and (b) learn other strategies. When

22 I'm trying to decide whether somebody's changed, you're

23 really looking for: can they get that level of arousal

24 and actually not react with violence?

25 One of the things that will get you out of The State

1 Hospital would be an ability to be provoked and not
2 respond with violence.
3 MR MACAULAY: Yes.
4 LADY SMITH: Morag, you said that it's violent men who
5 almost always give accounts of being victims as
6 children. What about women?
7 MS SLESSER: That's because I -- when you work with the
8 offender population, you don't see that many women, so
9 other people might answer that better. It would
10 probably be the same from a psychological point of view.
11 Certainly when I used to work in adult mental
12 health, I saw some women who would come saying, "I'm
13 losing my temper with my children, I can't control
14 myself. The tiniest trigger like them, you know, not
15 putting the top back on the toothpaste will make me
16 angry".
17 So there must be more than that, there must be loads
18 of examples of women not being able to control
19 themselves, whether it leads to actual physical violence
20 rather than just severe criticisms and rejections of
21 their children.
22 LADY SMITH: We certainly have examples amongst abusers of
23 violent women, particularly in religious orders,
24 actually. I don't know whether that tells us anything.
25 MR MACAULAY: Judi?

1 DR BOLTON: I was just going to say on religious orders
2 I was thinking of what Morag said, and I mostly work
3 with men as well, but you have from the domestic
4 violence literature, they nearly all report violence
5 used as problem solving or emotional coping. Those two
6 features would still be the same system if you like from
7 women to men and make the high numbers of people that
8 report they witnessed violence and then with women and
9 in religious orders that you would have that same
10 mechanism, that they have seen violence used for problem
11 solving and that emotional coping is omitted through
12 violence.
13 I also think there's something about cultural norms,
14 around how problems are dealt with, which may be
15 slightly more historical around attitudinal norms about
16 how violence was used. The things you hear about, "That
17 was normal then or in that environment".
18 MR MACAULAY: In your response, Judi, while you're there,
19 you do say that in your experience there are large
20 number of offenders with a history of abuse in
21 childhood, but the majority of that is physical abuse.
22 DR BOLTON: Yeah, so I was thinking -- I was realising when
23 I answered it you go straight to sexual abuse, but
24 actually if you think of it by volume or prevalence, the
25 journey from victim to perpetrator, if you use those

1 words, is -- the numbers would be virtually everyone
2 says about from violence that they grew up with domestic
3 violence. Or in organisations where violence was used
4 for emotional expression or for coping or problem
5 solving.
6 MR MACAULAY: In relation to sexual abusers in adulthood,
7 what do you find looking to their childhood as to what
8 had happened?
9 DR BOLTON: I would say that I think the evidence would be
10 around the combination of childhood adversity factors,
11 of which the sexual abuse will be a part, but it's
12 a holistic -- people have talked a lot about these
13 adversive childhood experiences. So sexual abuse would
14 be a part, but there would be other features that you
15 would need present as well around a lot of things we've
16 talked about. Attachment, protective relationships, the
17 culture they grew up in. It would be a part of a bigger
18 picture.
19 MR MACAULAY: Lorraine, you have your card up?
20 DR JOHNSTONE: In my experience, one of the most pathogenic
21 forms of care is living in an environment where there's
22 domestic violence.
23 It seems to cause a particular distortion in a young
24 child's ability to manage relationships, because the
25 person -- the way I've kind of reasoned it, which may be

1 completely wrong, but if you're a victim and there's
2 a perpetrator, you have a dyad in a relationship, where
3 you have someone who you love who is also a victimiser
4 on someone else that you love. That is a really
5 perverse environment, it causes huge distortions.
6 I don't know if Stuart would say the same, but one
7 of the things that we found in the IVY project and
8 certainly I found, so obviously, yes, maltreatment and
9 adversities and direct harm, but the prevalence of
10 severe domestic violence was really eye opening for me
11 and it was one of the things that emerged from that
12 whole sample of high-risk youth, was the impact of
13 severe domestic violence in the home.
14 I think it probably links into what Martin's saying.
15 It's security, it's safety and security. In a way, you
16 can almost -- you know, linking to Liz's point too, if
17 you have an abuser, you can form with them, you can
18 appease with them, you can sometimes manage a little bit
19 of the dynamic. You can never really control the
20 dynamic between parents who are engaging in domestic
21 violence.
22 So I think that's really important to acknowledge.
23 I do also think it is important to be mindful that
24 not all harm and violence and anger does stem from
25 emotion. I do think sometimes it is about control, it

1 is about -- you know, some of the child cruelty
2 behaviours, they're not really in response to emotional
3 distress. It is about control. It's a completely
4 different need.
5 When I think about, you know, different kind of
6 pathways, again I think there's huge complexity in the
7 pathways, but some people re-enact a behaviour because
8 they didn't realise it was wrong or actually they
9 enjoyed it. Some people, it's a psychological need that
10 they will have about control or dominance. Other people
11 it's very just distorted, "I thought that that was what
12 they wanted". In other people it can be around
13 relational deficits.
14 Again, I think the victim-to-perpetrator journey is
15 really complex and I think it's really important to
16 emphasise that we have huge gaps in the literature.
17 I was reflecting that although what we often know about
18 the victim-to-perpetrator journey will come from
19 perpetrators who told us how they got there. What we
20 don't have -- for example, the notion that boys could be
21 sexually abused was much further emerged in the
22 literature than girls, so we don't know really what it
23 is that is a great resilience factor and what stops
24 them.
25 Our literature is -- it's blunt to say, to put it

1 mildly, and again I think it is about being really
2 mindful ... for different people it will be different
3 needs at different times as well. So somebody might get
4 really angry and emotional, but they might also have
5 quite narcissistic tendencies and just quite like to be
6 cruel.
7 So there is -- not that I'm aware or I've never read
8 any clear predictive variable, except perhaps there's
9 two that if someone has a psychopathic-type personality
10 combined with a severe sexual deviation, the presence of
11 those two features make it more likely that the victim
12 will become a perpetrator, but again it's not
13 conclusive.
14 MR MACAULAY: I have two cards up, possibly even three.
15 Liz, I'll give you the floor.
16 PROFESSOR GILCHRIST: I have about three or four things to
17 say, but picking up on what Lorraine has just said. So
18 the offence-supporting beliefs, the cognitive
19 distortions that you might end up developing having
20 experienced different types of abuse in childhood. The
21 ones which stick with you -- so, for example, if it is
22 that children are sexual beings, then you might be more
23 likely to continue to think children are sexual beings,
24 and therefore when you have interactions with children,
25 that's in your mind.

1 The idea that being exposed to family violence and
2 that ambivalence, so the victim-blaming as a child,
3 holding your mother accountable, if it is the mother who
4 is being abused, and being really unable to handle both
5 the push-pull aspect of caring about father but not
6 liking the behaviours, the guilt, the use of the
7 children, all of that kind of real complexity around
8 family violence and domestic abuse does mean that young
9 people in the situation -- I've done research with young
10 people who have experienced family violence. That
11 inability to ask for help because they knew that people
12 would sweep in and change their family dynamics, that
13 their mum would be blamed for being drunk, that -- you
14 know, watching their mum giving evidence to the hospital
15 as to how something had happened and being really unable
16 to say that was a total lie, it was my dad who did it
17 because mum was actually also quite needy. So the
18 complexity of victims with additional vulnerabilities
19 and the needs of the children meant that they were
20 silenced effectively. They wanted people to understand
21 them and they couldn't explain, so that would lead on to
22 a lot of difficulties later on, for further abuse and
23 that's the other thing is that young people who have
24 experienced abuse in the family of origin and then have
25 experienced more chronic abuse and then are more open to

1 being sexually exploited as young women, you know this
2 pattern.
3 Then actually one of the explanations for women's
4 violence and women's offending is quite often in
5 reaction to violence from others or a threat from
6 others. At the higher level women's violence is often
7 explained as being a response to a direct -- from a male
8 perpetrator or it's because they've had previous
9 experience of abuse or actually it's going back to
10 childhood abuse and it's more often explained through
11 a sort of exposure to abuse than it is -- male violence
12 is quite often explained as a sort of direct
13 transactional, "This is the way to do it, this is what
14 I expect as a man", but there's a complex relationship
15 between the cognition, the exposure and then how we
16 model it.
17 MR MACAULAY: I'll take Stuart next and then Martin.
18 MR ALLARDYCE: Like Liz, I have several things I want to
19 say.
20 One is simply to note that if you look at
21 victimisation studies, more girls are sexually abused in
22 society than boys. But most perpetrators that we know
23 of -- and indeed even from victimisation data, most
24 perpetrators are actually male. So we can't make any
25 kind of causal connection.

1 MR MACAULAY: Are you talking there about sexual abuse?
2 MR ALLARDYCE: Yes, I'm only talking about sexual abuse.
3 I also think that when we talk about a kind of
4 victim-to-perpetrator journey, I think we need to be
5 very cautious, it's often about individualised pathway
6 and we need to be careful about the optics of this,
7 because I know many colleagues I work with talk about
8 the adverse childhood experience discourse around people
9 who commit offences as being just a set of excuses for
10 offenders. I think we need to be careful about how we
11 talk about this and indeed -- you know, need to point
12 out that maybe it has some explanatory power in some
13 contexts and also it maybe points to some kind of
14 developmentally orientated prevention that could be
15 possible in some situations.
16 The other things I was wanted to say -- picking up
17 on Lorraine's point -- I mean actually there was quite
18 a well-designed study by Arnon Bentovim back in the
19 1990s, I didn't submit this as part of our evidence,
20 it's only kind of come to mind just now. I would need
21 to reread the article, but Bentovim worked at the Child
22 Sexual Abuse Clinic in Great Ormond Street Hospital and
23 they looked at just over 200 boys who had been referred
24 into that clinic and then tracked them quite a long
25 period of time after they left that clinic, so 10/15

1 years, and they looked at how many had then either been
2 convicted for sexual offences or indeed had also not
3 been convicted for a sexual offence but there had been
4 some kind of sexual concern about them that had been
5 raised in some kind of child protection or safeguarding
6 process.
7 The figures -- I can't remember exactly, but it was
8 between 10 and 20 per cent of the boys ended up looking
9 as if there was some kind of sexual concerns in young
10 adulthood or beyond.
11 They then looked at whether there were any factors
12 statistically associated with that group, and one of the
13 factors supporting what's being said here is that these
14 were boys who had also experienced other kinds of
15 adverse childhood experience as well, so they had not
16 just experienced sexual abuse but they had been around
17 domestic violence and they had experienced emotional
18 abuse and neglect, and indeed physical violence, which
19 is interesting.
20 The other thing -- I've never seen this replicated
21 in another study -- was that actually there seemed to be
22 quite a high prevalence of individuals who had been
23 sexually abused by women. I think that's interesting,
24 I wouldn't want to put too much weight on it, but this
25 is my last point. I think the kind of emerging

1 literature now about kind of pathways -- an interesting
2 article by Ian Lambie that's come out recently, it was
3 a small sample but kind of interviewing those
4 individuals who had committed sexual offences in
5 adulthood who had been sexually abused themselves in
6 childhood. There did seem to be something around kind
7 of arousal patterns and deviant sexual arousal that was
8 a factor there.
9 I worked with a man recently who -- this maybe was
10 an excuse on his part, but I think he was honest and
11 genuine about it. He said to me, "Look, you know,
12 I know I've been arrested for looking at illegal images
13 of children, but the images of children were children
14 between ages 8 and 10, and I'm not putting this out here
15 as an excuse [he said] but I was sexually abused at that
16 time".
17 Then he went on to say:
18 "I'm not saying this to kind of get you off in any
19 way, because actually I was sexually aroused and
20 I masturbated to those images online that I was looking
21 at, so I got some kind of sexual gratification from
22 looking at these images of children."
23 He then said:
24 "I've never told anyone about my abuse, but I had
25 an erection when I was sexually abused and I've always

1 been left with this kind of puzzlement about that and
2 I think there was just something that wasn't quite
3 processed that came out in my online behaviour."
4 I think going back to the Ward & Siegert Model that
5 we talked a little about yesterday, you know there is
6 a pathway which is about distorted sexual scripts and
7 arousal and so forth which may kind of link in there
8 which might have some explanatory power for some
9 individuals in some circumstances.
10 MR MACAULAY: Martin, you wanted to come in?
11 MR HENRY: Yes, if there's time thanks.
12 It's really just to amplify the points that Stuart
13 has just made, but also an earlier point that Liz made
14 when she started off really answering your question
15 about this journey from victim to perpetrator. What
16 I detected from what Liz was saying was to urge a note
17 of caution here about how we interpret that and the
18 assumptions that we derive from it.
19 I think it's probably true to say in a nutshell that
20 the majority of people who I've met and who I've worked
21 with who have been survivors of sexual abuse, I am
22 pretty confident in saying that the majority of them
23 have not gone on to abuse. That's not to say that
24 they've all gone on to lead perfect happy lives, but
25 they have not gone on to do stuff to kids.

1 The majority of people that I've worked with who
2 have committed sexual offences -- now, the other caution
3 here is that this has been post-arrest or
4 post-conviction, so these aren't guys that I was
5 speaking to before the behaviour has been detected, have
6 used that opportunity as the first opportunity to talk
7 about what happened to them growing up. Why? Because
8 it's the first time anybody asked them.
9 I think that that's quite an important message here.
10 If people have gone over a threshold of arrest and
11 conviction before anybody takes the time to actually
12 piece together a life history that could be potentially
13 problematic, then we really need to maybe have a think
14 about that.
15 I think that the other issues that I would raise
16 from that is that I think -- certainly for one man that
17 I've spoken to -- it is actually reflected in other
18 people I've spoken to -- said:
19 "I thought that by telling people about my being
20 sexually abused as a kid, from that point on people
21 would be able to tell by looking at me that that had
22 happened to me."
23 It was almost like a mark of Cain idea that they
24 would be walking about and people would immediately know
25 somehow that that had been part of his experience and

1 therefore make the quantum leap assumption that, "Oh,
2 well, he must be a risk around kids".
3 That's a note of caution to me about how we piece
4 all this together and what we make of it.
5 I think the point that Stuart's making is
6 an important one though, that when people say, oh,
7 right, this is my first opportunity to talk about what
8 happened to me as a kid, they then think, oh, this is --
9 and it's actually true in some cases. It sounds to some
10 people as if what you're trying to do is to deflect
11 responsibility for what you've done and make excuses and
12 try for leniency, because you're trying to get people to
13 feel sorry for you or whatever else.
14 I suppose what I'm saying under this is a lot of
15 assumptions about that relationship between victims and
16 perpetrators and that so-called journey. What I have
17 found useful, and I think Stuart would echo this, is
18 using a psycho-educational approach with people is
19 actually really helpful. That's basically helping
20 people to understand how they tick and to learn a little
21 bit more about how what they went through fits with who
22 they've become.
23 Particularly for a lot of people who are at that
24 point of finding out stuff for the first time, it's
25 actually quite a helpful approach, because just by

1 making sense, joining up the dots, can actually be quite
2 therapeutic for people and it gives them a better sense
3 of not just who they've become, but what they need to do
4 to sort it.
5 MR MACAULAY: I think your key message, and this comes from
6 your report, is that most people who have been sexually
7 abused or exploited in childhood do not go on to abuse.
8 MR HENRY: My view would be from the many, many survivors
9 who I've met and worked with that's the case. I'm
10 pretty confident in saying it. If you put me up against
11 a wall and said: are you certain? I'm not, but I'm
12 pretty confident in saying that they have not got on to
13 do stuff.
14 MR MACAULAY: I think you have support from Stuart on that
15 front.
16 That's essentially your message as well.
17 Is there any different message around the table?
18 That might be a good point to adjourn for lunch.
19 Back at 2 o'clock.
20 (1.02 pm)
21 (The luncheon adjournment)
22 (2.00 pm)
23 MR MACAULAY: Good afternoon, all. I trust you're all
24 refreshed after the lunch break and ready to head into
25 the last lap. That's where we're heading now.

1 Before lunch we had been talking about the
2 victim-to-perpetrator journey, and part of the question
3 that you were asked in that connection was: what
4 protective factors, if any, may minimise the risk of
5 victims becoming perpetrators?
6 You have provided some thoughts on that, and perhaps
7 looking to what's being said, it's really not rocket
8 science as to what might protect victims from becoming
9 perpetrators. For example, I think, Morag and Liz,
10 you're on the same page, that one protective kind,
11 caring person can make a difference. I think that's
12 probably common sense, in a real sense.
13 PROFESSOR GILCHRIST: Yes. I suppose if we've got one
14 resilient person who is offering the opportunity to form
15 that secure attachment but also demonstrating and role
16 modelling the alternative ways of what appropriate
17 healthy relationships are and then maybe setting up
18 a comparison to that, you know, what is that healthy
19 relationship? Maybe offering the opportunity to ask and
20 question, offering a safe haven and a place to talk and
21 disclose, and actually when that disclosure is made,
22 listening. You know, I think all of those things are
23 really, really important.
24 I think all of us being proactive in asking
25 questions or having opportunities for people to maybe

1 question and disclose and discuss and debate, maybe
2 quite difficult things like, you know, what's normal
3 sexual functioning? Is that normal? Is that okay? But
4 that being there and ideally in somebody who isn't paid
5 to listen to you. Somebody who cares I think is a very
6 important aspect.
7 MR MACAULAY: You agree with that, I think, Morag?
8 MS SLESSER: Yes, I agree with that. I also think this idea
9 of forming attachments, if you can form one positive
10 attachment and start to trust one person, I think that
11 can spread, provided the other people are okay.
12 Because sometimes people don't form attachments
13 because they can't trust anybody, so they miss out on
14 people that they could be forming attachments with, who
15 would be all right to confide in or to spend time with.
16 I think sometimes you're having to break that feeling
17 that no one can be trusted. So I think that's
18 important.
19 In terms of other things that are protective,
20 I think just things like having a nice place to live,
21 not worrying about money, having employment, other
22 people feeling good about something that you're doing,
23 actually having fun and opportunities to have things
24 that make you feel good. You know, sometimes I just --
25 for instance when we were at The State Hospital, that

1 was a real struggle. People were living there for 10,
2 15 years of their life and trying to find things that
3 would actually be fun to do and -- not just fun, but had
4 some kind of adrenalin attached to it.
5 One of the examples I give is that we had bicycles
6 at The State Hospital but we weren't allowed to have --
7 it's on a hill, if anyone's been there, but nobody was
8 allowed to cycle down the hill, which would have
9 actually been fun to do. So there's a kind of sense
10 of -- it's back to the Good Lives Model. You need to
11 have things that are fun, engaging, exciting to do and
12 that can take your mind off other things, unpleasant
13 things. I think we really underestimate that. Well,
14 children we may be better at it, but with adults they
15 also need to have positive things to do that are
16 exciting and fun, really.
17 LADY SMITH: But, Morag, what if the thing that makes
18 somebody feel good and enjoy life is abusing children?
19 MS SLESSER: But that's why you need to introduce them to
20 other things that are not about abusing children. You
21 know, it's like often people who take drugs say, "The
22 only time I feel happy in my life is when I'm taking
23 heroin or when I'm stoned or I'm taking some sort of
24 party drug like ecstasy". There has to be alternatives
25 to that and you really see people's lives being

1 astonishingly impoverished and part of that isn't just
2 living somewhere and having nice housing, not worrying
3 about money, it's actually having something interesting
4 and exciting to do, where you feel like you're impacting
5 on the world in a positive way.
6 It could be things -- I don't want to put my own
7 values on this, I know what I like to do to have
8 an interesting time, but, you know, we forget about
9 that. There needs to be positive opportunities for
10 people.
11 MR MACAULAY: Stuart, you talk about a safe space, I think
12 and we've just had Liz mention a safe haven. What do
13 you mean by a safe space?
14 MR ALLARDYCE: I think that kind of goes back to the
15 discussions around secure attachment. A safe space is
16 a place where people can regulate their feelings because
17 actually there are no stressors in that particular
18 environment.
19 MR MACAULAY: Lorraine and I think also Martin, again you
20 mention secure attachment and adequate support systems
21 as being important.
22 DR JOHNSTONE: Quite often people will refrain from causing
23 harm, because they don't want to cause harm to their
24 loved ones as well. So if they're invested and they
25 have something meaningful to live for and they take

1 responsibility for them, then they can benefit from that
2 process as well.
3 But, you know, it's all contextual, isn't it? It's
4 relevant about, you know, people do have different needs
5 and different values, and trying to have a context where
6 people can feel invested and engaged in their life, even
7 if there are drivers or difficulties that are quite
8 tempting at times, but actually what they have is more
9 important and valuable to them.
10 MR MACAULAY: I think, Martin, you would agree with that.
11 You say the most important factor really is secure
12 attachment in childhood, you come back to that?
13 MR HENRY: Yeah, I think we always come back to that, rather
14 predictably. It's such an important message that we are
15 never going to downplay it, because it's critical to,
16 you know, who we are as a society, we depend on adults
17 who are functioning as well as they can.
18 There's a whole lot of issues associated with that.
19 One of them is equality, because in the society which is
20 challenged by poverty and lack of opportunity, people
21 have less capacity to function as well as they otherwise
22 might.
23 In terms of human development, we keep repeating
24 attachment as being a central issue.
25 But coming back to the issue of Good Lives and

1 I think to move on a little bit from what Morag was
2 saying, I think this thing about having fun is actually
3 quite important. I think it's because what we want to
4 do is -- I always remember working with offenders who
5 are like kind of a bit addictive in their behaviour,
6 particularly online offenders, and they keep revisiting
7 it. Then they come in and they say, because you are
8 trying to distract them onto something else and give
9 them something else to do that's prosocial and not about
10 that.
11 A guy comes in and says:
12 "Martin, I'm obsessed with going to the gym now and
13 I'm doing it to the point -- it's not -- I'm up at 6.00
14 in the morning, I'm staying at the gym for hours and
15 hours."
16 And I'm saying, "I'm happy with that, I'm much more
17 happy with you being obsessed about something like that
18 than putting your energies, and your fun, your dopamine
19 rush, into accessing indecent illegal images of
20 children."
21 Ultimately, spending his whole day in the gym might
22 not be where you want him to stop, but it's certainly,
23 in terms of a transition towards a better life, a lot
24 better than what he was doing before. It's not just
25 fun, but it's also better for the rest of us as well as

1 for him, but it teaches him about alternatives and how
2 to model alternatives and to still get the same result
3 in terms of the way his brain enjoys it. I think that's
4 quite an important thing.
5 MR MACAULAY: Morag?
6 MS SLESSER: I want to add just one thing on working with
7 men, not everybody is any good -- not just men, women as
8 well -- at sitting down and talking about their
9 problems. Sometimes the best way you get any connection
10 with someone, like Lorraine's saying, playing cards,
11 going for a walk with somebody, making cakes, you know,
12 some other connection. That's often where you start,
13 but it may be that's the only -- you just have to show
14 them a different way of getting pleasure. As you say,
15 your dopamine rush. That's a learning thing and I don't
16 know what the schools are like, but there used to be --
17 in some places there's a much better outdoor activity
18 agenda.
19 In Denmark, I have a step child who lives in
20 Denmark. They don't go to school until they're seven or
21 eight, a lot of it is then about playing, learning how
22 to enjoy yourself, learning to be creative. There's
23 a much bigger emphasis on that.
24 MR MACAULAY: Stuart?
25 MR ALLARDYCE: Actually, just picking up that theme about

1 kind of working with men. Actually, if I was going to
2 suggest a few things that might be helpful in stopping
3 that pathway of victim to perpetrator, whether it rarely
4 happens. Pay attention to the needs of boys and men who
5 have been sexually abused. We've not talked a lot about
6 gender here, but all the evidence would suggest that
7 actually the issues are around men who have experienced
8 sexual abuse, if there is a kind of transition.
9 Services that work with people who have experienced
10 sexual abuse need to speak to survivors, both children
11 and adults, about healthy relationships and sexual
12 functioning. I'm saying that as somebody who used to be
13 involved with managing a service for children who had
14 been sexually abused. I'm not convinced in hindsight
15 that we did enough about that, because one of the things
16 I think we've learned from all of this is for those
17 minority of individuals who have been sexually abused
18 who go on and harm, part of what's going on there -- and
19 you know this when you work with sex offenders -- is
20 that most sex offenders have had something that's nudged
21 their sexual development in childhood or adolescence or
22 young adulthood. It may be something that is abusive,
23 it may be something else that's happened, but that
24 nudging needs to be acknowledged and thought about and
25 supported.

1 The other things are making sure that there are
2 services for young adults and older adults who are
3 worried about their sexual thoughts and feelings but
4 haven't abused yet. I would say that because I'm head
5 of my sort of service.
6 Let me just read my notes here. (Pause)
7 Sorry, my handwriting is so terrible.
8 Oh yeah, the last thing: making sure that services
9 that work with survivors can also work with people that
10 have that dual status, who have harmed but are survivors
11 themselves.
12 I had a referral some time ago from a survivor
13 agency who said:
14 "We've had a referral for a man in his 30s who met
15 his abuser at a family event and is really torn up by it
16 and needs some support at the moment, but he told us
17 that he had done something inappropriate with another
18 family member when he was 14 or 15, so we can't work
19 with him because he's a perpetrator."
20 It's like -- well, I don't know whether we should
21 work with him, because it's not about child sexual abuse
22 prevention.
23 It's making sure that those therapeutic spaces are
24 available for those that have that dual status.
25 MR MACAULAY: Yes, Liz?

1 PROFESSOR GILCHRIST: I was actually just thinking that
2 meeting the needs in terms of mental health and
3 substance use would also be really important. If
4 somebody's been victimised, then potentially, as we were
5 all saying, actually the more likely outcomes are that
6 they're going to self-harm, have suicidal ideation, poor
7 mental health and potentially trajectories into coping
8 through using substances and actually often
9 interventions in that way as well.
10 LADY SMITH: Could I just pick up on something that's coming
11 out of the line you're going down at the moment. If we
12 were thinking about protective factors to minimise the
13 risk of any victim becoming a perpetrator, don't we have
14 to start by recognising that in the case of many
15 children we won't know while they're children, or even
16 when they're in early adulthood, that they were victims.
17 If you're then building into your thinking that
18 having been a victim, on the statistics you've given us,
19 demonstrates there's some risk -- not major overwhelming
20 risk, I think from what you're saying -- of them
21 becoming a perpetrator. Does that mean you have to
22 think in case of every child that there are ways of
23 guiding them, helping them when they're children? This
24 sounds in a way quite cold and brutal, but in the case
25 of every child, they may become an abuser when they're

1 older, and so there are strategies that you should
2 always use?
3 That sounds extreme, but I'm sorry, that's where my
4 thinking's going on the information you've given us.
5 PROFESSOR GILCHRIST: If I could say that actually universal
6 services and preventive -- so having positive mental
7 health coping through ways other than alcohol and drugs
8 and offering psycho-education and support mechanisms for
9 all children would not be a bad idea. That means that
10 if it's universally available, it's also universally
11 acceptable, so I'm not being treated as different
12 because something happened to me. I'm getting what
13 other people are in school.
14 Now, if I engage in a service and I have higher
15 need, it may well be that I can have additional input,
16 but it's not that I'm getting something different.
17 Universally offered, everybody gets something, and
18 actually that's what the children who had experienced
19 domestic abuse were saying, is they wanted staff in
20 schools so that they could understand what was
21 happening, but it not to be different for other people
22 to understand also and them not to be singled out.
23 Yes, I would be quite in favour of a universal
24 psycho-education.
25 MR MACAULAY: You had your card up, Lorraine?

1 DR JOHNSTONE: I would potentially frame it slightly
2 differently. I think obviously education about specific
3 issues is relevant. However, if we take a step further
4 back, if we approached the need to educate society about
5 healthy attachments and educated families on how to
6 nurture healthy attachments, like a public health model
7 for example, then I think you would see huge shifts on
8 all manner of adverse outcomes, whether that's
9 offending, addictions, poor relationships,
10 intergenerational transmission of abuse.
11 I think if you took a public health model around
12 attachment, which is a universal need, it's biologically
13 predetermined, it carries no stigma with it and it is
14 applicable to everyone, because attachment is, I would
15 say, the biggest source of resilience and there is no
16 negative effects with it. If you have a healthy
17 attachment, then targeted interventions will have more
18 effect. If you don't have the healthy attachment, you
19 don't have the building blocks and the targeted
20 interventions don't have the impact that you would want.
21 MR MACAULAY: Yes, Stuart, you wanted to come back in?
22 MR ALLARDYCE: I think it is about universal services.
23 I think there's something about what end of the
24 telescope you're looking at this problem from. Somebody
25 mentioned this earlier on, but in working with sex

1 offenders, many have experienced harm and indeed have
2 experienced sexual abuse, but the majority of people who
3 have been sexually victimised in childhood do not go on
4 and commit harm, so you don't want to create solutions
5 to a problem that's not a significant problem for the
6 majority of children who have experienced sexual abuse.
7 We know that things like Lorraine Radford's study in
8 the UK, between 1 in 6 and 1 in 20 children have
9 experienced sexual abuse, so I mean it's a massive issue
10 that we're dealing with, but when we think about what we
11 do in schools about promoting healthy relationships and
12 boundaries and sexual health, clearly there are messages
13 in there that could actually accommodate or respond to
14 the nudges that some children experience, whether it's
15 having a sexual experience that they're developmentally
16 not ready for, something that they've been exposed to,
17 or indeed adolescent use of pornography and how that can
18 introduce kind of various -- modelling and so forth.
19 Indeed, I think experiences of sexual abuse can be like
20 that in some ways for young people.
21 So making sure that we're accommodating the needs of
22 children who have had different experiences in our PSE
23 responsibilities in schools.
24 MR MACAULAY: I'm also going to bring you in, Judi, because
25 you talk about engagement in education and I think what

1 you call psycho-education on the effect of abuse as
2 being relevant in this context.
3 DR BOLTON: It was very much linked to Stuart's point there
4 about -- I mean obviously my job is in the NHS, but I'm
5 going into my own children's schools, they're usually
6 horrified, they say, "Please don't come in and speak,
7 I know what you're going to say". It would be around
8 having some impact that could universal incorporate
9 those concepts that would be meaningful around healthy
10 sexual functioning, developmental -- experiences they're
11 not developmentally ready for and the use of
12 pornography. Although in the schools my children go to
13 I'm banned from mentioning pornography now. I think
14 it's such a glaring omission and it would give
15 a narrative to children who may or may not have been
16 victims of abuse equally, because the narrative and the
17 messaging would be the same.
18 MR MACAULAY: Michele, you haven't come in, but I think in
19 short what you say in your response is that really
20 a positive support network is the key factor.
21 MS GILLULEY: Absolutely. I think combined with what
22 everybody else is saying though, healthy sexual beliefs,
23 healthy sexual functioning. Possibly even for people to
24 have the motivation and capacity to be able to engage in
25 the support and treatment that they need. That could be

1 a protective factor, because sometimes people just
2 really can't get there, they can't do that, and those
3 support mechanisms that we were talking about might be
4 one fundamental way of actually getting them from A to
5 B, which might just be the start of working to protect
6 them against the experiences that they had.
7 MR MACAULAY: Lorraine, you do mention in your response
8 about those individuals who have deviant sexual
9 interests but do not want to act upon the basis of those
10 interests. I think you suggest that they have to go
11 through multiple child protection, public protection
12 steps before they can get treatment. I think you're
13 critical of the process?
14 DR JOHNSTONE: Again, I think I've seen adults with this
15 too, but certainly older adolescents whereby they have
16 achieved some level of sexual maturity maybe physically
17 and they're experiencing arousal to children or indecent
18 images or thoughts and they get really troubled by that.
19 They know it's wrong, they don't want to act, they don't
20 want to be that way, they don't want to have that
21 interest.
22 Clinically what I've seen is they will get extremely
23 distressed and often present as acutely suicidal, and
24 they present -- because they literally say actually
25 death would be a preferable option to me than to be

1 troubled by a sexual attraction and deviation that
2 I don't want to have.
3 In my role, as I said yesterday, I've had experience
4 where I've had to work extremely hard with colleagues
5 who are trained in this area or related areas to not
6 respond in a disproportionate punitive way whereby, you
7 know, it becomes a child protection, the young person's
8 name is passed over to social work or police and it
9 becomes almost like a public protection exercise, where
10 actually the person's there saying:
11 "Please can you give me strategies to firstly
12 understand why I feel this way, and, secondly, help me
13 make sure that I never act on it."
14 Linking into the neuro atypical population, that is
15 something that I've seen with people who get preoccupied
16 with their sexual functioning. They aren't really
17 socially and relationally sophisticated. They can't
18 marry it together, so they get extremely confused,
19 extremely distressed, but it is such a difficult thing
20 to speak about.
21 One of the areas of practice that I've developed is
22 whenever I see an acutely suicidal adolescent male,
23 I always ask them about their sexual functioning and
24 what their thoughts are and feelings are about that,
25 because it's just what you were saying, very often

1 they're never asked and they just completely get the
2 wrong type of treatment in response.
3 MR MACAULAY: Are you comparing the contrasting position in
4 Scotland to other parts of the UK? Is there any
5 difference in other parts of the UK as to how this is
6 approached?
7 DR JOHNSTONE: No, I wouldn't think so. I don't think it's
8 easy for -- perhaps instead of -- as Stuart said, it's
9 not easy for people to go to anyone and say, "I have
10 a sexual interest in children", or, "I am aroused at the
11 thought of necrophilia".
12 That is not an easy thing to say, and immediately
13 because of the nature of it and because none of us want
14 to be managing a case where someone gets harmed and
15 we've not assessed the risk. You can imagine as
16 a clinician if someone comes and says, "I'm really
17 struggling to manage my impulses, I have sexually
18 deviant fantasies, I'd like to perpetrate a sexual
19 homicide and I'm seeing my cousins on Sunday".
20 Then what do you do with that?
21 Again, it's about education around the systems as
22 well, because we need to find a way to help people who
23 have these difficulties find an outlet and find support
24 to manage it.
25 There's very historical research I think that

1 identified that sexual fantasies of an offending nature
2 are much more prevalent than people might think, but
3 people don't act on them.
4 MR MACAULAY: Morag?
5 MS SLESSER: Yes, I just wanted to echo that clinically.
6 It's not just whether you have the thoughts, it's the
7 intensity of them and also how much control you feel you
8 have of them. Lots of people will have thoughts of
9 violent sexual fantasies or sexual fantasies about
10 inappropriate people, but they are way off acting on
11 them. I think that is the assessment that has to be
12 done and often what happens is people just respond to
13 the fact that thoughts exist without doing the more
14 complex analysis of how much control do you feel you
15 have? How often are you having these thoughts when you
16 don't act on them? Probably 99.99 per cent of the time.
17 So what is it that people fear?
18 It can also be linked to OCD, I think. I've
19 certainly seen a few people, just ordinary adults in
20 mental health practice that have feared that, they fear
21 they're going to suddenly reach out their hand and touch
22 somebody inappropriately. That's a mental health;
23 problem, that's not somebody who's about to abuse
24 a child.
25 MR MACAULAY: Yes, Stuart?

1 MR ALLARDYCE: To add something to maybe kind of make it
2 practical. At the service I manage, we do work with
3 people who are worried about their thoughts and feelings
4 towards children, who have not offended. Increasingly
5 we're seeing these people calling themselves
6 minor-attracted people. That's one of the terms that's
7 kind of used online.
8 Several of the people that we've worked with
9 recently, interestingly, were known to mental health
10 services, often because of stuff around suicide, as
11 Lorraine has said. Often when they talk about their
12 sexual thoughts and feelings towards children, even
13 though they've not offended, then the psychiatrist will
14 immediately inform the police, which is catastrophic for
15 a whole host of different reasons. Certainly by the
16 time we meet with them, often their sense of trust has
17 been shattered with professionals and we have to spend
18 a long time building up that sense of trust with them.
19 We also know there was a study that came out earlier
20 this year from Nottingham University, involved with
21 surveying individuals online with that presentation,
22 people who have not offended but are worried about their
23 sexual thoughts and feelings towards children. The
24 majority wanted to speak to their GP about it or speak
25 to a front-line health practitioner, partly for the

1 reason Lorraine was saying, because often it sits with
2 lots of anxiety as well.
3 I think what we need in Scotland is a very clear
4 care pathway for these individuals, insofar as if you're
5 worried about your sexual thoughts and feelings, then
6 you should know what to expect when you go to a health
7 practitioner and there should be some certain standards
8 that are in place with respect to how this is dealt with
9 from a child protection point of view if there are child
10 protection concerns, but also just in a more general
11 way. Also, staff need to be trained in how to respond
12 to these kind of issues.
13 I think there are tangible things we can do.
14 MR MACAULAY: Good. Thank you for these contributions on
15 that particular topic.
16 I want to just very briefly return to the previous
17 topic, because there was a point I was going to raise,
18 and it comes directly from something you said, Martin,
19 in your response when you were looking at the
20 victim-to-perpetrator journey, particularly in relation
21 to a sexual interest in children, because as you point
22 out, a sexual interest in children may also occur in
23 adults whose life trajectory has been relatively problem
24 free. They indeed might be the people who might end up
25 working in the care service.

1 MR HENRY: Yes, absolutely. I think that if anything for me
2 that just underlines the need for services like the one
3 Stuart manages.
4 I think there will be -- going back to the point
5 that was just made, sexual thoughts about children are
6 a lot more common than I think we as a society care to
7 admit. There is research on this, to be fair. There
8 are a surprisingly large number of adult men who will
9 have illicit thoughts sexually about young people.
10 These may be sporadic or they may be long-term, but they
11 never evolve into something that manifests itself as
12 illegal behaviour or offending.
13 But we nevertheless need to take cognisance of it,
14 because it might, and we have to help people to address
15 that, partly because it's affecting them and how they
16 function anyway, but also just in case there may be
17 other factors in their lives that trigger them into
18 acting on their thoughts rather than just keeping them
19 as fantasies.
20 I think yesterday I referred to some things that are
21 life events that we know along the pathway of people --
22 men, I'm talking specifically about men -- change in
23 their lives that actually do trigger crises. I think in
24 terms of crisis people start to sometimes behave in ways
25 that they otherwise might not have done in a perfect

1 world.

2 That could be -- I think Stuart would bear me out on
3 this -- we get people coming in who have been arrested
4 for offences and it's not surprising to find out that
5 actually when they're offending, their actual offending
6 began might be associated with things like loss through
7 bereavement, through redundancy, through other major
8 shifts in their lifestyle and the way that they -- and
9 usually they're not positive, they're negative.

10 We need to take cognisance of that, what can trigger
11 people to move from just thinking about something to
12 actually doing it.

13 We would prefer that people didn't think about it,
14 but when we come into the research that says a lot of
15 people have these thoughts and never go on to act on it,
16 I think it's something in a sense we have to live with
17 in a society, where we'd prefer it if they didn't, but
18 we're now getting a bit more intelligent in
19 understanding actually a lot of people do have illicit
20 thoughts but don't act on it.

21 My thinking is -- going back to the point that you
22 made earlier is, well, I suppose Lady Smith made it, was
23 about what would stop the trajectory from being a victim
24 to being an offender or a perpetrator. I suppose the
25 glib simple answer to that is: let's prevent sexual

1 abuse from happening in the first place.

2 It sounds glib and it's a challenge, it sounds like

3 an easy answer but it's a complicated answer. But it's

4 not singly about clinical interventions or the way

5 services are designed or any of the other things that we

6 have spent two days talking about, it's a challenge to

7 society from a public health point of view about how do

8 you take the issue of child abuse -- not just sexual

9 abuse, but child abuse and maltreatment -- seriously

10 enough to know what to do to prevent it from happening

11 in the first place.

12 The absence of abuse isn't the whole picture. We

13 also have to promote what a positive childhood looks

14 like. Because just having people not doing bad things

15 to kids is part of the picture but it's not the whole

16 picture. We need to have childhoods that are filled

17 with something else, other than the possibility of

18 abuse.

19 I suppose that takes us aspirationally to bigger

20 sociopolitical issues to do with how we deal with

21 poverty and opportunity and all the other things that

22 affect the life course for people growing up. I know

23 that sounds very grand, but I suppose going back to the

24 topic that we're here for for two days, which is

25 essentially about the prevention of child abuse in care,

1 the word "prevention" for me rings loud and clear and
2 I think for me it's something that perhaps we've not
3 touched on as much in this session and yesterday's
4 session as we otherwise might, perhaps because it's
5 sometimes the issue of prevention goes in the
6 too-long-to-do tray and we spend a lot of our time
7 talking about our own professional experiences and the
8 way services are designed, rather than the big
9 challenge, which is: what does prevention look like and
10 is it possible?
11 MR MACAULAY: Thank you. Since it was in your report,
12 I thought it was quite an interesting point.
13 Can we then move on to the last topic. That looks
14 at risk, recruitment and training.
15 Let's look, first of all, at risk and the barriers
16 to the implementation of risk management strategies.
17 First of all, risk assessments. I think a number of
18 you do indicate that you do use risk assessments and
19 what these risk assessments are. Liz, for example, you
20 mention a number of tools. I don't think I need read
21 out the acronyms for the tools, but do you find that
22 these tools are effective in assessing risk?
23 PROFESSOR GILCHRIST: Yes. I think, similarly to many of my
24 colleagues, the current approach is to use a structured
25 professional judgement approach. It's very much less

1 about ticking boxes and much more about gathering
2 together information that has been evidenced
3 internationally as being relevant and then applying it
4 to individuals. Gathering together information from the
5 individual, from their histories, from their behaviours
6 across a range of settings and patterning out and
7 profiling what the nature of the risk is, what the
8 nature of the harm is, the context in which the risk
9 occurs, what might be protective factors and what might
10 be the kind of individual risk factors, so it's a sort
11 of individual assessment. Done well, it then highlights
12 and identifies the kind of more likely repeat situations
13 or different situations that might occur, and then
14 offers a real sensible profile to step into risk
15 management. It's a very individual risk management
16 strategy rather than saying:
17 "Here's how we deal with everybody."
18 It's like:
19 "For this person, in this context, who's offended in
20 this way or who's abused in this way, here are the
21 things that are important for them, here's what might
22 help them desist and here's what we need to do, but we
23 can't rely on individual change, so who do we need to
24 tell, how do we do the safety planning and such like?"
25 MR MACAULAY: What barriers, what problems do you come

1 across then in adopting that approach?

2 PROFESSOR GILCHRIST: Time. Access to information. The

3 fact that you have to select the right tool. If you

4 have an adult population or an adolescent population,

5 you need to be thinking of the right tools. You need to

6 be viewing people in the right way. If I decided to do

7 a risk assessment based on general violence and actually

8 what I'm talking about is sexual violence, I might end

9 up with a slightly different skewed picture. You might

10 have to look at two or three different tools. I think

11 it is really actually these kind of risk assessments are

12 highly specialised, they're not generalised and it's not

13 answering one question.

14 What we tend to get is that at the time you're

15 getting this kind of risk assessment, it's only for

16 a minority of cases. The majority of cases there isn't

17 the time, resource, training and professional expertise

18 available for those types of assessments to take place.

19 In my head that's a kind of like the resource that

20 you would put in to ensure that that happens early and

21 actually all the planning comes from a really

22 comprehensive assessment is probably really worth it,

23 rather than having a lot of relatively fast, more tick

24 box, more generic assessments that actually do not meet

25 the need.

1 It's a bit of a hobby horse in some ways, but
2 actually I think it's really important to have good
3 specialist risk assessment.
4 MR MACAULAY: In the criminal justice system you have some
5 comments to make in relation to when treatment might be
6 accessible in that context.
7 PROFESSOR GILCHRIST: Yes. This may be about linking back
8 to sentencing and also letting judges know what is
9 available and what is not. Say, for example, some of
10 the treatments are only available in prison, so some of
11 the risk assessments will be asked to address specific
12 questions about sentencing, rather than necessarily
13 about treatment options or actually the treatment
14 options will already be linked to particular sentences.
15 So if the risk assessment isn't clear, then the judges
16 may offer different sentence options.
17 In prison, you might or might not have access to
18 specialist interventions. I know within the Scottish
19 Prison Service at the moment, they can be quite
20 overwhelmed with historic sexual abuse cases and
21 actually there's a huge, huge backlog of people waiting
22 for access to group work interventions that should
23 address their need but there's just not -- there's not
24 the number of spaces.
25 LADY SMITH: Of course, the court doesn't necessarily know

1 where the person will be in custody.
2 PROFESSOR GILCHRIST: Absolutely.
3 LADY SMITH: Judges aren't told, and they may be moved
4 around.
5 PROFESSOR GILCHRIST: Absolutely. Sometimes they're moved
6 around to access treatment or sometimes there will be
7 barriers to moving to access treatment as well.
8 Actually in the community, there's limited provision as
9 well in terms of meeting the needs of moderate- to
10 high-risk sex offenders. You know, there's specialist
11 training and there are programmes that run prison and
12 probation or criminal justice social work in Scotland,
13 but again there's only limited numbers of places.
14 We don't have, I don't think, yet, adequate
15 interventions for those who have committed offences
16 online. We're kind of not really quite sure where they
17 sit in terms of the treatment and treatment needs.
18 Certainly in terms of mandated programmes, I think
19 there's a move to try and develop aspects that would
20 address the needs of more internet offenders, but
21 I don't think it's fully evidenced.
22 MR MACAULAY: Morag, you wanted to come in on this?
23 MS SLESSER: Yes, it's interesting, because you'll have seen
24 that I put no submission here.
25 MR MACAULAY: Yes, I saw that.

1 MS SLESSER: Because actually anyone who knows me knows that
2 this is my pet subject, my whole professional life has
3 been about risk assessment and that is because all the
4 risk assessments that Liz is talking about are people
5 who have already offended.
6 MR MACAULAY: Yes.
7 MS SLESSER: That's great and we have good evidence,
8 probably the best we're going to get in that respect.
9 But I thought what you were thinking about was risk
10 in recruitment and to my knowledge, other people might
11 know better, I do not know how we're going to do that
12 risk assessment at the recruitment stage, because
13 I don't know the tools we have about that. I also don't
14 know whether these risk factors that we're talking about
15 now, the risk factors for sexual violence, we know what
16 they are in the people who have committed sexual
17 violence, because we've studied them a lot, but do we
18 know what they are for the people who are going to
19 commit sexual violence? That's just explaining where
20 I'm coming from. I don't know if we actually know that.
21 Other people might, but I don't.
22 MR MACAULAY: Any thoughts on that, Lorraine?
23 DR JOHNSTONE: Again I think what I would reiterate is there
24 is very unlikely to be a tool ever designed or developed
25 that will screen in or screen out someone who is

1 suitable for working with children, apart from at the
2 sort of higher end, obviously.
3 It comes down to -- it's like a goodness of fit, are
4 they a good fit and do we have an environment --
5 I interpret this risk in recruitment training -- do we
6 have a system around them that can optimise them to be
7 the best carers that they can? That there isn't really
8 an HR or interview process.
9 I think the best approach that you can do is have
10 high levels of training, so for example some of the
11 Scandic countries, that you have degree courses in
12 residential care, you have degree courses before people
13 come in, so there's a process of suitability on
14 placements and training, and then they come in and
15 they're on probationary periods so you can spend three
16 months/six months with somebody to see whether they're
17 coachable, whether they're a good fit, and then whether
18 they can be developed.
19 I don't think -- you know, even developing and
20 designing risk assessment tools based on offending
21 populations where there are established risk factors and
22 offences, they're variable.
23 MR MACAULAY: The focus, I think, has to be on those people
24 who perhaps want to work in the care service.
25 DR JOHNSTONE: Yes. I absolutely think it should be

1 a profession, it should be a recognised profession where
2 people are trained, they have placements, they have
3 mentors, they have supervisors, they have examined
4 competencies, they're on probationary periods, they are
5 on review periods, all of these things are how risk will
6 be managed as opposed to designing a set of questions to
7 ask somebody at interview.
8 We spoke about impression management yesterday.
9 Impression management at interviews, you know, you're
10 basically selling your best side. That process isn't
11 going to be effective.
12 MR MACAULAY: Yes, Stuart?
13 MR ALLARDYCE: I agree with all of that. I mean actually
14 there have been attempts to develop such tools. There's
15 one called the Abel Screening Tool that's used in the US
16 for screening people going into caring provisions.
17 I don't know whether it's validated. I would be highly
18 sceptical about that something of that nature for the
19 reasons that we're talking about.
20 Also, I think there's a danger of -- it gives
21 a false reassurance because it's a misunderstanding of
22 the nature of the problem. Because screening in the way
23 that we're describing it is a process to keep bad people
24 out, and actually what we know from our experience and
25 the research is actually it's more about what happens to

1 people within organisations.

2 There's very little evidence of any cases of anybody

3 who became a Catholic priest to sexually abuse children.

4 I certainly have not come across that in the literature

5 to date. It's about experiences and things that happen

6 to people when they're in a profession, recognising

7 their vulnerabilities that they bring into the

8 profession and what happens within the profession.

9 The more we build this gatekeeping process, the more

10 we misunderstand the nature of the problem and give

11 people false reassurance.

12 I think however, to push back on what Lorraine was

13 saying, there are things about good practice in HR that

14 are applicable here that we'll maybe come to.

15 MR MACAULAY: Judi, you raised the question of personality

16 assessments being carried out. Can you apply that to

17 the context of people who are going to be employed in

18 care homes, for example?

19 DR BOLTON: I think I raised it because it's a question I've

20 asked of people, so of course there's a response bias

21 that you have to be mindful of because these are people

22 who are convicted offenders. But I have asked --

23 probably for self-indulgent interest -- them the

24 question: what assessments did you have when you were

25 considering the priesthood? Particularly I was trying

1 to focus on their personality, particularly because
2 I would agree with Stuart, I think the concepts of tools
3 may be difficult, but we're thinking more in terms of
4 concepts rather than a tool per se.
5 We know there are some risk features around perhaps
6 narcissism, around concepts of entitlement or
7 self-centredness, and therefore I always ask them the
8 question of: what were you asked when you went for the
9 job?
10 I suppose I mention them in that context and because
11 we know there are organisations in the private sector
12 that assess people for roles within the church as well.
13 I'm not one of those people, so I've asked them what
14 process they went through to try and -- well, answer
15 your question, really, which I haven't answered, but
16 I would be aware that people are employed in that
17 capacity or thinking along those lines.
18 MR MACAULAY: How would this work if you're dealing with
19 someone who wants to work in the care service?
20 DR BOLTON: I think the care -- well, there are overlaps
21 with the care service. I think perhaps Lorraine
22 mentioned earlier around training and attachment, but
23 also self-reflection capacity in the people working in
24 the -- what you are really looking for is people who
25 have aspects of reflection and that capacity themselves.

1 I mean, certainly in industry I've worked with
2 people who have said that they would be administered
3 personality assessments and then have to go to interview
4 and argue against them. I don't think we've got there
5 in the care environment, and perhaps that's because it's
6 a difficult place to get to.
7 As Stuart said, it's not the recruitment process
8 alone. It's the steps further after the recruitment
9 process about the culture and the place where they are
10 working.
11 LADY SMITH: Are you indicating, Judi, that one needs to
12 look for credible indications of self-awareness,
13 self-knowledge, understanding of one's own weaknesses as
14 well as one's strengths?
15 DR BOLTON: That's exactly what I would say.
16 I mean, it's not very scientifically robust, because
17 it's by questioning, so I would ask questions like:
18 "What's your knowledge of healthy sexual functioning
19 and where did you get that from?" And:
20 "How did you think that was going to manifest in the
21 job that you were going to be working in around
22 celibacy?"
23 By asking opening questions you're asking for
24 an answer that implies self-reflection and insight into
25 one's own psychological functioning.

1 LADY SMITH: How would you apply that, for example, to
2 somebody who is seeking to be taken on by a Local
3 Authority as a foster carer?
4 DR BOLTON: I don't know if you would apply it any
5 differently, apart from perhaps that you're not -- the
6 requirements of the job might be different. If you
7 remove the aspect of celibacy, you're looking for
8 a different structure in the answer, but you're
9 essentially asking for the same thing about
10 an understanding of their knowledge base and
11 an understanding of the answers that they are going to
12 give in terms of their own functioning and how they see
13 the world.
14 MR MACAULAY: Yes, we'll start with Lorraine and then move
15 on to Morag.
16 DR JOHNSTONE: I think, as Stuart says, there are clear
17 questions that you would ask people, anybody: why do you
18 want the job? What are your motivations for being here?
19 What skills do you have to bring? What supports will
20 you need to do a good job? You want to have that type
21 of process and questioning.
22 I do think there is something around about foster
23 caring and caring, the residential environment and
24 caring for a child that is placed with you, I seriously
25 couldn't put into words how challenging that can be and

1 the expectations around what that is.

2 I think realistically it has to be a multifaceted

3 reasonably protracted period of assessment that observes

4 people, how they function, observes interactions,

5 observes real world constructs.

6 Because lots of people might say, "I'm really good

7 with children, I'm great with them, they really relate

8 to me", but then I might observe them as a psychologist

9 and think, "Oh, I don't really like that dynamic, that

10 dynamic's problematic".

11 Depending on what the role is obviously I think

12 there is about what the person brings but also the

13 expectations of what the job actually is. When

14 I recruit for residential staff, very few of them are

15 aware of the risk of violence that they face. Very few

16 of them. Very few of them are aware of the

17 interrogation and level of questioning that they will

18 face from young people and how to manage that. Foster

19 parents are often not aware of the systemic impact on

20 the whole family life that comes with a change in the

21 dynamic.

22 Absolutely recruiting the right people in, but also

23 finding ways to retain them, build their resilience,

24 make the job realistic. There isn't going to be sort of

25 ten set questions that achieve that, it's got to be

1 sophisticated.

2 MR MACAULAY: In your response you focus on three particular

3 points. The recruitment has to be rigorous, that's

4 I think what you're talking about, but you also say that

5 the staff that are recruited should be on probation and

6 they should be mentored and monitored.

7 DR JOHNSTONE: Absolutely.

8 MR MACAULAY: Does that happen at the moment?

9 DR JOHNSTONE: I would speak as a clinical psychologist,

10 it's absolutely as a rule that you must be

11 supervised/mentored. We are a --

12 MR MACAULAY: That's in your function, I'm talking about --

13 DR JOHNSTONE: Yes, so I suppose what I was mapping that

14 onto -- I don't know any other professional group that

15 has the same level of support as the norm. I think that

16 that is really important, often what people get is

17 supervision about performance, but not about process or

18 feeling or having a safe place to talk about the

19 difficulties. There isn't the mentoring, support and

20 CPD opportunities for residential workers that there

21 would be, for example, in other specialisms that you

22 would see, because it is extremely difficult.

23 MR MACAULAY: I think what you're saying is that's what

24 should be in place?

25 DR JOHNSTONE: It's absolutely what should be in place,

1 absolutely.
2 MR MACAULAY: Morag?
3 MS SLESSER: I don't have that much to add, because Lorraine
4 has more experience of the nuts and bolts than me, but
5 what I do have experience of is trying to recruit people
6 into somewhere like The State Hospital, where there are
7 loads of challenges and we need the right kind of
8 person. We do need to try and come up with something.
9 I know everyone's saying how difficult that's going to
10 be, but the truth is Lorraine's not going to be there
11 every time, so I think you do need to try and come up
12 with something and I think -- I don't know if this will
13 be the group, but we have to have some way of figuring
14 out who the right people are. I'm sure everyone has
15 some ideas about that. I think that will be better than
16 what we're doing now. That's the first thing to say.
17 The other thing to say is I think the way
18 occupational psychologists work is they look at the
19 people who are doing a good job now, people who actually
20 are doing the job the way that everybody thinks it
21 should be done and try and do some kind of analysis
22 around those people and try and figure out what are the
23 key things that those people are bringing and how can we
24 assess that?
25 It's the challenge that we face at The State

1 Hospital, especially when we are recruiting nursing
2 staff, and we had to do something, we needed 100 more
3 nursing staff, we had to do something about it, so maybe
4 it wasn't perfect, but --
5 MR MACAULAY: There's quite a number of cards waving, but
6 before you stop, Morag, you do mention in your response
7 The State Hospital research programme about good
8 psychological flexibility. Does that come into play in
9 this discussion?
10 MS SLESSER: Yes. That research came about because we had
11 very, very high levels of sickness at The State Hospital
12 which were costing lots of money, so we did a research
13 project around what predicted the health and well being
14 of our staff. You might think it would be because they
15 were victims of violence or aggression, of which there
16 is a reasonable amount, or certainly threat, but what we
17 found, the best predictor of health and well being, and
18 consequently absence, was people's psychological
19 flexibility or psychological resilience, but
20 psychological flexibility is a notion that comes from
21 the acceptance and commitment therapy world.
22 It's really about being able to see what's happened
23 to you in a compartmentalised way and make sense of it.
24 So you're not thinking, "Oh, this is all about me, I've
25 had a terrible day today, I can't cope when I get home".

1 It's about saying:

2 "Okay, so I was working with a difficult patient,
3 this is what happened, luckily I have my other
4 colleagues I can talk to about this."

5 So there is a kind of model of coping with stress.

6 We then haven't done the research, or maybe somebody
7 has now, about what else we know about those, whether
8 they're really good staff, but it certainly was
9 protective for them and that was an interesting -- we
10 used a psychological flexibility tool, but that's yet to
11 be shown whether that's predictive of a good member of
12 staff. It's a predictor of protecting themselves, yeah.

13 MR MACAULAY: I think there are a number of cards waving
14 about.

15 I think, Martin, you were first on.

16 MR HENRY: I'll try and be brief.

17 It's just when we come back to the question that
18 Lady Smith asked a few minutes ago, it's essentially
19 about foster care which of course always whets my
20 appetite a little bit, because it's almost as if we're
21 talking as if there's been no system of foster care
22 assessment and we're starting from scratch. We're not.

23 Foster carers have been assessed, so to speak, for
24 a long time. Not just screened in terms of recruitment
25 but actually assessed, prepared, a preparatory process

1 for caring for other people's children in your own home.
2 I think the problem seems to be, if I'm reading
3 between the lines, is that even though that happens,
4 children still have ended up being abused in foster
5 care. The issue would be, I suppose, first of all, is
6 the system of assessing foster carers and preparing them
7 robust and rigorous enough to get them to do -- to get
8 the right people in to do a really difficult, stressful
9 job? It's not just about residential care, it's about
10 actually looking after kids in your own home, which is
11 a very different kettle of fish. So there's that.
12 Also, back to the issues that have been made I guess
13 about supervision, if we're going to talk about
14 standards of -- see, what Stuart and I mean in social
15 work terms about supervision is very different to what
16 psychologists mean. It has a different tenor to it.
17 Maybe that needs to be bottomed out a bit more, because
18 if we're talking about systems of supervision and
19 extrapolating that from professions where it's quite
20 rigorous and quite high end into residential care, then
21 we have to extrapolate it into foster care as well. We
22 have to be able to look at what are we doing with foster
23 carers as they're actually being foster carers, rather
24 than just simply visitation visits and how's the
25 placement going and the formal training, but actually

1 around supervising them and supervising them in a way
2 that's meaningful, that is about their life events and
3 how they manage the impact of looking after other
4 people's children.
5 Not just that, how they actually manage their lives
6 in general, because their lives aren't all just about
7 looking after other people's children. It's still
8 living the lives they live.
9 I guess it's about supervision for me meaning
10 something different than it does currently for foster
11 carers, but asking again that question -- which
12 I suspect may be behind your question -- which is: are
13 the systems of assessment and preparation rigorous or
14 robust enough as they stand?
15 LADY SMITH: Going back to recruitment, I think I'm hearing
16 from what you're saying, Martin, that it should be
17 possible to identify where it's working, what are the
18 examples of successful fostering practice, and is the
19 challenge then to draw on that, learn from it, saying,
20 "There's a good building block; how can we help to build
21 more of those good building blocks and not put people
22 into that role who are never going to be another good
23 building block in our foster care system".
24 Have I got that right?
25 MR HENRY: Absolutely right.

1 LADY SMITH: Thank you.

2 MR MACAULAY: There were a couple of cards up, Liz and Judi,

3 but I think it's probably time to have our short break.

4 I'll bring you in after the break, if that's okay.

5 We'll have a short break and come back after that.

6 (3.04 pm)

7 (A short break)

8 (3.18 pm)

9 MR MACAULAY: Before we had our break, it was you, Martin,

10 who was in to bat. I think before you come out of the

11 crease, can I just ask your view on the disclosure

12 checks that we have under the PVG system, since you talk

13 about it in your report, as does Stuart.

14 MR HENRY: Yes, I would imagine some of my other colleagues

15 will have mentioned it in their submissions as well.

16 You'll never get me disparaging the PVG checks, they

17 have been a very, very important introduction in terms

18 of recruiting and selecting people into jobs, but they

19 are by far and away not the whole picture and we cannot

20 rest on our laurels when it comes to PVG checks.

21 It put me on mind earlier on and I was thinking

22 about it and I think I said it in my report on

23 recommendations as a result of the Football Inquiry,

24 that actually for many, if not all, certainly many of

25 the men who had been identified as abusers within

1 Scottish football that fell under the remit of my
2 report, they would not have been screened out by PVG.
3 PVG checks on them at the time would have come back
4 fine. There's a lesson there about whether we put all
5 of our eggs into the PVG basket or not.
6 Having said that, they still have brought something
7 important to the table and not just in terms of spitting
8 out people who have previous intelligence or previous
9 convictions that may exclude them from working with
10 children or vulnerable people, but also because it's
11 engaged us in a discourse within provisions about what
12 do risky people look like and why should we keep them --
13 so it has had a cultural change for us. This has
14 I think been an important marker.
15 But as a mechanism in and of themselves, I don't
16 think it's something that we can rest on. I think we
17 have to improve on it and build other safeguards around.
18 I suppose at times I do get slightly frustrated that
19 so much training and focus goes into PVG checking to get
20 it right, because people think that if I get that wrong
21 that something bad will happen, whereas actually what
22 that does is detracts a lot of energy and focus from the
23 other things they need to do to make sure that bad
24 things don't happen.
25 For me it's back to this discussion about what does

1 safe selection and recruitment actually look like, but
2 I would definitely say that PVG has its place.
3 MR MACAULAY: You mention attitudinal tests in your report.
4 MR HENRY: Yes, and it's back exactly to the issues we were
5 talking about just before the break, about testing out
6 and being reliable in how you test out. Do we have the
7 tools -- that's another question -- to be able to just
8 discern what is this person like, how do they function?
9 Not so much just how they function now, how will they
10 continue to function if and when we put them into a job
11 that is challenging and difficult and stressful? That
12 means that you don't just select as an event and then
13 move out. You have to become involved in a process with
14 them. That process -- some professions call it
15 supervision, call it what you like --is a process of
16 engagement, that not just judges about the way they're
17 doing their job but enables and empowers them to do it
18 better.
19 For me the recruitment and selection thing is only
20 a small part of that contract.
21 MR MACAULAY: We've already discussed in connection with the
22 clergy the human formation approach. You do talk about
23 that in this context as well. Can you again just
24 develop that?
25 MR HENRY: It's exactly as my colleagues have been

1 discussing. That really is around how people function.
2 It's exactly as Judi was saying, it's asking key
3 questions to make some kind of reliable assessment, not
4 just about how people think they'll function in their
5 job, but what was it like for them in the past? What's
6 their experience of growing up? Of having parents? Of
7 being a parent? Of not having parents? Of building
8 relationships? Of being rejected? All of these kinds
9 of things are things that you need to weave a picture of
10 somebody.
11 That's not just so you can say, "No, they're not
12 right for the job", it's so you have a picture of
13 somebody that you can use with them as they're in the
14 job to help them to recognise how they can do the job
15 better, because none of us who are in these kind of
16 provisions are just coming -- we're not machines. We
17 bring to these provisions our own values, experiences,
18 troubles, difficulties growing up, our memories. All of
19 these things are part and parcel of what we bring to the
20 table when we sit down with real human beings who are
21 struggling.
22 I don't want to make a big deal of that, but I think
23 sometimes we do downplay it. We talk a lot about our
24 training and our tools, but we also forget that some of
25 the tools we're using are our human tools, about

1 communication and about our ability to understand
2 ourselves.
3 Likewise, so do foster parents have to do that, so
4 do residential workers and so do nurses and other people
5 who are caring for young people.
6 That kind of holistic assessment of not just how
7 people will function in a job but what it was like for
8 them growing up and how they can use these experiences
9 or will use these experiences I think is a vital part of
10 that picture.
11 As you were rightly saying, Lorraine, not just the
12 interview bit, which is when you just put your best foot
13 forward. You know everybody knows how to say the right
14 thing and tell people what they want to hear. That's
15 not what we should be about when we're bringing people
16 into care services.
17 MR MACAULAY: Is it controversial to say, as you do, that
18 social workers should not be recruited from
19 undergraduate programmes?
20 MR HENRY: Did you want a "yes" or "no" answer to that?
21 Yes, it's controversial, but what I mean by that is
22 it's back to that issue of probation. It's really
23 essentially about putting in safeguards where you can
24 actually see how people do the job. Not performance
25 management, but literally about that human formation

1 thing and about how you adapt and how you engage.

2 I guess it's less likely to happen in professions

3 where you expect people just to be case managers. When

4 you're actually expecting people to engage with troubled

5 people, then the expectations are high, and I think we

6 have a responsibility to society to make sure that we

7 help them, not just judge them but help them. The way

8 you do that is you don't just bring people off

9 undergraduate courses and throw them into important

10 professional roles without some other phase to go

11 through that helps them to do it better and judges

12 whether they're capable of it or not.

13 MR MACAULAY: Liz, I think you had your card up quite a long

14 time ago. Can you remember what you wanted to say?

15 PROFESSOR GILCHRIST: Yes. I think it actually builds on

16 what Lorraine has said, in fact what everyone has been

17 saying. This is where I fess up that I have some

18 occupational psych training. One of the things that

19 I had been thinking is actually taking that profiling,

20 so taking our structured professional judgment, not

21 replicating the tools for risk assessment but actually

22 using what we know in terms of risks and then taking the

23 occupational psych approach to saying, what do we know

24 about when people do well? What strengths do they have?

25 What psychological skills do they have? What ability to

1 self-reflect? You know, how do they do it? We get
2 a sense of what we actually want in somebody to do it
3 well, what we might want to avoid, so we would put some
4 thresholds in there. Then you could get more of a sense
5 of a profile which allows you to set up competency-based
6 selection so rather than, "Here's the right answer", but
7 actually, what are the skills? What are the things that
8 we need you to recognise as being boundary violations.
9 As being inappropriate ways of relating or difficult
10 situations, what would I predict is difficult in this
11 job? What resource do I have coming forward, either
12 from my undergraduate course or my life that I could
13 then bring to bear.
14 That then not sitting as a one-off assessment, but
15 actually thinking with a different head on, both in
16 terms of risk assessment not being a one off, in fact in
17 revisiting that profile, what's going well and things,
18 but also in terms of professional development. As
19 a manager of a number of staff at one point we would
20 quite often do team assessments of different forms
21 interaction or different ways of being or working and
22 then recognise difference in strengths and such like
23 within teams. Actually having that, so that people
24 would know more about their team and themselves that
25 they could then say well this is a strength of mine

1 I can build on that and here's somewhere where maybe
2 I could focus more on developing.
3 That sense of being involved in ongoing training and
4 that being opportunities to develop those skills, so you
5 might start as somebody who is maybe really early in
6 foster care, so you have been seen as suitable, you have
7 a profile, you've kind of started so there's more
8 supervision and help, but as you go on it's not like
9 something you've abandoned to do it on your own, that
10 there's support.
11 MR MACAULAY: Judi, did you have your card up before? Oh,
12 it was Michele.
13 MS GILLULEY: I think possibly just to add to what people
14 are saying.
15 My experience of recruitment, and it's not
16 necessarily with recruiting workers for residential
17 child placements, but it tends to be perhaps a one-hour
18 interview and then for a lot of people it's learning on
19 the job. I don't think we should have learning on the
20 job when we're talking about such a vulnerable group of
21 people.
22 Lorraine mentioned about almost a programme of
23 training, much, much more extensive than what we have at
24 the moment, and I wouldn't disagree with that.
25 I was thinking about what would be an analogy here.

1 I'm not saying residential workers for children should
2 be police officers, but when we train police officers,
3 they go through a programme of training, an extensive
4 programme of training, to understand the law, to
5 understand how to protect the public, to work safely
6 with the public, and not all of them will make it at the
7 end of that period. I think there's a baseline that we
8 start from is that if you get selected after a brief
9 interview, that you will become a worker in
10 an environment with very, very vulnerable young people.
11 I'm not sure that that's the right approach that we
12 should take. I think that that's flawed, fundamentally
13 flawed.
14 I think when we recruit aspiring psychologists, we
15 may even put them through full days of rigorous -- put
16 them through whatever assessment we can think of and get
17 them to do prioritisation tasks and understand how they
18 should behave and think about their own professional
19 conduct. Even at that, that's only to get into
20 training, to then go on and be trained and be supervised
21 within an inch of their life, quite frankly. I'm not
22 sure that some of those principles that I talked about,
23 the police and with psychologists, social workers do it
24 as well, that we should be applying that rigour to how
25 we recruit, how we train, and it shouldn't be on-the-job

1 learning for a very vulnerable group of young people,
2 often within closed environments.
3 MR MACAULAY: Can I bring you in, Stuart, because you have
4 provided quite a detailed response on this particular
5 topic of recruitment. I think like Martin, although you
6 see the PVG system as useful and even important, it has
7 its downside.
8 MR ALLARDYCE: It can give a false sense of security.
9 I know that we have offered training to some
10 organisations around prevention of child sexual abuse
11 and sometimes we get a response from organisations
12 saying, "No, it's fine, our PVG checks are up to date",
13 so there's a lack of imagination and thinking about what
14 prevention would mean.
15 Actually the other thing about PVG checks is that --
16 I mean there are ways of getting around some of the
17 difficulties with them, which is why I mentioned in the
18 submission that in England and Wales, schools are
19 mandated to have staff attend what's called Safer
20 Recruitment training. I don't know whether this applies
21 to care sectors or not, but I certainly know it applies
22 in education. The training materials, which are
23 consistent in all training in this area are signed off
24 by the Department of Education in England and Wales.
25 There are three components to that training, which

1 I mention in the evidence. One is making sure that
2 recruiters are on the front foot in advertising for
3 staff about child protection. That actually they're
4 making a clear statement in job descriptions and
5 materials that go out to recruiters that this is
6 an organisation that is serious about child protection.
7 Then there is how references are followed up.
8 Recognising that one of the issues that can sometimes
9 emerge is individuals moving from one job to another
10 when concerns are raised, but the concerns are below the
11 threshold to perhaps trigger child protection processes
12 within the organisation or to actually start some kind
13 of disciplinary process or maybe the disciplinary
14 process is about to start but the person resigns and
15 moves on. So how, actually, do we make sure that
16 references are followed up correctly in those kind of
17 situations?
18 MR MACAULAY: I think you suggest that the referee should
19 actually be spoken to?
20 MR ALLARDYCE: This is not something that I'm saying. This
21 is something that's built into the training that's
22 provided for recruiters in schools in England and Wales.
23 The other thing is this stuff that's been talked
24 about here already, which is what questions are asked in
25 the context of the interview itself. So are you asking

1 a question about child protection, are you asking
2 a question about kind of boundaries between adults and
3 children and so forth.
4 There is actually another section in the training
5 which is about safer cultures within organisations as
6 well, but that's the kind of bare bones of Safer
7 Recruitment as it exists.
8 It's one piece in the jigsaw puzzle. There are
9 other bits of the jigsaw puzzle that are worth knowing
10 about or exploring as well. The other one which I'm
11 particularly interested in is over the last couple of
12 years we've started seeing some organisations in
13 England -- I don't know of any in Scotland using this
14 yet -- who have policies in relation to low-level
15 concerns. Actually what do you do if there is some
16 concern about the behaviour of a member of staff, but
17 once again the threshold is not quite kind of reached,
18 but how is information about that logged, how is it
19 dealt with as a performance issue, what are the signs
20 and indicators that employers should be concerned?
21 We saw this recently with the Sean Bell Inquiry in
22 Edinburgh, where there were some disclosures from
23 a member of staff who was in a relationship with another
24 member of staff about domestic abuse, but actually that
25 wasn't satisfactorily dealt with as an issue or even

1 seen as a flag that might have said something about
2 child protection. We know that that actually it
3 probably did say something about child protection in the
4 longer scale of things.
5 MR MACAULAY: You also support, I think, the notion of
6 an applicant being employed for a probationary period?
7 MR ALLARDYCE: Yes, absolutely. That is standard practice
8 in some children's organisations, but not all.
9 Certainly when I worked for Barnardo's there was a very
10 clear six-month probation period, which you had to get
11 through.
12 MR MACAULAY: Perhaps since we have you there on the stump
13 on the moment, as it were, you draw attention to the
14 fact that we do not have a national child sexual abuse
15 prevention strategy for Scotland.
16 MR ALLARDYCE: Yes.
17 MR MACAULAY: Can you just elaborate upon that? Should we?
18 MR ALLARDYCE: Gosh, where to start?
19 Let's try and keep this quite short.
20 One way of thinking about it would be this. In
21 England there is a national strategy for tackling child
22 sexual abuse, signed off by the Home Office last year.
23 There is a similar one that was signed off by the
24 Welsh government the year before.
25 There is no such strategy in Scotland.

1 What there is is a kind of raft of different action
2 plans, some of which speak to each other but many don't,
3 so there's an action plan about online safety, there's
4 an action plan about child sex exploitation, there's
5 an action plan about gender-based violence in schools.
6 But, once again, they don't coalesce and cohere into
7 a very clear strategy which in my view would need to be
8 a public health approach to what prevention of child
9 sexual abuse means, by which I means something that has
10 tertiary, secondary and primary prevention.
11 The last thing I'll say, I'll just explain what
12 I mean by that.
13 Unfortunately we all know about public health models
14 now because we've lived through two years of hell with
15 Covid.
16 Tertiary prevention is what happens after
17 an incident has taken place. For instance, with Covid,
18 it's after somebody's contracted it and the minority
19 will need hospitalisation and what have you. But
20 actually, our health systems just collapse unless we get
21 things right about getting the messaging out to everyone
22 about good public health with respect to Covid, whether
23 it's wearing masks or vaccinations, but also recognising
24 the secondary prevention that actually there will be
25 situations where there are higher risks, so those

1 individuals who need to be shielded in some way. So we
2 were increasing protective factors and reducing risk
3 factors for those individuals or situations like
4 football stadiums and what have you.
5 What would all of that mean for child sexual abuse?
6 Because almost everything we do is about responding to
7 things after they've happened. I know Martin has spoken
8 eloquently about the need for child sexual abuse
9 prevention here. Primary prevention is making sure that
10 all adults know what child sexual abuse is and know what
11 the practical things are that they can do about that and
12 that all children have a developmentally appropriate
13 knowledge and strategies that they can use.
14 Secondary prevention is those situations, like for
15 instance the one that's been talked about earlier on,
16 about people who are worried about their own sexual
17 thoughts and feelings towards children, that actually
18 there are some kind of services or support that can be
19 provided in those kind of spaces.
20 At the moment we have a system that's a bit like
21 putting ambulances at the bottom of a cliff and waiting
22 for people to fall off.
23 We need to stop people falling off the cliff in the
24 first place.
25 MR MACAULAY: Good. Just a couple of broad points.

1 The Care Review, which I think some of you will be
2 familiar with, refers to "a frustrated, anxious and
3 overwhelmed workforce struggling to meet the needs of
4 the children in their care". This question might answer
5 itself, but do you see that as a risk factor for
6 children in care?
7 Lorraine?
8 DR JOHNSTONE: Absolutely.
9 That was a problem before the pandemic and then add
10 in the pandemic, it's been extremely difficult.
11 On the ground, certainly in residential settings,
12 people are working double shifts and not having very
13 many days off. They are exhausted, they're burnt out,
14 they're facing highly arousing and high-threat
15 environments in amongst all the other things that they
16 bring to that, and it is an extremely -- even at best
17 it's a challenging environment, and with all the
18 complexities that are around, it's indescribably
19 difficult, I think.
20 I do think care workers aren't really valued the way
21 that they should be valued. I know, for example, one of
22 the organisations where I work, there's been real issues
23 with retaining staff because there's quite a significant
24 competitiveness around salaries, terms and conditions,
25 so it isn't even a level playing field, if you like. So

1 that creates some difficulties because people generally
2 don't feel valued.
3 There are staff issues in terms of numbers, staff
4 issues in terms of retention. There's problems with
5 morale, there's difficulties with mentoring, support and
6 supervision. There are occupational hazards within
7 certain residential and secure childcare environments
8 that are difficult to articulate, understand and respond
9 to as well.
10 For example, certain incidents will require to be
11 reported to the Care Inspectorate and that can feel
12 quite investigatory, as opposed to supportive and
13 facilitative and learning from events.
14 So the whole environment is -- it's incredibly
15 challenging.
16 Another huge frustration I think that I see in some
17 of the residential staff is that they will feel and
18 believe and the child's behaviour will tell them that
19 they're doing some good, that actually they're making
20 a difference. Then a decision will be made by someone
21 else in a room to end the placement or to move them on
22 or return them, and that can be absolutely devastating
23 for staff, I think, when they're investing so much in
24 trying to help and the placement is pulled. That can be
25 really difficult for people to sustain that kind of loss

1 in their working day as well.
2 MR MACAULAY: Is there a sense as to whether or not those
3 working in the care system see it as a fulfilling job?
4 DR JOHNSTONE: I think so. I have met some of the most
5 inspiring, incredible people ever. I don't know where
6 their unending compassion comes from and their
7 playfulness and their ability to be optimistic.
8 Generally, I think most people are there because it's
9 a vocational calling almost, it's something they're
10 really, really invested and engaged in. Most people
11 I work with in the settings will do the extra shifts,
12 will stay on an extra hour. They're constantly going
13 above and beyond.
14 I do think intrinsically it's something that people
15 find incredibly rewarding a lot of the time, but I think
16 perhaps how it's framed societally and how we reward
17 people for their efforts is something that isn't really
18 reflected the way it should be.
19 MR MACAULAY: The discussion we've had today about robust
20 referencing, referees being spoken to, mentoring,
21 probation, are these features that do not feature in the
22 system at the moment or do they feature to some extent?
23 DR JOHNSTONE: I think it's very patchy. There are practice
24 principles for everyone, but the implementation is very
25 patchy. It's difficult as well because, you know,

1 I think we all have experience of trying to provide
2 psychological support or reflective practice groups,
3 individual supervision, psychological resilience
4 building for residential care workers. You might start
5 off with the commitment that you expect 12 staff to come
6 along and on the day two will appear, because the other
7 ten are meeting some other priority.
8 I would say there is one organisation I do work with
9 down south who definitely do it differently and the
10 priority around the staff -- so they view and they're
11 very explicit, staff are our greatest asset, we must
12 invest in staff. If staff are functioning well, pretty
13 much everything else will function well, so their needs
14 are absolutely prioritised. So it would be, you know,
15 shocking if that staff group didn't come to all the
16 training. Whereas in other organisations it's really
17 difficult to free people up.
18 MR MACAULAY: Another point I just want to put to you all,
19 and this is in a way looking at it from the perspective
20 of the care workers or the foster carers, is that
21 working with children in care can expose staff and
22 foster carers to levels of disturbing behaviours and
23 information and can lead to what has been described to
24 me as vicarious traumatisation. Any views on that?
25 Stuart, is that something you want to talk about?

1 MR ALLARDYCE: I think there's a lot that's been talked
2 about in relation to vicarious traumatisation of people
3 working in social care settings. Clearly staff come
4 across kind of disturbing experiences I think on
5 a regular basis in residential care, you know, whether
6 it's experiencing or seeing violence or self-harm or
7 indeed even kind of suicidal behaviour from young people
8 in care.
9 Clearly these things can be extremely disturbing.
10 I think, though, I would try and keep a wider
11 perspective than just thinking about vicarious
12 traumatisation, which is often about staff beginning to
13 pick up and exhibit signs of trauma that mirror the
14 behaviours and presentations of the children that
15 they're looking after, because I think some of the
16 biggest issues are around things like compassion fatigue
17 and burnout with respect to the staff.
18 I think sometimes we use the trauma label a little
19 bit too readily and there's a whole range of other
20 things that we need to be mindful of in terms of impact.
21 MR MACAULAY: If you have this concept of vicarious
22 traumatisation, could that then become a risk factor in
23 an individual offending against children?
24 DR JOHNSTONE: I think certainly for physical retaliation,
25 absolutely. If someone's resources are low and you have

1 an adolescent who you're facing, "Come on, do it, do
2 it", and you're really stressed, lashing out is probably
3 an understandable dynamic, whereas if you're regulated,
4 calm, you can take a step back and have the
5 psychological flexibility to see the situation, you can
6 bring your best skills forward and regulate the
7 situation. So absolutely. You know, stressors and
8 difficulties, if you need to soothe or feel good, then
9 obviously opportunities that arise might be more
10 tempting.
11 I think what Stuart said is really important, that
12 there is definitely a sample of people who will be
13 vicariously traumatised through either one single
14 incident or repeated incidents and it's so debilitating,
15 they're off work or they leave the profession.
16 I think the compassion fatigue where it's that
17 constant stress and stress and stress. But I think
18 there's also another dimension to it, that some people
19 talk about moral distress as well, where you're
20 conflicted and caring for something that morally does
21 not sit well with your values and your own beliefs about
22 what is right or wrong.
23 Certainly in the secure care environment where
24 generally children who are in need and who have done
25 deeds, if you like, serious, that can be quite

1 difficult, so you have staff who are ultimately
2 functioning as custodians over a justice issue but also
3 adopting a very nurturing relational approach over
4 someone who's maybe come in for trauma. The moral
5 distress component is something that I think is not very
6 well articulated or managed, because quite often they're
7 just children and the complexities of children are they
8 come across a whole range.
9 That can make some groups more legitimate targets,
10 if you like. If you're in for a justice reason, you're
11 on remand for murder or rape or whatever it is and
12 you're residing with vulnerable children, then the moral
13 distress in the staff group can play out as well.
14 MR MACAULAY: Yes, Judi?
15 DR BOLTON: I think it's probably quite a small point, but
16 I was struck by thinking that we're implementing
17 processes in many organisations are going in the right
18 way, like the first step perhaps through mentoring or
19 through creating a reflective practice environment where
20 we ask people about compassion fatigue or burnout, but
21 then they perceive that they're punished for the answers
22 that they give. It's not enough to ask people alone,
23 you have to have a culture in the environment where you
24 manage the responses that you get. If there's
25 a sanction for the answer that you give, like a foster

1 carer, the children are removed or -- you know, there's
2 a sanction, then you're only going to get socially
3 desirable responding because you've put in a system
4 that's reflective and asks the right questions, but it's
5 not the asking alone, it's the responding to the answers
6 without the conflict of interest arising of perhaps --
7 I use the word "punishment" in a looser sense of well
8 then we've asked you honestly what you think and you say
9 something negative and then we're removing the children
10 from you. The asking is not enough alone.
11 MR MACAULAY: Any other thoughts, contributions, ideas?
12 Good.
13 We're almost at the end of the round-table hearing,
14 subject to one point. You're not quite off the hook
15 quite yet. I think you may be aware of what's coming.
16 Can I just say that ultimately of course it will be
17 for Lady Smith, as the chair of the Inquiry, to draw
18 conclusions from the contributions you have made to the
19 work of the Inquiry, both in your initial responses or
20 submissions and the development of your thinking in
21 these responses at this round-table.
22 For my part, your contributions have been thoughtful
23 and thought-provoking, and the range of your experiences
24 has brought to bear a real insight into the topic that
25 we have been considering over the last couple of days.

1 As I said at the very outset of the round table, the
2 primary purpose of the exercise is to provide Lady Smith
3 with an expert-informed platform upon which to build
4 recommendations for the future safeguarding of children
5 in care. I believe that there has been a dynamic and
6 effective discussion on the topics covered by the round
7 table. Indeed, the discussion has been wide ranging and
8 highly informative.
9 As you are aware, I think, your words are being
10 recorded, both yesterday and today, and rest assured,
11 when these words are transcribed, they will be carefully
12 trawled through by the Inquiry, and Lady Smith will
13 explain shortly what will happen thereafter.
14 In the meantime, I have one more request to make.
15 As I have said on several occasions, I have mentioned
16 that it is hoped that this round table will inform any
17 recommendations that Lady Smith decides to make. In
18 that connection -- I do believe that you have been
19 forewarned that this request was coming -- it would,
20 I suspect, be enormously helpful to Lady Smith for each
21 of you to leave us with a particular thought or even
22 a possible recommendation that you believe as advancing
23 the need to safeguard children in care.
24 Clockwise as before.
25 Lorraine, can I put the ball in your court on that

1 front?

2 DR JOHNSTONE: To stick to one is quite difficult, but I do

3 have a hot favourite and I think it's sort of linking to

4 what I said. I do truly believe that as a nation, as

5 a society, if we helped people understand attachment and

6 the fundamental importance of attachment, we would

7 reduce risk and we would promote resilience in

8 a proactive way.

9 Going forward, early intervention, prevention,

10 I think if we could help our systems understand the

11 importance of attachment, we would make a huge

12 difference going forward.

13 I have 100 other ones.

14 MR MACAULAY: Morag?

15 MS SLESSER: I'm glad Lorraine was so generic -- so

16 "wide-ranging", "generic" is the wrong word -- because

17 she's bound to have all the good ideas.

18 The thing that occurred to me was I think -- this is

19 just practical -- when somebody comes into care, and

20 it's kind of allied to my point about when new staff

21 come into The State Hospital. I think there would be

22 three things I would do.

23 I think what I would do is explain to the children

24 that you may see things that you're not happy with, that

25 make you uncomfortable. They might make you

1 uncomfortable a day later. And just make them aware
2 that that might happen. Not to say they're going to be
3 abused, but they may see things about other people, they
4 might see things about themselves. I think it's
5 important to do that.
6 Then I would say tell them what to do with that
7 information.
8 There are three bits to this.
9 The second bit is tell them what to do about the
10 information and maybe each child could have a mentor or
11 some sort of person that they can go to, but I think
12 that would need to become flexible because they may find
13 when they get there that they form attachments with
14 somebody who is not their mentor.
15 I would say something like that, and staff should be
16 alert to who that person might choose to go to.
17 The third thing about that is you need to tell the
18 children what would happen if they disclose -- this has
19 been mentioned a few times -- or if they raise an issue
20 of concern. Because the fears we've spoken about is us
21 having some sort of catastrophic reaction. I think I'd
22 be keen that you explained this is what would happen,
23 and that it would be kind of done in not an overly -- if
24 they did raise a concern, it wouldn't be overly
25 dramatically reacted to, that it could be seen from the

1 child's point of view that maybe a member of staff just
2 wasn't there the next day or they were on day shift
3 rather than night shift or there was a little bit of
4 a change around.
5 Because I think one of the frightening things that
6 stops people from disclosing their concerns or worse is
7 the kind of catastrophic scary reaction.
8 I think those would be my three -- it's not just
9 telling them what might happen, but telling them how it
10 would be dealt with and then seeing that something had
11 happened but not necessarily an awful dreadful thing
12 that got them into a room ... just giving them examples
13 of what might happen so that the channels of
14 communication were completely open or as open as they
15 could be.
16 I think that would be my example of what I would
17 like to happen.
18 MR MACAULAY: Thank you.
19 Stuart?
20 MR ALLARDYCE: I think one of the things that would really
21 help here is a national training programme in relation
22 to situational prevention of abuse in organisations,
23 that was available to all care settings. I would also
24 propose it went further and was available to all
25 child-facing organisations.

1 I think what that training should do is it should
2 introduce the idea that abuse is a preventable issue
3 within organisations. It should explain how abuse
4 happens in organisations, who abuses, but more
5 importantly how it happens, that idea of incremental
6 boundary violation.
7 Then I think the solutions need to be place-based,
8 they'll be different for different organisations.
9 I think organisations should then have a menu of ideas
10 that they can pull down on so that for instance in
11 a residential unit when you have concerns that don't
12 reach a threshold around whistle-blowing or child
13 protection policies, but, you know, a member of staff is
14 really concerned about Jimmy, a new residential worker,
15 and the kind of horseplay he's having, the physical play
16 with some of the kids in the unit. Actually, that's not
17 going to hit a whistle-blowing threshold, but what would
18 be a helpful conversation within the context of the unit
19 about that?
20 We've done some work like this with libraries in
21 Edinburgh, where we talked library managers through how
22 abuse happens both in organisations, in public settings,
23 and then we got them to do some scenario planning, so
24 identifying things that have happened, near misses or
25 concerns that have been raised in the past, and then got

1 them to think about actually what might happen in the
2 future and what might be some of the things that you can
3 do about it.
4 In one library, librarians said actually we have
5 a children's play area but where all the librarians sit
6 together, we have no sight lines to the children's play
7 area. So let's move some of the bookshelves so we can
8 see what's going on there.
9 In another library they realised that actually
10 because it's part of a library and social work centre
11 together, sex offenders who are waiting for treatment on
12 a Wednesday afternoon sit in some chairs in the library.
13 Actually, is there somewhere else that they could sit?
14 Just thinking about practical solutions, but
15 librarians were also saying things like actually can we
16 put up some posters that is say libraries need to be
17 safe places for everyone. If there's anything you see
18 that makes you worried, go and speak to a librarian.
19 Just getting some clear messaging out there.
20 I think there are lots of things that we could be
21 doing, but organisations need to decide themselves what
22 they look like but they need a bit of guidance, steering
23 and helping.
24 MR MACAULAY: Thank you.
25 Michele?

1 MS GILLULEY: My recommendation would come from something
2 that I mentioned previously about not forgetting to work
3 with the families, not forgetting to specifically work
4 with parents. When we remove children, to consider that
5 those children were removed possibly because of deficits
6 in parenting and inability to keep a child safe, and
7 that those parents may go on to have further families
8 and instead of removing the child and that is the end of
9 the story for those adults, those parents, it's not to
10 forget about them and to put something in place that
11 would be safeguarding against future and successive
12 children who will come to be removed from families if
13 nothing is put in place to make them safe and to protect
14 them.
15 MR MACAULAY: Thank you.
16 Judi?
17 DR BOLTON: Mine's probably more a micro or a smaller
18 example. I think it would have to be around broadening
19 the narrative of abuse to not just for young people in
20 care, but to young people in society and people that
21 work with care on a body of evidence that we have about
22 healthy sexual functioning. That would have to include
23 aspects on the use of pornography, which I think
24 I appreciate internet use is very dynamic and have to
25 incorporate the ever-changing landscape, but that we

1 have evidence on and that in school programmes that is
2 developmentally appropriate to age and stage.
3 MR MACAULAY: Thank you very much.
4 Liz?
5 PROFESSOR GILCHRIST: I think I'm going to go rather macro
6 in comparison.
7 One of the things that struck me is yesterday we
8 were talking a bit about the risks in closed
9 institutions and that separation and isolation.
10 Actually my thinking would be if we were going to
11 continue to have care facilities for children, to make
12 them open and porous and in the community and surveyed
13 by the community and not other, but actually involving
14 shared activities and space and use. Very much like the
15 sort of dementia homes in the Netherlands, where it's
16 part of us, people are in and out and things. So those
17 inappropriate rules, boundaries, et cetera, can't be
18 kept in secret.
19 MR MACAULAY: Thank you for that.
20 Finally, Martin?
21 MR HENRY: Yes, I'm not sure I'm going to be brief.
22 Unsurprisingly my thoughts on this are similar to
23 what Stuart's raised earlier. It's around the issue of
24 bystanders and that's something that surfaced in my
25 football report and it's something I feel quite strongly

1 about. I think it is more around the primary and
2 secondary prevent that Stuart was talking about earlier
3 on, because my take on this is all about rather than
4 continually putting our resources, our thinking and our
5 efforts into following up bad stuff after it's happened,
6 let's at least try to shift some of our resources and
7 energies onto stopping bad stuff happening in the first
8 place.
9 I think that one way that we identified in the
10 Football Inquiry, and I know other organisations have
11 done it, is the role of bystanders. Who are they in the
12 worlds of young people in care, for example? Who are
13 the bystanders who are occupying these worlds along with
14 young people? Similarly, who are the people who are in
15 the environments of people who are working with children
16 in care, who are the bystanders in their professional
17 working environment? Who are they in the workplace, but
18 also who are they in the wider community? What do
19 bystanders look like in the wider community in the lives
20 of children and young people?
21 I'm going somewhere with this.
22 What do they need to know to identify anything that
23 might be slightly concerning, back to under that
24 threshold thing of already having crossed the boundary,
25 the stuff that's just a little bit off and not right,

1 what do they need to know in order to identify what that
2 is?
3 Secondly, what do they need to do in relation to it
4 if they identify it and probably as, if not more,
5 importantly: how should they do it? Because in my world
6 it's not just about what you do, it's how you do it that
7 matters.
8 There's a way of intervening that isn't about
9 pushing people into a corner or whistle-blowing, for
10 example, but actually just trying to correct behaviours
11 that you think are not quite right and helping people to
12 do that as they go along instead of problematising
13 everything, trying to get in at the early end of it and
14 helping people to rethink how they might deal with
15 a situation, rather than dealing with it in a way that
16 might become problematic or part of a repertoire of
17 behaviours that escalates.
18 So what do we need to do and how do we need to do
19 it? But also what are the things that bystanders need
20 to know in general, and that's in the wider community,
21 about how to prevent abuse? It's not perhaps just
22 sexual abuse, but it's also bullying. It's also to do
23 with just the way people qualitatively relate to kids.
24 What are the things that people in the world need to
25 know about that and what can they do to fix some of it

1 in their own communities and neighbourhoods, as well as
2 in situations where children are in care?
3 I guess the point I would make about that though and
4 it's back to something I think Lorraine or perhaps Morag
5 said, it's about proportionality. It's about not
6 reacting to everything as if it's the worst thing in the
7 world, but to actually walk towards things rather than
8 running towards everything, in a way that actually helps
9 to fix problems proportionately before they get worse.
10 Instead of catastrophising everything to the point
11 where people are afraid to speak up, afraid to do
12 anything because it seems far too serious or too high
13 end, which I think effectively disempowers people.
14 To just finish on that, it really is about, I guess,
15 empowering people through information and training, in
16 a variety of environments around children and young
17 people in care that educates, permits and empowers them
18 to do stuff at the right time.
19 MR MACAULAY: Thank you, Martin, for that.
20 Thank you all for again your thought-provoking
21 ideas. We will obviously be taking account of them all.
22 Lady Smith?
23 LADY SMITH: It's so good to have the opportunity to say
24 I was right. At the beginning of our sessions yesterday
25 morning I explained that we viewed these sessions as

1 being likely to add considerable value to our work here
2 at the Inquiry, as being likely to enhance our learning
3 to a new level, actually, and that's happened.
4 It's really good to be able to say that. I'm so
5 grateful to you all for everything you've contributed.
6 It's also very good to be able to agree, and I agree
7 entirely with every compliment that Colin has already
8 paid you. It's been a wonderful two days. There's
9 a lot of work that I will now do, those who support me
10 will now do, in going back through everything that's
11 been discussed over the last two days, and we will take
12 it forward from there, but I know there are gold nuggets
13 here which I'm just so pleased about.
14 Separately, on a more pedestrian level, I understand
15 the transcripts are racing ahead. I'm very grateful to
16 our stenographers, who have been working with
17 a different format for the first time in these hearings
18 and they have quietly worked away there and certainly
19 never a complaint has come to my ear about this being
20 different and difficult and it being a task that they
21 wished they hadn't undertaken. Far from it.
22 We expect the transcripts to be available for you
23 very soon if you'd like to have a look at them and go
24 back and see if you satisfy yourself that you said what
25 you meant or whatever.

1 I have nothing more to say about the round-table
2 sessions at the moment.
3 Can I just take this opportunity to tell everybody
4 where we're going next in terms of public hearings?
5 On 3 May we will begin our foster care case study
6 hearings. It's a substantial case study, as I have
7 already said, and the press release that says a little
8 bit more about it should go out tomorrow. We understand
9 it should be available by about 10 o'clock or so
10 tomorrow. If not then, certainly by lunchtime for those
11 who want to have a look at it.
12 That, apart from repeating the thanks I've already
13 given you and wishing you all very well as you make your
14 way back to your other lives, is all I have to say.
15 (4.10 pm)
16 (The Inquiry adjourned until 10.00 am on
17 Tuesday, 3 May 2022)
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5 Round-table discussion 1

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