Witness Name: Dr Daniel Logan Grant
Statement No.: 001
Exhibits: DG/1- DG/3
Dated: 14/04/24

THIRLWALL INQUIRY

WITNESS STATEMENT OF Dr Daniel Logan Grant

I, Dr Daniel logan Grant, will say as follows: -

1. I am the Director of Safeguarding at Leaders in Safeguarding Ltd (LIS) and founder of the National Association of Designated Safeguarding Leads (NADSL). LIS is an independent safeguarding organisation with an established set of safeguarding standards and a registered quality mark. Organisations who can demonstrate that they meet the safeguarding standards receive the Leaders in Safeguarding Award. Leaders in Safeguarding have been identified in a Care Quality Commission published inspection report of the Royal Hospital for Neuro-disability as 'Outstanding Practice".

2. My Social Work England (SWE) Registration number is I&S I have worked in local authorities, the Probation Service, Prisons, Ofsted, Estyn and HMI Probation. I have a PhD in social work (safeguarding).

3. I have a number of senior independent board positions including safeguarding advisor to the Fire Service College, Landmarks Specialist College and Challenge TRG. I also provide safeguarding expertise to the Cavendish Education group of schools and to the Outcomes First Group.

4. As an independent social worker and risk assessment expert, I provide expert evidence in social work assessments for family proceedings. In addition, I conduct independent risk of reoffending reports to immigration tribunals. I was recently involved in interviewing adults who were abused as children on St Helena and the Ascension Islands. This has included the identification of historic failings in the Islands' child protection systems. In September 2018, I was appointed as safeguarding and social work expert by Ofqual. In 2020 I led a team of safeguarding experts in a large-scale review of safeguarding practice; Past Case Review 2 (PCR2) on behalf of a faith group in the north of England as part of the Independent Inquiry into Child Sexual Abuse (IICSA).

5. I am a reviewer of book proposals for Taylor Francis (Routledge) international publisher of professional texts and have the following publications:1999 Multi-agency Risk Management of Mentally Disordered Sex Offenders: A Probation Case Study. In D. Webb and R. Harris (eds.) The Mentally Disordered Offender: Managing People Nobody Owns. London: Routledge.1999 Change, Monitoring and Containment: A Selective Overview of the Nature and Efficacy of Professional Interventions with Child Sexual Abusers. In L. Deacon and B. Gocke (eds.) Understanding Perpetrators: Protecting Children. A Practitioners Guide to Working Effectively with Child Sexual Abusers. London: Whiting and Birch

6. Qualifications:

   1999 PhD Social Work. Thesis title: Supervising Sex Offenders in the Community. University of Hull.

   1992 Diploma in Child Protection. Joint Centre for Professional Studies. University of Sheffield and Sheffield Polytechnic.

   1990 Bachelor of Arts in Social Studies. Humberside Polytechnic

   1987 CQSW and Diploma in Social Work. Humberside College of Higher Education.

   1984 Regional Certificate in Youth Work. Yorkshire and Humberside Association of Further and Higher Education.

The National Association of Designated Safeguarding Leads (NADSL)

7. The National Association of Designated Safeguarding Leads (NADSL) was established in 2020. The purpose of NADSL is to provide support, information and guidance to DSLs working in safeguarding partnership organisations. I recognised that many DSLs do not receive structured support or specialist supervision from their employers for the work they do to keep children and vulnerable adults safe. Through NADSL I am involved in providing these services. It is a membership organisation sponsored by Leaders in Safeguarding Ltd.. Membership is open to DSLs working in all sectors including education, health, housing and charities. Members pay an annual subscription of £99 and receive weekly newsletters, updates to national guidance and changes in legislation. There is an online forum to discuss key issues, good practice and lessons learnt. Members can ask for advice and seek support.

Governance for NADSL was originally through a committee of founding members. Management is through the appointment of a Director of Safeguarding. Membership is currently around 120 DSLs. NADSL does not make a profit and receives financial support from Leaders in Safeguarding Ltd to remain operational.

8. In 2019-20 NHS England requested a meeting with NADSL. At the meeting I represented NADSL and NHS England was represented by their Assistant Director of Safeguarding. At this meeting NHS England expressed concern that NADSL had been established and that the term 'Designated Safeguarding Lead' (DSL) described an NHS role and as such NADSL had no authority or mandate to use it. NHS England made it clear in the meeting that they were unable to support NADSL. NADSL pointed out that the term 'DSL' was used widely in many other sectors including education, who we estimate to have over 100,000 DSLs. The meeting was good natured and I can remember commenting in the meeting that I felt as though NHS England had requested the meeting to 'tell me off'. Only a few NADSL members work in hospitals.

Keeping Babies Safe in Hospitals

9. It is my understanding that the NHS is one of the three statutory safeguarding partners who lead in local area safeguarding children partnerships. As such, each individual health setting and hospital have their own safeguarding policies and procedures and there are relevant procedures for the governing NHS Trust. Commissioning or contractual obligations will often stipulate safeguarding requirements and then the local Safeguarding Children Partnership will have their own set of procedures. In addition, all health care professionals have to follow safeguarding guidance from their professional associations and bodies, such as the Nursing Councils and General Medical Council. Beyond that, it is usual to see individual job descriptions set out the expectations for safeguarding, such as the named doctor for child protection and the designated safeguarding nurse/midwife.

10. Whistleblowing and Low-level concerns about staff conduct procedures are very important to ensure a culture of awareness and transparency is promoted.

11. I am aware of the following safeguarding guidance and legislation for keeping babies safe in Hospital:

- NHS Safeguarding Accountability and Assurance Framework V3, 21 July 2022
- Working together to Safeguard children (2023)
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019
- Looked After Children: Roles and Competencies of healthcare staff 2020
- Children and Families Act 2014
- Female Genital Mutilation Act 2003
- Promoting the Health of Looked After Children Statutory Guidance 2015
- NHS Constitution and Values (updated Jan 2021)
- Serious Violence Duty: Draft guidance 2021
- United Nations Convention on the Rights of the Child 1989
- European Convention on Human Rights

Working together to keep babies safe in hospitals.

12. I am aware that hospital staff at all levels and disciplines are required to complete standard safeguarding training which usually outlines a common responsibility to report any concerns about NHS colleagues. Questioning decisions and reporting concerns about colleagues' behaviour is now common in all good safeguarding training. The key to establishing a culture where staff are able to report concerns without any hesitation is in the quality of training and support received by staff, the dominant norms in the organisation and whether staff receive reminders and updates of key issues. To work effectively, all staff in safeguarding children partnerships have to trust in the judgements and practice of other professionals and disciplines. However, with any multidisciplinary work it can only ever really be effective if all agencies have clear boundaries and follow their own professional guidance and deliver their unique service. In my opinion child protection is no exception to this. Quality assurance of safeguarding and child protection work requires clear analysis of data, case reviews and benchmarking of volumes, early detection of emerging patterns, health checks on the culture of leadership and an element of independence in decision making is required so that senior leaders do not have conflicts of interest over potential litigation, reputational damage or performance set-backs.

13. It is my opinion that all staff working with babies in hospitals should consider that 'it could happen here' so that they are aware of the potential for even the most trusted staff members to have sinister motives and intentions.

14. It is my opinion that improvements could be made to the current safeguarding arrangements that are in place to keep babies safe in hospitals. The first of these is to introduce a process for recognising and reporting low-level concerns about staff conduct. In some settings such as education these are sometimes referred to as having a 'nagging doubt'. When this occurs and a report received by senior managers then the matter is reviewed. When a pattern emerges such as the same member of staff being reported by different people and for different low-level concerns about their conduct then this is an indicator or 'red-flag' of the potential for further and possibly more serious transgressions. Another improvement would be to have a more visible and accessible whistleblowing procedure that is promoted throughout the hospital. Close monitoring and quality assurance of the safeguarding arrangements would also help to ensure that all systems and processes were effective. Such as vetting of staff, compliance with training requirements, checking the quality of recording of notes and following protocols for administration of medicines and treatments. Where problems are identified there should be rapid-intervention that includes a degree of independence in reviewing standards of care in areas where concerns are detected.

The role of Local Area Designated Officer (LADO)

15. The LADO has a key role in protecting children from staff who work in organisations delivering services such as hospitals. LADOs will usually have good experience and be trained to a very high level. However, in my experience of liaising with LADOs as a social worker, probation officer, Ofsted inspector and safeguarding auditor/reviewer I can confidently say that all of the cases I have encountered have involved the LADO in a 'reactive' stance. LADOs will deal with matters that are reported to them and in my experience they will usually do this very well. I have not seen a single case where the original concern has been identified by a LADO (being proactive). This seems not to be an expectation of the role. However, in a few cases where transferrable risk is identified, such as a paramedic being charged by police over domestic abuse outside of work, then steps being taken to establish his suitability to continue in a role as a paramedic. In cases such as this then the LADO does have to consider the portability of these risks.

The role of local authorities recording and sharing suspicions and concerns about healthcare professionals.

16. At NADSL we circulate only trusted published information to our members and this has included:

- Information sharing. Advice for practitioners providing safeguarding services to children, young people, parents and carers. July 2018. (Exhibit DG/1 [INQ **INQ0107811**
- What to do if you're worried a child is being abused. Advice for practitioners 2015. Exhibit DG/2 [INQ **INQ0107812**
- Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework (Exhibit DG/3 [INQ **INQ0107813**
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary
- Independent Scrutiny and Local Safeguarding Children Partnership Arrangements – August 2022
- Bruises in Premobile Infants: A Contested Area of Research, Policy and Practice Andy Bilson & Alessandro Talia
- Risk, Response and Review: Multi-Agency Safeguarding a Thematic Analysis of Child Practice Reviews in Wales 2023 As the commissioners of this report, the National Independent Safeguarding Board (NISB) is pleased to be able to publish its analysis and findings today (2nd Oct 2023).

17. I am unaware of any LADOs being members of NADSL. However, we do circulate information to our members which relate to the role and purpose of LADO. These are:

- Working Together to Safeguard Children 2023
- Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework (SAAF)
- Information sharing. Advice for practitioners providing safeguarding services to children, young people, parents and carers.
- Low level concerns – Nadsl poster
- House of Commons: Research Briefing 9 October 2023 By David Foster. Duties to report child abuse in England.
- Care Inspectorate Scotland: Do you know how to raise concerns in the workplace.

Reporting concerns to the DBS

18. I am aware that the content of all good safeguarding training courses includes the legal requirement to pass on information to DBS of any member of staff that has a concern raised against them and have left their post prior to or during an investigation into their conduct. NADSL circulate the following information where this is stipulated:

- Working Together to Safeguarding Children 2023
- Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework (SAAF)

The NHS Safeguarding and Accountability Framework

19. This document pulls together an over-arching safeguarding policy for the NHS. Its published scope covers 'protection from harm from any source'. In my work as a safeguarding auditor at Leaders in Safeguarding I use this document as the foundation for safeguarding audits in NHS funded organisations.

20. I am aware that in 2015/16 there was a document in circulation called Safeguarding Vulnerable People in the reformed NHS – Accountability and assurance framework issued by the NHS Commissioning Board in July 2015 and updated in 2019.

21. It is my opinion that responsibility for developing guidance and training about safeguarding babies in hospitals lies with:

- The NHS Hospital Trust
- NHS England
- Professional Associations
- Safeguarding Children Partnerships

22. I have had no experience of Child Safeguarding Practice Review Panels or Child Death Review Meetings and Overview Panels.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Dan Grant

Dated: 14 April 2024