Date:	**Wednesday 13 March 2002**
Venue:	**Committee Room 2, National Assembly for Wales**
Title:	**Report of the Review on Safeguards for Children and Young People Treated and Cared for by the NHS in Wales**

Purpose

1. To provide the Committee with an overview of the report of the Carlile Review: A Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales and invite the comment of members on the recommendations of the Report.

Background

2. The report of the Carlile Review, a Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales was published on the 5 March 2002.

3. The Review Panel, which I established in September 2000 was chaired by Lord Carlile of Berriew QC, was asked to consider the safeguards for children and young people treated and cared for by the NHS in Wales.

4. The decision to establish the review arose from the evidence of the North Wales Child Abuse Inquiry 'Lost in Care' chaired by Sir Ronald Waterhouse. The Tribunal heard allegations from former in patients of a child and adolescent mental health clinic, called Gwynfa situated in North Wales. The unit has since closed. The Tribunal concluded that it was unable to consider these allegations as they were beyond its terms of reference since the children were not in the care of the local authority. The Welsh Office then gave an undertaking to the Tribunal that all allegations would be properly investigated by the appropriate agencies and that it would ensure that patients at such units in Wales were receiving proper care and were adequately safeguarded against abuse.

5. Accordingly in June 1998, the then Secretary of State for Wales invited the Health Advisory Service 2000 (HAS) to undertake an inspection of the two clinics and two associated adult wards that admitted young people occasionally. HAS 2000 made a number of recommendations for improved safeguards. In December 1999 HAS were invited to undertake a follow-up inspection to monitor the progress that had been made implementing the recommendations. HAS reported that it was satisfied that adequate

safeguards were in place in these units.

6. The Review Panel were asked to conduct a policy review of the safeguards in the NHS, taking into account the work undertaken by the Health Advisory Service and Sir Ronald Waterhouse. Relevant guidance, best practice and other developments have also been considered. The review covered all aspects of NHS services, not simply limited to in patient mental health services.

Summary of the Report

7. The Carlile Report contains 150 recommendations for improving standards and increasing safeguards for children and young people treated and cared for by the NHS in Wales. The recommendations are aimed at the Welsh Assembly Government, Health Authorities, NHS Trusts, Local Health Groups, contractor professions as well as partner agencies in social care.

8. The report rightly starts with children's rights and at the centre of the report is the need to put children and their safety at the heart of the NHS whenever and wherever they may have need to come into contact with it.

9. It recognises the need to ensure that everyone who has contact with children and their treatment; from Welsh Assembly Officials, non executive directors to doctors, nurses and practice receptionists are aware of the rights of the child and is alert to the possibility of abuse. The report takes the view that developing a culture of awareness of child abuse throughout the NHS will be the best possible way to protect young patients. Recommendations are made with regards to advocacy services, so that the voice of the child can be heard.

10. The report identifies that first and foremost it is essential to recruit appropriately trained staff to posts to provide safely for the health needs of children and in that connection it makes a number of recommendations to strengthen human resources policies throughout the NHS in Wales. It recognises the need for rigorous recruitment procedures as well as endorsing the need to have proper well-developed policies for handling whistleblowers and disciplinary procedures and supporting those against whom allegations have been made. It also emphasises the need to have sufficient numbers of staff in key posts, in this the report recommends an increase in the number of paediatricians and trained children's nurses across Wales.

11. The report recognises the important role of designated doctors and nurses for child protection at the strategic level and named doctors and nurses for child protection in trusts and recommends that the posts have protected time to allow them to undertake their duties and makes recommendations as to their location in the re-organised NHS.

12. The report makes recommendations with regards to hospital and specialised medical care. Here it builds on the Kennedy report into the Bristol Royal Infirmary and makes recommendations in a number of areas such as accident and emergency departments and children who are treated on adult wards.

13. Most sick children are not admitted to hospital for treatment. Their contact with the NHS is via their family doctor, health visitor, school and practice nurses, dentists and opticians. The report makes recommendations that will increase awareness of child protection issues in these professionals. Health visitors and school nurses are both commended for the excellent work that they undertake. The report recommends that the role of the school nurse is strengthened and that proper career paths are developed to encourage nurses into this important area of work.

14. The needs of those young people who are especially vulnerable are considered carefully in the report. This includes those with mental health problems, children cared for away from home and those in secure settings. The report makes a number of recommendations to ensure that these vulnerable groups have access to good quality health care. Here the report draws lessons from a case study of Gwynfa undertaken as a retrospective review of events. As well as drawing the lessons from this case study the report concludes that all actions that ought to have been taken in respect of the allegations have been taken.

Financial Implications

15. My Officials will be considering the financial implications as part of the production of the Welsh Assembly Government's response.

Compliance

16. The joint National Assembly/NHS review was established under the incidental powers contained in Section 40 of the Government of Wales Act 1998 and the voluntary participation of the NHS. Powers under Section 40 are delegated to the Minister. The review team is an ad-hoc group making recommendations to the Minister who will decide whether to accept them.

Action for Committee

17. The Committee is invited to comment on the recommendations of the report.

Jane Hutt
Minister for Health and Social Services