Truth Project Thematic Report

Child sexual abuse in healthcare contexts

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truth project

INDEPENDENT INQUIRY CHILD SEXUAL ABUSE

Disclaimer

This research report has been prepared at the request of the Inquiry's Chair and Panel. The views expressed are those of the authors alone. The information presented in Truth Project research outputs does not constitute formal recommendations by the Inquiry's Chair and Panel and are separate from legal evidence obtained in investigations and hearings.

This report contains descriptions of child sexual abuse. Reading the report can have an emotional impact. There are some support organisations that it may be helpful to contact if you have been affected by any of the content in the report: **www.iicsa.org.uk/help-and-support-0**

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Acknowledgements

We would like to thank all of the victims and survivors who came forward to share their experiences of child sexual abuse in healthcare contexts, the impacts this has had on their lives and their ideas about what needs to change to prevent similar abuse in future.

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Executive summary

Introduction

The Truth Project is a core part of the Independent Inquiry into Child Sexual Abuse ('the Inquiry') alongside Public Hearings and Research. It was set up to hear and learn from the experiences of victims and survivors of child sexual abuse in England and Wales. It offers victims and survivors an opportunity to share experiences of child sexual abuse. With the consent of participants, the Inquiry uses Truth Project information in a variety of ways, including for ongoing research and data analysis carried out by the Inquiry's Research Team. By doing so, Truth Project participants make an important contribution to the work of the Inquiry.

This report details the research findings in relation to the experiences of victims and survivors of child sexual abuse in healthcare contexts that were shared with the Truth Project. The term 'healthcare contexts' in this report describes child sexual abuse that occurred in healthcare organisations and institutions or was perpetrated by healthcare professionals. This includes hospitals, psychiatric institutions,[1] clinics and general practitioner (GP) practices. Healthcare professionals comprise doctors (including psychiatrists and GPs), nurses and other staff members in healthcare organisations.

This report presents the Inquiry's research findings about the experiences of victims and survivors of child sexual abuse in healthcare contexts and the response of institutions to such abuse. It describes the experiences of Truth Project participants sexually abused in healthcare contexts between the 1960s and 2000s, with the most recent cases in our sample beginning in the early to mid 2000s.[2]

This is the fifth research publication in a series of thematic reports examining the experiences of victims and survivors of child sexual abuse shared with the Truth Project. We have previously published research reports on child sexual abuse in religious institutions, children's homes and residential care, custodial institutions and sports.

[1] Psychiatric institutions are hospitals that specialise in treating mental health problems. Patients can be admitted voluntarily or can be involuntarily committed or 'sectioned' under the Mental Health Act 1983. Some general hospitals have specific wards or units in which they treat mental health problems.

[2] The research findings included in this report do not reflect all experiences of sexual abuse in healthcare contexts and are only indicative of the specific experiences of those who chose to share their experiences with the Truth Project. This sample is not random, and therefore the statistics produced are not representative of the general population. The wider analysis of Truth Project accounts is ongoing and we will publish a full report with a bigger sample size covering all institutional contexts of child sexual abuse at the end of the Inquiry.

Sample and methods

Of the 4,295 people who shared an experience of child sexual abuse between June 2016 and July 2020, 109 (3 percent) described sexual abuse that took place in a healthcare context. Eighty-three (76 percent) of these 109 participants reported being sexually abused by a healthcare professional. Ninety-four percent of participants reported being sexually abused by male perpetrators. Eighty-five of the 109 participants (78 percent) talked about sexual abuse in a healthcare location, such as a hospital or GP practice.

We have primarily adopted a qualitative approach in the analysis for this report, analysing nine of the 109 Truth Project accounts relating to child sexual abuse in healthcare contexts in detail. The accounts selected include a range of characteristics and circumstances, such as the time period in which the sexual abuse occurred, victim age and victim sex.[3] We have also reported descriptive, quantitative information for the 109 participants who were sexually abused in healthcare contexts who provided accounts to the Truth Project.

Ethical approval was obtained from the Inquiry's Research Ethics Committee prior to the collection and analysis of the data, and information is only included where Truth Project participants have agreed to their accounts being used for research purposes.

Key findings from the research

Overall the research findings, drawn from the descriptive, quantitative analysis of the 109 participants' accounts and the qualitative analysis of the accounts of nine participants, indicate there are some particular characteristics of child sexual abuse specific to healthcare contexts. The key research findings are:

- Participants' vulnerabilities were heightened in the context of healthcare due to the unique nature of the position of trust and authority occupied by healthcare practitioners. Participants reported they were often alone for examinations and procedures or isolated from their chaperones.
- Perpetrators were commonly male GPs or healthcare practitioners with routine 'clinical' access to children, meaning that their behaviour was not questioned by other staff, parents or children, even when they recommended procedures that were not appropriate or needed in order to sexually abuse children. Perpetrators abused their positions of trust and authority and many perpetrated child sexual abuse under the guise of medical/clinical procedures and examinations, which in some cases involved the use of medical equipment or medication.

> *I'd been going there since I was in the womb, you know. Like, it was a family doctor, it was just down the road ... a trusted person to me and I was taking myself to the GP when I was a child.*
>
> Truth Project participant sexually abused in a healthcare context

[3] A detailed explanation of the process used for carrying out analysis of Truth Project information can be found in the separate report, *Truth Project Research: Methods* (King and Brähler, 2019).

- There was very little evidence of grooming in participants' accounts. This is perhaps not surprising given the routine and easy access that perpetrators had to children that allowed them to examine and touch children without any need of 'special' explanation or persuasion. The accounts did indicate there were, at times, manipulation of children, and the manipulation or collusion of staff.

> *... what he did was – under the guise of performing a medical test, called a high vaginal swab, he used that as an opportunity to rape me.*
>
> Truth Project participant sexually abused in a healthcare context

- Participants' accounts revealed that the healthcare needs of many, but not all, of the participants were related to physical, psychological and sexual abuse by family members, and neglect; some had no family support; some were bullied and/or excluded or had stopped attending school. Children attended health institutions seeking treatment, care and recovery. Instead, they were sexually abused by healthcare professionals in positions of power and in violation of their professional duty to do good for their patients. Participants' accounts showed that the abuse of positions of trust and institutional failures in child safeguarding contributed to their increased health and psychological difficulties.
- As children, only a quarter of participants reported that they were able to disclose the sexual abuse. Accounts of the qualitative sample showed that although many disclosed the sexual abuse to trusted adults such as their parents or a healthcare professional during childhood, very few were believed and some were dismissed by healthcare professionals as sick or 'crazy'. Participants revealed that their vulnerabilities were often heightened due to their illness at the time of the sexual abuse. Communication difficulties, and adults' beliefs that children had mental illnesses, meant they were not listened to, or people did not take appropriate action to safeguard them.
- Participants' accounts revealed that there were no clear processes through which participants and their families could disclose sexual abuse in healthcare contexts. In residential healthcare settings, children had no one to turn or talk to, to disclose sexual abuse. Participants described a lack of appropriate safeguarding or effective responses to allegations of sexual abuse by healthcare practitioners.
- Similar to findings from participants sexually abused in other institutional contexts, those in healthcare contexts suffered lifelong mental health impacts. Participants were fearful of healthcare professionals, leading to avoidance of contact with them in later life. They reported feeling betrayed by perpetrators who had abused their positions of trust and by perpetrators' colleagues, as they did not intervene to prevent or stop the sexual abuse. This led to subsequent broader distrust of authority, systems and adults.

> *I just see [doctor/perpetrator] fingerprints on everything, you know, on every – you know, ... I look at my life and I just see his fingerprints ...*
>
> Truth Project participant sexually abused in a healthcare context

Note on language

Please see Appendix B for a glossary which contains definitions of various terms used throughout this report.

Chapter 1

Introduction

This chapter provides background information about the Inquiry, the Truth Project and the aims of this research.

1.1 Background to the Inquiry

The Independent Inquiry into Child Sexual Abuse ('the Inquiry') was set up as a statutory inquiry in March 2015. The Inquiry aims to consider the extent to which state and non-state institutions in England and Wales have failed in their duty of care to protect children from sexual abuse and exploitation, and to make meaningful recommendations for change. Child sexual abuse involves forcing or enticing a child or young person under the age of 18 to take part in sexual activities. It includes contact and non-contact sexual abuse, child sexual exploitation and grooming a child in preparation for sexual abuse. The Inquiry has 15 investigations into child sexual abuse, focusing on a range of different institutions. These investigations consider the nature and scale of, and institutional responses to, allegations of child sexual abuse in institutions. These investigations provide the Inquiry with a sound basis from which to consider contemporary, national issues concerning the sexual abuse and exploitation of children. Further information about how the Inquiry works and its Terms of Reference can be found on the Inquiry website.

1.2 Background to the Truth Project

The Truth Project is a core part of the Inquiry alongside Public Hearings and Research. It was set up to hear and learn from the experiences of victims and survivors of child sexual abuse in England and Wales. It offers victims and survivors an opportunity to share experiences of child sexual abuse. People can participate in the Truth Project through a private session – either in person, by phone or via video-conferencing – or by submitting a written account of their experience. By doing so, Truth Project participants make an important contribution to the work of the Inquiry. The Truth Project was piloted in November 2015 with the offer of private sessions commencing in June 2016. Up to the end of September 2020 over 5,000 people have come forward to share an experience. These experiences will influence the Inquiry's findings and help inform its recommendations for improving child protection in institutions across England and Wales. Further information about the Truth Project can be found on the Truth Project website.

1.3 Using Truth Project data for research

Information gathered through the Truth Project provides the Inquiry with valuable insights into child sexual abuse. With the consent of participants, the Inquiry uses this information in a variety of ways including for ongoing research and data analysis carried out by the Inquiry's Research Team. This is an important building block in helping the Inquiry develop recommendations to prevent child sexual abuse happening in the future and improve institutional responses to child sexual abuse. Further details about how and why Truth Project information is used for research can be found in the separate *Truth Project Research: Methods* report (King and Brähler, 2019).

1.3.1 Research questions

The Truth Project analysis explores two overarching research questions:

- **What have victims and survivors shared about their experiences of child sexual abuse and the institutional contexts in which it occurred and was responded to?**
- **What similarities and differences are there in victims and survivors' experiences of child sexual abuse across time periods, groups and institutions?**

This report sought to explore the first research question and its themes and research sub-questions (as set out at the start of chapters 4 to 10), specifically in relation to child sexual abuse experienced in healthcare contexts. With regard to the second research question, in this report we explored the similarities and differences in the experiences of child sexual abuse between participants abused in healthcare contexts.[4]

This report is the fifth Truth Project thematic report to be published. It describes Truth Project participants' experiences of sexual abuse in the context of healthcare. Our first thematic report focused on *child sexual abuse in the context of religious institutions* (Hurcombe et al., 2019), the second on *child sexual abuse in the context of children's homes and residential care* (Soares et al., 2019), the third on *child sexual abuse in custodial institutions* (Darling et al., 2020a), and the fourth on *child sexual abuse in sports* (Darling et al., 2020b). We will be conducting further analysis in future thematic reports and for the final report at the end of the Inquiry.

[4] Comparisons between experiences across different institutions and time periods will be undertaken at a later point when we have the opportunity to carry out a fuller comparative analysis.

Chapter 2

Sample and methods

This chapter provides information on the Truth Project dataset and the sampling framework used for this report. The information for this report was gathered from the experiences that victims and survivors shared with the Truth Project between June 2016 and July 2020.

In this chapter we have presented some of the key quantitative characteristics of the 109 participants who took part in the Truth Project (either by phone or video-link, in person or by submitting a written experience) up until the end of July 2020, and spoke about child sexual abuse that took place within a healthcare context. In the rest of the report, we have presented research findings from our qualitative analysis of nine of the 109 Truth Project accounts, while also drawing on the quantitative findings of the 109 accounts.

The experiences of sexual abuse in healthcare contexts presented in this report do not all relate to current-day experiences as 88 percent of the cases occurred prior to 1990 (where this information is known). Nevertheless, we aimed to identify common themes among participants' experiences across all time periods. We recognise that the research findings included in this report do not reflect all experiences of sexual abuse in healthcare contexts and are only indicative of the specific experiences of those who chose to share their experiences with the Truth Project.

2.1 Sampling

Truth Project participants' accounts were included if they occurred in the context of healthcare. Context here refers to both the location and the perpetrator of the sexual abuse.[5] Our criteria for healthcare locations where the sexual abuse occurred included:

- hospitals, including urgent-care centres, outpatient clinics, general practitioners (GPs), surgeries including practices located in GPs' homes;
- long-term healthcare and skilled nursing facilities;
- psychiatric institutions;
- home healthcare; and
- mobile emergency medical services (such as ambulances).

Our criteria for healthcare professionals who were perpetrators of the sexual abuse included:

- doctors, for example surgeons, GPs;
- specialist staff at hospitals, nurses, midwives;
- orderlies, auxiliary staff, hospital cleaners;
- dental practitioners;
- health visitors; and
- mental healthcare professionals.

[5] These are not exhaustive lists of the sampling criteria for healthcare locations and types of perpetrators.

Throughout this report the term healthcare professionals is used to refer to all types of staff working in healthcare contexts, unless otherwise specified.

Cases of child sexual abuse in familial or non-institutional contexts where the perpetrator was a healthcare professional but the sexual abuse was not linked to healthcare were excluded. First aid charities and third sector health organisations were also excluded. Healthcare delivered in school contexts and religious staff performing their duties in healthcare contexts were excluded as these cases were included in the Truth Project analyses and reports for child sexual abuse in the context of schools (forthcoming), and child sexual abuse in religious contexts (published), respectively.

2.2 Quantitative information

Of the 4,295 people who shared an experience (in person, in writing, by phone or via video-link) between June 2016 and July 2020, 109 (3 percent) described child sexual abuse that took place in a healthcare context (based on the location and/or perpetrator of the sexual abuse). Table 2.1 shows the key characteristics for this group of participants.

Eighty-three of the 109 participants (76 percent) talked about a perpetrator who was a healthcare professional. Other types of perpetrator reported included family members (mentioned by 10 participants), ancillary staff (mentioned by six participants), and older children/peers (mentioned by six participants). The majority of perpetrators spoken about were male, with 94 percent of participants talking about a male perpetrator and 9 percent reporting a female perpetrator.

Eighty-five of the 109 participants (78 percent) talked about sexual abuse in a healthcare location. Within the healthcare location category, 38 participants were sexually abused in hospitals, 20 in psychiatric hospitals or institutions and 30 in 'other' healthcare locations such as GP surgeries and healthcare centres (some participants reported more than one location).

Table 2.1 Characteristics of Truth Project participants sexually abused in healthcare contexts

Characteristic	Category	No. of participants
Time period when victim and survivor first experienced sexual abuse	Pre 1950s	0
	1950s–1960s	33
	1970s–1980s	53
	1990s–2000s	12
	2010s onwards	0
	Unknown*	11
Age when sexual abuse began†	11 years and under	56
	12 years and older	42
	Unknown	11

Characteristic	Category	No. of participants
Sex of victim and survivor	Female	75
	Male	32
	Unknown	2
Reported illness or condition (at the time of attending the Truth Project)‡	Yes	62
	No	47
Ethnicity of victim and survivor	Ethnic minority	3
	White	70
	Unknown	36
Type of sexual abuse¶	Abuse involving penetration	59
	Fondling	42
	Violations of privacy	29
	Abuse not involving penetration	24
	Exposing children to adult sexuality	13
	Exploitation	7
	Grooming for the purposes of sexual contact	3
	Unknown	15
Reported impacts of sexual abuse**	Mental health	95
	Relationships	53
	Financial	44
	Sexual behaviour	37
	Direct consequence	25
	Crime	11
	Physical health	7

* As Truth Project participants are not asked direct questions and can choose how much they share in their Truth sessions or written submissions, the information captured is not entirely comprehensive in all cases and some information may be unknown in an individual case.

† The age at which the sexual abuse commenced is divided into two groups: 11 years and under and 12 years and older, generally reflecting the difference between pre-pubescent and pubescent or post-pubescent age groups.

‡ Participant accounts include reports of medical conditions or illnesses at the time of the sexual abuse, or throughout their lives (e.g. in relation to the impacts of the abuse). These illnesses/conditions are discussed in the report; we have not made any independent diagnoses or verifications of conditions, or illnesses. Some conditions/illnesses result in many symptoms or effects on individuals that are generally not discussed in detail in the accounts and therefore not included in this report.

¶ Numbers in this category total over 109 as some participants reported more than one type of sexual abuse. All abuse reported here relates to experiences in healthcare contexts.

** Numbers in this category total over 109 as some participants reported more than one type of impact.

2.3 Qualitative sample and methods

The sample for qualitative analysis was selected from all 109 Truth Project accounts that related to healthcare contexts. We selected nine accounts[6] for in-depth analysis to ensure a range of characteristics and circumstances were represented within each of the following categories:

- time period in which the sexual abuse occurred;
- age of victim and survivor when the sexual abuse began;
- sex of victim and survivor when the sexual abuse began; and
- type of healthcare context where the sexual abuse occurred.

Cases in the qualitative sample included sexual abuse that occurred within the following healthcare contexts:

- GP practices including one where the practice was in the GP's home;
- hospitals and psychiatric wards;
- hospitals for children with emotional needs; and
- psychiatric institutions.

In this report, we have not systematically broken down our analysis by the specific type of healthcare contexts because of the small numbers of participants reporting sexual abuse in different settings. Such a breakdown was not appropriate as the analysis was focused on overall themes and trends.

The characteristics of the qualitative sample used for this report are detailed in Table 2.2. These cases reflected the quantitative sample as the majority of participants described sexual abuse that had taken place in healthcare contexts prior to 1990.

The framework approach was used as the method for the qualitative analysis. Further details of this approach can be found in the separate report, *Truth Project Research: Methods* (King and Brähler, 2019).

[6] This number provides a proportion of the planned overall sample of around 60–70 accounts we expect to include in the full qualitative analysis work. It also reflects an appropriate proportion of the anticipated number of participants who will take part in the Truth Project before the end of the Inquiry. A complete sample of around 60–70 accounts is anticipated to provide a large enough number to reach 'saturation'; in a research context this refers to the point at which the addition of further accounts would not provide new categories in analysis (Katz et al., 2017; Bowen, 2008). More than 50 is considered to constitute a large sample in qualitative participant-based research (Braun and Clarke, 2013; Sandelowski, 1995).

Table 2.2 Qualitative sample characteristics (Truth Project participants sexually abused in healthcare contexts)

Characteristic	Category	No. of participants
Time period of sexual abuse	Pre 1950s	0
	1950s–1960s	5
	1970s–1980s	2
	1990s–2000s	2
	2010s onwards	0
Age when sexual abuse began	11 years and under	4
	12 years and older	5
Sex of victim and survivor	Female	5
	Male	4
Type of healthcare contexts	GP practice	3
	Hospital	5
	Other organisations	1

2.4 Ethics and research strengths and limitations

All social research conducted or commissioned by the Inquiry is subject to approval from the Inquiry's Research Ethics Committee.[7] The Truth Project research is subject to rigorous ethical scrutiny as the data collected are highly personal and sensitive. In order to safeguard these data, each component of the research process was reviewed in line with strict ethical standards by the Inquiry's Research Ethics Committee. Ethical approval was obtained prior to the collection and analysis of the data.

Information is only included where Truth Project participants agreed to their accounts being used for research purposes. All information analysed for this report was anonymised prior to analysis and all identifying information has been removed. Further information about ethics and consent can be found in Appendix C of this report.

When considering the research findings in this report, it is worth bearing in mind a number of strengths and limitations. These are summarised in Table 2.3.

[7] The Inquiry's Research Ethics Committee is formed of external academics and experts as well as internal staff. The Committee is internal to the Inquiry, but independent of those commissioning and delivering its research.

Table 2.3 Strengths and limitations of the research

	Limitation	Strength
Predominantly qualitative analysis	The report includes some descriptive, quantitative findings but most research findings are based on the qualitative analysis of a small group of participant accounts	Approach emphasises participants' experiences and voices. In-depth and detailed analysis of accounts is possible by concentrating on a smaller number
Sample	Findings are based on a self-selecting sample of those who have come forward to the Truth Project and cannot be held as representative of the general population of those sexually abused in healthcare contexts	Qualitative sample has been selected to present a diverse range of experiences within healthcare contexts
Data	Truth sessions are participant led and not all participants talk about all, or the same, aspects of child sexual abuse	Accounts reflect the issues of particular importance to participants rather than more directed accounts (if a particular structure to the session had been imposed by the interviewer)

Chapter 3

Child sexual abuse in healthcare contexts

This chapter describes key contextual information relating to healthcare in England and Wales to help situate our research findings. Further information on key milestones and developments in healthcare can be found in Appendix A. This chapter is limited to focus on information relevant to the time period of the Truth participants' accounts in the sample (1950s to 2000s).

3.1 What is known about child sexual abuse in healthcare contexts

The healthcare sector has an important role to play in protecting children by safeguarding against all forms of sexual, physical, emotional and psychological abuse (Gil, 1982; Kendrick and Taylor, 2000). In addition, healthcare policies, regulation and codes of practice state that healthcare professionals and organisations have a duty of care to ensure patients are safe.

In this section we highlight research about child sexual abuse in healthcare contexts. This includes power dynamics between healthcare professionals and patients, sexualised behaviours by healthcare professionals during clinical or therapeutic encounters, safeguarding vulnerable children, organisational cultures, and whistleblowing and complaints.

3.1.1 Power dynamics and trust between healthcare professionals and patients

The doctor–patient relationship has evolved over time, from a 'paternalistic' relationship in which patients were viewed as passive recipients of 'expert' care, to the existing 'shared decision-making' model and 'patient-centred care', in which patients are active participants in healthcare treatment and decision-making (Gordon et al., 2010; Kon, 2010; HellÍn, 2002). It is important to note that, although existing research has largely focused on the doctor–patient relationship, the power and control dynamic also exists between other healthcare professionals and patients, especially because power is tied to the social institution of medicine and healthcare professionals more widely, by virtue of their qualifications and training.

The doctor–patient relationship has long been conceptualised as involving a balance between intimacy, trust and power (Gordon et al., 2010; Hall, 2005; Nadelson and Notman, 2002). Research has shown that an inherent power imbalance exists between patients and healthcare professionals (male or female) generally because of patients' disposition and reliance on expert healthcare professionals to 'help' and heal (Morgan, 2008). Doctors' positional power in society originated from their role as medical experts and authority figures. They have, in the past, been able to exercise influence, control and authority over patients through this legitimate and expert power (Morgan, 2008; French and Raven, 1959; Parsons, 1951). The dynamics of power and trust in the doctor–patient relationship may vary between outpatient settings, where a patient has willingly sought a consultation, compared with for example, hospital contexts (Gordon et al., 2010).

Trust is intrinsic to the doctor–patient relationship and is essential to the provision of care, in that patients must trust medical professionals in order to feel comfortable enough to share intimate and private information and comply with treatment (Hall, 2005). Exertions of power, exploitation and abuse have been made possible because trust underpins the doctor–patient relationship (Archard, 1998). While the growing emphasis on mutual equality, shared decision-making and greater informality in the doctor–patient relationship has been a marker of progress in patient rights, it has also been attributed to an increased likelihood that doctors may cross professional boundaries (Ost, 2016; Galletly, 2004). Maintaining clear professional boundaries has been an important aspect of healthcare (Combs and Freedman, 2002) and clinicians have a responsibility to ensure that patients' needs are met, without compromising their professional roles (Galletly, 2004).

3.1.2 Professional boundaries

The patient-centred approach of modern medicine gave rise to newer debates around professional and ethical codes of conduct. Healthcare professionals are trained to exhibit 'clinical empathy' and can develop longstanding relationships with individuals, families and communities. This is particularly important for healthcare professionals, such as family GPs and paediatricians, who are on the front lines of identifying signs of sexual abuse and neglect in children. An intimate professional relationship between patients and healthcare professionals can be established because healthcare professionals participate in patients' lives during stressful and traumatic periods; have access to confidential information such as health records (Galletly, 2004); and carry out intimate physical examinations. The role of 'touch' in the doctor–patient relationship, and relationships between healthcare professionals and patients more generally, is important because it can sometimes be clinically necessary to conduct physical examinations, but also because it can humanise patients and some patients feel that being touched is an important aspect of getting better (Stepansky, 2016).

Breaches of sexual boundaries can occur when healthcare professionals display sexualised behaviour[8] towards patients during clinical or therapeutic encounters. They involve the deliberate exploitation of patients and the use of a more powerful position to take advantage of patients (Ost, 2016).[9] They compromise the integrity of clinical or therapeutic relationships between practitioners and patients, including for example, sexual activity without consent, or using coercion or inducement (Ost and Biggs, 2012). The Professional Standards Authority for Health and Social Care stated that 'breaches of sexual boundaries do not just include criminal acts such as rape or sexual assault, but cover a range of behaviours including the use of sexual humour or innuendo, and making inappropriate comments' (Council for Healthcare Regulatory Excellence, 2009, p.3).

It is difficult to estimate the prevalence of breaches of sexual boundaries made by healthcare professionals, particularly those perpetrated on children, as most child sexual abuse remains hidden (Parke and Karsna, 2018). It might be difficult for patients to understand what has been done to them, and consequently sexual abuse is unlikely to be reported. In addition, research from the 1990s showed that patients who had been sexually abused were often reluctant to complain, because of feelings of guilt and shame, fear they would not be believed, and, sometimes, continuing concern for the doctor (Quadrio, 1996; Galletly, 1993).

Research into healthcare professionals who are perpetrators of sexual abuse is dated and sparse. Some of this research has suggested that healthcare professionals who were perpetrators of sexual abuse were likely to repeatedly offend (Benowitz, 1995; Bates and Brodsky, 1989). In the past, there have been concerns that inconsistencies in sanctions between different professions could have led some groups of healthcare professionals to perceive that their actions were less likely to be 'punished' than others (Searle, 2019).

[8] Sexualised behaviour is 'acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires'. (Council for Healthcare Regulatory Excellence, 2009).

[9] Note that Ost (2016) and others use the term 'sexual boundary violations' to describe this behaviour.

In 2019, a report for the UK Professional Standards Authority on fitness to practise cases in health and social care found that of the 275 cases reviewed, 232 related to sexual harassment or sexual abuse (Searle, 2019). The majority (88 percent) of perpetrators were male and those in healthcare settings were most commonly GPs, surgeons or staff working in mental health roles. Victims were typically vulnerable patients, such as those with mental health illnesses or young people (Croft et al., 2019; Searle, 2019). Four potential risk factors of medical misconduct were identified in a review of medical tribunals. These were: (i) being male, (ii) achieving a primary medical qualification outside the UK, (iii) working within general practice and surgical specialities, and (iv) having passed primary medical qualification over 20 years ago (Croft et al., 2019). A typology of healthcare perpetrators compared 'bad apples' and 'bad cellars': the 'bad apple'[10] described perpetrators who intentionally sought out vulnerable patients and subjected them to abuse such as sexual assault; the 'bad cellar' referred to misconduct that arose from environmental features such as poor or stressful working conditions (Felps et al., 2006; Searle et al., 2017).

3.1.3 Safeguarding vulnerable children in healthcare contexts

Vulnerable children, for example those with disabilities, have faced unique safeguarding challenges in the healthcare context. Over the decades, national legislation, guidance and policies have been developed to protect and safeguard vulnerable children specifically (see Appendix A). In 1989, the Children Act set out that every child has the right to protection from abuse and exploitation.

Since the 1990s, developments in community health services have resulted in a significant decrease in the number of healthcare settings that provide long-term care and accommodation for children,[11] with a shift away from institutionalised healthcare, and towards community-based care provision[12] (The King's Fund, 2019; 2020). Despite this progress, there have been sustained concerns regarding the treatment of individuals with disabilities, which includes, for example, prolonged hospitalisation and institutionalisation of individuals with learning disabilities, the excessive use of restraint, and overmedication with psychotropic drugs (NHS England, 2019).

People with mental health illnesses, including those with learning disabilities, have in the past been regarded differently from other types of patients. For many years they were considered as 'dangerous, incompetent, unable to care for themselves and childlike' (Ottati et al., 2005, p.100). These attitudes reinforced an 'active-passivity' approach for these patients and the power differential between doctors and patients. Before the 1970s, mental health residential and psychiatric hospitals were 'total institutions',[13] in which patients were 'depersonalised', isolated from society and often subject to mistreatment (Barton, 1976; Goffman, 1961). The deinstitutionalisation of UK mental health services began in the 1960s. The 1962 Hospital Plan for England and Wales sought to close asylums by introducing district general hospitals with acute psychiatric inpatient services and promoting community-based mental health care. These plans were not implemented until the 1980s (The King's Fund, 2020).

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[10] The term 'bad apple' has been used to describe individuals who take advantage of group resources such as trust and have negative effects on group functioning (Felps et al., 2006).

[11] Some of the Truth Project participants report sexual abuse (and other forms of abuse) that took place in such institutions.

[12] The Children Act 1948 suggested that places of residential care for children should not have more than 12 beds, but this guidance was not always adhered to and it was not until the late 1980s that the size of residential care homes rapidly decreased. Prior to the 1970s, homes varied in size with some accommodating up to 50 children (Bullock and Parker, 2014).

[13] 'Institutions' refers to residential healthcare settings characteristic of the 1950s, 1960s and 1970s and less of a feature of contemporary healthcare contexts.

It was not until the 1970s, following a number of scandals that highlighted the ill-treatment of mental health patients in healthcare institutions (such as those mentioned in Appendix A), that patients with mental health conditions began to be regarded as service users, with a voice in their care and decision-making. They are protected by the Mental Health Act 1983 and associated code of practice (Department of Health, 2015b), which has been recently independently reviewed (Gov.UK, 2018). Under the Act, it cannot be assumed that a patient is unable to make a decision for themselves, just because they have a particular condition or disability. Recognition of 'parity of esteem', which refers to valuing mental health equally with physical health, was not formally recognised during the time period in which the majority of Truth Project participants reported that they were sexually abused.

Safeguarding and consent

Healthcare should be delivered with the informed consent of patients. This means that professionals should explain to patients the nature of the proposed treatment or assessment, its purpose and why it is being recommended, and the range of likely effects and risks. The likelihood of the range of outcomes, both positive and negative, should also be given (General Medical Council, 2020).

Young people aged 16 or 17 are presumed to have the capacity to consent to healthcare treatment under the Mental Capacity Act 2005.[14] Children under 16 can consent if they have sufficient capacity to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. An assessment of the child's ability to meet these requirements is known as the Gillick test, following 1983 case law in this area. Children who meet these requirements are referred to as having 'Gillick competence'. There is no lower age limit for Gillick competence or Fraser guidelines[15] to be applied. However, it would rarely be appropriate for a child under 13 years of age to consent to treatment without a parent's involvement (General Medical Council, 2018).[16] In respect of sexual health, children under 16 are not legally able to consent to any sexual activity,[17] and therefore information that a child under 16 was sexually active may need to be acted on.[18] [19]

[14] Children's refusal of treatment can in some circumstances be overridden by a parent, someone with parental responsibility or a court. This would be in circumstances where the refusal of treatment would likely result in death, severe injury, or irreversible mental or physical harm.

[15] The Fraser guidelines specifically relate to contraception and sexual health advice that can be provided to those under 16 without parental consent, as long as the advice or treatment is in the young person's best interests.

[16] In An NHS Trust v A. B. C and A Local Authority (2014) EWHC 1445 (Fam) a pregnant 13 year old was deemed Gillick competent to decide whether to terminate her pregnancy (Family Law, 2014).

[17] Home Office (2004) guidance is clear that there is no intention to prosecute teenagers under the age of 16 where both mutually agree and where they are of a similar age.

[18] For more information on Gillick competence and Fraser guidelines, see NSPCC (2020) and for guidance on these issues, see the General Medical Council's guidance.

[19] The court cases leading to the rulings that resulted in the Gillick competence and Fraser guidelines took place in the 1980s, with the rulings in 1985, which post-dates the majority of sexual abuse cases provided to the Truth Project.

3.1.4 Organisational cultures can influence the perpetration, detection and response to child sexual abuse in healthcare contexts

Formal institutions, such as hospitals, can be understood as 'strong institutions' with organisational structures that can shape members' attitudes and behaviours. Research has shown that organisational structures had a role in facilitating abuse by allowing adults to obtain compliance over their victims. An organisation's physical design influenced opportunities for abuse, as is the case in 'total institutions' or residential institutions, such as hospitals that afforded abusers the opportunity to sexually abuse children undetected (Palmer and Feldman, 2018). Formal power that existed within hierarchical institutions suppressed victims and bystanders (or third parties) from making reports of sexual abuse out of fear of existing power and authority structures (Palmer and Feldman, 2018).

Research on the study of different types of abuse in healthcare contexts has found that the combination of power imbalances between patients and healthcare professionals, paired with the routine depersonalisation of patients, gave rise to environments conducive to patient abuse (Melville-Wiseman, 2012). Some research indicated workplace cultures could create such powerful norms that changes to formal policy contradicting years of experience about the consequences of speaking up resulted in the opposite effect to those intended, preventing employees from speaking up (Cunha et al., 2019). Research has also shown that exposure to others' wrongdoing 'corrupted' some professionals (Welsh et al., 2015). Furthermore, if managers were overburdened, weak chains of accountability eroded, resulting in direct or indirect collusion with abusive practices (Colton, 2002; Cambridge, 1999; Wardaugh and Wilding, 1993). Stress, strain and moral disengagement in healthcare contexts may have contributed to professional and workplace transgressions (Searle et al., 2017). A lack of accountability has been referred to as the 'corruption of care' (Wardaugh and Wilding, 1993). It has been argued that breaking toxic cultures of collusion could be done through effective clinical supervision and monitoring practice (Naish, 1997; Rae et al., 1997; Repper, 1995).

The mistreatment of patients in institutions has been the subject of several inquiries and investigations into malpractice, and these often highlighted staff hierarchies and cultures of silence as contributing factors to abuse and misconduct (Department of Health and Social Security, 1969; Department of Health, 2004; HM Government, 2005). Public confidence in the NHS was undermined by reports from whistleblowers of entrenched codes of silence, cultures of bullying, gagging orders and non-disclosure agreements that prevented staff from reporting malpractice (Holt, 2015; Patrick, 2012; McHale, 1993).

3.1.5 Whistleblowing and complaints procedures

The 1858 Medical Act established the General Medical Council and granted the healthcare profession self-regulatory powers, allowing it to set its own standards for its members. Up until the 1990s, the healthcare profession was, for the most part, 'self-regulated' and healthcare professionals were deemed trustworthy because of the values expressed in their codes of conduct. This 'collegiate' style of governance left the healthcare profession vulnerable to failures in professional conduct and resulted in a series of scandals.

Whistleblowing and its challenges were highlighted in 1965 when Barbara Robb, a psychotherapist, reported poor patient conditions at Friern Hospital, London. Robb's book, published in 1967, highlighted inadequacies of care and included accounts from nurses and social workers which became the subject of an inquiry led by the Regional Hospital Boards. At the time, these whistleblower reports were largely discredited by the Ministry of Health (Hilton, 2017). These events triggered other whistleblowers to come forward who corroborated Robb's allegations.

Despite developments in whistleblowing policies, some have argued that, in practice, little has actually changed (Dyer, 2019) and much more is needed to give staff an effective voice (Mannion et al., 2018). There have been concerns raised about the lack of focus on why organisations or managers did not hear or act on whistleblowing reports (Royal College of Physicians, 2018; Jones and Kelly, 2014). The emphasis on whistleblowing may also create the impression that it is the only channel for raising concerns (Martin et al., 2018; Tarrant et al., 2017; Jones and Kelly, 2014). Calls have been made for greater protection of whistleblowers, for example by preventing employers from refusing to employ them (Royal College of Physicians, 2018).

Patient rights movements gained traction from the 1960s onwards and gave rise to organisations such as the Patients Association that raised concerns regarding patient complaint procedures, access to medical records and the presence of medical students in consultations. In 1973 the NHS went through a restructure and Community Health Councils were established to be 'the voice of the consumer' within health services. The 1975 National Consumer Council came to represent the consumer within public services, such as health. A series of publications and guides to patients' rights followed in the 1970s and 1980s. The Patient Rights Bill put forward by the Patients Association in 1974 was rejected by ministers; however the Data Protection Act (1984) and Access to Health Records Act (1990) which followed were important legislative milestones in this area (Mold, 2012). Patients have always been able to complain about their medical care but not through a centralised and coordinated complaints system. The establishment of complaints procedures was not formalised until twelve years after the 1971 Davies Committee was set up to consider the issue. In 1985, the Hospital Complaints Procedure Act was passed, requiring all hospitals to have a complaints procedure in place.

3.2 The Inquiry's seminar into healthcare

In July 2017, the Inquiry sought information in writing from around 50 healthcare organisations across England and Wales about the measures that were in place to prevent child sexual abuse within healthcare settings, such as hospitals, GP practices and clinics. The issues raised in written submissions were subsequently discussed at a two-day healthcare seminar (for more information, see the Inquiry's website). Reflecting the issues raised in the Health Sector Seminar, the Inquiry's Chair and Panel made a number of recommendations in the Interim Report (Jay et al., 2018).

Chapter 4

Backgrounds of children sexually abused in healthcare contexts

The nine participants in the qualitative sample described their experiences of child sexual abuse (chapter 5) in healthcare contexts (chapters 6 and 7), the significant lifelong impacts of the sexual abuse (chapter 8) and their experiences of recovery (chapter 9). We begin the discussion of our research findings with a description of the family and early life backgrounds of the participants, and the role that healthcare played in their childhoods. The research findings discussed in this chapter address the research sub-question:

- **Who has come forward to the Truth Project to share an experience of child sexual abuse in the context of healthcare?**

4.1 Participants' backgrounds, families and childhoods

Seventy percent of the 109 participants sexually abused in healthcare contexts who reported their sex were female and 30 percent were male at the time of the sexual abuse. Almost all, 96 percent, of the 73 participants who provided details of their ethnicity were white. Twenty-nine percent of participants reported that they were age seven or under when the sexual abuse began. A further 29 percent were aged eight to 11 years. Thirty-two percent were aged 12 to 15 and 11 percent were aged 16 or 17 years when the sexual abuse began.[20] Fifty-seven percent of participants reported that, at the time they provided their Truth Project accounts, they had an illness or condition that affected their lives. Of these, 19 percent said that they had such an illness or condition at the time of the sexual abuse.

Participants in the qualitative sample described coming from a range of family and social backgrounds and experiencing a variety of domestic circumstances before they were sexually abused. Some reported that they had 'middle class' backgrounds, but most reported that they came from lower income backgrounds. The majority of participants described a distant relationship with one or both parents and/or disrupted and changing families due to bereavement, divorce, abuse and neglect, illness or work pressures. In many cases, these disruptions led to participants relocating to live with a relative or just one parent, which resulted in the participant living in poorer circumstances than prior to these events. Many of the participants talked about suffering sexual, physical and psychological abuse or neglect by family members, as described in more detail in the next section.

[20] Percentages reported are of those who reported their details.

4.2 The role of healthcare in participants' lives as children

Participants in the qualitative sample had a range of healthcare needs as children and were sexually abused while attending different types of healthcare settings congruent with these needs. In some cases, participants from abusive or neglected households had healthcare difficulties as a result of this abuse or neglect.

Three participants in the qualitative sample were sexually abused during the course of routine contact with healthcare professionals, such as attending regular visits to the GP. One participant had an accident not long after starting school, leading to an injury that required an operation when he was a teenager, and he was sexually abused in a hospital. Two participants lived with both parents; one participant talked about neglect and that her father was sometimes aggressive.

Three participants in the qualitative sample reported healthcare difficulties that resulted from abuse and/or neglect by family members. One participant described how she had no emotional connection to her mother and that her father had never really wanted children. The participant enjoyed staying with her grandparents, seeing her grandma as a mother figure. Another participant was the subject of a long custody battle following her parents' divorce. Eventually she was sent to live with her father and his partner, and his partner's mother. Another participant talked about her father's significant health difficulties and having neurodiversity difficulties. She thinks she would probably have been diagnosed with autism but, in the 1960s when she was a child, this was not recognised. Instead she reported she was viewed as naughty and received no help or support. She also had communication difficulties and was excluded from school when she was a young teenager.

These three participants reported experiencing a wide range of abuse from their family members. One participant was subjected to harmful sexual behaviour[21] by her brother, which was not addressed, despite her disclosure to her mother. Another described how her father was very emotional, abusive, and used substances, that she was physically abused by her mother and sexually abused by her grandfather. One participant explained how she was increasingly ostracised from the rest of the family. This participant reported that she was also psychologically and physically abused by her father's partner and her mother.

Three other participants had significant healthcare needs and were sexually abused in residential healthcare contexts. Two of these were residential healthcare institutions and one participant was moved to a healthcare institution for assessment from a residential school. Two of the participants explained how they suffered the bereavement of a parent, and the third that he was born in a workhouse[22] and his mother was unable to look after him, which resulted in a childhood of care and institutionalisation. He was placed in a care home when he was three weeks old, where he stayed until he was eight years old. He was then moved to a psychiatric institution, where he reported that children lived in wards and there was a culture of physical abuse.

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[21] Harmful sexual behaviour refers to sexual behaviours of children and young people under 18 years of age that are "*developmentally inappropriate, may be harmful towards self or others and/or be abusive towards another child, young person or adult*" (Hackett et al., 2019:13).

[22] An institution where those unable to financially support themselves were offered accommodation and employment (in Scotland, they were usually known as poorhouses). People were admitted to workhouses for a variety of reasons, for example if they were sick and had no one able to look after them. Unmarried and pregnant women who were disowned or sent away by their families due to the social stigma of this at the time entered workhouses. Prior to the establishment of the NHS in 1948, workhouses also provided free medical and midwifery care.

> *It was what they called a mental institution. I was put there because due to the fact that there was no proper place to put people like ourselves because, you know, having no family, which obviously didn't help.*
>
> Truth Project participant sexually abused in a healthcare context

One participant said that he struggled to cope with his father's death and described how he was then sent to a residential school. Another participant reported that the bereavement of her mother led to major changes in her family and that both she and her sister were sexually abused by their uncle. The participant disclosed this sexual abuse after witnessing the rape of her sister by her uncle. This resulted in the participant being moved into a care home. The placement in her first care home ended and she was then moved frequently between institutions and foster care placements, which she believed were all terminated due to her sexualised behaviour, and resulted in her being placed in a healthcare institution for 'emotionally disturbed children'.

In summary, the information shared by participants sexually abused in healthcare contexts revealed that around two-thirds of participants were female and one-third were male, with almost all being of white ethnicity. Over half reported that they had illnesses or conditions that affected their lives at the time they provided their Truth Project accounts, but only a small number reported having these conditions at the time they suffered sexual abuse in healthcare contexts. The findings from the qualitative sample revealed that participants' family backgrounds were mixed but the majority described the lack of a close relationship to one or both parents, as well as or in addition to disrupted and changing families. In addition, many disclosed suffering sexual, physical and psychological abuse or neglect by family members. Some participants had healthcare difficulties, often as a result of, or related to, sexual and physical abuse within the family, or neglect.

Chapter 5

Experiences of child sexual abuse in healthcare contexts

This chapter details the nature of the child sexual abuse participants experienced in healthcare contexts. Information is provided about the locations, timing and nature of the sexual abuse as well as details of who the perpetrators were and their roles within the healthcare institutions and organisations. It addresses the research sub-question:

- **What do people share about the nature of the child sexual abuse they experienced in the context of healthcare?**

5.1 Perpetrators

Ninety-six participants reported being sexually abused by male perpetrators, nine reported female perpetrators. As presented in chapter 2 (section 2.2), 83 participants in the quantitative sample reported that healthcare professionals were the perpetrators of the sexual abuse they suffered. Fifty-nine participants described being sexually abused by doctors: 32 of these were GPs and 28 described other types of doctors, such as psychiatrists or surgeons.[23] Eleven participants reported being sexually abused by nurses. Ancillary staff were reported by six participants, and older children or peers by six participants.

All the perpetrators of child sexual abuse spoken about by participants in the qualitative sample were male, and the majority of these were healthcare professionals who had routine access to children in order to conduct consultations, assessments or interventions. Most of the healthcare professionals discussed were doctors: two were psychiatrists and three were GPs. Two participants reported being sexually abused by nurses.

Participants described the GPs as local or family doctors, and spoke about longstanding relationships where the GP was trusted and well regarded by their families.

> *I'd been going there since I was in the womb, you know. Like, it was a family doctor, it was just down the road ... a trusted person to me and I was taking myself to the GP when I was a child.*
>
> Truth Project participant sexually abused in a healthcare context

This longstanding GP–patient relationship was a common feature across accounts from different time periods, with one participant, who was abused in the 1990s and 2000s, describing her GP as ***"a really nice guy"*** [Truth Project participant sexually abused in a healthcare context]. She explained, similar to other participants' accounts, that he was trusted by the family who had had a long relationship with him. For this participant's family, this trust was to such an extent that when this GP's behaviour was investigated (prior to the participant being abused), her parents wrote a letter in support of the GP, highlighting the level of trust they had in him.

A couple of participants in the qualitative sample talked about being sexually abused by psychiatrists. One of these psychiatrists had a senior role in his organisation. As an adult, one of the participants found out that the psychiatrist who had sexually abused him visited many residential schools, where it seems that children were identified for psychiatric assessments.

[23] This total does not sum up to 59 as participants mentioned being sexually abused by more than one doctor.

Other than doctors, a few participants in the qualitative sample reported nurses and other patients as perpetrators. Two participants were abused by nurses in the 1960s and 1970s, one in a psychiatric ward/hospital, and the other in a general medical ward in a hospital.

> *In the adult ward the staff were nearly all female nurses, but there was one male nurse. Although it was slightly early for 'flower power', he wore his ... hair fairly long ... I do not remember his name.*
>
> Truth Project participant sexually abused in a healthcare context

One participant said that he was sexually abused in the 1960s, by both staff and patients in the institution in which he resided. Another participant reported harmful sexual behaviour from an older child, who was a resident with her in the hospital for 'emotionally disturbed children'.

5.2 Location and timing of the child sexual abuse

Eighty-five out of the 109 participants sexually abused in healthcare contexts (78 percent), reported that they were sexually abused in healthcare locations including hospitals, psychiatric institutions, or 'other medical' locations such as GP surgeries and healthcare centres (see section 2.2).

Findings regarding the location and timing of the child sexual abuse varied between participants. For the majority of the participants who had common/routine healthcare needs, or healthcare difficulties, the location of the sexual abuse was in a healthcare location, such as the GP consultation room, or a hospital ward.

One participant in the qualitative sample who was sexually abused by his GP, explained that the GP's home was serving as his practice. In two other cases, participants were sexually abused by their GPs, despite having chaperones. In one of these cases the participant reported that her mother was present in the same room, while she was with the GP in a part of the room that was sectioned off with a curtain. In the other of these cases, the participant described visiting the longstanding family GP many times alone, where she was sexually abused on multiple occasions. On one occasion she asked her sister to attend with her, and despite this the GP sexually abused the participant in the guise of conducting a smear test.

> *He was surprised that [sister] was there, but not in a kind of weird way, just like, you know, he asked [sister] to sit round the corner and he pulled the screen round.*
>
> Truth Project participant sexually abused in a healthcare context

One participant reported that he was sexually abused in a hospital, where he was admitted to an adult ward. Instead of giving the participant, who was alone at the time, a preoperative injection, the nurse sexually abused him.

> *Although I was only [age], I was put in the adult ward as I believe there had been an outbreak of measles or similar in the children's ward. ... When the time came for my operation, I was changed into a hospital gown which tied at the back as usual. The male nurse came in and closed the curtains and said that he was going to give me my pre-op injection.*
>
> Truth Project participant sexually abused in a healthcare context

Two of the participants who had healthcare difficulties were sexually abused in psychiatric wards.[24] One participant was admitted to an adult ward[25] and placed in a single room. She was sexually abused by a nurse who took advantage of her physical isolation. The other participant was admitted to a general ward following an overdose, but was then moved without explanation or communication to a psychiatric ward.

> *I was horrified. (Crying). I was told to come out and meet the others, and I was so terrified, I'd only ever seen things of psychiatric wards on films or TV, I thought everyone was going to be an absolute lunatic. I stood and faced a corner and sobbed. I was too scared to turn around.*
>
> Truth Project participant sexually abused in a healthcare context

All of the participants with significant needs reported that they were sexually abused in healthcare institutions. One of the participants described how he was sexually abused by a psychiatrist in an isolated room. He also spoke of how frightening the psychiatric institution was to him:

> *I was there for ten days and I remember that episode through how frightened I was because there were – it was – it was an old hospital and they were – there was a couple of women walking, shuffling around with scars where they'd had lobotomies.*
>
> Truth Project participant sexually abused in a healthcare context

The two participants who were abused in residential healthcare settings talked about being sexually abused in secluded locations within the institutions.

> *The sad part about it all is that fact when these incidents were taking place, they weren't actually always on the ward itself. They were actually out in areas that no one would see.*
>
> Truth Project participant sexually abused in a healthcare context

One participant was subject to harmful sexual behaviour from an older child both inside the hospital, in the toilets, and also in the cinema during visits there at the weekend.

[24] Participants did not specify the types of wards/admission, but since they talk about being in the wards for a number of days and events that indicate overnight stays, it is likely these were inpatient admissions. We do not know if they were admitted voluntarily or 'sectioned' under the Mental Health Act 1983.

[25] Although child and adolescent psychiatric wards were established because young people's needs differ from those of adults and require different skills of staff, as well as being better able to safeguard children, it is common for children, especially older adolescents, to be admitted to adult wards. This can be due to a lack of children and adolescent provision, for example provision is limited in some geographical areas, and/or children and adolescent wards are full and patients are refused admission.

5.3 Nature of the child sexual abuse

Timing and onset

Findings regarding the location and timing of the child sexual abuse in the qualitative sample varied between participants. Those with routine healthcare needs were all sexually abused within the context of routine healthcare interactions. Two were sexually abused by family GPs; one by a nurse when he was receiving an operation to repair damage he suffered in an accident as a young child.

Participants who had healthcare needs resulting from sexual and other forms of abuse perpetrated by their family members, and in one case by friends of their family, reported that they were sexually abused in the course of routine healthcare for their needs. One participant described that as a result of her increasing anxiety and distress, she self-harmed and also ran away from home. This behaviour led to an assessment by a psychiatrist, which resulted in admission to an adult psychiatric ward. She was sexually abused by a nurse in this ward. Another participant was sexually abused by a psychiatrist following admission to hospital as a result of an overdose.

> *If you want to roll back from me taking an overdose, I didn't feel like I had much – where else to turn. I was very depressed, obviously. Things looked very bleak, I thought.*
>
> Truth Project participant sexually abused in a healthcare context

Two of the participants had significant health needs and were sexually abused in residential healthcare institutions, with the onset of the abuse not being clear in the accounts. A third participant explained that one day the matron of the residential school in which he was boarding left her office door open, and he took some paracetamol and overdosed, which resulted in admission to a hospital. When he returned to the school, he was questioned about the incident but gave a confused account, as he was trying to protect the matron, who was the headteacher's wife. A psychiatrist was present during this investigation and recommended that the participant be given a psychiatric assessment at a psychiatric hospital. It was during this psychiatric assessment that the participant was abused by the psychiatrist.

Grooming

Very little grooming was evident in the quantitative sample, with only three out of the 109 participants mentioning grooming (see Table 2.1 in chapter 2). No grooming was mentioned by the participants in the qualitative sample. As discussed in chapter 3, healthcare professionals are afforded a high level of trust and respect in society that means individuals believe and trust them, respond to their requests, and rarely challenge them or their judgement. Since grooming is used by some perpetrators to develop access to children and enable them to sexually abuse them, it is perhaps not surprising given the routine and regular access that healthcare professionals have to children, their positions of trust and authority, and their ability to routinely touch and examine children, that grooming was not evident in participants' accounts.

The participants' accounts suggest that there was some manipulation of other staff by perpetrators at institutions, or collusion by them (discussed in chapter 6). For most of the participants in the qualitative sample the sexual abuse started immediately, such as during a GP's consultation, a hospital visit, or a psychiatric assessment. In some cases, where participants resided in healthcare institutions, they were sexually abused by staff or residents after a period of being in the institution. When GPs were perpetrators, some participants visited the GP on many occasions and, in two cases, the sexual abuse escalated over time.

Nature of the child sexual abuse

Over half, 54 percent, of the participants in the quantitative sample reported behaviour involving penetration. Thirty-nine percent reported fondling, 27 percent reported violations of privacy and 22 percent described other behaviour not involving penetration. Exposing children to adult sexuality was reported by 12 percent of the sample. Forty-eight percent of the sample reported experiencing multiple instances of sexual abuse.[26]

All the participants in the qualitative sample reported contact sexual abuse. In one case, the participant described an assault by a senior psychiatrist. Prior to that the psychiatrist had also verbally abused and threatened her and engaged in non-contact sexual abuse via inappropriate examinations and questions, using his authority to get the participant to do what he wanted.

> *This nurse, again very young, brought me in, and it was the same doctor that I'd seen before … He said again that I was clearly not thinking straight, I'd caused an awful lot of distress to my parents and they were going through hell, and I had to be made to realise that I could never upset people like this and be selfish. Then he told me I had to get undressed, and I refused. He said he had to examine me, he had to do a thorough examination. I said, "Why?" and he said because he's a doctor and he was the head of that unit and I had to do exactly what he told.*
>
> Truth Project participant sexually abused in a healthcare context

In many cases, participants explained how perpetrators first engaged in non-contact sexual abuse before committing contact sexual abuse. One described how a psychiatric nurse watched the participant get undressed when she was first admitted to the ward. Another participant remembers non-contact abuse when he visited the GP with his mother:

> *I am standing in front of him with my pants and trousers round my ankles. Another childhood memory is of being on the scale in the surgery, again I am not wearing my trousers or pants, again my Mum is present, so I must have been very young.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants talked about perpetrators fondling and touching them prior to engaging in penetrative sexual acts. One described how a psychiatric nurse touched her breasts when she was in the shower and fondled her genital area at night.

In other accounts, participants explained how the sexual abuse was immediately penetrative. One participant, who was sexually abused by a nurse who had come to give him his preoperative medication, recalled:

> *I then felt a searing pain in my rectum. I knew that this was very different to what had happened before, but in those days you didn't question adults, they always knew best. I clenched my muscles as hard as I could, and now know that he was trying to insert one of his fingers into me. I continued to tighten my muscles in that area as hard as I could and the pain went on for about twenty seconds.*
>
> Truth Project participant sexually abused in a healthcare context

[26] These episodes could be related to any context, not just healthcare.

Several participants described how the sexual abuse was often perpetrated under the guise of medical or clinical 'examinations'. During consultations, one participant's family GP engaged in examinations of her breasts.

> *I'd be paranoid that I'd have small breasts, and he would then ask to examine them, every time, you know. And I would just assume that that was part of the procedure, part of the check-up.*
>
> Truth Project participant sexually abused in a healthcare context

Another participant described how the GP touched and watched him as part of 'examining' him:

> *I got on the couch and he asks me to "lift your clothes up so that I can examine you", as I do this he starts to undo my trousers, he doesn't take it past this at this point, he starts to probe my stomach and touches me all over my abdomen right down to the top of my pants. He then asks me to lift my bottom and he pulls my trousers and pants down to my mid thighs exposing my private parts, he returns to his touching and all the time he is doing this he is watching my penis, he never speaks and doesn't look at me. At this time he never actually touches my private parts but he keeps touching other areas until he has given me an erection. I am lying on the couch feeling totally mortified by this, I am thirteen, struggling with what is happening to my body, no one has explained any of it to me, I am totally naïve.*
>
> Truth Project participant sexually abused in a healthcare context

Participants also described how medication and medical equipment were used in the sexual abuse. In two cases, medication was used to perpetrate the sexual abuse. One participant resident in a psychiatric institution recalled one evening when she refused to go to her room. In response to this, she was given medication by the staff and she believes that a nurse raped her while she was under the influence of the medication. Another participant who underwent a psychiatric assessment was given what he now believes was 'narco-analysis'.[27] The participant described how he was given an injection of sodium amytal (a sedative) and something else (unknown). The psychiatrist then implanted false memories and sexually abused him.

> *He put that suggestion in. And it was real. I could feel the – I could feel myself being beaten. I was screaming, I was rolling about, I was crying. And then – and then it stopped and then he was – he was comforting me and telling me it was all right and soothing me. But while he was soothing me, his hand went down and he was fondling me. And then as soon as I got aroused it was back to this memory and back to being beaten. And I kept putting my hands behind me to try and stop it hitting the back of me and – and it – so he then pulled my arms forward and tied me at the wrists. And then more fondling. And it was – it was – it was the being fondled, being beaten, being fondled, being beaten over and over and over again until eventually I, kind of, passed out and that was it. I couldn't do any more where I'd gone. And I came round the next morning. I'd wet myself. I was tied by my hands and by my ankles.*
>
> Truth Project participant sexually abused in a healthcare context

[27] This refers to the practice of administering chemical substances to lower an individual's inhibitions with the aim that he/she will more freely share information and feelings. This was a controversial treatment at the time and many have questioned the reliability of information obtained via this method. The practice is questionable for legal and ethical reasons and has since been discredited in the UK.

Many of the participants in the qualitative sample talked about being sexually abused with medical instruments, for example one said: ***"I was given an instrument in an area which it shouldn't have been put"***. [Truth Project participant sexually abused in a healthcare context]. In some instances these instruments were used under the guise of medical/clinical examinations.

> *... under the guise of performing a medical test, called a high vaginal swab, he used that as an opportunity to rape me. ... I thought I was dying, but I also thought I had to be very quiet, because it was the right thing to do. And that gave him an opportunity – the bit that was worse is that I then saw him go away and he came back and it happened again.*
>
> Truth Project participant sexually abused in a healthcare context

One participant described how a GP raped her under the guise of performing a smear test:

> *He put the instrument in me, I always remember, he looked at me and I just remember then thinking, "I don't know what's happening". I don't know, it was really seriously uncomfortable in every way you can imagine. And I've obviously had subsequent smear tests and I know that what he did wasn't normal. He pushed it in and out. He was looking at me on moments and then when he pulled it out, he sniffed it, and I will always remember that. It's fucking disgusting.*
>
> Truth Project participant sexually abused in a healthcare context

When talking about sexual abuse perpetrated under the guise of assessments and medical/clinical examinations, participants did not talk about professionals obtaining informed consent. While these participants were older adolescents at the time and might have 'agreed' to the treatment assessments, from the accounts provided it is unlikely that they were given accurate or full information about the reason for the assessment, nature and purpose of the assessment and range of potential benefits and harms, as is required (see section 3.1.3).

5.4 Duration of sexual abuse and when the sexual abuse ended

Some participants who shared their experience through the Truth Project talked about multiple, distinct episodes of sexual abuse. In our analysis we define an 'episode' as one or more instance of sexual abuse involving a particular perpetrator(s) or institution(s). It may involve a single instance of sexual abuse or relate to more than one instance which takes place over a period of time. It may also involve a single perpetrator, or multiple perpetrators who have colluded together. Where a participant reports multiple episodes of abuse, this means they have experienced distinct episodes of sexual abuse, involving different, unconnected perpetrators and institutions.

Forty-eight percent of the participants in the quantitative sample reported experiencing multiple episodes of sexual abuse.[28] The sexual abuse participants experienced varied in terms of duration; the shortest period reported was one day and the longest 15 years. Participants abused in healthcare contexts reported an average duration of 2 years of abuse.[29]

[28] This includes participants who experienced multiple episodes of sexual abuse across different instutional contexts, ie not all episodes may have been in healthcare contexts.

[29] The average duration of sexual abuse is an average of the total duration of sexual abuse across all experiences reported by participants.

In three cases from the qualitative sample, the sexual abuse occurred as a single incident. In other qualitative sample cases, participants were sexually abused on more than one occasion during stays in hospital. A couple of participants spoke about sexual abuse perpetrated by GPs that lasted over a period of many years, made possible by the GPs recommending ongoing visits to monitor their health. One participant explained how the GP played on her fears about her health and lack of confidence in her body image, and recommended frequent check-ups and even a smear test, although she was under the age of 25 (the age at which smear tests are first recommended).

> *He told me it [smear test] was for cervical cancer, that I need to be careful; I could get blood clots because I smoked and, you know, I took the pill, which I know is true, but not after one year or less than a year, you know, and not like ten [cigarette brand] a weekend, you know.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants spoke of the sexual abuse ending when they left the healthcare location: in one instance the sexual abuse ended when the participant was discharged from the hospital; in another, the participant ran away from the hospital to escape. In other cases, the sexual abuse was ended with participants leaving the care of the healthcare professional. For example, one of the participants who was abused by her GP recalled:

> *He said ... something like, "I'm sure you want me to bend me over your knee – bend you over my knee and smack your bottom", and then that to be, you know, like to make that okay. And I just remember, in that moment, I was like obviously still politely [a] good girl, smiling along, acting like I was totally not phased by it, but I remember leaving and I was just like, I can't go back to him. So then, I started to go to another woman, a GP in the practice.*
>
> Truth Project participant sexually abused in a healthcare context

One participant sexually abused by a GP reported that his health improved when he was an older adolescent and changed jobs, and that he did not recall visiting the GP after that.

Only one participant talked about the sexual abuse stopping as a result of other people. This participant reported the sexually harmful behaviour of an older child, and the hospital staff subsequently kept the two children apart.

5.5 Additional experiences of abuse separate to sexual abuse

In some cases, participants reported experiencing child sexual abuse alongside other forms of abuse by the same perpetrator, such as physical and emotional abuse, and neglect. Thirty-seven percent of the quantitative sample talked about other forms of abuse they experienced alongside the sexual abuse. Twenty-six percent reported suffering physical abuse, 23 percent reported psychological abuse, and 14 percent reported emotional abuse or entrapment. Lower proportions of the participants in the quantitative sample reported other forms of abuse, with 8 percent reporting bullying, 7 percent witnessing the abuse of others, and 7 percent reporting neglect.

Some of the participants in the qualitative sample described suffering physical abuse during the sexual abuse. One participant recalled 'horrific' sexual abuse following which he woke up with black eyes. Others described receiving physical injuries.

> *And I was covered from just above my calf to just below my shoulders with red welts where I'd been beaten.*
>
> Truth Project participant sexually abused in a healthcare context

Another participant was physically abused in a healthcare institution, which caused lifelong damage:

> *First of all, I was thrown, lifted up ... Landed on my face, damaged my legs, my eyes were damaged but it wasn't discovered until I was moved to another one. ... I had to have two major operations because the retina had been damaged at the back of my eye.*
>
> Truth Project participant sexually abused in a healthcare context

One participant who was a resident in a healthcare institution described how her overall health was poor when she was moved from the institution to foster care:

> *... I can remember having very bad herpes all over my face, up my nose. Mama told me later on in my life, not in a kind way, that when I came to her from [healthcare institution] I was two-and-a-half stone, I was riddled with worms and full of head lice.*
>
> Truth Project participant sexually abused in a healthcare context

A couple of participants talked about the verbal abuse they experienced. One participant abused by a psychiatrist reported that he was verbally abusive to her and made threats, by telling her that it was his decision about what happened to her in the hospital and when she would be able to leave. Another participant who was admitted to hospital following an overdose recalled:

> *... the nursing staff told me at the time, they said I was disgusting, how dare I do this [overdose]. One of them actually whispered in my ear, I should be ashamed of myself. Really awful ... Nobody had given me any water, so I couldn't speak very well, I was very dehydrated, so I was finding it very difficult to speak.*
>
> Truth Project participant sexually abused in a healthcare context

The findings discussed in this chapter revealed that the majority of perpetrators, and all perpetrators reported by participants in the qualitative sample, were male. Just under one-tenth of the participants in the quantitative sample reported female perpetrators. Healthcare often involves one-to-one 'secluded' access to children in vulnerable situations, examinations and the use of medication as well as, or in addition to, medical instruments. The participants' accounts discussed in this chapter show how the perpetrators used this context to sexually abuse children. With the exception of the older child who engaged in harmful sexual behaviour (which reflects the 6 percent of the quantitative sample who reported sexual abuse perpertrated by a peer or older child), all the participants in the qualitative sample and the majority of participants in the quantitative sample reported that perpetrators had positions of trust which provided them with routine access to children and 'private' locations in which abuse could be perpetrated.

Participants reported that perpetrators abused their positions of trust, which in the case of GPs was all the more significant, as they had longstanding relationships with the families of the victims and survivors. These cases highlight the routine access to children and the power and authority of healthcare professionals. Noticeably, no grooming was discussed by the qualitative sample. Also, very few in the quantitative sample reported grooming, which is perhaps not surprising given the routine and easy access that perpetrators had to children which allowed them to examine and touch children without any need of 'special' explanation or persuasion. Participants described how some perpetrators recommended 'examinations' and 'assessments' that were not appropriate or needed in order to sexually abuse them. All participants in the qualitative sample reported contact abuse, with escalation from non-contact abuse in some cases, and many said that medical instruments were used in the sexual abuse.

Chapter 6

Institutional context and knowledge of the child sexual abuse

This chapter describes the characteristics and features of healthcare contexts and how these facilitated the perpetration of child sexual abuse. It considers what participants shared about the level of knowledge that institutions, and the individuals within them, had about abuse that was occurring at the time. This chapter explores the following research sub-questions:

- **How much did institutions know about what was happening?**
- **What have victims and survivors said about whether anything could have been done by the institutions at the time to prevent the child sexual abuse?**

6.1 Healthcare contexts' characteristics

The majority of the participants in the qualitative healthcare sample reported that they were sexually abused in GP practices or hospitals/institutions. Participants in the sample did not generally provide much information about the characteristics of these organisations.

The GP practices were described as family and local with typical consultation rooms. In one case, the participant described the practice as 'middle class'. Another practice was based in the GP's home and the participant described how he feared that people could see him being sexually abused:

> *... there are no nets, and no blind, just the open curtains. I fear that someone will pass and look in seeing me like this.*
>
> Truth Project participant sexually abused in a healthcare context

When healthcare institutions and hospitals were described, participants said they were old, horrible and forbidding.

> *This hospital was an old workhouse, as you can imagine, was quite forbidding, foreboding, dyed black with industrial soot.*
>
> Truth Project participant sexually abused in a healthcare context

There were many features of healthcare contexts described by participants in the qualitative sample that they felt allowed the sexual (and in some instances other forms of) abuse to occur. A recurring characteristic spoken about was the position of trust and authority occupied by healthcare professionals that enabled them to instruct or request things of patients without being questioned, even if that behaviour seemed unusual.

> *You've got to bear in mind, he was a doctor, I thought, "By God, this is really weird", but I didn't think how weird and how wrong it was, do you understand?*
>
> Truth Project participant sexually abused in a healthcare context

Many participants also pointed out that children were encouraged not to question their elders, which further increased the authority of the adult perpetrators.

> *As a young person, I think particularly back in the 60s and 70s we didn't question our elders and 'betters', also as we still do we place trust in our doctor so I never questioned what he asked. You think that he knows what he's doing and that there is a medical reason for him carrying out examinations.*
>
> Truth Project participant sexually abused in a healthcare context

Another feature spoken about was children's lack of knowledge about medical/clinical procedures and examinations. As mentioned in chapter 5, sexual abuse was often perpetrated under the guise of medical/clinical procedures and examinations, meaning that participants were not able to determine if what was happening to them was abnormal or wrong.

> *At the moment that it happened I didn't know what had happened. I didn't understand … All I knew was that something painful happened.*
>
> Truth Project participant sexually abused in a healthcare context

> *Although puzzled I still had no idea what he had been up to until I was a few years older and knew more of the facts of life.*
>
> Truth Project participant sexually abused in a healthcare context

Many of the participants described being young, innocent, naïve and trusting of healthcare professionals as children.

> *He then listened to my chest with his stethoscope and then asked me to get on the couch, I do this without question, he's my doctor and I am safe with him; that is what I thought despite feeling uncomfortable.*
>
> Truth Project participant sexually abused in a healthcare context

Participants spoke about how perpetrators used the physical characteristics of healthcare locations to commit sexual abuse. The availability of small rooms, or curtains that could be drawn around patients, provided perpetrators with locations in which they could sexually abuse children. Private space for consultations and examinations is a routine aspect of healthcare contexts. It is unlikely that children being alone with medical practitioners in these spaces would be questioned; in fact such behaviour is expected in healthcare contexts. In two cases, perpetrators were able to use a curtain to seclude children from their chaperones to perpetrate sexual abuse, even though the chaperones were in the same room. In another case, a nurse sexually abused a participant in a ward with other patients, with the curtain pulled around the participant's bed.

Participants explained that in many cases where sexual abuse occurred in a healthcare context, they were either unchaperoned when attending or living in healthcare institutions without family members being present. Two participants reported that they attended GP consultations alone when they were teenagers and one participant who went into hospital for a routine operation did not have his parents present until after the operation. Some participants resided in institutions as they had no family support at all, or very limited family contact. Participants described how there was no one for them to turn to for help, support or protection.[30] Only one participant talked about a supportive staff member in the healthcare institution, with just one nurse who made him feel looked after.

> *... there was one who was very good. ... She was a proper nurse and was ... very good. Made sure that you were looked after on a night and everything like that.*
>
> Truth Project participant sexually abused in a healthcare context

It is difficult to determine from the participants' accounts whether staff actively colluded in the sexual abuse. Participants did describe how staff did not question unusual behaviour by the perpetrators or take steps to safeguard children effectively. One participant described how a nurse took her across the hospital to the doctor (perpetrator).

> *They lent me a dressing gown and slippers and I was taken off this ward, I had to walk quite a way and see a doctor in a big room. He was sat behind his desk. The nurse that was sent to take me was very, very young, she can't have been much older than me, she was a trainee. I was stood in front of this doctor.*
>
> Truth Project participant sexually abused in a healthcare context

Another recalled how a nurse untied him after he had been sexually and physically abused by a psychiatrist and explained away his physical injuries.

> *This nurse came in to untie me and I asked her what these things were [red welts], and she said – she said, "Sometimes when the memory's that strong, the body will physically react but don't worry, I've got some cream and we'll sort that out" which I believed because, you know, I was about 14.*
>
> Truth Project participant sexually abused in a healthcare context

In a GP practice, one participant explained that the GP perpetrator told her to book a double session for a smear test with the receptionist and that the receptionist responded angrily, rather than question the GP as to why this was needed.

> *I remember so clearly going to the receptionist and saying, "[doctor] says I need a double session", and she said, "Why?" She was angry at me for saying that. And again, in that moment, that should have been a moment where instead of someone being mad at me for saying something that someone else said, she should have asked, why does this 16-year-old girl need a smear test, why does she need a double smear test and why is a man doing it?*
>
> Truth Project participant sexually abused in a healthcare context

[30] These cases predate the Children Act 1989, under which children in similar circumstances would be defined as 'children in need' as their health and development would be significantly impaired without the provision of service. Under the Act, local authorities have a duty to provide support to these children.

Some participants also noted that perpetrators took advantage of children's vulnerabilities. For example, one participant believed her home circumstances and poor relationship with her mother were noted by her GP.

> *Not only did he abuse me and take advantage of the fact that I – you know, actually physically abuse me; he took advantage of his position, in terms that he knew that I trusted him, and I had to trust him and I was a good girl and whatever else; but it really is definitely the thing that's kind of weighed very heavy on my mind, is that he took those bruises on my arm, not as a sign of abuse [crying] like to save me or to get someone involved, and to try and make my family life better for me, but he took that as a green light for him to do what he wants.*
>
> Truth Project participant sexually abused in a healthcare context

Another participant explained that the perpetrator selected the most isolated children:

> *The kids he [perpetrator] tended to pick on were those that, you know, didn't have any family, those that didn't really have anybody or friends that just kept them safe. So, I think he knew that he was doing wrong.*
>
> Truth Project participant sexually abused in a healthcare context

Only two protective features of this context were described by participants in the qualitative sample. One reported that following her disclosure of the harmful sexual behaviour by another hospital resident, the staff kept the two of them apart and she does not recall any further sexual abuse after that. In respect of the adult patients on the ward she was on, another participant reported that she felt safer around other patients, even though they were adults.

6.2 Institutional and wider knowledge at the time

Forty-eight percent of the participants in the quantitative sample reported that someone else in the institution knew about the sexual abuse. A smaller proportion, 19 percent, reported that they knew of someone else in the institution also being sexually abused.

In the qualitative sample, there was little evidence in the participants' accounts that other children were aware of the sexual abuse carried out by the perpetrators. Given that, in healthcare contexts, a practitioner is typically alone with a child for an examination, children were sometimes on adult wards, and children were often unaware of the GPs or healthcare staff of their peers, this is perhaps not surprising.

Participants in the qualitative sample did talk about being aware of other victims and survivors of sexual abuse. For example, one participant heard a complaint about the GP's behaviour.

Some participants in the qualitative sample now believe that the perpetrators sexually abused many others, but described how they were not aware of this when they were children. Some had investigated the perpetrators and organisations as adults. Some perpetrators were convicted, resulting in participants discovering the extent of the sexual abuse.

> *However, although he was convicted, I think they only did ten cases. He did horrendous things to these poor people. I think there must be hundreds of us that have had experiences.*
>
> Truth Project participant sexually abused in a healthcare context

Although she investigated as an adult and found no evidence, or reports of sexual abuse committed by the GP perpetrator against other people, one participant said: ***"I can't have been the only one because he was too good at it."*** [Truth Project participant sexually abused in a healthcare context].

In respect of adult awareness of the sexual abuse, many participants believed that staff in the healthcare institutions must have been aware of what was going on in some of the cases: ***"That hospital knew about it. They must have known about it. The staff knew about it."*** [Truth Project participant sexually abused in a healthcare context].

One participant explained that the residential school from where he was identified by the psychiatrist as requiring an assessment must have known about the sexual abuse, since his behaviour was so changed after the 'assessment':

> *It was just never mentioned. You know, nobody said anything and I didn't. They – they must have known something because – because I do know that I was – I used to say to the other kids in that place, you'd say, "You've gone funny". ... Because I'd – I'd just – a wall had gone up and I didn't want to talk to anybody, I didn't want to – so, they must have known. They must have.*
>
> Truth Project participant sexually abused in a healthcare context

Some adults (parents and staff) were also told about the sexual abuse by the participants when they were children, as discussed in the next chapter.

In summary, there were few protective factors present at the time of the sexual abuse in the healthcare contexts, which is in keeping with the reluctance of staff to question healthcare practitioners' behaviours, as discussed in chapter 3. Characteristics of the healthcare contexts that were used by perpetrators to sexually abuse participants included: routine access to children (such as one-to-one contact in secluded locations), the power and authority of healthcare practitioners, children's respect of adults' authority and lack of knowledge of 'normal' examinations, and cultures of abuse in some institutions. Participants highlighted that they believed some staff must have known or suspected that sexual (or other forms of) abuse were taking place. Unusual behaviours seem not to have been questioned, leaving participants to wonder why staff did not intervene. These factors led to many missed opportunities to safeguard the participants and other children, including those who had engaged in harmful sexual behaviour.

Chapter 7

Experiences of disclosure and responses by institutions

The first part of this chapter presents information about participants' experiences of disclosing the child sexual abuse, both as children and as adults, and how they were impacted by the responses to their disclosure. The drivers and barriers to disclosure shared by participants are also reported. The research sub-questions addressed in this chapter are:

- **What were victims and survivors' experiences of disclosing child sexual abuse (as a child/adult) that occurred in a healthcare context and what has helped or hindered disclosure?**
- **How were disclosures or allegations of child sexual abuse in healthcare contexts responded to by those within and outside institutions?**

7.1 Experiences of disclosure and impacts as a child

Disclosure of sexual abuse as a child can be very challenging, which is reflected in the quantitative sample, where only 28 participants reported that they told someone about the sexual abuse at the time. Of these participants, 12 disclosed the sexual abuse to a parent, 10 to a person in authority inside the institution and 9 to the police. Three participants told a healthcare personnel about the sexual abuse, and three told welfare/child protection officer.

Of those participants who did not disclose at the time of the sexual abuse, the most frequent reasons given were that they did not know that the behaviour was not OK (mentioned by 11 participants), the fear of not being believed (mentioned by 11 participants), feelings of shame and embarrassment (mentioned by 9 participants), or they had no one to whom they could disclose (mentioned by 9 participants).

In the qualitative sample, six of the nine participants reported that they disclosed the sexual abuse as children to trusted adults, such as parents or other healthcare professionals within institutional settings. In some cases, participants disclosed or attempted to disclose the sexual abuse to more than one adult. Three participants disclosed the sexual abuse to a trusted adult at the time or shortly after the abuse took place. Two others disclosed the abuse as a child, some time after the abuse occurred. Some participants did not disclose the sexual abuse. As discussed previously (see chapter 6, section 6.1), some participants indicated that they did not understand the perpetrator's behaviour was wrong or abnormal, which meant that they did not disclose what had happened to them.

A common theme discussed by participants who did disclose the sexual abuse was that their disclosures were disbelieved. Three participants attempted to disclose the sexual abuse to healthcare professionals within the institutions where the abuse had occurred. These reports of sexual abuse were not taken seriously, escalated or actioned.

> *When I reported the first incident I got laughed at. I just got laughed at. The sad part about it, there was nowhere really for me to turn. There was somebody who was looking after that particular ward and stuff like that but after that you also had what was known as [the] superintendent. But it never went as far as that superintendent.*
>
> Truth Project participant sexually abused in a healthcare context

Several participants described that a significant barrier to disclosure at the time of the sexual abuse was having no one to turn to, or that reporting mechanisms did not exist. Participants who were admitted to, and residing within, healthcare institutions, such as a residential home, hospital or within psychiatric wards, described that there was no one to turn to within these settings.

> *In [the 1960s] it was a different world than it is today and there were not the right avenues of complaint available.*
>
> Truth Project participant sexually abused in a healthcare context

In one case, staff in a healthcare-residential institution separated the victim and perpetrator but took no further action. This was the only example in the qualitative sample of action by healthcare staff or within a healthcare institution following a participant's disclosure of sexual abuse as a child.

One specific barrier described by participants sexually abused in healthcare contexts was that adults did not believe their reports of sexual abuse, not just because they were children, but also because they were labelled as sick patients.

Several participants reported that they were made to feel as though they had made up the sexual abuse because they were unwell. One participant recounts being disbelieved and discredited by her doctor at the psychiatric hospital:

> *I tried to talk to the doctor about not feeling safe and I was scared of the nurses and they were doing bad things. I don't think I really had the language to say what was happening but I can remember just the response of the doctor was like, you know, that I was a really, really sick person. You know, I was sick, you know, I was really sick and that I was going to need to be in hospital for a long time. It was like, you know, I might have to be in hospital all my life.*
>
> Truth Project participant sexually abused in a healthcare context

The status and position of some of the perpetrators as healthcare professionals was also talked about as a barrier to disclosure. A number of participants explained that they were afraid, or felt unable to disclose the sexual abuse as children, because questioning a figure of authority, such as a doctor, was not deemed acceptable or would be perceived by adults as 'naughty' behaviour.

> *Nobody asked me, no. No. But again, you know, in those days consultant psychiatrists were God, you know. Nobody questioned what they did really.*
>
> Truth Project participant sexually abused in a healthcare context

In one case, the longstanding relationship between the GP who perpetrated sexual abuse and the participant's family led to her being disbelieved by her parents. Not only was the participant disbelieved, but her parents also recommended the GP throughout an investigation which called into question his professional conduct.

> *My parents didn't do anything about it. I told them when we had that argument about, "Why didn't you tell me that he was struck off the list?" "Well, we didn't need to …". I maintain that I told them that he was like touching my breasts at every examination. My mum will say that I never, obviously, told her that.*
>
> Truth Project participant sexually abused in a healthcare context

Another common barrier to disclosure discussed by participants was their feelings of guilt, shame and self-blame.

> *I didn't think it had happened. I thought nothing – I thought that this was just a medical test and I was a particularly sensitive – and weak child. That I had been naughty somehow and this was my punishment for being naughty. That I had made it up because mum was right there and how could something like that happen.*
>
> Truth Project participant sexually abused in a healthcare context

One participant was afraid to disclose his sexual abuse because the perpetrator was the same sex, and he was worried and confused about his sexuality and how others would react to this.

> *I thought it was – the way I made sense of it was – was he'd stumbled on my secret and I couldn't tell anybody because it was my secret that I liked men but that was – that had to be kept secret.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants who did not explicitly disclose the sexual abuse to adults displayed abnormal behaviours, for example: re-enacting the sexual abuse through play, running away, withdrawing from social life or exhibiting volatile emotions. One participant faced physical barriers to disclosing the abuse, including speech and communication difficulties and hearing loss. The failure of adults to respond appropriately to behavioural signs of trauma was a further barrier to children disclosing the sexual abuse at the time.

> *There's so many things that could have stopped, there's so many moments in my journey where I was genuinely crying out to people and there was nothing, no one to listen to me.*
>
> Truth Project participant sexually abused in a healthcare context

7.2 Experiences of disclosure and impacts after the child sexual abuse had ended/as an adult

Fifty-eight participants told someone about the sexual abuse after it ended.[31] Of these participants, the police were most frequently disclosed to, with 34 participants reporting to the police. 'Healthcare personnel' such as a doctor or nurse were the second most frequently disclosed to (mentioned by nine participants), followed by a person providing mental health services (mentioned by eight participants), then a person in authority inside the institution (mentioned by six participants).

Participants in the qualitative sample described how they were better able to disclose the sexual abuse as adults because they were more equipped to distinguish between normal and abnormal medical examinations and relationships with healthcare professionals, and were more likely to be believed by other adults. In many cases, disclosure was necessary to protect the integrity of other aspects of their adult lives, such as their careers, families and health.

[31] Note that 'after the abuse had ended' could refer to disclosures made when the victim and survivor was still under the age of 18 or when they were an adult over the age of 18.

Almost all the participants in the qualitative sample chose to disclose the child sexual abuse to a healthcare professional at different points in their lives as adults. Access to professional support, such as counsellors and rehabilitation services, was a key facilitator to disclosure and recovery. Some participants chose to disclose the sexual abuse to trusted family members. For one participant, it was necessary to disclose the sexual abuse to staff in the sheltered accommodation where he was residing because he did not want to be touched by male members of staff. Members of staff went on to report his disclosure to the police on his behalf.

Compared with the negative experiences described by participants disclosing the sexual abuse as children, several participants talked about feeling relieved that their disclosure as adults was believed. Belief and support were identified as important facilitators to disclosure and recovery.

A common facilitator to disclosure in adulthood was learning about other victims and survivors who have come forward to report their experiences of child sexual abuse, for example through news reports. One participant chose to disclose the sexual abuse to the Truth Project after seeing other witnesses come forward at the Inquiry's public hearings. Several participants described how the courage of other victims and survivors coming forward motivated them to disclose their own experiences of sexual abuse. One participant wanted their voice heard more publicly, and made their disclosure through media channels. Many participants disclosed the sexual abuse to protect others who might have fallen victim to the same perpetrators, and to encourage others to make disclosures. One participant described:

> *Reading that brought all the memories and the horrors crashing back into my mind and my life and so I decided that I also needed to tell my story, for my own sake but also for anyone else who may have suffered at the hands of this person.*
>
> Truth Project participant sexually abused in a healthcare context

Several participants went on to pursue careers in social or mental health services and described their interactions working with victims and vulnerable young people as facilitators to their disclosure in adulthood. A common facilitator to disclosure was participants' motivation to find a way to ***"fight back"*** and participants seeking closure and justice.

> *It was kind of like I was reaching for something [crying] just someone to listen to me and someone to do something about it for me to feel like – so much bad stuff had happened to me and I was just trying to fight back in one way just for the first time.*
>
> Truth Project participant sexually abused in a healthcare context

Participants in the qualitative sample talked about a number of barriers to disclosure as an adult. Participants who came to misuse drugs and alcohol in adolescence and adulthood delayed their disclosure by numbing memories and pain associated with the sexual abuse. Several participants came to the realisation that disclosure would be necessary for recovery. Other barriers to disclosure in adulthood, carried forward from the negative experiences of disclosure as children, included a strong distrust in the police and frustration with having to explain their experiences in detail repeatedly to different people.

As children and adults, some participants delayed disclosure because the perpetrator was deceased and they felt there was no point in making the disclosure. Some participants said they felt they ***"got off lightly compared to others"*** [Truth Project participant sexually abused in a healthcare context] and felt unsure that their experience was serious enough to justify formally seeking help or making a report. Only nine participants who were sexually abused in healthcare contexts reported that they made disclosures to the police as children, but 34 said they reported the sexual abuse to the police as adults.

A couple of participants reported negative experiences of disclosing the sexual abuse as an adult to a healthcare institution. In one case, the participant found it strange that the GP surgery where she had been sexually abused for many years had asked her for a statement without involving the police. The surgery began withholding the participant's prescription medication and even attempted to refer her to a mental institution without her consent. This example demonstrates the power that healthcare institutions and clinicians have to manipulate individuals, even as adults.

> *"Why would I write you a statement?" That's when, after that, I rang the police because of that because I thought, I wouldn't hand you my evidence ... She just battered me off. Well, she – I really feel like they were trying to blackmark, blacklist me, make out that I was crazy.*
>
> Truth Project participant sexually abused in a healthcare context

Several patients reported that being able to disclose their experiences to the Truth Project was important in helping them feel listened to and empowered to effect change:

> *There's something about telling somebody that kind of – has some kind of authority ... And it's empowering ... It really is empowering. Because when you're in hiding for so long, you know, you suddenly say, "No, actually." So, thank you.*
>
> Truth Project participant sexually abused in a healthcare context

In summary, the information shared by participants showed that a third of the Truth Project participants sexually abused in healthcare contexts disclosed or attempted to disclose the sexual abuse as children to trusted adults. Most were disbelieved or dismissed. In some cases, participants did not explicitly disclose the sexual abuse but externalised behaviours were indicators of sexual abuse, which were missed by adults. Barriers to disclosure related to having no one to report to and no mechanisms for reporting in healthcare institutions at the time of the sexual abuse. The trusted status and authority of the healthcare professional, and stigma of being a patient and being unwell exacerbated these barriers. Others who attempted to disclose the sexual abuse were dismissed by healthcare professionals as sick or 'crazy'.

As adults, participants in both quantitative and qualitative samples indicated that they were better able to recognise, acknowledge and disclose their experiences of sexual abuse, with some encouraged by learning of other victims and survivors of sexual abuse who had come forward to disclose their experiences. For some participants, emotional breakdowns or the need for healthcare necessitated the disclosure of the sexual abuse.

Chapter 8

Impacts of the child sexual abuse

This chapter sets out the range of impacts that child sexual abuse has had on participants at different stages of their lives and addresses the research sub-question:

- **What are the impacts of child sexual abuse in the context of healthcare reported by victims and survivors?**

8.1 Impacts of child sexual abuse in healthcare contexts

Participants in the qualitative sample described extensive and diverse impacts of experiencing sexual abuse, many of which had an impact throughout their lives.

> *I just see [doctor/perpetrator] fingerprints on everything, you know, on every – you know, … I look at my life and I just see his fingerprints …*
>
> Truth Project participant sexually abused in a healthcare context

8.1.1 Direct impacts and consequences

Although participants as children may not have known they were subjected to sexual abuse at the time of the abuse, many participants recalled feelings of confusion and discomfort around the perpetrators.

> *My early memories of visiting Dr [name] were always of feeling extremely uncomfortable and uneasy in his presence, I'm sure that this is common in children, but this was something more for me.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants talked about the immediate direct impacts of the sexual abuse, such as physical pain and discomfort. Of the 109 participants who reported child sexual abuse in a healthcare context, 23 percent talked about direct consequences of the sexual abuse, such as pregnancy, physical injury and sexually transmitted diseases. In the qualitative sample, several participants also talked about direct consequences. Two participants recalled passing out or blacking out as a result of the sexual abuse. One participant described waking up disoriented from his blackout:

> *I woke up on the grass and I hadn't a clue where I was. I didn't even know what day it was.*
>
> Truth Project participant sexually abused in a healthcare context

Other participants recalled immediate physical impacts including feelings of searing and excruciating pain, bed-wetting, waking up with black eyes and discomfort when walking.

One participant described how the sexual abuse fundamentally changed him as a person:

> *She [sister] said, "You came back somebody else. You – you weren't that person anymore". You know, and I ran off. I just didn't want to be – it wouldn't be me.*
>
> Truth Project participant sexually abused in a healthcare context

8.1.2 Mental and physical health and wellbeing

Participants described a range of lifelong impacts of the child sexual abuse on their mental health and emotional wellbeing. Of the 109 people who reported child sexual abuse in a healthcare context, 87 percent talked about mental health impacts including, for example, 35 percent who talked about anxiety and 36 percent who talked about depression.

Many participants in the qualitative sample also mentioned mental health impacts. As children, three participants in the qualitative sample described experiencing recurring nightmares or insomnia. One recalled re-enacting the sexual abuse through play. Paranoia, fear, flashbacks, hallucinations and nightmares prevailed and continued to affect participants throughout adolescence and adulthood.

Some participants faced particular anxieties about their health because perpetrators who were healthcare professionals led them to believe something was wrong with them. For example, one participant believed she had severe fertility issues because she had been sexually abused by her GP under the guise of a smear test, and the surgery reported that her smear test results were 'inconclusive'.

A common theme was the emotional and psychological distress experienced by the participants as children. This included feelings of confusion, anger, guilt, fear and volatile moods.

> *I would get so unbearably angry that I would destroy things suddenly for no reason and then I would calm down ...*
>
> Truth Project participant sexually abused in a healthcare context

Several participants described a ***"tidal wave of emotions"*** [Truth Project participant sexually abused in a healthcare context], including feeling lonely, anxious, paranoid and afraid. In some cases, participants described withdrawing from social life and engaging in substance misuse from a young age in order to numb feelings and bury memories of their experiences of child sexual abuse.

In addition to drug and alcohol addiction, participants reported that they suffered from mental health conditions such as post-traumatic stress disorder, depression and anxiety. Others reported symptoms of psychosis, such as hallucinations. One participant reported suffering from bulimia, which led to other health complications.

Six participants reported that they self-harmed, attempted suicide or experienced an emotional breakdown, as teenagers or adults.

> *I was quite determined to kill myself at times, I think it did take quite a lot of people to persuade me not to. And I was quite dissociative, quite psychotic. I saw things. I was hearing things.*
>
> Truth Project participant sexually abused in a healthcare context

One challenge for victims and survivors of sexual abuse in healthcare contexts was facing the stigma associated with being labelled as sick, or mentally ill or as a patient.

> *My whole experience of being a psychiatric patient and not only experiencing the abuse but getting a label and the sense that, you know – and that everything was because I was this sick, ill, inadequate, stupid person.*
>
> Truth Project participant sexually abused in a healthcare context

Three of the participants who resided in vulnerable households as children reported that the sexual abuse they experienced in healthcare contexts exacerbated their neglect and mistreatment at home.

> *But the thing I feel that has damaged me is I went with labels to live with her [foster mother]. I don't know what those labels were, I don't have a – I don't know what my record was ... she [foster mother] thought I was such a sexual deviant, because she did treat me like I was a perpetrator. I've taught for a long, long time, and I've gone to enough safeguarding [...] the child is always the victim. And I was so young.*
>
> Truth Project participant sexually abused in a healthcare context

In all three cases, participants reported that poor relationships with family members worsened following the sexual abuse. Participants recalled feeling a lack of family support, making it difficult to disclose the child sexual abuse (as noted in section 7.1) and sought to leave home as soon as they could.

Some participants believed there was a link between their experience of sexual abuse and the development of physical illnesses as adults. One participant mentioned that she was heavily medicated throughout her stay at a psychiatric hospital and felt that she may not have needed the medication to begin with. She also explained that her first child was born with disabilities and health problems which she attributes to this medication. Other participants described suffering from heart conditions as a result of substance misuse. One participant suffered from health complications due to bulimia.

8.1.3 Relationships and sexual behaviour

Participants in the qualitative sample described how the child sexual abuse they suffered had an impact on their relationships, sexual health and behaviour, starting in young adulthood and often continuing throughout their adult lives. Of the 109 people who reported child sexual abuse in a healthcare context, 34 percent reported that the abuse had an impact on their sexual behaviour and 36 percent reported facing difficulties with trust and intimacy.

> *And then when I was heading into puberty and the idea of boys and sex, well that's just a catastrophe. That's not going to happen, that's not possible.*
>
> Truth Project participant sexually abused in a healthcare context

Participants described difficulties in forging trusting relationships with others from a young age. Some participants described feeling dirty, worthless, used and self-conscious as a result of the sexual abuse. These feelings may have contributed to difficulties in developing healthy relationships as adults. One participant described how his experience affected his perception of sex altogether, as something wrong and bad.

> *I think it was a very crude form of aversion therapy. And so my understanding of my sexuality was that it was wrong and it was bad and I needed to be punished for doing it, which has taken a lot of getting over.*
>
> Truth Project participant sexually abused in a healthcare context

One participant explained that her experiences of sexual abuse led to her negative view of men generally:

> *So unfortunately, when you've got a history of sexualised behaviour, I haven't got a great faith in men in terms of their ability to rein things in, if you like. That moral code that a child is a child.*
>
> Truth Project participant sexually abused in a healthcare context

Another participant described feeling as though same-sex attraction may be wrong or bad and that he may have been sexually abused because of his sexual orientation:

> *What does this mean: am I weird, am I gay, what did I do wrong? There must be something seriously wrong with me.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants reported engaging in sexual behaviours such as escapism through role-play and sadomasochism.[32]

> *I got ... drawn into kind of the sadomasochism. And my idea of a good session was if I felt like a dirty oiled rag that somebody had thrown in the corner, you know, because ... that's what his fingerprints were.*
>
> Truth Project participant sexually abused in a healthcare context

Of the 109 people who reported child sexual abuse in a healthcare context, 15 percent reported avoidance of or phobic reactions to sexual intimacy. One participant from the qualitative sample explained that she developed an aversion to sexual acts associated with the sexual abuse.

> *My [Perpetrator 1 – family member] performed oral sex on me, he bit me down there ... I do remember that ... because that's followed me into later life where I don't do anything like that, you know. And [Perpetrator 2 – healthcare] was doing that as well, and I was very uncomfortable with that.*
>
> Truth Project participant sexually abused in a healthcare context

Others spoke positively about the value of the relationships they established and families they built as adults in supporting their recovery (described in more detail in chapter 9).

8.1.4 Education and employment

Participants already facing difficulties at school prior to the child sexual abuse reported that the experience of sexual abuse exacerbated difficulties in terms of making friends, or attending classes. Sometimes this was due to the effects of drugs and alcohol used by several participants as a coping mechanism after the sexual abuse. However, many others described themselves as high achievers and went on to complete higher education studies, despite the sexual abuse.

[32] Sexual behaviour that involves inflicting physical pain or humiliation on oneself or others.

None of the participants in the qualitative sample spoke about any negative impacts of their experiences of sexual abuse on their employment. A number of the participants described successful careers. For these participants, their career ambitions were discussed as a distraction and coping mechanism to help deal with the impact of their experiences of child sexual abuse.

> *I just went totally off the rails, but maintaining 9–5, like really successful, really, you know, everyone thought I was great on the outside, but …*
>
> Truth Project participant sexually abused in a healthcare context

A few participants felt that they had developed a strong sense of empathy towards other vulnerable people because of their experiences of abuse. This may be related to their choice of careers that involved helping others or working with vulnerable people in mental health services, or working in public services.

> *I get that the pain that I went through is part of what I have to experience in order to know what it's like to feel like this, because I really, sincerely, I don't know what it's going to be, but I'm determined to do something that means that people like me never have to go through what I went through, sincerely.*
>
> Truth Project participant sexually abused in a healthcare context

8.2 Other impacts

Some participants in the qualitative sample described additional impacts of the child sexual abuse and its outcomes. Unsurprisingly, several participants stated that they dreaded becoming ill and avoided healthcare institutions and professionals because of their experiences. Two participants mentioned changing GPs following the sexual abuse.

> *… there were times when I was on a section and there were times when I was having to take medication I didn't want to take. There were times when I was given too much medication and collapsed and was … not really dealt with appropriately. And I don't know if it was because of those early abusive experiences that it was probably more or less impossible for me to actually trust staff at the hospital.*
>
> Truth Project participant sexually abused in a healthcare context

Of the 109 people who reported child sexual abuse in a healthcare context, 28 percent reported a lack of trust in authority. In a couple of cases, participants from the qualitative sample described a general distrust of healthcare institutions and adults. This was the culmination of three factors: (i) breaches of trust by those in positions of authority, (ii) failures in institutional and familial safeguarding and (iii) dismissal and disbelief of participants' reports of sexual abuse.

> *I had a – an occasionally – a quite violent father. And so I think that I really had decided that adults were all completely useless and I had to raise myself. And that meant that when it came to accepting help from anybody else, I was deeply suspicious.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants developed particular aversions to physical or verbal stimuli associated with their experiences of sexual abuse. For example, one man became averse to being touched by other men. Another participant described feeling emotional which was triggered by seeing sofas in consultation rooms.

> *I nearly got run over when I left because I was in such a state about the fact that I was in a room with a man with a couch of some kind.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants described being affected by stories of other victims and survivors of sexual abuse.

> *I don't have that filter between, kind of, something on the TV and me. So, when – if I'm watching the TV and suddenly there's a situation on the TV where someone's going to get caught, I'm going to get caught and I have to leave the room. I can't stay in the room with it.*
>
> Truth Project participant sexually abused in a healthcare context

8.2.1 Re-victimisation

In addition to some participants having reported experiencing sexual abuse prior to their involvement in healthcare contexts, a number described being subject to further victimisation following their experiences of child sexual abuse in this context. Some participants were re-victimised as children, and others as adults, and some were subjected to multiple episodes of re-victimisation.

The nature of the re-victimisation reported varied between participants. Some experienced verbal abuse such as bullying; others experienced physical and domestic abuse, and some were subjected to further sexual abuse. Some were abused by known family members and others by strangers.

One participant said she was re-victimised in a second healthcare context. The participant described that she had run away from the hospital where she was sexually abused and reported being assaulted by a stranger during this time. Shortly afterwards, she was admitted to a second hospital following attempted suicide. In the second hospital a nurse said he knew the participant, as he knew the nurse who had sexually abused her in the first hospital.

> *And so I had initially spoken to – gone to speak to this nurse who was again the nurse in charge to ask if I could have permission to go out to – and, you know, he said that he could give me permission to go out that – but if I wanted to go out, I would need to allow him to touch me. And again, he touched my breasts and I, sort of, said, "Well, I don't need to go out, I don't have to go out".*
>
> Truth Project participant sexually abused in a healthcare context

Another participant reported being sexually abused as a young teenager by seven men at a house party.

Participants also described being subjected to other types of abuse as adults. Two participants described being bullied by others. One participant reported being abused as an adult at his place of work. This abuse was reported to the police but the case did not proceed to court due to insufficient evidence.

Three participants described being in relationships with controlling and abusive partners. One participant said she felt ***"lucky to be alive"*** following a long-term relationship. Another said:

> *I met my abusive ex, and I got into a really abusive relationship for four years, where I really seriously almost died a few times, and I only just realise that now.*
>
> Truth Project participant sexually abused in a healthcare context

Another participant recalled being hospitalised as a result of domestic abuse and explained that her ex-husband had also accused her of abusing their child.

In summary, participants described a range of complex mental and physical impacts of the child sexual abuse. Many participants developed difficulties in forging trusting relationships with others from a young age. Another impact for some participants was a distrust of adults or authority, and in some cases participants stated that they dreaded becoming ill and avoided healthcare institutions and professionals because of their experiences. Two participants mentioned changing GPs following the sexual abuse. For some participants, the impact of the child sexual abuse worsened their existing relationships with family and friends. Several participants were subject to further victimisation by strangers or family members following their experiences of child sexual abuse. Despite these negative experiences, many participants in the qualitative sample described having successful careers, choosing careers in public services to help others. In some cases, these careers served as facilitators to their disclosure of the child sexual abuse, as noted in chapter 7.

Chapter 9

Experiences of recovery and support

This chapter highlights the coping strategies participants adopted to manage their experiences of child sexual abuse and its impacts, and the factors that have helped or hindered their recovery. It also describes their experiences of informal[33] and formal support.[34] This chapter addresses the research sub-question:

- **What has helped or hindered victims and survivors' recovery from child sexual abuse that occurred in the context of healthcare?**

9.1 Experiences of recovery

9.1.1 Coping strategies and aids to recovery

Participants' accounts highlighted a number of strategies that helped them to cope with the experience and impacts of child sexual abuse. These ranged from emotional avoidance by trying not to think about the abuse, or using alcohol to numb feelings, to talking about it and seeking support from others. Some participants felt a strong sense of resilience and did not want to be defined as victims of the sexual abuse for the rest of their lives.

> *But we survive. Yeah, yeah. I don't want to be – you know, I didn't want to be a victim of it. I wanted to – you know, okay that happened. I'll just move on. But look at it and then look at the good that's come out of it, you know, that I'm – I'm extra kind to people. I'm extra ... you know, I'm not – well, I'm just – I'm just a nice bloke, you know.*
>
> Truth Project participant sexually abused in a healthcare context

A number of participants described avoidance and dissociation strategies to bury the pain of the sexual abuse, limiting their ability to remember and disconnecting from their abusive memories. Some participants minimised their experiences of sexual abuse relative to other types of sexual abuse:

> *And I think now like, God, if I was that age in these days, I don't know actually what would have happened to me, because it wasn't as sexually aggressive, do you know what I mean, as it is these days.*
>
> Truth Project participant sexually abused in a healthcare context

[33] 'Informal support' here refers to participant experiences of support or lack of support from family, friends, partners and/or colleagues. In the context of healthcare, this could also include support from patients or visitors.

[34] 'Formal support' here refers to services, organisations or interventions that provide support, advice or treatment to victims, survivors and their families to reduce the impact of having experienced child sexual abuse. These services encompass a range of different types, sectors and providers and can be statutory, voluntary or private. Services may also be specialist or generalist in relation to child sexual abuse. Services are provided across different sectors such as criminal justice interventions, health service treatments, specialist counselling and mental health support.

One participant reported that she was conflicted about the medication she had been prescribed due to its side effects and because later in life she realised that she did not need the medication as she had been led to believe by healthcare professionals. However, she described how it helped to numb emotional pain:

> *At times I was on very high doses of the medication. It really affected how I could function. It has quite horrendous side effects but it affected, you know, how I could function as a person. It affected – one of the things it did do though is it closed down your emotions. So in some ways it was a way that helped me survive because, you know, as well as taking away the good bits it takes away the bad bits.*
>
> Truth Project participant sexually abused in a healthcare context

Such coping mechanisms were not successful aids to recovery in the long term and participants described becoming worried about the impacts of drug and alcohol misuse on their jobs, families and health.

> *And I realised I was about to blow it all up because I was becoming increasingly difficult to live with. My health was suffering. The codeine and the alcohol together were causing all kinds of heart problems and then – and I thought, "I'm going to die, if I keep doing this".*
>
> Truth Project participant sexually abused in a healthcare context

For several participants, making positive lifestyle changes, such as sobriety or engaging in reflective activities like meditation, was an important step in their recovery journey. Three participants felt it was important to find a new doctor to rebuild their trust of healthcare contexts. Others spoke about maintaining a focus on their careers to mitigate feelings of shame and low self-worth with ambition and accomplishments. As discussed in section 8.1.4, participants spoke proudly of choosing careers where they were able to help others.

Several participants described travelling, hobbies and creative outlets, such as writing and painting, as important aids to recovery.

> *I find the horses are a big stress buster, because when I come home and I've sorted everything out, even mucking out stables is nice, you know?*
>
> Truth Project participant sexually abused in a healthcare context

One participant mentioned writing and journalling as an important aid to recovery because it helped them piece together fragmented memories of their experiences.

Researching healthcare institutions, perpetrators and medical records was particularly important for participants who felt their reports had in the past been dismissed or disbelieved. Documenting experiences of sexual abuse empowered victims and survivors to regain control over their experiences and mitigated feelings of self-blame or dissociation/denial that the abuse took place.

> *Yeah, I've been writing – I've been writing a lot just to try and make sense of stuff, you know to try and get some emotions because I'm very good at just, sort of, going, "Did that happen? Did that happen? Did that happen?" So it's kind of like writing a life story and for the next few years I can just see, you know, that fingerprint of what he did just echoing all the way through, you know, and ... yeah.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants reported that they were able to cope better when they sought professional help to address their feelings and the impacts of the abuse, such as their addictions. Others found people whom they could talk to about the sexual abuse, and supportive relationships which helped them cope (see section 9.2 on participants' experiences of formal and informal support).

In some cases, participants reported that they were motivated to investigate the perpetrators and the context of the sexual abuse as adults, to better understand and validate their experiences, and as a means of finding closure. Two participants described contacting the British Medical Association, General Medical Council or local GP surgeries to obtain information relating to their medical records, the health institutions within which they had experienced the sexual abuse, or information relating directly to the perpetrator. Participants also attended libraries and visited online archives to piece together information relating to the context and nature of the abuse. Two participants consulted different GPs as adults, to ask about the medical/clinical examinations that perpetrators had used to disguise the sexual abuse.

9.1.2 Hindrances to recovery

Participants described numerous experiences that hindered their recovery. These included being subject to further victimisation (discussed in section 8.2), troubled or failed relationships (discussed in section 8.1.3) and challenges relating to mental and physical health and wellbeing (discussed in section 8.1.2). Coping mechanisms such as drug and alcohol misuse, and avoidance and dissociative behaviours, led to delays in some participants seeking help.

> *Part of me that didn't want to believe it happened, said, "No, you have – you're making it up. You're just not very well. You're doing – you have a stressful job. You're just not a very well person".*
>
> Truth Project participant sexually abused in a healthcare context

Some participants said that the stigma associated with mental health meant that they were not believed or supported by adults or healthcare professionals. The stigma also played a role in participants' beliefs that they themselves were to blame for their experiences of child sexual abuse.

> *And it made it a million times worse because for the rest of my life, I have had that stigma, I used to hate it ... "[Participant's name]'s mental state". There was nothing wrong with me.*
>
> Truth Project participant sexually abused in a healthcare context

Lack of family support and difficulties in participants' home lives as children were also hindrances to recovery, as it made it more difficult for participants to establish 'normal' relationships and to identify trusted individuals to disclose the sexual abuse to. Two participants highlighted that the lack of a maternal role model in their childhoods affected their sense of identity as adults.

> *With no maternal guidance, I didn't know actually how to be a woman, so I was just guessing half the time at, like, what I needed to – what I should do, or what character I could become, because I knew I could be anything, you know.*
>
> Truth Project participant sexually abused in a healthcare context

9.2 Experiences of support

9.2.1 Support from healthcare organisations and wider professional networks

A range of experiences of support were shared by participants, both formal and informal. Some participants drew on different types of support at different points of their lives. Many explained that reaching a 'breaking point' or having a breakdown led them to confront their thoughts and feelings with the help of others. Some participants have drawn on multiple forms of formal and informal support at different points of their lives.

> *The longer you leave it, the more you need.*
>
> Truth Project participant sexually abused in a healthcare context

9.2.2 Informal support

Participants reported mixed experiences of informal support, describing mostly negative or a lack of support as children, and positive support from friends, families and peers as adults. Some described having good friendship networks as children that allowed them to have 'normal' childhoods despite their experiences of child sexual abuse. Others reported being lonely and withdrawn. None of the participants in the qualitative sample described being supported by their parents after disclosure. One participant described a close relationship with her sister, who had also been a victim of child sexual abuse.

Several participants highlighted the importance of close friends, family and peers as adults, in supporting their recovery. Two participants reported that colleagues and employers had also been supportive, for example by allowing participants the flexibility to take time off work. One participant commented on the value of the support received from sheltered accommodation staff:

> *Oh, they've been magnificent. I mean they're a lovely group of people. I think, for me, they're the people who have looked after me.*
>
> Truth Project participant sexually abused in a healthcare context

One participant described her positive experiences of visiting a healer:

> *That's what triggered a lot of stuff, actually, coming up and I didn't realise at the time. I felt relatively normal, but that was the start of everything really coming right out.*
>
> Truth Project participant sexually abused in a healthcare context

Three participants highlighted the importance of informal community support and victim survivor groups.

> *And I think over the years, I've often been affected by stories of things around – and also to an extent, I've been involved with survivor groups and being involved in, you know, getting support from – I suppose my support has always been more peer support rather than professional support and that may be obvious why.*
>
> Truth Project participant sexually abused in a healthcare context

9.2.3 Formal support

On the whole, participants in the qualitative sample shared the view that talking about their experiences of child sexual abuse helped in coming to terms with the trauma and dealing with the long-term emotional impacts of the abuse. In many cases, disclosure of the sexual abuse, often after an emotional breakdown, was an important first step to seeking help and of long-term recovery.

Participants in the qualitative sample reported that they sought formal support from private and public healthcare services such as counsellors, psychiatrists, psychologists and therapists. Some participants said they underwent other specific forms of therapy such as hypnotherapy and eye movement desensitisation reprocessing.[35]

Two participants reported positive experiences in accessing counselling through their employers' health referral or medical insurance schemes. One participant described finding it difficult to find the right type of formal support and reported negative experiences. She changed GPs several times, felt that her counsellor was judgemental of her experiences and was disappointed by long NHS waiting lists and inadequate police support. She turned to private healthcare for formal therapy but continued to rely on the NHS for medication. The participant felt that the Truth Project served an important outlet and platform for her disclosure:

> *It's the first time in my life I haven't had to over-explain.*
>
> Truth Project participant sexually abused in a healthcare context

Some participants reported seeking formal support from psychiatrists. For example, one participant recalled admitting herself into a rehabilitation clinic to deal with her drug and alcohol addiction. Another described how seeing a psychiatrist helped her understand how the sexual abuse impacted other parts of her life:

> *I went to see a psychiatrist ... about my relationship problems, because I was thinking, what's wrong with me? But [psychiatrist] did a lot to talk to me about trying to focus on the things that have been successful. "And they're all down to you," he said. "Don't forget, they're not down to so and so and so and so, they're down to you".*
>
> Truth Project participant sexually abused in a healthcare context

[35] Eye movement desensitisation reprocessing or EMDR is a form of psychotherapy that focuses on rapid eye movements to reduce the effect of negative emotions. It is often used to treat post-traumatic stress disorder.

Another participant described the long-term and turbulent process of recovery as feeling like ***"climbing outside [of] a deep hole"*** [Truth Project participant sexually abused in a healthcare context]:

> *Even the plateaus are, "This is still too painful. This is still too hard". It's like being in labour for a year, you know, it's like this, you can take it for a day but not that long. And sometimes I would get to a plateau and [all] I think is – "Can I live like this? Can I stop trying to get better now?"*
>
> Truth Project participant sexually abused in a healthcare context

In general, participants felt that the formal support they had received helped them to recover from the trauma of the sexual abuse:

> *And I want other people to know that actually, you know, it doesn't start healing until you start talking about it and have somebody listen to you about it. That's – that's when it starts. So, that was what I wanted to put out.*
>
> Truth Project participant sexually abused in a healthcare context

> *I've been able to experience life, enjoy my family. Enjoy just not having painful thoughts and emotions all the time. So, before that, it's – I would have described the process as being in this intolerable position where every – your brain is just entirely become this engine of identifying its own pain and that's all it does, 24 hours a day, in the present.*
>
> Truth Project participant sexually abused in a healthcare context

In summary, participants' accounts highlighted a range of strategies that helped them to cope with the experience and impacts of child sexual abuse. These ranged from emotional avoidance by trying not to think about the abuse, or using alcohol to numb feelings, to talking about it and seeking support from others. Some of these strategies were not successful aids to recovery in the long term, as the use of drugs or alcohol to numb emotions in some cases compromised other aspects of participants' lives, such as their careers and relationships with family. Some participants made significant lifestyle changes to aid their recovery.

Many participants reported that they were motivated to find positive coping strategies because they felt a strong sense of resilience and did not want to be defined as victims of the sexual abuse for the rest of their lives. In many cases, disclosure of the sexual abuse, often after an emotional breakdown, was an important first step to seeking help and to long-term recovery. Participants' access to formal support services, such as counselling, and access to informal support from friends, family, peers and colleagues, were reported as important aids to recovery. Talking about their experiences of child sexual abuse helped in coming to terms with the trauma and dealing with the long-term emotional impacts of the abuse. Many participants highlighted that the experience of recovery was a long and tumultuous process.

Chapter 10

Summary of key findings from the research and victims and survivors' suggestions for change

This chapter provides a summary of the key research findings and themes identified in the report relevant to the research questions set out in chapter 1. It details the characteristics identified in these cases of sexual abuse in healthcare contexts. The chapter concludes by detailing the changes participants think are necessary to prevent future abuse in healthcare contexts, and to improve responses to, and support for, victims and survivors of child sexual abuse. In doing so it addresses the research sub-question:

- **What changes do victims and survivors suggest to improve child protection and prevent child sexual abuse in the future?**

10.1 Summary of key findings from the research

This report has detailed experiences of child sexual abuse in healthcare contexts, the institutional failures in relation to this abuse and the impacts on victims and survivors. Overall the research findings, drawn from the descriptive, quantitative analysis of the 109 participants' accounts and nine qualitative participants' accounts selected for the qualitative analysis, indicate there are some particular characteristics of sexual abuse specific to healthcare contexts.

The key research findings are:

- Participants' vulnerabilities were heightened in the context of healthcare due to the unique nature of the position of trust and authority occupied by healthcare practitioners. Participants reported they were often alone for examinations and procedures or isolated from their chaperones.
- Perpetrators were commonly male GPs or healthcare practitioners with routine 'clinical' access to children, meaning that their behaviour was not questioned by other staff, parents or children, even when they recommended procedures that were not appropriate or needed in order to sexually abuse children. Perpetrators abused their positions of trust and authority and many perpetrated child sexual abuse under the guise of medical/clinical procedures and examinations, which in some cases involved the use of medical equipment or medication.
- There was very little evidence of grooming in participants' accounts. This is perhaps not surprising given the routine and easy access that perpetrators had to children that allowed them to examine and touch children without any need of 'special' explanation or persuasion. The accounts did indicate there were, at times, manipulation of children, and the manipulation or collusion of staff.
- Participants' accounts revealed that the healthcare needs of many, but not all, of the participants were related to physical, psychological and sexual abuse by family members, and neglect; some had no family support; some were bullied and/or excluded or had stopped attending school. Children attended health institutions seeking treatment, care and recovery. Instead, they were sexually abused by healthcare professionals in positions of power and in violation of their professional duty to do good for their patients. Participants' accounts showed that the abuse of positions of trust and institutional failures in child safeguarding contributed to their increased health and psychological difficulties.

- As children, only a quarter of participants reported that they were able to disclose the sexual abuse. Accounts of the qualitative sample showed that although many disclosed the sexual abuse to trusted adults such as their parents or a healthcare professional during childhood, very few were believed and some were dismissed by healthcare professionals as sick or 'crazy'. Participants revealed that their vulnerabilities were often heightened due to their illness at the time of the sexual abuse. Communication difficulties, and adults' beliefs that children had mental illnesses, meant they were not listened to, or people did not take appropriate action to safeguard them.
- Participants' accounts revealed that there were no clear processes through which participants and their families could disclose sexual abuse in healthcare contexts. In residential healthcare settings, children had no one to turn to or talk to, to disclose sexual abuse. Participants described a lack of appropriate safeguarding or effective responses to allegations of sexual abuse by healthcare practitioners.
- Similar to findings from participants sexually abused in other institutional contexts, those in healthcare contexts suffered lifelong mental health impacts. Participants were fearful of healthcare professionals, leading to avoidance of contact with them in later life. They reported feeling betrayed by perpetrators who had abused their positions of trust and by perpetrators' colleagues, as they did not intervene to prevent or stop the sexual abuse. This led to subsequent broader distrust of authority, systems and adults.

10.2 Victims and survivors' suggestions for change

The majority of participants in the qualitative sample experienced child sexual abuse in healthcare contexts prior to 1990, with the most recent case in this context beginning in the mid 2000s. There have been significant developments in addressing child protection issues in healthcare since 2000 and some of the suggestions made may already have been implemented. However, we have presented all suggestions made by these participants as they reflect the issues they felt to be of particular importance in protecting children from sexual abuse. Participants had also experienced many difficulties throughout their lives since the time of the sexual abuse and shared their views on how victims and survivors of sexual abuse can be better supported in light of those experiences. In the qualitative sample, many of the participants have been involved in working to support victims and survivors of sexual abuse, or service users, and so they presented a large number of ideas for areas that required change.

Participants' suggestions that are specific to healthcare contexts have been categorised according to the four thematic areas outlined in the Inquiry's Interim Report (Jay et al., 2018); these are: structural; cultural; professional and political; and financial.

Table 10.1 represents the specific suggestions for change made by the participants in the qualitative sample. These suggestions relate not only to healthcare but also to other external organisations involved in protecting children and in responding to disclosures of child sexual abuse.

Table 10.1 Suggestions for change made by Truth Project participants sexually abused in healthcare contexts

Structural: The legislative, governance and organisational frameworks within and between institutions
Participants said: *Create a specialist, independent service to investigate and respond to disclosure of child sexual abuse. A team of frontline staff taking accurate details of allegations.* *Eliminate the need for victims and survivors to retell their experiences to many different people or services; have one point of contact and services working together; ensure representation for the victim or survivor.* *Institutions should be held to account for sexual abuse and work actively to prevent it.*
Cultural: The attitudes, behaviours and values that prevent institutions from responding effectively to child sexual abuse
Participants said: *We should empower children and they should be encouraged to question those in authority including doctors and nurses.* *We should be clear and educate children about what to expect and what is normal/typical in respect of medical/clinical procedures and examinations.* *We should listen to children and believe them including when they are ill or have disabilities and/or mental health difficulties.* *We should avoid attaching labels to and making judgements about children and treating them in accordance with such labels/judgements.* *Adults need better awareness of the signs that children display that might indicate that they have been sexually abused.* *Victims and survivors of child sexual abuse should be more visible in society, particularly to show recovery from sexual abuse.*
Professional and political: The leadership, professional and practice issues for those working or volunteering in relevant institutions
Participants said: *Practitioners and all staff should question the behaviour of others and actively safeguard and respond to abuse. Effective vetting processes and responses to allegations of sexual abuse by healthcare practitioners are needed.* *It is important to acknowledge and record sexual abuse.* *Policies should be focused on protecting children from [exploitation and abuse] by professionals in healthcare contexts.* *Victims and survivors of child sexual abuse should be supported.* *Organisations and practitioners should communicate regularly and effectively with victims and survivors.* *Service users should be involved in recruitment and decision making.* *There should be an effective chaperoning policy in healthcare. Systems should flag/require multiple approvals for 'adult' medication and testing on children.*
Financial: The financial, funding and resource arrangements for relevant institutions and services
Participants said: *More funding is needed for victim and survivor support and therapy.* *It needs to be easier for victims and survivors to access financial support, compensation and funding for healthcare.*

Appendices

Appendix A

Timeline of key healthcare developments in England and Wales

The table below outlines some of the key national legislation, policy, guidance and events that shaped the development of a publicly funded health service in England and Wales during the 1950s to 2020. This table is not intended to provide a comprehensive review of policy and legislative developments, but provides an overview of relevant milestones in which to situate the research findings.

Pre 1950s
The NHS in England and Wales was founded on a common set of values and principles that guided its service delivery. Doctors had authority over patients and patients were regarded as passive recipients in need of 'expert' care, unable to get better by their own decisions.
• In **1948**, the National Health Service (NHS) was established, introducing free access healthcare in England and Wales. • The **Children Act 1948** created mandatory Children's Committees and Children's Officers in local government, and specified duties of local authorities and standards of treatment for children in care.
1950s–1960s
The 1950s saw the development of a therapeutic model of the doctor–patient relationship which emphasised the importance of communication and listening on the part of doctors, placing patients as active participants in their own medical consultations. High profile inquiries into hospital failings highlighted a lack of procedures for dealing with complaints.
• The **United Nations Declaration of the Rights of the Child in 1959** stated that children enjoy special protection and should be protected against all forms of neglect, cruelty and exploitation. • In **1962 the Hospital Plan for England and Wales** proposed the construction of new District General Hospitals which included acute psychiatric inpatient services. • **From the 1960s**, patients' rights movements strengthened, exposing some high-profile failings of the NHS, including for example the use of patients in clinical trials without their consent. This led to the formation of the **Patients Association in 1963**, a charity and advocacy group set up to improve patient experiences of healthcare.

1950s–1960s *(continued)*

- In **1969**:
  - The Secretary of State for Wales took over much of the responsibility for health services in Wales and was supported by the Welsh Office **(established in 1965)**.
  - The **Ely Inquiry** was set up to look into allegations of patient brutality and mistreatment at Ely psychiatric hospital, Cardiff. Similar inquiries into the mistreatment of patients and suppression of complaints were undertaken for **Farleigh Hospital (1971)** and **Whittingham Hospital (1972)**.

1970s–1980s

Developments in psychosocial theories and patient rights prompted a shift in doctor–patient relationships away from the paternalistic 'doctor-centred' approach, characterised by patient compliance, towards a patient-centred approach. Patients with mental health challenges began to be regarded as service users, with a voice in their care and decision making.

- **From the 1970s**, England and Wales had a renewed focus on mental health services, with the aim of increasing the availability of residential accommodation and community care.
- The **1983 Mental Health Act** mandated that it could not be assumed that a patient was unable to make a decision for themselves, just because they had a particular condition or disability.
- The **1985 Hospital Complaints Procedure Act** mandated that hospitals in England and Wales put in place complaints procedures.
- In **1988**, **the inquiry into child abuse in Cleveland** published its report about paediatricians at Middlesbrough Hospital who had made 121 diagnoses of child sexual abuse in 1987.
- The **Children Act 1989** set out that every child had the right to protection from abuse and exploitation.

1990s–2000s

The modern approach to patient care viewed the patient as providing information that facilitated diagnosis and treatment, and placed them as mutual participants in clinical decision-making. The turn of the millennium marked a renewed focus on empowering patients with choice, information and the power of personal preference; improving links between health and social care; and improving rights and protections for vulnerable groups.

- The **National Health Service and Community Care Act 1990** established an **'internal market'** in England and Wales, separating the role between purchasers and providers, creating NHS trusts and changing the ways in which health services were commissioned.
- The **1991 Patients Charter** outlined patient rights with regards to receipt and quality of service and highlighted the importance of listening and acting on people's views and needs. The **1998 'Putting Patients First'** report led to a similar patient focus in Wales.
- The **1997 People Like Us** report made recommendations about children living in children's homes, foster care, boarding schools, and penal and health settings. In 2004, a review of actions since the report noted weaknesses in some healthcare settings, including for example worries about unsupervised access to children and concerns about children with psychiatric conditions spending long periods of time in hospitals.

1990s–2000s *(continued)*

- In **1999**:
  - The **1999 Protection of Children Act** aimed to stop persons deemed unsuitable from gaining employment in jobs with access to children.
  - Responsibility for **NHS Wales was devolved** to the National Assembly. Changes to health structures in Wales were informed by the **2001 'Improving Health in Wales' plan.** In England, health and social care were the responsibility of the central government.
- In **2001** the **National Patient Safety Agency** was set up.
- In **2002** the **Carlile Review** of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales made a number of recommendations to improve child protection measures. **The Care and Social Services Inspectorate Wales (CSSIW)** was established.
- The **Sexual Offences Act 2003** made it an offence for a person (over 18) with a position of trust to engage a person (under 18) in sexual activity. Notably, a violation of trust was recognised even if the individual was above the age of sexual consent (16 years old). New offences of causing, arranging, facilitating child prostitution, and grooming and paying for the sexual services of a child were also introduced.
- In **2004**:
  - Section 11 of **The Children Act 2004** placed a duty on NHS organisations to safeguard and promote the welfare of children.
  - Independent inquiries into the cases of **Clifford Ayling and Richard Neale and the NHS' mis-handlings of complaints** were published. **The Ayling Inquiry** made it mandatory for every NHS trust to have a formalised chaperone policy.
  - The **Healthcare Inspectorate Wales** was set up to promote quality and safety in health services.
- The **Mental Capacity Act 2005** was introduced to protect people who may lack the mental capacity to make their own decisions about their care and treatment.
- The **Safeguarding Vulnerable Groups Act 2006** established an Independent Safeguarding Authority to make barring decisions to prevent unsuitable adults working with children.
- The **2008 Health and Social Care Act** introduced the **Care Quality Commission*** which took the role of **independent regulator of public and private health and social care in England**, from the Healthcare Commission that was established in 2003.
- In **2009**:
  - The **Health Act 2009** established the 'NHS Constitution', setting out patient rights, NHS commitments and responsibilities, along with accountability and regulation measures.
  - NHS Wales moved away from the 'internal market' competition model, eliminating the split between commissioners and providers of health. The Trust and Local Health Board system was replaced with **single local health organisations responsible for delivering healthcare** services for particular districts.
  - The **General Medical Council** (established under the 1858 Medical Act as a self-regulating body) moved from appointing its own council members (mainly doctors) to independent membership selection processes.

* The Care Quality Commission brings together the work of Commission for Healthcare Improvement (CHI) established by the Health Act 1999, and the National Standards Commission (the independent regulatory body responsible for inspecting and regulating residential and domiciliary care).

2010s onwards

The 2010s were marked by a formal recognition that the barriers between physical and mental health needed to be broken down and investment in mental health and wellbeing services were needed to meet growing demand. The commitment to achieving 'parity of esteem' between physical and mental health service provision was reflected within the five-year national strategy and implementation plan for mental health for the NHS in England (NHS England, 2016). Patient choice, patient-centred care and ensuring patient safety continued to be a key driver of progress for the NHS in both England and Wales.

- In **2010,** the UK Government set out the Big Society agenda, which included ambitions to create a world-class, more responsive and patient-centred health service. The **Health and Social Care Act 2012** put NHS clinicians at the centre of commissioning by replacing strategic health authorities and primary care trusts with community care groups in England.
- Between **2011 and 2016,** more than 100 people came forward with allegations of physical and sexual abuse at **Aston Hall** in Derbyshire that took place during the 1960s and 1970s.
- Progress has also been made in providing specialised care for individuals with learning disabilities, including for example **mandatory 'Oliver McGowan'† training** for all health and social care staff who support patients with learning disabilities and autism.
- In Wales, the **Rights of Children and Young Persons (Wales) Measure 2011** enshrined children's rights in Welsh law.
- In **2013, Clinical Commissioning Groups (CCGs)** were set up to plan and commission local healthcare services, replacing primary care trusts and accountable to NHS England. NHS Wales delivered services through seven Health Boards and three NHS trusts, one of which was Public Health Wales.
- In **2013** Sir Robert Francis QC chaired a public inquiry into healthcare conditions in the main hospital in **Stafford** looking into patient deaths between 2005 and 2008.
- In **2013, an all-Wales whistleblowing policy** (or 'raising concerns' policy) was introduced in a package of measures aimed at preventing a Welsh equivalent to the Stafford hospital scandal. It highlighted that the safety and wellbeing of patients and service users was the responsibility of everyone involved in the provision of health and social care services.
- **The 2015 'Freedom to Speak Up' review** was commissioned to provide independent advice and recommendations on creating a more open and honest reporting culture in the NHS. All NHS organisations in England were expected to adopt the policy as a minimum standard to help normalise the reporting of malpractice and misconduct concerns.
- In **2014** Myles Bradbury was sentenced to 22 years for abusing children in his care between 2009 and 2013 at Addenbrooke's Hospital in Cambridge.
- The **2014 NHS Five Year Forward View** plan introduced primary care co-commissioning for Clinical Commissioning Groups (CCGs) to take on greater responsibility for general practice commissioning. The plan set out new care models, such as the multispecialty community providers and primary and acute care systems – both of which are examples of **Integrated Care Partnerships.**
- In **2014,** the Welsh Government introduced the **Social Services and Well-being (Wales) Act,** striving to put an individual and their needs at the centre of their care. **The Well-being of Future Generations Act 2015** established seven wellbeing goals for Welsh public bodies to achieve.
- The **2015 Lampard report** set out lessons learnt from NHS investigations into matters relating to the Jimmy Savile sexual abuse scandal.‡

† Oliver McGowan died in Southmead Hospital in 2016 when he was given olanzapine, an antipsychotic drug, to sedate him. NHS England is undertaking an independent learning disability mortality review to investigate the circumstances of Oliver's death.

‡ An Independent Inquiry (Department of Health, 2015a) found that Jimmy Savile's victims ranged from 5 years to 75 in age and included men, women, boys and girls at Broadmoor Mental Hospital and Leeds General Infirmary.

2010s onwards *(continued)*

- In **2015, the Montgomery judgement** required that healthcare professionals share all risks, as well as those of any reasonable alternative or variant treatments, and any risks to which a reasonable person in the patient's position would attach significance.¶
- In **2016,** NHS organisations and local councils formed **sustainability and transformation partnerships** providing joined-up care for patients. These partnerships evolved into 18 **integrated care systems** that support healthcare for local population needs across England.
- **Working Together to Safeguard Children** (published in 1990) emphasised a 'child-centred' approach to safeguarding and recognised the roles professionals play in protecting children in England. **Related guidance was published in 2018 following the Children and Social Act 2017** setting out the roles, responsibilities and accountabilities of healthcare staff in relation to child safeguarding.** The guidance gave CCGs legal responsibility (alongside social care and local police) for local child safeguarding systems.
- The **2019 Welsh Government's plan for the future of health and social care** in Wales and the **NHS England Long Term Plan** prioritised a seamless and 'whole system' approach and highlighted the growing importance of integrated care*** and population health.
- **The NHS 2020 improvement objectives** included implementing patient safety initiatives, making safer staffing decisions and closer alignment to the Care Quality Commission's quality assessment approaches.

¶ Montgomery v Lanarkshire Health Board [2015] SC 11 [2015] 1 AC 1430.

** For example: NHS, 2019a; General Medical Council, 2018; Royal College of General Practitioners et al., 2015; Royal College of General Practitioners and NSPCC, 2014; and Royal College of Paediatrics and Child Health, 2014.

***Integrated care systems are a key part of the NHS Long Term Plan, involving integrated care partnerships whereby providers and commissioners of NHS services work with local authorities and other local partners to deliver joined-up care plans for local population healthcare needs (NHS, 2020). The NHS Long Term Plan's ambition is that all parts of England will be served by an integrated care system by 2021 (NHS, 2019b).

Sources: Health Education England (2020); The King's Fund (2020); NHS Wales (2020a); NHS Wales (2020b); Public Health Wales (2020); BBC News (2019); NHS (2019a); NHS England (2019); Welsh Government (2019); HM Government (2018); The King's Fund (2018); Chan et al. (2017); NHS England (2016); NHS Improvement (2016); Francis (2015); Lampard and Marsden (2015); Well-being of Future Generations (Wales) Act 2015; BBC News (2014); NHS (2014); Social Services and Well-being (Wales) Act 2014; Francis (2013); Mold (2012); Health and Social Care Act (2012); Rights of Children and Young Persons (Wales) Measure 2011; Cabinet Office (2010); Gordon et al. (2010); Grosios et al. (2010); Kon (2010); Department of Health (2009); NHS England (2009); Health and Social Care Act (2008); Kaba and Sooriakumaran (2007); Leatherman and Sutherland (2007); Department of Health (2006); Safeguarding Vulnerable Groups Act (2006); Stuart and Baines, (2004); Department of Health, (2003); Sexual Offences Act (2003); HellÍn, (2002); National Assembly for Wales (2002); Goold and Lipkin (1999); Elwyn et al. (1999); NHS Wales (1998); Webster (1998); Department of Health (1991); National Health Service and Community Care Act (1990); Children Act (1989); Department of Health and Social Security (1969); Balint (1955); Children Act (1948); National Institute for Health and Care Excellence (n.d).

Appendix B
Glossary

Abuse involving penetration	This relates to vaginal, anal or digital penetration and oral sex.
Abuse not involving penetration	This relates to prolonged kissing, cuddling, french kissing and excessive touching.
Breaches of sexual boundaries	These occur when healthcare professionals exhibit sexualised behaviours towards patients, compromising the integrity of clinical or therapeutic relationships between practitioners and patients.
Child sexual abuse	Sexual abuse of children involves forcing or enticing a child or young person to take part in sexual activities. The activities may involve physical contact and non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse including via the internet. Child sexual abuse includes child sexual exploitation. For the purposes of this Inquiry 'child' means anyone under the age of 18.
Episodes of child sexual abuse/exploitation	An 'episode' relates to sexual abuse involving a particular perpetrator(s) or institution(s). It may involve a single instance of sexual abuse or relate to more than one instance which takes place over a period of time. We have defined an 'episode' of abuse as the following: • an instance or multiple instances of sexual abuse committed by a single perpetrator • a single instance of sexual abuse committed by multiple perpetrators • multiple instances of sexual abuse committed by multiple perpetrators, but only where there is collusion between the perpetrators An episode involving multiple perpetrators could include cases where there is collusion between perpetrators, such as gang rape, child sexual exploitation or abuse by networks organised for the purposes of child sexual abuse. An episode could also involve more than one institution, such as abuse perpetrated by one person but in several contexts.
Fondling	This relates to touching, masturbating or kissing a child's genitals and/or making a child fondle an adult's genitals.
Grooming for child sexual abuse	Building a relationship with a child in order to gain their trust for the purposes of sexual abuse or exploitation.

Harmful sexual behaviour	Harmful sexual behaviour (HSB) is developmentally inappropriate sexual behaviour which is displayed by children and young people and which may be harmful or abusive. It may also be referred to as sexually harmful behaviour or sexualised behaviour.
Healthcare contexts	Abuse perpetrated in healthcare organisations and settings or by healthcare professionals and staff.
Impact	A marked effect or influence on someone or something. Information on impacts presented in this report align with categorisations used in the Truth Project. It is used in this report to describe what victims and survivors themselves reported about the effects of the abuse they experienced.
Local authority	An administrative body in local government that is responsible for all the public services and facilities in a particular area.
Qualitative research	Qualitative research uses words and themes, rather than numbers, to answer research questions. Qualitative social research seeks to observe and understand social situations without measuring them using numbers, for example through interviews with people involved.
Rapid Evidence Assessment (REA)	A research methodology used in the identification, quality assessment and synthesis of existing literature on a particular topic. More structured and rigorous than a standard literature review, it is not as exhaustive as a systematic review.
Recovery	The act or process of returning to a positive, former or improved level of functioning following a traumatic experience that caused a decline in levels of functioning and wellbeing.
Residential care	This relates to institutions such as orphanages, children's homes/residential care, secure children's homes, specialised residential care units.
Re-victimisation	Becoming a victim of violence, crime and abuse, having already been victimised previously.
Sadomasochism	Sexual behaviour that involves inflicting physical pain or humiliation on oneself or others.
Safeguarding	Protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and taking actions to enable all children to have the best life chances.
Statutory agencies	Institutions set up by law to carry out public activities.
Victims and survivors	Defined in this report as individuals who have been sexually abused as children.

Sources: Department for Education (2014); Independent Inquiry into Child Sexual Abuse (n.d.); Ofsted (2018, 2019); King and Brähler (2019); Soares et al. (2019).

Appendix C
Ethics

All social research conducted or commissioned by the Inquiry is subject to approval from the Inquiry's Research Ethics Committee. It ensures that all Inquiry research complies with the Inquiry's Research Code of Ethics.[36] The Committee is formed of external academics and experts in addition to relevant internal staff, including a member of the Inquiry's Victims and Survivors Consultative Panel and a member of the Inquiry's Support and Safeguarding Team.

The Truth Project deals with highly sensitive and personal material and the Inquiry's Research Ethics Committee ensures that any Truth Project data used for the purposes of research adhere to strict ethical standards. The Inquiry's Research Ethics Committee has approved the use of Truth Project data for research purposes and it is subject to ongoing ethical scrutiny.

All facilitators and assistant facilitators working with victims and survivors in the Truth Project are provided training by the Research Team before commencing the role. This training covers the important ethical considerations relevant to conducting Truth Project private sessions, including the importance of informed consent.

Consent

Participants receive information about taking part in the Truth Project prior to their participation. This is in the form of a booklet and details are also available on the Truth Project website. The booklet contains a 'consent for research' statement, which informs participants that their information may be used to conduct research throughout the life of the Inquiry, unless they would prefer their information not to be used in this way. For participants who are unable to read, for example, consent is sought verbally.

At the start of a private session, all participants are reminded how their information may be used for research by the assistant facilitator, who reads out a number of statements that include how the Inquiry manages their data. Participants can choose to opt out of research at this point. They also receive information that they can change their mind and withdraw consent both during or after their session has taken place or they have submitted their written experience. Participants can ask to have their information removed from the analysis and reports up until the point that reports are finalised for publication. The supporting material provided to Truth Project participants also includes information about who they can contact if they decide that they do not want their information to be used in research.[37]

[36] www.iicsa.org.uk/key-documents/1382/view/iicsa-ethical-approval-guidance.pdf
[37] Further information about how Truth Project data is collected, managed and used in our research can be found in *Truth Project Research: Methods*.

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