Children in the care of Lambeth Council

Investigation Report

July 2021

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HC 704

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July 2021

A report of the Inquiry Panel
Professor Alexis Jay OBE
Professor Sir Malcolm Evans KCMG OBE
Ivor Frank
Drusilla Sharpling CBE

Presented to Parliament pursuant to section 26 of the Inquiries Act 2005

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Executive Summary

This investigation examined the scale and nature of the sexual abuse experienced by children in the care of Lambeth Council over several decades since the 1960s, and the extent of any institutional failures to protect children in care from sexual abuse and exploitation. It looked in detail at five of Lambeth Council's residential children's units – Angell Road, South Vale Assessment Centre, the Shirley Oaks complex, Ivy House and Monkton Street. The latter two cared for children with complex needs and communication difficulties. The Inquiry also examined the Council's foster care service.

It is hard to comprehend the cruelty and sexual abuse inflicted on children in the care of Lambeth Council over many years, by staff, by foster carers and their families, and by volunteers in residential settings. With one or two exceptions, a succession of elected members and senior professionals ought to have been held accountable for allowing this to happen, either by their active commission or complicit omission. Lambeth Council was only able to identify one senior Council employee, over the course of 40 years, who was disciplined for their part in this catalogue of sexual abuse.

By June 2020, Lambeth Council was aware of 705 former residents of three children's homes in this investigation (Shirley Oaks, South Vale and Angell Road) who have made complaints of sexual abuse. The biggest of these homes – Shirley Oaks – was the subject of allegations against 177 members of staff or individuals connected with the home, involving at least 529 former residents. It was closed in 1983. The true scale of the sexual abuse against children in Lambeth Council's care will never be known, but it is certain to be significantly higher than is formally recorded.

Frontline staff employed to care for these most vulnerable children frequently failed to take action when they knew about sexual abuse. In so many cases they showed little warmth or compassion towards the child victims, who were left to cope with the trauma of their abuse on their own. More widely, it was as if staff intended to create a harsh and punitive environment for children who had the misfortune to be in public care, through no fault of their own.

There were many black children in Lambeth Council's care. In Shirley Oaks in 1980, 57 percent of children in its care were black. During 1990 and 1991, 85 percent of children who lived at South Vale were black. Racism was evident in their hostile and abusive treatment by some staff.

Far from being a sanctuary from abuse and neglect, Shirley Oaks and South Vale were brutal places where violence and sexual assault were allowed to flourish. Angell Road systematically exposed children (including those under the age of five years) to sexual abuse. For many children, these homes did nothing to change their lives for the better. For many children, the experience they had was worse than living at home with their birth families.

Nor did foster care routinely provide a safe alternative for children in care. For many years, foster carers were not adequately vetted by the Council and were not the subject of criminal record checks. The Social Services Inspectorate (SSI) reported in 2000 that potentially large numbers of children in Lambeth Council's care had not been allocated a social worker,

were not placed with approved foster carers and had none of the protection afforded by regular visiting, monitoring or statutory reviews. Sexual abuse by carers and family members therefore occurred with no trusted adult available for a child to talk to. Dame Heather Rabbatts (chief executive from 1995 to 2000) initiated a review of all foster care placements to address the issue of criminal record checks. As a consequence, the number of foster care placements reduced from 240 to 160.

Some accounts described by victims in residential settings and foster care are given below.

LA-A307 was taken to Shirley Oaks at the age of nine. He described hearing other children screaming at night and he himself routinely experienced violence and sexual assault, including being photographed whilst being raped.

LA-A147 was in the care of Lambeth Council in the 1990s and 2000s, from the age of three. Over ten years, she was placed in nine children's homes and with four sets of foster carers. She described being raped by a foster carer's teenage son at the age of nine, and was also frequently sexually abused by older men she met whilst in care. By the age of 13, she had developed a drug addiction and was "*selling herself*" to fund it.[1]

LA-A2 was found dead in a bathroom at Shirley Oaks in 1977. Lambeth Council did not inform the coroner that he had alleged being sexually abused by Donald Hosegood, his 'house father'. In the course of Hosegood's employment at Shirley Oaks, six out of eight children looked after by him and his wife alleged sexual abuse by him.

LA-A7 described sexual abuse by three male members of staff, including two from South Vale. Two of them separately photographed him at their private homes when he was either naked or wearing only his underwear. One of them, Leslie Paul, was convicted of indecent assaults against LA-A7.

Lambeth Council's actions and decisions made it easy for the sexual abuse of children to occur, in four principal ways. It knowingly retained in its employment adults who posed a risk to children; it failed to investigate its employees when they were suspected of child sexual abuse; it exposed children to situations where they were at risk of sexual abuse despite, in several cases, having full knowledge of these risks; and it allowed adults suspected of sexual abuse to leave their employment and sexually offend elsewhere, without alerting any known employers. In respect of volunteers, it appears that Shirley Oaks opened its doors to anyone from the community who expressed an interest in befriending children – for example playing sports with them or taking them out – without any checks on their suitability. In other words, a potential licence for child sexual abuse.

Lambeth Council now accepts that children in its care were sexually abused and that it failed them. Their representative at the Inquiry gave a full apology on behalf of the Council, acknowledging that Lambeth Council "*created and oversaw conditions … where appalling and absolutely shocking and horrendous abuse was perpetrated*".[2]

Convicted perpetrators

Despite the scale of reported abuse and suspected abuse, only six perpetrators were convicted of child sexual abuse.

[1] LA-A147 20 July 2020 87/10-13
[2] Annie Hudson 2 July 2020 3/22-5/2

Patrick Grant: Convicted in 2019 of eight counts of indecent assault on a boy under the age of 16, two of which concerned a child in Lambeth Council's care. Sentenced to eight years' imprisonment.

William Hook: In 2001 pleaded guilty to 26 offences, including indecent assault, gross indecency and buggery, in respect of six children in the care of Lambeth Council and one he abused after leaving the Council. Sentenced to 10 years' imprisonment.

Philip Temple: In 2016 pleaded guilty to 29 counts of child sexual abuse related to 13 victims, four of whom had been at Shirley Oaks. Sentenced to 12 years' imprisonment, which was increased to 18 years upon the Attorney-General referring the case to the Court of Appeal.

Geoffrey Clarke: In 1998 was convicted of the sexual abuse of three children not connected to Lambeth, where he had worked in children's homes. Sentenced to three years' imprisonment. Later charged with numerous offences of indecent assault and possession of indecent images, but took his own life on the day the trial was to start.

Leslie Paul: Convicted on three separate occasions – in 1994, 2002 and 2016 – of a range of sexual offences against several children in Lambeth Council's care, including from South Vale. In 1994, he was sentenced to 30 months' imprisonment, in 2002 to 18 months' imprisonment and in 2016 to 13 years' imprisonment.

Michael Carroll: In 1999 was convicted of the sexual abuse of two boys in the care of Lambeth Council, as well as nine boys from a children's home in Liverpool. The indictment before the court in 1999 contained 76 counts relating to child sexual abuse. Carroll pleaded guilty to 34 charges and was sentenced to 10 years' imprisonment.

Culture

In the 1980s, politicised behaviour and turmoil dominated the culture of Lambeth Council. The desire to take on the government and to avoid setting a council tax rate resulted in 33 councillors being removed from their positions in 1986. That event and its consequences meant, amongst other things, the majority of elected members were not focussing their attention on what should have been their primary purpose of delivering quality services to the public, including children's social care. This continued into the 1990s and beyond.

Children in care became pawns in a toxic power game within Lambeth Council and between the Council and central government. Many councillors and staff purported to hold principled beliefs about tackling racism and promoting equality, but in reality they failed to apply these principles to children in their care. Neither councillors nor staff made any effort to check whether their implementation was being carried out in the true spirit of increased equality and diversity. Had they done so, the very real issue of racism in children's social care might have been addressed.

Despite this 'progressive' political agenda, bullying, intimidation, racism, nepotism and sexism thrived within Lambeth Council, all of which were set within a context of corruption and financial mismanagement, which permeated much of Lambeth Council's operations. The Appleby Report in 1995 documented the chaos of Lambeth Council's financial position from 1979, describing the significant number of Lambeth Council staff involved in this corruption and fraud, and the Council's tolerance of it. It stated that from the 1980s to the early 1990s

Lambeth Council's policies and actions had created the perfect conditions for systemic abuse by dishonest employees, dishonest members of the public and dishonest contractors.

This corruption also directly impacted upon the safety of children in care. It was suspected by Lambeth Council that the children's home officer, appointed to investigate an allegation of sexual abuse by the assistant officer in charge of Ivy House, LA-F12, was involved in the same fraud as the officer in charge of Ivy House. This was to the obvious prejudice of the investigation's probity and the well-being of the children concerned.

It is notable that intimidation was experienced even at the most senior level of officer leadership, in the cases of Chief Executives Herman Ouseley and Henry Gilby. Lord Ouseley described how both his office and home were 'bugged' at the instigation of one of his own staff. He also received threats to his family. Mr Gilby's office was the subject of a serious arson attack. His home and office were broken into and computer records were stolen during a time when he was attempting to deal with corrupt practices. Dame Heather Rabbatts was Chief Executive from 1995 to 2000. She described how she inherited a Council with a culture of *"fear and sexism and racism"*. No witness identified which individuals or groups were the driving force behind this vicious and regressive culture, but there was little doubt that a succession of leading elected members were mainly responsible, aided and abetted in some instances by self-serving senior officials.

Trade unions also played a part in this corrosive atmosphere, which worked against the protection of children, prioritising their members' individual interests over children's welfare. In this, they were supported on occasion by councillors, with whom it was frequently stated that a strong political axis existed.

Mr Robert Morton, Principal Manager (Children's Homes) was a lone voice in reporting to the Children's Homes Committee of the Council on four occasions over a two-year period, 1988–1990, on the poor state of the children's homes and his concerns about child protection and children's safety. He repeatedly told the Committee that many young children should never have been placed in homes, that little information existed about them, that there were no care plans and few children had an allocated social worker. He described the situation as "*very dangerous. I cannot impress this point too strongly. Members must be aware of the possible implications of the present situation*", and his final report in 1990 could not have been clearer.[3] The grossly inadequate response of councillors and senior officers amounted to negligence.

The Carroll case

The handling of the case of Michael John Carroll by Lambeth Council was examined in the Inquiry investigation, because it illustrated a determined and inexplicable loyalty to a known sex offender, regardless of the risk to children. It showed individual and systemic mistakes, and extremely poor personal and professional judgement on the part of protagonists.

Carroll was appointed to work in a Lambeth Council care home in 1978, having previously worked in a children's home in Liverpool.

On appointment, Carroll failed to declare a conviction for a sex offence against a child, in effect lying to his employer. He also failed to declare it when he was made officer in charge of Angell Road in 1981. The conviction came to light when he made an application to foster

[3] LAM028717_002

in a neighbouring authority to Lambeth and a police check revealed the offence, which he had again failed to disclose. It was subsequently the subject of a disciplinary hearing.

The hearing, in 1986, was chaired by David Pope, then Assistant Director of Social Services, later becoming Director, who gave Carroll a written warning but took no action to remove him from contact with children. Such a failure to disclose a conviction of this nature, on two occasions, would normally result in summary dismissal, but according to Mr Pope, the hearing felt "*on balance, that he was not a risk to children*".[4]

Later, Carroll and his wife made an application to foster with yet another local authority, and were supported in this by a senior manager of Lambeth Council, to the extent of putting pressure on the other authority to overlook Carroll's criminal conviction. Carroll was also allowed to investigate allegations of sexual abuse against other members of staff in Angell Road. He was finally dismissed by Lambeth Council for fraud in 1991. In 1999, he was convicted of the sexual abuse of two boys in the care of Lambeth Council, as well as nine boys from the Liverpool children's home where he had worked in the 1960s and 1970s. He pleaded guilty to 34 charges and was sentenced to 10 years' imprisonment.

The criminal justice system

The Metropolitan Police Service conducted five investigations of child sexual abuse linked to Lambeth Council from 1992 until the present date. These were Operations Bell, Pragada, Middleton, Trinity/Overview and Winter Key. The latter has been ongoing since 2015; in May 2020, it had around 50 active investigations.

Detectives failed to identify and investigate networks and links between offenders, despite the important and relevant information they held which should have been followed up. For example, when investigating the production of indecent images of children there was no liaison between the officers within Operation Pragada and Operation Bell to seek any material or information about Leslie Paul. During Operation Middleton, there was evidence of links between Hook and Hosegood, who both worked at Shirley Oaks, and these were not properly investigated.

In respect of the evidence of children, the Code for Crown Prosecutors in the late 1980s looked at these matters differently from the present day. In 1986, prosecutors were required to take into account whether there were "*matters which might properly be put to a witness by the defence to attack his credibility*".[5] The 1988 version of the Code noted that the "*credibility and credit of the child will often be of limited value and in the case of very young children may be nil*".[6] In consequence, it is unlikely that the criminal justice system at that time properly served many child victims in the care of Lambeth Council. Today's practice requires prosecutors not to focus solely on the child but rather the evidence of the allegation being made.

Audit, reviews and inspection

It became an almost automatic response for Lambeth Council to commission a review when serious incidents occurred in children's social care. These were usually carried out by an independent person with recognised expertise from outside the Council. In some instances,

[4] David Pope 8 July 2020 33/4-5
[5] CPS002784
[6] CPS002791_001; Gregor McGill 10 July 2020 94/2-4

such reviews or audits were imposed by a government department. There were also regular inspections of social services, and children's social care initially by the SSI, and later by Ofsted. In the period from 1985 to 2003, over 20 external inquiry and inspection reports concerning Lambeth Council's children's homes were produced, as well as Mr Morton's four internal reports to the Children's Homes Committee.

It is questionable whether Ofsted and its predecessors, particularly the SSI, did enough to identify the serious weaknesses in the protection of Lambeth Council's children in care or whether the SSI should have done more via the powers of the responsible government minister. The SSI did not specifically investigate the nature or extent of sexual abuse against children in care, despite being fully aware of there being at least one Schedule 1 offender in Council employment.

The reports commissioned by the Council varied in quality and rigour, but almost all of them described serious failures in services and staff practices which rendered children in care unsafe, often from the people who were paid to look after them. Most also made recommendations for change and improvement. It is therefore remarkable that so very little was achieved in response to these consistent messages, and to those of the inspectorates and regulators; nobody in positions of authority at Lambeth Council over decades could have said at any point that they did not know. The conclusion is unavoidable that those who ran the Council for the most part simply did not care enough to prioritise the protection of children.

Lambeth Council today

By 1994, most of Lambeth Council's 33 children's homes had closed. The percentage of children in Lambeth Council's care placed in residential accommodation in 2020 was 20 percent, including in secure units, children's homes or semi-independent living accommodation, run by organisations other than the Council. These placements are very often geographically distant, and bring serious issues of maintaining family and community links and providing regular professional support. This can also lead to failures in compliance with child protection procedures. The Inquiry heard of a specific example from 2016 of an allegation of rape made by one Lambeth Council child placed in Sheffield, when neither Lambeth Council nor Sheffield Council convened a strategy meeting, as should have happened.

During the Covid-19 pandemic, the visiting of looked after children was largely done virtually, with one-third done in person.

Lambeth Council opened its Children's Homes Redress Scheme in 2018, which is open to those who lived in or visited a Lambeth Council children's home. Whilst the Scheme was not part of the scope of this Investigation, we note that it has been criticised by some core participants, in part because of its exclusions from eligibility for the Scheme.

The Council's apology to the Inquiry was fulsome, but it did not make any meaningful apology until relatively recently, despite the many investigations and inspections over 20 years which made clear the duty of care it owed to so many child victims of sexual abuse, and failed to deliver.

Pen portraits

LA-A2

LA-A2 was taken into the care of Lambeth Council in 1962 and placed at Shirley Oaks children's home. In 1974, LA-A2 had made an allegation of sexual abuse against Donald Hosegood, a house father at Shirley Oaks.[7] LA-A2's sister told the Inquiry that she had also witnessed Hosegood abusing him.[8] In 1975, LA-A2 was one of four children who were complainants at Hosegood's trial, at which he was acquitted on all charges.

In 1977, LA-A2 was found dead in a bathroom in a home on the Shirley Oaks site. Lambeth Council did not inform the coroner that LA-A2 had alleged that he had been sexually abused by Hosegood, who had been his house father, or about his involvement in Hosegood's criminal trial. Lambeth Council suggested that there was no indication of LA-A2 having been unhappy in the period leading up to his death.[9] As Lambeth Council has acknowledged, this was "*extraordinary*" and "*not a true picture of what had happened to*" LA-A2.[10]

LA-A2's sister told us about the lack of support her brother received following the trial. In her view, if her brother had received some support he might still be alive.[11]

LA-A7

LA-A7 was taken into the care of Lambeth Council in the mid-1970s when he was about eight years old. Initially, he was placed with foster carers, which he described as an "*awful experience*".[12] He then spent time at Shirley Oaks, where he remembered "*running away*", before moving to South Vale and other children's homes.[13]

At South Vale, LA-A7 described sexual abuse by three male members of staff. One assaulted LA-A7 in the bath and took him to his flat, where he photographed LA-A7 naked.[14] LA-A7 was also abused by his keyworker Leslie Paul after washing or when being put to bed. On one occasion, Paul took LA-A7 to his flat and had him pose for photographs, before trying to assault him. LA-A7 escaped but the police returned him to South Vale.[15]

> "*I had often tried to report abuse to other staff members and sometimes to the police when I ran off. I would be accused of being a liar. I would tell the police I was scared to go back to South Vale, and I recall the police asking staff why I was so scared. I don't recall anything further happening about this … I tried to explain to them that I was being abused and they told me I was lying.*"[16]

[7] LAM029331_150
[8] Annie Hudson 2 July 2020 78/14-22
[9] Annie Hudson 2 July 2020 79/14-80/11
[10] Annie Hudson 2 July 2020 80/2-11
[11] Annie Hudson 2 July 2020 79/4-13
[12] LA-A7 29 July 2020 137/24
[13] LA-A7 29 July 2020 138/2
[14] LA-A7 29 July 2020 138/12-13
[15] LA-A7 29 July 2020 138/18-139/1
[16] LA-A7 29 July 2020 139/2-11

Paul was convicted for indecent assaults against LA-A7, who described giving evidence at the criminal trial as:

> "*extremely hard … It felt like I was in the witness box and for a lifetime and it was a very traumatic experience. I don't think that trial helped my mental health, forcing me to relive events that I had tried to forget.*"[17]

LA-A7 also explained that, because of the abuse, "*my education suffered and I didn't get any qualifications. This then affected my life afterwards and being able to get employment*".[18]

LA-A323

In the 1970s, when she was less than six years old, LA-A323 was in care in a home on the Shirley Oaks site. She said that the house mother would swear at her and tell her she was "*nothing*".[19] LA-A323 was hospitalised after being thrown into a table by the house father at the home. Two weeks later, it happened again.[20] She was also locked in a cupboard.[21]

While she was at Shirley Oaks, LA-A323 was sexually abused by a male visitor who, though not a relative, was described as an "*uncle*" and visited Shirley Oaks at night. Like other witnesses, she said that she was so young at the time that she had no idea what was happening to her.[22]

After leaving Shirley Oaks when she was six years old, LA-A323 was also sexually abused by a man on her housing estate. She described looking out of a window while she was abused and thinking about different things. The man would give her five pence.[23] She explained that her body did not feel like it was hers for years to come.

LA-A323 received money from Lambeth Council's redress scheme and described using this to help others:

> "*Every smile Lambeth took from me, I have made sure I have given a smile to someone else.*"[24]

LA-A327

LA-A327 came into the care of Lambeth Council in the 1970s when she was around 12 years old, having suffered physical abuse within her family, including being knocked unconscious by her mother.[25]

She spent time in several children's homes. Her first placement was at Cumberlow Lodge, where she described life as "*like hell*". LA-A327 and other children were locked in their bedroom at night, and she worried that if there was ever a fire she would die. She described being constantly subject to restraint and being placed in a room that resembled a cell in

[17] LA-A7 29 July 2020 139/17-21
[18] LA-A7 29 July 2020 140/7-12
[19] LA-A323 1 July 2020 4/7
[20] LA-A323 1 July 2020 6/3-7/1
[21] LA-A323 1 July 2020 9/19-10/8
[22] LA-A323 1 July 2020 11/17-13/1
[23] LA-A323 1 July 2020 15/6-15
[24] LA-A323 1 July 2020 25/4-5
[25] LA-A327 6 July 2020 33/3-34/14

a police station. Eventually LA-A327 said that she was forced, against her will, to take tranquillisers to calm her down.[26]

One member of staff at Cumberlow Lodge made children sit on his lap, especially if they were emotional or upset. LA-A327 said that he held the children around the waist so that they could not get up. He would shake uncontrollably and then when the shaking stopped, he would let the children go. At the time, LA-A327 was 12 years old but, having had no sexual education, she did not know what he was doing. Other children would also talk about it.[27]

LA-A327 then moved to Shirley Oaks, which she described as a very harsh environment, with the house parents staying in their office or speaking amongst themselves rather than interacting with the children. If she was late home, she would not receive any food. She did not go to school. One morning after breakfast, when all the other children had gone to school, LA-A327 heard one child – around three years old – screaming. A cleaner told her that the child was being toilet trained, but LA-A327 heard the child screaming for some time before it turned into sobbing. LA-A327 said she "*just knew that this kid wasn't being potty trained*". She left after that and never went back to Shirley Oaks, returning to Cumberlow Lodge.[28]

LA-A327 also lived in the Calais Street children's home. She described her time there as one of "*real danger*". She was "*raped continuously*" and, as a result, she became pregnant aged 15.[29] LA-A327 and her baby moved into a council flat, but she was left to cope alone:

> *"That was literally it. I walked out of Calais Street and went into a council flat. No help, no furniture, nothing … that was it. I was literally left to deal with it myself. No money, no nothing. Nothing … I left care with no-one. I went into care, I had family. I came out of care, I hadn't seen my family for 14 years."*[30]

LA-A307

At the age of nine, LA-A307 was taken to Shirley Oaks. He described hearing other children screaming at night: "*to hear it, it was just terrible*".[31] He said that physical abuse started "*within two to three weeks*", being "*woken up at night, my bed being stripped and I was being hit and then screamed at to stand on the stairs, with the house mother having a lot of fun doing that*".[32]

He was sexually abused twice while in the Shirley Oaks sick bay. He told two members of staff at the time – the matron and a house mother – but no action was taken.[33]

LA-A307 told us that he was asked to be involved in a play which LA-F64 (who held a senior staff role at Shirley Oaks) was organising, and would go to his house to rehearse. He recalled being photographed while being raped there, and did not ever recall returning to Shirley Oaks.[34]

[26] LA-A327 6 July 2020 35/7-38/15
[27] LA-A327 6 July 2020 39/10-19
[28] LA-A327 6 July 2020 43/8-22
[29] LA-A327 6 July 2020 44/11-20; 46/4-5
[30] LA-A327 6 July 2020 46/12-16; 49/14-16
[31] LA-A307 20 July 2020 57/13-17
[32] LA-A307 20 July 2020 57/20-25
[33] LA-A307 20 July 2020 61/7-63/1
[34] LA-A307 20 July 2020 63/25-67/18

LA-A147

LA-A147 was in care in Lambeth in the 1990s and 2000s. She was first accommodated by Lambeth Council when she was approximately three years old. Over 10 years, she was placed in nine care homes and with four foster carers. When she was nine years old, she told her care worker that she had been raped by a foster carer's teenage son, but she said that no action was taken. She told us that she was also sexually abused on a frequent basis by older men whom she met outside her foster placement or care home.[35] By the age of 13, she had developed a drug addiction and was "*selling herself*" to fund it.[36]

> "*I didn't even really consider these situations to be high risk. I didn't know what high risk was. It was just what I was doing … So instead of me getting the right support, I was just kind of struck off.*"[37]

LA-A147 told us about a time when a drug dealer hit her and raped her at his flat. She called the care home in a distressed state and told staff what had happened to her.[38]

LA-A147 was subjected to repeated sexual abuse and violence throughout her time in the care of Lambeth Council, which was aware of the abuse and of her drug addiction. LA-A147 said that she did speak with the police but told them that she didn't want to proceed with formal charges.

> "*This was quickly accepted without much question because it was easier.*"[39]

When asked if she was supported to make allegations against those who had abused her, she said: "*I can't say I feel like I was supported from what I remember*".[40]

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[35] LA-A147 20 July 2020 83/8-9
[36] LA-A147 20 July 2020 87/10-13
[37] LA-A147 20 July 2020 94/21-23; 95/21-23
[38] LA-A147 20 July 2020 88/3-90/1
[39] LA-A147 20 July 2020 97/6-8
[40] LA-A147 20 July 2020 93/5-6

Part A

Introduction

Introduction

A.1: Background to the investigation

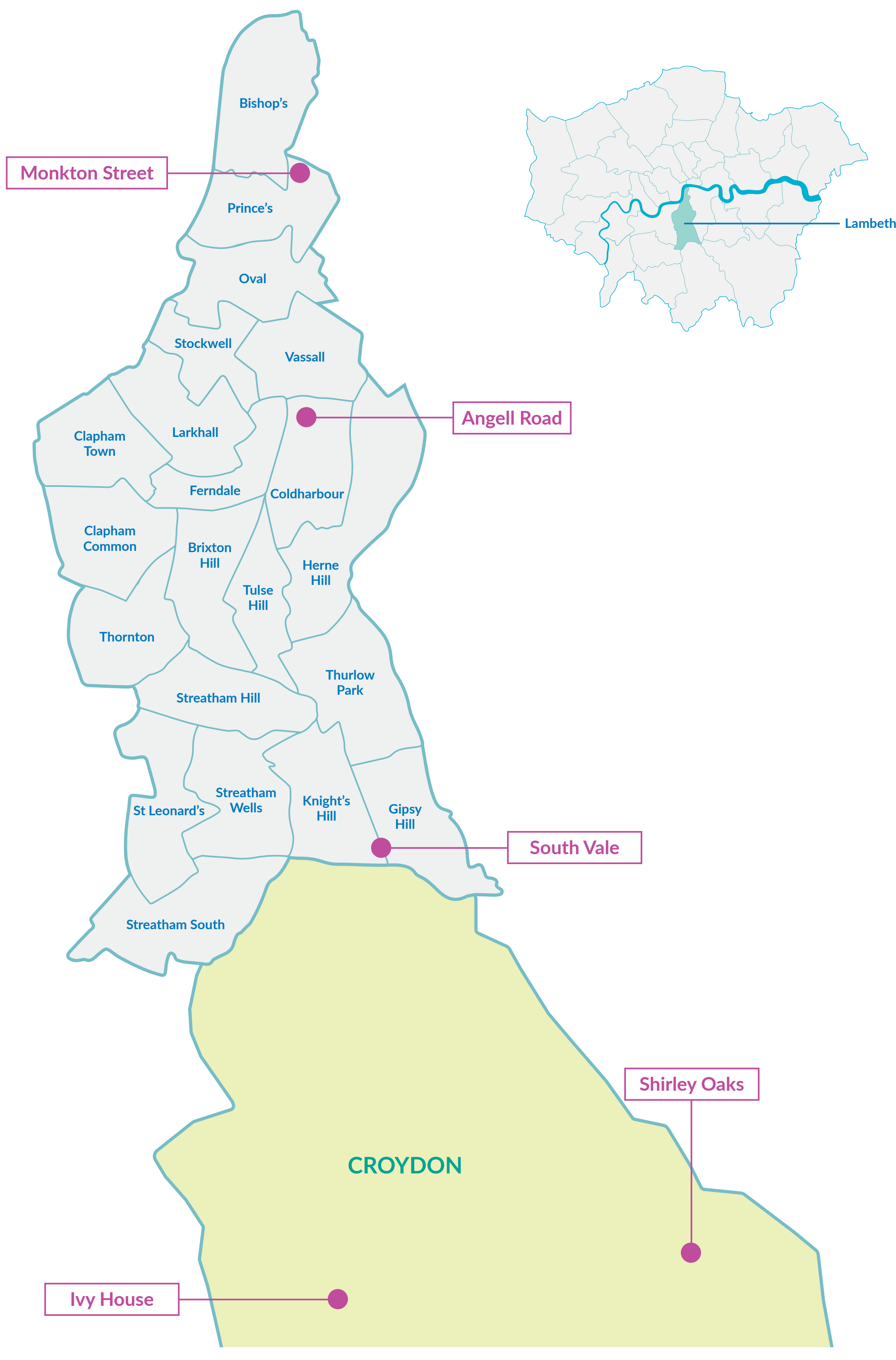
1. This is the third of three investigations by the Independent Inquiry into Child Sexual Abuse (the Inquiry) considering the sexual abuse of children in the care of local authorities.[41] It relates to institutional failures to protect children in the care of the London Borough of Lambeth (Lambeth Council) from sexual abuse.

2. Lambeth Council has been aware of individual allegations of sexual (and physical) abuse since at least the 1970s. It is now recognised – including by Lambeth Council – that physical and sexual abuse was pervasive in its children's homes.[42] This remained unchecked for decades. As at June 2020, Lambeth Council was aware of 720 allegations of sexual abuse arising from just three of its children's homes: Shirley Oaks, South Vale and Angell Road.[43] The Metropolitan Police Service was aware of 283 allegations being made by those who were children in the care of Lambeth Council.[44] It is likely that there are many more children who were sexually abused and where the abuse was either not disclosed or not reported to the authorities.

3. This report examines the scale and nature of abuse that children in the care of Lambeth Council suffered and its failure to protect those children, focussing on the experiences of complainants, victims and survivors. It also considers the role played by internal and external inspection, and responses (including of the Metropolitan Police Service and the Crown Prosecution Service) to allegations of sexual abuse made by those who were children in the care of Lambeth Council.

[41] The first concerned placements by Rochdale Borough Council – see Cambridge House, Knowl View and Rochdale Investigation Report (2018) and the second concerned children in the care of Nottingham City Council and Nottinghamshire County Council – see Children in the care of the Nottinghamshire Councils Investigation Report (2019).
[42] LAM029331_002-003
[43] LAM030213_002; LAM030157_006; LAM030227_048
[44] MPS004500_006

A.2: Lambeth Council



The London Borough of Lambeth and the children's homes considered in this report. (In September 1987, Ivy House was moved from the Shirley Oaks site to Warham Road, Croydon.)

4. The London Borough of Lambeth was formed in 1965. It covers an area of approximately seven miles north to south, and three miles east to west, close to central London, with the River Thames at its northern border. Its population centres are Kennington, Vauxhall, Brixton, Stockwell, Clapham, Streatham and Norwood.

5. The London Borough of Lambeth's population has fluctuated over the decades, falling from over 300,000 in 1971 to 239,500 in 1989 and rising again to a current population of nearly a third of a million. The socio-demographic profile of its community was forged in part by the Windrush generation who migrated from the Caribbean to the UK from the late 1940s and early 1950s onwards. The 1991 census recorded that "*Lambeth's ethnic population*" was 31.3 percent and in 2000 it was said to have "*the largest black Caribbean population of any London authority as well as a significant black African population*".[45] Figures for 2017 recorded 41.5 percent of the population in Lambeth as being from black, Asian and ethnically diverse groups. Historically the London Borough of Lambeth has had higher than average unemployment and higher levels of deprivation compared with other inner London boroughs.

6. Employed staff and elected councillors owed responsibilities towards children in care.

6.1. **Staff**: In terms of senior officers, in 1971 the statutory role of director of social services was created to replace the previous role of children's officer. The role of director of children's services was introduced in 2004, and the current director of children's services role in Lambeth Council is held by the strategic director for children's services, who has lead responsibility for delivery of all Lambeth Council's children's services for children and families. Over time there were a number of reorganisations, but the principle of different divisions being responsible respectively for social workers and children's homes remained, with each division being headed by an assistant director who reported to the director of social services. By 1970 Lambeth Council had replaced the role of town clerk with that of chief executive, who was the head of all the paid staff working for the Council.

6.2. **Councillors**: Over time, councillors have held positions as chair of the Children's Committee or Social Services Committee, and since 2004 as lead member for children's services within the cabinet system.[46] There were a number of sub-committees to which functions were delegated – including the Children's Homes Sub-Committee, which was replaced in 1989 by the Children and Young Persons Services Sub-Committee[47] – but overall responsibility for policy and governance of children's homes and children in care remained with the Social Services Committee. The committees reflected the political balance of the elected council. Committee meetings and their minutes were open to the public (except for sensitive matters).

6.3. **Local authority**: The Local Government Act 2000 brought in new governance arrangements for local authorities and Lambeth Council adopted a leader and cabinet model of governance. The Cabinet was responsible for taking all major executive and policy decisions, other than those which were delegated to Officers. A key part of the new arrangements was the Scrutiny Committee comprising

[45] LAM028733_064; LAM029179_014
[46] LAM029331_022
[47] LAM029167

backbench councillors designed to hold the executive of the Council to account.[48] In 2021, the director of children's services and the lead member of children's services within Lambeth Council share responsibility with all officers and members of the local authority to act as effective and caring corporate parents for looked after children.[49]

Children in care

7. There were high numbers of looked after children in Lambeth relative to other London local authorities.[50] Between 1965 and 2000, around 15,000 children were placed in Lambeth Council's care, with more than 9,000 of those placed in its children's homes.[51] Ms Annie Hudson, strategic director of children's services from May 2016 to March 2020, explained that Lambeth Council's poor planning and a lack of early intervention with families in need contributed to these high figures:

> "*there hadn't been investment in early intervention and ways of supporting families so that children didn't need to come into care. What one might imagine is there would have been a crisis and the kind of reaction was to – immediately to take them into care, either through the courts or through voluntary reception into care, as it would have been known at that point in time. So a very kind of reactive rather than a kind of considered approach to admitting children into care.*"[52]

8. There was evidence of overrepresentation of black children in Lambeth Council's care. A report of 15 April 1981 titled *Black Children in Lambeth Residential Care* was submitted to the Social Services Committee. It noted that figures for 1980 showed that an average of 55 percent of children in Lambeth Council's residential care provision were black and that an average of 57 percent of children at Shirley Oaks were black. The report stated:

> "*although a minority of children in care (23%) are placed in Lambeth residential establishments, the numbers of black children in residential care are disproportionate to their representation in the overall child population, which is approximately 40% in 0–19 age range*".[53]

9. Over time, Lambeth Council followed the national trend away from children's homes and towards foster care as the preferred placement for looked after children. In 1975, there were 2,961 children in care in Lambeth, with 34 percent (1,000 children) in children's homes.[54] Lambeth Council admitted very young children (under five years old) into children's homes throughout the 1980s and into the 1990s – long after this ceased to be acceptable practice.[55] By 1996, all but one of its children's homes had closed. By September 2019, there were 355 children looked after by Lambeth Council, of which 72 percent (259 children) were in foster care. The remainder were in children's homes, secure units, semi-independent placements, or other residential or family settings.[56]

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[48] LAM029331_25-26
[49] LAM029331_297-299
[50] See for example the figures set out in the 1992 Social Services Inspectorate report (LAM014117_010).
[51] Annie Hudson 2 July 2020 111/3-12
[52] Annie Hudson 21 July 2020 4/23-5/6
[53] LAM029331_076
[54] LAM029318
[55] Annie Hudson 21 July 2020 6/1-7/3; LAM029331_017; LAM028710_002
[56] INQ006483

Response to allegations of abuse

10. Between 1986 and 2000, as summarised below, Lambeth Council commissioned a number of internal and external reports relating to the sexual abuse of children in its care and its failures to protect children. Over a similar period, between 1991 and 2001, a series of external reports (such as by the Social Services Inspectorate – SSI) were highly critical of Lambeth Council. The Metropolitan Police Service investigated a number of allegations of sexual abuse in Lambeth Council's children's homes from the 1970s onwards (as summarised below).[57] It was supported during Operation Middleton by the Children's Homes in Lambeth Enquiry (CHILE), established by Lambeth Council in 1998, until 2003.

A.3: Methodology

11. The Inquiry investigated the nature and extent of the sexual abuse of children in the care of Lambeth Council, including those cared for in children's homes and by foster carers or adoptive parents as well as those with special educational or additional needs. We examined Lambeth Council's response to allegations of sexual abuse and its failures to protect children from abuse, as well as the response of police, prosecuting authorities, regulatory bodies and other agencies. The Inquiry also considered the extent to which Lambeth Council sought to investigate, learn lessons, implement changes, and provide support to victims and survivors, as well as the adequacy of its policies and procedures. More widely, we considered whether there was a culture within Lambeth Council which inhibited the prevention and investigation of child sexual abuse.[58]

12. The process adopted by the Inquiry is set out in Annex 1 to this report. Core participant status was granted under Rule 5 of the Inquiry Rules 2006 to 66 core participants, including 55 complainants and victims and survivors. The Inquiry held five preliminary hearings between March 2016 and January 2020, and a final public hearing over four weeks in June and July 2020 – conducted virtually given the restrictions imposed by the Covid-19 pandemic.[59]

13. As a result of the decades of abuse, this has been a complex investigation. Following submissions from core participants, the Inquiry selected five children's homes in Lambeth for detailed case studies.[60] In Part B of this report, we consider life in care at Shirley Oaks children's home and South Vale assessment centre. Two of Lambeth Council's three homes which catered for children with complex needs and communication difficulties – Ivy House and Monkton Street – are examined in Part C. Part D deals with events at Angell Road children's home. While these five children's homes cannot represent the totality of what happened to children in Lambeth, they were selected to assist the examination in detail of the institutional responses to allegations of sexual abuse, and to identify themes and issues over the course of more than 40 years. Part E examines the experiences of children in foster care.

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[57] MPS004500_008_025_040_060_075
[58] Children in the Care of Lambeth Council: Scope of Investigation
[59] Lambeth Investigation Preliminary Hearing 24 March 2016; Lambeth Investigation Preliminary Hearing 27 July 2016; Lambeth Investigation Preliminary Hearing 31 October 2018; Lambeth Investigation Preliminary Hearing 23 July 2019; Lambeth Investigation Preliminary Hearing 15 January 2020
[60] Notice of Determination on selected case studies

14. The Inquiry received evidence from a number of those placed in Lambeth Council's care as children throughout the four weeks of the public hearings. In total, we heard oral or written evidence from 57 complainant and victim and survivor core participants. With the assistance from all those who came forward and their legal advisers, the Inquiry's legal team prepared a comprehensive summary of experiences and key issues raised by complainant and victim and survivor core participants.[61]

15. The Inquiry received a detailed corporate witness statement from Lambeth Council prepared by Ms Annie Hudson along with six additional statements.[62] A dedicated witness statement was produced for each of the case study homes, with statements on Ivy House, Monkton Street, South Vale, Shirley Oaks and Angell Road, and a further statement about fostering.[63] A statement on independent visitors was provided by Lambeth Council at the request of the Inquiry during the course of the oral hearings.[64] Evidence was received from former and current staff and councillors.

16. During this investigation, in December 2017, Lambeth Council apologised for its:

> "*continuing failure to ensure that children were protected, and it is clear that the Council did not respond robustly and systematically to address the underlying risk factors and identified causes.*"[65]

17. The Metropolitan Police Service undertook a number of investigations into allegations of sexual abuse made by children in care and former children in care (including Operation Middleton) and recognised that it "*let victims of sexual abuse down*" in the past through its handling of investigations.[66] It established Operation Winter Key in June 2015 to assist the Inquiry and to investigate allegations of non-recent child sexual abuse by people of public prominence or institutions where there have been repeated failings.[67] Detective Inspector Simon Morley provided nine comprehensive statements in response to a number of detailed requests made by the Inquiry in this investigation and in addition Commander Murray gave oral evidence on behalf of the Metropolitan Police Service.

18. Evidence was received from a number of other institutions and individuals, including former employees of the SSI (which was replaced by the Commission for Social Care Inspection in 2004) and politicians, who were responsible for the inspection and monitoring of social services provided by local authorities. The Inquiry heard from Ofsted (the Office for Standards in Education, Children Services and Skills, which replaced the Commission for Social Care Inspection in 2006) and the Independent Office of Police Complaints (IOPC). The Crown Prosecution Service provided written and oral evidence from Mr Gregor McGill, Director of Legal Services.

19. The Inquiry also heard and obtained expert evidence from Dr Alison Steele (Royal College of Paediatricians and Child Health) and Dr Emily Phibbs, a clinical psychologist. Emma Harewood, The Lighthouse's development and service manager, provided information about The Lighthouse and its work as an organisation providing assistance and support for victims of child sexual abuse. The Inquiry was assisted by a statement from the Havens, a

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[61] 6 July 2020 74/4-113/8; 29 July 2020 97/14-176/12; 31 July 2020 29/16-47/22
[62] LAM029331
[63] LAM030078; LAM030068; LAM030157; LAM030227; LAM030269; LAM030213
[64] LAM030335
[65] LAM029331_001
[66] Simon Morley 22 July 2020 3/20-21
[67] MPS004497_002

London-wide service providing assistance to victims of rape and sexual assault, including forensic medical examinations. Cardiff University was also commissioned by the Inquiry to research the development of policing in child sexual abuse investigations.[68]

20. In preparation for the final public hearing, the Inquiry obtained more than 35,000 documents (totalling in excess of 360,000 pages) from a range of organisations, institutions and individuals, including Lambeth Council, the Metropolitan Police Service and the Crown Prosecution Service. Social services files were also reviewed, including those generated by Lambeth Council's five-year CHILE investigation of its children's homes.

21. A number of witnesses, including all complainant and victim and survivor core participants, were invited to provide their views about any practical recommendations they would like the Inquiry to consider. Those views were collated into a schedule which is included as Annex 4 to this report.

A.4: Terminology and references

22. Throughout this report, when referring to Lambeth Council and its statutory responsibility for children, including children in care, we have referred to 'children's social care' for consistency. Until 2006, this work was carried out by social services and then by children's services.

23. Where we refer to those who have made allegations of child sexual abuse and those allegations have not been proven by way of criminal conviction, civil finding or findings in the context of disciplinary proceedings, they will be referred to as complainants. Where a criminal conviction has been recorded or a finding has been made, individuals will be referred to as victims and survivors.

24. The allegations about child sexual abuse connected to Lambeth Council involve offending from, at least, the 1970s onwards. The Sexual Offences Act 1956 was then the prevailing legislation and referred to offences of indecent assault and buggery.[69] In May 2004, the Sexual Offences Act 2003 came into force and created a wide number of new offences. It included specific offences for sexual acts committed against children under 13 years of age, a new offence of meeting a child following sexual grooming and an increase in maximum sentences for a number of offences.[70]

25. References in the footnotes of the report such as 'LAM029331' are to documents that have been adduced in evidence or posted on the Inquiry website. A reference such as 'Hudson 2 July 2020 79/21-23' is to the witness, the date he or she gave evidence, and the page and line reference within the relevant transcript (which is also available on the Inquiry website).

[68] EWM000464
[69] Sexual Offences Act 1956 sections 12 and 14–15.
[70] Sexual Offences Act 2003 section 15. It replaced the offence of indecent assault with sexual assault and buggery with offences of rape for a person intentionally to penetrate with his penis the vagina, anus or mouth of another person without consent.

Investigations and reports related to Lambeth Council

The following is a list of internal and external investigations and reports that the Inquiry considers to be relevant to the specific homes examined in this report or to the broader context of how Lambeth Council operated during the period under consideration in this investigation.

Date	Report title	Author(s)	Referred to in this report as
December 1985	Notes of Management Inquiry into allegations concerning [LA-A26] – Ivy House	Don Thomas, Pauline Lawrence and Pat Salter	Initial investigation into the Ivy House complaint (LAM028780_097-101)
July 1986	Management Investigation into the Ivy House Complaint	Waveney Williams, Josie Durrant, Karen Ellison and Phil Sealy	Management investigation into the Ivy House complaint (no copy of report has been located)
1987	Whose child? The Report of the Public Inquiry into the Death of Tyra Henry	Elaine Arnold, Marlene Bogle, Felix Fernando, Ros Howells, Lova Ramsay, Stephen Sedley (chair) and Avice Warmington	Tyra Henry public inquiry report (LAM028613)
1987	An Independent Review of Procedures for Dealing with Allegations of Child Sexual Abuse in Establishments run by the London Borough of Lambeth chaired by Millius Palayiwa – Interim Report dated June 1987	Millius Palayiwa, William Theaker, Ermin Lee-Kin and Jennie Jarvis	Review panel interim report (INQ004910)
March 1987	Report to the Director of Social Services of the Management Investigation into Allegations of Child Sexual Abuse at Monkton Street Children's Home	Tony Emett, Mary Webb, Pat Bell and one other panel member	First Monkton Street report (LAM000573 – extract)
July 1988	Investigation into Allegation of Child Sexual Abuse – Monkton Street	Heather Stephenson and Pauline Rowe	Second Monkton Street report (LAM000575)
September 1988	Children's Home Sub-Committee Report of Senior Management – Children's Home Service	Robert Morton and Josie Durrant	First Morton report (LAM028710)
June 1989	The Principal Manager Overview of the Children's Home Service	Robert Morton	Second Morton report (LAM010549)

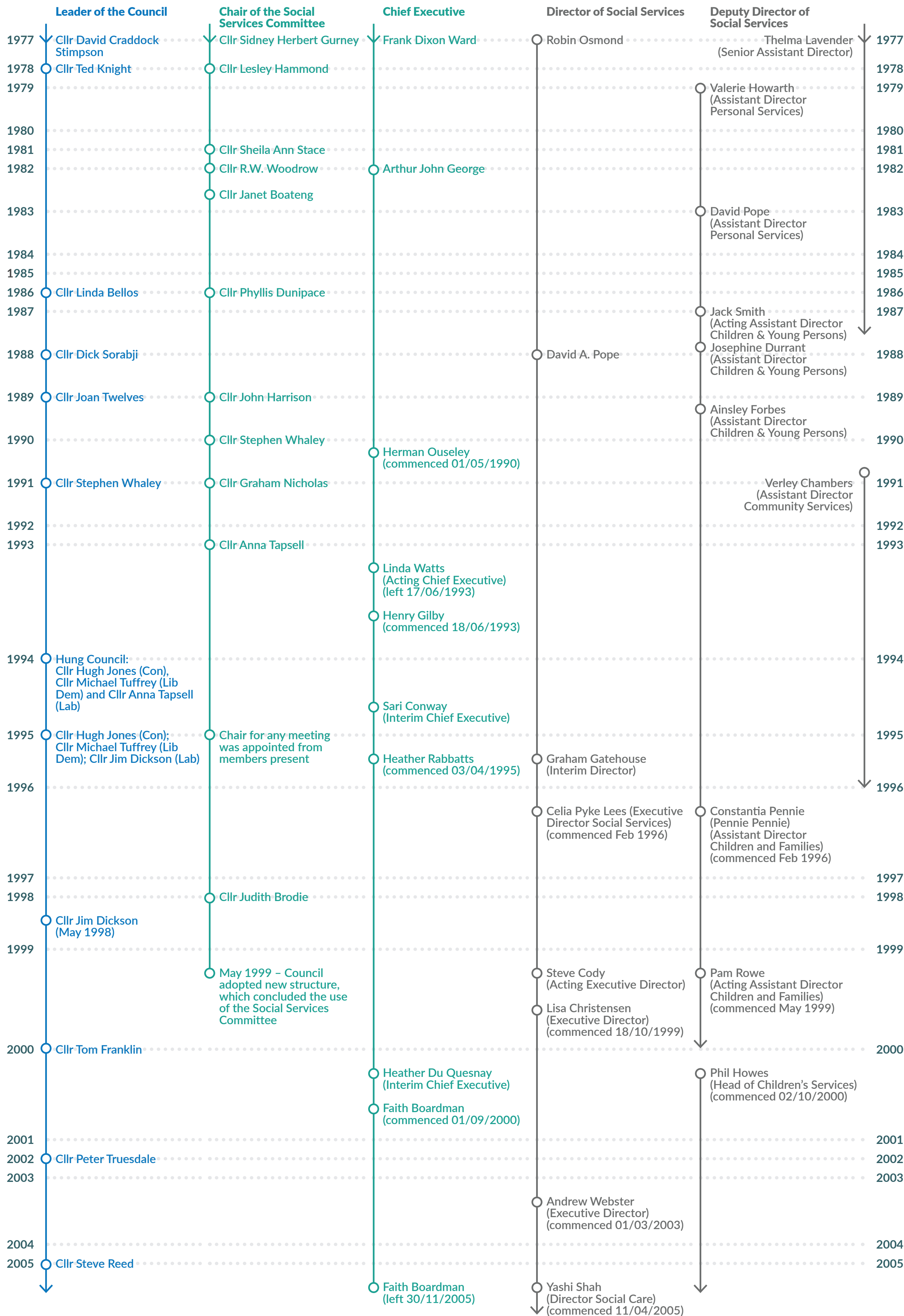
Date	Report title	Author(s)	Referred to in this report as
July 1989	Doreen Aston Report	Lewisham Social Services Department	Doreen Aston inquiry report
July 1989	Children's Home Sub-Committee Report by Principal Manager, Children's Homes	Robert Morton	Third Morton report (LAM028717)
January 1990	Quality and Equality: The Report of the Enquiry into the South Vale Assessment Centre	Edgar Zephyrine, Hugh Alexander, An Hayes, Geraldine McGuiness and Albert Rose	Zephyrine report (LAM029172)
September 1990	Children's Homes Section Report Report by Principal Manager Children's Homes	Robert Morton	Fourth Morton report (INQ002077)
June 1991	Child Protection Services in Lambeth	Arran Poyser, Kevin Mansell and Jim Carlton	SSI 1991 report (LAM010629)
November 1992	The Mia Gibelli Report	David Pope (director of social services)	Mia Gibelli report (LAM014045)
June 1993	An Independent Inquiry Commissioned by the London Borough of Lambeth	Richard Clough	Clough report (LAM000020)
March 1993	An Inspection of Three Residential Children's Homes in the London Borough of Lambeth	SSI	SSI 1993 report (LAM028733)
December 1993	Investigation into Alleged Breaches of the Council's Equal Opportunities Policies in the Housing Directorate	Eithne Harris, Jeanne McNair and Yvette Adams	Harris report (LAM028615)
May 1994	SSI Lambeth Residential Child Care Inspection	SSI	SSI 1994 report (LAM000316)
July 1995	Inquiry Report of Miss Elizabeth Appleby QC	Elizabeth Appleby QC	Appleby report (LAM000025)
June 1997	Inspection of Planning and Decision Making For Children Looked After – Lambeth	SSI	SSI 1997 inspection (LAM001997)
May 1999	Interim report to the Chief Executive (Heather Rabbatts)	John Barratt	Barratt interim report
September 1999	The Lambeth Independent Child Protection Inquiry 1999: The Factual Background – Part 1	John Barratt	Barratt Part 1 report (LAM000022)

Date	Report title	Author(s)	Referred to in this report as
May–June 2000	Inspection of Child Protection and Planning and Decision Making For Looked After Children – London Borough of Lambeth	SSI	SSI 2000 inspection report (LAM029179)
September 2000	Review of Events and Circumstances Associated with Changes to Services at a Home Providing Residential Respite Care for Children with Disabilities	Richard Evans, Elisabeth Ford	Evans report (LAM012344 – extract)
October 2000	Two Lambeth Independent Child Protection Inquiries 1999–2000: the Final Report	John Barratt	Barratt final report (LAM000021)
December 2000	Review of Lambeth Borough Council Social Services	SSI	SSI 2000 review report (LAM013017)
August–September 2001	Follow-Up Inspection of Child Protection, Planning and Decision Making For Looked After Children – London Borough of Lambeth	SSI	SSI 2001 report (LAM018930)
31 July 2003	Children's Homes in Lambeth Enquiry (CHILE) 1998 to 2003	Helen Kenward	CHILE

Key Metropolitan Police Service investigations related to child sexual abuse linked to Lambeth Council

Investigation	Year	Summary of investigation
Operation Bell	1992 to 1994	Allegations of child sexual abuse arising from South Vale assessment centre. It focussed on care worker Leslie Paul but also investigated allegations against other care workers: LA-F4, LA-F5 and LA-F8. (See Part B)
Operation Pragada	1993 to 1994	Allegations made by LA-G1 of child sexual abuse and the creation of indecent images of children, which came to light as a result of a report into the housing directorate of Lambeth Council (the Harris report). (See Part J)
Operation Middleton	1998 to 2003	Allegations of abuse committed against children in the care of Lambeth Council between 1974 and 1994. Of these, 16 cases were sent to the Crown Prosecution Service and charges were brought against Leslie Paul, LA-F14, William Hook, Geoffrey Clarke and LA-F38. (See Part J)
Operation Trinity/ Operation Overview	2012 to 2015	Further allegations of child sexual abuse involving Leslie Paul, LA-F8, John Hudson and LA-F41. Resulted in charging Leslie Paul, Patrick Grant, LA-F8, June Entecott and Brenda Ball. (See Part J)
Operation Winter Key	2015 to present	This investigative team is responsible for the Metropolitan Police Service's ongoing investigations into child sexual abuse. As at May 2020, it had around 50 active investigations.

Timeline of senior leaders at Lambeth Council



Part B

The reality of life in the care of Lambeth Council

The reality of life in the care of Lambeth Council

B.1: Introduction

1. Between 1965 and 1994, when most of its children's homes closed, Lambeth Council had 33 children's homes.[71] In this part of the report, we focus on the reality of life as a child in care in two of these homes – Shirley Oaks children's home and South Vale assessment centre.

B.2: Case study: Shirley Oaks

Background

2. Shirley Oaks opened in 1905 and was intended to provide homes for groups of children in small cottages rather than in a large institution. There were approximately 38 cottages on the site, which could together accommodate approximately 350 children at any one time.[72] However, this approach was considered out-of-date by 1965, when Lambeth Council was formed and became responsible for Shirley Oaks. In April 1964, the regional inspector wrote that "*the house mothers in these crowded cottages rarely achieve a high standard of care*".[73] Shirley Oaks had its own school, its own medical facilities and its own leisure facilities for children.[74] It closed in 1983.[75]

[71] LAM029165
[72] LAM030213_014-015
[73] HOM002320_010
[74] Annie Hudson 21 July 2020 14/12-15/3
[75] Annie Hudson 21 July 2020 13/8

Shirley Oaks children's home

Sexual abuse at Shirley Oaks

3. More than 2,400 children were placed at Shirley Oaks between 1965 and 1983.[76] As at June 2020, Lambeth Council was aware of at least 529 people who allege they were sexually abused while at Shirley Oaks by a total of 177 adults employed or connected with the home.[77]

4. There were no successful prosecutions until 2001. Donald Hosegood was acquitted of sexual abuse charges in 1975 and died in 2011.[78] In 1978, Patrick Grant was also prosecuted but not convicted, although he was convicted in 2019 of eight offences of indecent assault against three victims and sentenced to eight years' imprisonment.[79] In 2001, William Hook was charged with 37 offences against seven victims; he pleaded guilty to 26 offences and was sentenced to 10 years' imprisonment.[80] Philip Temple was interviewed by police regarding allegations of child sexual abuse in 1977 but not charged. In 2016, he pleaded guilty to 29 offences, including 27 child sexual abuse offences against 13 children, for which he was sentenced to 12 years' imprisonment.[81]

William Hook (1964 to 1974)

5. William Hook lived in a Shirley Oaks cottage with children in the care of Lambeth Council for 10 years from 1964. He did so free of charge in return for providing swimming lessons.[82] He also had a role as a house father or social uncle.[83]

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[76] LAM030213_028-029
[77] Annie Hudson 21 July 2020 12/18-13/5; LAM030213_002
[78] Simon Morley 22 July 2020 58/17-18
[79] Simon Morley 22 July 2020 63/14-15; CPS004943_012
[80] Simon Morley 22 July 2020 48/22-49/2; LAM030213_086
[81] Simon Morley 22 July 2020 56/1-56/6; LAM030213_104
[82] Annie Hudson 21 July 2020 44/11-22
[83] LAM030213_087-088

6. In February 1974, the police were called to a hotel by staff concerned about the welfare of a young teenage boy who was staying with Hook in a room at the hotel. The boy was in the care of another local authority. The police notified that local authority about the incident, commenting that they had significant information about Hook and expressing surprise that he had ever worked with children.[84]

7. Staff at Shirley Oaks already had concerns about Hook's behaviour, with several referring to widespread rumours.[85] It does not appear from the evidence received by the Inquiry that these concerns were acted on.

7.1. One former house father referred to rumours that Hook had "*children who used to hang around him … and the rumours were that he was supposedly playing around with them*".[86]

7.2. LA-A63 and LA-A64 both described being given lavish gifts by Hook after he began sexually abusing them. LA-A64's mother complained about the gifts but nothing happened.[87] Both children were abused by Hook in the mid-1970s. LA-A63 was aged between 15 and 16. LA-A64 was abused between the age of 8 and 13. Hook later pleaded guilty to the abuse of these boys.

7.3. Children also knew Hook by different names, which should have raised questions. It is unclear if any staff member queried his use of different names.[88]

8. In 1974, LA-A203 (a child in care at Shirley Oaks), when aged 11, made allegations against Hook of sexual abuse at a swimming lesson. He described Hook making him swim naked and touching him inappropriately. LA-A203 said that he felt "*shattered*" after these experiences.[89] Lambeth Council subsequently terminated Hook's employment, but did not inform the police about him.[90]

9. In 2001, Hook was charged with more than 40 offences of child sexual abuse. He pleaded guilty to 26 offences in respect of six children in the care of Lambeth Council and a child he had abused after leaving Lambeth.[91] He was sentenced to 10 years' imprisonment.[92] Lambeth Council was aware of 65 children who have made allegations of sexual abuse against Hook.[93]

Geoffrey Clarke (1969 to 1991)

10. Geoffrey (or Geoff) Clarke was a computer programmer who worked for Lambeth Council between 1969 and 1991. He also volunteered at Shirley Oaks from around 1973 – "*the phrase they then used was a 'social uncle' for children*" – spending almost every weekend there and taking children on holiday abroad alone.[94]

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[84] LAM030213_099
[85] Opening Statement 29 June 2020 108/18-109/3
[86] MPS003859_001-002
[87] Opening Statement 29 June 2020 109/4-18
[88] Annie Hudson 21 July 2020 46/10-12; LAM030213_102
[89] LA-A203 29 July 2020 132/22-133/3; LAM030213_091-092
[90] Annie Hudson 21 July 2020 45/21-46/8
[91] Simon Morley 22 July 2020 48/22-25; LAM030213_086
[92] Simon Morley 22 July 2020 49/1-2
[93] Annie Hudson 21 July 2020 47/1-9; 28 children were in the care of Lambeth Council; 4 were in the care of other councils, 33 were in the care of councils which could not be established (LAM030213_087).
[94] Annie Hudson 21 July 2020 47/12-48-14; Annie Hudson 21 July 2020 50/18

11. There were also rumours about Clarke. One Lambeth Council social worker between 1970 and 1978 recalled that staff:

> "*had our doubts about Geoff … The reason we had doubts about Geoff was because we couldn't really understand why he was there at Shirley Oaks, spending so much time with the children without getting paid for it … generally, he was trusted to spend time with the children unsupervised, within and outside the house … In the evenings he'd take the children up to bed. He'd go upstairs on his own with them and spend some time up there. I don't know how long generally, but it was long enough for us to assume he was reading to them. Probably at least half an hour or more, possibly longer.*"[95]

12. LA-A306 lived at Shirley Oaks in the 1970s. He described being sexually assaulted by the swimming teacher as well as physical abuse and violence by staff.[96] He remembered Clarke, who managed the football team:

> *"All of my siblings would go to his house and get bathed there and he would try and buy us sweets. He would make us feel really special. He drove a Mini and would let us drive around on his knee."*[97]

13. Even when specific concerns were raised, senior staff in children's social care in Lambeth Council failed to understand the risk Clarke posed. For example, Clarke involved himself in LA-A51's life, interfered in relationships with his family and with foster placements, and was asked to limit the time he was spending with him.[98] This began when LA-A51 was aged approximately seven or eight years. When LA-A51 was aged 13, LA-A51's father wrote to Lambeth Council questioning whether Clarke was fit to work with children.[99] As conceded by Ms Annie Hudson, strategic director for children's services at Lambeth Council from May 2016 to March 2020, Clarke:

> "*managed to override some of the views of some professionals who were concerned about his relationship with this particular child – certainly the concern of* [the] *father, who subsequently at some point made a complaint – and continued to have contact with this child even though he was told that he shouldn't … He was interfering in this way which absolutely was not in the child's interest.*"[100]

14. In 1984, Clarke applied to become a foster parent for Southwark Council, together with a female house parent from Shirley Oaks, although they were not a couple.[101] This may have been an attempt by Clarke to avoid his application being rejected as it most likely would have been at that time if he had applied as a single man. One of the referees from Lambeth Council, LA-F81, referred to Clarke teaching a child about control of his penis in support of the fostering application.[102] This contact between a 'social uncle' and child was regarded as positive, rather than raising concerns. Clarke was subsequently approved as a foster carer by the London Borough of Southwark and at least one child in the care of Lambeth Council was placed with him for four years.[103]

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[95] Opening Statement 29 June 2020 109/19-110/8; MPS003779_004-005
[96] LA-A306 29 July 2020 131/3-14
[97] LA-A306 29 July 2020 131/17-20
[98] Annie Hudson 21 July 2020 48/20-49/-21; LAM030213_133-137
[99] Annie Hudson 21 July 2020 49/6-9; LAM030213_136
[100] Annie Hudson 21 July 2020 48/20-49/25
[101] Annie Hudson 21 July 2020 50/1-14; LAM030213_139
[102] Annie Hudson 21 July 2020 50/1-51/13
[103] LAM030213_131

15. Clarke remained involved with Shirley Oaks until its closure in 1983. After it closed, he started visiting Chevington children's home, also in Lambeth, and built up relationships there. He left Lambeth Council's employment in 1991 but continued working in a children's home outside London.[104]

16. In 1998, Clarke was convicted of the sexual abuse of three children (none linked to Lambeth Council) and sentenced to three years' imprisonment.[105]

17. Further allegations were made against Clarke by children in care – in Lambeth and elsewhere – between 2000 and 2002, during Operation Middleton. He was charged with numerous offences of indecent assault and possession of indecent images. In March 2003, he took his own life on the day his trial was due to start.[106] Lambeth Council was aware of at least 49 children – including 37 in its care – who have alleged sexual abuse by Clarke.[107]

Donald Hosegood (1968 to 1975)

18. Donald Hosegood and his wife were appointed jointly as house parents at Shirley Oaks in May 1968.

19. LA-A25 moved to Hosegood's cottage in September 1968, when she was around 12 years old. While she described her initial house parents at Shirley Oaks as "*really lovely and caring*" who "*treated us as if we were their own children*", this was not her experience with the Hosegoods.[108] For example, LA-A25 described coming back to Shirley Oaks from a family visit:

> "*when I got upset from coming home from my nan's, I would cry, so he'd make me stand on the landing for hours … The more I cried, the longer I would have to stand there.*"[109]

20. Hosegood looked at LA-A25 (for example through keyholes) when she was washing.[110] One staff member on two or three occasions witnessed Hosegood walk into a toilet which LA-A25 was already using, but did not take the matter further because they had only worked at Shirley Oaks for a short time.[111] Another member of staff at Shirley Oaks saw Hosegood entering a toilet with a child, and was sufficiently concerned to tell a senior management officer about this. Annie Hudson said that Lambeth Council were unable to locate any response to this complaint.[112] LA-A25 said that for around four years Hosegood raped her approximately three times a week. He also tried to force her into sexual activity with another child, and showed her pornographic films.[113] He threatened her should she tell anyone:

> "*That he'd kill me, and then, when it got more worse, the things he was doing to me, he said he could get me locked up and no-one would believe me, and I'd be away forever.*"[114]

21. A parent of another child at Shirley Oaks – who said that their child was being abused by Hosegood – asked LA-A25 if it was happening to her and she told them that it was. LA-A25 finally spoke to her manager at work, who contacted the police (although he also told her

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[104] LAM030213_131
[105] Annie Hudson 21 July 2020 48/14-16; MPS004542_007
[106] Annie Hudson 21 July 2020 51/14-21
[107] LAM030213_132
[108] LA-A25 6 July 2020 54/17-21; LA-A25 6 July 2020 56/6-18
[109] LA-A25 6 July 2020 56/25-57/8
[110] LA-A25 6 July 2020 57/16-58/11
[111] Opening Statement 29 June 2020 112/14-113/9
[112] Annie Hudson 21 July 2020 23/14-24/4; LAM030213_143
[113] LA-A25 6 July 2020 58/23-59/25
[114] LA-A25 6 July 2020 59/9-59/14

that she would be dismissed from her job if she was lying).[115] The police officer told her that he "*did believe me*", which LA-A25 struggled to accept having been told before that she was a liar.[116] As she told the police that Hosegood had threatened her, the police ensured that LA-A25 did not go back to Shirley Oaks.[117]

22. LA-A2 was born in 1961. He and his older sister were taken into care in the early 1960s.[118] His sister explained that Hosegood would pick on LA-A2 because he was "*generally slow at doing things*" and "*had trouble speaking*".[119] One night, LA-A2's sister was walking past his bedroom and saw Hosegood kneeling at the side of his bed. It was obvious to her that he was doing something to LA-A2. She shouted and pulled back the covers and saw that Hosegood was abusing her brother. Even after this, LA-A2 did not speak to her about the abuse he was suffering.[120]

23. LA-A69 described abuse by Hosegood over an eight-year period in the 1970s, when she was six or seven years old. Hosegood also abused the girl with whom she shared a bedroom, which LA-A69 witnessed. Hosegood told LA-A69 that if she said anything about his behaviour to anyone, he would kill her. She was terrified and believed him.[121]

24. In 1975, Hosegood was tried for 11 charges of rape and indecent assault involving four children.[122] Lambeth Council was willing to provide a letter about Hosegood for the purposes of the criminal investigation. An internal memo sent by Mr N Elliott, senior children's homes officer, to Lambeth Council's chief solicitor stated that:

> "*it is the belief in this Directorate that the majority of allegations against the housefather* [Hosegood] *are pure fantasy. The history of the children is that some are given to sexual fantasy and the previous relationship between the house father* [and] *these children also suggests an element of victimisation against him.*"[123]

Mr Elliott's letter records that Mr and Mrs Hosegood were asked to leave their cottage for "*two weeks pending developments*".[124]

25. Hosegood's trial collapsed after four days.[125] The children who made allegations against Hosegood were not offered support by Lambeth Council or through the criminal justice process. LA-A25, who gave evidence at the trial, left care and her job, and received no support.[126] Less than two years after Hosegood's trial, LA-A2 was found dead in the bathroom of a Shirley Oaks cottage. His sister said that:

> "*Following the court case, LA-A2 was even less like his old self. He hardly spoke and he never seemed to be happy or engaging when I saw him. Had fate been kinder to my beloved LA-A2, and had counselling and support been available, LA-A2 may have been*

[115] LA-A25 6 July 2020 60/25-62/23
[116] LA-A25 6 July 2020 64/3-65/1
[117] LA-A25 6 July 2020 65/2-24
[118] LAM029331_150
[119] Annie Hudson 2 July 2020 78/9-13
[120] Annie Hudson 2 July 2020 78/14-25
[121] Opening Statement 29 June 2020 106/18-24
[122] LAM030213_143
[123] LAM030203
[124] LAM030203
[125] Annie Hudson 21 July 2020 25/1-4
[126] LA-A25 6 July 2020 65/25-67/13

> *able to represent himself today. The police charged Hosegood with many sexual crimes against minors. What failed my beloved brother more than anything was the total lack of support offered when the judge dismissed the charge against Mr Hosegood."*[127]

26. The outcome of the criminal case was treated as the end of the matter. There was no disciplinary investigation.[128] An assessment of the risk to children should have been initiated by senior staff in children's social care in Lambeth Council. Failure to do so showed complete disregard for generally accepted safeguarding principles, and put children at significant risk of sexual abuse.

27. Hosegood was reinvestigated to a limited degree by Operation Middleton, which ran from 1998 to 2003 (see Part J). Six complainants (including three involved in the 1975 trial) came forward to make allegations of sexual abuse against Hosegood. Three further potential victims were also identified, including a child with special educational needs who a number of individuals (including children who were at Shirley Oaks at the time) thought might have been sexually abused by Hosegood.[129] Despite this, the Metropolitan Police Service did not speak to Hosegood during Operation Middleton. Detective Inspector (DI) Simon Morley told the Inquiry that Hosegood was not pursued because officers mistakenly believed that all of the allegations made against Hosegood were dealt with in 1975. Ms Hudson confirmed that the Children's Homes in Lambeth Enquiry (CHILE) mistakenly believed he had died and told some individuals who came forward this.[130] Hosegood died in 2011 without being the subject of any further police investigation.[131]

28. In the course of Hosegood's employment at Shirley Oaks, six of the eight children who lived in his cottage and one other child accused him of sexually abusing them.[132]

Philip Temple (1975 to 1977)

29. In 1975, Philip Temple was employed as a house father at Shirley Oaks. Although Lambeth Council was not aware of it, he had left his previous employment at a Wandsworth Council children's home after two children there made allegations of sexual abuse. Temple was not charged by the police but resigned.[133]

30. In 1977, two young boys at Shirley Oaks had made allegations that they had been sexually abused by Temple. Their social care files recorded that the children were interviewed by a detective constable, in the presence of their social workers. One child twisted in his chair, hid his face and cried. The social worker noted that:

> *"at this point the DC almost ran from the room, saying he would not question him further. He was too young. He later said that he had not questioned anyone as young as these two in this type of case before."*[134]

[127] Annie Hudson 2 July 2020 79/4-13
[128] Annie Hudson 21 July 2020 22/17-23/13
[129] Annie Hudson 21 July 2020 25/5-13; MPS004500_128-129
[130] Annie Hudson 21 July 2020 26/21-27/12
[131] MPS004500_135
[132] LAM030203
[133] Annie Hudson 21 July 2020 27/19-24; Simon Morley 22 July 2020 55/19-56/5
[134] Annie Hudson 21 July 2020 29/4-15

31. The social workers and children were recalled to the police station the following day. They were told:

> "*House father had been interrogated for the second time that afternoon and had threatened suicide but still maintained that the children had fabricated the story. The police felt this was quite plausible and that, as a person's career was at stake, they must question the children further.*"[135]

32. It appears that the children were being pressured about their accounts. Despite this, the social worker noted that one of the children "*simply stated and restated that he had told the truth, even when CP emphasised how serious the effects could be for uncle and how much the truth mattered*".[136] ('CP' was a member of staff who worked for Temple at the cottage, 'uncle' was how the children referred to Temple.) He was asked if he was lying to help his friend and why he had not cried the previous day. When the other child was questioned again, he "*broke down and cried*". The detective constable said "*He's halfway there. We're sure it's a string of lies. He's about to tell the truth.*" The social worker "*felt the police seemed relieved they could exonerate*" Temple, who they described as "*desperate*".[137] As a consequence, the police investigation went no further. A record from April 1977 stated that "*the police have told him they believed him and not the children*".[138]

33. Senior staff in children's social care did not institute Lambeth Council's own misconduct investigation or process following the decision not to charge Temple. This meant that there was nothing to prevent Temple from being able to resume his role as house father and raised the question of whether the children would remain in his care. Temple was only prevented from returning to his role at the home because of the efforts of a more junior member of staff. She was given no support by senior managers but was left to confront Temple and "*virtually put in the position of justifying her refusal to accept him as house father at Rowan*".[139] This did not resolve the position. Temple then requested a meeting with the staff in the home at which the staff were instructed not to refer to the child abuse allegation at all and to "*reject him*" purely in terms of "*house management*".[140] Temple requested that a senior manager did not attend these meetings. It was Temple, not senior staff, who took charge of the process which determined whether he would return to the house.[141]

34. Within weeks, a sibling of a third child came forward and told a social worker that his brother, LA-A4, had been sexually abused by Temple when he was at Shirley Oaks in 1976. Police were provided with a statement from LA-A4. A meeting to discuss the allegation was then held between the police, the social worker and Ms Marjorie Moyce, the principal children's officer who had already been involved in the earlier allegations. There is no evidence to suggest that Lambeth Council took any steps to investigate the allegations internally or to review the allegations of the two other boys.[142]

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[135] Annie Hudson 21 July 2020 30/1-9
[136] Annie Hudson 21 July 2020 30/9-12
[137] Annie Hudson 21 July 2020 30/19-23
[138] Annie Hudson 21 July 2020 31/6-10
[139] Annie Hudson 21 July 2020 33/10-12
[140] Annie Hudson 21 July 2020 33/14-35/10
[141] Annie Hudson 21 July 2020 33/6-34/11
[142] Annie Hudson 21 July 2020 36/16-37/16; LAM030213_115-116; MPS004500_085-086

35. Some time later, as recorded in a note to the Department of Health and Social Security dated July 1977:

> "*Two senior managers advised the house father of this further allegation whereupon he admitted that there was truth in it. He resigned immediately and returned to Liverpool*".[143]

Although he confessed to the sexual abuse of children in its care, senior staff in children's social care in Lambeth Council allowed Temple to resign and failed to inform the police.

36. Temple went on to abuse other children. In 1998 and 1999, he was prosecuted for three offences of indecent assault on a boy aged 15, which had happened in 1997. He was acquitted but later pleaded guilty to two counts of perjury relating to these trials.[144] In April 2016, Temple pleaded guilty to 29 counts of child sexual abuse relating to 13 victims. Four of the children had been in care at Shirley Oaks between 1976 and 1977 and had provided information to Operation Middleton. Temple was sentenced to 12 years' imprisonment, although this was increased to 18 years on appeal by the Attorney General, on the basis that it was unduly lenient.[145]

Patrick Grant (1977 to 1985)

37. In May 1977, Temple was replaced at Shirley Oaks by Patrick Grant, who became officer in charge of one of the cottages in August 1977. Patrick Grant was subsequently to work at South Vale between 14 July 1980 and 15 October 1981.[146]

38. In February 1978, he was charged with 10 counts of indecent assault on seven boys. Five of the children had been in his care when he worked for a different borough, and two of the children lived in his cottage at Shirley Oaks.[147] One of these children from Shirley Oaks was also one of the children who had disclosed that they had been sexually abused by Philip Temple. In December 1978, Grant's trial stopped after six days, resulting in his acquittal. Despite being accused of sexual abuse by two groups of children from two different boroughs, senior staff in social care did not undertake any further investigation or institute disciplinary proceedings after his acquittal.[148]

39. While he was awaiting trial, Grant was temporarily transferred to adult services to undertake administrative duties and Lambeth Council offered him a secondment to undertake training to become a qualified social worker, which he completed in 1980. This included Lambeth Council paying the fees for a two-year training programme at a higher education institution and also a salary.[149] The decision was made by Marjorie Moyce (principal officer, social work) and a training officer, but the director of management services, the director of finance, the senior assistant director homes and daycare provision and the senior personnel officer were all included in the correspondence to Grant. The decision of Lambeth Council to second Grant on professional social work was a gross error of judgement.[150] Plainly, he was a risk to children.

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[143] Annie Hudson 21 July 2020 37/17-38/5
[144] MPS004500_070-071_090-091; LAM030213_104
[145] MPS004500_117; LAM030213_104
[146] LAM030213_120-121
[147] Annie Hudson 21 July 2020 39/1-25
[148] Annie Hudson 21 July 2020 42/13-43/3
[149] Annie Hudson 21 July 2020 40/1-12
[150] LAM030213_122

40. Following his qualification, Grant worked at South Vale as a manager between July 1980 and October 1981.[151] He was subsequently an administrative officer for the Children's Home Service until April 1985.[152]

41. In 2019, Grant was convicted of eight counts of child sexual abuse, including in respect of one child who had been at Shirley Oaks in the care of Lambeth Council in the 1970s.[153] Lambeth Council is now aware of at least 15 children who have alleged sexual abuse by Grant, eight of whom were in its care.[154]

B.3: Case study: South Vale

Background

42. South Vale was built as an assessment centre and opened in 1967. It was intended to provide short-term care for children in order to assess their longer term needs, a relatively common approach in the 1970s and into the 1980s.[155] Over time, South Vale became used as a general children's home, with some children "*drifting*" and staying there for a considerable period of time.[156] South Vale gained the reputation for taking children who were difficult to place elsewhere.

43. It also housed very young children, under the age of five years. In her report of January 1990, Councillor Clare Whelan recorded that "*Under fives are placed at South Vale with no worker trained to look after this age group*".[157] Children of this age should not have been living in residential homes at all. Such young children required one-to-one care and continuity of care to ensure that their emotional and developmental needs were met.

44. Due to "*limited available historical records*", Lambeth Council was not able to provide an accurate number of children admitted to South Vale, but it exceeded 3,500 between 1968 and 1993.[158] As at June 2020, Lambeth Council was aware of at least 140 people who had disclosed child sexual abuse at South Vale.[159]

45. South Vale was managed along punitive lines. It operated a system of privileges which meant there was the "*opportunity for the system to be manipulated by staff particularly as they were untrained and there was favouritism displayed towards certain children*".[160] It was not, in reality, a system which rewarded children for good behaviour, rather they had to earn a certain number of points just to have access to basic activities. It was more of a system for punishment than privilege.[161] The Zephyrine report (an internal inquiry initiated by Lambeth Council in 1989, discussed below) recorded that some staff saw it as "*behaviour modification*" or a "*quasi-psychotherapeutic*" method of children coming to terms with their behaviour and that many staff reported abuse of it.[162]

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151 LAM029331_053
152 LAM029331_053
153 CPS004943_012; LAM030213_119
154 LAM030213_120
155 Annie Hudson 21 July 2020 52/14-21
156 Annie Hudson 21 July 2020 54/5-55/6
157 LAM030157_036-037
158 LAM030157_016
159 LAM030157_006
160 MPS000523_003
161 Annie Hudson 21 July 2020 60/15-61/24
162 LAM029172_010-011

46. When interviewed by the police in 2001, Leslie Paul tried to suggest – in response to the allegations against him – that the children at South Vale were disturbed and difficult.[163] While it may have suited Paul and others to convey this image of South Vale, this was an attempt to justify its punitive environment. It put children at risk by stigmatising them and creating the impression that they were not to be trusted.

Sexual abuse at South Vale

Leslie Paul (1979 to 1992)

47. Leslie Paul worked for Lambeth Council from 1979. He worked at South Vale as a residential child care officer from 1979. Apart from a brief period as an acting team leader in 1980, he remained a residential child care officer until 1989. He was promoted to the role of team leader at South Vale from April 1989 until April 1991. In 1991, he became an administrative assistant in the Area 8 Team Office until his dismissal in 1992.[164]

48. In 1978, prior to his employment by Lambeth Council, Paul became a special constable working from the West End Central Police Station in London. Records from Operation Bell refer to him being stopped in July 1979, when he was a special constable, in suspicious circumstances in the toilets at Piccadilly Circus. He remained a special constable until he resigned in October 1981 citing pressure of work.

49. The extent of Paul's offending was only revealed, incrementally, over the course of three prosecutions.[165] Lambeth Council is now aware of at least 43 children who have alleged sexual abuse by Paul, 39 of whom were in the care of Lambeth Council.[166]

50. During his employment, there were suspicions and concerns about Paul's inappropriate conduct towards children, which did not result in an investigation into Paul.

50.1. One care worker at South Vale in the late 1970s and 1980s recalled one child, aged approximately nine years old, who needed cream applied to his anus and Paul volunteered to do this. He also offered to supervise the boys' showers. She attended a camping trip with Paul and some boys from South Vale; she slept in one tent, he slept in another with the boys. She also referred to him taking boys to Soho, with which she disagreed. Given Soho's reputation at this point in time, that Paul was taking children there should have prompted immediate action and investigation. She told police about these incidents in 2003 but said that "*It was at the point of his conviction that the things I have mentioned in this statement took on significance*".[167]

50.2. A child reported concerns to staff at South Vale because he was worried about the level of interest that Paul had in another child.[168]

50.3. One social worker confirmed to the police that in the late 1970s or early 1980s LA-A19, a child he was responsible for, told him he was being sexually abused by Paul at South Vale. He described the child as very quiet and matter-of-fact. The social worker believed him.[169] The child said that he did not want the police informed. The social

[163] Opening Statement 29 June 2020 53/17-21
[164] LAM030157_049
[165] LAM030157_050-051
[166] LAM030157_045
[167] MPS000361
[168] Annie Hudson 21 July 2020 77/8-11
[169] MPS000544_003-004

worker stated that he discussed this with a team manager, who said they had to respect the child's wishes. LA-A19 was returned to South Vale, where Paul was still working, until another placement was identified. The social worker said that as the child's social worker he was probably the only person to whom this child could have turned.[170] In the face of credible information Paul was left in an immediate position whereby he could abuse children. No investigation was initiated into the allegations.

50.4. Another child sexually abused by Paul left South Vale to live in a different institution in 1989. His social worker knew that he was living with Paul at weekends and that Paul took the child on a three-week holiday. It was, however, his mother who expressed concern to Lambeth Council about the expensive gifts Paul was buying for her son. The mother was articulating a fear about what might be happening to her child.[171]

50.5. A team leader who worked at South Vale in the mid-1980s subsequently stated that there was concern about Paul seeing children who had lived at South Vale outside work.[172]

(If these matters were reported to the Zephyrine inquiry – discussed below – they are not dealt with in its report.)

51. Despite these concerns, Paul was not apprehended until Operation Bell in 1992. Of the four men investigated as part of that investigation, Paul was the only person convicted.

52. As part of Operation Bell, Paul was charged with nine offences of child sexual abuse in respect of LA-A17, LA-A157 and LA-A319, one of whom was in the care of Lambeth Council at South Vale.[173] At the time of the abuse, all of the children were aged 14 or 15 years. Paul gained the trust of a parent in order to be able to sexually abuse two of these children.[174]

53. Paul was convicted in January 1994 of two counts of indecent assault, one count of indecency with a child and one count of taking indecent photographs of a child.[175] He was sentenced to two and a half years' imprisonment.[176]

54. Operation Bell also investigated whether Paul was involved in the commercial making and distribution of indecent imagery of children.[177] When Paul was arrested, police searched the flat and found a large quantity of photographs, videotapes, photographic slides and computer discs, many of which depicted naked images.[178] Some of these images appeared to be of young people around the age of 16 years old. Numerous photographs of children were found during the search of his flat. A number of his victims have described being photographed by him.[179] He also made a film showing the abuse of a child in the care of Lambeth Council. Concerns have endured that Paul was involved in the large-scale production of pornography and indecent images of children and that other staff from Lambeth Council may have been involved. The extent to which this featured in Operation Bell is considered in Part J.

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170 Annie Hudson 21 July 2020 83/13-84/7; MPS000544_003-004
171 Annie Hudson 21 July 2020 81/10-83/12
172 Annie Hudson 21 July 2020 77/5-8
173 MPS004500_251-252
174 MPS004500_239
175 LAM030157_050-051; LAM029331_054
176 LAM030157_050-051
177 Simon Morley 22 July 20201 25/2-26/22
178 MPS004500_240
179 MPS004500_018 _240 _260-261; LA-A300 20 July 2020 40/19-21, 43/7-16 and 44/22-45/3

55. In Operation Middleton, Paul featured prominently in that 11 individuals came forward to allege that they had been sexually abused by him. He was again arrested and charged in respect of the sexual abuse of six children.[180] He was convicted in November 2002 of five counts of indecent assault against four children. The children were aged between 12 and 17 years at the time of the abuse. Paul was sentenced to 18 months' imprisonment. Three of those whom he sexually abused provided evidence of the devastating effect that this abuse had on their later lives.[181]

56. Following Operation Trinity in 2016, Paul was convicted of 18 counts of child abuse against four children (15 counts of indecent assault, one count of indecency with a child, one count of aiding and abetting indecency with a child and one count of making an indecent image). The victims were all children who had been in the care of Lambeth Council and placed at South Vale between 1980 and 1988 whilst aged between 10 and 14.[182] The charges included one case where the victim was subjected to "*vile group sexual abuse*" with other unidentified men. Paul was sentenced to 13 years' imprisonment, and the judge commented that Paul was knowledgeable about and in contact with "*a group of paedophile men*".[183]

57. In addition to evidence about the offences for which Paul was convicted, the Inquiry also heard evidence from core participants who had lived at South Vale about their experiences as children in Paul's care. LA-A300 described herself as able to "*get away with things*" with Paul, and that he gave her cigarettes, sweets and money.[184] She described going to Paul's home and taking other children there, where they would drink, smoke and eat.[185] Even when she moved to another home, LA-A300 ran away to Paul's home.[186] She described the attention that she received from him as being the first time anyone had paid attention to her – "*Finally, somebody is just paying me a bit of attention*".[187] LA-A300 also recalled that he had a dark room at his flat and many photographs of children. There "*was a wall and it was just full of black and white pictures. I'd never seen anything like it*".[188] Paul always had a camera on him but she never heard anyone query this.[189] LA-A300 also told us that, on one of the occasions she stayed with him, Paul tried to rape her.[190]

58. LA-A7 was abused by Paul, who had been his key worker. He described how, on one occasion, Paul also took him to his flat to take photographs of him. Paul then tried to sexually assault him. LA-A7 said that he ran into the road crying and that the police must have been called because that is how he got back to South Vale.[191] He gave evidence at one of Paul's trials and Paul was convicted of abusing him.[192] LA-A7 told the Inquiry that the trial had been a very traumatic experience.[193]

59. One victim of Paul, LA-A19, reported in 2014 that he had been sexually abused at an unknown address by four men, one of whom was Paul. Lambeth Council confirmed to the Inquiry that it had no evidence or information as to how LA-A19 came to be abused by a

[180] LAM030157_51
[181] MPS004500_288-289_291-292
[182] LAM029331_055
[183] LAM030157_050-051; INQ006464
[184] LA-A300 20 July 2020 40/19-41/8
[185] LA-A300 20 July 2020 42/16-25
[186] LA-A300 20 July 2020 43/20-23
[187] LA-A300 20 July 2020 42/4-5
[188] LA-A300 20 July 2020 43/8-9
[189] LA-A300 20 July 2020 42/24-43/16 and 44/19-45/3
[190] LA-A300 20 July 2020 52/17-53/7
[191] LA-A7 29 July 2020 138/18-139/1
[192] LA-A7 29 July 2020 138/22-139/1
[193] LA-A7 29 July 2020 139/15-23

group of men.[194] Paul was however charged and convicted as part of Operation Trinity with aiding and abetting the sexual abuse of LA-A19 by others. This offence occurred between 1980 and 1983, when LA-A19 would have been aged between 10 and 13 years.[195]

LA-F8 (1987 to 1992)

60. LA-F8 was a children's residential care officer at St Saviour's children's home from November 1987 until its closure in September 1988. He then went to work at South Vale, where he was promoted to team leader in April 1989 (until April 1991, when he moved to the Adoption and Fostering Team).[196]

61. In 1989, another staff member found LA-F8 on a bed with a child (LA-A71).[197] She reported it to the Zephyrine inquiry.

62. In 1989, the assistant manager at South Vale found LA-F8 in a room with LA-A71, who was entirely undressed.[198] Although she should have done so, she did not report this to the Zephyrine inquiry or anyone else until 1992, when LA-F8 was subject to criminal investigation. Her explanation for not reporting it was that the officer in charge (LA-F205) favoured LA-F8 and was not supportive of her.[199] Ms Hudson confirmed that there are records which stated that the manager of South Vale, LA-F205, had a "*fascination*" with LA-F8.[200]

63. In 1991, LA-F8 was a short-term carer for periods of a week or two for LA-A71. LA-A71 was 14 years old at the time.[201] This was sanctioned by children's social care, despite concerns already raised about LA-F8.[202]

64. LA-F8 was arrested in November 1992 during Operation Bell's investigation into South Vale. The Metropolitan Police Service arrested LA-F8 due to evidence from social workers about LA-F8's conduct towards LA-A71.[203]

65. The child involved (LA-A71) did not make any disclosure during Operation Bell. DI Morley said in evidence that LA-A71 was initially not responsive to questions and that later his social worker informed police that LA-A71 did not want to speak to police. No further action appears to have been taken to obtain an account from LA-A71 and LA-F8 was not charged. DI Morley told us that there is "*no rationale for this decision in the Operation Bell files, but it seems likely that it would have been based – at least in part – on the refusal of the complainant to speak with police*".[204]

66. In 1993, a disciplinary process which was held after the completion of a management investigation – based on the same two incidents in which LA-F8 was found with children in wholly inappropriate situations – concluded that LA-F8 was guilty of gross misconduct.[205] The disciplinary panel included Verley Chambers (assistant director of community services)

[194] LAM030157_095-096
[195] MPS004500_299
[196] LAM030157_084
[197] Annie Hudson 21 July 2020 70/8-21 and 73/15-18
[198] Annie Hudson 21 July 2020 70/22-71/11
[199] Annie Hudson 21 July 2020 73/14-19
[200] LAM030157_085
[201] LAM030157_085
[202] Annie Hudson 21 July 2020 75/13-76/14
[203] LAM030157_085
[204] MPS004500_318
[205] Annie Hudson 21 July 2020 73/2-6 and 74/12-75/12

as chair. David Hine (principal manager, children's homes) was presenting manager. The panel recognised and proceeded on the basis that this was serious misconduct. LA-F8 should have been dismissed, but instead the panel gave him a final written warning with a direction that he should not work with children.[206] LA-F8 remained employed by Lambeth Council (where he then worked with vulnerable adults).

LA-F5

67. LA-F5 worked at Lambeth Council between January 1988 and September 1992, first as a senior residential care officer (until June 1988) and then as an assistant group leader (until October 1989) at South Vale. Between 3 October 1989 and 25 September 1992 he worked as a social worker at Family Finders, the Lambeth Council in-house fostering service.

68. In December 1992, LA-F5 was arrested as part of Operation Bell and charged with sexually abusing LA-A80, who alleged that LA-F5 sexually abused him when he lived at South Vale between 1988 and 1989.[207] LA-A80 would have been eight or nine years old at the time. During Operation Bell, a team leader at South Vale confirmed that "*LA-A80 and LA-F5 seemed very close, especially in the mornings*". An assistant unit manager confirmed the same information to the police.[208]

69. LA-A80 gave evidence at the trial of LA-F5 in 1993. LA-A80 found giving evidence "*extremely distressing*". The allegations were dismissed when LA-A80 did not want to continue being questioned.[209] At the time LA-A80 was 12 years old, with special educational needs and learning difficulties.[210]

70. Despite the gravity of the allegation and that the trial ended without LA-A80 being able to finish his evidence, there is nothing to suggest that Lambeth Council instituted any form of internal investigation into LA-F5.[211] LA-F5 had been able to resign from being a social worker at Family Finders before the trial, in September 1992. The exact circumstances in which he resigned are not known but it is clear that this was a matter of days after LA-A80 made the allegations of sexual abuse.

Patrick Grant

71. Patrick Grant came to work at South Vale after his acquittal in December 1978 and his qualification as a social worker. He became a manager at South Vale in July 1980 until 16 October 1981.

72. As noted above, in 2015 Paul was convicted of the sexual abuse of LA-A19, who also alleged that he was sexually abused by Grant whilst at South Vale, between 1980 and 1981. LA-A19 would have been 10 years old at the time. He disclosed this to police during a police interview which took place in 2014 as part of Operation Trinity. LA-A19 identified Grant at an identity parade. The investigation into Grant took three years and he was charged in 2018. LA-A19 gave evidence against Grant at his trial in 2019. Grant was convicted of having sexually abused a child from Shirley Oaks. He was acquitted in respect of LA-A19's allegations.[212]

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[206] LAM030156; Annie Hudson 21 July 2020 74/12-75/12
[207] MPS004500_231
[208] LAM030157_070
[209] LAM030157_070_073
[210] LAM030157_070
[211] LAM030157_065
[212] LAM030157_064

73. The Inquiry is aware of other individuals who lived at South Vale and who allege that they were sexually abused by Grant.

74. It is clear that LA-F5 (1988–1989), LA-F8 (1988–1991) and Paul (1979–1991) overlapped while working at South Vale. Grant's employment at South Vale (1980–1981) overlapped with Paul's employment. The same child alleged that he had been sexually abused by Temple and then by his replacement Grant at Shirley Oaks. LA-A19 alleged that he had been separately sexually abused by Grant and Paul. This evidence demonstrates that children may have been sexually abused by successive carers. It also shows the movement of abusers between homes.

75. There is no direct evidence that any of the care workers at South Vale accused of sexual abuse coordinated sexual abuse or abused children together.[213] Nevertheless, that these staff were all employed at South Vale during a relatively short period in the home's history suggests that their concurrent employment was more than mere coincidence.[214] It either points to the poor management of South Vale as attracting individuals with a sexual interest in children (or enabling them to remain employed there) or that these men (and possibly their sexual proclivities) were known to each other. It is highly unlikely that the allegations against these individuals and the convictions of Paul reflect the totality of the sexual abuse of children at South Vale.

Other abusers

76. Several witnesses gave evidence to the Inquiry about sexual abuse while they were resident at South Vale.

> **76.1.** LA-A131 described South Vale as a place of emotional, physical and sexual abuse. He said that he was sexually abused by one male member of staff, in the early 1980s, as well as subjected to physical and emotional abuse by another male member of staff.[215]
>
> **76.2.** LA-A7 told us that he suffered physical and sexual abuse in the late 1970s and early 1980s. He described being indecently assaulted at bath-time by LA-F24. LA-F24 also took him to his flat where a camera was set up, and he would photograph LA-A7 naked.[216]
>
> **76.3.** LA-A312, who was placed at South Vale and Shirley Oaks, said that he was anally raped and physically abused by a member of staff on three occasions at South Vale. This occurred in the late 1970s. He also met a barber who took him to his shop and took photographs of him naked. He was made to meet other men (including a man in a toilet in Croydon who sexually abused him) and told that, if he did not, the naked photographs would be shown to his family.[217]

B.4: Increased risk of sexual abuse

77. Adults were given access to children in the care of Lambeth Council without appropriate checks or supervision. Hook was able to secure a live-in position in a Shirley Oaks cottage, despite little being known about him. LA-A138 told us that a man (Clarke) – who he assumed

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213 MPS004512_023
214 LAM030157_095
215 LA-A131 29 July 2020 134/18-20
216 LA-A7 29 July 2020 138/3-14
217 LA-A312 29 July 2020 113/5-13

was a member of staff at Shirley Oaks but later discovered was a volunteer – visited and played football with the children; he also allowed children to drive his car while sitting on his lap and would indecently touch them while they did so.[218] LA-F39 was employed by Lambeth Council in 1990, despite a conviction (and five-year prison sentence) for unlawful wounding.[219] He went on to work at other children's homes in Lambeth, including Monkton Street and Chestnut Road. He was the subject of allegations of sexual abuse at Chestnut Road which were considered in the Evans report in 2000. The Evans report noted that:

> "*some senior managers of the Directorate had been oblivious to the potential danger that a convicted criminal with offences such as those committed by* [LA-F39] *posed to vulnerable children. As can be seen the appointing officer was perfectly aware of the convictions from as early as June 1990 and was also aware that* [LA-F39] *had falsified his declaration in respect of these – in itself a serious matter.*"[220]

78. Shirley Oaks and South Vale exposed children to the risk of sexual abuse. Isolation, violence, intimidation and humiliation would almost certainly have deterred many children from reporting sexual abuse at the time. Other children from these homes did report sexual abuse. The evidence demonstrates that some staff had suspicions or even knowledge that children were being sexually abused. A common issue in both case study homes was that where sexual abuse was disclosed or suspected, it was not adequately responded to. Failures to respond to allegations perpetuated sexual abuse.

79. Another common theme is the extent to which lack of oversight or intervention exposed children to the risk of sexual abuse. Both homes were "*organised and engineered to preserve the interests of those with power and authority rather than protecting children in their care*".[221] This is demonstrated by attitudes and responses to racism and the consistent priority given to the interests of staff above those of children.

80. There was also a lack of professional concern from some Lambeth Council social workers for children in care.

81. LA-A138 said he would be told that his social worker was coming to see him, only for them not to attend – he felt that he was just "*a number*".[222] He did not disclose abuse by multiple perpetrators at Shirley Oaks. When he was 12 or 13 years old, a member of staff at Shirley Oaks started to show an interest in him:

> "*there was one occasion when I was sat in her car with her, and she basically put her hand on my leg and said she wanted to sleep with me*".[223]

82. LA-A138 said he did not tell anyone "*because they wouldn't have believed me*". His sense of his social workers was that they were not interested in his well-being:

> "*All they were trying to do was get you off their books, get rid of the problem*".[224]

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[218] LA-A138 6 July 2020 17/24-18/17
[219] Annie Hudson 21 July 2020 57/12-19
[220] Annie Hudson 21 July 2020 58/12-19; LAM012344-065
[221] LAM030157_061
[222] LA-A138 6 July 2020 12/2-6
[223] LA-A138 6 July 2020 12/6-13/2
[224] LA-A138 6 July 2020 14/11-12

A closed environment

83. Shirley Oaks operated as a self-sufficient village, giving children little access to the outside world. Schooling, leisure and medical facilities were provided on-site. Many children referred to not leaving the site at all.[225] LA-A158, a victim of long-term sexual abuse, recalled:

> "*we were very isolated at Shirley Oaks. You went to school on site until you were 11 years old. Everything was provided for. We never went shopping for clothes or food. We had our own swimming pool so we never had to leave site even, for swimming lessons. We went on holiday for two weeks in the summer, which is probably the only time we saw proper shops.*"[226]

84. South Vale also operated on its own terms and with little external scrutiny. It was an oppressive place for children to live, more like a place of punishment than a home for children. From the outset of its opening in 1967, South Vale appears to have been a restrictive and punitive environment. LA-A449, who was in care at South Vale in the early 1970s, described not being allowed to leave without staff present. He felt locked up and imprisoned.[227] LA-A300 also described South Vale as being like a prison in the late 1970s:

> "*Literally, every door was locked behind you. I just always remember, you went through that door, they locked it; you went through the next door, they locked it.*"[228]

An early record shows the foster carers of one child to have described children as "*virtually imprisoned in Southvale*".[229] They also raised the concern with the children's officer that their foster child described having clothes taken away from her at South Vale and being made to wear the institution's clothes. This worried them as they had been taught by the childcare officer that this removed a child's sense of identity.

85. Issues about the manipulation and humiliation of children were raised, in 2013, by a former temporary staff member at South Vale in the 1980s, who explained to the police its operation. Many children stayed at South Vale for years. It was staffed by individuals untrained in social care and childcare. Favouritism was displayed towards certain children, particularly by Paul. The former staff member also said that there was a culture of not believing children at South Vale, justifying this by referring to their histories and using their past experiences against them. The more the children raised concerns, the less likely they would be believed.[230]

86. These observations were an echo of the serious concerns raised by two members of South Vale staff who came forward in 1989, resulting in the Zephyrine inquiry. One said that the environment was punitive with excessive control, emotional and physical abuse, and inappropriate restraint. Children were called "*animals*" by South Vale staff, "*humiliated, intimidated and bullied*" (as well as having their care histories used against them or mentioned in front of other children), with "*all the spark gone from them*".[231] The care worker tried to talk to senior staff at South Vale about her concerns but was told that "*We do things our way here, and if you don't like it, leave*".[232]

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[225] Opening Statement 29 June 2020 18/21-22
[226] Opening Statement 29 June 2020 29/2-12
[227] LA-A449 29 July 2020 98/6-10
[228] LA-A300 20 July 2020 38/16-21
[229] Opening Statement 29 June 2020 46/3-47/6
[230] MPS000523_003
[231] Annie Hudson 21 July 2020 62/25-64/9; LAM013310
[232] Annie Hudson 21 July 2020 64/10-21; LAM013310

87. As a result, in July 1989, Lambeth Council initiated an internal inquiry to investigate allegations from staff members of racism and sexism, as well as poor childcare and management practices. The panel was chaired by Edgar Zephyrine, principal manager, community and voluntary services.[233] Its conclusions were published in January 1990, in a report entitled *Quality and Equality: The Report of the Enquiry into the South Vale Assessment Centre* (the Zephyrine report).[234] It was critical of the management culture and practices at South Vale. It recommended that the centre be closed for up to three months in order to allow a restructure of the management, staff and working practices. However, there were flaws in the inquiry.

87.1. There was no analysis of the allegations made by care workers which had prompted the investigation.

87.2. Sexual abuse was not addressed.[235] The report noted that there was a strong view that LA-F8 was favoured by the officer in charge and received special privileges, but it failed to mention that it had been reported to the panel that LA-F8 had been found on a bed with a child.[236] Mr Zephyrine later confirmed that the allegation was made to his panel, but that they accepted LA-F8's version of events.[237] That the Zephyrine report does not mention the allegation or the basis on which they preferred LA-F8's version of events demonstrates poor judgement and lack of child focus. The Zephyrine report should have considered explicitly whether there was "*a potential for sexual abuse*" at South Vale, and whether the "*environment was safe and … children could speak out*" if they needed to.[238] Instead, it focussed on "*staff and management and about keeping control rather than about how you create a kind of good home for children*".[239]

87.3. Despite its terms of reference empowering it to hear evidence from children, the panel did not speak to any children.[240] They did speak to 50 members of staff.[241] As a result, the focus of the Zephyrine report was the staff. For example, it referred to staff not seeing the regime as institutional or repressive. It identified that children were not allowed to attend an external therapeutic group if they misbehaved; they had to wear night clothes from an early point in the evening; they lacked any free time not under observation; and they were silenced during meals.[242] Despite this, as Ms Hudson accepted, the Zephyrine report "*dismissed and minimised*" allegations of emotional and physical abuse.[243]

87.4. The recommendations arising from the Zephyrine report were "*weak*", with little clarity as to what was wrong and what was needed to put things right.[244] Detective Superintendent Brian Tomkins, senior investigating officer at Operation Bell, described the Zephyrine report as being shallow, with little depth to the questioning of witnesses.

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[233] LAM029331_182
[234] LAM029172; Annie Hudson 21 July 2020 65/23-66/2
[235] Annie Hudson 21 July 2020 70/8-16
[236] Annie Hudson 21 July 2020 70/8-16 and 73/15-18; Officers from Operation Bell also discussed this incident with Mr Zephyrine, who confirmed that the allegation was made to his panel but that they accepted LA-F8's version of events (OHY009725). The Zephyrine report did not explain the basis on which LA-F8's version of events was preferred.
[237] OHY009725
[238] Annie Hudson 21 July 2020 71/3-11
[239] Annie Hudson 21 July 2020 68/3-5
[240] LAM029331_182-183; LAM029172_009-010
[241] LAM029172_009; Annie Hudson 21 July 2020 66/15-24
[242] Annie Hudson 21 July 2020 68/11-69/6; LAM029172_017
[243] Annie Hudson 21 July 2020 67/8-16
[244] LAM029172_030-033; Annie Hudson 21 July 2020 67/16-20 and 69/10-70/7

The fact that no children were interviewed suggested that it had been intended only as a means of changing the regime at the home, not to identify and investigate malpractice.[245]

Violence and intimidation

88. In both homes children experienced violence and intimidation. Children's lives at Shirley Oaks were bleak and, in some cases at least, they endured hardship or suffering worse than that which brought them into care. There was little evidence that the house parents provided supportive and nurturing environments.

88.1. LA-A449 was abused between 1976 and 1978, and recalled Shirley Oaks as a threatening and violent environment:

> *"I remember often witnessing the children crying or cowering in the corners of the home. Children were scared on site."*[246]

88.2. LA-A354 lived at Shirley Oaks in the mid-1970s. He told us that the mistreatment and abuse he experienced there came to feel normal:

> *"when you start hearing those words and that treatment, you know, the punishment methods they used to use, you think it's normal. You think that's how everybody else is treated … ".*[247]

88.3. LA-A299 was taken into care in the late 1970s when he was just under eight years old.[248] When he first arrived, he was taken to see the doctor at Shirley Oaks, who sexually assaulted him. LA-A299 told the house mother, and he said that she ensured he did not see the doctor alone again.[249] LA-A299 also described bullying and intimidation by other children, which escalated to him being raped by another child. His house father at Shirley Oaks forced him and his siblings, who were Muslim, to eat pork.[250]

88.4. LA-A325, who was sexually abused in the 1970s and lived at Shirley Oaks as well as other care homes in Lambeth, told us:

> *"I thought that being in care would mean that I would be treated better than I was at home. In fact, I was treated a lot worse."*[251]

89. LA-A354 was placed at Shirley Oaks in the mid-1970s, when he was four or five years old. He told us about a man who put children on his lap to drive his car at Shirley Oaks, and also put children's hands on his genitals:

> *"I didn't know how wrong it was – because I was so young, I didn't understand that."*[252]

[245] Simon Morley 22 July 2020 21/4-22/7
[246] LA-A449 29 July 2020 98/11-13
[247] LA-A354 20 July 2020 9/9-15
[248] LA-A299 1 July 2020 44/21-45/16
[249] LA-A299 1 July 2020 53/21-55/20
[250] LA-A299 1 July 2020 48/11-49/9
[251] LA-A325 29 July 2020 103/23-25
[252] LA-A354 20 July 2020 13/1-16

He also told us about everyday cruelties and humiliations at Shirley Oaks. If children were caught talking after they had gone to bed, they were made to empty out the contents of the kitchen cupboards and replace them correctly or be made to start again – "*That could take hours. That could take most of the night*".[253]

90. If children were heard to speak after they had gone to bed, LA-A138 (who was placed at Shirley Oaks aged three) said that they were made to stand in a locker room facing a wall in a particular position, such as standing with their arms out.[254] He described children being hit over the knuckles or head with cutlery at mealtimes.[255] When LA-A138 moved to a new cottage at Shirley Oaks, a female member of staff was very violent and would hit children – he described it as a "*real eye-opener*", adding that "*it was really violent stuff*".[256]

91. South Vale was managed in an authoritarian, punitive style.

91.1. Russell Specterman was in care from the age of 11 in the 1970s and 1980s. He was placed at Shirley Oaks, South Vale, in foster care and at other care homes. He recalled being constantly frightened at South Vale. He said that staff in charge were violent and spiteful. One staff member told him he would end up in prison just like his father.[257]

91.2. LA-A309 was placed at South Vale, Shirley Oaks and Chevington in the 1970s and 1980s. She described South Vale as a horrible place:

> "*Most of the staff were horrible to you and did and said things to humiliate you.*"[258]

The shock and stress led LA-A309 to start bedwetting, which in turn led to her being punished. She remembered having her head shaved to prevent her from running away.[259] She also said that the worst thing she ever witnessed was at South Vale, the rape of an eight-year-old girl. A group of older boys forced another boy with learning difficulties to rape the girl. LA-A309 was forced to watch and threatened with being next.[260]

Racism: policy and practice

92. In February 1980, a report prepared by a race relations adviser and presented to the Social Services Committee noted the concern within the black community in Lambeth about appropriate standards of care for black children in local authority care. The report highlighted the specific needs of black children and the need to employ staff able to meet their needs.[261] On 15 April 1981, a further report – *Black Children in Lambeth Residential Care* – was presented to the Social Services Committee. It stated that "*the numbers of black children in residential care are disproportionate to their representation in the overall child*

[253] LA-A354 20 July 2020 4/16-5/11
[254] LA-A138 6 July 2020 3/14-4/13
[255] LA-A138 6 July 2020 7/23-8/21
[256] LA-A138 6 July 2020 9/15-18
[257] Russell Specterman (formerly LA-A243. Mr Specterman waived his right to anonymity in relation to his involvement in this investigation following the investigation's public hearing) 29 July 2020 101/5-10
[258] LA-A309 29 July 2020 114/13-15
[259] LA-A309 29 July 2020 114/15-20
[260] LA-A309 29 July 2020 115/4-10
[261] LAM015618

population". The report made a number of recommendations, including the need to "*recruit more black staff for residential establishments*" and "*maximise the number of black foster and adoptive parents*".[262]

93. Lambeth Council went on to produce the *Good Practice Guide for Working with Black Families and Black Children in Care*.[263] This referred to it being "*essential that work with black families and black children in care fully takes into account the dynamics and cultural milieu of black families as well as recognising the impact of racism*". With regard to placements of children with substitute families, it emphasised that an "*essential ingredient of any substitute home for black children should be the ability of the placement to encourage and enhance positive black identity in the child*".

94. In 1986, Lambeth Council set out its same-race placements policy. The stated aim of the policy was that "*no child should remain in residential care without a family placement being tried and that the family placement should reflect the child's own ethnic origin and family background*". The timescale for ensuring that black children should be placed with black families was set as being by 1 April 1988.[264]

95. The reality was that during 1990 and 1991, 85 percent of children who lived at South Vale were black.[265] Their disproportionate representation in a home like South Vale demonstrated that the longstanding policy aim of placing black children in foster care was not being met.

96. One of the terms of reference of the Zephyrine report was to investigate racism at South Vale. It reported on racism at chapter 7 ('South Vale and Equal Opportunities'). One member of staff referred to children's requests for food appropriate to their ethnic background being "*trivialised and ignored*". Black children were made to use the same skin and hair products as white children, showing a "*total disregard*" for their specific needs.[266] The findings about children (chapter 7, section 1, subsection 'Racism and Child Care Practice') included the availability of "*ethnic meals*", the absence of a diverse range of books and magazines and that staff lacked awareness of Lambeth Council's *Good Practice Guide for Working With Black Families and Children in Care*.[267]

97. Ms Hudson explained that there had been "*multiple allegations*" about Paul's racist behaviour and about the inappropriateness of him working in a children's home.[268] In 1984, Paul was given a written warning following a disciplinary process into allegations that he had made a racist comment to a child and other inappropriate comments.[269] An allegation was also made in 1990 by a residential social worker which referred to Paul being racist.[270] A parent also alleged that Paul had used offensive, racist language towards them.[271] It appears that Paul went on sick leave and then took up an administrative position in Area 8. He was not suspended until a police investigation in 1992 revealed him to have been in possession of indecent images of children.[272]

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262 LAM010408
263 LAM014686
264 LAM029175
265 LAM030157_018
266 Annie Hudson 21 July 2020 64/22-65/4; LAM013310
267 LAM029172_21-22
268 Annie Hudson 21 July 2020 78/12-13
269 Annie Hudson 21 July 2020 78/17-19
270 Annie Hudson 21 July 2020 80/5-7
271 Annie Hudson 21 July 2020 80/17-21
272 Annie Hudson 21 July 2020 80/5-16

98. The evidence we heard demonstrated that once in care, far from their needs being given specific consideration or a sense of identity being encouraged, children from black, Asian and ethnically diverse backgrounds experienced overt racism. This had a lasting impact.

98.1. LA-A354 told us that staff at Shirley Oaks had "*no fear of using racist words*", and that these words became so normal that they lost significance to him.[273] Other children also experienced racism. LA-A24 also described regular racist abuse at Shirley Oaks. He said that one house parent made up racist phrases about him which the other children would copy.

> "*being at Shirley Oaks made my whole life hell*".[274]

98.2. One house father at Shirley Oaks called LA-A138 racially abusive names and would not let him participate in games.[275] He also told LA-A138 that he:

> "*didn't want me in the house because there were enough black people in the house and he didn't want any more and he wasn't the sort of person that felt like black kids and white kids should play together*".[276]

98.3. LA-A309, who was placed at Shirley Oaks in the mid-1970s, said that her house parents told her that children of mixed parentage ended up in care, that races were not supposed to mix, and that the Bible forbade mixed relationships.[277]

98.4. LA-A456 was placed at Shirley Oaks when she was 12 years of age. She said that LA-F322 raped the girl with whom she shared a bedroom, and described hearing awful sounds coming from the girl's bed and shaking with fear. LA-F322 went on to sexually abuse her. She could not believe that this would happen in a children's home.[278] Her house parents at Shirley Oaks who were white would not let her play with their daughter because of her ethnicity. Staff were racist and would say they would make her "*clean and white*". Racial abuse was a daily occurrence.

98.5. LA-A304 was placed in various care homes and alleged sexual abuse by a male member of staff at a care home between approximately 1979 and 1982, involving forced oral sex and digital penetration. She described being racially abused during this sexual abuse. She recalled Shirley Oaks staff witnessing the abuse:

> "*On one occasion, the lady I mentioned walked into the kitchen and saw us in a cupboard with the man and walked straight back out again. She didn't do anything to stop what was going on or ask what was going on.*"

She told the house mother about a cigarette burn inflicted by her abuser, but she was told that "*I shouldn't tell tales … She told me if I complained no-one would believe me*".[279]

LA-A304 describes never having her cultural needs met and the house mother being unable to manage her hair, so much so that she cut it off so she did not have to comb it.[280]

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[273] LA-A354 20 July 2020 8/9-23
[274] LA-A24 6 July 2020 94/15-16
[275] LA-A138 6 July 2020 10/17-11/7
[276] LA-A138 6 July 2020 10/14-17
[277] LA-A309 29 July 2020 114/21-115/3
[278] LA-A456 29 July 2020 158/5-21
[279] LA-A304 31 July 2020 36/6
[280] LA-A304 31 July 2020 35/12-15

Part C

Children with complex needs and communication difficulties

Children with complex needs and communication difficulties

C.1: Introduction

1. Children with complex needs and communication difficulties are among the most vulnerable in society, including to sexual abuse. The terms 'complex' or 'additional' needs encapsulate a range of conditions that affect a child's ability to communicate, including intellectual disability, mental health problems and physical impairments. Small communication signs or changes in behaviour indicating sexual abuse can be both harder to identify in children with complex needs and more easily dismissed, particularly when the child is cared for by multiple carers.[281]

2. In order to examine how complaints of sexual abuse from children with communication difficulties were dealt with, we considered documentary evidence and heard from witnesses involved in investigations into allegations of abuse at two of Lambeth Council's homes for children with complex needs, Ivy House and Monkton Street. We also received evidence from the mother of LA-A26, a former short-stay resident at Ivy House.

C.2: Provision for children with complex needs in the care of Lambeth Council

3. Prior to the opening of specialist homes, children in care in Lambeth with complex needs were accommodated in long-term hospital care or placed in private and voluntary homes, often far from their families, or moved from home to home.[282] One care file reviewed by the Inquiry recorded a very young child (described as having learning disabilities due to possible brain injury at birth) being in care from the age of three and moved at least 14 times during a 16-year period.[283]

4. In 1974, nine years after taking over responsibility for children's residential care, Lambeth Council acknowledged the lack of provision to meet the needs of children with disabilities.[284] Ivy House opened in 1976, located initially on the Shirley Oaks site in Croydon, to provide short breaks for 15 children with complex needs.[285] Families with children who had complex needs were entitled to six weeks per year of short-stay care. At the peak of its use in 1988, 80 families used the services of Ivy House.[286] Two further homes providing care for children with complex needs followed: Chestnut Road in 1979 for long-stay care for up to 12 children

[281] INQ005640_002-004
[282] Herbert Botley 23 July 2020 58/2-4, 13-20; LAM029781
[283] Opening statement 29 June 2020 64/23-65/5
[284] LAM029781
[285] LAM030078_008
[286] LAM029785_010; Ivy House is referred to in some documents by the address Warham Road.

and Monkton Street in 1980 for long and short-stay care for 13 children.[287] By 2000, all three specialist homes had closed: Ivy House in 1990, Monkton Street in 1996 and Chestnut Road in 2000.[288]

5. Allegations of sexual abuse at Ivy House were investigated by Lambeth Council staff in 1985 (the initial investigation into the Ivy House complaint)[289] and 1986 (the Management investigation into the Ivy House complaint). There were also two investigations related to Monkton Street in 1987 and 1988 (the first Monkton Street report and the second Monkton Street report).[290] Although the Metropolitan Police Service was involved, there were no prosecutions in relation to either home. A report in 2000 into the closure of Chestnut Road revealed that complaints of sexual abuse had also arisen there in the late 1990s. At the time, Lambeth Council concluded that there was insufficient firm evidence to form the basis of any disciplinary proceedings.[291]

C.3: Case study: Ivy House

6. In 1984, LA-A26 – a teenage girl with learning difficulties and autism – started visiting Ivy House for short-stay care. In December 1985, LA-A26 told her mother that she had been sexually abused by LA-F12, the assistant officer in charge at Ivy House. LA-H3, LA-A26's mother, told us that:

> "*She indicated that the perpetrator was a particular male member of staff at Ivy House. She could tell us the person's name clearly. She told us exactly what happened and where. Touching her vagina, then her mouth, she indicated that a sexual act had been performed on her. She also told me that the man had put his penis in her mouth.*"[292]

7. The following day, LA-H3 informed a social worker, Ms Anne Worthington, of her daughter's allegation. Ms Worthington in turn reported the matter to senior management.[293] LA-F12 was put on 'special leave' and the Metropolitan Police Service was contacted.[294] An initial internal investigation was carried out by Mr Don Thomas (the senior children's homes officer) who was responsible for all children's homes, Pat Salter (another children's homes officer) and a personnel officer.[295] Mr Thomas had responsibility for children's homes and was not an appropriate investigator. He was also subsequently dismissed in 1987 for his role in a fraud which involved diverting food donated to children's homes to staff, who then sold it on.[296] This investigation did not seek evidence from LA-A26 or LA-H3. Its five-page report stated that there were "*very real questions over LA-A26's ability to verbalise sentences*" and that "*it was considered very unlikely that any member of staff (male or female) would be in a position to act privately with LA-A26*". The panel concluded that they "*could not find any suggestion to proceed with the charge*".[297]

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287 LAM030068_004; LAM030078_008
288 LAM029165
289 LAM028780_097-101
290 LAM000573; LAM000575_001-002
291 LAM012344_064-065
292 LA-H3 31 July 2020 60/8-14
293 Dr Anne Worthington 2 July 2020 155/7-156/11
294 LAM028780_050-051
295 LAM029201_002
296 David Pope 8 July 2020 10/1-20
297 LAM028780_097-101

8. The police investigation commenced shortly afterwards.

8.1. Interviewing LA-A26 in the presence of LA-H3 and Ms Worthington, the police officer noted that LA-A26:

> "*was unable to communicate properly and incapable of forming a complete sentence … It was quite obvious that LA-A26 could never give any evidence in a court of law*".[298]

8.2. LA-F12 was interviewed by the police on two occasions, and "*strongly denied the allegation*".[299]

8.3. The police concluded there was no evidence to indicate a further investigation and that the matter would not be pursued.[300] The Crown Prosecution Service advised that "*it is not possible to proceed against him in view of the inability of the alleged victim to give evidence*" and "*there is no corroboration in the way of medical evidence*".[301] The Metropolitan Police Service confirmed that the matter would not be pursued.

9. LA-F12 returned to his post at Ivy House. In January 1986, Mr Robin Osmond (director of social services from 1977 to 1988) wrote to the parents of all children using Ivy House. He stated that neither the police nor the internal investigation had found evidence to support the allegations, and that he hoped "*that this letter will now put an end to any rumours or speculation*".[302]

10. LA-H3 said that, at the time, she:

> "*felt strongly that the matter had not been investigated properly. I felt that we, as a family, were not taken seriously and Lambeth would rather save the reputation of the man involved and cover up what happened to my daughter than conduct a full investigation into such a serious matter. I felt at the time, and still do, that due to LA-A26's mental disability, the matter was brushed under the carpet.*"[303]

Neither senior managers at Lambeth Council in its initial internal investigation nor the Metropolitan Police Service took any active steps to secure expert assistance to facilitate communication with LA-A26. Mr Osmond later recognised (in March 1987) that the failure to meet with the parents of LA-A26 was a "*fundamental error*" and, more generally, that an attitude by staff and middle management that discounted the possibility of a member of staff being involved in abuse was naive; "*my concern is how we do something about it in the future*".[304] Mr Thomas, who was in charge of children's homes, should not have been placed in charge of the initial internal investigation. It should have been investigated by someone from social care who was not responsible for residential homes.

11. In January 1986, LA-A26's parents instructed lawyers to make a formal complaint, demanding a full enquiry and seeking the suspension of LA-F12 pending its outcome. Councillor Lady Janet Boateng (chair of the Social Services Committee from May 1982 to April 1986) intervened on the family's behalf, and it was agreed in March 1986 that a formal enquiry would be established.[305] It was accepted by Mr Osmond that the composition of

298 OHY007771_020
299 OHY007771_020
300 OHY007771_020
301 OHY007771_025
302 INQ002123_001
303 LA-H3 31 July 2020 63/16-24
304 LAM000507_002
305 LAM028780_050-051

the panel of officers for the initial internal investigation had been inadequate, lacking both a race relations adviser and any person with specialist knowledge of child sexual abuse. Further, it was accepted that the focus of the investigation had been too limited, considering only the last visit of LA-A26 to Ivy House and failing to interview her parents.[306] Ms Waveney Williams (a senior social services manager at Lambeth Council) was appointed as chair, assisted by two panel members, a race relations adviser and an independent adviser with specialist knowledge of child sexual abuse.[307] Over 14 days in June 1986, the enquiry heard from a number of witnesses, including Ivy House staff. Dr Lorna Wing, a psychiatric consultant and expert in autism, said that LA-A26 was from a group of autistic children who did not invent. She also confirmed that LA-A26 had "*very clear and accurate speech and quite a large vocabulary*", although she noted that "*you have to know and understand LA-A26 to communicate with her fully*".[308] Mrs Ann Bannister (an independent expert in child sexual abuse from the NSPCC), who interviewed LA-A26, told the enquiry that:

> "*Because of what LA-A26 has said and demonstrated to me, I am quite sure that she has been sexually abused … In my experience of disclosures by children, LA-A26's demonstration was extremely detailed and convincing.*"[309]

The enquiry concluded in August 1986 that LA-A26 suffered sexual abuse by LA-F12 on more than one occasion at Ivy House.[310]

12. In light of this, disciplinary proceedings were brought against LA-F12 for gross misconduct.[311] Following a three-day hearing in September 1986, the disciplinary panel concluded – by a majority of two to one – that there was a high probability that LA-A26 had been abused and that this could have happened at Ivy House, but that misconduct had not been "*satisfactorily proven*".[312] One panel member, Mr Jack Smith (principal officer, social work) "*felt that the management case had proved that abuse was possible at Ivy House, but he still felt it was highly improbable*", noting that "*the risk of detection was incredibly high*" and that "*there was still a possibility in his mind that the abuse could have occurred at home. He felt that the management had not investigated the alternative places very fully*".[313] The disciplinary panel rejected the conclusions of the earlier enquiry, but the record of its deliberations did not demonstrate it engaged in detailed consideration of the evidence presented, including that of Dr Wing. It also does not appear to have taken legal advice about issues such as hearsay and the weight to be placed on evidence raised on behalf of LA-F12. The disciplinary panel's race relations adviser subsequently referred to the decision as "*unreasonable and perverse*".[314] The disciplinary panel failed to give due regard to the available evidence, including from LA-A26, and to the gravity of allegations of sexual abuse against a vulnerable child inside a children's home.

13. Despite the disciplinary panel concluding that abuse could have occurred at Ivy House, senior staff in children's social care in Lambeth Council did not take action to review the safeguarding in place at Ivy House or more widely. Instead, in November 1986, a 'review panel' (chaired by Mr Millius Palayiwa, a race relations adviser to Lambeth Council) was

[306] LAM028780_050-051
[307] LAM028780_057-058
[308] LAM029201_020
[309] LAM000502_011
[310] LAM029201_068
[311] LAM028780_041
[312] LAM029202_002; LAM029201_075-076
[313] LAM029201_072-073
[314] LAM029202_001

created to review arrangements for the investigation of allegations of sexual assault, and to consider improvements to management and supervisory systems.[315] It found that "*no system currently exists which facilitates a client making a complaint against a member of staff in a way which guarantees impartial investigation and in a way which protects the complainant*".[316] The review panel interim report recommendations (dated June 1987) included:

- developing a written complaints procedure, impartial panels and social worker support for the alleged victim and family;
- the immediate suspension of a member of staff against whom an allegation had been made;
- a homes manager responsible for personal supervision and professional development of officers in charge of children's homes, and for a full-scale review of each establishment four times a year;
- increased staff training on child sexual abuse;
- exploring the possibility of establishing, in conjunction with other South London boroughs, a child sexual abuse unit aimed at achieving an effective and coordinated approach to the issue.[317]

Mr Palayiwa submitted the review panel interim report to the chief executive, Mr Arthur John George, and considered that it was for the chief executive to take steps to publish it.[318]

14. Mr George did not publish the review panel interim report. One of the three special panel members disagreed with some aspects of the review panel interim report, which prevented it being finalised, and it appears sufficient steps were not taken to resolve this.[319] We have seen no evidence that the review panel interim report was circulated formally within Lambeth Council, including to elected councillors. No councillor who gave evidence to the Inquiry had read it. Councillor Phyllis Dunipace, who was chair of the Social Services Committee from 1986 and had expressed concerns about how LA-A26's complaint had been handled, was aware of the commissioning of the special panel.[320] She also advised councillors that any recommendations of the special panel be made available for public disclosure. This did not happen.[321] Mr Osmond was aware of the concerns of the special panel and of "*uncertainty*" regarding the publication of the review panel interim report.[322]

15. One of the review panel members, Mr William Theaker (now deceased) also attempted to pursue "*grave concerns*" about the consideration of complaints of child sexual abuse at Ivy House and Monkton Street.[323] Those concerns included the role of the police (in particular in relation to medical examinations of children), potential collusion of staff members which might have contributed to the initial dismissal of the case against LA-F12 and the ongoing employment of LA-F12.[324] Mr Theaker raised these concerns with the Social Services Inspectorate (SSI) in 1987, which in turn discussed them with Mr Osmond.[325] Mr Osmond

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[315] LAM000314_014-015
[316] INQ004910_003
[317] INQ004910_019
[318] Millius Palayiwa 3 July 2020 59/16-60/12; Millius Palayiwa 3 July 2020 65/14-66/5
[319] CQC000126_001
[320] LAM000314_014
[321] LAM000314_008, 014; Phyllis Dunipace 3 July 2020 123/21-125/8
[322] CQC000123_001-002; Robin Osmond 3 July 2020 97/20-98/16
[323] CQC000367_001
[324] CQC000367_001-003
[325] CQC000123_001-002

accepted at the July 1987 meeting with the SSI that the initial investigation by Mr Thomas into LA-F12 had been superficial and unsatisfactory. He also noted that the officer in charge of Ivy House was part of the food fraud in which the chair of the investigation, Mr Thomas, was also implicated. This pointed to collusion.[326] Mr David Lambert, the chief inspector of the SSI, commented to Mr Theaker in November 1987 that:

> "*The uncertainty about the publication of the report could be seen by some as further reason for an anxiety or concern about the willingness of the Social Services Department to act responsibly in these and future instances of a similar nature.*"[327]

However, other than meeting with Mr Osmond, it appears that no action was taken by the SSI to monitor publication of the review panel interim report or to consider any underlying concerns identified by its own chief inspector.

16. The review panel interim report was never published nor its findings and recommendations acted on. It was not until the Inquiry contacted Mr Palayiwa in 2020 that the copy of the review panel interim report he lodged at the Bodleian Library came to light.[328] Lambeth Council was unable to find any copy of the review panel interim report during the disclosure process in this investigation.

C.4: Case study: Monkton Street

17. LA-A49, a 12-year-old with significant learning disabilities, received short-stay care at Monkton Street. In 1986, approximately six months after the allegation at Ivy House, his mother noticed a blood clot and redness on LA-A49's bottom when bathing him. She told a doctor that LA-A49 had named LA-F26, a care worker at Monkton Street, and used words suggesting anal abuse. LA-A49 was examined first by a GP and then by a doctor from a hospital child sexual abuse team, neither of whom found any abnormality or indication of sexual abuse.[329] It was, however, reported to the Metropolitan Police Service and the police surgeon who examined LA-A49 concluded that there was "*overwhelming evidence of anal abuse consistent with buggery*".[330]

18. As a result, the Metropolitan Police Service immediately sought to arrange a medical examination by a police doctor for all children at Monkton Street.[331] Letters to parents referred to an incident of indecent assault that was being investigated and stated that it might be necessary for other children to be examined by a police doctor, although parents were also free to consult their own GP.[332] The police surgeon examined eight children in July 1986 and reported evidence of sexual abuse in relation to five and possible abuse in a sixth child.[333] One child, following a medical examination which required the child to be physically restrained, indicated to his mother that he had been locked in a bathroom and a man had hurt his bottom, although his mother was unable to discern any clear reference

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326 CQC000135_001
327 CQC000123_002
328 Millius Palayiwa 3 July 2020 66/7-11
329 LAM000573_013-014
330 LAM000573_016
331 LAM000573_024
332 LAM000573_008
333 LAM000573_009

to a particular member of staff.[334] No other children made any allegations of abuse. The Metropolitan Police Service arrested LA-F26 in July 1986 but did not subsequently press charges.

19. A management inquiry panel (assisted by independent advisers, including a consultant paediatrician, a child protection consultant and a team leader working within schools for children with disabilities) was established by Mr Osmond in July 1986.[335] In contrast to the initial investigation into the Ivy House complaint, its terms of reference included all alleged incidents of child sexual abuse at Monkton Street. The parents of children who were the subject of any allegations were interviewed and invited to meet the inquiry panel.[336] The management inquiry panel was unable to reconcile the contradictory medical opinions regarding whether or not LA-A49 had been sexually abused.[337] In addition, having met with the independent consultant paediatrician, the police surgeon subsequently expressed the view that, while there was justifiable suspicion in six cases that the child had been sexually abused, there was also an acceptable alternative explanation for the medical findings in each of those cases. A consultant obstetrician conducted a second examination of one child at the request of her parents and concluded that it was "*extremely unlikely*" that the child had ever been subjected to vaginal or rectal intercourse.[338] The management inquiry panel – in the first Monkton Street report (dated March 1987) – was critical of the police surgeon and the police investigation.

> "*In several cases the medical examination of children, by the Police Surgeon, involved the child being physically restrained. This may have had traumatic effects on the children concerned, and could have increased the chances of the child confusing the medical with any actual sexual abuse that may have occurred. We deplore the use of force: we think that the use of 'disclosure interviewing', in a safe and comfortable environment, linked to a medical examination afterwards, would have been a reasonable alternative … On the basis of the evidence given to us, several children were either frightened, upset or confused by the Police Surgeon's medical examination. In some cases, physical force was used to restrain the child – we think this was wrong and in itself constituted a form of child abuse.*"[339]

The management inquiry panel made a number of recommendations to Mr Osmond. Similarly to the review panel, it proposed the production of a leaflet for parents and the public on identifying and responding to suspected child abuse, increased training for staff and a review of inter-agency collaboration with the police in cases of alleged child sexual abuse.[340] There is no record, however, of its recommendations being implemented.

20. There was a second Monkton Street investigation in 1988, conducted by Heather Stephenson (social services manager) and Pauline Rowe (personnel officer). This considered whether an allegation of sexual abuse against a member of staff (LA-F2) – although referred to by the mother of LA-A49 in the first inquiry – had been fully investigated. On the basis of the original investigation and the further investigations made by the second panel, it was concluded that there were no grounds for disciplinary action against LA-F2.[341]

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[334] LAM000573_019
[335] LAM000573_001
[336] LAM000573_001
[337] LAM000573_025
[338] LAM000573_021-022
[339] LAM000573_024,026; see also LAM000573_009
[340] LAM000573_027
[341] LAM000575_001-002

21. On the recommendation of the panel, LA-F26 was reinstated but in view of the events and the feelings of parents "*to a post elsewhere in the Directorate*".[342]

C.5: Other concerns arising from the case studies

Increased risk of sexual (and other) abuse of children with communication difficulties

22. Children with complex needs are at significantly greater risk of sexual abuse.[343] As Dr Emily Phibbs set out in her report to the Inquiry (dated May 2020):

> "*Children with intellectual disabilities may struggle to access memory and cognitive functioning in a way that allows them to clearly define what has happened to them in a coherent narrative.*"[344]

Expressive language may also be impacted in the case of certain disorders. Children may lack the means to describe what has happened and are especially vulnerable to being targeted by sexual offenders as a consequence.[345]

23. Children with complex needs have varying abilities to communicate, often as a result of their developmental stage and the child's ability to adapt to their environment with social communication skills (cognitive and adaptive functioning). Communication is further hampered if adults lack the skills to overcome these difficulties.[346] Children in residential care depend on a number of carers knowing them and their method of communication. Children who communicate non-verbally – through behaviour, idiosyncratic movements or signing – may convey the trauma of sexually abusive experiences through changes in their behaviour or day-to-day functioning.[347]

24. As we saw, the inability of some adults to communicate with LA-A26 was crucial in the initial dismissal of her complaint of sexual abuse. In the 1980s, no specific guidance existed about obtaining complaints from children with communication difficulties.[348] Nevertheless it was open to both Lambeth Council and the Metropolitan Police Service in their early investigative processes to obtain specialist expert assistance, as Lambeth Council went on to do within the context of its management investigation in respect of LA-F12. Instead LA-A26's ability to provide an account of sexual abuse was discounted at an early stage.

Medical examinations of children

25. The medical examinations of children housed at Monkton Street in 1986 were inappropriate. Some were conducted at the police station, others at Monkton Street. No attempt was made to interview the children prior to any decision about the need for an

[342] LAM000573_027
[343] INQ005640_002-003
[344] INQ005640_005
[345] INQ005640_002-007
[346] INQ005640_003
[347] INQ005640_006
[348] The first edition of *Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children* was published in September 2001, and legislation around special measures to enable vulnerable witnesses to give improved evidence in court came into force in the same year.

examination. Relevant background material, such as each child's medical records, was not requested by the Metropolitan Police Service or supplied by Lambeth Council before the examinations were conducted.[349]

26. As recognised by the Monkton Street management investigation, the use of physical force during the examinations, particularly for children with complex needs and communication difficulties, caused them to be "*frightened, upset or confused*" and itself "*constituted a form of child abuse*".[350] Detective Inspector Simon Morley explained that, today, the approach of the police would be to hold an initial interview with the child at a specialist facility, with the assistance of intermediaries and working "*in partnership with other experts to enable the very, very best evidence possible to come forward*".[351] (See Part J.)

Inadequate staffing and the consequences

27. Children with complex needs require a higher staff-to-child ratio in order to provide suitable and safe care. This should have provided protection for children, limiting the opportunities for a single member of staff to have access to children out of sight of their colleagues. However, as early as 1968, Lambeth Council identified difficulties in recruiting residential staff.[352] In November 1981, its Children's Homes Sub-Committee of councillors recorded their "*extreme concern*" about staffing levels at Ivy House, Monkton Street and Chestnut Road. The staffing levels at these three specialist homes for children with complex needs were described as "*inadequate*".[353]

28. By 1988, all Lambeth Council's homes were "*running at below 60 percent of full operational capacity due to staffing shortages*".[354] The shortage appears to have remained particularly acute in the case of specialist homes, where higher ratios of staff-to-children were needed. The officer in charge of Monkton Street, Herbert Botley, resigned in January 1989 in protest at the staffing crisis:

> "*I felt unable to maintain a service that was not safe and, without some assurance of imminent practical support, my resignation was immediate.*"[355]

By February 1989, the staffing levels at Monkton House were described as in "*crisis*".[356] This should have triggered an immediate response by senior staff in children's social care in Lambeth Council to take steps to protect these especially vulnerable children.

Regulation of care workers within children's homes more generally

29. In both the Ivy House and the Monkton Street case studies, members of staff who had been the subject of unproven allegations remained in employment. LA-F12 was provided with a reference for a role involving access to adults with complex needs. At a meeting with the SSI, Mr Osmond is recorded to have made it clear that "*it was not possible in terms of employment legislation to refer to this matter if a reference from the Council was requested*".[357] Ms Annie Hudson, strategic director for children's services at Lambeth Council from May

[349] LAM000573_025
[350] LAM000573_026
[351] Simon Morley 22 July 2020 66/18-68/21
[352] LAM007940_003
[353] LAM029791_003
[354] LAM028400_004
[355] Herbert Botley 23 July 2020 63/18-64/10
[356] LAM029871_002
[357] CQC000135_001

2016 to March 2020, confirmed that the position remains the same today.[358] Where an allegation is made against an employee but found to be unsubstantiated, false or malicious, in accordance with the London Safeguarding Children Board Child Protection Procedures (the London-wide Procedures) any reference provided by Lambeth Council will not refer to that allegation, to ensure fairness towards an employee.[359] This underlines the importance of taking allegations seriously, and conducting careful and considered disciplinary proceedings.

30. It also highlights the importance of carrying out appropriate recruitment checks, to reduce the risk to all children in care. Children with communication difficulties who require additional support reporting sexual abuse are placed at increased risk when cared for by those with a history of abusive behaviour. This was evidenced in the report commissioned by Lambeth Council in March 2000 into the closure of Chestnut Road children's home. It included a section entitled 'Employment Practices – dangerous employees and the paramountcy of the welfare of the child'.[360] One employee, LA-F39, appointed by Lambeth Council in April 1990 subject to references, police checks and medical clearance, was later revealed to have committed seven offences between 1971 and 1979, including robbery, unlawful wounding, burglary and theft – with one offence resulting in a five-year prison sentence. Despite being made aware of his convictions, Lambeth Council took the extraordinary decision to confirm his appointment as a care worker working with vulnerable children – a decision which was authorised by the appointing officer.[361] LA-F39 took up a post at South Vale children's home and, while there, it was alleged he used physical force against the children, although the subsequent investigation was "*inconclusive*" because witness statements were not consistent.[362] When South Vale closed in 1995, LA-F39 was offered a post at Monkton Street; then in 1996, when Monkton Street closed, he was relocated to Chestnut Road, where allegations of sexual abuse were made against him. He was suspended following:

> "*complaints from parents that something had happened to their children whilst receiving respite care at Chestnut Road. The first child made a complaint to his mother and the second parent came forward after a letter to all parents regarding* [his] *suspension. Both cases were investigated, although complicated by the children's difficulty in communicating what had happened to them. The result was again inconclusive and the Child Protection Report found no firm evidence to form the basis of either criminal prosecution or a disciplinary hearing … It was agreed that references would be 'minimal'.*"[363]

31. In the Inquiry's Interim Report in April 2018, we recommended regulation of the children's homes workforce.[364] The Department for Education is yet to respond to that recommendation. Such regulation has been in place for several years in Scotland, Wales

[358] LAM030334
[359] London Child Protection Procedures (6th edition 2020): Allegations Against Staff or Volunteers, who work with Children at 7.7.6
[360] LAM012344_064
[361] LAM012344-065
[362] LAM012344_065
[363] LAM012344_065
[364] *Interim Report of the Independent Inquiry into Child Sexual Abuse*

and Northern Ireland, but not in England. Lord Kamlesh Kumar Patel, chair of Social Work England (which is responsible for the regulation of social workers), was asked if there were any plans for children's homes workforce regulation. He replied:

> "*So I think we've got two very concrete plans, I think, that are really important to this Inquiry. I believe there's approximately 35,000 social care workers in children's homes, and they're not regulated by anybody. I absolutely believe that we have the infrastructure, the processes, to be able to register those 35,000 individuals and give them the same conditions that we give social workers in terms of their professional standards, of their continuing professional development.*"[365]

The second plan related to students. In Lord Patel's view, student social workers should also be registered, "*not only for the pipeline and the better quality and raising standards, but for the protection of the public*".[366] Lord Patel went on to say that the Department for Education and the Department of Health and Social Care would have to "*give us those powers to regulate the children's care workforce*".[367]

[365] Lord Kamlesh Patel 28 July 2020 61/3-11
[366] Lord Kamlesh Patel 28 July 2020 62/2-4
[367] Lord Kamlesh Patel 28 July 2020 63/7-9

Part D

Case study: Angell Road

Case study: Angell Road

D.1: Introduction

1. Angell Road opened as a children's home in January 1981 and closed in March 1995.[368] It was intended to provide short-term accommodation for 15 to 16 children before they moved on to longer term placements, with two self-contained flats intended for use by staff.[369] Lambeth Council provided a corporate witness statement, by Ms Annie Hudson (strategic director for children's services at Lambeth Council from May 2016 to March 2020), which detailed the history of the home, how it operated, the background of members of staff who worked at the home and the allegations of child sexual abuse linked to the home or its staff.[370] Detective Inspector (DI) Simon Morley also provided two witness statements, on behalf of the Metropolitan Police Service, about staff members who worked at Angell Road.[371]

Angell Road children's home

2. At the time of the Lambeth Council investigation public hearing in June and July 2020, Lambeth Council was aware of 36 children who had made allegations of sexual abuse against nine adults employed by Lambeth Council or connected to Angell Road. These adults

[368] LAM030227_009
[369] LAM030227_010-011; LAM030227_014
[370] LAM030227
[371] MPS004500; MPS004545_003-004_012-013_055-056_070

included Michael John Carroll (sometimes known as John Carroll), LA-F4 and Steven Forrest, discussed further below.

D.2: Michael John Carroll: a sexual offender

3. Carroll became a full-time member of staff at St Edmund's Orphanage, Liverpool in the early 1970s. He had been a child in care there.[372] From March 1978, he worked at Lambeth Council's Highland Road children's home. He was made the officer in charge of Angell Road children's home on its opening in 1981, and remained there for the next 10 years.

4. The Rehabilitation of Offenders Act 1975, which makes provision for the circumstances in which offences become spent, is subject to a number of exceptions. These are set out in the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as amended). In 1978, one exception was employment by a local authority in connection with the provision of social services enabling the holder to have access to children. Such employment required disclosure of convictions even if they were considered spent under the Rehabilitation of Offenders Act 1974.[373] Carroll had a conviction in 1966 for the indecent assault of a child.[374] Carroll did not disclose it to Lambeth Council, as required, in his application form.[375] A check made by Lambeth Council with the Department of Health did not bring the conviction to light.[376] Consequently Lambeth Council was not aware of his conviction at the time of his original application or his application in respect of Angell Road.

5. In July 1999, Carroll was convicted of the sexual abuse of two boys in the care of Lambeth Council between 1980 and 1983, as well as nine boys from St Edmund's Orphanage in the 1960s and 1970s. The indictment before the court contained 76 counts relating to offences of child sexual abuse. Carroll pleaded guilty to 34 charges and was sentenced to 10 years' imprisonment.[377]

1986: awareness of Carroll's conviction

6. Between 1985 and 1986, Carroll and his wife (who worked at the Highland Road children's home) sought to foster a child in the care of Croydon Council.

7. During checks in its fostering process Croydon Council identified that Carroll had a conviction for the sexual abuse of a child from 1966 which he had not disclosed to Croydon.[378] Croydon Council rejected the Carrolls as foster carers for three reasons:

- The standards which applied in employing staff in residential childcare should apply equally to family placements. (In other words, if Croydon Council would not employ a convicted abuser to work in a children's home, it would not permit them to foster a child.)
- Carroll had not disclosed the conviction to Croydon Council prior to it obtaining references.

[372] MPS004545_003
[373] Section 4 of the 1974 Act read with paragraph 12 of Schedule 1 Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as it stood in 1978).
[374] LAM001506
[375] LAM001516_002
[376] LAM000020_009
[377] Gregor McGill 10 July 2020 110/8-111/1; CPS004939_002; MPS004545_004. Other charges were "*left to lie on the file*". A criminal charge is allowed to lie on file when the presiding judge agrees that there is enough evidence for a case to be made, but that it is not in the public interest for prosecution to proceed.
[378] WAN000002_204

- Croydon Council's "*responsibilities in placing a child 'in trust' in a family setting, precludes the nature of the risk in this case*".[379] (We understand that what Croydon Council meant by this was simply that it owed responsibilities to the child in question, and the risk of placing the child with the Carrolls was too great.)

These reasons were communicated orally to the Carrolls on 21 January 1986 and then in writing on 5 February 1986.[380]

8. Croydon Council also told Carroll that they would inform Lambeth Council about his conviction. They gave him a month to inform Lambeth Council first.[381] Against that background, it appears that, at some point, Carroll told Mr Don Thomas (the senior children's homes officer) about his conviction, who in turn told Mr Robin Osmond, the director of social services.[382]

9. This appears to have taken place prior to Croydon sending a letter dated April 1986 informing Lambeth Council about the 1966 conviction.[383] Consequently there was a period of time between early February 1986 and April 1986 when Lambeth Council officers were likely to have been aware of Carroll's conviction. Lambeth Council waited for the letter from Croydon Council before charging Carroll with misconduct offences.[384]

Disciplinary action

10. The information from Croydon Council led to disciplinary action being taken against Carroll by Lambeth Council for misconduct. The charges were set out in a letter of 22 April 1986 and the hearing commenced on 19 May 1986. Carroll was not suspended during the disciplinary process.[385] The two grounds for misconduct were:

- Carroll's failure to declare the conviction under the Rehabilitation of Offenders Act 1974 in his applications to Lambeth Council in 1978 and 1980; and
- that as an officer in charge of a children's home, these actions undermined the trust that Lambeth Council placed in him.[386]

Lambeth Council did not treat the conviction itself as a ground for misconduct. Nor did it treat Carroll's dishonesty in withholding the conviction from Croydon Council as a ground for misconduct.

11. In May 1986, Mr Thomas presented the management case against Carroll to a panel of two senior members of staff – Mr David Pope, then assistant director personal services (social work services), and Mr Gerallt Wynford-Jones, senior personnel officer.[387] It appears that little investigation took place in the approximately five weeks between notification in April and the disciplinary hearing in May, including in relation to Carroll's conviction. Mr Pope, the chair of the disciplinary panel, asked Mr Thomas "*if he had checked further into the nature of the offence*", but Mr Thomas "*only had the information contained in the letters from Croydon dated 10th and 15th April*".[388] He stated that, because of the length of time

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[379] WAN000002_141
[380] WAN000002_141
[381] WAN000002_139; LAM001516_003; LAM001523
[382] LAM001516_003
[383] LAM001523; LAM001516_003
[384] LAM001516_001
[385] LAM001516_001
[386] LAM001516_002
[387] LAM001516_001
[388] LAM001516_004

that had elapsed since the conviction, the conviction was not the basis of the management case.[389] In his view, the sexual offence committed in 1966 "*would not necessarily have precluded Mr Carroll from being shortlisted for the posts*".[390] The misconduct charge was based on Carroll's failure to disclose the offence; he had contravened policy in not declaring his conviction under the Rehabilitation of Offenders Act 1974. Further, his failure to disclose the information "*breached the trust placed in him by the Council, particularly because the offence is directly relevant to the work which he undertakes*".[391]

12. Carroll told the disciplinary panel that the "*incident*" had taken place when he was 17 years old in the children's home in which he had been a resident (in fact the offence took place when he was visiting the home after he had left). He said that they had been "*larking around grabbing each other's testicles*" while changing for a football match. He said that the mother of one of the boys "*pursued*" a charge.[392] He explained that he "*did not disclose his conviction … as he had worked previously in a social services setting*".[393]

13. At the conclusion of the hearing, the disciplinary panel found that the first charge was proven.[394] As for the second charge, regarding trust and confidence, the panel:

> "*had made a note of statements made in mitigation and so had not been able to reach a decision in respect of the second charge until management had obtained information from the relevant statutory authorities and confirmed Mr Carroll's statements about the incident.*"[395]

14. Further information was received from Merseyside Police in July 1986. This stated that Carroll returned to his former children's home and:

> "*Entered a bedroom of a 12 years* [sic] *old boy and tickled him then pulled his pyjamas down and played with his penis.*"[396]

Despite this description of the offence contradicting Carroll's account of it during the misconduct hearing, the minutes of a further hearing in July 1986 recorded that the information differed only "*slightly*".[397]

15. The disciplinary panel also received information from Carroll's former referees, who both seriously minimised the significance of Carroll's sexual offence.[398] One referee, Mr McHugh, said that Carroll, as the *"oldest boy"* present at the time:

> "*had to take responsibility for something quite harmless, which should have been dealt with on the spot … The organisation of St Edmund's did not take the matter seriously*".[399]

[389] LAM001516_003
[390] LAM001516_004
[391] LAM001516_004
[392] LAM001516_005
[393] LAM001516_006
[394] LAM001516_009
[395] LAM001516_009
[396] LAM001508
[397] LAM001519_005
[398] LAM000020_035
[399] WAN000001_144

16. The other (we understand to have been a nun) who was in charge of the St Edmund's home at the time of the offence, said that:

> "*John suffered the consequences of what happened namely boys larking about … I think it is very sad that he has now to have a fault of twenty years standing put before him, a fault that should be now spent and forgotten*".[400]

While both had been Carroll's original referees in 1978, Mr Pope told this Inquiry that the disciplinary panel did not know this.[401]

17. The hearing was adjourned again until August 1986, when the second charge was also found proven.[402] The disciplinary panel imposed a final written warning:

> "*We have taken into account the mitigating factors … we have viewed your criminal offence in the context of your age at that time and the fact that you were in care and the detailed circumstances of that offence. Additionally there is no evidence of any other offences or incidents of a similar nature, or managerial concern regarding your conduct and relationships with children placed in our care during your 8 years of service …* "[403]

18. There were a number of obvious weaknesses in the misconduct process.

18.1. Given the potential risk to children in care, there should have been a more rigorous investigation into Carroll by Mr Thomas. Having employed a man with a conviction for the sexual assault of a child to run a children's home, Mr Pope should have considered the risk that he posed to children. Mr Pope told us "*at the time we felt, on balance, that he was not a risk to children*".[404] The disciplinary panel lacked any foundation for that conclusion.

18.2. The way the hearing developed should have been a cause of concern for Mr Pope and Mr Wynford-Jones. By the time of the first hearing, Mr Thomas had not investigated the underlying facts of the conviction, despite having had some weeks to do so. Throughout the misconduct process, he did not make any of the points that he might have been expected to make (such as the fundamental breach of trust represented by a failure to declare a conviction). On the contrary, he presented the case in a way which was favourable to Carroll.[405] In his evidence to us, Mr Pope said that he and Mr Wynford-Jones:

> "*were concerned that the case was being presented as if – almost in a way it was just going to be dealt with without any further information being gathered or without any real scrutiny. I mean, he hadn't been suspended from duty when the offence came up, and it did appear that management were not pursuing a particularly strident line*".[406]

18.3. There is little evidence of any such concern reflected in the notes of the hearing or the questions asked by the disciplinary panel.[407] For example, Carroll was not challenged about the different answers he gave about why he had failed to disclose the conviction, or about his suggestion that he did not understand the basic requirements

[400] WAN000002_176
[401] David Pope 8 July 2020 27/05-28/14
[402] WAN000002_179-180
[403] WAN000002_180
[404] David Pope 8 July 2020 33/4-5
[405] David Pope 8 July 2020 8/5-9/22
[406] David Pope 8 July 2020 9/16-22
[407] LAM001516; LAM001519

of the Rehabilitation of Offenders Act. The question 'do you have a conviction?' does not require an understanding of the legislation but a willingness to be truthful. Mr Pope admitted that the disciplinary panel gave greater weight to Carroll's account than to the objective evidence before it:

> "*Yes, there is no doubt about that, because it's crystal clear we did, but what we did was, we talked – we got information from the nuns and the staff who were looking after him to see if this behaviour that he was describing was something that was taking place in the home, and they confirmed it was. So, ultimately, yes, we did. We took his explanation of it, rather than what the charge said, yes.*"[408]

18.4. At the time of the offence, Carroll was 18 years old. This was clear from the record of his conviction (which showed the date of the offence and that it was before a magistrates' court not a juvenile court).[409] Mr Pope said that the disciplinary panel accepted Carroll's assertion that he was 17 years old, rather than calculating or establishing it themselves; he said that "*in my head for a long time, when I talked about it, I thought he was 17 and a half*".[410] Mr Osmond – despite having been sent as director of social services the record of Carroll's offence by Wirral Magistrates' Court – also told the Inquiry that "*My understanding was that he was 17. But that's only my understanding*".[411] These senior staff failed to establish the basic fact of Carroll's age at the time of the offence or to investigate Carroll's account.

18.5. When asked by Mr Pope whether there had ever been any reason to question Carroll's behaviour, Mr Thomas said there was "*none whatsoever*".[412] However, an anonymous letter received by Lambeth Council's social services department in 1984 referred to Carroll as a "*dictatorial autocrat*" who, for example, treated in 1993 items such as the home's minibus as though they were his, and required staff to do laundry and cook for teenage boys who were no longer in care.[413] Mr Pope confirmed to us that this was the sort of letter that would be kept in a personnel file.[414] Mr Richard Clough, former chief executive of the Social Care Association, led an independent inquiry in 1993 into Lambeth Council's retention of Carroll; see Part G). The Clough report referred to the letter having been misfiled. It was, however, made available to Mr Clough.[415] It is difficult to understand how that letter could have been made available in 1993 to Mr Clough but not to the misconduct hearing in 1986. If Mr Thomas was aware of it, he did not mention it to the disciplinary panel.[416]

19. The 1986 misconduct proceedings against Carroll were clearly inadequate. There was little real investigation by Mr Thomas or by the disciplinary panel of Carroll's conviction, and no substantive consideration given to the potential risk Carroll posed to children in Lambeth Council's care. Carroll sought to minimise the offence and the lack of rigour from Mr Thomas and the disciplinary panel (Mr Pope and Mr Wynford-Jones) enabled him to do so.

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[408] David Pope 8 July 2020 24/6-13
[409] LAM001506
[410] David Pope 8 July 2020 22/13-15
[411] Robin Osmond 3 July 2020 104/7-8
[412] LAM001516_008-009
[413] LAM000020_030
[414] David Pope 8 July 2020 18/24-19/01
[415] LAM000020_029
[416] The anonymous letter was considered in an independent inquiry by Richard Clough in 1993 about the retention of Carroll, which stated that it was referred to the internal audit team by senior social services officers at the time (LAM000020_010).

20. Carroll failed to declare the conviction twice to Lambeth Council. He also failed to declare the conviction to another local authority in the context of a fostering application. He actively misled both. Mr Clough confirmed that the normal response to someone who falsified or failed to declare a conviction in this context would be summary dismissal.[417]

21. The panel's decision to retain Carroll was made relying on their subjective assessment of Carroll and what they thought about the position. The panel failed to make an objective judgement about his continued employment based on the clear evidence of Carroll's dishonesty and the risk he presented to children. The decision was blatantly wrong and Carroll should have been summarily dismissed.

22. In its written warning, the panel wrote:

> *"The disciplinary panel acting on behalf of the authority has the responsibility to ensure that any identified risk of abuse to the children in our care from our own staff is eliminated."*[418]

Far from eliminating risk, the decision by Lambeth Council to retain Carroll in 1986 (and its subsequent failure to monitor him in the light of his conviction) resulted in children at the Angell Road children's home remaining at risk of sexual abuse from him.

Institutional response to the misconduct proceedings

23. A number of individuals within Lambeth Council were aware of Carroll's conviction at the time of the misconduct proceedings or soon thereafter.

24. After the 1986 misconduct hearing, Councillor Phyllis Dunipace (chair of the Social Services Committee) was told about at least some of its conclusions by Mr Osmond. In oral evidence to the Inquiry, she said the following:

> *"A: He* [Mr Osmond] *would have told me after the disciplinary.*
>
> *Q: What did he tell you? Can you remember?*
>
> *A: That there had been a disciplinary and that he'd been given – that he* [Carroll] *hadn't been dismissed.*
>
> *Q: Did he tell you about the sexual offence that Michael Carroll had committed?*
>
> *A: I don't recollect the detail. I presume he* [Mr Osmond] *did, but I don't recollect the detail."*[419]

No one appears to have pursued as an issue of concern that a convicted child sexual offender was working in a children's home.

25. Carroll remained in charge of the Angell Road home for a further five years. His conviction did not surface again until after he was dismissed in July 1991 for fraud.[420] Carroll appealed against the dismissal, and Councillor Anna Tapsell was appointed to hear the appeal

[417] Richard Clough 7 July 2020 71/16-72/4
[418] WAN000002_179-180
[419] Phyllis Dunipace 3 July 2020 126/3-10
[420] INQ002209_003

in 1992.[421] The papers she received as part of that appeal made no mention of Carroll's prior final written warning.[422] She told the Inquiry that she learned of his conviction for child sexual abuse from someone at Wandsworth Social Services.[423]

26. It is clear from documentation at the time that Councillor Tapsell had "*major concerns*"[424] about the decision to retain Carroll and to allow him to continue in his position. She wrote to David Lambert, assistant chief inspector at the Social Services Inspectorate (SSI) in September 1992, stating:

> "*In allowing John Carroll to continue working at Angell Road the department put him in a terribly vulnerable position. I happen to believe that they also put children at unnecessary risk.*"[425]

27. The question was raised by the SSI as to whether, in the light of this information, children who had been in the care of Carroll ought to be interviewed.[426] Lambeth Council suggested at a meeting with the SSI in October 1992 that, rather than instigate a child protection investigation, "*under cover of a research project*" it would send children a questionnaire about their experience in care. To that end, it identified "*3 dozen*" children to approach.[427]

28. David Pope sent a memo in November 1992 to Jim Carlton (a principal officer within the Social Services Department) about this questionnaire:

> "*You will be aware of the need for this matter to be immediately progressed in view of recent correspondence and the inevitable meeting for DSS in late November to explain action (or lack of it by DSS). It would be extremely helpful to me if the list of identified children had been sent the very simple questionnaire by late November which allowed for them to respond and agree to an informal meeting. Please do all you can to help in this timescale*".[428]

29. In a statement to Operation Middleton, Mr Carlton said that he created a questionnaire which was sent out to about 20 ex-residents of Angell Road asking whether they had any concerns whilst they had been in care. He sent these by post to their last known addresses. As far as Mr Carlton was aware, one former resident responded to the questionnaire and made contact.[429] DI Morley was unable to find records of the questionnaire to confirm the situation regarding any responses.[430]

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[421] Anna Tapsell 8 July 2020 130/13-15; David Pope 8 July 2020 44/3-12
[422] Anna Tapsell 8 July 2020 131/3-11
[423] Anna Tapsell 8 July 2020 131/12-14
[424] INQ002209_002
[425] INQ002209_002
[426] CQC000298_003-004
[427] CQC000298_007
[428] MPS004545_012
[429] MPS000342
[430] MPS004545_013

30. This work of seeking responses to questionnaires was apparently superseded by investigations into the death of Mia Gibelli and South Vale children's home.[431] When questioned by the Inquiry, Mr Pope was unable to recall this questionnaire and Ms Hudson stated that she did not think that it went anywhere.[432] This exemplifies how Lambeth Council dealt with external scrutiny. As John Rowlands, assistant chief inspector at the SSI noted:

> *"I would have thought the possibility of undiscovered abuse having taken place in a Lambeth children's home would have made that a considerable priority for the Council's attention … there is the danger of the SSD's management not taking the right steps because of being compromised by their earlier incompetencies – a familiar phenomenon in residential child care."*[433]

Instead, in the face of proper concern that children may have been at risk at Angell Road, the questionnaire appears to have been no more than an effort to appease the SSI. It did not, for a moment, constitute a serious attempt to ascertain whether children had been abused.

31. After the disciplinary process concluded in 1986, neither Mr Pope nor Mr Osmond took any steps to reduce the risk Carroll might pose to children. Lambeth Council did not move him to a different position within social services, review his management of Angell Road, review the well-being of children there or monitor the home.

32. Instead, Carroll retained distinct responsibilities for carrying out a form of work with children at Angell Road that was claimed to be therapeutic in nature and was referred to as 'direct work'. Senior staff in children's social care in Lambeth Council also supported and facilitated Carroll and his wife having access to specific children they wished to foster and allowed him to play a key role in the investigation of allegations of sexual abuse against other members of staff at Angell Road.

Direct work

33. Direct work was "*an attempt to ensure that children could be encouraged to express themselves and talk about what their own feelings were*".[434] It included "*intensive preventative work, intensive creative rehabilitation programmes, and careful work at depth in preparing children for adoption*".[435] The Inquiry was told that it was conducted on a one-to-one basis between the social worker and the child.[436] Direct work was described as "*a greatly neglected area*" in Lambeth.[437]

34. In 1984, Helena Allen (a social worker) and Carroll proposed that the staff flat at Angell Road be used as a site for residential staff from the home and field social work staff to do 'direct work' with children.[438] It was intended to be a shared resource for Area 3 social workers and Angell Road staff.[439]

[431] Mia Gibelli was killed by her mother when she was 7 weeks old. An older sibling had already been thrown from a window by their mother. CQC000298_007
[432] David Pope 8 July 2020 51/21; Annie Hudson 21 July 2020 123/11-12
[433] CQC000298_004
[434] Valerie Suebsaeng 7 July 2020 4/17-19
[435] LAM030248_002
[436] Valerie Suebsaeng 7 July 2020 6/4-7
[437] LAM030248_002
[438] LAM030248_005
[439] LAM030248_005

35. The Inquiry has not seen written confirmation that this proposal was officially approved or that any implementation plan existed. However, Mrs Valerie Suebsaeng, a team leader in the social services department, confirmed that Carroll set up a direct work centre at Angell Road, with a special room set aside at Angell Road for this purpose.[440]

36. Whilst direct work included play, it was claimed to be therapeutic in nature. There was specific reference to it including techniques that were a form of psychotherapy.[441] Contemporary records listed equipment such as toys, arts materials and baby equipment.[442] Councillor Clare Whelan visited Angell Road twice between 1991 and 1994, and on one occasion the member of staff who showed her around said that "*grown up people had crawled around that room in nappies*". The member of staff also picked up two anatomical dolls and placed them in a sexual position.[443]

37. Ms Hudson told us that direct work "*needed to be undertaken by really well-trained and well-supervised people*".[444] However, by 1988, the majority of staff at Angell Road had undertaken only basic training on direct work with children. This included Steven Forrest, accused of sexually abusing children when employed at Angell Road, and LA-F4.[445] Despite this, they practised with individual children – for example, to develop techniques to enable children through play to ventilate feelings of grief, loss and anger.[446]

38. Direct work was carried out unsupervised, on a one-to-one basis.[447] As a result, and as recognised by Ms Hudson, Carroll and other members of staff were given "*carte blanche*" to do direct work with children "*without any of the kind of checks and balances and oversight*" that would be expected.[448] This created an obvious risk of emotional and psychological harm to children. It also provided an obvious opportunity for sexual abuse.

39. Some concern was raised about Carroll in respect of this work. Carroll attended an advanced social work course in 1986 or 1987, and was required to submit a piece of work related to working with a child. Carroll showed Ms Allen photographs of his work with a child. One picture showed the child wearing only underpants. Ms Allen regarded it as unusual, and Carroll's tutor on the course also spoke to Ms Allen about it because she thought it was inappropriate.[449] Carroll told Ms Allen that the reason the child was undressed was due to hot weather.[450] Ms Allen was no longer employed as a social worker by Lambeth Council at this time and there is no evidence that she communicated these concerns, including to senior staff in Lambeth Council.

[440] Valerie Suebsaeng 7 July 2020 4/6-15; Valerie Suebsaeng 7 July 2020 6/21-24
[441] Annie Hudson 21 July 2020 94/2-6
[442] LAM030248_009
[443] Clare Whelan 8 July 2020 104/15-25
[444] Annie Hudson 21 July 2020 96/9-12
[445] Opening Statement 29 June 2020 37/8-10
[446] Annie Hudson 21 July 2020 100/11-16
[447] Valerie Suebsaeng 7 July 2020 6/6-7
[448] Annie Hudson 21 July 2020 96/13-20
[449] MPS003322_004
[450] MPS003322_004

40. In a report of January 1990 in Mr Pope's name (as director of social services) it was recommended that Angell Road specialise in working with "*children who had suffered abuse, and emotionally damaged young people requiring 'longer term work'*".[451] Mr Pope told us that he did not recall connecting Carroll's conviction with this proposed change in Angell Road's functions.[452] He said:

> "*if it had registered, I would still not have thought that wasn't appropriate, because I did not believe at the time that he was a risk to children. Otherwise, he wouldn't be there in the first place.*"[453]

41. It appears that there were also children who spent time at Angell Road during the day despite not being in care and without any formal process or criteria for admission. Ms Hudson accepted that this was:

> "*a very haphazard … bordering on irregular, kind of mechanism by which children came to be there, for what, for how long, and so on. So it is kind of odd. At certain points external managers who were kind of coming in new were sort of saying, 'What is this about?', and nobody has a kind of good answer.*"[454]

Children from the Highland Road home stayed at Angell Road occasionally.[455] As discussed in Part E, LA-A23 also stayed at Angell Road with his foster carer (who had been dismissed as a teacher for gross indecency with children).[456] Children whose presence at Angell Road lacked any formal framework, and whose selection for being there was open to question, were very vulnerable. Their presence also suggests that Carroll was selecting children to spend time in the home.

42. Baroness Virginia Bottomley, Secretary of State for Health between April 1992 and 1995, agreed that permitting direct work with vulnerable children in a children's home run by a man with a conviction for the sexual assault of a child "*beggars belief*".[457]

D.3: Failures to investigate sexual offending

LA-F4 and allegations made by young children

43. There are strong grounds for believing that there were other individuals who were working at Angell Road who sexually abused children during the period that Carroll was officer in charge. In particular, there were serious allegations involving three children. In order to protect their identity, we refer to them as Child X, Child Y and Child Z.

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[451] INQ0002069_015
[452] David Pope 8 July 2020 37/16-38/10
[453] David Pope 8 July 2020 38/6-10
[454] Annie Hudson 21 July 2020 91/11-17
[455] Annie Hudson 21 July 2020 92/2-5
[456] Annie Hudson 21 July 2020 92/6-11
[457] Virginia Bottomley 27 July 2020 139/2

43.1. In April 1988, LA-F4's staff supervisor at Angell Road wrote to Carroll with specific concerns about two children, including Child X. LA-F4 (a residential care worker) was spending a lot of time with Child X (including when he was off duty, on leave or off sick) as well as buying presents for Child X:

> "*He will be there for X night and day. This causes a lot of problems with … other children feeling left out.*"[458]

The supervisor also stated that LA-F4 continued to see a number of children after they left Angell Road, undermining staff at those placements and leading to one of those placements breaking down.[459]

43.2. In November 1988, in the course of a therapeutic interview with a care worker at Angell Road (who was unqualified to undertake disclosure interviews with children), a child also made an allegation that suggested that LA-F4 had sexually abused Child X.[460]

43.3. Around the same time, in another therapeutic interview, Child Y (who was less than five years old) described circumstances involving her, LA-F4, another adult and Child X that indicated that she and Child X might have been sexually abused. That such an interview took place at all is troubling. At the time, Child Y was not in care – she spent time at Angell Road on an informal basis and did not appear to have a social worker.[461] The care worker who conducted the interview was not qualified to do so, and yet anatomical dolls were used.[462]

43.4. LA-F4 was suspended in mid-November. He was suspected of being in subsequent contact with Child X, and also went to another children's home to ask a child to give a statement on his behalf.[463]

43.5. On 18 November, Carroll went to see Child Z alone in her bedroom about LA-F4, and she made a disclosure to him about LA-F4.[464] At the end of November 1988, another child told Carroll that she saw LA-F4 and Child Z kissing and that she had seen LA-F4 go into Child Z's bedroom.[465]

43.6. Carroll spoke alone to other children who had made allegations, including Child X.[466] On 25 November, Carroll went to see Child X alone, putting Child Y's disclosure to him (which, according to Carroll, Child X denied). However, Child X did make a disclosure to him about LA-F4 and Child Z.[467]

43.7. On 16 December 1988, there was a meeting between Ms J Durrant (now Dr Kwhali; assistant director children and young persons division from mid 1987 to March 1989), Ms M Ahluwalia (personnel officer) and LA-F4 (and his National and Local Government Officers' Association [NALGO] representative). This meeting drew together the disclosure made by Child Y and the allegations made in relation to Child Z. Ms Durrant observed that the allegations were serious and unconnected to each

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[458] Annie Hudson 21 July 2020 98/25-99/15
[459] Annie Hudson 21 July 2020 99/16-21
[460] Annie Hudson 21 July 2020 100/1-9
[461] Annie Hudson 21 July 2020 101/9-20
[462] Annie Hudson 21 July 2020 100/19-101/9
[463] Annie Hudson 21 July 2020 101/24-102/8
[464] Annie Hudson 21 July 2020 102/3-5
[465] Annie Hudson 21 July 2020 102/13-15
[466] Annie Hudson 21 July 2020 102/2-15
[467] Annie Hudson 21 July 2020 102/8-11

other.[468] As set out below, by this date, Ms Durrant and other senior officers within Social Services, including Mr Verley Chambers (assistant director) and Mr Jack Smith (principal officer, social work), knew of Carroll's conviction. Indeed, they were dealing contemporaneously with the consequences of Wandsworth Council's refusal to approve the Carrolls' application to foster.

43.8. In mid-January 1989, Carroll was supposed to see Child Y's mother about Child Y's disclosure but said he was unwell and sent another Angell Road staff member. The staff member did not actually have any detail of what might have happened to Child Y.[469]

43.9. By January 1989, a social worker appointed to Child Y's family realised that Child Y's mother had not been told, or had not been given a full account, of her child's disclosure.[470] The social worker telephoned Carroll and, according to his notes, recorded that Carroll first said he had told Child Y's mother everything and did not understand why she would give the impression that he had not. Thirty minutes later, Carroll called back to say he did not mention anything about adults being involved when he spoke to the mother. The social worker said:

> "*I asked him what exactly was going on and had procedures been followed. He could not tell me why it seemed that, in the two months since the disclosure, nothing had been done*".[471]

43.10. Records gathered as part of the Children's Homes in Lambeth Enquiry (CHILE) documented that Carroll told others that the police had been contacted at the time about the allegations, but had decided not to proceed with them. He also said that Ms Durrant was dealing with it.[472] At the end of January 1989, the Metropolitan Police Service informed one area manager for Lambeth Council's social services department that they could not have been told anything about Child Y's disclosure because they would have spoken to her parents.[473] This gives rise to the real possibility that Carroll was deliberately mis-stating the position.

43.11. In early February 1989, three months after Child Y's disclosure, there was a planning meeting about her. This was attended by various Lambeth Council Social Services staff including Carroll, a hospital doctor and three representatives from the Metropolitan Police Service. While there was an offer of some assessment for therapeutic work, no child protection case conference was proposed. A police representative said that LA-F4 would not be prosecuted, as there was not enough evidence, and it was too late for them to examine or interview Child Y.[474] A decision was made to close Child Y's case.[475]

43.12. Despite Child Y's disclosure raising the possibility of sexual abuse involving two adults and another child, none of the professionals or organisations involved pressed for any further investigation. They did not even see the value of interviewing Child Y, and prejudged that an interview would be of no value. As for Child Z, there were other

[468] LAM004635
[469] Annie Hudson 21 July 2020 102/21-103/1
[470] Annie Hudson 21 July 2020 103/8-13
[471] Annie Hudson 21 July 2020 103/22-25
[472] Annie Hudson 21 July 2020 103/2-5
[473] Annie Hudson 21 July 2020 104/2-5
[474] Annie Hudson 21 July 2020 104/17-20
[475] Annie Hudson 21 July 2020 104/23

children who were able to corroborate her account, but this did not lead to any further investigation. Her disclosure was not referred to the police at that time. The different sets of allegations were not dealt with together and treated as raising a single, very serious child protection issue in relation to LA-F4.[476] Again, this was despite the fact that staff already had independent concerns about LA-F4's relationships with other children, including Child X.

43.13. The Metropolitan Police Service made a premature decision to close the investigation into Child Y's allegations. Where such serious allegations were made, despite the passage of time, an interview with Child Y was merited. There was also clear evidence that Child Z was being abused, but her case was not considered to even merit investigation.

43.14. Child X's mother went to an area manager in 1994, alleging that Child X had been sexually abused by LA-F4.[477] It appears the police were involved in child protection meetings. There was no criminal investigation.[478] When CHILE sought to investigate these events in 1998, it was not easily able to locate the files for Child X.[479]

44. These events raise a number of matters of concern.

44.1. No immediate action was taken by Lambeth Council in relation to Child Y's original disclosure. The need for prompt and careful interviewing of Child Y was obvious. The police may well not have been contacted until some three months after Child Y had made her original disclosure. The police chose not to interview her at that time. As noted above, in light of the gravity of the allegation, this decision was premature. An attempt should have been made to take an account from her.

44.2. The information was not shared by Lambeth Council with the family at the time of the complaint being made by Child Y.

44.3. It appears that Carroll was able to control the investigation into Child Y's disclosure about LA-F4. LA-F4's supervisor had specific concerns about LA-F4's conduct months before any allegations were made against him by children at Angell Road, but Carroll did not act. Carroll managed to hold external involvement – by the police and Lambeth Council more generally – at arm's length for a significant period of time.[480]

44.4. Similarly, despite the fact that there was corroborative evidence that demonstrated Child Z might be being abused by LA-F4, her case was not subject to investigation by Lambeth Council and not referred to the police.[481] There is no explanation as to why these allegations were not referred to the police, either alone or in conjunction with Child Y's disclosure.

44.5. The social work team should have taken charge of investigations in 1988 and 1989. The delay in conducting a planning meeting in Child Y's case, and the consequent decision to close her case because of the time that had elapsed, indicates the unwillingness of senior staff in children's social care in Lambeth Council to prioritise and deal with serious allegations.

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[476] Annie Hudson 21 July 2020 108/12-110/3
[477] Annie Hudson 21 July 2020 107/6-10
[478] MPS004545_072
[479] Annie Hudson 21 July 2020 110/18-111/5
[480] Annie Hudson 21 July 2020 107/11-108/11
[481] Annie Hudson 21 July 2020 102/1-15; 109/14-20

44.6. As set out below, by August 1988 it is clear that some senior officers, including Ms Durrant, Mr Smith and Mr Chambers, were aware of Carroll's conviction for indecent assault and yet Carroll assumed a central role in the investigation into LA-F4.

44.7. No effective action was taken by other senior managers to assess the safety of children at Angell Road. Ms Hudson accepted that Lambeth Council did not question Carroll's involvement in the investigation into Child Y's disclosure, despite Carroll's actions being contrary to proper investigatory procedures. His interviewing of children on his own was, in Ms Hudson's words, "*incredibly inappropriate*"[482] and "*flaunting the requirements … in a very profound way*".[483]

45. Misconduct proceedings were brought against LA-F4 in 1989, on three grounds:

- sexual abuse of one or more children at Angell Road;
- an inappropriate relationship between LA-F4 and the parent of one of the children; and
- behaviour of a sort that was inappropriate given his position as a residential care worker.[484]

These allegations were found by the disciplinary panel to be proven, and LA-F4 was dismissed. This disciplinary panel was made up of staff within social services (Sylvia Medhurst, assistant director) and John Ballatt (principal manager, daycare) and a personnel manager (Yvette Adams). Subsequent to the disciplinary hearing, Sylvia Medhurst raised concerns with David Pope about Carroll's knowledge of LA-F4 and his role in the case. She stated that Carroll as officer in charge must have known that "*something irregular*" was happening between LA-F4 and the victim.[485] Ms Medhurst said that she told Mr Pope of her concern and, according to her, Mr Pope said that he would need proof of her concern before he would look into it.

46. LA-F4 appealed. The appeal panel (consisting of Councillors Hunter, Shakespeare and Watson) was only in a position to find the third allegation proved.

47. There were no statements from the children concerned, nor any recorded interviews with them. Although there was some evidence of what children had said, this was set out in statements from staff from the Angell Road home, including Carroll. The appeal panel found that this did not amount to a proper process of gathering evidence specific to the allegations. There was a single taped interview with Child Y, but the appeal panel decided that it was of "*no evidential value*" because the interview had not been conducted according to "*proper disclosure principles*".[486] The interview was carried out by the same care worker from Angell Road who conducted the first interview with Child Y. The appeal panel recorded its concern about the absence of proper procedures for securing the children's accounts:

> "*It is a sad fact in this case, although the staff concerned do appear to understand the meaning and importance of proper disclosure sessions, none were actually instigated. It is regrettable that for whatever reason outside expert assistance was not forthcoming.*"[487]

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[482] Annie Hudson 21 July 2020 108/7
[483] Annie Hudson 21 July 2020 109/6-7
[484] LAM004649
[485] LAM028444
[486] LAM004569
[487] LAM004569

48. The appeal panel made a number of recommendations at the conclusion of the hearing, including that guidance be produced as a matter of urgency "*setting out basic rules of evidence*" for appeal proceedings. The panel also recommended that the director of social services investigate how disclosure sessions with children were being carried out to ensure that they conformed to legal requirements and that they were being conducted by appropriately qualified persons. LA-F4 was not reinstated at the conclusion of the hearing.

49. The panel found the third allegation proved because LA-F4 admitted to unprofessional conduct. This conduct included buying children presents, kissing and hugging a child and entering the bedrooms of female children at night. The panel recorded it was "*very concerned*" that this conduct had been:

> "*allowed to continue for a prolonged period without adequate Management action after they had been clearly advised of the concerns of staff in respect of the poor professional standards and behaviour displayed by the appellant*".[488]

50. These findings demonstrate that Carroll failed to act in the face of information that a member of his staff was acting in a disturbing way towards children at Angell Road. Furthermore, the failure to institute a child protection investigation impacted on the findings which were made in the misconduct proceedings.

Other evidence of sexual abuse at Angell Road

51. The situation brought about by the failure to take proactive steps at Angell Road created the ideal opportunity for the sexual abuse of children. Carroll posed a direct risk to children and, as the officer in charge, he was also able to influence the investigation of allegations of sexual abuse made against others. He was able to defer external investigation into LA-F4 in respect of Child Y until the police considered that it was too late to interview her.[489]

52. In 1992, evidence emerged of prior harmful sexual activity between children at Angell Road. There was evidence that three older children had involved a child who was under the age of four years in this. This should have been the subject of an urgent investigation, but this did not take place.[490] Files related to these allegations have been lost. Ms Hudson confirmed to us that "*Lambeth is aware*" that this was one of a number of incidents whereby files that were potentially relevant to sexual abuse linked to Angell Road went missing.[491] This was not the only incident of missing files that were relevant to child sexual abuse, as set out above in the case of Child X.

Steven Forrest

53. In 1996, LA-A29 (who was in care from two years old) alleged that he had been sexually abused by Steven Forrest. Forrest was a team leader and a senior residential care officer at Angell Road from 1982 until 1991, and died of an AIDS-related illness in 1992.[492]

[488] LAM004569
[489] Annie Hudson 21 July 2020 104/7-20; 108/12-110/3
[490] Annie Hudson 21 July 2020 115/5-17
[491] LAM030227_049
[492] LAM000022_026

53.1. Lambeth Council's failure to respond appropriately to this disclosure – despite its potential gravity and possible broader implications for the health and well-being of the child concerned (as well as other children) – was the subject of the independent Barratt inquiry. John Barratt was appointed by Lambeth Council in December 1998 to examine its response to LA-A29's allegations about Forrest.

53.2. Mr Barratt was sufficiently concerned about what he discovered in the course of his investigation about LA-A29 that he issued an interim report to Lambeth Council in May 1999. He informed Heather Rabbatts, the chief executive, that he considered it his duty to make this report, referring to his "*deep concern about the continuing fractured and ineffective practice of Child Protection by the Lambeth Social Services Department which the inquiry has revealed*".[493] His report, *The Lambeth Independent Child Protection Inquiry, 1999, Part 1* (dated September 1999), referred to a "*catalogue of organisational incompetence*" and characterised the care of LA-A29 as "*shocking*".[494] It set out, in extensive detail, a number of failures on the part of Lambeth Council.[495] These may be summarised as Lambeth Council's failure to care for LA-A29 generally; that he spent almost the entirety of his childhood in the Council's care; the "*practical irrelevance of the Council's splendid-sounding Child Care Policies of 1982 and 1991*" and the failure to respond to LA-A29's disclosure of sexual abuse ("*nothing actually happened. Even when it was subsequently pointed out that nothing had happened, still nothing happened*").[496] Returning to LA-A29, the Barratt Part 1 report found that he made a specific allegation in early 1996 that he had been sexually abused by Forrest. LA-A29 was a young teenager.[497]

53.3. Senior staff in children's social care in Lambeth Council were aware that Forrest had died of an AIDS-related illness, and the question was raised as to whether other children might have been abused.[498] Mr Barratt noted that, despite the existence of genuine concerns, children's social care "*failed as lamentably in relation to wider issues of possible/probable extensive child abuse as it continued to do in relation to LA-A29's individual care*".[499]

53.4. A planning meeting about LA-A29 was held in February 1996, but the Metropolitan Police Service did not attend.[500] DI Morley said that, as a result, the police missed an opportunity to influence the investigation and to ascertain whether other children might have been abused by Forrest.[501]

53.5. Forrest's death meant that there would be no criminal investigation into his behaviour. However, as Mr Barratt pointed out, the possibility that more than one child had been abused was "*substantial*" and "*the possibility that a paedophile working in a children's home might have had associates could not be dismissed*".[502]

[493] LAM000022_009
[494] LAM000022_011
[495] LAM000022_001
[496] LAM000022_001-016
[497] LAM000022_045
[498] LAM000022_046
[499] LAM000022_046
[500] LAM000022_049
[501] MPS004545_055-056
[502] LAM000022_049

53.6. October 1996 marked the end of any attempt by Lambeth Council to respond appropriately to LA-A29's disclosure. The wider issues raised by the possibility that other children may have been put at risk "*lay untouched*" and nothing was achieved in response to LA-A29.[503] No child protection investigation took place.[504] The matter remained dormant until the allegations were discovered by Operation Care (the criminal investigation into Carroll) in 1998.

53.7. Mr Barratt also wrote a final report (of 24 October 2000), which set out his broader conclusions about the operation of Lambeth Council's social services department. Among his conclusions were: Lambeth Council had repeatedly failed to fulfil its statutory duties and its own policy objectives towards children; it had failed, for over a decade, to create and control an effective social services department; and the Council's chain of command had decayed and disintegrated.[505]

54. It is difficult to overstate the seriousness of Lambeth Council's failure to respond to LA-A29's allegations. In addition to sexual abuse, there were significant possible implications for the health and well-being of LA-A29 (and potentially other children) at Angell Road.

D.4: Carroll's fostering applications

55. The Inquiry is aware of several attempts by Carroll and his wife to foster children. The first related to an 11-year-old boy in the care of Croydon Council, an application that was refused in February 1986 and brought Carroll's conviction to light.

56. Another attempt to foster was made in respect of two children in the care of Lambeth Council who were living at Angell Road in 1986.[506] Mrs Suebsaeng, the social worker for these children, explained that the Carrolls were not subject to any formal process of assessment related to fostering them. They were interviewed in order to determine whether or not they should be formally assessed.[507] Lambeth Council decided not to proceed with a formal assessment, preferring another family who offered the children a permanent home. The application was therefore not referred to an independent local authority for assessment.[508] According to Mrs Suebsaeng, Carroll argued strongly against the decision not to place the children with him and his wife.[509]

The Wandsworth assessment

57. In addition, in 1987 the Carrolls sought to foster two other boys who lived at Highland Road children's home, where Carroll's wife worked, after they developed a relationship with them.[510]

58. Carroll asked Mrs Suebsaeng for a reference in support of his application to foster. Despite Carroll having told her about his conviction and about the misconduct proceedings, she provided the reference supporting the application. Mrs Suebsaeng told us that Carroll "*minimised*" the offence and was "*grooming*" her.[511] She said that at the time she was

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[503] LAM000022_082
[504] LAM000022_083
[505] LAM000021_010
[506] WAN000002_024
[507] Valerie Suebsaeng 7 July 2020 13/3-14
[508] Valerie Suebsaeng 7 July 2020 13/8-14/21
[509] Valerie Suebsaeng 7 July 2020 15/1-19
[510] LAM000020_013
[511] Valerie Suebsaeng 7 July 2020 16/17, 17/5-7

balancing knowledge of the criminal conviction "*against the fact … that this had happened 20 years previous, that John had actually been a child in care himself and was expressing a wish to give something back to children in care*" and her own experience of him as "*committed and popular in the area she worked in*".[512] She also stated that she spoke to Mr Pope, who confirmed that Carroll had been given a full written warning but was allowed to continue to work.[513] Nevertheless Mrs Suebsaeng should have applied professional judgement to the provision of a reference based on all of the information available to her. It was a poor decision to provide a reference and when doing so Mrs Suebsang did not adequately consider the risk Carroll posed to children. She accepted in her evidence to the Inquiry that it was "*the wrong decision*".[514]

59. Ms Hudson explained that during the 1980s there was a general agreement across Greater London that it was not appropriate for authorities to undertake assessments of their own staff to be approved as foster carers; other local authorities would undertake the assessments with a view to ensuring objectivity. In 1981, there was an established practice that Wandsworth Council and Lambeth Council would undertake this work on behalf of each other's authority. Lambeth Council asked Wandsworth Council to carry out the assessment of the Carrolls.[515]

60. In 1987, the case was referred to Ms Bernadette Khan, a Wandsworth Council social worker, by Ms Brenda Jones, principal officer for the Lambeth Adoption and Fostering Unit. In the early 1970s, Ms Khan had been a co-opted member of the Lambeth Social Services Committee. She was not elected and had no political powers but was able to attend meetings and carry out visits to children's homes. This included Shirley Oaks.[516] Ms Khan said that Ms Jones "*reported the application to be a fait accompli*" – the children already spent weekends and holidays in the Carrolls' home and Lambeth Council was supportive of the application.[517]

61. Records demonstrate that Lambeth Council staff sought to interfere with the independent assessment.

61.1. In March 1988, Ms Khan made the following note:

> "*Brief discussion with Alison Barraball, Principal Officer, who had already had discussions with Brenda Jones, Principal Officer, Lambeth Adoption and Fostering Unit, as to the complications of the case and which Panel the report should be submitted to. It has been suggested and agreed in joint discussions between Brenda Jones and Jack Smith, Chair of Lambeth Adoption and Fostering Panel, that my report state against police reference 'satisfactory' and Jack Smith will take personal responsibility for dealing with the matter at his Panel*".[518]

This suggests that Wandsworth Council officers were being invited to make a dishonest entry on a report to a fostering panel, and to have the case dealt with at a Lambeth Council, not Wandsworth Council, fostering panel.

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512 Valerie Suebsaeng 7 July 2020 19/13-18; Valerie Suebsaeng 7 July 2020 17/22-23
513 Valerie Suebsaeng 7 July 2020 17/24-19/1
514 Valerie Suebsaeng 7 July 2020 19/24-25
515 LAM000020_013; LAM030227_105-106
516 Bernadette Khan 3 July 2020 27/11-16
517 Bernadette Khan 3 July 2020 28/14-29/7
518 WAN000002_062

61.2. Ms Khan recorded in her notes that she had:

"*Expressed my concern about the case in general, in particular Mr Carroll's denial of the incident, and the direction given by Lambeth personnel in dealing with the police reference matter, which I found unprofessional and irresponsible, given our responsibilities towards children in care as their guardians. I have stated I would not be prepared to collude with such disgraceful professional practice.*"[519]

This concern was raised with Alison Barraball, Miss Khan's supervisor and principal officer (fostering) Wandsworth.

61.3. Mr Jack Smith, the principal officer for social work, admitted that he asked for the telephone call to Wandsworth Council to be made.[520] He also confirmed that he had written a note supporting the Carrolls' application, even though, as chair of the Lambeth Council Foster Panel, he should have been neutral about this application.[521] As the Clough report concluded, Mr Smith "*should not have become involved in this particular case in the way that he did and his professional behaviour during this time is a cause for regret and concern*".[522] Mr Smith was asked by the Inquiry to explain these (and other) actions under rule 9 of the Inquiries Rules 2006. Mr Smith declined to do so, and as he lives abroad he could not be compelled to provide a statement.

62. It appears that Carroll provided Wandsworth Council with information about the conviction. He gave Ms Khan a similar account to that which he had given to his misconduct hearing. Ms Khan saw the record of conviction and challenged Carroll "*with the police report stating that the incident took place in a bedroom*".[523] In her evidence before us, she referred to Carroll's "*repeated dishonesty relating to the facts surrounding his conviction*".[524]

63. The Wandsworth Council adoption and fostering panel rejected the Carrolls as foster carers at a hearing in August 1988, with its reasons including that Carroll needed to come to terms with his conviction.[525] After this, there were "*quite a number of telephone calls*" between the two councils.[526]

64. Lambeth Council was made informally aware of Wandsworth Council's decision not to approve the Carrolls as foster carers.[527] Confirmation was delayed until December 1988 (because Wandsworth Council considered that it needed the permission of the Carrolls to provide this information).[528]

65. Ms Patricia Orton became an area manager in Lambeth Social Services in 1987. She reported to Jack Smith, who in turn reported to the assistant director, Verley Chambers. She became involved in the children's case because she was the manager of their social worker. On 31 August 1988, Ms Orton wrote to Jack Smith (principal officer, social work), copying the letter to Ms Constantia Pennie (principal manager adoption and fostering), Verley Chambers and Ms Durrant. She stated that she had been informed that the main reason

519 WAN000002_062
520 LAM000020_052
521 LAM000020_054
522 LAM000020_054
523 WAN000002_011
524 INQ005655_009
525 WAN000002_036
526 WAN000002_035
527 LAM000020_ 047
528 LAM000020_014; LAM000020_021

that the Carrolls' fostering application had been rejected by Wandsworth was because of Carroll's conviction for a Schedule 1 offence. Ms Orton observed that if this was correct it had serious implications for Lambeth Council as his employer.[529]

66. In September 1988, despite knowing that Wandsworth Council had concluded that the Carrolls were not fit to be foster carers, senior officers from Lambeth Council formalised the Carrolls' role as so-called social uncle and aunt to the children.[530] The officers involved in this decision making were Mr Pope, Ms Durrant, Mr Chambers and Mr Smith. This meant the children stayed with the Carrolls at weekends and during school holidays.[531]

67. In a letter of 21 September 1988, Ms Orton set out her concern, having discovered that the Carrolls, without permission, had the children staying at their home during the summer holidays. She said that she failed to understand how Carroll could not know that children were only allowed to stay away from their placement as part of a care plan. She said that the Carrolls must seek her permission for any visits and that overnight visits were not permitted. She also clarified that the children could not visit unless both Carrolls were present.[532] Despite Ms Orton's clearly expressed views on the issue, the children continued to stay with the Carrolls.[533]

68. In May 1989, Ms Orton wrote to Mr Chambers about the new Accommodation of Children (Charge and Control) Regulations. She considered that they applied to the arrangement with the Carrolls and that the Carrolls needed to be assessed. This would involve a police check. She received a response from Mr Chambers that there was no point in doing this as they already knew what the check would say. She wrote a couple of further memos to Mr Chambers and Mr Smith but received the same reply. In her view "*they were just covering it up*".[534]

69. In November 1989, Ms Khan learned that the children continued to spend weekends and holidays with the Carrolls. She considered that "*it makes a nonsense of the whole process of assessment*", and described Lambeth Council's conduct in letting the children stay with the Carrolls as an abuse of procedures "*through a professional network system, whose main responsibilities and accountability are to the overall welfare and protection of children*".[535] She was concerned that these children and others were being put at risk.[536] She was correct – this was another demonstration of Lambeth Council putting children in its care at risk.

70. Although there remained concerns about contact between Lambeth and Wandsworth councillors and staff, the Clough report found no evidence of improper contact between Lambeth councillors on the one hand and Wandsworth councillors on the other, or between Lambeth councillors and Wandsworth staff.[537] Lambeth Council's children's social care revived its internal investigation (it having been suspended pending the production of the Clough report) into the same allegations and exonerated Mr Smith.[538] Its conclusions were inconsistent with the Clough report, Ms Khan's note and the admission by Mr Smith recorded in the Clough report. Mr Pope insisted to us that there was no evidence that

529 LAM028510_061
530 LAM000020_018
531 LAM028510_062
532 PTN000016
533 PTN000020
534 PTN000001
535 INQ005655_009-010
536 WAN000002_038
537 LAM000020_054
538 INQ002206_001-003

Mr Smith provided a reference for Carroll.[539] However, an inventory of the contents of the desk used by Ms Pennie (now the assistant director for children and families) referred to a letter dated 3 November 1992 from Mr Pope to Mr Smith asking about the provision of a reference for Carroll. The inventory states:

> *"Attached are the answers provided by Jack Smith including a statement that he did provide a reference".*[540]

71. Wandsworth Council officers who dealt with the Carrolls' application strongly disagreed with the findings of the internal report (which had been shared with them). They wrote to Henry Gilby, the chief executive of Lambeth Council, stating:

> *"The investigation may have concluded that there was no evidence of improper motives by Lambeth Officer. However, as the workers within Wandsworth who were involved in this case, we wish to place on record our view that an improper and unprofessional suggestion was made to the Principal Officer (Fostering) Wandsworth. We are clear that this suggestion came from the Principal Officer (Social Work), and the team leader acted as messenger in communicating this. In our view, this was contrary to good child care practice, in particular in relation to the role of Social Services staff in protecting vulnerable children."*[541]

This disagreement was not reflected in the internal investigation by senior staff written in the name of Mr Pope to the Social Services Committee in February 1994.[542] The only action taken as a result of that internal investigation was a reprimand for Ms Jones for unprofessional behaviour.[543] Action should have been taken against Mr Smith (Lambeth Council principal officer, social work).[544] By reprimanding Brenda Jones and taking no action against Mr Smith, Lambeth Council demonstrated the lengths it was prepared to go to protect a senior manager, Mr Smith.

Southwark Council

72. In 2014, in a press report, it was suggested that Lambeth Council asked Southwark Council to assess the Carrolls (prior to approaching Wandsworth Council) and that an unnamed politician had telephoned Southwark Council to indicate that he was unhappy that Southwark Council had refused the application.[545] While the source was not named, it said that a new witness told the Labour MP Tom Watson that a Southwark social worker had advised that the fostering should be halted because of Carroll's conviction.

73. Southwark Council has no record of it being asked to carry out any such assessment.[546]

74. Mr Clive Walsh, head of fieldwork and community services at Southwark Council from 1985 to 1989, told us that Southwark Council had been asked to assess the Carrolls as foster carers.[547]

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[539] David Pope 8 July 2020 61/25-62/14
[540] LAM026926_003
[541] WAN000002_080
[542] David Pope 8 July 2020 69/1-19; INQ002206
[543] INQ002206_008
[544] INQ002206_008
[545] INQ006467
[546] LAM028774
[547] Clive Walsh 7 July 2020 25/17-25

74.1. His recollection was prompted by reports about Carroll from around 2013 or 2014, which led to him preparing a written account of events. Mr Walsh gave his written note to his former Southwark colleague, Tony Watson (father of Tom Watson MP), and spoke to him because – although these events were memorable – they had been difficult to understand and, in his words, "*I'm not very good with, and never have been very good with, memories – with names*".[548] He could not provide the dates when Southwark Council considered this application, although he was clear that "*there was an extant fostering application that was unlikely to succeed, but that formally it hadn't been yet rejected*". He told the Inquiry that Croydon Council had learned of Carroll's conviction during its consideration of a separate fostering application, that there had been a disciplinary hearing and that Carroll had been given a warning.[549] If this is correct, then, on Mr Walsh's evidence, any such application to Southwark is likely to have been made after August 1986 (the date of Carroll's final misconduct hearing and when Carroll was given a warning).

74.2. However, Mr Walsh also believed that the children were in the care of Croydon Council. When asked why Lambeth Council would ask Southwark Council to assess the Carrolls as foster carers for children in the care of Croydon Council, Mr Walsh suggested that this was because Croydon Council did not intend to approve the Carrolls as foster carers, and that the Lambeth Council approach to Southwark Council had "*all the hallmarks of a side movement*" to get approval for the Carrolls to be foster carers.[550] We note, however, that there would have been no conflict in Croydon Council assessing the Carrolls as foster carers for children in its care, and only Croydon Council could ultimately determine who fostered the children in its care. It may be that Mr Walsh confused the application that Croydon Council did consider and refuse – in respect of the 11-year-old boy in its care – and the application to Wandsworth Council regarding the two boys in Lambeth Council's care. Such confusion may be understandable given the time that has elapsed, but it reinforces the need to approach Mr Walsh's evidence with care.

74.3. Mr Walsh said that he refused the application and confirmed this to Mr Don Glen (a principal officer at Southwark Council) to pass on to Lambeth Council. He also indicated to Mr Glen that he could inform Lambeth Council that he did not think that Carroll should be running a children's home. In his words:

> "*I delivered, as I would quite ordinarily, my decision to Mr Glen and the area office at the time in writing, and made it clear in that they were free to share this with their counterparts in Lambeth.*"[551]

74.4. A few days later, Mr Walsh said that he attended a meeting with Lambeth Council representatives. According to Mr Walsh, these were Janet Boateng (later Lady Janet Boateng) – who at the time either was, or had been, chair of the Social Services Committee – and two officers. Mr Walsh believed one of these officers to have been responsible for giving Carroll his final warning and the other to have been the senior

[548] Clive Walsh 7 July 2020 28/2-29/24
[549] Clive Walsh 7 July 2020 32/1-22
[550] Clive Walsh 7 July 2020 39/14
[551] Clive Walsh 7 July 2020 42/15-43/8

officer in charge of Lambeth Council's fostering and adoption function.[552] According to Mr Walsh, the main reason for this meeting was that Lambeth Council wanted Mr Walsh to withdraw his view of the inappropriateness of Carroll working as a head of a home.[553]

74.5. In her evidence to us, Lady Boateng denied participating in any meeting that discussed the Carrolls' fostering application. She considered the allegations "*absurd*" and without "*sense*".[554] Lady Boateng recalled another meeting that she attended with Southwark officials related to her membership of the Secure Accommodation Review Board (a national board to review secure accommodation cases). When she visited one such establishment – which she thought was Orchard Lodge, run by Southwark Council – a child approached her and said that he had been sexually abused.[555] She informed Mr Osmond (the director of social services at Lambeth Council) as there were children in Lambeth Council's care accommodated there. This led, in turn, to a heated meeting with Southwark Council officials.[556] When asked if he attended a meeting with Lambeth Council about a child at Orchard House, Mr Walsh said that he would not have been at any such meeting, as secure accommodation was outside his area of responsibility.[557] In response, Mr Walsh was asked why he would not have been part of such a meeting given his responsibilities for fieldwork in Southwark. He said that he would have been involved if his residential counterpart had been part of that meeting but the meeting described by Lady Boateng was not a meeting that he was part of.[558]

74.6. Mr Walsh also said that, after the meeting, he received a phone call from a man who said that he was Mr (now Lord) Paul Boateng, asking if he "*could be of assistance in resolving this troublesome matter*".[559] Lord Boateng told us that he did not telephone Mr Walsh, that he did not know Carroll and that the focus of his life from 1985 or 1986 until 1987 was being elected to Parliament.[560] In a witness statement to the police in 2014, Mr Walsh had referred to Lord Boateng being a member of parliament at the time, although he was not elected until June 1987 (over a year after his wife had been suspended as a councillor).[561]

74.7. In terms of the timing of the meeting, Mr Walsh was very clear that Carroll had been disciplined but retained by Lambeth Council at the time. Lady Janet Boateng was disqualified as a Lambeth councillor in March 1986.[562] She would not have been a Lambeth councillor at the point in time when, on Mr Walsh's evidence, the meeting occurred, after Carroll's misconduct hearing in August 1986. Neither would Lord Boateng have been a member of parliament.

74.8. Taking these various points into account, it is possible that Lambeth Council staff could have asked Southwark Council to consider approving the Carrolls as foster carers in respect of the same children that Wandsworth Council was asked to assess. This could have happened when it became apparent that Wandsworth Council was not going to approve the application. If Mr Smith was prepared to ask Wandsworth

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[552] Clive Walsh 7 July 2020 44/4-24
[553] Clive Walsh 7 July 2020 47/11-22
[554] Lady Janet Boateng 7 July 2020 94/22-95/5
[555] Lady Janet Boateng 7 July 2020 96/21-97/1
[556] Lady Janet Boateng 7 July 2020 96/13-97/8
[557] Clive Walsh 7 July 2020 52/9-11
[558] Clive Walsh 7 July 2020 52/12-22
[559] Clive Walsh 7 July 2020 49/9-19
[560] Lord Paul Boateng 23 July 2020 134/11-24
[561] Clive Walsh 7 July 2020 50/4-8
[562] Lady Janet Boateng 7 July 2020 95/12-21

Council officials to lie so that the Carrolls might be able to foster, then the possibility that Lambeth Council also asked Southwark Council to carry out an assessment cannot be excluded. However, if there was such a meeting, we are not satisfied based on the evidence available to us that Lady Boateng was present or that Lord Boateng telephoned afterwards or had any involvement in the matter.

Part E

Children in foster care

Children in foster care

E.1: Introduction

1. Fostering is the provision of care in a family home for a child unable to live with their birth parents. It can take many forms, including emergency, short and long-term placements, short breaks, family and friends (kinship) care, fostering for adoption, private fostering and specialist therapeutic care.[563] A local authority placing a child with foster carers has a continuing statutory duty to safeguard and promote the child's welfare, in the same way as if they were in residential care.[564]

2. Although Lambeth Council's policies were predicated on a generally accepted principle that it was better for a child to be in foster care rather than in a children's home, Ms Annie Hudson (strategic director of children's services from May 2016 to March 2020) told us:

> *"By the early 1970s, approximately 35% of all children in care nationally were fostered … by the late 1970s Lambeth still had relatively more children in children homes, and a lower proportion fostered, than the country as a whole. By 1985 the proportion of children in care fostered nationally, had risen to 50%, and then to 66% by 2000. Today it is approximately 75%."*[565]

E.2: The 1980s: LA-A23

3. LA-A23 was taken into the care of Lambeth Council aged nine in 1978 and moved to South Vale. He was then placed at a therapeutic centre outside Lambeth, but this placement was not successful. A subsequent placement at another children's home, Cotswold Community House, also broke down.[566] During this period, which was 1979–1981, LA-A23 spent two short holiday breaks with LA-F36 (who he had met during his first placement) in Cornwall. LA-F36 offered to take LA-A23, then aged 12, to live with him in Cornwall and Mr Christopher Hussell, a senior social worker within Lambeth Social Services, agreed.[567] LA-A23 went to live with LA-F36 in October 1981.[568]

4. By November 1981, Mr Jack Smith (principal officer social work) was sent information about LA-F36 that suggested LA-A23 was at risk. A letter from the assistant principal of Cotswold Community House stated that there were "*real grounds*" to be worried about his future contact with LA-A23.[569]

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[563] https://www.gov.uk/becoming-foster-parent/types-of-foster-care
[564] Children Act 1989, section 22
[565] LAM029331_129
[566] Chris Hussell 24 July 2020 35/20-37/11
[567] LAM030015
[568] LAM030269_052-053
[569] LAM030016

5. A few days later, Mr Hussell (who supervised LA-A23's allocated social worker, Mr Andrew Small) confirmed to LA-F36 that "*we would like to proceed towards accepting your proposal … to offer a permanent home to* [LA-A23], *and … to provide* [LA-A23] *with education*". The letter to LA-F36 stated that Lambeth Council "*would contemplate paying your fees*" as though LA-F46 was the proprietor of a private school.[570] Mr Hussell told us:

> "*we didn't have anywhere else for him to go, and here was the availability of somewhere he could go temporarily. The alternative would have been to get him back into the traditional, long-term residential – not necessarily long term, but into the residential care system, which we were anxious to avoid.*"[571]

One month after he was sent to Cornwall, LA-A23's placement had still not been formalised. He was being treated as though he was on a holiday.[572] There was no formal process or assessment of the suitability of this placement.[573]

6. In February 1982, as recorded in notes of a visit to Cornwall by Mr Small, references had still not been obtained for LA-F36.[574] There were further matters of concern identified by Mr Small's visit:

- LA-A23's education was "*non-existent*"; LA-F36 said he had not had time to organise anything, although five months had passed. Mr Hussell suggested to us that LA-F36 had used every opportunity to teach LA-A23, but this was not supported by Mr Small's note.[575]
- "*LA-F36 has identified needs in LA-A23 to regress to infantile levels, ie, LA-A23 asked if LA-F36 could buy a baby's feeding bottle, which he did.*"[576] Mr Hussell did not find it alarming that a foster carer was giving a 12-year-old a baby bottle. He explained that he and Mr Small saw it as an indication of LA-A23's needs, instigated by LA-A23 and which LA-F36 seemed to understand.[577]
- LA-F36 was sleeping in LA-A23's room, but Mr Hussell again did not see this as a cause for concern. Instead, he considered it a sign that LA-A23 needed to "*regress to quite an infantile level*", having "*attachment needs, which had never been met*".[578]
- LA-F36's house was said to be a "*shambles*" and "*very dirty*", with LA-F36 and LA-A23 using only one room. Mr Hussell suggested to us that this indicated LA-F36 was "*barely able to cope*".[579]

7. Despite these varied and significant issues, Mr Small and Mr Hussell did not appear to consider moving LA-A23. Mr Hussell explained that he considered the arrangement was preferable to LA-A23 being in residential care as "*the available alternatives were not going to meet his needs any better*".[580]

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570 LAM030015
571 Chris Hussell 24 July 2020 39/13-18
572 Chris Hussell 24 July 2020 38/24-39/12
573 LAM030269_052
574 LAM030013; Chris Hussell 24 July 2020 41/18-43-15
575 Chris Hussell 24 July 2020 46/7-47/5
576 Chris Hussell 24 July 2020 47/7-13
577 Chris Hussell 24 July 2020 47/12-48/7
578 Chris Hussell 24 July 2020 48/10-18
579 Chris Hussell 24 July 2020 49/5-16
580 Chris Hussell 24 July 2020 49/17-50/1

8. In March 1982, Cornwall Social Services expressed concern to Mr Hussell about LA-A23's placement. Devon & Cornwall Police confirmed to him that LA-F36 had been dismissed as a teacher (in a decision upheld by the Department of Education) as a result of allegations of indecent assault by three boys, who LA-F36 had taken home with him. Members of the public had also *"complained about LA-A23's welfare"*.[581]

9. Mr Hussell and Mr Small interviewed LA-F36, who told them that he had held one boy in his arms and kissed him on the lips. Despite the information received from Cornwall Social Services and Devon & Cornwall Police, Mr Hussell accepted LA-F36's account:

> "*This was my second meeting with LA-F36. On the first occasion, I had found him a likeable, intelligent and sensitive man, in whom I had some confidence as a parent figure for LA-A23. On the second occasion, I was even more impressed by his depth of concern and commitment to LA-A23, which had strengthened in the previous six months by … the frankness with which he answered all of the questions. I was left in little doubt that the story he had told me was the truth, at least as far as he viewed it.*"[582]

Mr Hussell told us that this did not "*raise any anxieties in me regarding abusive behaviour*".[583] It plainly should have done.

10. LA-A23 remained with LA-F36. Cornwall Social Services refused "*to co-operate on any level with supervising*" the placement; Mr Hussell confirmed that they were horrified by it.[584]

11. In March 1982, the police relayed to Mr Hussell that the NSPCC had received an anonymous referral about LA-A23 and LA-F36's overbearing attitude towards him.[585] Lambeth Council's file also included a letter from the Probation Services to Cornwall Social Services, which described LA-F36 shouting at LA-A23 in a pub, LA-A23 not attending school and LA-F36's house being dirty and disorganised. LA-F36 was also said to be seen drunk frequently.[586]

12. A further letter was sent to Mr Hussell in May 1982, following an interview of LA-F36 and LA-A23 by an educational psychologist. It stated that LA-A23 was not receiving any formal education, instead spending much of his time wandering alone. The letter noted that Lambeth Council had no monitoring system for LA-A23's education.[587]

13. Mr Hussell and Mr Small still failed to remove LA-A23. The placement collapsed in June 1982. LA-A23 and LA-F36 were brought to live for two weeks at Angell Road children's home (managed at the time by Michael John Carroll, who was subsequently convicted for sexual abuse of children in the care of Lambeth Council; see Part D).[588] Mr Hussell was not concerned about bringing an adult dismissed for indecent assault to live in a children's home. It seemed to him to be an "*imaginative*" solution, which would enable them to observe LA-F36's ability to exercise "*care and control of LA-A23 in any meaningful way*".[589] Ms Hudson

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[581] LAM030003_010
[582] Chris Hussell 24 July 2020 54/3-14
[583] Chris Hussell 24 July 2020 52/10-54/1
[584] Chris Hussell 24 July 2020 55/12-21
[585] Chris Hussell 24 July 2020 55/23-56/7
[586] Chris Hussell 24 July 2020 56/11-25
[587] Chris Hussell 24 July 2020 57/5-22
[588] LAM030269_053
[589] Chris Hussell 24 July 2020 58/2-25

described this move as "*inexplicable*" and "*an extraordinary and, in my view, a professionally irregular decision, in the light particularly that it was so singularly dismissive of the views and judgements of the social services manager and police in Cornwall*".[590]

14. A short time later, having been moved to another children's home without LA-F36,[591] LA-A23 told a staff member from another local authority that LA-F36 had tried to sexually assault him. He would not give any detail about this.[592] Mr Small visited LA-A23, who described LA-F36 attempting to sexually assault him in his bed.[593] (In 1999, LA-A23 told the police that sexual abuse did occur during the foster placement.)[594] Despite this, case conference notes from March 1984 stated that contact between LA-A23 and LA-F36 would not be discouraged. When asked to explain this, Mr Hussell said:

> "*I would guess that we considered that there were still some positives in the relationship and discussions with A23 indicated that, actually, that was the case, that he did have some respect and liking for F36.*"[595]

15. The placement of LA-A23 with LA-F36 by Mr Hussell and Mr Small is a demonstration of a social work culture in Lambeth Council that consciously exposed children to obvious risk of sexual abuse. There was little if any formality to the placement. Mr Hussell and Mr Small ignored the risk of sexual abuse to LA-A23 or the promotion of LA-A23's welfare (still less subjected either to any assessment). They did nothing in the face of mounting evidence that the placement was unsafe. On the contrary, they regarded LA-F36's disturbing behaviour (including giving LA-A23 a baby's bottle) as being beneficial to the child. This culture and the failings it exposed remained uncorrected by any processes or safeguarding procedures that Lambeth Council should have been implementing.

16. This reflected the broader culture of Lambeth Council in the 1980s. A vulnerable child was sent to live with an adult whose suitability had not been properly checked, and about whom little was known. Even when information became available that LA-A23 was at significant risk of sexual abuse, staff in children's social care in Lambeth Council failed to act. Mr Hussell suggested that he had no education or awareness of grooming and child sexual abuse in 1982, but other organisations (such as Cornwall Social Services and Devon & Cornwall Police) recognised the potential risk posed by LA-F36.[596] Ms Hudson accepted that LA-A23 "*should never have been placed with LA-F36*" and should have been removed at a very early stage as concerns came to light. That LA-F36's motives and behaviour were never challenged or questioned represented "*abject practice failures*" by Lambeth Council. The consequence for LA-A23 was "*profound harm and deep distress*".[597]

[590] LAM030269_058
[591] LAM030269_060
[592] Chris Hussell 24 July 2020 59/8-60/5
[593] Chris Hussell 24 July 2020 60/12-61/4
[594] LAM030269_061
[595] Chris Hussell 24 July 2020 61/9-20
[596] Chris Hussell 24 July 2020 61/21-62/15
[597] LAM030269_062-063

E.3: The 1990s: LA-A61

17. LA-A61 was fostered as a baby in the 1990s, before being placed with adoptive parents when she was around two and a half years old in 1995. From the outset, her adoptive parents were concerned about some of her behaviour, which suggested that she had been sexually abused.[598]

18. In 1995, Lambeth Council held its first meeting in respect of this case. At a subsequent planning meeting in January 1996 (at which the police were not present) it was acknowledged that LA-A61 had probably been abused. The Adoption and Fostering Unit of children's social care was asked to investigate.[599] By March 1996, Lambeth Council had undertaken to involve the police but failed to arrange a meeting with them. In April 1996, the Metropolitan Police Service wrote to children's social care, noting lack of response to its correspondence and asking for a meeting as soon as possible.

19. Although LA-A61's adoptive parents had raised concerns about child sexual abuse in 1995, it was not until July 1996 that the Adoption and Fostering Unit investigation into the foster carers had been completed and a final report provided to Ms Constantia Pennie (principal manager adoption and fostering). LA-A61 had not been interviewed by the police. Other boroughs and agencies had, however, been informed that LA-F31 and LA-F32 should not be fostering.[600]

20. The Lambeth Family Finders and Adoption Unit report concluded it was unclear what had happened to LA-A61. LA-A61 was described as a child who had experienced considerable trauma, evidenced in her sexualised behaviour and her ongoing anxiety and distress. It was noted that 65 children had been placed with LA-F31 and LA-F32 between 1979 and 1997.[601] As a result of other serious child protection concerns, it recommended that LA-F31 and LA-F32 be deregistered as foster carers.[602] (This did not occur until October 1997, more than two years after the initial complaint.)

21. At a further meeting in May 1997, the Lambeth Council investigation was described as "*inconclusive*" about who had abused LA-A61. A psychologist, a play therapist, a home support worker and a doctor agreed that LA-A61 had been sexually abused when she was placed with LA-F31 and LA-F32.[603] By the time of this meeting, a check of foster carer files revealed that LA-F32 had been convicted in 1959 for indecent assault of a four-year-old, when he was 12 years old.[604]

22. In February 1999, concerns were raised about links between LA-F31, LA-F32 and another foster carer whose name (and that of LA-F31) were found following a police search of Michael John Carroll's home (on his arrest as part of Operation Care).[605]

23. In March 1999, Ms Helen Kenward (who was leading the Children's Homes in Lambeth Enquiry (CHILE) team supporting Operation Middleton) reported on LA-A61's case to Dame Heather Rabbatts, Lambeth Council's chief executive. Ms Kenward concluded that the failure to investigate LA-A61's case rigorously was itself a disciplinary matter. In her view, it

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598 LA-A61 29 July 2020 83/3-84/7
599 LA-A61 29 July 2020 90/11-22
600 LA-A61 29 July 2020 91/7-9
601 LAM030269_066
602 LA-A61 29 July 2020 91/10-21; LAM029331_144
603 LA-A61 29 July 2020 92/3-11
604 LA-A61 29 July 2020 92/3-6; LAM029331_143
605 LA-A61 29 July 2020 93/3-11

was "*outrageous*" that after nine meetings over 12 months the investigation was inconclusive and had failed to establish either abuse or, in the interests of justice, the innocence of the foster carers. The Lambeth investigation report was first forwarded to police in 1999 by Ms Kenward.[606]

24. A further CHILE report on LA-A61's case in 2000 noted that she had five social workers between her birth in 1992 and 1995, as well as periods with no allocated social worker. There was a lack of continuity and she suffered from the incompetent management of her case. The report stressed that it was clear to professionals that LA-A61 had suffered greatly in the foster placement. The impact of her highly distressed behaviour on her adopted family was traumatic.[607] More generally, the CHILE report also concluded there was no investigation of other children who were, or had been, in LA-F31 and LA-F32's care. The report noted that "*Lambeth felt the adoptive parents were troublemakers*", despite their comprehensive recording of LA-A61's distress and repeated requests for help and support.[608]

25. The handling of this case demonstrated a failure to recognise the urgency of the situation and a lack of focus by staff in children's social care on the need to help and support the adoptive parents and to progress the investigation into the abuse of LA-A61 promptly. It was a profoundly damaging process for LA-A61 and her adoptive parents.

E.4: The 2000s: LA-A147

26. LA-A147 was in care in Lambeth during the 1990s and 2000s.[609] She was in foster care aged nine years old with another child (also being fostered) who would get LA-A147 to touch him.[610] LA-A147 remained in foster care but ran away, staying with a family member who she did not believe had been assessed.[611] She said that, when she was only 13 years old, she was sexually abused on a frequent and repeated basis by older men when staying with this family member.[612] She started smoking cannabis from 12 years old and was addicted to it by 13, telling us that "*I was actually selling myself to buy cannabis*".[613] LA-A147 returned to children's homes between the ages of 13 and 16. In one children's home over a six-week period she was offered ecstasy, crack and heroin. LA-A147 described how a staff member – whose role it was to protect her – planned to go to a nightclub with her and to obtain ecstasy. The professional relationship which should have been in place was absent. LA-A147 went to get some clothes for this but met a man who offered her cannabis and raped her at his flat.[614] She telephoned the care home about this in a distressed state.[615]

[606] LA-A61 29 July 2020 93/18-94/3
[607] LA-A61 29 July 2020 94/4-14
[608] LA-A61 29 July 2020 94/15/95/1
[609] LA-A147 20 July 2020 80/21-23
[610] LA-A147 20 July 2020 82/9-24
[611] LA-A147 20 July 2020 82/25-83/6
[612] LA-A147 20 July 2020 83/7-85/2
[613] LA-A147 20 July 2020 85/3-5 and 86/16-18; LA-A147 20 July 2020 87/12-13
[614] LA-A147 20 July 2020 88/8-90/1
[615] LA-A147 20 July 2020 88/3-5

27. LA-A147 disclosed sexual abuse on a number of occasions, including telling an education welfare officer in 2001 that she had been raped while in the care of a foster carer. She also said that she told staff at a children's home that four people had had sex with her without her consent.[616] LA-A147 explained that when it came to a much older man who abused her:

> *"I thought that, at some point, me having sex with him, he might start loving me. I know it's – as an adult, it's not real, but as a child, I just wanted to feel love, and I thought maybe if I had sex with him, he might love me."*[617]

28. LA-A147 stayed in nine care homes and four foster placements during her time in care. As LA-A147 described very clearly in oral evidence, she had suffered and reported sexual abuse while in care, was addicted to substances and was not receiving an education. She did not receive assistance or support while in care to enable her recovery. The inability of Lambeth Council – even in the early 2000s – to protect LA-A147, to make constructive care plans or promote LA-A147's welfare within any fostering arrangement is self-evident.

E.5: The safety of children in foster care: 2000

29. These examples suggest wider dysfunction in Lambeth Council's fostering and adoption services. When Mr Eric de Mello took up his role as service manager within the department in 1998, he discovered that not all foster carers had undergone police checks.[618] He issued an instruction in July 1998 that all foster carers – current and prospective – should be checked against Lambeth Council's central social care records and with the police.[619] The checks were not completed.[620]

30. On 5 February 1999, Mr de Mello wrote formally to Ms Celia Pyke-Lees, executive director of social services, stating that he could not guarantee the safety of foster care households.[621]

31. An independent auditor, Diane Edwards, was appointed to undertake an audit of foster carer records to ascertain the extent of the problem regarding the safety and suitability of foster carers. By the time she had reached the files of foster carers with names beginning with a 'C', 35 percent of the files had identified a range of serious problems, including foster carers who had failed to reveal convictions that were later recorded on their files and foster carers who had not been subject to any police checks. This revealed the serious failures by staff in children's social care in Lambeth Council in the vetting of foster carers.[622]

32. Due to the scale of the problem, Lambeth Council's anti-fraud team was commissioned to undertake an investigation, including the interviewing of foster carers to establish their identity and status details, with requests being made where necessary for police checks to be carried out. As a result, in March 2000, almost 50 percent of foster carers were removed from the list of available carers.[623]

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[616] LA-A147 20 July 2020 90/2-19 and 92/5-11
[617] LA-A147 20 July 2020 93/14-18
[618] Annie Hudson 21 July 2020 134/8-15
[619] Annie Hudson 21 July 2020 134/3-15
[620] Annie Hudson 21 July 2020 134/8-20; LAM030269_029-030
[621] LAM030269_030
[622] LAM030269_030
[623] LAM030269_030-031

33. In July 2000, the CHILE team commenced a task that led to the review of over 100 foster carers. This exercise was referred to as the Fostering in Lambeth Audit.[624] The audit noted that there was no concise database of children looked after by foster carers; data (including children's and carers' names, as well as the numbers of children placed) were incorrect; finances were unclear, with irregular payments and payments ceasing; the immigration status of some children was unclear; there was a lack of clarity as to the legal status of some children and Lambeth Council's involvement with them; and some children did not have clear care plans.[625]

34. The gravity of the position was reflected in the Social Services Inspectorate (SSI) 2000 inspection report.[626] Eighteen of 196 children on the child protection register were unallocated and 82 of 731 looked after children were unallocated.[627] Lambeth Council had also discovered a "*hidden looked-after population*" of children or young people placed with family or friends.[628] The SSI 2000 inspection report stated that:

> "*These children were not regarded as looked after and so were omitted from the SSD's statistics. Neither were they allocated a social worker, visited or reviewed. No checks were made on their carers.*"[629]

35. It was unclear how or why this had happened, but the SSI was "*extremely concerned*" that children and young people were "*without recourse to any support*" and the protections afforded by visiting, monitoring or statutory reviews.[630] The SSI stated that:

> "*Urgent action to clarify the situation was needed, and to ensure that children are provided, where necessary, with approved, monitored care*".[631]

36. This was an extremely serious issue. It is clear that there was no proper procedural structure in place at all in respect of the approval of foster carers in Lambeth Council in 1999. The fact that this was the position in 1999 is extraordinary. Children were placed at risk in children's homes within Lambeth into the 1990s and, on the closure of children's homes, they were subsequently exposed to risks within foster placements as well.

[624] LAM030269_033-034
[625] LAM030269_033-034
[626] LAM029179
[627] LAM029179_041
[628] These children were supported through either regular payments under section 17 of the Children Act 1989 or boarding out payments under regulation 11 of the Foster Placement (Children) Regulations 1991
[629] LAM029179_041
[630] LAM029179_042
[631] LAM029179_042

Part F

The culture of Lambeth Council

The culture of Lambeth Council

F.1: Introduction

1. In this Part, we examine the extent to which the culture of Lambeth Council – including corruption, bullying, intimidation and racism – impacted upon children in its care and the handling of allegations of sexual abuse. We also consider the role of trade unions and the relationships between elected councillors and staff.

F.2: Corruption

2. The issue of corruption within Lambeth Council was considered by Elizabeth Appleby QC in a report commissioned by Lambeth Council and eventually published in 1995 (the Appleby report).

2.1. The Appleby report considered the district auditor's reports and documented the chaos of Lambeth Council's financial position from 1979.[632]

2.2. It described the involvement of Lambeth Council's staff in fraud and corruption, and the Council's tolerance of it. In 1993, it seemed that there could be as many as 400–500 employees engaged in benefit fraud (related to housing benefit or income support) against Lambeth Council.[633] Staff known to have been involved in the fraudulent claiming of benefits remained employed.

2.3. Lambeth Council's policies and actions from the 1980s to the early 1990s were said to have created the perfect conditions for systemic abuse by dishonest employees, dishonest members of the public and dishonest contractors.[634]

2.4. It also discussed that "*in the eighties and early nineties (1991/92) Lambeth operated an unwritten policy not to collect its rates and taxes and not to collect rent and the failure to collect continues*".[635] Political opposition to rate capping resulted in the refusal by around 30 Labour Party councillors to set a council tax rate in 1986. These elected members were required, by the district auditor, to pay for the losses that accrued from this failure. They were also disqualified from their positions as councillors.[636] This had an immediate and far-reaching effect on Lambeth. Disqualified councillors were replaced by councillors who, with the exception of three, had no former experience in local government. Collection difficulties persisted. In 1993, on the introduction of the council tax, Lambeth Council should have collected £65.5m – it collected only 10 percent of what was owed.[637]

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[632] LAM000025_013
[633] LAM000025_043
[634] LAM000025_017
[635] LAM000025_045
[636] LAM000025_012
[637] LAM029331_027

2.5. In short, the Appleby report concluded that Lambeth Council was in "*an appalling mess*". Vast amounts of funds were wasted. It had been unable or unwilling to translate plans and ambition into positive action. It stated that it would be surprising if any directorate was free of mismanagement. The report concluded that the 1980s had created a "'*culture' in which Lambeth is trapped*". The mismanagement of Lambeth had "*merely grown and grown*".[638]

3. Ms Anna Tapsell was an elected councillor between 1990 and 1998 (and chair of the Social Services Committee for part of this period), having previously been employed between 1978 and 1989 as a home care organiser, a trade union official and chair of the Lambeth branch of the National and Local Government Officers' Association (NALGO) during the 1980s. She described everyday corruption within Lambeth Council, which was deployed to obtain leverage. For example, employees in children's homes were coerced into accepting food donated to children's homes for children "*because they were persuaded that was the norm*". Once accepted, the employee was compromised.[639] Ms Tapsell also explained that members of Lambeth Council's Direct Labour Organisation obtained leverage by offering elected members free labour, such as repairs. If a councillor accepted, they were compromised.[640]

4. This corruption impacted directly upon the safety of children. For example, there were serious concerns that an initial investigation into the sexual abuse of children at Ivy House was tainted by fraud. Mr Thomas, in his role as children's home officer, was appointed to investigate an allegation of sexual abuse made by LA-A26 against LA-F12 (assistant officer in charge at Ivy House). The officer in charge of Ivy House was suspected of involvement in a food fraud, together with Mr Thomas.[641] In 1987, in discussions with the Social Services Inspectorate (SSI), Mr Robin Osmond (director of social services 1977 to April 1988[642]) admitted that Mr Thomas' investigation of abuse at Ivy House had been superficial and unsatisfactory and that the officer in charge at Ivy House being part of the food fraud did point to collusion.[643]

5. Mr Thomas also presented the case against Michael John Carroll (the officer in charge of Angell Road children's home from 1981 to 1991) at a misconduct hearing in 1986 (see Part D). Prior to this, in 1984, an anonymous written allegation was made against Carroll by someone who described him as an autocrat, more suited to bringing up boys in the army than caring for young children. It also said that Carroll regarded everything in the home as his own, such as the minibus, which should have been used by staff to bring children to school.[644] That letter was not referred to in the misconduct proceedings, and Carroll was not dismissed until 1991 for fraud, having spent funds intended for the purchase of items such as groceries for children at Angell Road on cigarettes and alcohol. There were also irregularities about overtime and 'sleeping-in' claims.[645] It appears that the SSI was informed that the police had declined to investigate Carroll for fraud against Lambeth Council, which was "*consistent with Lambeth local practice involving theft against an employer*".[646] In fact, Carroll's

[638] LAM000025_053-054
[639] Anna Tapsell 8 July 2020 116/23-117/13
[640] Anna Tapsell 8 July 2020 119/2-18
[641] CQC000367_002; CQC000135_001
[642] Robin Osmond 3 July 2020 73/7-19
[643] CQC000135_001
[644] LAM000020_030
[645] CQC000298_006
[646] CQC000298_006; The SSI file note of this discussion also referred to the Melting Pot, where "*there were suspicions of money being laundered from 'crack' sales to Jamaican bank accounts*".

involvement in fraud had not been referred to the police; the Clough report recorded that the police were not informed on the basis that they would not be interested in "*fraudulent use of petty cash*".[647] Lambeth Council officers (including David Pope, the director of social services from 1988 to 1995) similarly failed, until 1992, to notify the Department of Health about Carroll's dismissal for fraud so that it could consider barring Carroll from working with children or recording that he had been dismissed for fraud. The SSI queried whether it was the view of Lambeth Council staff that "*embezzlers and con people are the sorts of people we want to look after children in the public care*".[648]

F.3: A state of chaos

6. The disqualification of more than 30 Labour councillors in 1986, as set out above, led to a period of turmoil. Ms Joan Twelves, one of those who subsequently took office in 1986 and subsequently leader of Lambeth Council between 1989 and 1991, recognised the effect of disqualification:

> "*the effect of it, when you look back at it, was enormous. Some people were very highly qualified. We had a couple of people who had worked in senior positions in other councils and knew how things were meant to work … But the majority had no experience of the council at all, and therefore, depending on what their jobs were in ordinary life, it totally was, you know, pot luck almost.*"[649]

7. Dr Josephine Kwhali (formerly Ms Josie Durrant) was a social worker in Lambeth between 1983 and 1989. She worked initially in children's day care services, and was subsequently the assistant director children and young persons division from mid-1987 to March 1989. She described the situation as:

> "*There were major budgetary issues, I assume arising from the failure to set a budget. There were recruitment freezes … there were gaps in senior management and middle management across the children's services. We were working excessively long hours against the background of, as I said, competing pressures and significant challenges at that time.*"[650]

8. The failure to set a council tax rate in 1986 must have constituted a huge distraction and required energies and resources that ought to have been focussed on frontline services. Mr Stephen Whaley was another who first became a councillor in 1986. He considered that his background as a trade unionist in a university provided him with experience of working under pressure, but he viewed the situation in 1986 as extraordinary.[651] He considered "*the pursuit of an ideological opposition to the government*"[652] (during the previous leadership of councillor Ted Knight) meant more energy had been spent by his predecessors on confronting the government than dealing with the issues within Lambeth Council:

> "*the council started to be run as a political campaign rather than necessarily as an organ for delivering services to the people*".[653]

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[647] LAM000020_075
[648] CQC000297_003
[649] Joan Twelves 24 July 2020 113/23-114/6; Joan Twelves 24 July 2020 114/14-23
[650] Josephine Kwhali 3 July 2020 3/24-4/10
[651] Stephen Whaley 24 July 2020 73/3-4
[652] Stephen Whaley 24 July 2020 71/12-18
[653] Stephen Whaley 24 July 2020 71/19-22

This and the cycle of crises and damning reports (discussed in Part I) – contributed to its inability to attract good staff, as reflected in consistently high numbers of children not being allocated a social worker. In turn, this impacted upon children's safety and protection.

9. Mr Whaley also described further turmoil in 1991 when Labour councillors were suspended by the national party because they were acting against its policy in various areas. The councillors became a minority group in their own right within Lambeth Council. Mr Whaley described how factions among councillors were able to stifle decision-making:

> "*what would happen is that something would be voted down, but then, because they would then switch allegiance so that they then put it back up again, so you ended up with an inability to make a decision.*"[654]

Labour continued to have control in Lambeth until 1994, when the local election resulted in no party having overall control of the Council.

10. This coincided with the appointment of Dame Heather Rabbatts as the chief executive in 1995. Her appointment came in the aftermath of the Appleby report and she described "*overwhelming chaos*" within Lambeth Council.[655] She regarded the Appleby report analysis as:

> "*hugely accurate and really shines a light on what was decades of political mismanagement. This had gone on for over 20 years. Lambeth was behaving, in many ways, unlawfully. It wasn't collecting its rates. It had huge numbers of public interest reports because it did not abide by the requirements of a public service organisation, and that was very much inspired by the politicians during that time and also, in particular, an ideological view that there should be a system of tripartite government, or local government, which meant that the trade unions were heavily involved and there was a real undermining of any sense of managerial leadership or managerial authority.*"[656]

11. Within three months of her arrival in Lambeth there was a major crisis in the community care budget, which was overspent by mid-year (against a political priority of not increasing council tax).[657] She regarded it as absolutely shocking that this should have occurred and it was agreed that Mr Pope would leave.[658]

12. Dame Heather Rabbatts also described that on her arrival there was an inability of management to discipline staff. She regarded trade unions as having access to elected members and management as being "*very much cowed*".[659] This view was supported by Mr Whaley, who considered that middle managers were hesitant to discipline staff because "*the political leadership might be perceived to side with the trade unions*".[660] He did not think that councillors interfered or sided with trade unions in disciplinary hearings, but rather that trade union officials "*had a close ear of the councillors*" and that councillors had a tendency to listen to unions.[661] This would subsequently be reflected in their decisions in disqualification or grievance hearings.

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[654] Stephen Whaley 24 July 2020 75/14-18
[655] Dame Heather Rabbatts 7 July 2020 114/23-24
[656] Dame Heather Rabbatts 7 July 2020 106/22-107/10
[657] Dame Heather Rabbatts 7 July 2020 113/4-8
[658] Dame Heather Rabbatts 7 July 2020 112/23-113/21
[659] Dame Heather Rabbatts 7 July 2020 107/11-108/7
[660] INQ004913_005
[661] Stephen Whaley 24 July 2020 73/13-22

13. Mr (now Lord) Herman Ouseley was the race relations adviser to Lambeth Council in 1979, assistant chief executive between 1984 and 1986 and chief executive of Lambeth Council between 1990 and 1993. He told us about his attempts as chief executive to tackle the direct labour organisations, which had been implicated in corrupt practices. He described impediments to making progress in Lambeth. Having informed the then leader of the council that he needed to remove three directors if progress was to be made, within minutes Mr Ouseley:

> "*then had a telephone call from the chair of one of the committees representing one of the directors I was referring to, telling me that under no circumstances – under no circumstances – his director would be leaving and if I think that's what I'm going to get up to, I've got something else coming*".[662]

Lord Ouseley also explained that much of his three-year tenure as chief executive was taken up with the investigation of fraud, but "*every time we got close to evidence, the evidence vanished*".[663]

14. It is clear that for many years – between the 1980s and into the 1990s – the political agenda of elected councillors and the consequences of that agenda dominated Lambeth Council. The 1980s appears to have seen the origins of the state of crisis or near crisis that continued over the ensuing years. The impression created is that Lambeth Council's lack of order and control meant it was incapable of effecting change or dealing with anything other than each immediate crisis.

15. This lack of order and a failure to effect meaningful change within children's services persisted into the 2000s. As set out in the Barratt final report (discussed in Part I.4):

- Lambeth Council – through its inadequate arrangements in the Social Services Committee and children's social care – repeatedly failed to fulfil both its statutory duties and its own policies relating to the care and protection of children;
- it repeatedly tried and failed to create and control an effective children's social care department; and
- the chain of command (if it had ever existed) linking department action to councillors had decayed and disintegrated.[664]

The Barratt final report also noted that it would be unfair not to recognise that Lambeth Council repeatedly tried to bring its children's services up to a proper standard and that the reforms had been effective in some respects. It referred, for example, to three major reorganisations (in 1991/2, 1993/4 and 1995/6) and detailed 'action plans' put forward by staff in 1993/4 and 1997.[665]

16. Further crises in 1998 related to the allegations about Mr Steven Forrest and in 2000 in relation to fostering also demonstrate that there remained serious and deep-rooted problems concerning the care of children by Lambeth Council.

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[662] Herman Ouseley 9 July 2020 29/6-11
[663] Herman Ouseley 9 July 2020 32/4-5
[664] LAM000021_010
[665] LAM000021_013

F.4: Bullying, intimidation and racism

17. In 1979, when he was the race relations adviser, Mr Ouseley was tasked with ascertaining why building sites undertaking Lambeth Council building works had no black employees. The director of construction services told him that this was determined on site. Mr Ouseley met with the leader of the trade unions of the construction services, and with 29 stewards who operated on the building sites. He was met with hostility and racism, and described this to us as an example of the "*complex web of people*" with "*vested interests that they seek to protect if they think someone is trying to move things in a different direction*".[666]

18. Fear, intimidation and racism permeated Lambeth Council. Intimidation was used as a lever even against the most senior officers. For example, when as chief executive he was conducting investigations into fraud, Lord Ouseley told us that:

> "*I was getting calls in the middle of the night … I had all four of my tyres slashed in one go. I had my windscreen smashed.*"[667]

One member of an extreme right-wing organisation said to him that his "*home number is on every – on the walls of every public convenience in Lambeth*", which is how he came to understand how so many people were able to telephone him.[668] It was also reported in the press in 1997 that his office and home had been bugged.[669]

19. Mr Henry Gilby – the director of amenity services, then director of environmental services and finally chief executive of Lambeth Council (between June 1993 and December 1994) – also described being subject to intimidation. As director of amenity services, his office was the subject of a serious arson attack.[670] When attempting to tackle corrupt practices as director of environmental services, his office was broken into and computer records stolen.[671] During his time as chief executive, his office and home were broken into, he was threatened and his car tyres slashed.[672]

20. In February 1993, a Lambeth Council employee Mr Bulic Forsythe (whose responsibilities included building management) was killed. His body was found in his home, which had been set on fire. In June 1993, his murder was featured on an episode of the television programme *Crimewatch*. The murder of Mr Forsythe remains unsolved. It was the subject of a recent review by the Metropolitan Police Service (Operation Redsnow), as a result of concerns that there was a connection between Mr Forsythe's employment at Lambeth Council and his murder, but no evidence of such a connection was found.[673] At the very least, the murder of Mr Forsythe is likely to have caused concern and fear on the part of staff and councillors.

21. A report in 1994 into Lambeth Council's Housing Directorate – the Harris report – identified racism, sexism, nepotism and fear.[674] It arose following allegations that Lambeth Council employees were involved in making or distributing images of child sexual abuse. One member of staff was alleged to have told others that the content included sadism, bestiality

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[666] Herman Ouseley 9 July 2020 37/10-38/9
[667] Herman Ouseley 9 July 2020 33/2-7
[668] Herman Ouseley 9 July 2020 34/9-12
[669] Herman Ouseley 9 July 2020 33/2-3
[670] HGL000046_015-016
[671] HGL000046_015
[672] HGL000046_015-016
[673] MPS004500_023-024
[674] LAM028615

and imagery of children, with films said to have been home produced by staff or people with whom they were associated.[675] The exchange of pornography was also alleged to have occurred.[676] The report described evidence of informal networks of men, and a department operated by cronyism and favouritism, which served to sustain organisational racism and sexism. It concluded:

> "*The Panel is of the view that a network of exchange of pornographic videos does or did exist and that there is wider knowledge of this within housing than the Panel was able to obtain from witnesses.*"[677]

22. The Harris report also referred to 'Les' or 'LP', who was thought to have links to the officers in the housing directorate implicated in the exchange of pornography.[678] While the Harris report did not specify the identity of this person, as DI Morley said in oral evidence, it might well have been Mr Leslie Paul, a care worker for Lambeth Council who was subsequently convicted of child sexual abuse.[679] It also referred to:

- a Lambeth employee of a hostel for adults receiving a letter, intercepted by staff, which offered pornographic video material and "*referred to providing children*", but "*no management action was taken on the letter which was returned by the more senior manager*";[680] and
- allegations that the personnel officer in housing had interfered in the investigation into an allegation of sexual assault made by a female officer against a male housing officer, which witnesses described as a "*cover-up*".[681] (The Harris report also described "*sinister*" aspects of the investigation into the allegations of sexual assault, such as the removal of items of evidence by the personnel officer).[682]

F.5: Trade union influence

23. A number of witnesses considered that trade unions had too great a grip on Lambeth Council staff and councillors. Lord Ouseley considered there to have been close relationships between several councillors, different trade unions and trade union leaders.[683] Many of those councillors projected themselves as representing the interests of the staff or believed that they had an affinity with the lower ranks of employees.[684] This resulted in suspicion and a lack of trust between officers and councillors.

[675] LAM028615_013-014
[676] LAM028615_010
[677] LAM028615_014
[678] LAM028615_015
[679] Simon Morley 22 July 2020 29/17-33/25
[680] LAM028615_033
[681] LAM028615_016
[682] LAM028615_023
[683] Herman Ouseley 9 July 2020 42/21-23
[684] Herman Ouseley 9 July 2020 43/9-10 and 39/5

24. Trade unions were able to influence the investigation of child protection failures, as shown by the public inquiry report (dated 1987) concerning the death of Tyra Henry, a child who was killed by her father when she was in the care of Lambeth Council.[685] Stephen Sedley QC (now Sir), chair of the public inquiry, noted that Lambeth Council had conducted two internal inquiries into her death.

> "*The reports of both inquiries were unacceptable to the staff and to the local branch of their union, NALGO, with the result that the independent panel whose report this is was invited by the council to conduct a public inquiry with the following terms of reference.*"[686]

Sir Stephen Bubb, a councillor from May 1982 until his disqualification in 1986, said that there was very strong resistance from the NALGO branch to an inquiry into the death and it tried to prevent the setting up of such an inquiry.[687] The Tyra Henry public inquiry report also referred to the "*unconcealed pique*" that "*one limb or other of the council*" showed "*at the fact we were not doing what it thought we ought to be doing*". For example, five days before it was due to start taking evidence, Lambeth Council's Special Committee, without consulting the inquiry, decided to postpone the hearings indefinitely because of the non-cooperation by Lambeth NALGO.[688]

25. When Mr Richard Clough conducted his investigation in 1993 into the retention of Carroll, a Lambeth Council employee with a conviction for child sexual abuse, he guaranteed those employees to whom he spoke confidentiality even though it was for internal purposes. Mr Clough regarded it as possible that staff would not be as candid as they might be without an assurance of confidentiality.[689]

26. In 1999, Mr John Barratt investigated Lambeth Council's failure to respond effectively to an allegation of child sexual abuse against Steven Forrest, a care worker at Angell Road children's home. Having been troubled by his findings, Mr Barratt issued an interim report and informed Dame Heather Rabbatts that he had "*read and heard enough to be satisfied that Child Protection practice, in Lambeth, remains worryingly inadequate and incoherent, and therefore ineffective*".[690] Shortly afterwards, Mr Jon Rogers, the branch secretary of UNISON, wrote to Mr Barratt advising him that in view of his interim report and the suspension of Assistant Director for Children and Families, Ms Constantia Pennie, UNISON would advise its members to play no further part in the investigation.[691] In the course of our investigation, Mr Rogers sought to justify this on the basis that there was considerable anger among UNISON members that Ms Pennie was being scapegoated, and that the Barratt interim report should not have been used in this way when it had said it could not attribute individual blame.[692] When asked how UNISON sought to balance the interests of children in care and their protection against the rights of individual UNISON members when giving advice, Mr Rogers regarded this question as misconceived. He explained that "*as a UNISON representative, it was my responsibility to give guidance to UNISON members to protect their interests. It would not have been appropriate for me to have taken it upon myself to*

[685] LAM028613
[686] LAM028613_004
[687] Stephen Bubb 24 July 2020 15/23-16/21; Mr Bubb was also a member of the Social Services Committee from 1982, Vice Chair of the Social Services Committee from 1983 until 1985, and the Chief Whip to the Labour Group between 1985 and 1986.
[688] LAM028613_161-162
[689] Richard Clough 7 July 2020 60/20-61/8
[690] LAM000022_009
[691] LAM018236_001
[692] Jon Rogers 9 July 2020 84/10-16

undertake the balancing exercise which is implied by the question".[693] Mr Rogers considered that his letter did not impact upon Mr Barratt's investigation (which did not ultimately criticise UNISON). UNISON encouraged its members to cooperate with the police investigation, Operation Middleton.[694]

27. Whilst Mr Rogers may have been advising and supporting the members of UNISON, it should be borne in mind that defending particular sectional interests can result in the failure to fully recognise the wider interests of children. It is in the interests of all children in care that child protection failures are properly investigated, that individuals are held to account and that failures of practice continue to be identified to better protect children.

28. The Barratt final report ultimately concluded that in the 1980s "*managerial freedom was devalued by political decision-makers … including too close a relationship between them and the Trade Unions*".[695]

29. Industrial disputes also impacted upon children's homes. The failure by staff in children's social care to hold a review of each child kept in secure accommodation in 1984 was explained as a result of senior managers within children's social care being "*very heavily engaged in additional work resulting from the industrial action, which had necessitated the closure of the majority of children's homes*".[696] The Children's Homes in Lambeth Enquiry (CHILE) produced a document entitled 'The History of Lambeth Social Services', covering the period up to 1998. This stated that:

> "*The effects of the industrial action touched all of Lambeth's Children's Homes and incidents were widely reported in Local and National press. The headline 'Night Staff Walk Out on Children' (Daily Telegraph 18/06/81) appeared after staff left children unsupervised all night at Calais Street children's home. The British Association of Social Workers believed that children had already suffered.*"[697]

30. The chairman of the British Association of Social Workers Lambeth and Wandsworth branch, Mr John Wheeler, stated in the press:

> "*We have supported the idea of a National Review from the beginning because we saw the danger in industrial action. Once you encourage Authorities to use the private and voluntary sector, they might decide to carry on doing so.*"[698]

31. The interests of children became secondary to the interests of staff.

F.6: Tensions between councillors and staff

32. In the "*fraught*" atmosphere of Lambeth Council in the early 1980s, Stephen Sedley QC reported that he sensed a marked tension between staff in children's social care and councillors with a "*new preparedness*" to intervene to redress racial disadvantage in the borough.[699] The Tyra Henry public inquiry report considered the extent to which this tension manifested itself in the conduct of the Cases Subcommittee and the Social Services Committee. According to the Tyra Henry public inquiry report, the subcommittee became

[693] Jon Rogers 9 July 2020 86/7-12
[694] Jon Rogers 9 July 2020 84/24-85/8
[695] LAM000021_022
[696] LAM015770_002
[697] LAM002007_017
[698] LAM002007_017
[699] LAM028613_108

more vocal and involved in decision-making during the period that Councillor Boateng was chair of the Social Services Committee and the Cases Subcommittee, and Councillor Bubb was the vice chair of both.[700]

33. As set out in the Tyra Henry public inquiry report, between 1982 and 1986, the Cases Subcommittee disagreed with the recommendations of officers in only 9 of 326 cases, despite reports of its activism.[701] The report concluded that allegations of councillors being too interventionist were overstated. In her evidence to the Tyra Henry investigation, Councillor Boateng had stated that:

> "*there are certain decisions that have to be taken by officers irrespective of whether or not I have an open door policy … it would be quite foolish of me as a member, for instance, to decide the placing of a child and who it be placed with over a recommendation which an officer has to place that child.*"[702]

34. On the evidence we have received, councillors exercised influence over the decision-making of professional officers. A CHILE report noted:

> "*The mid-eighties also saw the development of a conflict between social workers and local elected councillors. The former made claims that councillors were refusing to accept their judgement in an increasingly politicised environment. An inquiry was set up by the Environment Secretary, Mr Patrick Jenkin, with one of the terms of reference to look at the increasing politicisation of local councils. Working relationships appeared to have deteriorated over the last three years until they had been described as 'nothing short of "poisonous"'. Sub Committee Meetings to discuss the action to be taken in particular cases had become platforms for abusing social workers and some councillors had scorned staff recommendations on the grounds that they, as elected representatives, knew more about the needs of the community (Guardian Newspaper 27/07/85). Committee meetings had turned into arguments about who knows best.*"[703]

35. In his evidence to this Inquiry, Sir Stephen Bubb did not recognise this characterisation of the relationship between councillors and staff. He regarded staff as being committed to the same agenda as councillors when it came, in particular, to the interests of black children.[704] When asked whether he recollected staff "*walking out*" of children's homes in the 1980s, Sir Stephen Bubb pointed to there being considerable industrial unrest at this point. He had been a trade union official, so he knew the tactics involved, and that would have been one of them.[705]

36. Ms Pauline Lawrence was a senior personnel officer in children's social care from October 1984 to December 1986. She found the culture to be "*extraordinary*" and "*damaging to service delivery*". She recalled that the director and assistant directors of social services "*seemed relatively powerless*", while the chair of the Social Services Committee, the race relations adviser and the NALGO senior steward all seemed to hold sway on the direction

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700 LAM028613_138
701 LAM028613_139-140
702 LAM028613_140-141
703 LAM028530 _018-019; Stephen Bubb 24 July 2020 4/9-5/8
704 Stephen Bubb 24 July 2020 8/8-11
705 Stephen Bubb 24 July 2020 8/17-19

of decisions. Ms Lawrence told us that the lack of management grip on performance and the standards applied in employment matters did not wholly fit with her personal or professional values.[706]

37. Ms Phyllis Dunipace, another Labour councillor who first took office in 1986, was chair of the Social Services Committee between 1986 and 1988. She had been an active member of the Labour Party and, when almost all councillors were disqualified, explained that those involved in the Labour Party were successful in their bids to become councillors. She referred to the newly elected councillors as being on a steep learning curve. Her prior experience was as a teacher and she said she was committed to children's welfare.[707] In Ms Dunipace's opinion, in 1986, councillors were too involved in operational decision-making and were unable to provide sufficient challenge and hold officers appropriately accountable.[708]

38. On the wider evidence received in this investigation, it is likely that officers orientated their decisions in the direction councillors would wish to see and in the direction they knew councillors would approve. Councillors did not need to intervene directly.

39. One clear example of elected members becoming involved in operational decision-making was the McCootie case. This concerned a child in Lambeth Council's care who was convicted of the rape of a 53-year-old woman in 1991. On sentencing the child for offences of rape and robbery, the judge asked that Lambeth Council investigate why he had not been in secure accommodation at the time the offences were committed.[709] The subsequent report set out that Lambeth Council had no legal power to delegate functions to an individual member, nor could urgent action between committees be taken by the leader or chairs of committees acting alone.

> "*Despite this, it had become 'custom and practice' that before an urgent request for secure accommodation could be made, the oral 'agreement' of the Chair or Vice Chair had to be sought. This is precisely what happened in N's case. To discover exactly how the decision was made has meant relying on the memories of the people involved, largely because 'custom and practice' has been not to minute formally decisions other than those which result in obtaining a secure accommodation order, despite the procedure … In N's case, it would appear that social worker advice that N should, for a period, be placed in secure accommodation was not agreed by the Chair and the outcome was that secure accommodation was not sought.*"[710]

40. The chair referred to was Mr Whaley. He told us that, even at the time of the investigation into the McCootie case, he had not recalled the conversation. He accepted:

> "*that becomes my word against his word, which is a very untenable position, and is also a very clear indication as to why that type of procedure is an entirely inappropriate one for making a decision as important as taking somebody into secure accommodation.*"[711]

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[706] Pauline Lawrence 3 July 2020 68/13-23
[707] Phyllis Dunipace 3 July 2020 112/22-113/13
[708] Phyllis Dunipace 3 July 2020 117/7-10
[709] CWH000015_001, 018-019
[710] CWH000015_036
[711] Stephen Whaley 24 July 2020 87/19-23

This case suggests poor administration of a decision not to place the child in secure accommodation but, more significantly, a systemic lack of an appropriate boundary between a professional, specialist decision by staff and the strategic oversight role of councillors on the other.

More generally councillors should not have overstepped the boundary between their own strategic and policy role, and the professional decision-making which was the responsibility of staff. Ensuring that decisions made by staff fitted with policy did not entitle councillors to intervene in decisions for vulnerable children or individual care plans and reviews.

41. There was no sense of councillors and officers working together to provide better public services until some time after the appointment of Dame Heather Rabbatts in 1995.

> **41.1.** Evidence of divisiveness and a lack of trust between councillors and officials was demonstrated within correspondence between Councillor Clare Whelan and the chief executive, Mr Ouseley. In 1992, Councillor Whelan gave the police a list of people who may have had information about allegations of abuse within children's homes. Mr Ouseley considered that Councillor Whelan should also have taken her concerns to the director of social services, David Pope. In one letter, Mr Ouseley referred to her as continuing "*to hurl innuendo about mismanagement in the Social Services Directorate without any precision*", adding "*I would stress that we cannot go on with such a ridiculous relationship between you and* [the director of social services]".[712] In reply, Councillor Whelan said that she was "*shocked*" that as the opposition spokesperson on social services she had not been briefed on any internal or external investigations.[713]

> **41.2.** Similar tension was evident in correspondence related to Councillor Whelan's attempts to visit children's homes and to examine records held at homes (a legal duty which was generally not met in Lambeth).[714] In her view, there was "*written and lip service encouragement of visits to children's homes*" but she felt they were in fact discouraged or being prevented by officers.[715]

> **41.3.** There is also evidence of councillors' concerns being downplayed. In one instance a memo from Mr Pope to Mr Ouseley about a proposal from councillors that they agree a blanket ban on not employing convicted sexual offenders was described as arising out of the "*furore*" about Carroll. Mr Pope regarded such a blanket ban or policy debate as "*fraught with complex matters, not least the civil liberties issues and the problem of how many offences (including rape/assault/robbery etc etc) may need to be considered*".[716]

F.7: Deaths in care and cover-up

42. It is difficult to overstate the significance of the unlawful killing of a child in the care of a local authority. Tyra Henry was 22 months old and suffered appalling injuries. Her father had grievously injured her brother, when he was a toddler, prior to Tyra's birth. The Tyra Henry public inquiry report chronicled the circumstances that led to Tyra living with her father despite the fact that she was in Lambeth Council's care. The report noted, in stark terms, that "*Lambeth's own position as Tyra's legal parent was effectively forgotten*" during the

[712] LAM009897_001-002
[713] LAM009895_001
[714] Clare Whelan 8 July 2020 99/12-24
[715] Clare Whelan 8 July 2020 100/22-24
[716] LAM009870

course of her short life.[717] The inquiry brought with it external and detailed public scrutiny of failures by individual staff, of systems and of the committee system. It should have been an impetus for change, but it was not.

43. In 1993, a report into the death of Mia Gibelli, who was killed by her mother when she was just seven weeks old, also led to criticisms about Lambeth's Social Services directorate.[718] Staff had known that her mother had previously injured a sibling by throwing the child from a third-storey window.

44. In December 1992, after the death of Mia Gibelli, when it became known that Lambeth Council had retained Carroll in the face of his conviction for the sexual assault of a child, when there were investigations into South Vale and when it was known that Lambeth Council had one of the highest numbers of unallocated cases in London, as leader of Lambeth Council Mr Whaley signed a letter to Mr Lambert of the SSI. The letter welcomed a full inspection of homes by the SSI or an independent inquiry into care arrangements. The letter also stated:

> "*During the last few months, the Council has been working closely with the SSI and the police investigating what had been happening in the past … We have improved our practices during the last two years with better management and procedures and are confident that we are providing a high standard of care for the children we are responsible for.*"[719]

45. Mr Whaley said that this letter would have been written by the director of social services. He accepted in oral evidence to the Inquiry that when this letter was written practices had not improved.[720] He said that Lambeth Council spent a lot of time not being transparent and that problems were covered up. He thought that it was a culture amongst staff, but perhaps also between councillors. It was a defence against criticism, a tendency to try to avoid the issues, to hide the facts and to try to find a way of putting a positive spin on it.[721] Mr Whaley also accepted that this pointed towards the reputation of the council being prioritised over concerns about what was happening to children in care in Lambeth.

> "*I think by the time we got to the point where we had started to recognise the sheer chaos which we were operating under, I think, just the size and scale of everything did mean that the particular issues within childcare in the children's homes were not seen as being as important as the bigger picture of meltdown and corruption, and I think that's something which we have to accept and bear responsibility for.*"[722]

46. Tyra Henry and Mia Gibelli were only two of a number of children to have died in Lambeth Council's care in the period considered by the Inquiry.

47. In 1975, a baby died in a Lambeth children's home in shocking circumstances. She was found dead, harnessed to a top bunk bed in a children's home. There was an internal inquiry but no independent inquiry (save for a limited coronial process) and there was no police

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[717] LAM028613_068
[718] LAM014045
[719] LAM013141_001-002
[720] Stephen Whaley 24 July 2020 101/16-22
[721] Stephen Whaley 24 July 2020 101/25-104/5
[722] Stephen Whaley 24 July 2020 105/11-19

investigation.[723] Her brother, Russell Specterman, told the Inquiry that "*to this day*" neither he nor his family have received a full explanation as to what happened to his sister. This lack of understanding causes him "*overwhelming pain*".[724]

48. A child in Lambeth Council's care was placed at Birtley Farmhouse in Surrey in the early 1990s. Birtley Farmhouse was for teenagers with therapeutic needs. The child Lambeth Council sent to live there was seven years old. He was supposed to be there on an emergency basis but he stayed for five months. Before he was placed there, Surrey County Council wrote to Lambeth Council setting out concerns about Birtley Farmhouse. The child made allegations that he had been sexually abused there. An affidavit from his social worker suggested that he was still living in Birtley Farmhouse when he made the disclosure. An alternative placement was found for him but he was not moved immediately. He took his life some years later, while still a child in Lambeth Council's care. A review following his death referred to a "*lesson in the potentially disastrous consequences of failure to plan/implement plans for children in care*".[725]

49. As set out in Part B, LA-A2 (who was taken into care in the 1960s) was found dead in the bathroom of a Shirley Oaks cottage, having given evidence two years earlier in the trial of his house father Donald Hosegood. LA-A2's sister recommended to the Inquiry that:

> "*when a child or adolescent dies whilst being looked after in care, whether the death is suspicious or not, professional agencies should be completely transparent when communicating details with parents or guardians and family members*."[726]

50. In 1998, Helen Kenward (an independent consultant in child protection with 37 years' experience) came to Lambeth Council to lead the Children's Home in Lambeth Enquiry. One of her first tasks was to try and secure the records of children who had been in homes. She gave evidence to the Inquiry of the sheer difficulty involved even in this task because of the ways files were treated. She regarded the treatment of children's files (which contained the record of their life stories) as emblematic of the chaos and the disrespect for children's lives as well. She found a total lack of respect and extraordinary things written in those files. Professional curiosity should have meant that these were investigated – this was just basic social work. She regarded it as "*not necessarily criminal, just basic social work was lacking*".[727] Ms Kenward found evidence of people lying about files, hiding them, denying working with or knowing individuals being investigated. She confirmed that workers who had been involved in the previous investigations were resentful and had to be reminded of a social worker's duty of care. There were some who were subversive and withheld files, hiding them in drawers and cupboards.[728]

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723 LAM029331_149-150
724 Russell Specterman (formerly LA-A243. Mr Specterman waived his right to anonymity in relation to his involvement in this investigation following the investigation's public hearing) 29 July 2020 103/4-6
725 LAM018471_047
726 Annie Hudson 2 July 2020 80/14-24
727 Helen Kenward 23 July 2020 83/20-21
728 Helen Kenward 23 July 2020 84/2-12

51. Ms Kenward agreed that there was a culture of withholding, hiding and concealing information that was difficult. She also thought that there was a culture of lazy social work; she did not suggest that it was "*all necessarily malevolent but … there was a lot of laziness about it*".[729] The files reflected that, and Ms Kenward suspected that social workers were reluctant to let CHILE look at the files because files had not been supervised and scrutinised in the normal social work way.

52. A statutory duty to report all child deaths in care to the Department for Education (and its predecessors) did not come into effect until the early 1990s. It was not until the Children Act 2004 that a child death review process was introduced.[730] In response to a request from this Inquiry, Lambeth Council identified 15 known cases of children who died in its care between 1969 and 1992. It was unable to confirm if this figure was accurate or that its summary about those 15 children was comprehensive.[731] This figure is markedly different from the 48 deaths between 1970 and 1990 that were cited by Ms Gillian Delahunty (a senior training officer for residential child care from 1990 to 1991) in her 1992 dissertation.[732] Ms Delahunty told us that:

> "*Statistics were required to be kept by local authorities and sent to the Department of Health on a range of things, including admissions to childcare and reasons for discharge, and they had a set of codes for each of the reasons for discharge, and one of the set of reasons for discharge was – included deaths of children in care, and I collated those into this 20-year table and, you know, those were the figures that it came to. I'm sure I would have double-checked them, because, particularly for the years '74 and and '75, they did appear, you know, and do appear, particularly high. But unfortunately I no longer have the background papers.*"[733]

53. In the absence of underlying documents it is not possible to reconcile the two figures, 15 and 48. It is indicative of the chaotic record-keeping (even without an obligation to report all child deaths) and the lack of value placed on a child in care's life that Lambeth Council was unable to provide this Inquiry with accurate and comprehensive figures and details for children who lost their lives whilst in the care of Lambeth Council.

F.8: Lambeth Council in 2020

54. The percentage of children in the care of Lambeth Council who were placed in residential accommodation fluctuated between 20 percent and 37 percent from 1965 to 1996. Following the closure of Lambeth Council's children's homes and a nationwide shift towards foster care as the preferred option for accommodating children, the percentage of children in the care of Lambeth Council placed in residential accommodation reduced to between 1 percent and 6 percent in the years 2008 to 2018.[734] In 2020, 72 percent of children (259) were in foster placements and 20 percent (71) in secure units, children's homes or semi-independent living accommodation.[735]

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[729] Helen Kenward 23 July 2020 84/21-22
[730] LAM029331_147
[731] LAM029331_148_152
[732] MPS002923_188
[733] Gillian Delahunty 9 July 2020 150/2-13
[734] LAM029318
[735] Explore education statistics gov.uk

55. Councillor Edward Davie, the designated statutory lead member for children's services from April 2020, confirmed to us that Lambeth Council has no residential homes in 2020 and of those children placed in residential care, "*they are nearly all out of borough*". Councillor Davie told us that the majority of children are looked after in foster care.[736] In 2020, figures for all children in the care of Lambeth Council reveal that 47 percent (170) of children in the care of Lambeth Council are placed out of borough and within 20 miles of their home, and 18 percent (65) are in placements outside the borough and more than 20 miles from home.[737]

56. Lord Herbert Laming described to us how it could become a case of "*out of sight, out of mind*" for children who are placed far away from their home.[738] He also referred to his concerns regarding the placing of children in unregistered accommodation and children undergoing multiple moves of placements and schools. As Lord Laming asked rhetorically, "*Is that what a good parent does to a child in care?*"[739]

57. This concern is applicable to residential and foster placements and vigilance is required in vetting foster carers and conducting visits. Councillor Edward Davie noted that he had "*no reason to doubt*" the vetting of foster carers employed by external agencies.[740]

58. In relation to visiting looked after children during the Covid-19 pandemic, in June 2020, Councillor Davie said that "*89% of our visits that we're meant to carry out took place, despite coronavirus. The majority of those, two-thirds, were done virtually, and one third were done in person.*"[741] This means, of course, that 11 percent of visits did not take place.

59. Ms Carolyn Adcock, a senior inspector with Ofsted, gave evidence to the Inquiry about the current situation regarding the placing of children out of borough:

> "*London, as a region, doesn't have that many children's homes, so the London authorities tend to use children's homes not too far away from London, but looking possibly towards Kent and in the south-east. But for particular specialist placements, they may place children further away in the country or may, on occasion, perhaps place in Scotland or Wales.*"[742]

She acknowledged that Ofsted was aware of the concerns that children placed a long way out of borough could both be removed from family ties and also at risk of being insufficiently supervised because of the geographical distance. This was something taken into account in selecting cases for inspection.[743] Ms Adcock also referred to a particular case in 2016, when an inspection took place of children in Lambeth Council's care placed in Sheffield. The documents recorded a failure of staff in children's social care "*to support young people placed a long way from home and out of the area*".[744] Specifically, when there was an allegation of rape made by one Lambeth Council child placed in Sheffield, neither Lambeth Council nor Sheffield Council convened a strategy meeting.

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[736] Edward Davie 29 July 2020 34/14-18
[737] Explore education statistics gov.uk
[738] Herbert Laming 27 July 2020 108/3
[739] Herbert Laming 27 July 2020 109/14-18
[740] Edward Davie 29 July 2020 41/2-4
[741] Edward Davie 29 July 2020 35/20-23
[742] Carolyn Adcock 28 July 2020 2/19-25
[743] Carolyn Adcock 28 July 2020 3/8-11
[744] Carolyn Adcock 28 July 2020 3/21-22

60. Ms Adcock told us that she contacted Lambeth Council about the case and received an immediate acknowledgement from Ms Annie Hudson (strategic director for children's services at Lambeth Council from May 2016 to March 2020), who was very concerned:

> "*We got a further, more detailed response within a few working days of making that referral. They clearly had looked at the case, and they did acknowledge that they should have taken more robust action which we would agree with*".[745]

This specific response is a positive departure from previous practice.

61. The Inquiry received substantial evidence from former children in care that their voices were not heard within Lambeth. LA-A131, in written submissions made at the conclusion of the inquiry, commented:

> "*Information and education should be provided to all children at the commencement of their care experience about right and wrong behaviour from those who are charged with their care, and other children in care, along with key information about to whom, and how, complaints can be made.*"[746]

62. We were told that children looked after by Lambeth Council today are given information on how to make a complaint. There is also a dedicated participation officer for looked after children and care leavers, who is able to appoint an independent advocate to support the young person with a complaint if they wish.[747] There is no obligation for children to approach the participation officer; they can also go straight to the independent advocacy service or speak to a teacher or foster carer.[748] The intention is to facilitate the raising of a complaint, not to put up barriers to concerns being raised. The advocacy service is described as a child-centred service, independent from all statutory agencies, that allows the child or young person to have their views and interests put forward by an independent advocate.[749] In 2017/18, 29 complaints were referred to the independent advocate, in 2018/19 there were 34 complaints and in 2019/20 there were 38 complaints.[750] In addition to dealing with individual complaints, feedback from the advocacy service and the annual report is intended to enable themes and patterns to be identified and disseminated so as to inform learning and improve the service offered.

63. Councillor Davie was asked about the Children's Social Care quality assurance annual complaints report 2019/2020, which set out a complaint that was upheld about care leavers and carers receiving financial support on time. Councillor Davie recognised when asked in oral evidence that it was "*totally unacceptable*" that problems with financial control systems in the 2019/20 period resulted in certain invoices from care leavers not being paid on time.[751] He told us that all outstanding invoices had now been paid, and new financial control systems were in place to make sure that it does not happen again.

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745 Carolyn Adcock 28 July 2020 5/2-8
746 Closing Submissions of LA-A131 para 13
747 LAM029331_296
748 Annie Hudson 2 July 2020 108/5-16
749 LAM029331_296
750 Annie Hudson 2 July 2020 108/21-23
751 Edward Davie 29 July 2020 21/18-22/4

64. With specific reference to care leavers, Councillor Davie was of the view that whilst they were provided with an assistant to help them access services such as education, housing and health, more could be done to provide a wider range of opportunities in the training and jobs market.[752] We note that the 2018 Ofsted inspection report observed:

> "*Foster carers provide good support and care, and increasingly more young people are able to live with their foster families after they are 18 years old, particularly if they attend university. Children who are looked after are doing well in education and receive good support to achieve their best.*"[753]

65. Corporate parenting requires all Lambeth Council staff and councillors to do as much as they can to improve the lives of children in care, and to ask the critical question in respect of children 'would this be good enough for my child?'[754] Councillor Davie told us that:

> "*at the heart of* [corporate parenting] *is ensuring that the children that we are legally responsible for as children looked after have the same opportunities, protection and safety as I would provide for my biological children, who happen to be in my household.*"[755]

66. When asked by the Chair whether newly appointed elected members are given induction training into their role as corporate parents – and more widely into their statutory responsibilities concerning the welfare of children – Councillor Davie said they were, but such training was not currently mandatory. He told us: "*That is certainly something I would like to change*".[756]

67. Regular and updated training into developing issues surrounding child protection and the role of corporate parents should be mandatory for elected members.

F.9: Apologies and redress

68. Victims and survivors told us how important it was for them to receive a meaningful and genuine apology.

69. LA-A25 was sexually abused by Hosegood in the 1970s. She told us in June 2020 that she had recently received a letter of apology from Lambeth Council. She explained that it was important for her to have her experience acknowledged and to be believed.

> "*I felt relieved, because … it gave me a sense that I was believed, after all, and they were sorry. But it isn't this Lambeth that needs to be sorry.*"[757]

70. Lambeth Council's full apology to this Inquiry, made by Ms Annie Hudson, is welcomed.[758] However, Lambeth Council was aware – from numerous reports, inspections and investigations throughout the 1980s and 1990s – of the nature of its failings and that the incidence of child sexual abuse was likely to be significantly higher than the reported numbers of complaints and convictions. It did not make any meaningful apology until relatively recently.

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[752] Edward Davie 29 July 2020 20/18-22
[753] LAM029303_010
[754] *Applying corporate parenting principles to looked-after children and care leavers: Statutory guidance for local authorities*, Department for Education, February 2018.
[755] Edward Davie 29 July 2020 5/21-15
[756] Edward Davie 29 July 2020 41/14-19
[757] LA-A25 6 July 2020 72/23-73/12
[758] Annie Hudson 2 July 2020 3/3-5/21; LAM029331_001-004

71. In response to those who were abused or lived in fear of abuse whilst in its care as children, Lambeth Council opened its Children's Homes Redress Scheme in January 2018. This scheme is open to those who lived in or visited a Lambeth Council children's home. By August 2020, there had been more than 1,600 applications to the scheme, and more than £46 million had been paid in compensation to victims and survivors.[759] We understand that Lambeth Council has extended the closing date of the scheme until 1 January 2022. The Inquiry has not examined this scheme (as explained during our preliminary hearing on 15 January 2020), although redress schemes were considered during our Accountability and Reparations investigation.[760] We note, however, that the Lambeth redress scheme has been criticised by some core participants to this investigation.[761] These criticisms included:

- The redress scheme does not provide compensation for abuse suffered in a foster placement before a child was placed in a Lambeth Council children's home.[762]
- Racial abuse and loss of earnings and education are not sufficiently compensated.[763]
- The Melting Pot has not been included in the scheme, although children in the care of Lambeth Council were placed there (and we have received evidence from some who suffered sexual abuse there).[764]
- Confining the provision of housing assistance to the small geographical area of Lambeth significantly reduces its value to survivors of sexual abuse, some of whom may need to live elsewhere.[765]

In its closing submissions, Lambeth Council stated that it continues to deal with claims based on negligence (such as where a child was placed in care incorrectly or it failed to provide appropriate oversight of a child placed in foster care) on a case-by-case basis through the civil justice system, separately to its redress scheme.[766] It confirmed that the scheme does not apply to those abused in private or voluntary children's homes not managed by Lambeth Council, although it had placed children in care in these establishments.[767]

72. The Inquiry recognises the devastating consequences of sexual and other forms of abuse to children in care. The potential for redress schemes to offer accountability and reparation to victims and survivors of child sexual abuse was considered in detail in the Inquiry's *Accountability and Reparations Investigation Report*.[768] It has arisen in a number of other investigations and therefore any further consideration will be dealt with in the Inquiry's final report.

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[759] LAM030403_010-011
[760] Preliminary Hearing 15 January 2020 10/7-11/17; *Accountability and Reparations Investigation Report* (September 2019)
[761] INQ006079; INQ006161; INQ006308
[762] INQ006161_059-060
[763] INQ006308_006; INQ006079_002-005; INQ006161_054-061
[764] INQ006308_001-010 LA-A351 6 July 2020 110/8-113/6; LA-A352 29 July 2020 129/6-130/23; LA-A353 6 July 2020 107/4-110/6
[765] INQ006079_004
[766] LAM030403_010
[767] LAM030403_010
[768] *Accountability and Reparations Investigation Report* (September 2019) Part G.2

Part G

The role of leaders in relation to children in care

The role of leaders in relation to children in care

G.1: Introduction

1. In this Part we examine the failures of senior leaders to protect children in care, to oversee and implement safeguarding measures and to respond appropriately to allegations of child sexual (and other) abuse.

2. Ms Annie Hudson (strategic director of children's services from May 2016 to March 2020) on behalf of Lambeth Council set out the structure of the Council as it evolved over time, identifying its senior staff and councillors. During the periods of time examined by the Inquiry, the failures by leaders within Lambeth Council to protect and keep children safe lasted decades.[769] These failures of management and oversight persisted despite changes in staff, councillors and the political composition of Lambeth Council.[770]

G.2: Leadership roles within Lambeth Council

3. Although there were structural changes within local government over the many years covered in this report, the key leadership roles responsible for the protection of children under the care of Lambeth Council remained with the director of social services, the assistant directors, elected councillors working as chairs or vice-chairs of the Social Services Committee or Sub-Committees, successive leaders of the Council and the chief executive.[771] The individuals who held these posts during the main periods examined by the Inquiry are set out in the timeline in Part A.

G.3: Themes

Knowledge and response to direct allegations of sexual abuse in the 1970s

4. During oral evidence it was emphasised by some witnesses that knowledge of child sexual abuse in the 1970s was limited and understanding developed significantly during the 1980s and 1990s.[772] While it may be the case that statutory guidance in the form of *Working Together to Safeguard Children* developed in the 1980s to include child sexual abuse, all categories of sexual activity against children were illegal as clearly set out in the Sexual Offences Act 1956 and no one working with children can have thought otherwise.[773]

[769] LAM029331_019
[770] LAM029331_021-026
[771] LAM029331_019-026
[772] Baroness Virginia Bottomley 27 July 2020 126/24-127/9
[773] NSC000938

5. This investigation focussed on five case study homes to enable the Inquiry to examine the experiences of children in Lambeth, including the experiences of those who were especially vulnerable and where communication was difficult.[774] The evidence received by the Inquiry demonstrates that some children in care in Lambeth were speaking up very clearly about child sexual abuse in the 1970s.[775]

6. In addition, criminal prosecutions had been brought in the 1970s against Lambeth Council employees such as Donald Hosegood and Patrick Grant and there is little doubt that senior leaders must have known something about the sexual abuses that were perpetrated within Lambeth Council children's homes. Nevertheless, there was a complete disregard for the position of the children who made the allegations, and at a senior level within children's social care the complaints against Hosegood, for example, were dismissed as "*pure fantasy*" by Mr N Elliott (senior children's homes officer).[776]

7. Allegations were effectively suppressed. Internal investigations were limited and alleged perpetrators were returned to the home where the sexual abuse had taken place. In 1974, when a child made allegations of sexual abuse against another employee (William Hook), Lambeth Council terminated his employment but did not inform the police.[777]

8. While it is clear that for some children the experience of being in care – which included violence, intimidation and racism – prevented their speaking out about sexual abuse, the reality was that from the 1970s some children did report sexual abuse and senior staff and councillors must have had direct knowledge of children's allegations. Senior staff, in the face of credible information, chose to reject children's accounts or to ignore the risk that these individuals posed to children. Too often, the outcome of criminal proceedings determined the response to children's allegations. Staff failed to take responsibility for ensuring that children were safe thereafter. This had devastating consequences for the protection of children in care.

Failures to deal with known sexual offenders

9. Mr Robin Osmond was the director of social services at the time when disciplinary action was taken against Michael John Carroll for misconduct in 1986 (as set out in detail in Part D).[778]

10. The management case was presented by Mr Don Thomas (senior children's homes officer) to a panel of two: Mr David Pope (assistant director of social services) and Mr Gerallt Wynford-Jones (senior personnel officer). The panel largely accepted Carroll's version of events. This was in spite of clear documentary evidence indicating that Carroll was not being truthful about what had happened.[779] Mr Pope's decision to retain Carroll put a sexual offender's interests ahead of the interests of children in Lambeth Council's care.

11. Lambeth Council recognised that it had a responsibility "*to ensure that any identified risk of abuse to the children in our care from our own staff is eliminated*".[780] The decision to retain Carroll, however, was compounded by Mr Pope's failure to address the risks that Carroll

[774] Notice of Determination on selected case studies
[775] Annie Hudson 21 July 2020 39/1-25 45/21-46/7; LAM030213_104_143
[776] LAM030203
[777] Annie Hudson 21 July 2020 45/21-46/7
[778] Robin Osmond 3 July 2021 73/7-14, 102/11-21
[779] LAM001508; LAM001519_005
[780] WAN000002_179

might pose to children. This failure must also be judged in light of the Angell Road home being a centre for supposedly therapeutic 'direct work' in Lambeth at the time. Carroll was not moved to a different role; there was no monitoring of Angell Road where he worked or of the well-being of children who lived there.[781] Mr Pope proceeded on the unjustified basis that Carroll posed no risk to children.[782] Incomprehensibly, Lambeth Council children's services department proposed making Angell Road a specialist home for abused children, with Carroll in charge. Although it is unclear whether this proposal took effect, it is clear that Angell Road continued to care for extremely vulnerable and very young children.

12. A number of senior staff and councillors knew about Carroll's disciplinary proceedings at the time. Ms Phyllis Dunipace (then chair of the Social Services Committee) told the Inquiry that Mr Osmond informed her of the disciplinary proceedings and about some of the criticisms of Carroll. Nevertheless, no one appears to have pursued as an issue of concern that a convicted child sexual offender was working in a children's home.[783]

13. The failure to recognise the significance of convictions for sexual offences became apparent again some years later. On 8 December 1992, Mr Pope wrote to Mr Herman Ouseley (at this point the chief executive) regarding leader of the Council Mr Stephen Whaley's request to agree a blanket policy of not employing "*any Schedule 1 offenders*".[784] Mr Pope explained in the note that this was not possible because of his current workload and the complexity of the issue. In particular, it was "*likely to cut across existing* [Equal Opportunity] *policies*". Asked in evidence about the response of Mr Pope, Mr Whaley considered that Mr Pope was "*putting up smokescreens*".[785] These were not complex issues. The outcome of this failure was that no review of whether sexual offenders were employed by the Council was carried out when it should have been. Safeguarding children was not a priority.

Failure to take action on internal and external reports

14. A significant number of internal, external and inspection reports were written in respect of the social care provided for children in Lambeth. The proliferation of reports stands in stark contrast with action designed to implement any recommendations. The extent to which this was a feature of Lambeth Council's response to issues is striking. The Appleby report alone referred to 15 other reports that had been commissioned or were being produced at the same time.[786]

15. Each crisis seemed to be followed by an inquiry, only to repeat the process when a crisis occurred again. When reports were commissioned, it is clear from the evidence that they were not followed up effectively or were damagingly undermined.

Ivy House, Monkton Street, Special Review Panel (1985–1987)

16. As set out in Part C, in 1985, LA-A26 (a child with complex needs) made an allegation of sexual abuse against a staff member working at Ivy House. Mr Osmond (the director of social services at the time) was involved from the outset in Lambeth Council's response to the sexual abuse allegations made at Ivy House (1985) and also subsequently at Monkton

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[781] David Pope 8 July 2020 34/5-18
[782] David Pope 8 July 2020 33/4-5
[783] Phyllis Dunipace 3 July 2020 126/3-10
[784] LAM009870
[785] Stephen Whaley 24 July 2020 94/22-23
[786] LAM000025_005

Street (1986). He wrote to parents of children at Ivy House informing them that an internal inquiry had found no evidence to support the allegations of sexual abuse. This letter relied entirely on the first and peremptory investigation chaired by Mr Thomas and overseen by Ms Thelma Lavender, both of whom had been dismissive of LA-A26's allegations and provided no independent scrutiny of the complaint.

17. Following intervention by Councillor Janet Boateng and lawyers on behalf of LA-A26's family, Mr Osmond recognised the inadequacies of the initial Ivy House inquiry that had dismissed LA-A26's complaint.[787] Mr Osmond agreed to the setting up of a second detailed management investigation. The panel was assisted by a race relations adviser, an independent expert in child sexual abuse and a consultant psychiatrist who knew LA-A26. The management inquiry concluded in August 1986 that LA-A26 suffered sexual abuse by LA-F12 on more than one occasion at Ivy House.[788] In light of this, disciplinary proceedings were brought against LA-F12 for gross misconduct.[789]

18. In February 1987, Black and in Care and the Brixton Family Support Group wrote to Ms Linda Bellos, the leader of the Council, pursuing demands for "*a complaints procedure for children with mental disabilities in Lambeth children's homes*".[790] Ms Bellos, whilst still in post but towards the end of her period as leader, properly referred the letter to Ms Dunipace and Mr Osmond for their attention.[791]

19. In a memo dated 19 March 1987, following the conclusion of the management investigation, Mr Osmond said:

> "*I think that in learning to understand the importance of the child's point of view in these matters, we have become much more open to the possibility that the reality is that child* [sexual] *abuse may have occurred.*"[792]

20. He referred to the initial inquiry – discounting that a staff member could have abused a child – as being "*naive*", saying "*in retrospect my concern is how we do something about it in the future*". Mr Osmond ended his memo:

> "*I agree that many of the points have implications for the future management of Ivy House and our other establishments. I have referred some of these to the special review panel and there are a number of associated issues that have since arisen in relation to allegations of child sexual abuse in other settings.*"[793]

21. The Special Review Panel (chaired by Mr Millius Palayiwa) had been created in November 1986, to review arrangements for the investigation of allegations of sexual assault, and to consider improvements to management and supervisory systems.

22. Mr Palayiwa gave evidence to the Inquiry that he submitted the Review Panel interim report dated June 1987 to the chief executive, Mr Arthur John George, and considered that it was for the chief executive to take steps to publish it.[794] It is apparent that there was disagreement between the special panel members, which prevented finalisation of the

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[787] LAM000524
[788] LAM029201_068
[789] LAM028780_041
[790] LAM013171
[791] LAM013168
[792] LAM000507
[793] LAM000507
[794] Millius Palayiwa 3 July 2020 59/16-60/12 and 65/14-66/5

Review Panel interim report.[795] Publication never happened and there is no evidence to suggest that outstanding issues were pursued by Mr George to ensure that the Review Panel interim report was finalised and its recommendations made known.

23. When questioned about the fact that the Review Panel interim report was never presented to the Social Services Committee and its recommendations were not implemented, Mr Osmond replied:

> "*I have no recollection of why that report was not submitted to committee. My only recollection is, having read the documents which you provided, my understanding from those documents is that the report was requisitioned by the chief executive at the time. Having read the papers, I assumed that it was his responsibility for the report to be delivered or withdrawn, but I have no recollection of it*."[796]

Mr Osmond appears to have washed his hands of the Review Panel interim report, despite its importance.

24. Mr Osmond, in addition to his involvement in the Ivy House complaint, had also initiated the Monkton Street inquiry. This was a detailed inquiry that appropriately called on experts and heard from parents. Recommendations included additional staff training and the suggested production of a leaflet for parents and the public on identifying and responding to suspected child abuse. There is no record, however, of its recommendations being implemented.

25. In light of Mr Osmond's role as director of social services, and his knowledge of a number of child sexual abuse complaints, the implementation of both the Monkton Street panel's recommendations and those of the special panel should have been a priority.

26. Ms Dunipace (chair of the Social Services Committee from 1986 to 1988) was aware of the commissioning of the Special Review Panel.[797] She had also advised councillors that any recommendations of the special panel should be made public.[798] Yet when no report was produced for the Committee there is no evidence to indicate that she enquired about the report's contents or its production. When asked whether its recommendation for a child sexual abuse investigation unit might have been followed up at this time, Ms Dunipace said "*I think it is a pity that we missed an opportunity*".[799]

The Morton Reports (1988–1990)

27. In 1988, Mr Robert Morton became the principal manager, children's homes. He wrote four reports during his time in post (the 'Morton Reports').[800] In 1988, he co-authored a report with Ms Josie Durrant (assistant director children and young persons division) (the first Morton report). This report was submitted to the Children's Homes Sub-Committee of Lambeth Council and raised a number of important issues, including that children were being taken into residential care when they should not have been. A considerable number

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[795] CQC000126_001
[796] Robin Osmond 3 July 2020 98/3-10
[797] LAM000314_014
[798] LAM000314_008
[799] Phyllis Dunipace 3 July 2020 124/25-125/1
[800] LAM028710; LAM010549; LAM028717_002; INQ002077_02

of children aged five years old or younger were being referred for residential care.[801] Having been taken into care and required to live in a children's home, few care plans for children existed. The majority of the homes had little information about the children living there.[802]

28. There was little if any knowledge of the quality of care provided in these homes. Part of the reason for this lack of knowledge was because of the numbers of children who did not have an allocated social worker.

29. When Mr Philip Byron took up his post as placement officer in September 1988, he also "*was frankly appalled at the state of affairs*".[803] Children's social care did not know anything about some of the children living in homes as well as very young children living in children's homes because of a lack of available foster parents.[804]

30. In June 1989, Mr Morton prepared an overview of the children's homes service for councillors (the Second Morton report). He identified that basic information was not available, including how many children were in Lambeth homes; how long children had been in care for and for what reasons; reasons for admissions to homes; as well as the age range of children and their ethnic background. This information was obtained by a monitoring process set up by Mr Morton.[805] He set out a number of proposals for the reform of the service, which he described as having "*decayed over a number of years*". He added that it was paramount that the interests of children, not staff, came first.[806]

31. The failures of management and oversight detailed in the Morton reports were systematic and entrenched. They went beyond setting out the poor quality of care afforded to children once they were admitted to Lambeth Council children's homes. They demonstrated that children were being taken into care in the first place because of failures in preventative social work.[807] Once in care, children were exposed to the risks of abuse, including sexual abuse. The interests of children appeared to be secondary to those of adults.

32. The evidence before the Inquiry showed no indication that senior staff or councillors took appropriate action in response to the June 1989 report. In July 1989, Mr Morton wrote a further report (the Third Morton report):

> "*The situation in the Section, as I have detailed at every Sub-Committee meeting, verbally and in writing, is not only at crisis point but very dangerous. I cannot impress this point too strongly. Members must be aware of the possible implications of the present situation.*"[808]

33. Mr Morton's final report (the Fourth Morton report) was written in September 1990, after which he left Lambeth Council. He summarised the position as follows:

> "*My personal fear, concern and indeed a factor of my decision to move on, relate to the standard of care, lack of planning and lack of* [adherence] *to good professional standards and procedures … We continue to admit young people into care contrary to*

[801] LAM028710_002
[802] LAM028710_002
[803] LAM028400_003
[804] LAM028400_007
[805] LAM010549_011-012
[806] LAM010549_038-039
[807] Annie Hudson 21 July 2020 4/23
[808] LAM028717_002

Council Policy, when totally inappropriate. Young people remain in care due to lack of planning intervention and appropriate resources. Young people are placed in private and voluntary accommodation which have not been visited, are miles away from the community and indeed some cases miles away from London. There can be little regard for placing young people appropriately which very often results in black teenagers being placed in a white rural community. The number of under fives admitted into care continues to grow and the timescale for young people remaining in care has continued to escalate. The number of unallocated cases, the lack of statutory reviews, clear planning is totally unacceptable … ".[809]

34. The Morton reports demonstrate a state of affairs that is consistent with other evidence the Inquiry heard about the risks that children were exposed to during this period.

35. Mr Osmond, as the director of social services, was responsible for the unsatisfactory state that children's social care was in leading up to April 1988. During his significant tenure, child care policy around admitting children into care was not adequately implemented. The failures in area social work resulted in children coming into care when that outcome could have been avoided. Many of these children ended up living in children's homes that were not safe. Mr Osmond failed to recognise that there had been a chronic lack of planning and management within social care during his term as director. He told the Inquiry, however:

"*I don't think there was a lack of planning and management in those days. But I recognise that they were extremely difficult times; particularly in the aftermath of the closure of the Shirley Oaks homes, which took something like three or four years longer than I expected.*"[810]

36. Ms Joan Twelves was leader of Lambeth Council between May 1989 and May 1991. She was not familiar with the Morton reports. When asked about them, she said:

"*The whole time I was leader, it was a matter of crisis management of one sort or another, so it's – there were so many different reports that obviously – I hate to think of it that they might have got submerged, but I don't think I ever saw them.*"[811]

37. Ms Twelves described the "*major effect*" of the influx of so many inexperienced councillors taking up positions in 1986 as one of almost "*pot luck*" when it came to relevant experience for various posts.[812] She explained that during her time she focussed on housing and education. As far as children's social care was concerned, she said that she benefited from having two deputy leaders in succession who had been Chair of the Social Services Committee. She explained that she largely depended on their feedback, although also made it clear that she still expected the Chair of the Social Services Committee to come to chairs' meetings and report.[813] It was clear from Ms Twelves' evidence that she was unaware of a number of key issues in children's services that had arisen during her tenure.

[809] INQ002077_02
[810] Robin Osmond 3 July 2020 83/24-84/4
[811] Joan Twelves 24 July 2020 120/21-25
[812] Joan Twelves 24 July 2020 113/21-114/6
[813] Joan Twelves 24 July 2020 129/9-17

38. Ms Dunipace was Ms Twelves' deputy between 1989 and 1990 and chair of the Social Services Committee between 1986 and 1988. She was asked in oral evidence whether she had seen Mr Morton's reports. Ms Dunipace said that when she was deputy leader she was:

> "*in charge of introducing a community charge into Lambeth. So my recollection is stronger of that side than on the children's homes side. So I really don't remember those reports.*"[814]

It is clear from this evidence that neither the leader nor Ms Dunipace as deputy leader focussed on the serious issues raised by Mr Morton's reports.

39. Mr Whaley, however, saw Mr Morton's reports and discussed Mr Morton's concerns with Councillor Clare Whelan. Mr Whaley was chair of the Social Services Committee (1990 to 1991) and later leader of the Council (1991 to 1994). In his evidence he explained that he had decided that children's homes should be shut. The reasons included that he did not consider that Lambeth Council could run children's services or homes in a safe manner.[815] Mr Whaley was candid in his evidence to the Inquiry about both the situation that existed, his response and his inability to make progress. In relation to the issue of allocation of social workers to children, he accepted that this left him worried that they were leaving children at risk. Nevertheless, Mr Whaley signed a letter to the Social Services Inspectorate (SSI) in December 1992. The letter invited an inquiry into children's homes and, in spite of the problems that beset Lambeth Council, presented a falsely optimistic view of the services provided to children:

> "*During the last few months, the council has been working closely with the SSI and the police investigating what had been happening in the past. We have improved our practices during the last two years with better management and procedures and are confident that we are providing a high standard of care for the children we are responsible for.*"[816]

40. Mr Whaley believed that this letter had been drafted by the Director of Social Services, Mr Pope, and that Lambeth Council had not improved its practices. Mr Whaley's view was that the Council spent a lot of time inhibiting transparency and that problems were covered up.[817]

41. No one who read Mr Morton's reports between 1988 and 1990 could have been in any doubt about the seriousness of the situation for children in care in Lambeth and which had continued to develop during the 1980s. The child care practice leading to Mr Morton's findings and the collective response to these reports was grossly inadequate.

42. Although councillors and officers bear a joint responsibility for the gravity of the situation and failure to effect changes described by Mr Morton, some senior officers were in a position to act and to respond effectively to Mr Morton's warnings and did not do so.

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[814] Phyllis Dunipace 3 July 2020 118/10-13
[815] Stephen Whaley 24 July 2020 80/13-81/5
[816] Stephen Whaley 24 July 2020 101/16-22
[817] Stephen Whaley 24 July 2020 101/25-104/5

43. Mr Pope submitted a report to the Social Services Committee on 30 January 1990. The expressed objective of his report was:

> "*promoting the continuing development of the service … to change and to clarify the precise role of the childrens homes, to bring the service as a whole more fully into line with changing needs and circumstances.*"[818]

44. It is apparent from the evidence the Inquiry heard that the response to Mr Morton's reports was inadequate. The report and policy that were produced in response to Mr Morton's concerns failed to improve the situation for children. As the December 2000 SSI review report, *Joint Review of Lambeth Borough Council Social Services*, stated, even 10 years later, there remained areas within social care that needed urgent attention, including whether "*over 100 children who were placed with carers or relatives are in safe placement*". As Ms Hudson accepted:

> "*regrettably, even by 2000, Lambeth was unable to appropriately prioritise and adequately meet the needs of the children to whom it owed a responsibility … appropriate standards were not being met*".[819]

45. Mr (now Lord) Ouseley was chief executive between 1990 and 1993. He told us that the September 1990 Morton report had not been brought to his attention at the time and he did not see this (or any of Mr Morton's earlier reports) until they were sent to him by this Inquiry. Lord Ouseley's initial impression was that social care:

> "*was reasonably well led … I thought that the chair* [of Social Services] *and the director had a close relationship in which the director was accounting to the chair*".[820]

In response to the question who did he rely on as chief executive to bring concerns within social care to his attention, Lord Ouseley explained that, across all 11 directorates, concerns would come to him from a number of sources, including backbench members, leading members, chairs of committee and members of the public.[821]

46. It became apparent from Lord Ouseley's oral evidence that in practice as chief executive he was reliant to a large extent on the information provided to him by Mr Pope and other senior social care staff. Lord Ouseley explained that:

> "*problems being faced in childcare and child protection within Lambeth were matters that came up incidentally in most cases at our management team meeting and presented by the Director of Social Services*".[822]

47. In 1990, Mr Ouseley became aware through a press report that the SSI had reported on the large number of unallocated child protection cases in Lambeth. A memo suggests that he was not aware of the position until he read about it in the newspaper. Having read a press report, Mr Ouseley sent a memo to social care staff asking about it. Mr Verley Chambers responded with an eight-point action plan.[823]

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[818] INQ002069
[819] LAM029331_261
[820] Herman Ouseley 9 July 2020 11/3-10
[821] Herman Ouseley 9 July 2020 11/13-24
[822] Herman Ouseley 9 July 2020 15/18-25
[823] LAM014041

48. There is no evidence to suggest that any chair of social services or councillor brought concerns to Mr Ouseley that they had no confidence in Mr Pope to manage or lead social care. In 1992, however, Councillor Whelan had communicated with the police, raising a number of concerns about children's homes and about South Vale children's home, in particular.[824] Councillor Whelan spoke directly with Mr Ouseley about these matters. The correspondence that followed between Mr Ouseley and Councillor Whelan was fractious on the part of Mr Ouseley (see Part F), but he told us in evidence that he agreed she had every right to go to the police with her concerns and that this was not his frustration. As Councillor Whelan had good relationships with the director, he questioned "*why on this occasion is she saying she won't go to the director, she's coming to me, I'm the post box*".[825]

49. It must be said that enormous demands were placed on Mr Ouseley as chief executive between 1990 and 1993, significantly exacerbated by his exposure to disgraceful intimidation in the workplace. Lambeth Council's working environment was not conducive to the sharp and relentless focus that child protection demanded from its chief executive.

The Clough report (1993)

50. In 1993, some seven years after the event, Richard Clough was commissioned by Lambeth Council to undertake an independent inquiry into Lambeth Council's retention of Carroll. The terms of reference were agreed between Lambeth Council and the Department of Health. The terms of reference included – among others – to examine and comment on the process of Carroll's application to foster, and the propriety of formal and informal communication between Wandsworth Council and Lambeth Council staff and councillors during that process. We note the terms of reference were narrow and did not include express consideration of the risk posed by Carroll and whether children at Angell Road or Highland Road may have been harmed. Mr Clough told us that Lambeth Council did not make him aware of any allegations of child sexual abuse made against Carroll subsequent to his conviction. No one he interviewed expressed concerns about the risk Carroll posed or concerns that he might have been abusing children at the time.[826]

51. Mr Clough did not make recommendations but within his report he told us that he made "*in the region of 20 findings*".[827] Mr Clough arrived at conclusions about the foster application considered by Wandsworth Council in 1988 (see Part D). The report concluded that Mr Jack Smith (principal officer for social work) "*should not have become involved in this particular case in the way that he did and his professional behaviour during this time is a cause for regret and concern*".[828]

52. Following receipt of the Clough report, as director of social services Mr Pope submitted a report in February 1994 to the chair of social services (Councillor Anna Tapsell) setting out the findings of an internal management inquiry conducted by Mr Chambers (assistant director community services). This came to different conclusions from those reached by Mr Clough and purported to exonerate Mr Smith from any wrongdoing.[829]

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[824] Clare Whelan 8 July 2020 91/13-98/5
[825] Herman Ouseley 9 July 2020 21/13-19
[826] Richard Clough 7 July 2020 57/4-16
[827] Richard Clough 7 July 2020 70/10-14
[828] LAM000020_054
[829] INQ002206

53. This is a striking example of Lambeth Council commissioning an external and independent report (the Clough report) and then producing another report that wholly undermined the original. That original report had been critical of Mr Pope, amongst others. The effect of this was to negate the very purpose of having independent scrutiny and to protect the interests of those staff criticised by Mr Clough. This action was potentially detrimental to the safety of children. The Clough report should have been sufficient on its own for councillors and the chief executive to decide whether disciplinary action was warranted. Mr Pope should not have been part of any decision-making in response to the criticisms made of individuals in that report.

54. Councillor Tapsell was chair of the Social Services Committee at the time that the internal report was published. The report was specifically addressed to the chair and vice-chair of the Social Services Committee.[830] The internal report came to different conclusions from the Clough report and yet this was neither challenged nor action taken against Mr Smith in the light of Mr Clough's conclusions. The Social Services Committee under Councillor Tapsell's leadership provided no oversight or scrutiny of the response by senior staff to the Clough report or the role played by Mr Pope and other senior staff in relation to Carroll. It did not consider any lessons learned. Mr Smith's ongoing role was not questioned by Councillor Tapsell or any other councillor and he remained in post until January 1996.

The SSI reports (1991–2001)

55. Councillors Tapsell and Whelan demonstrated willingness to enlist the assistance of the SSI and ministers to address a number of their concerns relating to the safety of children in children's homes. In the case of Councillor Tapsell, her correspondence with the SSI contributed to the appointment of Mr Clough to conduct his investigation into the retention of Carroll.

56. Consideration of the SSI reports does not appear to have caused any councillors or leaders of the Council to challenge the ability of any individual senior staff to manage social care and to effect change. Mr Pope told the Inquiry that, before his eventual departure in 1995, no councillor had ever suggested to him that he should consider resigning, nor had they questioned directly or indirectly his fitness to be the director of social services.[831]

57. Mr Whaley was questioned about whether Mr Pope should have been disciplined in relation to the decision to issue Carroll with a warning in 1986. Mr Whaley explained that, at the time, they were dealing with many issues and he did not think that this was something that they should pursue. He was of the view that it was a matter for the chief executive as the head of the service. Mr Whaley accepted that he could have raised any loss of confidence in Mr Pope with the chief executive.[832]

The Barratt reports (1999–2000)

58. Mr Pope was the director of social services between 1988 and 1995. This was a period during which Lambeth Council was subject to near constant criticism for its failures towards children in its care. The reports of John Barratt considered Lambeth Council's failure to respond adequately to disclosures made about Steven Forrest (Part D). Mr Barratt's final

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[830] INQ002206
[831] David Pope 31 July 2020 11/3-10
[832] Stephen Whaley 24 July 2020 95/13-/96/5

report (published in 2000), *Two Lambeth Independent Child Protection Inquiries 1999–2000*, drew three basic conclusions, which encompassed Mr Pope's time as director of social services. These conclusions went to the basic functions of the Social Services Directorate:

- The Council through its inadequate arrangements in the Social Services Committee, the Department and the Division has repeatedly failed to fulfil both its statutory duties and its own policies relating to the care and protection of children.
- The Council has repeatedly tried during the past decade, but repeatedly failed, to create and control an effective Department and Division.
- The Council's executive chain of command (assuming it once existed) linking departmental action to the Council has decayed and disintegrated.

59. The Barratt final report criticised Ms Celia Pyke-Lees (executive director) and Ms Constantia Pennie (assistant director for children and families) for serious failings in their response to LA-A29's allegation of sexual abuse against Steven Forrest in January 1996. Ms Pennie did not respond appropriately to the significance of LA-A29's disclosure, persistently failed to involve child protection specialists and other managers in planning meetings and did not appreciate the departmental significance of the allegations.[833] In May 1999, Ms Pennie was suspended. Ms Pyke-Lees failed to understand the serious implications of the disclosure and to "*grip the situation*" in her conduct of a meeting called to discuss it.[834] Mr Barratt found that these were very serious errors of leadership.

60. Ms (now Dame) Heather Rabbatts became chief executive in 1995 and remained in post until March 2000. She faced formidable challenges. One of the issues she identified was a concern that the chief executive was too distant from the service and she sought to address this by creating a children's first audit team located in the corporate centre. She explained that this allowed the SSI and chief executive to have a much closer relationship with the corporate centre.[835] This was essential to improve communication and to ensure that the leadership could respond appropriately to recommendations and embed a culture that learnt from past failures.

61. Dame Heather Rabbatts described how she addressed the issue of police checks for foster carers. That not all foster carers had been subject to police checks came to light in 1998 after the appointment of a new service manager for the adoption and fostering service. This resulted in the appointment of an independent auditor who uncovered that the scale of the problem was significant and action was taken.[836]

62. Dame Heather Rabbatts gave evidence about the action plan that she put in place in January 1999, to address issues in the Directorate of Social Care. She sought to recruit a high-calibre leadership team at an early stage and to set a vision and direction for the whole of the Council.[837] She described the culture of Lambeth Council as one of "*fear and sexism and racism*" prior to her arrival.[838] Dame Heather Rabbatts viewed the recruitment and retention of good social workers as one of the key priorities.[839]

[833] LAM000021_087
[834] LAM000021_087
[835] Dame Heather Rabbatts 7 July 2020 124/9-20
[836] LAM030269_030
[837] Dame Heather Rabbatts 7 July 2020 104/3-14
[838] Dame Heather Rabbatts 7 July 2020 116/9-10
[839] Dame Heather Rabbatts 7 July 2020 121/11-122/-14

63. Despite her efforts, Lambeth Social Services went into special measures in November 1999.[840] The problems were too extensive and too entrenched for one leader to resolve within a five-year period.

64. Lambeth Council failed many vulnerable children for over four decades. Political chaos and management dysfunction combined to distract senior officials and councillors from delivering a good service to children in their care. It would appear that only one senior council employee was held to account through disciplinary proceedings for the disastrous environment that compromised children's safety. Undoubtedly, there were many staff and councillors trying to do their best but who were frustrated by the near paralysis of the senior leadership. This sorry state of affairs was left unchecked for too long by too many people.[841]

[840] LAM029331_256
[841] LAM029303_001; OFS012621; Carolyn Adcock 28 July 2020 22/5-24/14

Part H

Allegations of improper interference

Allegations of improper interference

H.1: Introduction

1. In this Part, we consider specific allegations about improper interference in investigations in Lambeth in the late 1990s. Specifically, we consider whether a police investigation known as Operation Trawler was improperly ended to protect high-profile individuals. We also consider the origins of Operation Trawler, its replacement by Operation Middleton and the Children's Homes in Lambeth Enquiry (CHILE), and whether political considerations played a part in the events that led to the establishment of Operation Middleton.

2. Speculation appeared in the media from 2014 about several public figures said to be linked to children's homes in Lambeth, and whether political influence protected some high-profile individuals from investigation.

> **2.1.** Former detective inspector (DI) Clive Driscoll (now Dr Driscoll) spoke to the BBC in 2014 about the circumstances in which he was removed from a police investigation – Operation Trawler – into Lambeth Council's children's homes in the 1990s. Dr Nigel Goldie (a former assistant director of corporate strategy and quality at Lambeth Council) also questioned whether DI Driscoll was removed from the investigation because he named politicians said to have been linked to Lambeth Council's children's homes. The implication was that he had been removed to protect these individuals from investigation.[842]

> **2.2.** In July 2015, *The Mirror* newspaper published an article alleging that, in 1998, the government was briefed about an investigation in which a minister was a suspect before the investigation was halted. It cited Dr Driscoll as saying that he had been stopped from investigating the minister in 1998 after he named the politician as a suspect. The article also quoted Dr Goldie as having said that he had a discussion with the government inspector about this politician. The implication of this article was that the Social Services Inspectorate (SSI) was briefed about the Driscoll investigation, a possible link between Lambeth Council's children's homes and a government minister, and that steps were taken to end the investigation because of this link.[843]

3. In this Part, we also consider whether there is any evidence to support the speculation that, in 1998, the names of politicians (including the then MP, Mr (now Lord) Paul Boateng) said to have visited Angell Road children's home were provided to the Metropolitan Police Service or to Lambeth Council, and that this information was provided to the SSI (and thereafter provided to the Minister of Health, Mr Frank Dobson MP, or to Mr Boateng, then a parliamentary under secretary in the Department of Health).

[842] INQ006449
[843] INQ006451

H.2: Operation Trawler

Background

4. Michael John Carroll's sexual abuse of children came to light as a result of an investigation by Merseyside Police named Operation Care. This commenced in 1993 to investigate the possible sexual abuse of children by Carroll at St Edmund's Children's Home, Liverpool. By 1998, it was investigating allegations against Carroll related to his employment by Lambeth Council as well.[844]

5. Clive Driscoll was a police officer in the Metropolitan Police Service. He was made a detective inspector in 1998 and joined the Lambeth Child Protection Team.[845] He retired in 2014 in the rank of detective chief inspector. He explained that Merseyside Police needed the assistance of the Metropolitan Police Service in order to further its investigations into Carroll in London.[846] This assistance took the form of a Metropolitan Police Service investigation that became known as Operation Trawler. Dr Driscoll explained that his role within the Child Protection Team was a demanding one and that, at most, he worked for about 30 days on Operation Trawler. This mostly involved supervising a detective sergeant and a detective constable, and attending meetings. He explained that there was a meeting every Friday with Lambeth Social Services in respect of Operation Trawler.[847]

6. A contemporaneous report from 1998, written by then DI Driscoll, described that in June 1998, the Metropolitan Police Service was asked to assist Operation Care.[848] It had been agreed that Lambeth Council would forward the names and dates of birth of children who had lived at Angell Road and Highland Road (the other Lambeth Council home that Carroll had worked in). The Metropolitan Police Service agreed to locate those children and forward them letters from Operation Care, "*inviting children to disclose offences*".[849] The report also stated that the response to this exercise had produced allegations against other staff at Angell Road and Highland Road, which were the responsibility of the Metropolitan Police Service to investigate.[850]

7. In keeping with the suggestion that other allegations had come to light that were for the Metropolitan Police Service to investigate, Dr Driscoll explained that he spoke to individuals linked to Lambeth Council with information about Lambeth Council's children's homes. This included former councillor Ms Anna Tapsell and Ms Theresa Johnson, who he believed had been the manager of Angell Road.[851] He explained that Ms Johnson's concerns were that funds and food from Angell Road had been stolen, that parties were taking place in a flat that Carroll used on the premises and that people attended who were not connected to

[844] Clive Driscoll 10 July 2020 3/4-4/3
[845] Clive Driscoll 10 July 2020 2/6-12
[846] Clive Driscoll 10 July 2020 8/8-25
[847] Clive Driscoll 10 July 2020 12/16-21 and 13/7-13
[848] LAM009435_001
[849] LAM009435_001
[850] LAM009435_001
[851] We note here that there may be a slight confusion in Dr Driscoll's evidence about Ms Johnson's job at Angell Road. In or around 1981 and 1982, Ms Johnson was undertaking a qualification in social work. She did a practice placement at the Angell Road home for three or four months during this period; Gillian Delahunty 9 July 2020 152/24-153/8

the home.[852] According to Dr Driscoll, Ms Johnson told him that she had seen Mr Boateng at Angell Road.[853] Dr Driscoll explained that although Ms Johnson mentioned this specific name, in his words "*there were other people that I was really concerned about*".[854]

8. In his evidence to the Inquiry, Dr Driscoll was asked about a notebook he kept at the time. This had an entry marked "*Angel Town 1981*". It stated:

> "*The child followed Carroll everywhere. Secrets. And other child excluded from school. Petrified of John. Would not talk about anything. Uncle John would be angry.*"

Dr Driscoll confirmed that this was information that Ms Johnson provided to him in 1998.[855] This was the only entry in the notebook specific to Angell Road. Dr Driscoll suggested that he had other notebooks, and that a list had been drawn up of 10 children who had made complaints relating to the time that Carroll was in charge of Angell Road. Dr Driscoll confirmed that this list went to Operation Care.[856]

9. In his evidence to the Inquiry, Dr Driscoll was asked whether during Operation Trawler anyone had provided him with information about Lambeth Council approaching Southwark Council to consider an application to foster by the Carrolls (see Part D). Dr Driscoll said that Ms Bernadette Khan (a social worker with Wandsworth Council) had told him about such an application to Southwark Council during Operation Trawler.[857] In her written evidence, Ms Khan referred to her knowledge of applications to foster being made to Croydon and Wandsworth Councils; she made no mention of any application considered by Southwark Council.[858] Ms Khan was the person who was most involved in the fostering application made by the Carrolls – she regarded them as unsuitable to be foster parents and was highly critical of Lambeth Council's support of the Carrolls.

10. Dr Driscoll was also asked about the suggestion he made in his witness statement to the Inquiry that he had spoken to Mr Clive Walsh during his investigation in 1998.[859] Between 1985 and 1989, Mr Walsh was the head of fieldwork and community services at Southwark Council. He provided evidence to the Inquiry that Southwark had been asked by Lambeth to approve the Carrolls as foster parents. Mr Walsh gave evidence to the Inquiry that he spoke to DI Driscoll in or around 2013 or 2014 about this (when there was press reporting about Carroll), not in 1998.[860]

11. Aside from Mr Walsh and Dr Driscoll, the Inquiry has not seen any evidence of knowledge of any application to Southwark Council by or on behalf of the Carrolls being known about in 1998 or before 1998. There is no mention of any application to Southwark Council in Wandsworth Council's records about the Carrolls' fostering application. Mr Richard Clough carried out an inquiry into Carroll's employment by Lambeth Council in 1993. He confirmed to us that no one mentioned such an application to him. It is reasonable to assume that individuals like Ms Khan (who had no reason not to disclose it) would have mentioned it to Mr Clough if they knew of any approach to Southwark Council.[861]

[852] Clive Driscoll 10 July 2020 27/4-13
[853] Clive Driscoll 10 July 2020 29/11-23
[854] Clive Driscoll 10 July 2020 29/20-22
[855] Clive Driscoll 10 July 2020 31/1-19
[856] Clive Driscoll 10 July 2020 32/5-25
[857] Clive Driscoll 10 July 2020 33/9-34/15; Bernadette Khan 3 July 2020 30/12-16
[858] Bernadette Khan 3 July 2020 31/6-20
[859] Clive Driscoll 10 July 2020 33/19-35/3
[860] Clive Walsh 7 July 2020 34/2-9
[861] Richard Clough 7 July 2020 55/18-56/15

12. This demonstrates the need to approach Dr Driscoll's recollection of events in 1998 with some caution. Although he was clear in his memory that he spoke to Mr Walsh in 1998, the evidence of Mr Walsh undermines that. It is not surprising that there should be some confusion about these events, which took place a long time ago. There is also an obvious risk that press reporting after the event may conflate what witnesses knew at the time with what they now believe they knew, having read these press reports.

13. In addition, Dr Driscoll confirmed that he worked on Operation Trawler for a relatively short period of time. He also explained the demanding nature of the role of detective inspector on the Child Protection Team. The majority of his time "*was taken trying to improve relationships*". He attended case conferences with investigating officers and had several cases that were going to court as well at this time.[862]

14. It is important to understand therefore that Operation Trawler was of short duration and that during it, as a detective inspector, Clive Driscoll was not working on it full time.

15. Dr Driscoll told us that his working relationship with Lambeth Council had been amicable until the point that he began raising questions about the involvement of people other than Carroll at Angell Road. After that point, the relationship became "*very strained*".[863] Dr Driscoll also gave evidence that there was a meeting on 28 August 1998 with Lambeth Council, during which he mentioned the names of some people that had been provided to him in the course of his investigations. According to Dr Driscoll, after this meeting he spoke with Dr Goldie and Mr Paul Clark (an inspector with the SSI) about those names. According to Dr Driscoll, Mr Clark said he would speak to Mr Dobson about this. This was a reference to Mr Frank Dobson MP, the then Secretary of State for Health.[864]

16. Dr Driscoll said that after this meeting (during which he had named individuals said to be linked to Angell Road), Lambeth Council pressured him into repeating the names at a further meeting.[865] He said that senior police officers had also encouraged him to disclose the names, although he also said that he made the decision to disclose the names and that it was his responsibility.[866] As described below, he was removed from the investigation shortly after this point.

17. Dr Goldie was made the assistant director of corporate strategy and quality in Lambeth Council in 1996. He was not a social worker and was not an expert in child protection. He became responsible for the Lambeth Council child protection team, which he explained was to ensure that the child protection team had a different line of management and independence from the social work field offices. He told us this was management at a high level, with experts beneath him.[867] He said:

> "*I'd been managing a range of functions, and this was at a high level. It was management with the experts beneath me. I wasn't – so I felt confident about – in the light of having some very good people working in that unit, that they would be able to advise me and*

[862] Clive Driscoll 10 July 2020 10/23-11/23
[863] Clive Driscoll 10 July 2020 36/4-11
[864] Clive Driscoll 10 July 2020 19/12-20/4
[865] Clive Driscoll 10 July 2020 41/23-42/15
[866] Clive Driscoll 10 July 2020 44/5-11
[867] Nigel Goldie 9 July 2020 91/19-92/5

> *access the source of professional knowledge, because they were the ones who were dealing at the front-line with chairing cases – planning meetings and so on and so forth. That was something that was not for me to do.*"[868]

18. In 1998, Operation Care discovered that a child (LA-A29) had made allegations some time before of sexual abuse by Steven Forrest, a careworker at Angell Road. This allegation, and Lambeth Council's failure to adequately respond to LA-A29's disclosure at the time, formed the basis of John Barratt's interim, Part 1 and final reports.[869]

19. Dr Goldie's evidence assists in understanding how Operation Care, Operation Trawler and the Barratt final report link together. The Barratt final report explained that it was Merseyside Police's involvement that finally prompted a full Lambeth Council social services' response to LA-A29's disclosure. According to the report, had it not been for the involvement of Merseyside Police, LA-A29's disclosure would have been overlooked.

20. Although the Barratt final report was extremely critical of Lambeth Council's response to LA-A29's disclosure, the report does refer to Lambeth Council child protection officers having taken action to try to get a child protection process reinstated when they first became aware of the disclosure.[870] Dr Goldie explained that he then became part of Lambeth Council's liaison with Operation Care when LA-A29's disclosure came to light again.[871]

21. Dr Goldie attended a meeting with the Metropolitan Police Service, which he thought might have been in July 1998, at which Mr Clark was also present. Dr Goldie said that, at this meeting, DI Driscoll mentioned information about politicians visiting Angell Road. Dr Goldie said that after this meeting he asked Mr Clark what he was going to do about it and that Mr Clark said he would speak to Frank Dobson MP.[872]

22. Dr Goldie wrote to the chief executive of Lambeth Council, Dame Heather Rabbatts, briefing her about developments in the Carroll prosecution and ongoing investigations. Although this briefing is undated, it refers to Carroll's committal date at court being scheduled for 14 September 1998, and so must have been written before this. Carroll had been charged and was awaiting trial at this point.

23. This briefing does not mention anything about politicians visiting Angell Road. It stated that the SSI were well briefed on matters, and that Mr Clark would do a briefing for Frank Dobson MP directly, given the sensitivities over "*the Boateng*" connection with Lambeth Council.[873] Dr Goldie confirmed that this was a reference to Mrs (now Lady) Janet Boateng having been involved as a councillor in Lambeth (Mr (now Lord) Paul Boateng being the Parliamentary Under Secretary in the Department of Health until 28 October 1998). Dr Goldie said that he did not list the names of politicians who were being linked to Angell Road until he had a "*clearer indication that there was some basis for doing that*".[874]

24. This briefing may confirm that Dr Goldie and Mr Clark were at a meeting together prior to 14 September 1998, and spoke about Mr Boateng being connected to Lambeth Council (through his wife), but it does not confirm that the names of politicians were mentioned to Mr Clark, in relation to Angell Road.

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[868] Nigel Goldie 9 July 2020 91/22-92/5
[869] LAM000022; LAM000021
[870] LAM000021_084
[871] Nigel Goldie 9 July 2020 109/4-24
[872] Nigel Goldie 9 July 2020 110/22-112/23
[873] NGD000011_002
[874] Nigel Goldie 9 July 2020 122/ 1-15

25. Dr Goldie was asked about the suggestion that Lambeth Council staff pressured DI Driscoll to name high-profile people in the course of Operation Trawler at meetings. Dr Goldie did not recollect that having occurred at all.[875] He recalled a meeting in November 1998 (the date of which he remembered because it coincided with press activity concerning Steven Forrest) in which DI Driscoll named politicians.[876] The meeting was intended to bring together social workers who might be able to support and engage in disclosure work with victims during the police investigation. Dr Goldie said that, during this meeting, DI Driscoll suddenly started speaking in a very open way about the allegations concerning politicians. Dr Goldie said that this alarmed him because press reporters were looking for a news story, and Lambeth Council was prone to leaks.[877] He said that his concern was that, by revealing these names to the audience of social workers, DI Driscoll was endangering Operation Trawler.

26. This disclosure caused Dr Goldie such concern that he went to see Dame Heather Rabbatts the same afternoon. She said that she would speak to her contacts in Scotland Yard, which Dr Goldie said she started with an immediate telephone call, and he left.[878] Following this, Dr Goldie was asked to meet Detective Superintendent (Det Supt) Richard Gargini of the Metropolitan Police Service. They met at a café and, according to Dr Goldie, he was probed about what DI Driscoll had said and was told that he should not speak to anyone about it – the police would get back to him.[879] At a further meeting with Det Supt Gargini (which Dr Goldie recalled happened the following week), Dr Goldie said he was told that the police "*had looked into the allegations that Clive Driscoll was making and they had not found anything to support them*", and that DI Driscoll would be suspended and disciplined.[880] Dr Goldie did not think that this would be the outcome:

> "*I was very shocked at that comment because I hadn't thought it would lead to something of that nature. It didn't seem, to my mind, to have warranted that kind of dramatic response.*"[881]

He said this left him with the feeling that "*a decision had been taken 'We're going to put the lid on this'*".[882]

27. Mr Gargini retired from the Metropolitan Police Service in the rank of commander in 2010.[883] He retained a note of his first meeting with Dr Goldie (made immediately afterwards and that Dr Goldie did not dispute).[884] It recorded that Dr Goldie communicated a number

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[875] Nigel Goldie 9 July 2020 123/16-21
[876] Nigel Goldie 9 July 2020 135/10-16
[877] Nigel Goldie 9 July 2020 136/3-21
[878] Nigel Goldie 9 July 2020 138/1-7
[879] Nigel Goldie 9 July 2020 140/3-5
[880] Nigel Goldie 9 July 2020 140/14-24
[881] Nigel Goldie 9 July 2020 140/25-141/4
[882] Nigel Goldie 9 July 2020 141/22-23
[883] Richard Gargini 10 July 2020 50/8
[884] Richard Gargini 10 July 2020 56/5-15; Nigel Goldie 9 July 2020 143/8-144/6

of concerns. The first was about a leak to a newspaper of confidential and sensitive information, and concern about whether that leak might have come from DI Driscoll. The note stated:

> "*Mr Goldie referred to highly sensitive and inappropriate remarks made by DI Driscoll in structured meetings. He was particularly concerned about the disclosure of unsubstantiated rumour in relation to prominent politicians in the presence of junior members of the Social Services Department. Mr Goldie alleges that DI Driscoll has linked a number of senior political figures without foundation.*"[885]

It further stated that "*Mr Goldie asserted that DI Driscoll failed to understand the impact and the implications of repeating the names in a structured meeting*". The note referred to Dr Goldie telling Det Supt Gargini that trust and confidentiality had been breached and that he compared DI Driscoll unfavourably with the Operation Care officers. The note ended by recording that Dr Goldie stated that progressing the enquiry with DI Driscoll in post would be difficult.[886]

28. DI Driscoll wrote a report during the course of Operation Trawler about his relationship with Lambeth Council and working with them. The report was written because of his concerns about the working relationship between the police child protection team and the social services child protection team.[887] It was written prior to the meeting at which DI Driscoll named politicians in November 1998. The report set out his concerns that decisions made as to what the Metropolitan Police Service would investigate in Operation Trawler were being attacked, and that an attempt was made to steer the police away from investigating Angell Road and Highland Road homes. DI Driscoll referred to a Lambeth Council child protection officer as having said that investigation into these homes would cause embarrassment to social workers who were still employed. The note summarised DI Driscoll's main concerns as being that: decisions were being overturned without consultation; files were being tampered with; an attempt was being made to control a criminal investigation; information was being passed through unauthorised channels; and meetings were taking place between Lambeth Council and Operation Care without the Metropolitan Police Service's involvement.[888]

29. In the course of his oral evidence to the Inquiry, the Chair asked Dr Driscoll about his evidence that efforts had been made to steer him away from Highland Road and Angell Road. In terms of where this came from, he said "*it was more of a concerted effort on behalf of Lambeth*". When asked what the motivation might have been, Dr Driscoll replied "*Embarrassment*".[889] He went on to say:

> "*I worked for an organisation that is very loyal. I have to say that sometimes that really gets us into trouble, because I think sometimes we may look at the organisation to protect it, when, in fact, we need to be open and transparent … I think Lambeth realised that, after thinking that in 1996 the Appleby had sorted it out, that here we are in 1998 and it still looks like a nightmare where files go missing and bits and pieces.*"[890]

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[885] INQ005746_015
[886] INQ005746_015-016
[887] LAM009435
[888] LAM009435_001-002,004
[889] Clive Driscoll 10 July 2020 47/23-25
[890] Clive Driscoll 10 July 2020 48/1-9

30. The evidence does not demonstrate that the removal of the then DI Driscoll from investigating child sexual abuse in Lambeth Council children's homes amounted to improper interference with Operation Trawler by the Metropolitan Police Service. DI Driscoll's contemporaneous report shows that he had serious concerns about Lambeth Council's attitude to Operation Trawler. The then Det Supt Gargini's note of his meeting with Dr Goldie demonstrates that a complaint was made to the Metropolitan Police Service by Lambeth Council that DI Driscoll had disclosed unsubstantiated rumours about prominent politicians to staff unconnected to the investigation. According to Det Supt Gargini's note, Lambeth Council questioned whether the investigation could be progressed while DI Driscoll remained in post. Det Supt Gargini confirmed how seriously this complaint was taken.

H.3: Operation Middleton and CHILE

31. Det Supt Gargini became the officer who led Operation Middleton. This was the successor to Operation Trawler. Mr Gargini began his evidence with an apology for any failings or missed opportunities during his tenure as senior investigating officer and member of the Gold Group for Operation Middleton.[891] He said that he was "*deeply saddened that more victims and survivors had not had prompt access to justice which they deserved and continue to deserve*".[892]

32. Mr Gargini explained to the Inquiry that he had been asked to conduct a review of the Metropolitan Police Service's response to Operation Care, and that it was in this context that he was asked to respond to Lambeth Council having raised issues about DI Driscoll.[893] He added that Dr Goldie's complaint about DI Driscoll's naming of politicians had raised "*deep concerns with me and would have resonated with senior officers within the Metropolitan Police*".[894] He explained that:

> "*if you put the name of a high-profile individual into a meeting and the inference is that there is criminality around that individual, bearing in mind the importance of that individual, to do that without the proper level of consent and knowledge of the most senior police officer on southwest area would have been regarded as a misconduct issue.*"[895]

In Mr Gargini's view this amounted to a senior police officer sharing highly sensitive and highly confidential information suggesting that there was a link between an individual and criminality when the proper enquiries had not been undertaken. The appropriate course of action would have been to seek guidance and permission and consent at the appropriate level (which would have been the assistant commissioner).[896]

33. Mr Gargini told us that the remit of Operation Middleton was to investigate child sexual abuse within Lambeth Council across its 35 children's homes over a period of 20 years, from 1974 to 1994. In addition to the police investigation, there was an independent social work team that was to work with the police.[897]

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[891] Richard Gargini 10 July 2020 51/3-8
[892] Richard Gargini 10 July 2020 51/3-5
[893] Richard Gargini 10 July 2020 52/8-20 and 55/14-56/1
[894] Richard Gargini 10 July 2020 57/24-58/1
[895] Richard Gargini 10 July 2020 58/1-7
[896] Richard Gargini 10 July 2020 59/1-16
[897] Richard Gargini 10 July 2020 64/1-5

34. This social work element of Operation Middleton became known as the Children's Homes in Lambeth Enquiry (CHILE) and was led by Ms Helen Kenward.[898] Ms Kenward was appointed, on the recommendation of the Department of Health, to lead CHILE as an independent inquiry in December 1998.[899] She had 37 years' experience as a social worker and was a specialist in child protection, and she had led other investigations. CHILE was established with 16 social workers, researchers and administrative staff. In order not to risk the independence of CHILE, only two of these had been Lambeth Council employees.[900] Ms Kenward explained that CHILE developed a protocol about working with the police. It would be open, honest, share information and keep the child at the focus of all the investigations.[901]

35. One witness who took issue with the approach adopted by Operation Middleton was former councillor, Ms Tapsell. She gave evidence to the Inquiry that she had a meeting with Det Supt Gargini and Ms Kenward at which she raised a number of concerns about the sexual abuse of children in Lambeth Council's care. She explained that she felt this meeting was intended to put her off investigating these issues further.[902] A manuscript note of this meeting exists. It recorded a meeting of two and a quarter hours, with Det Supt Gargini and Ms Kenward asking Ms Tapsell what she wished to add to the statement that she had already made to Operation Care.[903] Mr Gargini did not recognise Ms Tapsell's characterisation of the meeting. He thought that Ms Tapsell may have been slightly frustrated that material she showed them that related to other matters was not within the remit of Operation Middleton.[904] When asked about Ms Tapsell's view of the meeting, Ms Kenward observed:

> "*That's not my recollection. My recollection is that Anna Tapsell had a lot of knowledge and experience of Lambeth, lots of documents which she was very open to sharing and allowing us to use. She was – I think it is true to say that her concerns didn't always understand the difference between intelligence and evidence*".[905]

Ms Kenward thought that Det Supt Gargini's response to Ms Tapsell was about containing gossip rather than gossip being allowed to spread like wildfire, and thought that he had been very patient.[906]

36. Ms Kenward was also asked about the approach that she and Det Supt Gargini took to Ms Theresa Johnson. They visited Ms Johnson after she had provided a statement to Operation Care (which is referred to above).[907] Ms Kenward described it as "*a very, very sad interview*".[908] Ms Johnson "*was in a very distressed state*" and also unwell.[909] She "*felt bullied, marginalised and dismissed … and that her experiences at Angell Road with John Carroll had been ignored*".[910] As regards Ms Kenward's assessment of Ms Johnson's information that Paul Boetang had visited the Angell Road home, Ms Kenward explained that she and Det Supt Gargini had no evidence to support that information from any of the documents that they had seen or any of the information that they had previously been given.[911]

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[898] Richard Gargini 10 July 2020 64/8-13
[899] Helen Kenward 23 July 2020 73/6-7
[900] Helen Kenward 23 July 2020 79/6-20
[901] Helen Kenward 23 July 2020 75/7-18
[902] Anna Tapsell 8 July 2020 145/15-25
[903] INQ002089_001
[904] Richard Gargini 10 July 2020 72/10-24
[905] Helen Kenward 23 July 2020 107/19-25
[906] Helen Kenward 23 July 2020 108/2-7
[907] Richard Gargini 10 July 2020 73/19-74/5
[908] Helen Kenward 23 July 2020 109/19-22
[909] Helen Kenward 23 July 2020 109/21-22
[910] Helen Kenward 23 July 2020 109/22-110/11
[911] Helen Kenward 23 July 2020 110/5

37. Ms Kenward explained that she and Det Supt Gargini agreed that they should approach this information with a need "*to be circumspect and not leave it open to gossip and innuendo and surmise*".[912] They agreed that they would not disclose this information to anyone outside the Home Office, Number 10 and the Operation Middleton Gold Group.[913]

H.4: The Social Services Inspectorate

38. A further aspect of the suggestion that there was political interference in the investigation into Lambeth Council children's homes is linked, as set out above, to the involvement of the SSI. As noted above, it was suggested by both DI Driscoll and Dr Goldie that Mr Clark of the SSI had told them that he would provide a briefing to the Secretary of State for Health, Frank Dobson MP, about politicians' names being linked to children's homes in Lambeth.[914]

39. Mr Clark did not have a clear memory of being involved in Operation Trawler, although he agreed that some records suggested he had attended some meetings about it.[915] He had a much clearer memory of Operation Middleton. He thought that Dr Driscoll's evidence that he (Mr Clark) had cautioned care about naming high-profile people sounded like the sort of advice he would give.[916] However, he did not recall being at any meeting where the names of politicians were mentioned.[917]

40. Mr Clark also explained that he would not have briefed the Secretary of State for Health personally.[918] There was a chain of command and briefings were passed through this chain. Mr Clark confirmed that what was communicated to the Minister was calibrated through a formal process of ministerial briefing. Mr Clark had no memory of ever having provided a briefing on high-profile persons linked to Lambeth Council. His recollection was that Lambeth Council was full of gossip. It was not his job to report gossip but to report on the facts around the progress of Lambeth Council or Operation Middleton. Mr Clark was asked the direct question of whether he would have provided a briefing in order to tip off a minister or a Secretary of State about high-profile people being linked to investigations. Mr Clark stated that his "*career has always been to protect vulnerable children, not to obscure investigations*".[919] He stated that he had not provided a briefing to be given to Frank Dobson MP, with the names of any high-profile individuals or persons who had been mentioned in the course of Operations Trawler and Middleton.[920]

41. Ms Jo Cleary was the SSI's assistant chief inspector for the London region between 1998 and 2002, to whom Mr Clark reported.[921] She was asked about her state of knowledge in August 1998, when she prepared briefings about investigations into Lambeth Council.[922] These briefings do not refer to allegations about high-profile persons having visited Lambeth Council children's homes.[923] Ms Cleary stated that when she wrote them she was not aware

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[912] Helen Kenward 23 July 2020 110/10
[913] Helen Kenward 23 July 2020 111/10-23
[914] Clive Driscoll 10 July 2020 19/12-20/4; Nigel Goldie 9 July 2020 110/22-112/23
[915] Paul Clark 27 July 2020 32/14-17 and 33/10-11
[916] Paul Clark 27 July 2020 32/22-33/14
[917] Paul Clark 27 July 2020 33/23
[918] Paul Clark 27 July 2020 33/15-34/5
[919] Paul Clark 27 July 2020 35/11-14
[920] Paul Clark 27 July 2020 35/15-20
[921] Jo Cleary 27 July 2020 2/7-13; Jo Cleary 27 July 2020 13/23-25
[922] CQC000002_001
[923] CQC000002_001

of any information linking political figures or 'VIPs' to children's homes in Lambeth.[924] She also prepared a briefing for the then chief inspector of the SSI in November 1998. It concerned the press reporting about the allegations that a child in Lambeth Council's care had alleged sexual abuse against Steven Forrest as early as 1992. It also referred to a meeting that had taken place the night before between Ms Cleary, Mr Clark, Dame Heather Rabbatts and the then director of social services, Celia Pyke-Lees, about this situation. Ms Cleary referred to Lambeth Council appreciating the seriousness of the situation and that an independent inquiry was to be launched into these allegations.[925] Although this briefing is marked 'draft', it is nonetheless helpful for its recording of events for the reasons set out below.

42. Dame Denise Platt was the chief inspector of the SSI in 1998. She explained that the briefings prepared by Ms Cleary in August 1998 had not been provided to any minister. Ms Cleary had done some further work checking some points for accuracy (conveyed in an email by her).[926] Dame Denise Platt noted that Mrs Boateng had been chair of social services during part of the period of Carroll's employment. That constituted a clear conflict of interest for her husband, the then Minister for Social Care. Dame Denise Platt told us that she spoke to Mr Boateng in a face-to-face meeting, informing him that there was a potential conflict of interest, as a result of which the SSI could not brief him on the specifics of the investigation about Carroll. Mr Boateng understood the point and so was not briefed on any aspects of the Carroll investigation or police investigations in Lambeth Council.[927] Dame Denise Platt also confirmed that John Hutton MP took over Mr Boateng's role as Minister shortly afterwards, from October 1998.

43. Dame Denise Platt also gave evidence that, during this period, when she was briefed on the investigations into Lambeth Council children's homes, she was not aware of any information linking political figures or VIPs to children's homes in Lambeth Council. She was not aware of any information, even speculation or rumour, suggesting that Mr Boateng visited the Angell Road children's home or knew Carroll.[928]

44. In addition to there being no mention of information or speculation about politicians visiting Angell Road in Dr Goldie's memo (at some point prior to 14 September 1998), there is no mention of it in the contemporaneous SSI briefings.

45. Lord Boateng told the Inquiry that the only occasion when investigations into Lambeth Council were raised with him when he was a minister in the Department of Health was in a discussion with Dame Denise Platt. He explained that she raised with him that there was an investigation in which the SSI was involved that covered a period where Mrs Boateng had been chair of social services in Lambeth. He said:

> "*She raised the issue with me of an investigation in which the SSI was involved, told me that it covered a period where my wife had been chair of Social Services in Lambeth, and we agreed, readily, that, because of that, I should have no – I should recuse myself from any engagement or involvement at all in any work the Department of Health did with the Social Services Inspectorate or with Lambeth or with the police or with anyone else.*"[929]

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[924] Jo Cleary 27 July 2020 19/4-8
[925] INQ002185
[926] CQC000002_022
[927] Denise Platt 27 July 2020 71/4-23
[928] Denise Platt 27 July 2020 73/10-23
[929] Lord Paul Boateng 23 July 2020 128/3-18

46. Ms Johnson, who is now deceased, made a statement in 1998 to Merseyside Police. She made no reference to Mr Boateng or any other politician visiting Angell Road in that statement. In a later statement, in 2013, she referred to visits by Mr Boateng to Angell Road. In a further statement, in 2015, she referred to Mr Boateng visiting Angell Road, a child sitting on his knee and his going upstairs with the child.[930] Lord Boateng told us that he had no recollection of visiting Angell Road.[931] He might have done so if, as a solicitor, he was representing a child who had lived there, but he could not recollect a specific instance of that happening. He had no recollection of meeting a man named Michael Carroll or Michael John Carroll and certainly did not know him personally. Neither he nor his wife knew anyone at Angell Road so there was no way that he would have attended social events there. He stated that he would most certainly not have taken children up to the flat at Angell Road or on outings from Angell Road. He further stated that he did not volunteer with the Association of Combined Children's Youth Clubs (ACYC). He had no institutional involvement as a patron. He had no connection with any adults who went on trips with ACYC. He did not attend any holiday camps the ACYC were involved in running.[932]

47. The evidence does not support the contention that Mr Clark, Dame Denise Platt or Ms Cleary had grounds to believe in 1998 that Mr Boateng's name had been mentioned in relation to Angell Road and tried to tip him off about this or interfere with any investigation. Dame Denise Platt and Ms Cleary (who prepared the briefings) both said that they were unaware of allegations linking high-profile persons to Lambeth Council children's homes. Dame Denise Platt was aware that Mrs Boateng had been the chair of the Social Services Committee. This caused her to suggest to Mr Boateng that he should not be part of the information chain or decision-making in respect of the investigation into Lambeth Council children's homes. He readily agreed to this. The SSI took appropriate steps to ensure that neither he nor the investigation were compromised.

H.5: Freemasons

48. As part of this investigation, we considered whether there was evidence of Freemasons influencing investigations into sexual abuse of children in Lambeth Council's care.

49. The Inquiry received evidence that Donald Hosegood, who was prosecuted for sexually abusing children in his care at Shirley Oaks, waved a Masonic handbook when he was arrested.[933] DI Simon Morley accepted that this was clearly done in an attempt to influence the arresting officers.[934] While the records from the time show that, in DI Morley's words, "*it held no truck*" with the arresting officers, it is of concern that Hosegood had the impression that being a Freemason would assist him.[935]

[930] Theresa Johnson 31 July 2020 49/20-50/2
[931] Lord Paul Boateng 23 July 2020 135/14-25
[932] Lord Paul Boateng 23 July 2020 136/6-12
[933] Simon Morley 22 July 2020 57/11-14
[934] Simon Morley 22 July 2020 5715-25
[935] Simon Morley 22 July 2020 57/23-58/1

50. The terms of reference for the 1995 report by Elizabeth Appleby QC referred to "*the extent of freemasonry within Lambeth*".[936] Elizabeth Appleby QC exchanged correspondence with the Grand Secretary of the Freemasons.[937] She commented in her report:

> "*During the course of my inquiry I have received numerous allegations as to the cause of Lambeth's problems including the influence of Freemasonry, a 'Mafia' exerting pressure over the officers and a pornographic ring holding officers and members to ransom. I have received no evidence to substantiate these allegations.*"[938]

51. This Inquiry contacted the United Grand Lodge of England, the governing body for Freemasonry in England and Wales.[939] We heard evidence from Dr David Staples, who is the chief executive and Grand Secretary.[940] Ahead of Dr Staples giving evidence, a list of names – including perpetrators and alleged perpetrators of sexual abuse within Lambeth Council, members of the Metropolitan Police Service investigating complaints of abuse and Lambeth Council staff – together with, where possible, their dates of birth, was provided to the Grand Lodge to identify whether these individuals matched with members' details. Dr Staples stated, "*I think it would be difficult with absolute certainty to say that somebody was not*".[941] He confirmed that they would not be able to guarantee someone was not a Freemason just because there was not a match.[942] There was, however, one exact match of someone who was a Freemason – this was confirmed to be Donald Hosegood.[943]

52. We also asked male witnesses (the Freemasons being a male-only organisation) who were involved in the investigation of child sexual abuse and gave oral evidence to this Inquiry whether they were Freemasons. The only person who said 'yes' was Dr Clive Driscoll, who said that he had been a Freemason for "*30-odd years*".[944] He said that, during his time as a police officer, no one had ever approached him about "*looking the other way*" as a result of being a Freemason.[945] Mr Gargini told the Inquiry that he was not, nor had ever been, a Freemason.[946] Mr Pope told us that he was not a Freemason and similarly had never been one.[947] Mr Osmond also said that he was not a Freemason, as did Mr Clark of the SSI.[948]

53. The Inquiry did not receive any direct evidence of Freemasonry influencing or obstructing the investigation of child sexual abuse. We understand from the closing submissions of Lambeth Council that the requirement to sign a declaration of interest for all staff has been a part of its Code of Conduct since the late 1990s, and this includes whether they are a member of the Freemasons.[949] It is important that declarations of relevant interests are made to ensure greater transparency.

[936] LAM000025_004
[937] INQ005605
[938] LAM000025_018-019
[939] David Staples 9 July 2020 54/5-8
[940] David Staples 9 July 2020 54/5-8
[941] David Staples 9 July 2020 66/17-18
[942] David Staples 9 July 2020 66/22-67/1
[943] David Staples 9 July 2020 66/19-21
[944] Clive Driscoll 10 July 2020 46/14-15
[945] Clive Driscoll 10 July 2020 46/20-22
[946] Richard Gargini 10 July 2020 79/24-25
[947] David Pope 31 July 2020 12/22-24
[948] Robin Osmond 3 July 2020 105/12-15; Paul Clark 27 July 2020 44/17-18
[949] LAM030403_009

Part I

Inspection, oversight and external reviews

Inspection, oversight and external reviews

I.1: Introduction

1. We examined whether inspection and externally commissioned reviews by internal units and external bodies were effective in identifying failures by Lambeth Council to protect children from sexual abuse. We also considered Lambeth Council's responses to critical reports and their recommendations.

2. The responsibility for the quality of services in children's social care and child protection lies ultimately with the Council that provides or arranges these services.

I.2: Regulatory framework

3. The oversight of children's homes operated at a number of levels, both internal and external. The obligation to visit and inspect was regulated by statute and developed over time.

> **3.1.** The Administration of Children's Homes Regulations 1951 required monthly visits to children's homes by members or officers. The visitor was required to "*satisfy himself whether the home is conducted in the interests of the well-being of the children and shall report to the administering authority upon his visit*".[950]
>
> **3.2.** Under the Community Homes Regulations 1972, local authorities were required to arrange visits at least once a month by such persons as they considered appropriate, and for written reports to be produced on the conduct of the home.[951] The 1972 Regulations were replaced by the Children's Homes Regulations 1991. These similarly required monthly visits, with the official guidance stating that these should be unannounced and that, in the case of local authorities' reports, should generally be "*presented to an appropriate committee of members of the authority*".[952]
>
> **3.3.** In April 1985, the Social Services Inspectorate (SSI) was established. It formed part of the Department of Health and its role was to inspect, monitor and advise local authorities with social care responsibilities.
>
> **3.4.** From 1991, children's homes came within the remit of internal inspection units. These were instigated by the National Health Service and Community Care Act 1990, and required local authorities to establish internal inspection units to oversee adult and subsequently child residential care services.[953]

[950] LAM000021_092; Administration of Children's Homes Regulations 1951
[951] Community Homes Regulations 1972
[952] LAM000021_094
[953] National Health Service and Community Care Act 1990

3.5. In 2004, the SSI was replaced by the Commission for Social Care Inspection (CSCI). In 2007, the CSCI was in turn replaced by the Office for Standards in Education, Children's Services and Skills (Ofsted).[954] In addition to its role of inspecting education and skills, Ofsted had powers under the Care Standards Act 2000 to inspect residential care, including children's homes and fostering agencies.

3.6. Lambeth Council had a duty to ensure that inspections of children's homes took place on a regular basis.[955] By its own admission, Lambeth Council failed to comply with its own policies or statutory guidance regarding visits.[956]

I.3: Internal inspection and oversight

Visits by staff and councillors

4. Some councillor visits did take place. Ms Bernadette Khan (a co-opted member of the Lambeth Social Services Committee in the 1970s) explained her visits to children's homes, including Shirley Oaks:[957]

> "*the children's home visits were rota visits which were carried out in pairs by committee members, who would report back on those visits at committee meetings*".[958]

Mrs (now Lady) Janet Boateng, a councillor and chair of the Social Services Committee from 1982 to 1986, also referred to a rota of visits by committee members. She told us that she was keen to visit all children and adult residential establishments, accompanied by staff, when she became chair of the Social Services Committee.[959]

5. In 1987, a review chaired by Mr Millius Palayiwa (see Part C) recommended that "*a formal full scale review of each establishment be completed by the Homes Manager in conjunction with the officer-in-charge, four times a year*".[960] Mr Palayiwa considered that there was a lack of "*reviewing visits*" of children's homes at the time. This recommendation was never implemented.

6. Ms Phyllis Dunipace, who chaired the Social Services Committee between 1986 and 1988, recalled visiting personally each children's home approximately once a year, but she was uncertain of the frequency of councillor visits more generally or whether visits were recorded.[961] Ms Joan Twelves, councillor from 1986 to 1994 and Leader of Lambeth Council from 1989 to 1991, said "*I definitely never visited a children's home*", although she was not a member of the Social Services Committee and she was aware that other councillors were visiting.[962] Mr Stephen Whaley, former chair of the Social Services Committee who succeeded Ms Twelves as Leader in 1992, told us: "*I don't remember actually visiting homes*".[963]

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[954] LAM029331_189
[955] LAM029331_062
[956] LAM029331_062
[957] See Part D: in 1987 Ms Khan was working for Wandsworth Council as a social worker and the Carrolls' application to be foster carers was passed to her for assessment.
[958] Bernadette Khan 3 July 2020 27/15-16 and 39/8-11
[959] Lady Janet Boateng 7 July 2020 92/8-93/9
[960] Millius Palayiwa 3 July 2020 57/25-58/6; INQ004910_010
[961] Phyllis Dunipace 3 July 2020 114/5-115/2
[962] Joan Twelves 24 July 2020 118/11
[963] Stephen Whaley 24 July 2020 108/19-20

7. Ms Clare Whelan was a Lambeth councillor from 1990 to 2014 and a member of the Social Services Committee between 1990 and 1994. She told us that she undertook visits in the early 1990s, but:

> "*I was concerned that even though there was some written and lip service encouragement of visits to children's homes, the fact was that they were being discouraged or prevented … I was concerned that there would be an unalterable rota and officers would therefore have control over which homes were visited and when. I think, given my concerns about children's homes and what was going on in them, I felt it was important that I should have the right to go to children's homes unannounced acknowledged.*"[964]

8. In 1993, following an inspection of three of Lambeth Council's children's homes – Stockwell Park Road, Lorn Road and Angell Road – the SSI recommended that, within six months:

> "*Elected members and senior managers should agree and operate a system of routine visiting to all children's homes*".[965]

The SSI 1993 report also stated that visits should focus on areas of concern raised during inspections, and that reports and findings in respect of the visits should be presented to Lambeth Council's Social Services Committee for comment and action.

9. Ms Anna Tapsell, a Lambeth councillor between 1990 and 1998 and chair of the Social Services Committee from 1993 to 1996, described undertaking visits to children's homes herself. She also referred to practical problems, such as coordinating visits in pairs: "*often, it wasn't possible for other councillors to do it because they were working*".[966]

10. In a subsequent report in May 1994, the SSI noted that "*Elected members had not made regular visits to the units to monitor the quality of care*".[967]

11. Even after the two SSI reports, there was no effective or regular system of visits to Lambeth Council's children's homes by elected councillors or staff, despite their legal obligation to do so.

12. In 2000, the final report by Mr John Barratt (which concerned allegations of child sexual abuse by Steven Forrest at Angell Road children's home) identified a consistent failure to undertake councillor visits as required:

> "*the Committee both squandered this monitoring opportunity, and failed to realise, and act upon, its own repeated and obvious ineffectiveness in organising such visiting*".[968]
>
> "*Plans were followed by failed implementation, failed implementation was followed by criticism, criticism was followed by concern, and concern was again followed by plans etc. It is an account of repeated failure to observe legal requirements over many years.*"[969]

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[964] Clare Whelan 8 July 2020 100/21-101/15
[965] LAM028733_010
[966] Anna Tapsell 8 July 2020 128/6-129/10
[967] LAM000316_024
[968] LAM000021_088
[969] LAM000021_091

13. A succession of councillors did not carry out their statutory obligation to visit children's homes. This failure persisted over decades. There appears to have been a readiness to assume that someone else was undertaking visits, without checking whether this was the case.

14. The Barratt final report was equally critical of officers' failure to visit:

> "*Normal management within the Department should include monitoring, and most monitoring should be carried out by, and as a part of, normal management. Systematic internal monitoring of good quality, covering all activities, can only come from a sound management system, and it is a basic Conclusion of this Report that such a system has been lacking.*"[970]

15. Regular visits by staff to children's homes do not appear to have been a priority, including among senior staff. When asked if he visited any of the children's homes during his last two years as director of social services, Mr Robin Osmond (director from 1977 to 1988) told us that he visited children's homes:

> "*more regularly in the early days of my time at Lambeth … But increasingly the volume of work and the intensity of work in all sorts of ways meant that I visited less frequently. So I wouldn't have visited different homes at more than, say, a six-monthly interval.*"[971]

Mr David Pope, director of social services from 1988 to 1995, told us that, while it was his aim to visit the approximately 80 establishments for which he was responsible – and he did visit some children's homes – he was unable to visit all of them.[972]

Lambeth Council's inspection unit

16. In accordance with guidance under the National Health Service and Community Care Act 1990, local authorities were required to set up units to inspect adult and children's residential care.[973] Lambeth Council's internal inspection unit was formed in April 1991 and continued to operate until 1998.[974] Its purpose was to provide a structured internal inspection system, which would act to alert senior management to problems or failing standards of care.

17. During its first year, 1991/92, the inspection unit and children's services managers jointly inspected 10 of the Council's 11 children's homes. Although the intention appears to have been for an annual inspection of every home, after 1991/92 there were no further inspections of children's homes, despite there being seven children's homes in operation in both 1992/93 and 1993/94.[975]

[970] LAM000021_089
[971] Robin Osmond 3 July 2020 78/24-79/8
[972] David Pope 8 July 2020 4/20-21
[973] National Health Service and Community Care Act 1990
[974] LAM029331_063-064
[975] LAM029331_064

18. The unit's 1994/95 annual report stated that it would not carry out any further inspections of children's homes due to the closure process that was underway.[976] The planned closure of children's homes did not alter Lambeth Council's legal obligation to inspect them while they were in operation. The closures were not completed until 1996, and even then Chestnut Road remained open.[977]

19. In April 1994, the SSI carried out an inspection of Lambeth Council's inspection unit.[978] Its report concluded that the unit had not met its statutory and advisory targets.[979]

20. This reflected an established pattern by Lambeth Council staff and councillors.

I.4: External inspection and oversight

21. External inspection and oversight provide a means for central government to be assured of the quality of services in local authority areas, including commissioned provision from the voluntary and private sectors. As identified by the Barratt final report, external monitoring could "*never be a substitute for effective internal monitoring*" – it should have acted to "*supplement, confirm or deny criticisms being formed within the Council, and to provoke Councillors to inquire for themselves*".[980]

22. From its establishment in April 1985 until its replacement in 2004, the SSI, as part of the Department of Health, had the role of inspecting, monitoring and advising local authorities with social care responsibilities.[981] In addition to evaluating services, the SSI also had power to place a local authority in 'special measures', requiring it to set out an action plan to address identified problem areas, prior to re-inspection. This power was not used in relation to Lambeth Council until 1999.[982]

23. During its existence as the inspection body of local authority social services, the SSI undertook eight relevant inspections of Lambeth Council's social care. In 1991, it reviewed Lambeth Council's progress in implementing recommendations of both the 1987 Tyra Henry public inquiry report and the 1989 Doreen Aston inquiry report and, more generally, to examine the management of child protection services in Lambeth Council.[983] Its report stated that while "*all recommendations had been reviewed and actioned … some issues had received insufficient follow-up*".[984] Its detailed examination of written files for children in the care of Lambeth Council revealed a more alarming picture:

> "*work appeared to be fraught with delay in investigating, conferencing and programming … Conferences sometimes failed to distinguish individual children's needs or consider the risks in respect of all children … Current procedures could be improved by better coverage of in-care abuse investigation*".[985]

[976] LAM029331_064; LAM014617 (Annual Report of Lambeth Social Services Inspection and Quality Assurance Unit 1991–1992); LAM013016 (Annual Report 1992–1993); LAM019774 (Annual Report 1994/1995).
[977] LAM029331_064
[978] LAM012276
[979] LAM012276_005
[980] LAM000021_089
[981] Jo Cleary 27 July 2020 4/7-8
[982] LAM013017_014-015
[983] The Tyra Henry public inquiry report (dated 1987) concerned the death of Tyra Henry, a child who was killed by her father when she was in the care of Lambeth Council: LAM028613; Doreen Aston died in September 1987 aged 15½ months. She had been on Southwark Council's Child Protection Register since shortly after her birth. Although Southwark was the authority with statutory responsibility for child protection regarding Doreen, the recommendations had implications for practice more widely, including Lambeth: LAM010629_005
[984] LAM010629_056
[985] LAM010629_058

As a result, the SSI's recommendations included annual consideration of child protection training priorities and improved management of records and information about children.

24. These would be recurrent themes. Indeed, they had already been identified but not adequately addressed. In 1988, in a report to the Children's Home Sub-Committee, Robert Morton (principal manager of children's homes) highlighted staff training, poor record-keeping and failure to plan for children as issues of real concern.[986]

25. Ostensibly, the recommendations of the SSI 1991 report were considered. In June 1992, the Social Services Committee was shown a table listing the recommendations and a management action plan with progress to date.[987] However, as Ms Annie Hudson, strategic director of children's services, accepted:

> *"A distinction must be drawn between changes in policy and changes in practice. Although the Council took action in response to the recommendations, Lambeth has not been able to locate any material that demonstrates whether or not that action had a consequential impact on practice."*[988]

26. Subsequent critical reports were to demonstrate that any impact on practice, or improvement for children in Lambeth Council's care, was negligible or non-existent. An SSI report in 1992 identified Lambeth Council as having one of the highest numbers of looked after children without an allocated social worker (known as 'unallocated cases') in the London region.[989] It stated of Lambeth Council (and others with high levels of unallocated cases), "*this represents a serious long term failure to fulfil statutory responsibilities towards children requiring protection*".[990]

27. The pattern of a critical report, a detailed list of recommendations and an action plan in response from Lambeth Council became a familiar one. The similarity of the recommendations across the totality of the SSI reports, and the persistent failure of Lambeth Council to effect change, is evident. Lambeth Council did little more than perpetuate a cycle of action plans that nominally responded to recommendations whilst consistently ignoring the fact that children continued to suffer neglect and abuse in a system that was failing on every level. Reports that should have caused serious concern amongst the management of social care in Lambeth and provoked real change appear instead to have been accepted as routine.

28. There were, however, some individuals who were sufficiently concerned at the situation that they highlighted concerns at the most senior levels. The concerns of Councillor Whelan about the quality of Lambeth Council's children's services led her to write to Mrs (now Baroness) Virginia Bottomley MP (Minister of State for Health from October 1989 to April 1992, and Secretary of State for Health from April 1992 to July 1995) in January 1991, and subsequently to meet with her.[991] Councillor Whelan's letter stated:

> *"Since my election to Lambeth Borough Council in May 1990 I have become more and more concerned about the quality of Lambeth's children's services."*[992]

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[986] LAM028710
[987] LAM029271
[988] LAM029331_194
[989] LAM014117_005
[990] LAM014117_005
[991] CWH000037
[992] CWH000037_005

29. She enclosed with her letter the 1990 report of Mr Morton, in which he stated:

> "*The problems are so wide ranging and numerous … To put right, what I personally consider to be an unacceptable state of affairs, is going to take not only considerable management time but a clear commitment by the department and council in not tolerating certain situations.*"[993]

30. Baroness Bottomley told us that having received the letter and after meeting Councillor Whelan:

> "*Lambeth was well and truly flagged, from my point of view, as having a children's Social Services that needed attention, and I was in dialogue with the SSI as to what the next step might be.*"[994]

31. Councillor Whelan wrote again to Virginia Bottomley MP in October 1992, referring to "*paedophile activity in Lambeth children's homes*".[995] Tim Yeo MP (the Under Secretary of State for Health from April 1992 to May 1993) responded, stating that there would be both an independent inquiry into the employment of Carroll (which would become the Clough report) and an inspection of Lambeth Council's residential child care services by the SSI.

> "*The SSI inspection will look at the overall management of Lambeth's residential child care service and also the quality of service provided at individual children's homes.*"[996]

32. This coincided with Councillor Tapsell writing to Mr David Lambert at the SSI in September 1992, stating:

> "*In allowing John Carroll to continue working at Angell Road the department put him in a terribly vulnerable position. I happen to believe that they also put children at unnecessary risk.*"[997]

33. A meeting was called in October 1992 between the SSI and Mr Pope (then director of social services) to address Councillor Tapsell's concerns about Carroll at Angell Road (see Part D), the allegations of sexual abuse perpetrated by staff at South Vale over the previous five years (see Part C) and Councillor Whelan's efforts to secure a Department of Health enquiry into the management of residential child care. The note of the meeting stated:

> "*DSS* [Mr Pope] *said he did not question Councillor Tapsell's motives in seeking an enquiry but they did not agree on what form this should take. DSS's view was that the only solid evidence against Carroll was of dishonesty and that did not justify an investigation into possible sexual abuse under local procedures … Eventually a compromise had been struck that the Department under cover of a research project into the experience of Lambeth children in care would issue a questionnaire about their time in care on the pretext of developing the Complaints Procedure. This work was to be undertaken by the PO Child Protection and a senior Admin Manager. About 3 dozen children had been identified and had been traced. However plans to undertake the work had been superseded by the Gibelli and South Vale investigations.*"[998]

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[993] INQ002077_002
[994] Baroness Virginia Bottomley 27 July 2020 133/14-17
[995] CWH000037_011
[996] CWH000037_017
[997] INQ002209_002
[998] CQC000298_007

This exemplifies how senior staff dealt with external scrutiny. In the face of proper concern that children may have been at risk at Angell Road, the preparation of a questionnaire appears to have been no more than an effort to appease the Department of Health. It did not for a moment constitute a serious attempt to ascertain whether children had been abused. Neither does it appear that the SSI followed up on this issue or sought to ascertain whether complaints were received from children in the care of Lambeth Council.

34. In February 1993, Tim Yeo MP commissioned an independent inquiry about the employment of Carroll.[999]

> "*Following discussions with the SSI, I had agreed to ask Lambeth to arrange an independent person to carry out the review of Michael Carroll's employment. Lambeth appointed Richard Clough to do that*."[1000]

The terms of reference, set by the SSI, did not include investigation of the risk of sexual abuse that arose during Carroll's management of the home.

35. In March 1993, Tim Yeo MP requested that the SSI conduct an inspection of children's homes to consider the quality of care offered by Lambeth Council.[1001] Initially referred to as an inspection to "*look at the overall management of Lambeth's residential child care service and also the quality of service provided at individual children's homes*", it was limited to an inspection of just three children's homes. In his evidence to us, Mr Yeo was unable to recall if he was involved in the decision to limit the scope of the SSI's investigation to three children's homes – Stockwell Park Road, Lorn Road and Angell Road – or the reason for that decision. Given the extent and nature of concerns, it is unclear why such a narrow approach was taken. Mr Yeo said that he had a close working relationship with the SSI and most important decisions were a matter of joint discussion.[1002] In such circumstances, it seems likely that the decision would have been a matter of discussion and agreement between the minister and the SSI.

36. It is evident – to reiterate the words of Baroness Bottomley – that by this stage, within the SSI and at ministerial level, "*Lambeth was well and truly flagged*"[1003] as a local authority where there were concerns of the utmost severity about both the risk of sexual abuse and deplorable standards of basic care for children within the Council's care.

37. The SSI 1993 report about the Stockwell Park Road, Lorn Road and Angell Road children's homes highlighted significant concerns, including a lack of clear management plans for the development of good practice in homes, a lack of staff training and an uncertainty surrounding plans for the children's futures.[1004] It also identified staff vetting as a specific area of concern.[1005] The report recorded that "*Senior managers in the department will need to begin remedial action at once to improve the quality of standard of residential child care*". It noted that "*Lambeth have made some progress in improving the situation, but there is much to be done*".[1006]

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[999] LAM029331_195
[1000] Tim Yeo 27 July 2020 150/21-24
[1001] LAM029331_209
[1002] Tim Yeo 27 July 2020 147/10-17
[1003] Baroness Virginia Bottomley 27 July 2020 133/14-17
[1004] LAM028733_005
[1005] LAM028733_058
[1006] LAM028733_006

38. The detail of the report provided a sense of the state of the children's homes and the neglect of those within them:

> "*The exterior to the front houses rubbish containers and was smelly and not clean. The rear garden contained a boarded-up wendy house and a large pile of broken, disused furniture and junk. It contained items of discarded, dirty clothing, waste paper, broken toys and a slide that had been waiting for erection for over two years.*
>
> *The standard of decoration, furnishings and equipment for the young people resident at the unit was seriously inadequate. The building was characterised by dirty, broken and inappropriate furniture and equipment and clothing scattered throughout the building and its grounds.*
>
> *Fridges, work surfaces, sinks and microwaves were dirty, and in one home, breakfast cereal four months past the stamped sell-by date was put out for children's breakfast.*"[1007]

39. A management action plan (in response to both the Clough and the SSI report) was presented to the Social Services Committee by the director of social services, Mr Pope. The plan was said to be "*a single clear coherent framework for monitoring the Council's progress in implementing all the various items on which the Council has given commitments*", progress against which would be reported to the Social Services Committee.[1008] Mr Pope provided the Committee with five updates to the action plan during 1993 and 1994.[1009] However, the SSI 1994 report raised a number of issues, including that basic information about children was missing from their files, written care plans were not on file or known to staff and training on child protection had begun but progress was uneven.[1010] It stated that:

> "*despite the activity proposed and described by senior managers in their reports, the impact upon practice fell short of their expectations and of the requirement of regulations.*"[1011]

It concluded that "*the improvements were limited and patchy and some worrying essentials of practice (care plans and supervision) were still not adequate*".[1012] It should have been apparent then, if not before, that Lambeth Council was incapable of change of its own accord.

40. Lord Laming, Chief Inspector of the SSI from 1991 to 1998, told the Inquiry that, for the SSI, "*it was an unremitting slog to try and bring about change*".[1013] He said:

> "*SSI could recommend, they could even humiliate, if that's not too strong a word. But at the end of the day, they weren't responsible for managing the services.*"[1014]

[1007] David Pope 31 July 2020 1/25-2/21
[1008] LAM029325
[1009] LAM029268
[1010] LAM000316_004
[1011] LAM000316_003
[1012] LAM000316_004
[1013] Lord Herbert Laming 27 July 2020 83/13-14
[1014] Lord Herbert Laming 27 July 2020 86/22-25 and 102/22-24

41. In 1993, a report was also published into the death of Mia Gibelli, who was killed by her mother when she was seven weeks old. Staff had known that her mother had previously injured a sibling by throwing the child from a third-storey window. The report into Mia's death made a number of criticisms about Lambeth Council's children's social care. This prompted Tim Yeo MP to make a public statement that:

> "*Lambeth have been once again guilty of the grossest degree of incompetence, but it is, I'm afraid, part and parcel of their record generally in relation to childcare.*"[1015]

42. Mr Yeo left his position as Parliamentary Under-Secretary of State for the Department of Health in May 1993, prior to the Clough report and the SSI 1994 report. His evidence to the Inquiry was that he did not consider that the SSI 1993 report concerning the three Lambeth Council homes warranted ministerial action.[1016] Baroness Bottomley, who remained as Secretary of State for Health from April 1992 to July 1995, told us that:

> "*I think the reports* [of the SSI] *were pretty clearly worded and hard hitting. So I don't think at that time, I would have done anything other … It's just the persistent refusal to learn the lessons which with hindsight, is so unforgivable … for them to fail to act, looking back on it, is extremely serious, but … at that time, they didn't – they weren't sufficient of an outlier. Worrying, serious, ominous, but not sufficiently at that moment to take further steps.*"[1017]

43. Baroness Bottomley's evidence accorded with the view of Lord Laming, that Lambeth "*wasn't a particular outlier*".[1018]

44. In 1997, the SSI inspected Lambeth Council as part of a programme of national inspections, and evaluated planning and decision-making for children looked after by the Council. It noted that there had been a:

> "*fundamental and sustained change over the last 3 years. There had been an almost complete change in the Social Services Department's (SSD) senior management team during that period.*"[1019]

45. Ms Cleary was an SSI Inspector from 1990 to 1998 and Assistant Chief Inspector for the London region between 1998 to 2002. She told us that the role "*was to manage business relating to Social Services across the whole of London, and there were 33 London boroughs*".[1020] By comparison with other London local authorities, she said that Lambeth Council was "*regarded at the time as the worst*".[1021] Ms Cleary told the Inquiry that:

> *"the special monitoring of authorities came in, I think it was in 1999, but before that, particularly in relation to Lambeth, we were already intensifying our monitoring of their performance*";[1022] and
>
> "*after 1998 there was more concerted effort to try and address the … endemic issues.*"[1023]

Dame Heather Rabbatts was viewed as giving a "*high level of co-operation*" to the SSI.

[1015] LAM009811
[1016] Tim Yeo 27 July 2020 151/8-18
[1017] Baroness Virginia Bottomley 27 July 2020 142/3-17
[1018] Lord Herbert Laming 27 July 2020 98/24
[1019] LAM001997_006
[1020] Jo Cleary 27 July 2020 3/18-20
[1021] Jo Cleary 27 July 2020 9/3
[1022] Jo Cleary 27 July 2020 6/5-10
[1023] Jo Cleary 27 July 2020 9/9-16

46. Subsequent critical reports by the SSI suggest that any improvements by Lambeth Council were superficial, temporary or limited in scope.

47. Operation Care, the Merseyside Police investigation into Carroll, commenced in 1998. This in turn prompted the setting up of Operation Middleton and the Children's Homes in Lambeth Enquiry (CHILE). Mr Barratt was separately appointed to examine Lambeth Council's response to allegations that Forrest had sexually abused a child in the Angell Road home. Mr Barratt produced an interim report in May 1999 and a Part 1 report in September 1999.

48. In November 1999, Lambeth Council was placed under special measures and formally monitored by the Department of Health, due to "*increasing concerns about the quality of their performance and their ability to actually turn around the council*".[1024]

49. In October 2000, the Barratt final report set out that:

- Lambeth Council repeatedly failed to fulfil both its statutory duties and its own policies relating to the care and protection of children;
- Lambeth Council had repeatedly tried and failed to create and control an effective department; and
- the executive chain of command (if it had ever existed) linking department action by staff to councillors had decayed and disintegrated.[1025]

50. Mr Barratt also said:

> "*It would be unfair not to recognise that the Council has tried repeatedly to bring its children's services up to a proper standard, and that those reforms have been effective in some respects. However, if the first Conclusion is correct, the failure of those reforms to achieve a competent Department is self-evident.*"[1026]

The three major reorganisations – in 1991/92, 1993/94 and 1995/96 – had not prevented the failures. In 1993/94 and 1997, officers put forward detailed 'action plans'. The formal acceptance of these plans "*did not prove to be a means of re-creation and control*" of an effective social services department within Lambeth Council.[1027]

51. As a result of ongoing concerns from the Minister of State for Health, John Hutton MP, about Lambeth Council's performance, the SSI undertook an inspection in May–June 2000. It was highly critical of childcare practice:

> "*We were particularly concerned about potentially large numbers of children who had not properly been regarded as looked after … Urgent action was needed to trace these children and secure their safety.*"[1028]

[1024] Dame Denise Platt 27 July 2020 63/9-17; LAM029331_256
[1025] LAM000021_010
[1026] LAM000021_013
[1027] LAM000021_013
[1028] LAM029179_008

52. It made 22 recommendations and set out the following:

> "*The overall impression we formed during the inspection was of a children and families division struggling under considerable and relentless pressure. In many areas basic work systems were functioning poorly or had collapsed. This led to inefficient, fragmented and inconsistent work practices. There were difficulties in almost every operational and support area.*
>
> *This inevitably led to considerable variation in the quality of service to high priority children. At best some children and young people received an acceptable level of care and protection. Many did not. We were not confident that practice was safe and that children always received the care and protection that they deserved and needed.*"[1029]

53. In November 2000, John Hutton MP (Minister of State for Health) issued 20 formal ministerial directions to compel Lambeth Council to rectify the situation identified in the May–June 2000 inspection.[1030] The directions (which were to be complied with by 31 August 2001) included that all children in care should have an allocated social worker, and that children should be visited at the required frequency, whether they were in a residential home or with foster carers or parents. There was also a direction that all local authority foster carers should be subject to appropriate checks.[1031] These ministerial directions were in addition to the imposition of 'special measures' in November 1999, which were formally monitored by the Department of Health.[1032]

54. One consequence of being in special measures was that an SSI and Audit Commission Joint Review of Lambeth Council Social Services was instigated, to take place alongside the May–June 2000 SSI inspection, and reported in December 2000.[1033] It made 28 recommendations and looked more widely at Lambeth Council social services, concluding that they were:

> "*not serving people well and that its prospects for improvement are worrying … The Authority needs to achieve comprehensive improvements in children's services … Standards of professional practice are unacceptably low in some parts of the service, with particular concerns about the delivery of effective and safe services to children looked after and in need of protection.*"[1034]

55. In response to the SSI 2000 review report and the SSI 2000 inspection report, Lambeth Council prepared action plans to respond to the recommendations set, detailing the instances where targets had been met.

56. In September 2001, the SSI assessed Lambeth Council's progress in complying with the ministerial directions.[1035] It identified areas that still needed to be addressed, including such fundamental issues as a requirement that "*all looked after children should have an allocated*

[1029] LAM029179_006
[1030] LAM029331_258
[1031] LAM019888
[1032] LAM029331-256
[1033] LAM013017
[1034] LAM013017_021
[1035] LAM018930

social worker" and that "*all children on the child protection register should be reviewed at the required frequency*".[1036] The SSI 2001 report made a further 19 recommendations, about which Lambeth Council developed another action plan, and concluded:

> "*The authority had put a great deal of effort into complying with the directions. The Chief Executive and councillors were working together with the Children and Families Division and were supportive of their efforts to bring about required changes. However because of the number and depth of issues needing action there was still much to do. Nevertheless we found that morale and motivation had improved and the direction of change was gradually upwards.*"[1037]

57. Dame Denise Platt told us about her discussion with John Hutton MP after that report, about whether the social services function should be removed from Lambeth Council and a commissioner put in place:

> "*We had to consider, if we did take even more drastic action, what would be the effect on the children? Were the children really seriously at risk at that point? Or was sufficient being done that we could be confident that their situation was safe but we could do much more and keep in place the enhanced monitoring and not put in anything further. Actually, it was a very finely balanced decision because you can either keep pulling up the roots and never giving anything a chance to settle, or think, is this the point at which actually, we think the signs are the most positive that they have been and we will support them.*"[1038]

58. The decision taken was "*not to take further drastic action*".[1039] As a result, the special measures ended in May 2002.[1040] This meant that Lambeth Council was no longer being formally monitored by the Department of Health. The SSI continued to carry out inspections, including an inspection of children's social care in 2003 that concluded that Lambeth Council was only serving some children well and had uncertain prospects for improvement. The report also recommended that the Council should develop a more coherent corporate parenting strategy.[1041]

Office for Standards in Education, Children's Services and Skills (Ofsted)

59. In 2004, the SSI was replaced by the Commission for Social Care Inspection (CSCI). In turn, in 2007, the CSCI was replaced by the Office for Standards in Education, Children's Services and Skills (Ofsted),[1042] led by Her Majesty's Chief Inspector of Education, Children's Services and Skills.

[1036] LAM018930_008
[1037] LAM029331_264; LAM018930_008-009
[1038] Denise Platt 27 July 2020 66/4-16
[1039] Denise Platt 27 July 2020 65/16-66/18
[1040] LAM029331_189
[1041] LAM029331_284
[1042] LAM029331_189

60. Ofsted undertook fostering and adoption inspections of Lambeth Council from 2007. In 2008, Ofsted undertook an inspection of the adoption service. This inspection resulted in an overall quality rating of 'good':

> "*Children benefit from a service which has a strong approach to matching them with suitable families. Recent recruitment activities to attract black adopters are being successful in addressing an identified and long-standing gap … The service is managed effectively both operationally and strategically. There have been some excellent initiatives to address long-standing issues and historical concerns*."[1043]

61. In May 2009, Ofsted inspected Lambeth Council's fostering service. It gave an overall quality rating of 'good' and reported in these terms:

> "*The authority strives to safeguard children, with a number of well thought out strategies. There is strong leadership, excellent partnerships and a clear focus on improving outcomes for children.*"[1044]

62. In 2012, Ofsted conducted an inspection of Lambeth Council's safeguarding and children looked after services, and assessed them as 'outstanding'.[1045] This presented a remarkably positive view of Lambeth Council's children's services. In 2015, Lambeth Council's children's services were judged as 'inadequate'.[1046] This was a four-week inspection in 2015 encompassing child protection, looked after children, care leavers and local authority fostering and adoption services in one inspection. The report stated:

> "*some children continue to live in circumstances that are harmful and neglectful for unacceptable periods of time.*"[1047]

63. In respect of this dramatic change in Lambeth Council's rating between 2012 and 2015, Councillor Edward Davie (Lambeth councillor since 2010, chair of Children's Social Work Scrutiny Committee from 2016 to 2018 and lead member for children's services in 2020) told us that the 2012 inspection:

> "*found us to be outstanding across five categories, was more based on what senior management were able to show the inspector rather than the inspectors delving in-depth into individual casework. Therefore, it was easier to get through the inspection with high marks if you were really good at impressing the inspectors is my understanding. To be honest, I think there was a deterioration of service, but it was also partly that the inspection requirement was toughened up and, in 2015, they looked at much more front-line casework and spent more time on the front line and looking at cases and I think to be honest, it was a more accurate reflection of the quality of the service than the 2012 rather glowing inspection report. I also think there was a lot of change between 2012 and 2015. A lot of senior managers left. There was a lot of disruption. There was a lot of change but to be honest with you I'm not sure that the 2012 glowing five 'outstandings' out of five was a fair reflection of the practice.*"[1048]

[1043] OFS012619_004
[1044] OFS012617_004
[1045] LAM029292
[1046] OFS012616
[1047] Carolyn Adcock 28 July 2020 15/13-15
[1048] Edward Davie 29 July 2020 16/24-17-19

64. Lambeth Council volunteered for support and intervention from Ofsted between 2015 and 2018, resulting in eight monitoring visits. There was also active engagement from Ms Hudson as strategic director of children's services from 2016. Despite the level of monitoring and the programme of visits over a three-year period, Lambeth Council was assessed by Ofsted in 2018 as 'requires improvement'. In April 2019, after a focussed visit, Ofsted concluded that further improvements had been made observing:

> "*Senior leadership in Lambeth is robust and there is a determination to improve outcomes for children and young people in the care of the local authority. The quality of permanence planning is improving. Children are seen regularly, and some are benefiting from more timely intervention. However, senior managers recognise that there is still a considerable amount of work to do to ensure effective and timely planning for young people*".[1049]

65. Lambeth Council now has a system of assistants to support care leavers aged 18 to 25.[1050] However, inspection of some accommodation for 16 to 17-year-olds remains out of the reach of Ofsted. Ms Carolyn Adcock, Senior Her Majesty's Inspector at Ofsted, told us that the Department for Education was consulting on this issue in 2020.[1051]

[1049] OFS012616
[1050] Edward Davie 29 July 2020 20/1-5
[1051] Carolyn Adcock 28 July 2020 13/5-16; Dame Denise Platt 27 July 2020 49/1-4

Part J

Receiving and prosecuting allegations of child sexual abuse

Receiving and prosecuting allegations of child sexual abuse

J.1: Introduction

1. In this investigation we examined how allegations of sexual abuse were obtained from children by the prosecuting authorities.

J.2: Achieving Best Evidence guidance

2. In order to be successful in the discharge of their responsibilities, the police and the Crown Prosecution Service must engage with child victims and enable them to give their best evidence and accounts of abuse.

3. Achieving Best Evidence guidance was originally drafted and published in January 2002 on behalf of the Home Office, and subsequently updated in 2007 and 2011.[1052] The 2011 Achieving Best Evidence guidance sets out good practice when interviewing witnesses and victims, and for preparing them to give their best evidence in court. It considers planning and preparation for interviews, the video-recording of interviews, and the special measures available to support vulnerable witnesses when giving evidence. One special measure is the use of an intermediary, who provides clear guidance about a child's communication ability and ways to support a child in answering questions. When a case is in court, an intermediary may facilitate communication between a child and any person who is asking questions, including with the answers given by the child in reply.

The evolution of the national approach to investigating child sexual abuse

4. In order to understand the development of investigations by police into child sexual abuse on a national basis, the Inquiry commissioned research by Cardiff University.[1053] This identified the following key developments:

- From 1963, Home Office circulars (which provide advice and guidance for police forces) referred to the need for coordination between police forces and other agencies, including local authorities, in relation to children in need of care, protection and control.[1054]
- By 1988, sexual abuse was included explicitly in the definition of child abuse. Joint working with social services was expected, and the paramount consideration was the welfare of the child.[1055]

[1052] NAP000012_013
[1053] EWM000464
[1054] EWM000464_006
[1055] EWM000464_008

- By the end of the 1990s, all forces had child protection units, which normally took primary responsibility for investigating child sexual abuse cases.[1056] In 1999, the concept of 'safeguarding' entered official usage, and the police were expected to work with other agencies to safeguard and promote the welfare of children.[1057]

5. A thematic review by Her Majesty's Inspectorate of Constabulary (HMIC) in 1999 identified that there was limited guidance for senior investigating officers conducting large and complex investigations. It also stated that there was a lack of preventative and proactive interventions – the majority of child protection unit staff understood their role to be primarily reactive, responding to reports or complaints made by victims.[1058]

6. The importance of conducting high-quality investigative interviews with children was recognised by 1999. Researchers also identified:

> *"A long-standing challenge for police investigators is that for many child abuse allegations, a statement by the victim may constitute the only substantive evidence as to what happened. Accordingly, in preparing a case for prosecution, police were expected to provide to the Crown Prosecution Service lawyers an assessment of a child victim's competency to act as a witness."*[1059]

7. Researchers identified that not all police officers were completing this task. We note, however, that an obvious pitfall with this task was whether and what information was obtained by the police to complete it. Without detailed, child-specific evidence around communication, there were risks of assumptions being made about a child's competence and, consequently, their allegations not being heard.

8. From 2000 onwards, a key focus was improving the training of those working in child protection.[1060] The police role was no longer understood as solely concerned with the conduct of the criminal investigation but also with considering welfare issues for children.[1061]

9. The 2018 report by Cardiff University noted that:

> *"All forces have made the protection of vulnerable people a priority in their area, and there has been an increase in both resources and the attention given to the policing arrangements to achieve this. However, HMIC found a mismatch between stated priorities and practice on the ground. More attention needs to be given to the quality of practice and the outcomes for children of police efforts."*[1062]

The Metropolitan Police Service

10. In 2016, HMIC inspected Metropolitan Police Service child protection services and made a number of criticisms.

10.1. Individuals and teams were not achieving consistently good results for children in London. Within a sample of child protection cases, 278 of the 374 cases examined demonstrated policing practice that needed improvement or was inadequate.

[1056] EWM000464_008
[1057] EWM000464_008
[1058] EWM000464_009
[1059] EWM000464_008
[1060] EWM000464_010
[1061] EWM000464_013
[1062] EWM000464_011

10.2. Thirty-eight cases were referred back to the Metropolitan Police Service – one had been judged as 'requires improvement' and three as 'inadequate' by the Metropolitan Police Service itself. However, until prompted by HMIC inspectors, it had taken no action to address the issues it had identified.

10.3. Whilst there were good examples of officers working quickly and effectively to protect children when the risk of harm to them was evident, they frequently failed to consider whether other children might be at risk from the same perpetrator, for example by checking which other young people he or she was in contact with.

10.4. Officers frequently failed to request strategy discussions with all relevant partner agencies, such as children's social care and health services.[1063]

11. The renamed Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) published a series of reports in 2017, 2018 and 2019, monitoring the progress made by the Metropolitan Police Service to improve its practices.

12. In 2018, the inspection found that the Metropolitan Police Service continued to review and refine its structures and systems to manage child protection work.[1064] A re-structuring replaced 32 borough operational command units with 12 basic command units, each with a dedicated safeguarding lead. A dedicated inspection team reviewing child protection cases after the 2016 inspection was described by inspectors as a strength. Criticisms, however, included concern about the Metropolitan Police Service response to indecent images of children and online child sexual exploitation, and its management of registered sexual offenders.

13. By 2019, there was appropriate senior-level oversight of child protection. However, there remained significant concerns around achieving outcomes for children. The March 2019 report concluded:

> "*We are assured that there has been, and continues to be, a focus on child protection matters, and that long-term planning is in place. However, we remain concerned about the consistency of decision making and whether children benefit from effective or improved outcomes when they require help and protection from the Metropolitan Police Service.*"[1065]

14. In oral evidence, Commander Alex Murray (Central Specialist Crime, Metropolitan Police Service) acknowledged the work ahead. He told us:

> "*I think the point made in 2016 and 2018, and I think it is still an issue, is consistently good interventions across the board for children in London. I think we still have some significant challenges in London in relation to that, particularly for more complex cases involving exploitation, county lines, for example; particularly involving missing persons reports; and, as you have highlighted, in relation to sexual offenders as well. We have got some big IT developments, as you would imagine, joining up the systems. They are taking time … I think we still do have some challenges.*"[1066]

[1063] OHY003222_006
[1064] MPS004476_004
[1065] MPS004476_007
[1066] Alex Murray 23 July 2020 24/2-15

The Crown Prosecution Service

15. The Crown Prosecution Service was established in 1986 to prosecute criminal cases investigated by the police and other investigative organisations in England and Wales. It decides, independently, which cases should be prosecuted, determines the appropriate charges in more serious or complex cases and advises the police during the early stages of investigations. It also provides information, assistance and support to victims and prosecution witnesses.[1067]

16. All criminal prosecutions brought by the Crown Prosecution Service are governed by the Code for Crown Prosecutors. The current version was issued in October 2018.[1068] The Code provides guidance to prosecutors on the general principles to be applied when making decisions about prosecutions. Prosecutors must only commence a prosecution when the case satisfies the Full Code Test. The Test has two stages:

- **evidential sufficiency**: a prosecutor must be satisfied that there is sufficient evidence to provide a realistic prospect of conviction; this is an objective test, based on the prosecutor's assessment of the evidence (including any information about the defence); and
- **the public interest**: having passed the evidential stage, the prosecutor will consider whether a prosecution is required in the public interest.[1069]

As Mr Gregor McGill (director of legal services, Crown Prosecution Service) agreed, there is a strong public interest in prosecuting cases of sexual abuse:

> *"It's a serious offence and there should be a presumption of prosecution unless there are public interest factors weighing against prosecutions more so than in favour of, but those are rare."*[1070]

J.3: The investigation and prosecution of child sexual abuse relating to children in the care of Lambeth Council

17. In response to requests from the Inquiry, the Metropolitan Police Service identified from its records a total of 283 allegations of sexual abuse made by children in the care of Lambeth Council.[1071]

Period	Number of allegations made to the Metropolitan Police Service
1963 to 1988	18
1989 to 1999	63
2000 to 2010	109
2011 to 2020	93

Source: Simon Morley 22 July 2020 6/11-19

[1067] https://www.cps.gov.uk
[1068] Code for Crown Prosecutors 2018
[1069] Code for Crown Prosecutors 2018
[1070] Gregor McGill 10 July 2020 93/6-9
[1071] Simon Morley 22 July 2020 6/6-7/3; DI Simon Morley explained that the records now available for the earlier time periods pre-date electronic recording of crimes and that victims may have come forward to the police without complaints being properly recorded.

18. By contrast, as at June 2020, Lambeth Council was aware of 705 former children in care who have made allegations of sexual abuse linked to three of the case study homes:

- 529 individuals made allegations against a total of 177 adults employed at or connected with Shirley Oaks;[1072]
- 140 individuals made allegations in respect of South Vale;[1073] and
- 36 individuals made allegations arising from Angell Road against nine adults and further unknown persons.[1074]

19. The figures from the Metropolitan Police Service and Lambeth Council are both likely to be a significant under-representation of the number of children who were sexually abused. As Dr Clive Driscoll (retired detective inspector (DI) with the Metropolitan Police Service) observed, the Shirley Oaks Survivors Association obtained complaints from more than 600 people:

> "*How has that happened when we were the agency that should investigate and we were the agency that should have been focusing on what the victims – their needs?*"[1075]

DI Simon Morley agreed that the number of allegations made to the police (compared with the number of allegations of which Lambeth Council is aware) suggests a failure by the police to "*properly engage with victims and give them the confidence to come forward*".[1076] LA-A311, for example, was at South Vale in the late 1970s and described sexual abuse by two staff members. He said that he tried to report it to police, but "*they didn't want to know*".[1077]

20. In terms of prosecutions before the 1990s, the Inquiry is aware of two acquittals – of Donald Hosegood and Patrick Grant in 1975 and 1978 respectively.[1078] Hosegood was the house father at Fir Cottage in Shirley Oaks between 1968 and 1975. Grant was officer in charge at Rowan House in Shirley Oaks in 1977. Following his acquittal, Grant was moved from Rowan House into adult care, but remained working for Lambeth Council until 1985.[1079]

21. Prior to 1992, investigations into allegations of child sexual abuse were conducted by individual officers based at local police stations, without any more comprehensive or joined-up approaches considered.[1080] As Commander Murray told us, these Criminal Investigation Department (CID) officers in London dealt with "*a whole array of crime*" in the 1970s and 1980s, despite sexual offences requiring different skill sets.[1081]

22. Children in care were frequently stereotyped and the Inquiry received evidence that their complaints were dismissed.

22.1. In February 1977, two children made an allegation of sexual abuse against Philip Temple, a house father at Rowan House, Shirley Oaks. They were accompanied to the police station by social workers. One social worker noted that one child became upset when questioned. The police officer said that he would not question the child any

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[1072] Annie Hudson 21 July 2020 12/21-23
[1073] LAM030157_006
[1074] LAM030227_048
[1075] Clive Driscoll 10 July 2020 46/5-10
[1076] Simon Morley 22 July 2020 8/6-12
[1077] LA-A311 29 July 2020 125/12-13
[1078] Simon Morley 22 July 2020 58/18 and 63/14-15
[1079] Annie Hudson 21 July 2020 40/1-12; LAM029331_048
[1080] MPS004500_020
[1081] Alex Murray 23 July 2020 7/24-8/14

further as he was "*too young*", and also that he had "*not questioned anyone as young as these two in this type of case before*".[1082] Temple was interviewed twice – he "*threatened suicide but still maintained that the children had fabricated the story*".[1083] The children were questioned further, "*as a person's career was at stake*".[1084] As the social worker recorded, one of the children:

> "*apparently broke down and cried and the DCs then left him to talk to CP and came out saying, 'He's halfway there. We're sure it's a string of lies. He's about to tell the truth'. At this point, we felt the police seemed relieved they could exonerate the house father whom they described as desperate. We felt that the police simply had no technique for interviewing the children, which they admitted themselves.*"[1085]

Temple was released without charge but a further allegation of sexual abuse was made in April 1977 by the family of LA-A4. Another police officer visited the family and was provided with a statement from LA-A4.[1086] In June 1977, LA-A4's social worker recorded that "*the police had not been back and nothing else had been heard about the matter*".[1087] It does not appear that the Director of Public Prosecutions's (DPP) Office was approached for advice at the time.[1088] LA-A4's allegations were raised with Temple by managers from Lambeth Council in July 1977 – Temple "*admitted that there was truth in it* [the allegations]" and resigned.[1089] Lambeth Council did not take any other action, including to inform the police.[1090] In 2016, Temple pleaded guilty to 29 offences, including 27 child sexual abuse offences against 13 children (including LA-A4), of which a number dated back to the 1970s.[1091] As a result of concerns about the performance of the Metropolitan Police Service in investigating Philip Temple, there was a self-referral to the Independent Police Complaints Commission in 2016.[1092]

22.2. In 1984, LA-A156 was in care. She reported to the police that she had been sexually abused. The alleged abuser was prosecuted in relation to other victims, but he was not prosecuted in relation to LA-A156. She told us that the police said:

> "*they already had enough evidence from the other girls and 'would not prosecute relating to my assaults' … I was made to feel the assault was my fault. It felt like they thought I was lying and yet they knew LA-F259 had already been charged in the past for assault on another girl.*"[1093]

22.3. LA-A457 lived in a foster placement in Lambeth in the 1980s. As a young child, she was interviewed by the police about her allegations of sexual abuse by the foster carer's son.

> "*I remember the look on the police officers' faces at how forward I was, describing this sort of abuse in a lot of detail at 8 years old. Surely, this should have set off alarm bells. I was taken back home.*"

[1082] Annie Hudson 21 July 2020 29/13-15
[1083] Annie Hudson 21 July 2020 30/3-9
[1084] Annie Hudson 21 July 2020 30/3-9
[1085] Annie Hudson 21 July 2020 30/17-25
[1086] MPS004500_085
[1087] MPS004500_086
[1088] CPS004943_007
[1089] Annie Hudson 21 July 2020 37/19-38/04
[1090] Annie Hudson 21 July 2020 37/7-16
[1091] LAM030213_104
[1092] MPS004500_118
[1093] LA-A156 29 July 2020 155/8-16

23. As the interview took place in her foster carer's presence, LA-A457 did not feel able to give the name of the alleged perpetrator to the police. She said that her foster carer:

> "*told the officers that I was just a drama queen; that was the end of it. There was no further questioning, no investigation. It was swept under the carpet.*"[1094]

24. Some children ran away from care and were sent back, despite making allegations of sexual or other abuse.

24.1. LA-A7 tried to report abuse by Leslie Paul (a care officer at South Vale children's home in Lambeth) in the 1980s, when he ran away from South Vale. He said:

> "*I would be accused of being a liar. I would tell the police I was scared to go back to South Vale, and I recall the police asking staff why I was so scared. I don't recall anything further happening about this.*"[1095]

He was sent back to the home after making these disclosures. In December 2015, Paul was convicted of the sexual abuse of LA-A7 in 1980.[1096]

24.2. LA-A131 also described sexual abuse by Paul. He was too afraid to report the abuse as he was frightened of Paul:

> "*I feared that things would get worse if I said anything. My response was to run away. By this point in my life, it was my natural reaction – to run away from things I did not like, particularly violence and abuse.*"[1097]

24.3. LA-A311 described abuse by two staff members at South Vale. He says he ran away from South Vale on three or four occasions. The police would take him back, "*even though I told them what was happening. They were not interested*".[1098]

24.4. LA-A271 was abused by LA-F145 at Shirley Oaks and said that "*I did quite a bit of running away from Shirley Oaks as I couldn't handle what was happening any more*". LA-A271 reported physical abuse to local police "*but they weren't having any of it and no-one was arrested*".[1099]

24.5. Russell Specterman was placed at numerous care homes. When he was 12, he ran away from one of the care homes, at which he was being sexually abused. He said:

> "*I told the police what was happening to me. They did not believe me and I was returned to my abusers. I'd run home and was found hiding under the bed.*"[1100]

25. Although the police were sympathetic to some complainants when they recounted abuse, that did not always result in investigation or prosecution.

[1094] LA-A457 29 July 2020, 170/14-171/5
[1095] LA-A7 29 July 2020 139/2-7
[1096] MPS004500_067_297
[1097] LA-A131 29 July 2020 135/17-21
[1098] LA-A311 29 July 2020 125/12-17
[1099] LA-A271 6 July 2020 88/18-89/1
[1100] Russell Specterman (formerly LA-A243. Mr Specterman waived his right to anonymity in relation to his involvement in this investigation following the investigation's public hearing) 29 July 2020 102/3-5

25.1. In 1971, LA-A67 reported to his house mother that he had been sexually abused by LA-F93, a deputy superintendent at Shirley Oaks.[1101] The abuse had occurred between 1969 and 1971, when LA-A67 had been between 10 and 12 years old. He was subsequently interviewed by the police, with his house mother present. LA-A67 said:

> "*At one stage the officers told this woman* [the house mother] *to stop interrupting or we will cancel the interview and start all over again. She said go ahead and cancel it. It won't make any difference to us and we believe not a word of it is true … They took my statement in writing. This was the first time somebody believed me, I wasn't called a liar or accused of making it up. The police told me they believed me, and thanked me for giving an honest interview from memory they said my evidence would not stand up in court because I was a juvenile and unreliable witness and I wouldn't be able to stand up to a defence barrister and it would be too much for me to bear. They said they felt sorry for me but there was nothing they could do. At this point the woman seemed very relieved. We got up and left the police station.*"[1102]

LA-A67 recalled feeling "*shattered*" by the experience and by returning to live in Shirley Oaks with LA-F93 still present. He said, as a result, he was "*resigned*" to abuse by another man working at Shirley Oaks, William Hook (who he knew as 'Mr Mark'), as he felt that no one would believe him, given what happened when he reported LA-F93.[1103]

25.2. LA-A25 was sexually abused by Hosegood (house father at Shirley Oaks) and gave evidence at his trial in 1975. When she made her initial complaint to the police, the interviewing officer said that "*I know you are telling the truth*".[1104] However, the process took all day. When the officer left the room, she was locked inside.[1105] She also told us that, after her interview, she received "*no support*" from the police.[1106]

26. Children with communication difficulties were dealt with dismissively. For example, as set out in Part C, in 1986 the Metropolitan Police Service investigated sexual abuse alleged of LA-F12 by LA-A26. Interviewing LA-A26 at the police station in December 1985 in the presence of her mother and a social worker, Ms Anne Worthington, the interviewing officer, recorded that LA-A26:

> "*was unable to communicate properly and incapable of forming a complete sentence … It was quite obvious that LA-A26 could never give any evidence in a court of law*".[1107]

27. Following an attempted physical examination of LA-A26, a police divisional surgeon (now deceased) stated that LA-A26 was "*barely able to communicate*" and "*could not give evidence*".[1108] The prosecutor examining the case noted that:

> "*As the law stands at present it is not possible to proceed against* [LA-F12] *in view of the inability of the alleged victim to give evidence in person, on oath or otherwise. There is no corroboration in the way of medical evidence and the law as it stands is that it is unsafe to proceed … I do not even have the benefit of the victim's evidence*".[1109]

[1101] LAM029331_049
[1102] MPS003841_013-017
[1103] MPS003841_013-017
[1104] LA-A25 6 July 2020 64/13-14
[1105] LA-A25 6 July 2020 63/12-63/24
[1106] LA-A25 6 July 2020 65/21-24
[1107] OHY007771_020
[1108] OHY007771_039
[1109] OHY007771_025

28. The police were not asked by the Crown Prosecution Service to consider how they might interview LA-A26. Mr McGill told us that:

> "*if the police require early investigative advice or investigative advice, we have a procedure whereby we can provide that to them. I don't know what the procedure was in 1986, but prosecutors should, if requested by the police, provide such advice, but it needs to be remembered that we have no power to direct the police to do anything and we have no power to direct them to come to us to seek advice. We will provide advice if asked by the police, but we have no power to make them do anything.*"[1110]

If LA-A26 was reporting an allegation to the police today, it would be expected that her communication skills would be properly assessed and that she would be assisted by an intermediary during a police interview.

29. The Crown Prosecution Service provided legal advice in respect of the situation at Monkton Street children's home. A number of children had been medically examined for signs of sexual abuse. There was no primary evidence from the children within Monkton Street – rather, an account and an interpretation of that account by one parent in particular. A meeting was held in November 1986 between the Crown Prosecution Service and DI Graham Barnett to discuss the case. This was followed up by a letter in November 1986 in which Assistant Branch Crown Prosecutor David Hewett wrote:

> "*Having considered the matter and taking into account the fact that the prosecution will derive no assistance from any forensic evidence, I am of the view that there is insufficient evidence to justify a prosecution against LA-F26. I am, as you know, concerned about the surrounding circumstances of this case and, if any further evidence were to come to light which you considered strengthened the prosecution case, then I would ask you that the evidence be passed to me immediately.*"[1111]

On 26 November 1986, it was confirmed that the DPP had decided not to prosecute.[1112] In oral evidence to the Inquiry, Mr McGill agreed that Mr Hewett's approach was one that kept the lines of communication between the police and the Crown Prosecution Service open.[1113]

30. Dr Alison Steele, a member of the Royal College of Paediatrics and Child Health, and formerly the named doctor for safeguarding for Great Ormond Street Hospital, told us about current practice in the medical examination of children following allegations of sexual abuse. She said that care is needed in any medical examination conducted prior to a child giving an Achieving Best Evidence interview, so as not to undermine or contaminate the criminal justice process.[1114] In Dr Steele's view, a medical examination following a sexual assault:

> "*can actually be quite a positive experience if it is done properly, if children are prepared, they're re-empowered, they're given choices, they have got questions they might want to ask about their body, about what's happened to them. So I actually think it is actually – not for all children, but I would hope that it would be a more positive thing for most children and it gives them the opportunity to discuss things that maybe they haven't been able to discuss with people who aren't doctors or health professionals.*"[1115]

[1110] Gregor McGill 10 July 2020 104/16-25
[1111] Gregor McGill 10 July 2020 107/19-108/3
[1112] CPS004930_11
[1113] Gregor McGill 10 July 2020 108/4-6
[1114] Alison Steele 28 July 2020 79/3-10.
[1115] Alison Steele 28 July 2020 86/5-15

Operation Bell, 1992

31. Operation Bell, which was established in 1992, was the first Metropolitan Police Service investigation to focus on allegations of child sexual abuse at a children's home run by Lambeth Council.

32. It was led by Detective Superintendent (Det Supt) Brian Tomkins (the senior investigating officer) and DI Robert Randall (the investigating officer). There were no formal terms of reference, but Det Supt Tomkins later described his approach:

> "*Whilst we were dealing with specific allegations in relation to LA-A17 and LA-A157 there were concerns about the possible abuse of other children resident at South Vale and of the activities of some of the staff and management at the home. My policy was to investigate the specific allegations and any other allegations that came to light that were supportable or allowed avenues of investigation. Whilst the policy was to concentrate on activities within South Vale Children's Home where specific allegations were made other allegations would be investigated regardless of the location.*"[1116]

33. As no decision log was maintained or notes taken of meetings, it is difficult to evaluate the investigative strategy and decision-making.[1117] In 2001, Det Supt Tomkins told Operation Middleton that they used a Metropolitan Police Service questionnaire to identify witnesses from whom to take a statement. DI Morley told us that about 40–50 questionnaires were sent out to various former residents at South Vale, inviting them to talk about any concerns or to list any concerns they had.[1118] Witness interviews were to be conducted jointly by a police investigator and a member of social services staff independent of South Vale. Where possible, at least one of the interview team was required to be of the same gender as the witness.[1119]

34. The Inquiry was aware of the suggestion that Michael John Carroll (who worked at Angell Road and was subsequently convicted of sexual offences) was a social services link working with Operation Bell.[1120] We note that Operation Bell began in 1992 and Carroll left Lambeth Council's employment in August 1991.[1121] DI Morley confirmed that he had not seen anything to suggest that Carroll was around at that time, or that Carroll was a social services lead or link for Operation Bell.[1122]

Prosecutions arising from Operation Bell

35. Operation Bell investigated four alleged perpetrators of abuse. Three men were charged, but Leslie Paul was the only man convicted.

> **35.1.** In December 1992, Paul was charged with nine offences of child sexual abuse in respect of LA-A17, LA-A157 and LA-A319, one of whom was in the care of Lambeth Council at South Vale.[1123] He was convicted, in January 1994, of two

[1116] MPS000333_002
[1117] Simon Morley 22 July 2020 12/9-21
[1118] Simon Morley 22 July 2020 15/9-25
[1119] MPS004500_010; MPS000333_002-003
[1120] Simon Morley 22 July 2020 16/12-19
[1121] LAM000020_027
[1122] Simon Morley 22 July 2020 16/12-19
[1123] MPS004500_018; LAM030157_050-051

counts of indecent assault, one count of indecency with a child and one count of taking indecent photographs of a child. He was sentenced to two years and six months' imprisonment.[1124]

35.2. LA-F5 (a care worker) was charged with buggery against LA-A80, a former South Vale resident.[1125] A trial took place in May 1993, but the judge directed a 'not guilty' verdict. It appears that this was because LA-A80, who was only 12 years old, became upset and was unable to complete his evidence.[1126]

35.3. LA-F4 (who worked at Angell Road) was charged with rape and indecent assault of LA-A74. The trial, in 1993, was discontinued on the first day.[1127] Allegations against LA-F4 by LA-A94 in the late 1980s were reconsidered by Operation Bell. However, a decision was made by the officer not to trace LA-A94 as *"over 3 years had passed since the alleged incident"*.[1128]

Failures of Operation Bell

36. As recognised by the Metropolitan Police Service, Operation Bell did not begin to establish the scale of abuse being perpetrated against children at South Vale or more widely against children in the care of Lambeth Council.[1129] Although Paul was convicted in 1994, the investigation into him lasted only for around six months. Operation Bell did not take adequate steps to contact former residents at South Vale.[1130] As a result, it did not detect the extent of Paul's offending (which required three investigations in total) or the scale of child sexual abuse at South Vale.

37. Operation Bell did not investigate thoroughly on receipt of some information.

37.1. A house father provided information about LA-F205, LA-F5, Paul and LA-F8, and identified 23 children at South Vale who he thought were "*close to Les* [Paul] *or certainly vulnerable*".[1131] Initial research seems to have been undertaken in relation to 14 children but not followed up, while some former residents were not traced.[1132] Four of the children subsequently came forward to Operation Middleton.[1133] As DI Morley noted, Operation Bell had an "*uneven*" or inconsistent approach to former children in care, which led to it failing to identify victims of Paul – some former residents were simply not traced or spoken to.[1134]

37.2. Having received information from a member of staff at South Vale and other individuals about the care of children at the home, Councillor Clare Whelan passed it on to the police.[1135] She told them about a "*3 year, high level cover up of child abuse*", naming 14 individuals, divided into "*involved or implicated*", "*have knowledge or covered up*" and "*information providers*".[1136] There is no record of Operation Bell officers meeting with

[1124] LAM030157_050
[1125] MPS004500_018
[1126] MPS004500_018
[1127] MPS004500_070
[1128] MPS004500_070
[1129] Simon Morley 22 July 2020 23/7-23
[1130] MPS004500_309-310
[1131] MPS004500_017_241_242
[1132] MPS004500_242-247_309
[1133] MPS004500_020-308-309
[1134] MPS004500_309
[1135] Clare Whelan 8 July 2020 91/16-92/16
[1136] MPS000252_002

Councillor Whelan or of obtaining any statement from her. A briefing note reveals that there was some caution about her political motivation for making the complaint.[1137] It also appears that the police made contact with some but not all of the individuals named – it is unclear why some were not contacted.[1138]

38. Investigation files were lost within Operation Bell.[1139] We were told by the Metropolitan Police Service that papers became separated and were unavailable to a subsequent investigation, Operation Middleton. DI Morley was unable to ascertain how or why the files became separated.[1140] The separated files were likely put together again in 2013, but the loss of records hampered the prosecution of some perpetrators later investigated by Operation Middleton.[1141]

39. The failure to locate the Operation Bell papers was considered to be "*fatal*" to proceeding with the Operation Middleton prosecution of LA-F8 for sexual abuse of LA-A71, who was in care at South Vale in 1991.[1142] The Crown Prosecution Service considered that it could not meet its disclosure obligations (including whether LA-A71 had made an earlier allegation to Operation Bell – which he had not) and decided that there was not a realistic prospect of success.[1143]

40. The absence of notes or logs affected subsequent police investigations and prosecutions. Abuse of process arguments could be raised on behalf of defendants in an application to dismiss prosecution cases. The failure to keep records of allegations made by complainants safe was a serious oversight.

41. In December 1994, Det Supt Tomkins wrote to Mr David Pope, director of social services, to bring to his attention "*some areas of concern*" identified by those interviewed about South Vale. While he did not "*presume to criticise your department, but offer them for your consideration*", Det Supt Tomkins made it clear that the Zephyrine report had been shallow, with little interrogation of witnesses or discussion with children.[1144]

42. In September 1992, during Operation Bell, officers searched Paul's flat and recovered naked photographs of a child (who was not in the care of Lambeth Council). DI Randall, a police officer in Operation Bell, recorded:

> "*During the course of searching Paul's address, a large quantity of homosexual pornography was seized. As a result of subsequent inquiries made, and indeed, as a direct consequence to what police have been told by a victim of indecency, it is the firm belief of the investigating officers that Paul is concerned in a commercial enterprise involving male paedophilia … In order to pursue this line of enquiry, it is necessary to establish the identities of the other persons concerned with Paul in this commercial enterprise.*"[1145]

[1137] MPS000252_002-003
[1138] MPS004500_013-017
[1139] Simon Morley 22 July 2020 12/15-13/20
[1140] MPS004500_054
[1141] Simon Morley 22 July 2020 13/1-14/3; Gregor McGill 10 July 2020 117/8-118/12
[1142] Gregor McGill 10 July 2020 121/17-21
[1143] Gregor McGill 10 July 2020 121/3-13
[1144] MPS004500_019
[1145] OHY009185_003

43. After Paul's release on bail in 1992, covert surveillance of his property was established within Operation Bell.[1146] It took place over four days from 30 November 1992.[1147] Nothing of note was recorded on the surveillance log.[1148] DI Morley told us that it was difficult to imagine that a document was not produced concluding the surveillance.[1149] He also said that establishing covert surveillance after Paul's arrest would have reduced its impact:

> "*the obvious time to do that would be in an evidence-gathering phase before you made any arrests, and to do it for a longer period of time. There is an element, when I take a look at that, of thinking, well, the horse has bolted there, rather.*"[1150]

44. The alleged making and distribution of child sexual abuse images was not investigated adequately in 1993. As DI Randall noted above, officers believed Paul was involved in a commercial enterprise and that it was necessary to establish the identities of others involved in the enterprise. And yet, no others went on to be identified by the Metropolitan Police Service.

45. In 1993, during an investigation called Operation Pragada, allegations that "*pornography, possibly involving children, was being made and distributed within Lambeth Council*" were being considered by the Metropolitan Police Service.[1151] There was no liaison between the officers within Operation Pragada and Operation Bell (for example, to seek any material about Paul). This was an important opportunity to examine potential links between sexual offenders at the time, and it was missed.

Operation Middleton, 1998–2003

46. Operation Middleton was established in November 1998 and closed in June 2003.[1152] It initially supported a Merseyside Police investigation – Operation Care – into alleged abuse by Carroll.[1153]

47. Run as a joint investigation with Lambeth Council social services, Operation Middleton was an early example of the police and social services working together. The Lambeth Council team was known as CHILE (Children's Homes in Lambeth Enquiry), led by an independent consultant (Ms Helen Kenward) with a team of independent social workers who had no prior affiliation to the Council.[1154] Its Gold Group, responsible for strategic review and oversight, included senior officers of the Metropolitan Police Service, Dame Heather Rabbatts as Lambeth Council's chief executive and Ms Kenward. A Crown Prosecution Service lawyer also attended its meetings.[1155]

48. CHILE's remit (as set out in terms of reference agreed in December 1998) was to investigate all alleged offences of abuse committed by any persons over the age of 18 against children who were in the care of Lambeth Council between 1974 and 1994, where

[1146] Simon Morley 22 July 2020 26/5-15
[1147] MPS004500_250
[1148] MPS004500_250
[1149] Simon Morley 22 July 2020 37/5-17
[1150] Simon Morley 22 July 2020 36/9-14
[1151] MPS004500_027; Simon Morley 22 July 2020 29/17-30/18
[1152] MPS004500_042
[1153] Richard Gargini 10 July 2020 52/14-20
[1154] Richard Gargini 10 July 2020 68/19-69/5
[1155] Richard Gargini 10 July 2020 65/12-22 and 66/3-12

"*credible evidence or intelligence exists*".[1156] The principle of agencies cooperating with each other was to be adopted and the Crown Prosecution Service was approached at an early stage with a view to having a special case worker appointed as the point of liaison.[1157]

49. Operation Middleton was initially staffed by a mixture of detectives with differing expertise. There were detectives from murder teams, recruited because it was to be run on the HOLMES system, which they had used before and which, DI Morley told us, "*needs people with specialist training to do it*".[1158] Officers with child protection experience were also part of the team and more were recruited as the investigation progressed.[1159] However, as accepted by DI Morley, there were insufficient officers with a strong understanding of child protection.[1160] Team numbers never exceeded a total of 14. Detective Chief Inspector (DCI) Steve Ranson, senior investigating officer for Operation Middleton, did not feel that the operation was adequately staffed and raised concerns throughout the investigation.[1161] By comparison, the now ongoing Metropolitan Police Service investigation into child sexual abuse (Operation Winter Key) involves 80 to 85 officers.[1162] Deputy Assistant Commissioner Carole Howlett told the Inquiry that she did not have any further resources available to allocate to Operation Middleton.[1163]

50. Operation Middleton's approach was 'intelligence led', which DI Morley said meant:

> "*working with CHILE to identify potential offenders and potential victims and, from that starting point, to move forward.*"[1164]

51. There were various strands to this approach:

- social workers liaised with police to review documentary evidence provided by Lambeth Council to identify individuals to investigate;
- the Metropolitan Police Service made enquiries about specific people, including staff members in children's homes where there were concerns;
- a telephone hotline staffed by CHILE; and
- a media strategy to deal with people coming forward and to correct misinformation in the press.[1165]

52. However, in January 1999, Operation Middleton decided not to send generic letters to former children in care. This "*cold letter approach*" – which was used in Operation Care, including to contact former Angell Road residents – was considered to be "*a very insensitive approach*".[1166] Mr Gargini told us that he received advice from the Association of Chief Police Officers (ACPO) lead to the effect that there would need to be "*a proper risk assessment around the impact of an approach by police*" before this type of contact letter could be adopted.[1167] As a result, it was decided: "*All victims to receive personal visit after*

[1156] Simon Morley 22 July 2020 42/21-43/13
[1157] OHY005634_005-006
[1158] Simon Morley 22 July 2020 86/19-25
[1159] Simon Morley 22 July 2020 87/1-7
[1160] Simon Morley 22 July 2020 87/8-10
[1161] MPS004500_048-049; MPS004518_006
[1162] Alex Murray 23 July 2020 2/9-12
[1163] MPS004518_007
[1164] Simon Morley 22 July 2020 39/24-40/1
[1165] Richard Gargini 10 July 2020 68/19-69/20, 81/9; MPS004500_049-050
[1166] Richard Gargini 10 July 2020 68/1-8; Simon Morley 22 July 2020 81/25-82/8
[1167] Richard Gargini 10 July 2020 67/22-68/4

proactive intelligence led approach. To reduce distress to victims and families".[1168] While it is important to avoid unnecessary distress to victims, Operation Middleton could have sought to make contact in a sensitive way. As Commander Murray commented, when asked about intelligence-led approaches to investigations:

> "*the senior investigating officer would need to assess what is the best approach to look for either additional witnesses or additional victims. That could be questionnaires, it could be direct approaches. Often the way we do it is by saying, rather than 'Have you been a victim of crime?', 'Have you witnessed something?', so it can minimise the disruption to people's lives if they weren't expecting a visit.*"[1169]

Prosecutions arising from Operation Middleton

53. Operation Middleton investigated 124 allegations of abuse.[1170] Sixteen cases were referred to the Crown Prosecution Service and five men were charged.[1171]

53.1. Paul was convicted of five offences of indecent assault against a child and was sentenced to a total of 18 months' imprisonment.[1172]

53.2. Hook was charged with 37 offences against seven victims and pleaded guilty to 26 offences.[1173] He was sentenced to 10 years' imprisonment.[1174]

53.3. Geoffrey Clarke, who had been charged with numerous offences of indecent assault and possession of indecent images, killed himself before the conclusion of his trial.[1175]

53.4. The case against LA-F38, who had been charged with multiple counts of rape and indecent assault, was discontinued by the Crown Prosecution Service because of a lack of supporting evidence and material that was said to undermine the credibility of the victim.[1176]

53.5. LA-F14 was charged with indecent assault against a child and firearms offences. When he pleaded guilty to the firearms offences, the indecent assault charges were discontinued.[1177]

54. The Crown Prosecution Service did not prosecute LA-F37, who was seen by a house mother in LA-A76's room after sexually assaulting LA-A76. The assault was also witnessed by another girl in the room, LA-A105. Although there is no longer a file, it would appear concerns were raised about the impact of any prosecution upon LA-A105 and LA-A76 and the impact this might have upon the prospects of conviction and whether a prosecution was required in the public interest. LA-A105 was deemed too vulnerable to give evidence, although she was willing to do so. With the evidence of LA-A76 and the house mother "*a prosecution could potentially have continued even without LA-A105*", as the Crown Prosecution Service noted.[1178]

[1168] INQ005746_ 021
[1169] Alex Murray 23 July 2020 4/15-24
[1170] OHY005634_003
[1171] Simon Morley 22 July 2020 47/19-24
[1172] LAM030157_051
[1173] Simon Morley 22 July 2020 48/22-25
[1174] Simon Morley 22 July 2020 49/1-2
[1175] Simon Morley 22 July 2020 48/15-17; Annie Hudson 21 July 2020 51/14-21
[1176] Simon Morley 22 July 2020 49/3-9
[1177] Simon Morley 22 July 2020 49/7-17
[1178] CPS004943_015-016; MPS003648_003-006

Failures of Operation Middleton

55. Operation Middleton closed in July 2003, although this had been contemplated since February 2002.[1179] The decision to close was made jointly between the Metropolitan Police Service and Lambeth Council, on the basis that "*all outstanding trials and lines of inquiry*" had been completed.[1180] However, as senior officers were aware, it had not reached all or even most victims. In August 2003, DCI Ranson noted:

> "*In total 6008 children are known to have been placed in care by Lambeth during the period mentioned in the terms of reference. The borough now has computerised records of these and all their staff. As the investigation was intelligence led about 15% of this total was seen by the joint team. It would therefore be naive and wrong to think that all victims and suspects were identified by this investigation.*"[1181]

As a result, a number of perpetrators were not identified by Operation Middleton. The investigation closed prematurely and without fulfilling its terms of reference.

56. A strategic decision was made by Operation Middleton to prioritise investigation of those perpetrators who still had contact with children, in order to deal first with those who might pose the greatest ongoing safeguarding risk.[1182] As a result, long-term offenders – such as Paul, who worked in a Lambeth Council children's home for over 10 years – were not prioritised.[1183] The scale of his offending did not come to light until much later, during Operation Trinity.

57. There were numerous allegations against Temple and he was identified as a suspect, but Operation Middleton failed to speak to him. This was justified on the basis that he had been the subject of a previous investigation.[1184] DI Morley described this as "*serious investigative failures*".[1185] It placed children at risk.

58. Operation Middleton failed to investigate adequately whether children in the care of Lambeth Council were abused by Steven Forrest (a team leader at Angell Road children's home between 1983 and his death in 1992, from an AIDS-related illness).[1186]

> **58.1.** The Metropolitan Police Service was aware of allegations made in 1996 by LA-A29 of sexual abuse by Forrest at Angell Road when LA-A29 was less than 10 years old.[1187] A planning meeting was organised by Lambeth Council but the Metropolitan Police Service decided not to attend because Forrest was dead.[1188] Attending that meeting would have allowed officers to assess the evidence first hand and to consider in light of that whether further steps were necessary.[1189] The failure to contact LA-A29 at that time, as acknowledged by DI Morley, was a basic investigative step that should have been taken.[1190] As concluded by Mr John Barratt (an independent investigator instructed by Lambeth Council) in his 1999 investigation into Lambeth Council's

[1179] MPS004518_009
[1180] OHY005634_003
[1181] OHY005634_003
[1182] MPS004500_052
[1183] MPS004500_052
[1184] Simon Morley 22 July 2020 56/20-25
[1185] Simon Morley 22 July 2020 57/4-5
[1186] LAM000022_018_026
[1187] LAM000022_025
[1188] LAM000022_049
[1189] LAM000022_049
[1190] MPS004545_055

failure to respond effectively to these allegations, the fact that Forrest had died did not mean that an investigation was not required. The prospect that other children had been abused was *"substantial"* and the possibility that Forrest had associates "*could not be dismissed*".[1191]

58.2. An investigation was only reopened by the Metropolitan Police Service because of the intervention of Merseyside Police in relation to LA-A29 in 1998.[1192] Merseyside Police was conducting an investigation into Carroll at the time. When a Metropolitan Police Service officer spoke to LA-A29 in October 1998, the interview was unplanned. Mr Barratt's view was that this was inappropriately conducted:

> "*the interview with LA-A29 was patently ill-prepared and was not conducted in accordance with recognised good practice. With no warning, a policeman, unaccompanied, talks to LA-A29 in his bedroom, about LA-A29 being sexually abused by a man in his bedroom at Angell Road!*"[1193]

59. Operation Middleton did not investigate potential links between alleged offenders. In 2016, Paul was sentenced to 13 years' imprisonment for 18 offences of child abuse. The sentencing judge is reported to have stated:

> "*If you were not part of a paedophile ring, you were at least knowledgeable about and in contact with a group of paedophile men.*"[1194]

Paul had been a special constable (a part-time volunteer for the Metropolitan Police Service) between 1978 and 1981. In July 1979, he was stopped in "*somewhat suspicious circumstance*s" in the toilets in Piccadilly Circus, but "*no further action*" was taken – there is no surviving documentation which records what these circumstances were. In 1981, Paul resigned as a special constable "*due to pressure of work*".[1195] A care worker at South Vale in the late 1970s and 1980s told the police (in 2003) that Paul had taken children into Soho.[1196] The taking of children into the West End of London by a sexual offender (an area reported as being a congregating spot for boys and young men where they were solicited and sexually exploited by older men) raises questions about where he was taking them and who they were with.

60. DI Morley accepted that there was evidence of links between Hook and Hosegood, who both worked at Shirley Oaks.

> "*I think there are clear links in statements that were taken where Hook in particular and Hosegood are linked together, and there are definite links there, and I see no evidence that they were properly investigated during Operation Middleton.*"[1197]

One complaint referred to Hosegood showing a child in care pornographic photographs of adults while someone named 'Mark' was present.[1198] 'Mark' was one of Hook's known aliases.

[1191] LAM000022_049
[1192] LAM000022_086
[1193] LAM000022_088
[1194] INQ006464
[1195] MPS004500_237
[1196] MPS000361_004
[1197] Simon Morley 22 July 2020 59/14-18
[1198] Simon Morley 22 July 2020 60/20-62/5

61. Another separate allegation involving Hook and another man was reported in 2016 by LA-A337. She described an indecent assault by LA-F93, also alleging that Hook had held her shoulders and prevented her from leaving. The Metropolitan Police Service appeared to minimise the allegation against Hook. As regards Hook, the investigation closure report stated that "*No sexual assault allegations are made as such against suspect 2, Hook. Facilitating is alluded to*".[1199]

62. There was a similar lack of engagement by Operation Middleton, when evidence emerged that Lambeth children had been placed at Bryn Alyn Community Children's Homes in North Wales. These homes were owned (during the 1970s and 1980s) by John Allen, who was convicted in 1995 and 2013 of a total of 33 counts of child sexual abuse.[1200]

62.1. In February 2000, Ms Kenward told Dame Heather Rabbatts that:

> "*I have researched the number of children placed by Lambeth at Bryn Alyn and so far we have seventeen. The team has the files and are preparing the necessary information to interview all seventeen … the North Wales Police have not alerted us to these young people as part of their inquiry*".[1201]

62.2. DCI Ranson recorded, later in February 2000, that 45 children had been identified as placed in North Wales.[1202] Research and trace actions were raised against 36 names, but 29 of those were closed in October 2002 without any action being taken:

> "*No current investigation relevant to these actions. Operation closing down decision of Strategy Group. All other investigation into this have complete. No identified lines of inquiry.*"[1203]

DI Morley confirmed that there is no evidence to suggest that Operation Middleton investigated links between perpetrators or the placement of children in the care of Lambeth Council in North Wales children's homes.[1204]

62.3. LA-A311 was one of those children traced through CHILE. When aged 12, he was sent to a private care home in North Wales, for about four years between 1975 and 1980, where he alleged abuse by a member of staff. He said that the local police "*didn't want to know*" at the time but, in 2000, his allegation made to Operation Middleton was referred to North Wales Police.[1205]

63. When Carroll was dismissed from Lambeth Council's employment, DI Morley confirmed he went to live in North Wales and purchased a "*pub/hotel*" there.[1206] Ms Kenward told the Inquiry:

> "*There was considerable doubt in my mind about John Carroll, who had, after he left Lambeth, bought a hotel in North Wales … I asked the question of the police, 'How does that happen?' You know, 'How can a man, who has had that kind of career and comes from that kind of background, afford to buy a hotel?' So I passed that information on, and*

[1199] Simon Morley 22 July 2020 73/17-75-5
[1200] For further information regarding abuse at children's homes in North Wales, see the Inquiry's *Accountability and Reparations Investigation Report*, Part B.2.
[1201] LAM015018
[1202] MPS004574_008-009
[1203] MPS004574_010
[1204] MPS004574_006
[1205] LA-A311 29 July 2020 125/13; MPS004574_010
[1206] MPS004574_011

> *I was concerned about it, and there was information about, you know, where did all the money go? There's no proper audit trail in Lambeth, or there wasn't, to show where money was paid to and who had access to it, and so on.*"[1207]

64. In February 1999, concerns were raised about links between LA-F31, LA-F32 and another foster carer whose name was found (with that of LA-F31) following a police search of Carroll's home (on his arrest as part of Operation Care).[1208]

Retention of records

65. As set out above, LA-F8 was investigated three times: first under Operation Bell in 1991, then Operation Middleton in 2003 and finally in 2013, when he was prosecuted. He was not charged during Operation Middleton as a result of Operation Bell papers being missing – the Crown Prosecution Service advised that no further action be taken and LA-F8 was released without charge.[1209]

66. There is, as Mr McGill commented, the difficulty in retaining large volumes of paperwork. However, Crown Prosecution Service policies surrounding retention of non-recent sexual abuse case files have not changed, despite the availability of electronic storage methods.[1210] Mr McGill recognised that the record retention policy would "*benefit from review to ensure that it not only meets current business needs but also societal expectations*", and told us that a review has been requested.[1211]

Operation Trinity, 2012–2015

67. Operation Trinity was set up in 2012 and was led by officers who had experience in child protection.[1212] This included Detective Constable Suzanne Lister, who had worked on Operation Middleton and was familiar with the allegations against Paul.[1213] While on secondment at Lambeth Council in 2012, she received notice of two further allegations of sexual abuse: LA-A1's allegation concerned Paul, whose name she recognised, and LA-A71's allegations were about LA-F8.[1214] This resulted in Operation Trinity commencing.

68. Following Operation Trinity, Paul was convicted in 2015 of the sexual abuse of a further four children, and sentenced to 13 years' imprisonment.[1215] Paul was convicted of aiding and abetting another man in his sexual abuse of LA-A19. On speaking to Operation Trinity, LA-A19 also made allegations of sexual abuse against Patrick Grant.[1216]

69. In 2019, and after a lengthy investigation, Grant (who worked at Shirley Oaks and South Vale Assessment Centre) was convicted of a number of child sexual abuse offences in Sutton, South Wales and Lambeth.[1217] Grant was convicted of one offence in 2019 of touching an 11 or 12-year-old's genitals while masturbating in the presence of another named male in a bathroom of a care home.[1218]

[1207] Helen Kenward 23 July 2020 113/6-21
[1208] LA-A61 29 July 2020 93/3-11
[1209] Gregor McGill 10 July 2020 121/3-123/2
[1210] Gregor McGill 10 July 2020 88/20-22
[1211] CPS004979_001-002
[1212] MPS004500_060
[1213] MPS004500_060
[1214] MPS004500_060-061
[1215] MPS004500_067
[1216] MPS004500_067
[1217] MPS004500_068
[1218] Simon Morley 22 July 2020 64/18-65/7

J.4: Key issues

70. In considering the various investigations about child sexual abuse and prosecutions in Lambeth, a number of issues have arisen.

Investigating offenders and links between offenders

71. It is clear that the scale of offending against children in Lambeth Council's care was not identified by the Metropolitan Police Service at the time of its occurrence or during Operations Bell and Middleton. The Inquiry has identified failures to follow up evidence leads – in particular, the links between perpetrators that may have led to the identification of further offending.

Listening to children and obtaining cogent accounts

72. The police are required to identify vulnerable or intimidated witnesses, and provide assistance as necessary to ensure equal access to justice. Where children are concerned, this may include the introduction of communication aids or intermediaries during interview, especially where the child is very young or has complex needs.

73. Assumptions must not be made about a child's credibility or competence at an early point of contact with the police. With this in mind, in 2001 the Home Office produced guidance, *Vulnerable Witnesses: A Police Service Guide*.[1219] In 2001, the guidance stated that the initial assessment of a witness is not an assessment of competence – it is about understanding how to obtain best evidence from that child.[1220] As Mr James Bowler (director-general for policy communications and analysis in the Ministry of Justice) said, the initial contact and the guide is about "*achieving best evidence and how you can help to do that*".[1221]

74. The updated version of the guidance, published in 2011, is more useful in providing advice to the police than its predecessor in many important respects.[1222] However, the starting point – that competency is presumed at that stage and the initial police contact is not about assessing competency – is not made explicit. Mr Bowler made the point that police officers are now specialists, trained to deal with child sexual exploitation, for example, and the 2011 guidance may therefore be aimed at a more educated and trained audience than earlier versions.[1223] While that may be true in principle, as Mr Bowler conceded it would be preferable to make it explicit at the outset that the police are not assessing the competence or credibility of a child at this early stage.

75. Any interview with a child should comply with the guidance *Achieving Best Evidence in Criminal Proceedings* (the ABE 2011 guidance).[1224] We understand that, in December 2014, a joint inspection team considering the handling of child sexual abuse cases recommended that the Ministry of Justice should update the ABE 2011 guidance, including by producing a booklet or *aide-mémoire* to assist the police in their pre-assessment, planning for interview and considerations on engaging an intermediary.[1225] The 2014 joint inspection team also

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[1219] James Bowler 23 July 2020 41/5-43/10; NAP000011 [2001]
[1220] James Bowler 23 July 2020 44/23-48/6
[1221] James Bowler 23 July 2020 45/3-4
[1222] James Bowler 23 July 2020 47/4-6; NAP000011 [2001]; NAP000118 [2011]
[1223] James Bowler 23 July 2020 48/17-49/5
[1224] Achieving Best Evidence in Criminal Proceedings 2011
[1225] Achieving Best Evidence in Child Sexual Abuse Cases: A Joint Inspection December 2014

recommended that an update should clarify interviewing and obtaining best evidence from children, particularly in complex cases and where multiple interviews are required (this need for an update appears to be recognised by the Metropolitan Police Service, the Crown Prosecution Service and the Ministry of Justice).[1226]

76. At the time of the hearing in July 2020, the ABE 2011 guidance had not yet been updated, nor an *aide-mémoire* produced.[1227] Steps should be taken as soon as possible to implement these changes recommended in the 2014 joint inspection. Mr Bowler told us that he agreed that the guidance needed to be updated for a number of reasons, including that the Ministry of Justice was due to publish a new Victims' Code at the end of 2020.[1228] An updated *Code of Practice for Victims of Crime* (the Victims' Code) was published by the Ministry of Justice in November 2020 and was updated in April 2021.[1229] As a statutory code, it sets out the minimum level of service that victims should receive from the criminal justice system (including the police and the Crown Prosecution Service), with 12 separate rights for victims and a system of redress where that level of service is not met.[1230]

77. Dr Emily Phibbs, a psychologist, explained how children and vulnerable witnesses can be assisted to provide cogent accounts of sexual abuse.[1231] It is crucial that the communication skills of the child are fully understood:

> "*It is essential to consider each child's individual needs as it is entirely possible that a child who does not appear to have complex communication difficulties may have hidden disabilities or complex trauma which would immediately impact on their ability to communicate effectively.*"[1232]

78. As Dr Phibbs said, there will on occasion be significant background information available about a child (such as psychological services or speech and language assessments). Information-sharing at a multidisciplinary strategy meeting prior to interviewing a child may provide a good source of information for police officers. In respect of these multidisciplinary strategy meetings, Dr Phibbs told us:

> "*They may offer an opportunity for officers to talk with teachers and social workers who may have prior knowledge of a vulnerable child. This point of information exchange however is often not capitalised upon because in my experience the interviewing officer is not always the officer who attends the strategy meeting.*"[1233]

79. As we heard in evidence from Dr Phibbs, trained intermediaries are now used to assist those children who have communication difficulties to speak to the police.[1234] Both the questions and the setting are important in order to "*have the best chance of allowing a child to give best evidence*".[1235]

[1226] James Bowler 23 July 2020 53/3-25
[1227] James Bowler 23 July 2020 53/3-25
[1228] James Bowler 23 July 2020 39/9-24 and 52/3-19
[1229] Code of Practice for Victims of Crime in England and Wales November 2020
[1230] James Bowler 23 July 2020 52/6-7; 56/6-14
[1231] Emily Phibbs 29 July 2020 45/13-81/5
[1232] INQ005640_035
[1233] INQ005640_035
[1234] Emily Phibbs 29 July 2020 59/11-64/22
[1235] Emily Phibbs 29 July 2020 78/19-21

80. In a report, *Barnahus: Improving the response to child sexual abuse in England* (2016), the Children's Commissioner referred to the issues facing children who disclose sexual abuse:

> "*Children who disclose that they have been sexually abused face multiple interviews with social workers, the police and medical professionals in a variety of settings. Interviews are often the only source of evidence in sexual abuse cases, yet for many children the interviews led by the police do not enable them to provide the best possible evidence … Children can be traumatised by having to give an account of their abuse to multiple professionals in multiple locations.*"[1236]

81. The Inquiry heard from Ms Emma Harewood, development and service manager at The Lighthouse in London. The Lighthouse is available in five north London boroughs to children and young people who have experienced sexual abuse.[1237] In terms of Achieving Best Evidence interviews, The Lighthouse offers two options. First, a police officer can lead the interview with the child as they would normally, but they can do this in the environment provided at The Lighthouse, with the appropriate support in place. Second, The Lighthouse can offer a psychologist to lead the interview. The psychologist will conduct a pre-interview assessment, work with the child to build their confidence and then move through to do the video-recorded interview. When describing the skill involved, Ms Harewood gave this example:

> "*a great example, I think, of the added value a psychologist brings is in a case example the other week. A young boy aged 9 was becoming very dissociated and distracted in the interview and she* [the psychologist] *was able to bring him back in the moment with a clapping mirroring game, with some stop/start stones they use, with a short break.*"[1238]

We note that this ability to focus the interview may well have been difficult for even highly trained police officers to achieve.

82. As Ms Harewood explained, The Lighthouse provides children with:

> "*a holistic service all under one roof in a place where they can really feel safe to talk. So we aim to allow them to tell their story and gather the best evidence, whether that's through a forensic examination … or through a video-recorded interview. We want to help them get the best out of the criminal justice process by supporting them through that, to give them a really holistic medical and then provide the emotional and well-being support not only for them, but also for their family as well.*"[1239]

As Commander Murray noted, there are issues of scale, capacity and cost in implementing this approach: "*it's how we industrialise that I think is the challenge*".[1240]

83. Engagement with victims and learning about their communication skills is critical to the detection and prosecution of child sexual abuse offences. We were pleased to see that, at the conclusion of the hearing, the Metropolitan Police Service encouraged complainants to contact them about any unreported allegations as well as any unsatisfactory police response to an earlier report.[1241]

[1236] Barnahus: Improving the response to child sexual abuse in England
[1237] Emma Harewood 28 July 2020 113/25-114/4
[1238] Emma Harewood 28 July 2020 119/21-120/2
[1239] Emma Harewood 28 July 2020 114/6-17
[1240] Alex Murray 23 July 2020 32/4-20
[1241] Metropolitan Police Service Closing submissions 31 July 2020 159/24-160/5

84. The court process is also adapting to the needs of child witnesses. Children may now give evidence at trial with the assistance of intermediaries. 'Ground rules' hearings take place so that a judge will scrutinise the proposed cross-examination of a child and make restrictions on what will be asked, where necessary.[1242] Those with complex needs can give evidence using communication aids or props.[1243] Children have their evidence-in-chief video recorded before trial, and soon will have their cross-examination pre-recorded before any trial as well.

Training and support for officers

85. Officers involved in the investigation of child sexual abuse must be trained to recognise and understand the nature of risk.

86. As with all crimes, there must be forensic assessment and detailed scrutiny of evidence when investigating child sexual abuse. It is also crucial that police officers are trained to consider the wider picture and to engage in comprehensive risk assessment. For example, Paul's access to children and the Operation Bell offences should have led to consideration by the Metropolitan Police Service (and of course Lambeth Council) of whether he had abused other children. LA-A337's allegation that Hook held her whilst LA-F93 touched her indecently should have raised concern about the joint conduct of both men.

87. We also note the challenges of recruitment and retention in child protection investigations. Commander Murray told us:

> "*The risk that you carry as a child protection officer and some of the stuff you're exposed to that victims have suffered is significant, and the amount of scrutiny you're under, and then, when things go wrong, it's also very, very difficult and we need to rise to that challenge … But it is a challenge and we have a shortage of detectives in this area and we want to make it an attractive area to work, but it is one I think that is considered quite high risk because so much can go wrong and the workload burdens are very high, as you can imagine.*"[1244]

The judgements of trained and experienced police officers make a real impact on sexual abuse investigations and ultimately the outcomes for victims. It is crucial that officers – such as the 2,000 currently working in safeguarding in London – are properly funded, continuously trained and supported to undertake their role.[1245] We noted in our Interim Report that victims and survivors felt that their encounters with the police were "*positive when compared with their contact with the police in previous decades*", but that issues remained.[1246]

88. In our Interim Report, the Inquiry recommended that any police officer (or staff equivalent) who wants to progress to the chief officer cadre must (i) be required to have operational experience in preventing and responding to child sexual abuse and (ii) achieve accreditation in the role of the police service in preventing and responding to child sexual abuse. We recommended that the Home Office should amend entry requirements, using its powers under the Police Regulations 2003 to achieve this.[1247] As at July 2019, the Home

[1242] The Advocate's Gateway: ground rules hearings and the fair treatment of vulnerable people in court: Toolkit 1
[1243] The Advocate's Gateway: Using communication aids in the criminal justice system: Toolkit 14
[1244] Alex Murray 23 July 2020 30/23-31/12
[1245] Alex Murray 23 July 2020 30/16-31/16
[1246] Interim Report of the Independent Inquiry into Child Sexual Abuse April 2018 p52
[1247] Interim Report of the Independent Inquiry into Child Sexual Abuse April 2018 pp67–68

Office and College of Policing had drawn up a programme of non-legislative changes to ensure there is understanding of safeguarding and vulnerability across all levels of leadership in policing. The UK Government response also stated that the Home Office had not yet identified any need for legislative change but would keep this under review.

The assessment of the evidence of a child

89. As acknowledged by Mr McGill, the Code for Crown Prosecutors in the late 1980s looked at things very differently in terms of the evidence of children.[1248] In 1986, the matters prosecutors were required to take into account when examining the evidence included whether there were "*matters which might properly be put to a witness by the defence to attack his credibility*", as well as whether "*child witnesses … are likely to be able to give sworn evidence*".[1249] The 1988 version of the Code noted, regarding the prosecution of sexual offences involving children:

> "*The credibility and credit of the child will often be of limited value, and in the case of very young children, may be nil.*"[1250]

90. Children in care are vulnerable to sexual abuse and have also been disadvantaged when it comes to the evaluation of their evidence in criminal proceedings. Private and sensitive details about their lives are documented in social care files, and records may be made by those who do not know the child well, have a vested interest in discrediting the child or are simply inaccurate. The rules of disclosure require consideration of material held in care files and assessment of the effect that it might have on the case. We were told this could result in the discontinuation of proceedings. For example, in 1992 the prosecution of LA-F4 (a residential care worker at Angell Road) for the rape and sexual assault of a child in care was discontinued after disclosure of the child's records was ordered.[1251]

91. The disclosure of care files is now subject to greater scrutiny and regulation. For example, in 2013 a protocol was drawn up to deal with the disclosure of information in cases of child sexual abuse and linked criminal and care directions hearings. This made provision for the Crown Prosecution Service to notify a local authority where it considered that material provided by the local authority fell to be disclosed in criminal proceedings. The local authority was afforded the opportunity to object to disclosure including on the grounds that the person affected by the disclosure did not consent.[1252]

92. The Crown Prosecution Service's *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated in November 2018) now states:

> "*Children or young people who have been in the care of, or have come to the attention of, social services will inevitably have a great deal of information about them contained within social services records compared to other children or young people. Every episode of misbehaviour, even of the most minor nature, is likely to be a matter of record. Most children misbehave but not every child has their misbehaviour recorded. Victims who are,*

[1248] Gregor McGill 10 July 2020 94/8-10
[1249] CPS002784
[1250] CPS002791_001; Gregor McGill 10 July 2020 94/2-4
[1251] MPS004545_070
[1252] 2013 Protocol and Good Practice Model: Disclosure of information in cases of alleged child abuse and linked criminal and care directions hearings paras 13.9–13.10.

or have been, in the care of social services should not be disadvantaged in the criminal process by this fact, and prosecutors should be prepared to address this issue as part of the presentation of the prosecution case."[1253]

This highlights the disadvantage clearly and requires prosecutors not to focus solely on the child but rather on the evidence of the allegation being made.

Children giving evidence at court

93. As in other investigations, we heard that children often found the experience of court proceedings traumatic. They must remember and relive the abuse in order to provide evidence, and encounter their abuser again.

93.1. LA-A25 lived at Shirley Oaks in the 1960s and 1970s. From 1968, Hosegood was her house father. She was abused at Shirley Oaks by Hosegood between the age of 11 and 16. The abuse consisted of physical violence, indecent assaults and rapes. In 1975, Hosegood was prosecuted in relation to abuse of four children at Shirley Oaks, including LA-A25. She told us that giving evidence in court in the 1970s was frightening. She was 17 years old at the time of the trial. No one explained the outcome to her: she discovered Mr Hosegood had been acquitted from her sister. She got no support after the trial.[1254]

93.2. In 1993, LA-F5 stood trial for the indecent assault of LA-A80, following allegations being made to his social worker in 1992 that LA-F5 had perpetrated sexual abuse against him. LA-F5 was charged with buggery.[1255] During the course of his evidence, LA-A80 "*broke down*" during cross-examination and was unable to continue. He was 12 years of age. As a result, the judge directed the jury to return a 'not guilty' verdict.[1256] Charlie Elliott, a team manager at Lambeth Council, wrote to Inspector Ian Gordon of the Metropolitan Police Service noting the "*extreme disappointment*" felt at the outcome of the trial.[1257]

93.3. LA-A7 (who gave evidence at Paul's 2015 trial) said:

"*Giving evidence was extremely hard for me, it felt like I was in the witness box for a lifetime and it was a very traumatic experience. I don't think that trial helped my mental health, forcing me to relive events that I had tried to forget.*"[1258]

94. As Mr McGill acknowledged, a child facing their abuser in court, as well as the court environment generally, would have been "*a much more intimidating environment*" in the 1970s, 1980s and 1990s than it is now.[1259] Victims are now able to have their evidence-in-chief pre-recorded over video. Shortly, a scheme facilitating pre-recorded cross-examination of victims will be available nationally. Through such means, victims will not be required to give evidence at court.

[1253] Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse (November 2018) para 53.
[1254] LA-A25 6 July 2020 68/6-19
[1255] MPS004500_018
[1256] MPS004500_018
[1257] LAM030157_073
[1258] LA-A7 29 July 2020 139/15-23
[1259] Gregor McGill 10 July 2020 124/10-12

95. We stated in our *Accountability and Reparations Investigation Report* that victims and survivors of child sexual abuse often find it difficult to access support at the right time, particularly during the criminal justice process.[1260] Mr McGill noted, "*the more support you can give victims, and the more specialist support you can give them, can only benefit them*".[1261]

[1260] *Accountability and Reparations Investigation Report*, Part E
[1261] Gregor McGill 10 July 2020 130/4-6

Part K

Conclusions and recommendations

Conclusions and recommendations

K.1: Conclusions

1. Lambeth Council now accepts that children in its care were sexually abused and that it failed them. At the Inquiry's public hearing, Ms Annie Hudson, strategic director of children's services from May 2016 to 31 March 2020, gave a full apology on behalf of Lambeth Council, in which she acknowledged that it "*created and oversaw conditions … where appalling and absolutely shocking and horrendous abuse was perpetrated*".[1262]

Nature and extent of allegations of child sexual abuse

2. The sexual and other abuse of children was widespread in Lambeth Council's residential and foster care during the 1960s, 1970s, 1980s and 1990s. Lambeth Council is aware of 705 former residents of three children's homes examined in this investigation (Shirley Oaks, South Vale and Angell Road) who have made complaints of child sexual abuse. The true number of children sexually abused over the decades is likely to be significantly higher.

3. The Inquiry heard evidence from a number of witnesses describing their experiences while under the care of Lambeth Council. This included accounts of rapes and indecent assaults, and sexual abuse by multiple individuals. Children in care were also made the subject of child sexual abuse images. Witnesses spoke of the profound, lifelong consequences of the abuse being exacerbated by other issues linked to the poor quality of care in Lambeth. Many also described violence, intimidation and racism, which formed part of their daily lives.

4. A number of victims reported sexual abuse to adults at the time – such as to other staff or their social workers – but in many cases this did not result in the investigation or prosecution of alleged offenders, or any disciplinary action being taken. Some children were too frightened to tell anyone, or were threatened with violence by the perpetrator if they reported the abuse. Others thought it was not worthwhile to report sexual abuse as a result of a dismissive response to a previous disclosure or because they thought nothing would change.

5. For many children, living in care did nothing to change their lives for the better. For others, far from being a sanctuary from abuse or neglect, what they experienced there was worse.

Child protection failures by Lambeth Council

6. Children are usually admitted into the care of a local authority because they have experienced, or are at risk of experiencing, significant harm, including abuse or neglect within their family. Not all children in Lambeth Council's care were there because of a risk at

[1262] Annie Hudson 2 July 2020 3/6-5/21

home. In the early years, some children were from families whose problems were rooted in poverty or poor housing. From the 1980s onwards, too many children were taken into care because of a lack of family support, poor planning and poor children's social care practice, often carried out by unqualified staff.

7. Children should be safe, nurtured and protected in care, but many Lambeth Council staff in children's social care appeared to demonstrate a callous disregard for the vulnerable children they were paid to look after.

8. In many instances, their needs, their well-being and their childhoods appeared to be of little or no importance. LA-A309 told us: "*I felt from an early age that my feelings were inconsequential and of no value and that my pain doesn't matter. It was clear to me from an early age that no-one really cared about me*".[1263] LA-A138 said: "*they didn't care about you … nobody cared*".[1264] This lack of care had devastating consequences for many children, leading to emotional, physical and sexual abuse, and in some cases death.

9. Children with complex needs and communication difficulties are among the most vulnerable in society, including to sexual abuse. This is particularly the case when adults lack the training and skills to appreciate what the child is trying to convey. In 1986, LA-A26's allegations of sexual abuse were discounted by the Metropolitan Police Service and initially by Lambeth Council because they could not understand them and made no effort to find ways of doing so. The additional needs of vulnerable child victims were not recognised within the criminal justice system and trained intermediaries were not used to enable effective access to justice.

10. Foster care did not routinely provide a safe alternative for children in care. For many years, foster carers were not adequately vetted and some placements were arranged informally. The Social Services Inspectorate (SSI) reported in 2000 that potentially large numbers of children had not been allocated a social worker, were not placed with approved foster carers and had none of the protection afforded by regular visiting, monitoring or statutory reviews.[1265] This exposed these children to an increased risk of sexual and other abuse.

11. At Shirley Oaks, children lived in small groups under the care of 'house parents', most of whom were unqualified. In addition to physical abuse, some of these house parents sexually abused children in their care. Staff viewed these children with hostility and as given to "*fantasy*".[1266] This complete disbelief of children was incomprehensible and further increased their vulnerability. Children learned that they could not trust adults around them or speak out about abuse. Even when their allegations proved to be substantiated, they were shown no compassion and given no support.

12. Children at Shirley Oaks also spent time with 'social aunts' or 'social uncles' who were volunteers working with children but without proper vetting or checks on their suitability. They were permitted to undertake activities with the children or to take them on day trips. This allowed children to be exposed to some adults with a sexual interest in them, including Geoffrey Clarke, who was convicted in 1998 of the sexual abuse of three children not in the care of Lambeth Council. Clarke had been allowed to stay at Shirley Oaks and to have regular

[1263] LA-A309 29 July 2020 119/21-25
[1264] LA-A138 6 July 2020 27/18-28/15
[1265] LAM029179
[1266] LAM030203

and unimpeded access to children there since the early 1970s. He was charged, as part of Operation Middleton, with 13 offences of indecent assault and possession of indecent images, but took his own life before he was tried. Lambeth Council is now aware of at least 40 complainants who have made allegations against Clarke.

13. South Vale assessment centre created an environment which put children at risk of sexual abuse. The regime there was punitive, stigmatising and encouraged favouritism. Senior staff and social workers failed to protect children, even when confronted with direct evidence that children were being sexually abused.

The role of senior staff and councillors

14. Staff and councillors failed in their professional and statutory duties when it came to responding to extremely serious allegations of staff misconduct, including criminal behaviour, towards looked after children. One particularly shocking example was Michael John Carroll, a member of staff at the Angell Road children's home who had failed to disclose in the 1970s a previous conviction for child sexual abuse but was retained when this was eventually found out, following a disciplinary hearing. He was also supported by Lambeth Council staff in respect of his applications to foster children. Carroll was subsequently convicted in 1999 of 34 counts of child sexual abuse, including of two boys in the care of Lambeth Council between 1980 and 1983.[1267]

15. There is clear evidence that sexual offenders and those suspected of sexual abuse were co-workers in Lambeth Council's children's homes at the same time. Some may have had a role in recruitment of other staff. In addition to the direct risk that Carroll posed to children, as the officer in charge of Angell Road he also had a role in the recruitment of others and in the investigation of allegations of sexual abuse made against others. In the case of at least one, LA-F4, Carroll contributed (as did the ineptitude of Lambeth Council) to the avoidance of an effective investigation. Through such poor practice and its failure to respond to concerns and allegations, Lambeth Council put vulnerable children in the path of adults known or suspected to be perpetrators of child sexual abuse.

16. Too often, senior staff in children's social care failed to take disciplinary action against alleged perpetrators. Even when Lambeth Council did so, it frequently reached conclusions that failed to protect children or that prioritised the interests of those accused, as in the case of Carroll. In his case, misconduct proceedings, chaired by Mr David Pope, who later became director of social services, were inept, superficial and lacked a rigorous investigation of the grounds of the disciplinary hearing. Carroll should have been dismissed, but he was not – he was allowed to continue working with children with no assessment of whether or not he posed a risk. Having made the wrong decision at the disciplinary hearing, Lambeth Council staff did not simply fail to remove the risk that Carroll posed to children but allowed him to maintain additional responsibilities for highly questionable therapeutic work with vulnerable children in the Council's care, in close and unsupervised settings within the Angell Road children's home.

17. Numerous senior managers and elected councillors were aware of significant issues in relation to children in care from a series of reports produced by a staff member, Mr Robert Morton, from 1988 to 1990.[1268] These reports indicated that many statutory requirements

[1267] Gregor McGill 10 July 2020 110/8-111/1; CPS004939_002
[1268] LAM028710_001; LAM010549; LAM028717; INQ002077

for looked after children were not being met, and that standards in children's homes were unacceptable. The lack of interest and low priority accorded to taking action on these reports by councillors and senior staff represented a failure to discharge Lambeth Council's statutory duties towards children in care. This was high handed and dismissive in respect of their responsibilities to vulnerable children and their futures.

18. Although similar concerns were raised in external reports (such as by the SSI) around the same time, senior managers and councillors continued in their failure to take action. Plans were drawn up, but with little real change to the appalling conditions in which children in care were living and no apparent accountability for lack of progress.

19. Councillors failed to hold senior staff accountable for the dismal quality of children's social care, and did not themselves take responsibility for setting an appropriate strategy or ensuring improvements were made in order to protect children in their care. They crossed the boundary into operational and professional decision-making, when they should not have done so. While a few councillors (such as Ms Anna Tapsell and Ms Clare Whelan) did visit children's homes and make some critical reports, councillors collectively did not discharge their statutory duty to provide robust and independent scrutiny of children's homes.

20. There was no sense of councillors and staff working together to improve public services until some time after the appointment of Dame Heather Rabbatts as chief executive in 1995. Even then, children's social care remained mired in poor and careless practice, leaving children at serious risk of harm and abuse. In 1999, for example, it was recognised there had been and continued to be major deficiencies in the carrying out of police checks on foster carers and other household members. An audit resulted in large numbers of foster carers being deregistered.[1269]

21. While it is apparent that there are now much-improved systems in Lambeth, the Inquiry heard evidence of a more recent case – in 2016 – of a child in the care of Lambeth Council placed in Sheffield who made allegations of rape, but neither local authority convened a strategy meeting, as should have happened.[1270]

The extent to which Lambeth Council sought to investigate, learn lessons and implement changes

22. There have been numerous investigations and reports – by Lambeth Council staff, by experts commissioned by the Council, by external inspectors and by the police – about children in the care of Lambeth Council. Many dealt with a single individual or incident, but similar themes arose in these reports. The list of weaknesses consistently described by the authors was long and well-rehearsed, so there could be little doubt about what needed to be done. This included a chronic lack of planning, poor record-keeping, overuse of unqualified staff, high numbers of unallocated cases and poor staff training, including on child sexual abuse. Ten years after the Morton reports, there remained (as demonstrated by the Barratt and SSI reports) extremely serious weaknesses in Lambeth Council's ability to protect children in its care.

23. Lambeth Council also withheld information to avoid criticism of its handling of child sexual abuse allegations and other child protection issues. In the case of LA-A2, for example, whose death occurred in the late 1970s while he was in care, Lambeth Council staff told

[1269] LAM015822
[1270] Carolyn Adcock 28 July 2020 3/16-5/8

the coroner that there appeared to be "*no indications of him being unhappy*", despite LA-A2's allegations of sexual abuse by his house father and his involvement in a subsequent criminal trial.[1271] In concealing this information, staff showed a complete disregard for LA-A2 and prevented any real understanding of the circumstances of his death from emerging at the inquest.

The culture of Lambeth Council

24. There was limited evidence among councillors of serious commitment or application to their statutory duty towards children in their care. Ms Joan Twelves (who took office in 1986 and was leader of Lambeth Council between 1989 and 1991) stated that some of those councillors elected in 1986 had been "*enthused by Lambeth's battle against the Tory government but … had very little idea about running the local state to provide services for local residents*".[1272]

25. In the 1980s, politicised behaviour and turmoil dominated Lambeth Council. The desire to take on the government and to avoid setting a council tax rate became their primary purpose rather than the provision of quality services, including children's social care. During that time, children in care became pawns in a toxic power game within Lambeth Council and between the council and central government. This turmoil and failure to act to improve children's social care continued into the 1990s and beyond.

26. Despite a self-styled 'progressive' political agenda, bullying, intimidation, racism and sexism thrived within Lambeth Council, all of which was set within a context of corruption and financial mismanagement which permeated much of Lambeth Council's operations. Intimidation was experienced by those at the most senior levels of leadership within Lambeth Council, such as chief executives Herman Ouseley and Henry Gilby. Their seniority suggests that there were undermining, even criminal, forces at work which were undeterred by high status or the possibility of complaint to the police.

27. Many staff and councillors purported to hold principled beliefs about tackling racism and promoting equality, regarding Lambeth Council as a leading local authority in these areas. However, such ideals were of little practical consequence to most children in care in Lambeth and made minimal difference to their quality of life.

28. Black and ethnic minority children were overrepresented in Lambeth Council's children's homes and faced additional hardships, despite policies intended to encourage their sense of self and to ensure that their cultural needs were met. Some were subject to overt racism or suffered indirect discrimination. We also heard of a lack of recognition of physical needs, such as hair and skin care, and diet.

29. The Inquiry received evidence regarding staff lying about or hiding files, and denying knowledge of individuals under investigation when that was not true.[1273] Some staff were keen to avoid criticism and placed their own interests above the children they were supposed to assist and support. Rather than a culture of openness and a willingness to improve when it came to the fundamental interests of children, there was instead defensiveness and resistance to change – children's interests were secondary to those of staff and councillors.

[1271] Annie Hudson 2 July 2020 79/14-80/11
[1272] Joan Twelves 24 July 2020 114/14-23
[1273] Helen Kenward 23 July 2020 84/2-17

30. Trade unions were able to influence the investigation of child protection failures, prioritising the interests of their members above the welfare of children, however evident the failings of their members were. In this, they were often supported by councillors, with whom it was suggested that a strong political axis existed.

Professional leadership

31. In September 1988, Mr Morton co-authored a report which made it clear that there was "*little sense of direction or objectives, bad management and in some cases general apathy*".[1274] Lambeth Council's children's homes were recognised as being in "*a very poor state*", while other children were being placed in private and voluntary sector homes, sometimes for years, without any knowledge of the quality of care offered in those establishments.[1275] This unacceptable state of affairs in 1988 had not occurred overnight. It mainly developed under the stewardship of Mr Robin Osmond and later Mr Pope, when Lambeth Council's children's social care remained in severe and ongoing crisis. There were numerous critical reports, investigations and inspections during Mr Pope's period as director, including Mr John Barratt's final report (1999 to 2000) which concluded that Lambeth Council repeatedly failed to fulfil both its statutory duties and its own policies relating to the care and protection of children.

32. For several decades, senior staff and councillors at Lambeth Council failed to effect change, despite overwhelming evidence that children in its care did not have the quality of life and protection to which they were entitled, and were being put at serious risk of sexual abuse.

33. When systemic failures were identified, time and again they were minimised and levels of risk ignored. Crisis, the commissioning of reports and going through the motions of responding to reports became the primary mechanism by which children's social care operated. In spite of a constant stream of negative reports, Lambeth Council remained impervious to change.

Allegations of interference

34. There was rumour and speculation about political interference in Lambeth Council's children's social care, which sought to attribute what happened to children to the involvement of politicians and high-profile persons. It was further alleged that a protective network was formed around some individuals, principally Carroll, so as to insulate him from investigation. In addition, there have been persistent rumours that high-profile individuals or politicians were linked to the sexual abuse of children in Lambeth Council's homes.

35. Serious issues have been raised as to the effectiveness of Operation Middleton, but the evidence received by this Inquiry does not suggest that it deliberately avoided the investigation of high-profile persons. It did, however, take a more cautious approach in its handling of information about high-profile individuals than had been the position under Operation Trawler.

[1274] LAM028710_002
[1275] LAM028710_002-003

36. The reality is that some Lambeth Council staff and councillors were complicit in putting children in care at risk of sexual abuse because they simply did not care enough. With some exceptions, they treated children in care as if they were worthless. As a consequence, individuals who posed a risk to children were able to infiltrate children's homes and foster care, with devastating, lifelong consequences for their victims.

Inspection and oversight

37. In the 1980s, Lambeth Council's own inspection unit was ineffective in its scrutiny of children's residential care. It did not identify even the most obvious weaknesses, such as the physical fabric of the buildings, let alone challenge the attitudes of staff or the protection offered to children, or require prompt action to be taken on any problems identified.

38. Many councillors failed in their individual and collective duty to conduct routine visits to children's homes. In some cases, where individual councillors did undertake visits, there is evidence of deliberate obstruction by officers. The failure to inspect, visit and provide reports meant that councillors did not see for themselves what daily life might look like for children living in Lambeth Council's children's homes. This also contributed to the closed nature of the environments experienced by children – as if they were captive victims. Sexual offenders operating within children's homes were likely to have had a sense of being untouchable, while children were left feeling isolated and ignored.

39. SSI reports were an important source of scrutiny and monitoring information for both staff and councillors, and should have been a means of prompting change within Lambeth Council. However, as the Barratt final report concluded, SSI reports were dealt with at committee level "*in an unrealistically bland way*".[1276] Despite detailed action plans, many of the recommended improvements did not materialise. Nor was any accountability demanded by councillors of their senior officers for the lack of progress.

40. The culture of cover-up, inability to effect real change and lack of concern for the day-to-day lives of children in its care characterised Lambeth Council's response to inspection and oversight. While it is clear that SSI inspection did not expressly identify the nature and extent of sexual abuse within Lambeth Council's children's homes, the SSI identified many chronic and serious safeguarding weaknesses and it was Lambeth Council's responsibility to remedy them. Without verification of action, checked by the SSI or its equivalent independent agency, and a commitment to change from Lambeth Council, failure of the inspection and oversight process was inevitable.

41. The dramatic improvement to an 'outstanding' rating in 2012 from Ofsted (which had replaced the SSI), after years of failure, was followed three years later in 2015 by an assessment of 'inadequate'. In light of the years of well-documented failures and critical reports from the SSI, as noted by Councillor Edward Davie (who, in 2020, was lead member for children's social services), Ofsted's 2012 rating is unlikely to have been an accurate reflection of practice within Lambeth Council at that time. In the 2015 inspection, Ofsted adopted a more detailed and in-depth approach, and concluded that some children continued to live in circumstances that were harmful and neglectful for unacceptable periods of time.

[1276] LAM000021_017

Investigation and prosecution of child sexual abuse

42. Opportunities to identify networks and links between offenders were missed by detectives. For example, when investigating the production of indecent images of children there was no liaison between the officers within Operation Pragada and Operation Bell to seek any material or information about Leslie Paul. During Operation Middleton there was evidence of links between William Hook and Donald Hosegood and these were not investigated.

43. In other areas, investigatory practice has developed since the 1970s and 1980s. Officers are now trained both to interview children and to work with social care professionals. However, as was recognised by Commander Alex Murray, the Metropolitan Police Service should embed "*a culture of professional curiosity*", so that officers act appropriately and promptly in response to any concerns about a child.[1277]

44. There are also practical challenges associated with the recruitment and retention of police officers in child protection work across London. There is no doubt that it is difficult work, but the judgements of trained and experienced police officers make a real impact on sexual abuse investigations, and ultimately on the outcomes for victims and survivors. It is crucial that this work is properly resourced.

45. Contact with and support for complainants through the criminal justice process is also vital to the successful detection and prosecution of sexual offenders. Many victims have found the experience of giving evidence in court to be traumatic, causing some to feel as if they were on trial rather than the defendant. The Code for Crown Prosecutors in place in the late 1980s looked at things very differently in terms of the evidence of children.[1278] In 1986, the factors prosecutors were required to take into account when examining the evidence included whether there were "*matters which might properly be put to a witness by the defence to attack his credibility*".[1279] The 1988 version of the Code noted that "*The credibility and credit of the child will often be of limited value, and in the case of very young children, may be nil*".[1280]

46. Today's practice requires prosecutors not to focus solely on the child, but rather on the evidence of the allegation being made.

47. The changes in practice over the years have been designed to provide greater support to victims of child sexual abuse. Nevertheless, the mistakes of the past, whether related to policy or practice, cannot now be fully corrected: the true scale of offending against children in the care of Lambeth Council will never be known.

K.2: Matters to be explored further by the Inquiry

48. The Inquiry will return to a number of issues which emerged during this investigation, including but not limited to:

- mandatory reporting;
- section 9 of the Children Act 1989; and

[1277] Alex Murray 23 July 2020 21/4-6
[1278] Gregor McGill 10 July 2020 94/8-10
[1279] CPS002784
[1280] CPS002791_001; Gregor McGill 10 July 2020 94/2-4

- the potential for redress schemes to offer accountability and reparation to victims and survivors of child sexual abuse.

We anticipate these issues will be addressed in our final report.

K.3: Recommendations

The Chair and Panel make the following recommendations, which arise directly from this investigation. Other local authorities should consider the issues identified in this report and take action as appropriate to their own circumstances.

Lambeth Council and the Metropolitan Police Service should each publish its response to these recommendations, including the timetable involved, within six months of the publication of this report.

Recommendation 1: Response to this investigation report

Lambeth Council should develop and publish a comprehensive action plan which details the actions that it will take in response to the issues raised throughout the Inquiry's investigation report. The action plan should be developed and published within six months of the publication of this investigation report, and should be accompanied by timescales for completing identified actions as soon as possible.

Recommendation 2: Training for elected councillors

All Lambeth Council elected members should receive training on: (i) safeguarding and (ii) corporate parenting. Newly elected members should receive training on these matters as soon as possible following their election. Training should be mandatory and repeated on a regular basis.

The training content should be regularly reviewed and updated.

Recommendation 3: Review of recruitment and vetting checks of current foster carers and children's home staff

Lambeth Council should review the application of recruitment and vetting procedures for all current foster carers directly provided by Lambeth Council, to ensure that the procedures have been followed correctly.

In addition, Lambeth Council should seek assurances from external agencies and other local authorities, in which children in the care of Lambeth Council have been placed, that recruitment and vetting procedures have been followed correctly for all foster carers and residential children's homes' staff working with children.

Recommendation 4: The death of LA-A2

The Metropolitan Police Service should consider whether there are grounds for a criminal investigation into Lambeth Council's actions when providing information to the coroner about the circumstances surrounding LA-A2's death.

Annexes

Annex 1

Overview of process and evidence obtained by the Inquiry

1. Definition of scope for the case study

This case study is an inquiry into the extent of any institutional failures to protect children in the care of Lambeth Council from sexual abuse and exploitation.

The scope of this investigation is:[1281]

> *"1. The Inquiry will investigate the nature and extent of, and institutional responses to, the sexual abuse of children in the care of Lambeth Council ('the Council'), including those cared for in children's homes, by foster carers and/or by adoptive parents. The investigation will incorporate case-specific investigations and a review of information available from published and unpublished reports and reviews, court cases, and previous investigations.*
>
> *2. In doing so, the Inquiry will consider the experiences of victims and survivors of child sexual abuse while in the care of the Council, and investigate:*
>
> *2.1. the nature and extent of the sexual abuse of children in the care of the Council;*
>
> *2.2. the nature and extent of the failings of the Council to protect such children from sexual abuse;*
>
> *2.3. the appropriateness of the response of the Council, law enforcement agencies, prosecuting authorities, and other public authorities or statutory agencies to reports of child sexual abuse involving children cared for by the Council, and/or reports of child sexual abuse by individuals, who were employed by or contracted by the Council;*
>
> *2.4. the extent to which the Council sought to investigate, learn lessons, implement changes, and provide support and reparations to victims and survivors, in response to:*
>
> *a. allegations that individuals with access to children cared for by the Council had sexually abused children;*
>
> *b. criminal investigations and prosecutions and/or civil litigation in relation to alleged abuse of children within the care of the Council;*
>
> *c. reports, reviews and inquiries into child sexual abuse;*
>
> *d. safeguarding, including but not limited to the Clough Report, the Harris Report, the Barratt Report, and the Children's Homes in Lambeth Enquiry; and/or*
>
> *e. other external guidance;*

[1281] Children in the Care of Lambeth Council – Scope of investigation

2.5. the adequacy of the policies and practices adopted by the Council in relation to safeguarding and child protection, including considerations of governance, training, recruitment, leadership, reporting and investigation of child sexual abuse, disciplinary procedures, information sharing with outside agencies, and approach to reparations;

2.6. the extent to which children who were sexually abused may have had special educational needs and/or any other form of special need or vulnerability and whether that may have made them more vulnerable to sexual abuse;

2.7. the extent to which there was a culture within the Council which inhibited the proper investigation, exposure, prevention, and reparation for child sexual abuse; and

2.8. the appropriateness of the relevant inspection and regulatory regimes.

3. Specific matters to be considered within the investigations may include, but are not limited to:

3.1. a consideration of child sexual abuse which took place at Angell Road, Monkton Street, Ivy House, South Vale, and Shirley Oaks Children's Homes;

3.2. the involvement of Michael Carroll in the sexual abuse of children in the care of the Council; his recruitment and continued employment by the Council; and the circumstances surrounding his application to foster a child and the Council's subsequent account to the Clough Inquiry;

3.3. Steven Forrest's involvement in the sexual abuse of children; and his recruitment and continued employment by the Council;

3.4. allegations that individuals with information about the sexual abuse of children in the care of the Council were the subject of intimidation and potentially lethal violence; and allegations that there was inappropriate interference in law enforcement investigations into the sexual abuse of children in the care of the Council.

4. In light of the investigations set out above, the Inquiry will publish a report setting out its findings, lessons learned, and recommendations to improve child protection and safeguarding in England and Wales."

2. Core participants and legal representatives

Counsel to this investigation:

Rachel Langdale QC
Clair Dobbin
Clare Brown
Amelia Nice
Ruth Kennedy

Complainant core participants:

LA-A25	
Solicitor	Richard Scorer (Slater and Gordon)
LA-A61, LA-A103, LA-A115, LA-A154, LA-A155, LA-A156	
Counsel	Iain O'Donnell (1 Crown Office Row)
Solicitor	Marie Forbes (Verisona Law)
LA-A99, LA-A147	
Solicitor	Alan Collins (Hugh James Solicitors)
LA-A131	
Counsel	Stephen Simblet QC (Garden Court Chambers)
Solicitor	Christopher Ratcliffe (Uppal Taylor Solicitors)
LA-A24	
Counsel	Aswini Weereratne QC (Doughty Street Chambers)
Solicitor	Peter Garsden (Simpson Millar LLP)
LA-A136, LA-A138, LA-A139, LA-A141, LA-A142, LA-A143, LA-A144, LA-A221, LA-A222	
Solicitor	Malcolm Johnson (Hudgell Solicitors)
LA-A7, LA-A109, LA-A181 (deceased 2020), LA-A203, Russell Specterman (formerly LA-A243), LA-A271, LA-A298, LA-A299, LA-A300, LA-A302, LA-A303, LA-A304, LA-A305, LA-A306, LA-A307, LA-A308, LA-A309, LA-A310, LA-A311, LA-A312, LA-A321, LA-A322, LA-A323, LA-A324, LA-A325, LA-A326, LA-A327, LA-A330	
Counsel	Susannah Johnson (7 Bedford Row)
Solicitor	Amy Clowrey (Switalskis Solicitors)
LA-A184, LA-A351, LA-A352, LA-A353, LA-A354, LA-A355	
Solicitor	Imran Khan QC (Imran Khan & Partners Solicitors)
LA-A456	
Counsel	Iain O'Donnell (1 Crown Office Row)
Solicitor	Charles Derham (Remedy Law)
Joan Twelves	
Counsel	Henry Toner QC
Solicitor	Desmond Doherty
Anna Tapsell	
Counsel	Aswini Weereratne QC (Doughty Street Chambers)
Solicitor	Peter Garsden (Simpson Millar LLP)

Richard Gargini (Retired Commander, Metropolitan Police Service)	
Counsel	James Berry (Serjeants' Inn Chambers)
Solicitor	Deborah Britstone (3D Solicitors)
Dr Nigel Goldie, Stephen Whaley	
Counsel	Chrisopher Jacobs (Landmark Chambers)
Solicitor	David Enright (Howe & Co)

Institutional core participants:

Lambeth Council	
Counsel	Alex Verdan QC (4 Paper Buildings)
Solicitor	Alison McKane (London Borough of Lambeth Legal Services)
Crown Prosecution Service	
Counsel	Edward Brown QC (QEB Hollis Whiteman)
Solicitor	Laura Tams (Crown Prosecution Service)
Metropolitan Police Service	
Counsel	Samantha Leek QC (5 Essex Court)
Solicitor	Sara Royan (Metropolitan Police Service Legal Services)
Secretary of State for Education	
Counsel	Cathryn McGahey QC (Temple Garden Chambers)
Solicitor	William Barclay (Government Legal Department) Treasury Solicitor
Independent Office for Police Conduct	
Counsel	Gerard Boyle QC (Serjeants' Inn Chambers)
Solicitor	Katharine Grasby (IPCC) Rachel Taylor (IPCC) Emily Keenan (IOPC)

3. Evidence received by the Inquiry

Number of witness statements obtained:
145
Organisations and individuals to which requests for documentation or witness statements were sent:
A Higgs, former Lambeth Council employee
A J D Waring, former Lambeth Council councillor
Alison Barraball, former Lambeth Council manager of adoption and fostering services
Andrew Small, former Lambeth Council social worker
Angela Baker, former Lambeth Council social worker
Anna Tapsell, former Lambeth Council chair of social services and Lambeth Council councillor
Anne Worthington, former Lambeth Council directorate of social services

Anthony Goss, former Southwark Council councillor
Arran Poyser, former Lambeth Council liaison and monitoring inspector
Bernadette Khan, Croydon Council councillor
Brenda Jones, former Lambeth Council team manager
Carole Howlett, commander and deputy assistant commissioner at Metropolitan Police Service
Christopher E M Hussell, former Lambeth Council social worker
Claire Crawley, former Lambeth Council social worker
Clare Whelan, former Lambeth Council councillor
Dr Clive Driscoll, retired detective chief inspector, Metropolitan Police Service and former investigator, Lambeth Council Child Protection Team
Clive Walsh, former Southwark Council assistant director of social services
David Pope, former Lambeth Council director of social services
Dame Denise Platt, former chief inspector for Social Services Inspectorate
Dr Emily Phibbs, clinical psychologist
Gerallt Wynford Jones, former Lambeth Council senior personnel officer
Gillian Delahunty, former lecturer for social care programmes for Lambeth Community Education
Greta Akenepeye, former Lambeth Council councillor
Dame Heather Rabbatts, former Lambeth Council chief executive
Helen Kenward, independent consultant in child protection
Henry Gilby, former Lambeth Council chief executive
Herbert Botley, officer in charge of Monkton Street
Lord Herbert Laming, former chief inspector for Social Services Inspectorate
Lord Herman Ouseley, former Lambeth Council chief executive
Jack Smith, former Lambeth Council employee and former chair of the Lambeth Council adoption and fostering panel
Jane Allison Hunter, Queen's Counsel
Lady Janet Boateng, former Lambeth Council councillor and chair of the social services committee
Jeanne McNair, former assistant to Mary Eithne Harris, former Lambeth Council senior assistant director of financial services
Ramanand (Jim) Jinkhoo, former Lambeth Council employee
Jo Cleary, former assistant chief inspector for Social Services Inspectorate
Jo Hughes, former Lambeth Council social worker
Joan Twelves, former Lambeth Council councillor
John Mann, former Lambeth Council councillor
John Stanton, former Lambeth Council social worker
Jonathan Rogers, former Lambeth Council civil emergency planning officer
Dr Josephine Kwhali, former Lambeth Council assistant director for children and young people
Joshua Anim, former Lambeth Council employee

Judith Chester, former Lambeth Council team manager
Julie Barnes, former inspector Social Services Inspectorate
Kim Hollis, Queen's Counsel
Linda Bellos OBE, former Lambeth Council councillor
Linda Daley, former Lambeth Council social worker
Mark Clarke, former Lambeth Council race relations adviser
Mary Eithne Harris, former Lambeth Council senior assistant director of financial services
Mary Griffith-Jones, former Wandsworth Council social worker manager
Millius Palayiwa, former Lambeth Council senior officer
Nicola Kingston, former Lambeth Council employee
Dr Nigel Goldie, former Lambeth Council assistant director of corporate strategy and quality
Pat Orton, former Lambeth Council area manager
Pat Salter, former Lambeth Council social worker
Lord Paul Boateng, former Minister of the Crown
Paul Clark, former inspector, Social Services Inspectorate
Pauline Lawrence, former Lambeth Council senior personnel officer in the social services directorate
Phil Scott, former Lambeth Council principal officer, personnel and training
Phil Sealy, former Lambeth employee
Phyllis Dunipace, former Lambeth Council councillor
Richard Clough, former general secretary to the Social Care Association
Richard Gargini, retired commander, Metropolitan Police Service and former senior investigating officer, Operation Middleton
Robin Osmond, former Lambeth Council director of social services
Ruth Gardner, former Lambeth Council social worker
Spencer Pickett, former Lambeth Council audit manager
Sir Stephen Bubb, former Lambeth Council councillor
Stephen Whaley, former Lambeth Council councillor
Steve Ranson, former detective chief inspector, Metropolitan Police Service
Edward (Ted) Knight (deceased), former leader of Lambeth Council and local politician
Tim Yeo, former Under-Secretary of State for Health
Valerie Suebsaeng, former Lambeth Council team manager
Baroness Virginia Bottomley, former Secretary of State for Health
Waveney Williams, former Lambeth Council coordinator
Yvette Adams, former Lambeth Council directorate of social services
LA-A7
LA-A24
LA-A25

LA-A61
LA-A99
LA-A103
LA-A109
LA-A115
LA-A131
LA-A136
LA-A138
LA-A139
LA-A141
LA-A142
LA-A143
LA-A144
LA-A147
LA-A154
LA-A155
LA-A156
LA-A181
LA-A184
LA-A203
Russell Specterman
LA-A271
LA-A298
LA-A299
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LA-A449
LA-A351
LA-A352
LA-A353
LA-A354
LA-A355
LA-A369
LA-A457
LA-A456
LA-A481
LA-H1
LA-H3
Care Quality Commission
Crown Prosecution Service
Croydon Council
Department for Education
Home Office
Independent Office for Police Conduct (IOPC)
Lambeth Council
London Metropolitan Archive (Comptroller and City Solicitor)
Merseyside Police
Metropolitan Police Service
MI5
Ministry of Justice
NHS England
Ofsted
Royal College of Paediatrics and Child Health

Social Work England
Southwark Council
The Faculty of Forensic & Legal Medicine
The Havens
The Lighthouse
United Grand Lodge of England (UGLE)
Wandsworth Council

4. Disclosure of documents

Total number of pages disclosed: 39,276 pages

5. Public hearings including preliminary hearings

Preliminary hearings	
1	24 March 2016
2	27 July 2016
3	31 October 2018
4	23 July 2019
5	15 January 2020
Public hearings	
Days 1–5	29 June 2020–3 July 2020
Days 6–10	6 July 2020–10 July 2020
Days 11–15	20 July 2020–24 July 2020
Days 16–20	27 July 2020–31 July 2020

6. List of witnesses

Forename	Surname	Title	Called/read	Hearing day
LA-A323			Called	3
LA-A321			Called	3
LA-A299			Called	3
Annie	Hudson	Ms	Called	4, 12
Anne	Worthington	Dr	Called	4
Josephine	Kwhali	Dr	Called	5
Bernadette	Khan	Ms	Read	5
Millius	Palayiwa	Mr	Called	5
Pauline	Lawrence	Ms	Read	5
Robin	Osmond	Mr	Called	5
Phyllis	Dunipace	Ms	Called	5

Forename	Surname	Title	Called/read	Hearing day
Brenda	Jones	Ms	Read	5
LA-A138			Called	6
LA-A327			Called	6
LA-A25			Called	6
LA-A308			Read	6
LA-A302			Read	6
LA-A222			Read	6
LA-A324			Read	6
LA-A271			Read	6
LA-A298			Read	6
LA-A221			Read	6
LA-A24			Read	6
LA-A303			Read	6
LA-A115			Read	6
LA-A355			Read	6
LA-A353			Read	6
LA-A351			Read	6
Valerie	Suebsaeng	Ms	Called	7
Clive	Walsh	Mr	Called	7
Richard	Clough	Mr	Called	7
Janet	Boateng	Lady	Called	7
Heather	Rabbatts	Dame	Called	7
David	Pope	Mr	Called	8
Clare	Whelan	Ms	Called	8
Elizabeth (Anna)	Tapsell	Ms	Called	8
Herman	Ouseley	Lord	Called	9
David	Staples	Dr	Called	9
Jon	Rogers	Mr	Read	9
Nigel	Goldie	Dr	Called	9
Gillian	Delahunty	Ms	Called	9
Clive	Driscoll	Dr	Called	10
Richard	Gargini	Mr	Called	10
Gregor	McGill	Mr	Called	10
LA-A354			Called	11
LA-A300			Called	11
LA-A307			Called	11

Forename	Surname	Title	Called/read	Hearing day
LA-A147			Called	11
Simon	Morley	Detective Inspector	Called	13
Mary	Harris	Ms	Read	13
Sara-Louise	Davis	Ms	Called	13
Spencer	Pickett	Mr	Read	13
Alex	Murray	Commander	Called	14
James	Bowler	Mr	Called	14
Herbert	Botley	Mr	Read	14
Helen	Kenward	Ms	Called	14
Paul	Boateng	Lord	Called	14
Stephen	Bubb	Sir	Called	15
Christopher	Hussell	Mr	Called	15
Stephen	Whaley	Mr	Called	15
Joan	Twelves	Ms	Called	15
Jo	Cleary	Ms	Called	16
Paul	Clark	Mr	Called	16
Denise	Platt	Dame	Called	16
Herbert	Laming	Lord	Called	16
Virginia	Bottomley	Baroness	Called	16
Tim	Yeo	Mr	Read	16
Carolyn	Adcock	Ms	Called	17
LA-H1			Read	17
Kamlesh	Patel	Lord	Called	17
Robin	Osmond	Mr	Read	17
Alison	Steele	Dr	Called	17
Emma	Harewood	Ms	Called	17
Edward	Davie	Mr	Called	18
Emily	Phibbs	Dr	Called	18
LA-A61			Called	18
LA-A449			Read	18
Russell	Specterman	Mr	Read	18
LA-A325			Read	18
LA-A181			Read	18
LA-A481			Read	18
LA-A322			Read	18
LA-A312			Read	18

Forename	Surname	Title	Called/read	Hearing day
LA-A309			Read	18
LA-A326			Read	18
LA-A311			Read	18
LA-A310			Read	18
LA-A352			Read	18
LA-A306			Read	18
LA-A203			Read	18
LA-A131			Read	18
LA-A7			Read	18
LA-A103			Read	18
LA-A141			Read	18
LA-A144			Read	18
LA-A142			Read	18
LA-A156			Read	18
LA-A456			Read	18
LA-A155			Read	18
LA-A109			Read	18
LA-A457			Read	18
LA-A154			Read	18
LA-A184			Read	19
LA-A330			Read	19
LA-A304			Read	19
LA-A139			Read	19
LA-A136			Read	19
LA-A143			Read	19
LA-H3			Read	19

7. Restriction orders

On 23 March 2018, the Chair issued a restriction order under section 19 of the Inquiries Act 2005 granting anonymity to any individual designated as a complainant core participant in the Inquiry's investigations. The order covered (i) disclosure or publication of any information that identifies or tends to identify any complainant core participant as a complainant core participant; (ii) disclosure or publication of any information with the name or address of a complainant core participant if such disclosure or publication would tend to identify him or her as a complainant core participant; (iii) disclosure or publication of any still or moving image of any complainant core participant if such disclosure or publication would tend to identify him or her as a complainant core participant.

8. Broadcasting

The Chair directed that the proceedings would be broadcast, as has occurred in respect of public hearings in other investigations. For anonymous witnesses, all that was 'live streamed' was the audio sound of their voice.

9. Redactions and ciphering

The material obtained for the investigation was redacted and, where appropriate, ciphers applied, in accordance with the Inquiry's Protocol on the Redaction of Documents.[1282] This meant that (in accordance with Annex A of the Protocol), absent specific consent to the contrary, the identities of complainants, victims and survivors of child sexual abuse and other children were redacted and if the Inquiry considered that their identity appeared to be sufficiently relevant to the investigation a cipher was applied. Pursuant to the Protocol, the identities of individuals convicted of child sexual abuse (including those who have accepted a police caution for offences related to child sexual abuse) were not generally redacted unless the naming of the individual would risk the identification of their victim, in which case a cipher was applied.

10. Warning letters

Rule 13 of the Inquiry Rules 2006 provides:

> *"(1) The chairman may send a warning letter to any person –*
>
> a. *he considers may be, or who has been, subject to criticism in the inquiry proceedings; or*
> b. *about whom criticism may be inferred from evidence that has been given during the inquiry proceedings; or*
> c. *who may be subject to criticism in the report, or any interim report.*
>
> *(2) The recipient of a warning letter may disclose it to his recognised legal representative.*
>
> *(3) The inquiry panel must not include any explicit or significant criticism of a person in the report, or in any interim report, unless –*
>
> a. *the chairman has sent that person a warning letter; and*
> b. *the person has been given a reasonable opportunity to respond to the warning letter."*

In accordance with rule 13, warning letters were sent as appropriate to those who were covered by the provisions of rule 13, and the Chair and Panel considered the responses to those letters before finalising the report.

[1282] Inquiry Protocol on Redaction of Documents (Version 3)

Annex 2

Glossary

Term	Definition
Achieving Best Evidence interview	Recorded interviews conducted with vulnerable or intimidated witnesses (including children) planned and carried out in accordance with the Achieving Best Evidence guidance.
Achieving Best Evidence in Criminal Proceedings (2011)	The 2011 version of the guidance on interviewing victims and witnesses, including guidance on obtaining consent from and conducting interviews with children.
Administration of Children's Homes Regulations 1951	Regulations which governed the administration of children's homes from 1 September 1951.
Barratt final report	Report written in 2000 by John Barratt, who had been appointed by Lambeth Council to examine the institutional response to allegations of abuse made by a child against Steven Forrest. The interim and part 1 reports published in 1999 focussed on the child who made the allegations. The final report concerned a more general evaluation of Lambeth Council's child protection practices.
Care plans	Detailed and live documents written for each child in care explaining why a child is living where they are, eg in a children's home, and setting out what should happen while they remain there.
Care Standards Act 2000	Legislation governing the administration of a variety of care institutions, including children's homes. It came into force in April 2002 and superseded the Children's Homes Regulations 1991.
Chief executive	Head of Council's paid services who operates as the main link in the governance structure between council members and officers.
Child Protection Register	Confidential list of all children in the local area who have been identified as being at risk of significant harm.
Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse	Crown Prosecution Service guidelines that set out the approach that prosecutors should take when dealing with child sexual abuse cases.
Children Act 1989	An Act reforming the law relating to children which allocates duties to local authorities, courts, parents and other agencies in the UK to ensure children are safeguarded and their welfare is promoted.
Children's Homes Regulations 1991	Regulations made under the Children Act 1989 applicable to the conduct and administration of children's homes from 14 October 1991. They were replaced by the Care Standards Act 2000 in April 2002.
Clough report	Independent report written by Richard Clough. It was commissioned by Lambeth Council in February 1993 into the circumstances in which John Carroll was retained as the head of Angell Road children's home after his Schedule 1 conviction was disclosed (in 1986).
Code of Practice for Victims of Crime	Also referred to as the Victims' Code. Issued by the Secretary of State for Justice, it sets out the services that organisations in England and Wales must provide to victims of crime.

Community Homes Regulations 1972	Regulations governing the housing of children in community homes which came into force on 1 April 1972. Superseded by the Children's Homes Regulations of 14 October 1991.
Complainant	A person who has made an allegation of child sexual abuse.
Complex needs	Two or more needs affecting a person's physical, mental or social well-being.
Director of social services	Head of the social services department of Lambeth Council.
Evans report	Report by Richard Evans and Elisabeth Ford published in September 2000, titled *Events and Circumstances Associated with Changes to Services at a Home Providing Residential Respite Care for Children with Disabilities*. It focussed on events in Chestnut Road, a specialist home for children with disabilities.
First Morton report	Report by Robert Morton written in 1988 for the Children's Homes Sub-Committee.
Foster Placement (Children) Regulations 1991	Legislation governing the placement of a child in foster care by a local authority or voluntary organisation.
Ground rules hearing	Court hearing to plan and discuss adaptations to questioning and/or the conduct of the hearing that may be necessary to facilitate the evidence of a vulnerable person. It should take place in the presence of the trial judge, advocates and any intermediary who has been appointed.
Harris report	Report into allegations of the sharing of pornographic material within the housing department at Lambeth Council.
London Safeguarding Children Board Child Protection Procedures	Procedures that are regularly updated by the London Safeguarding Board. They set out the requirements of how agencies and individuals should work together to safeguard and promote the welfare of children and young people.
National Health Service and Community Care Act 1990	Legislation imposing a duty on local authorities to carry out assessments of people who appear to be in need of community care services and to arrange packages of care.
Operation Bell	Metropolitan Police Service investigation running from 1992 to 1994. Investigated allegations of child sexual abuse arising from South Vale Assessment Centre. It focussed on Leslie Paul but also investigated allegations against LA-F4, LA-F5 and LA-F8.
Operation Care	Investigation by Merseyside Police into allegations of child sexual abuse in Merseyside children's homes. It ran from July 1996 to September 2003. It was as a result of Operation Care that John Carroll was convicted in relation to sexual abuse against children in Lambeth Council's care.
Operation Middleton	Metropolitan Police Service investigation running from 1998 to 2003. Investigation into alleged offences of abuse committed against children in the care of Lambeth Council between 1974 and 1994. Charges were brought against Leslie Paul, LA-F14, WIlliam Hook, Geoffrey Clarke and LA-F38.
Operation Pragada	Metropolitan Police Service investigation running from 1993 to 1994. Investigation into allegations of child sexual abuse and creation of indecent images of children made by LA-G1 which came to light as a result of Lambeth Council's Harris report into the housing directorate.

Operation Trawler	Metropolitan Police Service investigation set up in 1998 to support Merseyside's Operation Care investigation into John Carroll. Changed into Operation Middleton.
Operation Trinity	Metropolitan Police Service investigation running from 2012 to 2015. Investigation set up as a result of further allegations of child sexual abuse against children in Lambeth Council's care. Investigated Leslie Paul, LA-F8, John Hudson and LA-F41, and expanded in scope as investigations progressed. Resulted in the charging of Leslie Paul, Patrick Grant, LA-F8, June Entecott and Brenda Ball.
Operation Winter Key	The current and ongoing Metropolitan Police Service investigation into allegations of child sexual abuse.
Rehabilitation of Offenders Act 1974	Legislation aimed at rehabilitating offenders when they have not been reconvicted of any serious offence for periods of years. It allows individuals the right not to disclose spent convictions and cautions when applying for most jobs. When read with the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 there are particular jobs, including working for a local authority and being exposed to children, where these exemptions do not apply.
Schedule One offender	Term previously used to describe someone who had been convicted of an offence of a violent or sexual nature. Now this term has generally been replaced with 'a person posing a risk to children'.
Sexual Offences Act 1956	Legislation setting out offences relating to sexual abuse (until May 2004). Set out the offences of indecent assault and buggery.
Social Services Committee	Committee set up by Lambeth in 1971 as required by the Social Services Act 1970. It had the objective to provide social support as necessary to sections of the community in need, such as children's services and services for older people.
Tyra Henry public inquiry report	Report published in 1987 of the public inquiry that investigated the death of Tyra Henry, a child in Lambeth Council's care. The inquiry was chaired by Sir Stephen Sedley QC.
Victims' Code	Short title for the *Code of Practice for Victims of Crime*, described above.
Vulnerable Witnesses: A Police Service Guide	Guidance designed to assist police in supporting vulnerable or intimidated witnesses to give them equal access to the criminal justice system and provide them with an opportunity to give their best evidence at any trial.
Working Together Under the Children Act 1989 (1991)	Statutory guidance published on inter-agency working under the Children Act to promote the welfare of children.
Zephyrine report	The report of the Enquiry into South Vale Assessment Centre, commissioned by Lambeth Council and published in January 1990. It investigated allegations of racism, sexism and poor management in South Vale. The panel was chaired by Edgar Zephyrine.

Annex 3

Acronyms

ACPO	Association of Chief Police Officers
CHILE	Children's Homes in Lambeth Enquiry
CID	Criminal Investigation Department
CPS	Crown Prosecution Service
CSCI	Commission for Social Care Inspection
Det Supt	Detective Superintendent
DPP	Director of Public Prosecutions
HMIC	Her Majesty's Inspectorate of Constabulary
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
HOLMES	Home Office Large Major Enquiry System (UK police information system)
IOPC	Independent Office for Police Conduct
MPS	Metropolitan Police Service
NALGO	National and Local Government Officers' Association
NSPCC	National Society for the Prevention of Cruelty to Children
Ofsted	Office for Standards in Education, Children Services and Skills
SSD	Social Services Department
SSI	Social Services Inspectorate

Annex 4

Recommendations proposed by core participants

A number of witnesses, including all complainant and victim core participants, were invited to provide their views about any practical recommendations to prevent child sexual abuse in the future and to improve the response to such allegations. Responses are collated below.

Proposed recommendation	Proposed by
Mandatory reporting of child sexual abuse	
There should be a statutory duty to report suspected and actual cases of child sexual abuse; a clear and unambiguous legal requirement to report abuse and reasonable suspicion of abuse, breach of which can give rise to criminal sanctions.	LA-A7, LA-A24, LA-A25, LA-A61, LA-A103, LA-A109, LA-A115, LA-A131, LA-A136, LA-A138, LA-A139, LA-A141, LA-A142, LA-A143, LA-A144, LA-A147, LA-A154, LA-A155, LA-A156, LA-A181, LA-A184, LA-A203, LA-A221, LA-A222, Russell Specterman, LA-A271, LA-A298, LA-A299, LA-A300, LA-A302, LA-A303, LA-A304, LA-A305, LA-A306, LA-A307, LA-A308, LA-A309, LA-A310, LA-A311, LA-A312, LA-A321, LA-A322, LA-A323, LA-A324, LA-A325, LA-A326, LA-A327, LA-A330, LA-A351, LA-A352, LA-A353, LA-A354, LA-A355, LA-A449, LA-A456, LA-A457, LA-A481 The Department for Education submitted that the government would consider introducing new statutory measures regarding mandatory reporting *"if the evidence from its work, and/or that of the Inquiry, strongly suggested that to do so would make children safer"*.[1283]
Mandatory training of elected councillors	
Newly elected councillors should be given mandatory training on corporate parenting and safeguarding of children. Councillors should also be trained in institutional racism and cultural differences.	LA-A7, LA-A24, LA-A25, LA-A181, LA-A203, Russell Specterman, LA-A271, LA-A298, LA-A299, LA-A300, LA-A302, LA-A303, LA-A304, LA-A305, LA-A306, LA-A307, LA-A308, LA-A309, LA-A310, LA-A311, LA-A312, LA-A321, LA-A322, LA-A323, LA-A324, LA-A325, LA-A326, LA-A327, LA-A330, LA-A354, LA-A457, Stephen Whaley, Dr Nigel Goldie
Regulation of social care staff	
Regulation of the children's home workforce is urgently needed for social care workers. There should be an overarching local authority regulator or national safeguarding body that is able to compel action and impose financial sanctions on local authorities which are in breach of their statutory duties towards and causing harm to children.	LA-A7, LA-A24, LA-A181, LA-A203, Russell Specterman, LA-A271, LA-A298, LA-A299, LA-A300, LA-A302, LA-A303, LA-A304, LA-A305, LA-A306, LA-A307, LA-A308, LA-A309, LA-A310, LA-A311, LA-A312, LA-A321, LA-A322, LA-A323, LA-A324, LA-A325, LA-A326, LA-A327, LA-A330, LA-A457

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Proposed recommendation	Proposed by
Training of social care staff	
Social workers should have proper training and qualifications. Foster carers should have better training regarding child care in general.	LA-A299, LA-A300, LA-A330, LA-A354, LA-A327
All social care staff and foster carers should be given training on how to deal with concerns about potential abuse, disclosures of abuse, how to identify the signs of child sexual abuse and what to do to address it. Each child should have access to abuse prevention programmes and to social workers with expertise in child sexual abuse and substance abuse.	LA-A99, LA-A103, LA-A141, LA-A143, LA-A147, LA-A300, LA-A330, LA-A308, LA-A327, LA-A103
Vetting of social care staff and foster carers	
Stringent background checks should be carried out for all those people working with children, including social workers, foster carers and the individuals entering children's homes as visitors.	LA-A7, LA-A25, LA-A61, LA-A99, LA-A103, LA-A136, LA-A142, LA-A147, LA-A156, LA-A181, LA-A184, LA-A299, LA-A307, LA-A321, LA-A323, LA-A330, LA-A351, LA-A355, LA-A449, LA-A457
Background checks should be regularly updated.	LA-A156, LA-A355
Monitoring of children and placements	
There should be intensive monitoring of children placed in care. Children's homes and foster placements should be subject to regular visits by independent experts.	LA-A103, LA-A109, LA-A115, LA-A131, LA-A143, LA-A155, LA-A156, LA-A303, LA-A351, LA-A353, LA-A354, Russell Specterman
A child's behaviour should be carefully observed. Systems should be put in place to record changes in behaviour and to examine whether behavioural issues, such as absconsion, are indicative of sexual or other abuse.	LA-A11, LA-A99, LA-A109, LA-A131, LA-A147, LA-A299, LA-A303, LA-A307
Children's homes should have CCTV in order to monitor and evidence any abuse that takes place in these homes.	LA-A115, LA-A143, LA-A307
Social workers should be contactable at any time so that the child may have support in an emergency.	LA-A302, LA-A326

Proposed recommendation	Proposed by
Implementation of safeguarding policies	
Policies and procedures should be in place to safeguard children. They must be actually implemented.	LA-A25, LA-A142, LA-A147, LA-A309, LA-A457
Policies should include training for staff regarding child sexual abuse, including an action plan regarding how to investigate allegations of such abuse.	LA-A139, LA-A141, LA-A143
Care planning	
Children should not be kept for long periods in children's homes. Children should be involved in decisions about their lives and who will care for them. Specific action decisions about a child must be carried through. Foster placements should not be physically isolated.	LA-A115, LA-A155, LA-A354
There should be a reduction of multiple moves between care and foster placements. Constant moves undermine stability and any trust a child can have in the people around them. This further reduces the possibility of a child feeling able to tell anyone about abuse. Similarly, there should be limited staff turnover, which is also disruptive.	LA-A115, LA-A138, LA-A147
Allocated social workers	
Children in care should always have an allocated independent social worker. The social workers should work closely with the children they are assigned to so that the children can build trust and confide in them.	LA-A25, LA-A103, LA-A115, LA-A271, LA-A300, LA-A307, LA-A327, LA-A353
Voice of the child and responding to allegations of child sexual abuse	
The approach to children placed in care should be child-centred. The child, his or her experience and their feelings about where they are should be at the centre of institutional work around children. The child's feelings have value; their pain matters.	LA-A136, LA-A309, LA-A327, LA-A353, LA-A354, Anna Tapsell
Children in local authority care should have access to someone independent who can have independent meetings with the child. Children need someone who can act as an independent sounding board – like a nurse, or an advocate; someone the children can speak to.	LA-A25, LA-A103, LA-A131, LA-A155, LA-A221, LA-A300, LA-A322, LA-A327

Proposed recommendation	Proposed by
There should be a support network around each child and more than one avenue by which a child can make a complaint. Keeping children connected to wider family members also reduces their vulnerability.	LA-A99, LA-A138, LA-A299
If a child reports any allegations of sexual abuse, immediate investigations should be carried out with coordination and cooperation between child care authorities and the police. The alleged abuser must be stopped immediately from ongoing contact with children.	LA-A61, LA-A99, LA-A155, LA-A156, LA-A302, LA-A310, LA-A323, LA-A449, LA-A457
The child should be questioned in a safe environment away from their caregivers to ensure they feel able to share. A child should never be punished for disclosing abuse. Rather, he or she must feel they will be protected if they come forward to disclose sexual abuse.	LA-A18, LA-A99, LA-A103, LA-A144, LA-A147, LA-A154, LA-A302, LA-A308
Children should be listened to properly when abuse is alleged. Authorities are too quick to dismiss children when they speak out about their sexual abuse. Simple disbelief causes long-term psychological damage.	LA-A7, LA-A30, LA-A131, LA-A138, LA-A144, LA-A154, LA-A156, LA-A303, LA-A307, LA-A309, LA-A310, LA-A323, LA-A326, LA-A449, LA-A456, LA-A457
All complaints should be effectively documented by those to whom they are reported.	LA-A99, LA-A147, LA-A351
When police interview a child, someone should be present who has experienced abuse and can understand the child and ensure they are treated with respect.	LA-A307
Protocols and guidelines are implemented to promote transparency within police investigations.	Dr Nigel Goldie, Stephen Whaley
Counselling and other support should be provided to a child who has made an allegation of abuse. The counselling provided ought to be by an organisation or agency that has specialist expertise in working with young people who have been affected by and experienced sexual abuse.	LA-A25, LA-A115, LA-A131, LA-A141, LA-A147, LA-A154, LA-A181, LA-A203, Russell Specterman, LA-A271, LA-A305, LA-A311, LA-A324, LA-A330

Proposed recommendation	Proposed by
Support should also be provided to the victim or survivor after he or she has spoken to police or participated in a trial.	LA-A61, LA-A109, LA-A369
After care support is vital. Care leavers should be provided with proper support to cover basic human necessities. At minimum, the authorities must ensure care leavers have somewhere to live and to cook.	LA-A24, LA-A131, LA-A147, LA-A327
There should be a transparent child-centred complaints procedure in place that is understood by children, staff, volunteers and families. The complaints policy must outline roles and responsibilities, approaches to dealing with different types of complaints and obligations to act and report. Complaints must be taken seriously, responded to promptly and thoroughly, and reporting, privacy and employment law obligations met. Children, staff, volunteers and families should know who to talk to if they are worried or are feeling unsafe. Information should be provided in accessible, age-appropriate and meaningful formats to children and families who use the service, mindful of their diverse characteristics, cultural backgrounds and abilities.	LA-A99, LA-A131, LA-A138, LA-A147, LA-A184, LA-A222, LA-A271, LA-A302, LA-A322, LA-A457
Revision of section 9 of the Children Act 1989	
Section 9 of the Act restricts the powers of a court so that it may not make orders under section 8 of the Act in respect of children who are in care. Section 8 orders include contact orders, residence orders, prohibited steps orders and specific issue orders. Removing the statutory restriction set out in section 9 would reduce the discrimination between children in care and those not in care.	Hudgell Solicitors, Switalskis Solicitors, Slater and Gordon, Verisona Law, Dr Nigel Goldie, Stephen Whaley, Anna Tapsell. Lambeth Council provided legal submissions on this point and remains neutral. This was not supported by the Department for Education or the Ministry of Justice.

This report was originally published by the Inquiry in July 2021 and two typographical corrections were subsequently made to the original version. These errors have been corrected in the present version.

The following typographical corrections were made to the original version of this report on 2 August 2021:

- Section J.3, paragraph 52: amended to read 'Mr Gargini told us that he received advice from the Association of Chief Police Officers (ACPO) lead to the effect that there would need to be *"a proper risk assessment around the impact of an approach by police"* before this type of contact letter could be adopted.'
- Annex 1, paragraph 2: amended to read 'Deborah Britstone'.

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