INDEPENDENT INQUIRY
CHILD SEXUAL ABUSE

Investigation reports of the Independent Inquiry into Child Sexual Abuse

Children in the care of the Nottinghamshire Councils

Accountability and Reparations

The Roman Catholic Church

Case Study: English Benedictine Congregation

1. Ealing Abbey and St Benedict's School

2. Ampleforth and Downside: update

September 2022

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The Independent Inquiry into Child Sexual Abuse (IICSA) was established by the then Home Secretary in 2015 to look at the extent to which institutions in England and Wales have discharged their duty to protect children from sexual abuse. The Inquiry is chaired by Professor Alexis Jay OBE.

The programme of public hearings and their investigation reports has now finished, and all 19 investigation reports have been published. The reports which make up this volume and which are now prepared for presentation to Parliament were originally published by the Inquiry in July 2019, September 2019 and October 2019.

All of the Inquiry's investigation reports are available on the Inquiry's website and on the Inquiry's collection page on gov.uk.

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Executive Summary

This is one of three investigations by the Inquiry into the nature and extent of allegations of sexual abuse of children in the care of local authorities. The primary purpose of this investigation was to examine the institutional responses to such allegations of Nottinghamshire County Council, Nottingham City Council, and other organisations such as Nottinghamshire Police and the Crown Prosecution Service, and to consider the adequacy of steps taken to protect children from abuse.

These two councils were chosen because of the high level of allegations of sexual abuse of children in their care over many years. The Inquiry received evidence of around 350 complainants who made allegations of sexual abuse whilst in the care of the Councils from the 1960s onwards, though the true scale is likely to be higher. This is the largest number of specific allegations of sexual abuse in a single investigation that the Inquiry has considered to date.

For more than five decades, the Councils failed in their statutory duty to protect children in their care from sexual abuse. These were children who were being looked after away from their family homes because of adverse childhood experiences and their own pre-existing vulnerabilities. They needed to be nurtured, cared for and protected by adults they could trust. Instead, the Councils exposed them to the risk, and reality, of sexual abuse perpetrated primarily by predatory residential staff and foster carers.

In residential care, there were poor recruitment practices, few qualified staff and little in-service training. This was compounded by overcrowding and low staffing ratios. It was as if anyone could carry out the important work of being a substitute parent to damaged children. In some instances, a sexualised culture existed in residential homes, with staff behaving wholly inappropriately towards children, paving the way for sexual abuse. Whilst set standards of conduct and child protection procedures were put in place, there was little proper training provided to help staff understand their employers' requirements, nor action taken against those who did not comply. Staff ignored these standards and procedures with impunity.

Nevertheless, it must be borne in mind that, regardless of all other considerations, the sexual abuse of children should have been regarded by all staff as a criminal offence.

Residential care carried little priority with senior managers, even when they were aware of escalating numbers of allegations of sexual abuse. Whilst there were some improvements over time, with awareness of the problem improving, directors of social services and children's social care failed to fully address the issue in both residential and foster care. Nor were elected members informed of the scale of the abuse.

Neither of the Councils learned from their mistakes, despite commissioning many reviews which made clear what changes were needed in their care systems to stop the sexual abuse of children.

During the 1970s, 1980s and 1990s, physical violence and sexual abuse occurred in many of the Councils' children's homes and in foster care. This included repeated rapes (vaginal, anal and oral), sexual assaults, and voyeurism. Harmful sexual behaviour also occurred between children in both settings.

Between the late 1970s and 2019, 16 residential staff were convicted of sexual abuse of children in residential care, 10 foster carers were convicted of sexual abuse of their foster children, and the Inquiry is aware of 12 convictions relating to the harmful sexual behaviour of children against other children in care. The offences in residential care took place in Beechwood and a number of other children's residential units, including the following 12 establishments: Hazelwood, Skegby Hall, Edwinstowe, Sandown Road, Wollaton House, Hillcrest, Risley Hall, Greencroft, Beckhampton Road, Woodnook, Amberdale and Three Roofs.

Some of the convicted offenders are detailed below:

> Two offenders, Norman Campbell and Christopher Metcalfe, were convicted of sexual assaults against children in both residential care and foster care.
>
> Patrick Gallagher was convicted of 55 counts of sexual abuse committed between 1998 and 2010 against 16 children, seven of whom were in care. He was given 13 life sentences, with a minimum of 28 years' imprisonment.
>
> Robert Thorpe was convicted in 2009 of several counts of indecent assault and unlawful sexual intercourse with a girl under 13 who was being fostered by his friends. He was given five years' imprisonment.
>
> Dean Gathercole was convicted of six counts of indecent assault and three counts of rape of two residents at Amberdale in the late 1980s. He was given a prison sentence of 19 years in 2018.

Accounts of abuse include:

> L17 was raped on "*four or five occasions*" by staff member Colin Wallace, who was later convicted. She was made to masturbate Wallace in a communal lounge in Beechwood, where other children and staff were present.
>
> P2 was in foster care in the 1960s, and was raped by her foster father on camping holidays.
>
> P13 was sexually abused between 1979 and 1981 by the 21-year-old brother of his foster mother and was forced to masturbate him and perform oral sex.
>
> A76 spent 16 years in care in 21 placements. She was abused by older boys in several children's homes and was the victim of rape and sexual assault.

Over the years, as local authority boundaries changed, responsibility for some of the services referred to in this report moved between the County and the City. The Inquiry selected three case studies to examine in detail the responses of institutions to sexual abuse of children in the care of the two councils.

Beechwood

Beechwood operated for 39 years, from 1967 to 2006, and was run for periods by the City and County. It was run first as a remand home, then as an observation and assessment centre, and later a community home. In common with residential care across England at the time, it was poorly resourced and managed. Care staff were predominantly unqualified and received little, if any, training. Even with these similarities, however, no other residential homes in Nottinghamshire have had the level of allegations of sexual abuse which have been made about Beechwood staff.

It was not a safe environment for vulnerable children. Staff were threatening and violent, physical abuse was commonplace and children were frightened. Sexualised behaviour by staff was tolerated or overlooked, allowing abusers such as John Dent, Barrie Pick and Andris Logins to flourish. Managers at Beechwood, notably Ken Rigby, were either complacent or deliberately ignored the plight of children under their care. There were only two disciplinary actions taken when allegations of sexual abuse were made, and those were inadequate. When the City took over the running of Beechwood in 1998, the staff environment had not improved and children and young people were still at risk of sexual abuse. The City allowed Beechwood to continue operating for a further eight years, when it should have been closed much earlier.

As one example, L29 was remanded into the care of the City in 2005 and placed at Beechwood for four months, when he alleges he was repeatedly abused by a male member of staff. In 2015, he came forward to the police and felt that they believed him. He had not received an apology from the City, which made him "*very angry*". He said, "*I don't see any future for myself. I understand that I had problems before Beechwood, but, in my opinion, Beechwood put me where I am today*".

Foster care

This case study considered the institutional responses to sexual abuse in foster care from the 1960s to the present day. Foster care has been, and still is, the most common placement for children in the care of both of the Councils. The overall picture from the mid-1970s to the 1990s shows an inconsistent approach to the recruitment, assessment and support of foster carers, and the supervision of children's placements. When allegations of sexual abuse were made, there was too much willingness on the part of Council staff to take the side of the foster carers and to disbelieve the child. There was no effective or rigorous assessment of individual allegations.

In one particularly shocking case, in the 1970s, the County returned children to foster care after the foster carer pleaded guilty to the sexual assault of his two nieces. In 1985, a County foster carer (who was also a residential care worker) admitted sexually assaulting a foster child, after previous allegations against him had been regarded as "*malicious*" by children's social care. In January 2014, NO-F77 was convicted of sexually abusing children in foster care, having fostered over 30 children in the care of the County between 1998 and 2012 although there had been previous allegations of sexual abuse, most significantly in 2000, when social workers concluded that they had "*no doubt*" that the abuse did not occur. Foster children were left at risk by the County, resulting in preventable abuse.

There was also sexual abuse by City foster carers. For example, Raymond Smith was deregistered as a foster carer in 2004 following allegations of sexual abuse by children in foster care and was, in 2016, convicted of sexually abusing a child not in care. By this time it was noted that, during Smith's time as a foster carer, there had been allegations "*by a number of young people of a sexual nature*".

L35, who was physically and sexually abused whilst in foster care in the 1980s, was angry "*that the foster carers were allowed to get away with abusing children in their care for so long and nothing was done about it. No one took foster children seriously … there was no punishment for the foster parents. They got away with everything.*"

Despite improvements, there continue to be weaknesses in foster care practice in both Councils.

Harmful sexual behaviour

For most of the period under review in this investigation, harmful sexual behaviour between children in the care of the Councils has not been well understood by professionals involved with children in care. Between 1988 and 1995, five separate reports into harmful sexual behaviour in five County community homes were conducted. In one home, all children resident over a 12-month period were found to have been exposed to harmful sexual behaviour. Policies and procedures were established but the issue was not viewed holistically across the five homes, so the work was largely wasted and learning was lost.

D31, a victim of harmful sexual behaviour at Greencroft when she was aged 12, told us of five incidents of sexual abuse involving older male residents. She had been placed at Greencroft with much older children which, along with a failure to monitor risks posed by other children and a lack of guidance for staff, left her at risk of abuse.

Neither of the Councils have a satisfactory approach to addressing the issue of harmful sexual behaviour of children in care. The County has taken steps to audit its practice. The City provided very little evidence to the Inquiry about its current practice, or of any recent steps taken to improve it, notwithstanding the inclusion of harmful sexual behaviour as a case study in this investigation. Despite present, widespread awareness of the issue, there is no national strategy or framework for the prevention of, or response to, harmful sexual behaviour between children in care.

Nottinghamshire Police

In 2011, Nottinghamshire Police initiated Operation Daybreak to investigate allegations of non-recent abuse of children in residential care. However, this was not adequately resourced, the police did not treat allegations with sufficient seriousness, and valuable time was lost. In 2015, Operation Daybreak was subsumed into Operation Equinox. Since that time there have been a number of prosecutions, bringing increased confidence amongst complainants in the force's commitment. Nevertheless, only now have Nottinghamshire Police begun to address weaknesses in its approach to child protection, as identified in recent HMIC (known as HMICFRS from summer 2017) inspection reports.

Apologies, acknowledgment and support

The Councils have taken different approaches to apologising for non-recent abuse and acknowledging past failures to protect children in their care. Whilst the County have made a public apology, the City have been guarded and slow to apologise or express appreciation for the level of distress felt by complainants. An example of this was the reported comment, in 2018, from the then City Council Leader that "*we will apologise when there is something to apologise for*". This was crass and caused avoidable upset.

Provision and consistency of support and counselling for those who have suffered sexual abuse in care remains an issue.

Recommendations

We make recommendations covering issues such as risk assessments of current and former foster carers and residential care staff, and the approach to harmful sexual behaviour.

Pen portraits from children in the care of the Nottinghamshire Councils

This investigation received many accounts of sexual abuse from those who were in the care of the Nottinghamshire Councils. A selection of these are set out here, and others are referred to throughout the report.

D6

D6[1] was born in 1995 and taken into foster care in 2005 after a horrific experience at home. He was in the care of the City, which, whilst retaining responsibility for him, placed him in foster care in Yorkshire with NO-F70, via an independent fostering agency. Multiple allegations of abuse were made against NO-F70, but investigations were dropped quickly and NO-F70 moved with D6 to the Isle of Wight.

Following the move, social work visits to D6 became "*sporadic*" and were often cancelled. D6 told us of being physically assaulted and intimidated by NO-F70 and then, in 2007, sexually abused by him. D6 was eventually removed from NO-F70's care after two allegations of child sexual abuse were made against NO-F70, although there was no investigation at that time into whether D6 had also been abused by NO-F70.

In 2017, D6 reported his abuse to the police but there was some confusion about which force should be investigating it. The abuse resulted in D6 trying to take his own life on a number of occasions, and standing outside the City's offices having covered himself in petrol. He told the Inquiry:

> "*I am still full of fury about what NO-F70 did to me. I don't understand how someone with an allegation of underage sexual assault made against them can have been allowed to continue to foster children.*"

L29

L29[2] was born in 1990. In 2005, he was remanded into the care of the City and placed at Beechwood for four months. He alleges being forced to perform oral sex on a male member of staff, NO-F61:

> "*He would give me things such as fags and money, before and after the abuse. I think this was his way of getting me to comply and keep the abuse a secret.*"

[1] D6 5 October 2018 20/19-84/7
[2] L29 3 October 2018 153/1-156/10

L29 would run away to escape the abuse and, on occasion, would be returned by the police. He did not tell them what was happening with NO-F61 as he did not trust them. He came forward again more recently to the police, in 2015, and says that he felt they believed him. He had not received an apology from the City, which made him "*very angry*":

> *"I don't see any future for myself. I understand that I had problems before Beechwood, but, in my opinion, Beechwood put me where I am today."*

L35

L35[3] was born in 1982 and was placed in foster care with NO-F116 and NO-F117 in 1987. She had previously been physically and sexually abused at home; in 1989, a number of adults in L35's family were convicted of abuse against her, her siblings and cousins.

In foster care, L35 was physically and sexually abused. She said that NO-F116 "*would sometimes touch me between my legs. I remember being sat on the sofa and he would put his hand down my trousers. He never forced himself on to me but would make me touch his penis and him touch me.*"

L35 disclosed the abuse in 1989, but did not leave the placement for another six months. An investigation by the police and children's social care was conducted subsequently into allegations from her and others. L35 was not interviewed. The foster carers were not prosecuted, although L35 was told that they would not be allowed to foster again. L35 is angry that the foster carers "*were allowed to get away with abusing children in their care for so long and nothing was done about it. No one took foster children seriously. We made disclosures. There were various investigations and to an extent we were believed but there was no punishment for the foster parents. They got away with everything.*"

N1

N1[4] was taken into the care of the County in 1982, aged 12, having been sexually abused at home. She was placed at Beechwood for around 18 months, during which time she was sexually abused by Andris Logins, a member of residential care staff. She described how Logins was "*really friendly*" towards her, recalling that "*He was the only person there that was nice to me.*" She told us of a number of instances in which they had sexual intercourse at Beechwood and said "*All, if not most, staff members at Beechwood knew about the abuse but failed to prevent or report it.*"

After leaving care, N1 turned to drugs, drink and "*prostitution*" and was living a "*really dysfunctional life*". She only told the police about the abuse in 2012 when they contacted her as part of their investigation into Beechwood. She was very positive about her treatment by the police, who updated her regularly. Logins was convicted in 2016 of sexually abusing her and others.

D22

D22[5] was born in 1969 and taken into care in 1978. He had various different placements, including two at Beechwood in 1978 or 1979 and in 1984. At Beechwood, he was sexually abused by two male members of staff, NO-F29 and another.

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[3] L35 4 October 2018 154/7-156/6
[4] N1 3 October 2018 1/9-54/7
[5] D22 3 October 2018 145/19-148/19

> *"I remember that both men abused me on multiple occasions. They both touched me inappropriately. They both forced me to masturbate them. They both forced me to perform oral sex on them."*

D22 also recalls being sexually abused by two male members of staff at Skegby Hall, as well as being physically and racially abused there. At South Collingham Hall, another children's home, he was sexually abused on three occasions by an older boy, including one rape, one attempted rape and an incident of sexual touching.

He did not tell anyone about the sexual abuse at the time. He did not think he would be believed:

> *"I never wanted anyone to find out what had been done to me. As a young black kid, I didn't know who to turn to or who to trust. I remember that I tried to run away from Beechwood and the staff caught me just down the road. I think this happened about three times. I remember that I told them that I didn't want to go back to Beechwood."*

He also says at times he blamed himself: "*The abuse I suffered has always been a source of shame and embarrassment for me. The thought of talking about it has been, and still is, very frightening.*" In the last 10 years he has contacted solicitors and reported his abuse to the police, who have kept him updated about their investigation.

A76

A76[6] was born in 1969 and spent 16 years in care, moving placement 21 times, including both children's homes and foster placements. She was raped twice by an older boy at one children's home: "*He told me that if I told anyone about what he had done, he would beat me until I was dead.*" She tried to tell a female staff member but was "*just too scared*". She was also sexually assaulted by another boy at the home, but did not report it:

> *"I never stayed in one place long enough to feel like I had any one adult who I could trust to report what had happened to me at the time."*

A76 noted that, in her social services records, there was a letter from a social worker dated February 1990, which stated that "*her experiences in care were not a credit to the department*". A76 told us, "*With the greatest respect, this feels like the understatement of the century. I was treated appallingly by Social Services and they know it.*"

L48

L48[7] was born in 1964 and admitted into care in 1969. In 1971, he was placed in foster care with NO-F275 and NO-F358. He moved with them to Cheshire, but remained in the care of Nottingham City Council. He was sexually abused by NO-F275 but, as he was not able to see a social worker alone, felt unable to disclose the abuse.

His next foster placement was with NO-F276, who sexually abused him when he was aged 11 and treated all of the foster children as "*slaves*". L48 was unable to disclose the abuse as he was frightened people would not believe him and the abuse had made him confused about his sexuality.

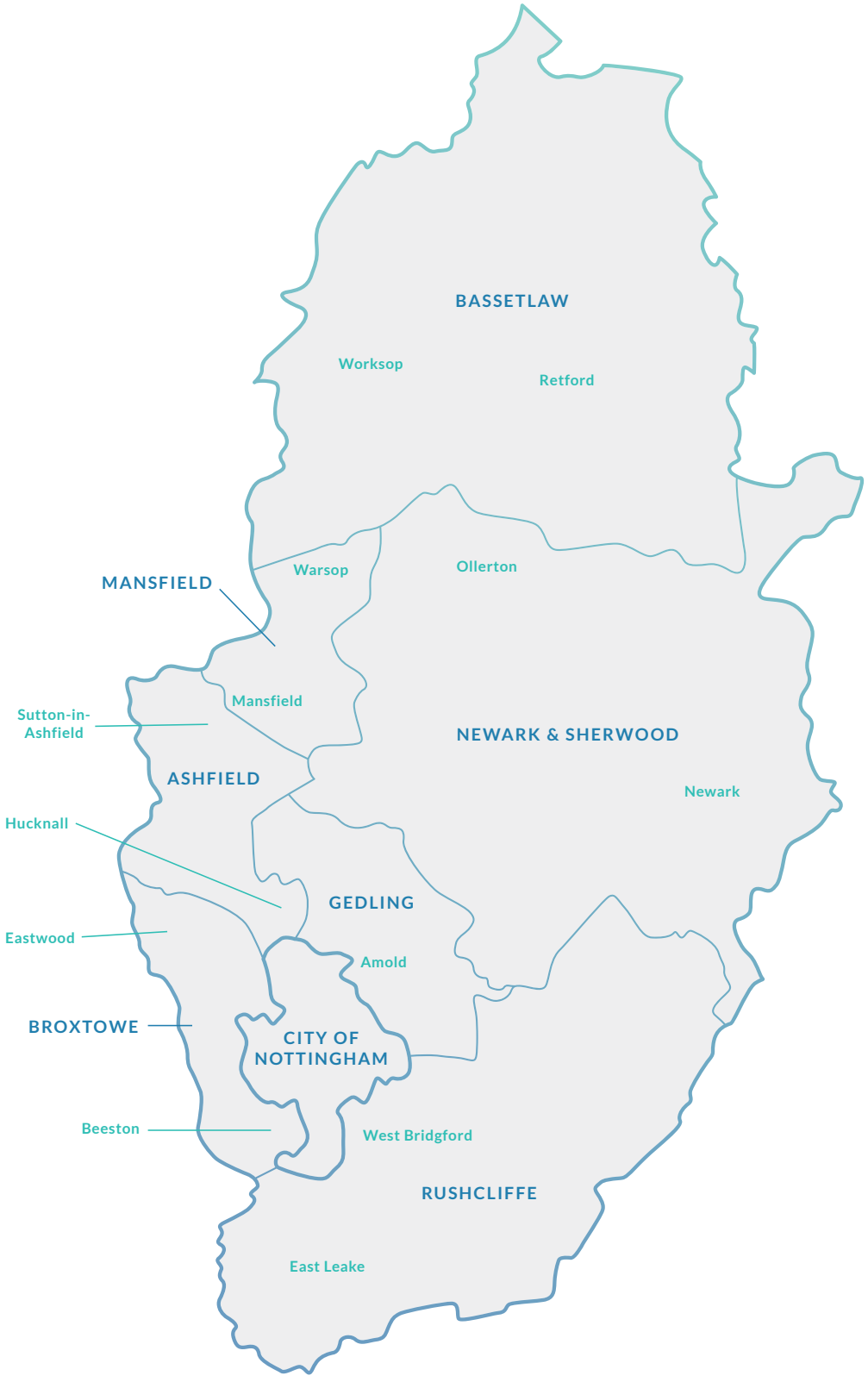
[6] A76 5 October 2018 113/10-121/12
[7] L48 4 October 2018 1/6-48/24

He first reported the abuse to the County's children's social care service in 1985, but felt that he was not believed from the outset. He withdrew the complaint. He complained to the County again in 2015 and felt believed by Steve Edwards (then Service Director for children's social care), who organised counselling and for him and other complainants to give talks to social workers and foster carers about their experiences in care and the lessons to be learned.

In 2017, NO-F275 was acquitted after being charged with abuse of L48. L48's sexual abuse allegations against NO-F276 were investigated by the City's Safeguarding Children Board, which found that they were unsubstantiated. L48 found the process followed by the Safeguarding Children Board to be "*insulting*".

Part A

Introduction



Nottinghamshire

Introduction

A.1: Background

1. This is the second of three investigations considering the sexual abuse of children in the care of local authorities.[8] In this report, we focus on children in the care of Nottingham City Council (the City) and Nottinghamshire County Council (the County) (together, the Councils). Specifically, we consider the nature and extent of allegations of sexual abuse of children in the care of the Councils, the response of the Councils, Nottinghamshire Police and the Crown Prosecution Service to those allegations, and the steps taken to protect children in care in light of them.

2. Until 1974, in Nottinghamshire, responsibility for children in care was divided between the County, Nottingham Borough Council (the precursor to the City) and the Home Office. Between 1974 and 1998, the County was the sole local authority responsible for all children in care across the city and the county. Since a local government reorganisation in 1998, the City and the County have been two separate local authorities. Where we refer to a geographical area including both the County and the City, we use the term 'Nottinghamshire'.

3. The two Councils are responsible for a geographical area of approximately 2,160 square kilometres.[9] In 2017, there were roughly 818,000 people living in the County[10] and 329,000 in the City.[11]

4. The number of children in care within the area covered by the Councils has fluctuated over time.

[8] The first concerned placements by Rochdale Borough Council, which reported in April 2018 – see *Cambridge House, Knowl View and Rochdale, Investigation Report*, April 2018 – and the third concerns children in the care of Lambeth Council, for which public hearings will take place in 2020.
[9] https://www.nottinghamshireinsight.org.uk/d/184228
[10] https://www.nottinghamshireinsight.org.uk/research-areas/key-facts-about-nottinghamshire/
[11] https://www.nottinghaminsight.org.uk/research-areas/key-facts-about-nottingham/

Table 1 **Number of children in care per 1,000 children**

	England	Nottinghamshire County	Nottingham City
1973[a]	6.8	3.9	14
1989[b]	5.7	8.6[c]	15.9[d]
2002[e]	5.4	3.1	9.5
2009[f]	5.4	3	7.9
2013[g]	6	5.4	9
2018[h]	6.4	4.8	9.1

[a] NSC000526_4; [b] NSC000104_20-21; [c] This figure includes children who were located within the City area but were in the care of the County (NSC000104_21); [d] This figure does not relate to children who were in the care of the City (which did not exist at that time), but to those who were in the care of the County and located in the City (NSC000104_21); [e] Statistics of Education: Children Looked After by Local Authorities, Year Ending 31 March 2004, Volume 2: Local Authority Tables, Department for Education and Skills, March 2005, pp5–6; [f] Children Looked After in England 2009–2013; [g] Children Looked After in England 2009–2013; [h] Children Looked After in England 2014–2018

The City's consistently higher proportion of children in care is likely to reflect its higher levels of deprivation.[12] Both Councils saw a significant reduction in these numbers between 1989 and 2002, as more community-based services for children were developed.

5. In terms of residential care provision, the City now has seven registered children's homes (managed within children's social care) and, since 2015, has had no children's homes with more than four long-term beds.[13] It also places children in its care in 19 children's homes run by private or voluntary organisations,[14] but a "*high proportion*" of children in residential care are placed outside the City, in children's homes run by other local authorities, due to a lack of available placements.[15] The County has six registered children's homes[16] and, as at March 2018, had 93 children who were placed in children's homes, 79 percent of whom were in privately-run homes.[17]

6. Foster care has long been the preferred placement for the majority of children in care. The most recent figures suggest approximately 63 percent of children in the care of the County,[18] and 73 percent of children in the care of the City,[19] are in foster care. Similarly, of those in foster care, 43 percent of those in the County and 56 percent of those in the City are placed through independent fostering agencies.[20]

7. In early 2010, local media in Nottingham reported that a number of people who had spent time in children's homes between the 1970s and the 1990s alleged that they had been sexually abused by staff. As the number of allegations increased, Nottinghamshire Police initiated a dedicated investigation, Operation Daybreak, which is now part of the ongoing Operation Equinox. By 2014 or 2015, the media focus shifted to the apparent lack

[12] For example, the City was the eighth most deprived district in England in the latest Index of Multiple Deprivation (2015). By contrast, the County was ranked 98th.
[13] NCC003691 para. 3.122, 3.90
[14] NCC003691 para. 3.88
[15] NCC003691 para. 8.7
[16] NSC001235 para. 3c.i.28; including children's homes for three or four children and short-break children's homes for between eight and 16 young people with disabilities (The Big House, Minster View, Caudwell House, Oakhurst, Lyndene, West View).
[17] Response to Freedom of Information Request 28.01.19
[18] NSC001235 para. 1.3; NSC001474 para. 4f.1
[19] NCC003691 para. 3.135; Nottingham City Council Corporate Parenting Board July 2018, pp13–14
[20] NSC001474 para. 4f.1; NCC003807 para. 3.9

of outcomes from the police investigations or action by the Councils. Locally, there was a widespread perception that the allegations had not been properly investigated, as there had not been (at that time) any prosecutions as a result.

8. Between the late 1970s and 2019, in Nottinghamshire, the Inquiry is aware of:

- 16 staff convicted of sexual abuse against more than 30 children in residential care;
- 10 foster carers convicted of the sexual abuse of approximately 25 children in their care;[21]
- three foster carers convicted of the sexual abuse of seven children not in their care;
- two relatives of foster carers convicted of sexually abusing two children in foster care; and
- 12 convictions in relation to harmful sexual behaviour between children in care. This figure only includes those cases which we know resulted in a conviction or a caution. We do not have an accurate number of substantiated cases. There are large numbers of allegations which were regarded as substantiated at the time by the County's children's social care service, and some in which charges were recommended. However, we do not have evidence of convictions in these cases.[22]

Further detail of these convictions is included in Annex 3.

A.2: Nature and extent of allegations of sexual abuse

9. The sexual abuse of children in the care of the Councils[23] was widespread in both residential and foster care during the 1970s, 1980s and 1990s.

10. The sexual abuse alleged in this investigation varies widely. It includes repeated rapes and other sexual assaults, related physical abuse, voyeurism and sexually inappropriate physical contact. The abuse was carried out by a range of perpetrators, including residential care staff, foster carers and their relatives, and children in care. Some allegations relate to single perpetrators, whereas others concern sexual abuse by more than one perpetrator at the same time. Several complainants make a number of allegations of sexual abuse during their time in care, including within the same placement.

11. Children in the care of the Councils have also been victims of child sexual exploitation.[24] By the mid-to-late 1990s, the County and then the City began to address this issue, including the introduction of a joint protocol with Nottinghamshire Police, a multi-agency group on sexual exploitation and a Home Office pilot project.[25] (This report does not consider child sexual exploitation in detail, as this will be addressed in a separate investigation within the Inquiry.[26])

[21] Including two who were also residential staff.
[22] See NSC000438_019 and NSC000104_107
[23] From 1974 to 1998, children were solely in the care of the County.
[24] Until the mid-to-late 1990s, this was often regarded, and referred to, as prostitution.
[25] NSC000054; NCC003691 para. 6.34; NSC001235 para. 6j.11; NSC001642. This work led to the award of a National Social Care Award (CQC000038_21).
[26] Relevant evidence will be considered through the Inquiry's investigation into Child Sexual Exploitation by Organised Networks

12. In addition to evidence from complainant core participants, the Inquiry has reviewed information from police investigations, civil litigation claims, disciplinary investigations and foster care investigations. Around 350 individuals report having been sexually abused whilst in the care of the Councils from the 1960s onwards. This includes 259 accounts of sexual abuse in residential care,[27] 91 in foster care[28] and 89 accounts of harmful sexual behaviour.[29] Of the 71 complainant core participants who provided a statement to the Inquiry but were not called to give evidence, 57 make allegations of sexual abuse in residential care and 18 in foster care, and 13 give accounts of being the victims of harmful sexual behaviour by other children.[30]

13. The true number of children who suffered sexual abuse in the care of the Councils is likely to be higher than these figures. There are multiple barriers to disclosure during childhood, many of which continue into adulthood. Additionally, there are very few remaining records from the Councils regarding their response to allegations of sexual abuse before the 1980s, and none from the police, because records have been destroyed in accordance with the record retention policies of the day. If a child did report sexual abuse at the time, it may never have been recorded. The absence of records therefore does not mean children were not being sexually abused during this period, simply that we do not have documentary evidence.

14. In some cases, there have been convictions for sexual abuse of children in care, as well as dismissals or disciplinary action taken against staff members, deregistration of foster carers and the settling of civil claims. In others, complainants were not believed, alleged perpetrators died before allegations were reported, or children's social care, the police or the Crown Prosecution Service decided not to take any action.

A.3: Case studies

15. In order to investigate the institutional responses to allegations of child sexual abuse in Nottinghamshire, including the barriers to disclosure, the Inquiry selected three case studies.[31]

15.1. Beechwood was initially a remand home, then an observation and assessment centre, before being designated as a children's home in 1984. Since 2011, it has been the subject of extensive police investigation into allegations of sexual abuse, as well as a focus of the local media. It is also the single institution with the largest number of allegations of sexual abuse made to the Inquiry.[32] Although a large number of allegations of child sexual abuse had been made in recent years, there was little evidence of allegations being made or responded to at the time. This case study illustrates the barriers to reporting faced by children in care.

[27] INQ002577; INQ002574
[28] INQ002575; INQ002574
[29] INQ002576; INQ002574; a number of complainants make allegations across residential care, foster care and harmful sexual behaviour.
[30] INQ002574
[31] *Notice of Determination on Selection of Case Studies*, 28 February 2018, as provided for under paragraph 3 of the investigation's Definition of Scope
[32] INQ002574; INQ002576; INQ002577

15.2. Foster care, throughout the period under review, has been the primary placement for children in care. Complainant core participants made 26 allegations of sexual abuse in foster care[33] and there were a substantial number of documents dealing with the Councils' responses to complaints made at the time.

15.3. Harmful sexual behaviour between children in care does not appear to have been the focus of any public inquiry in the UK. However, it is estimated that between one-third and two-thirds of allegations of child sexual abuse in the UK are made against young people under the age of 18.[34] In Nottinghamshire, five internal investigations were conducted into harmful sexual behaviour between 1988 and 1995 in five separate children's homes.

16. In addition, there were many allegations of sexual abuse falling outside these specific case studies, which relate to other residential homes (such as Amberdale, Skegby Hall, Greencroft and Hazelwood). These are recorded in summary tables,[35] and institutional responses to some of those allegations are addressed further below.

A.4: Methodology

17. The methodology adopted by the Inquiry is set out in Annex 1. Core participant status was granted under Rule 5 of the Inquiry Rules 2006 to 96 core participants, including 88 complainants who alleged they were sexually abused whilst in the care of the Councils.

18. The overarching issues considered in this investigation derived from the scope of the investigation set by the Inquiry[36] and the Terms of Reference for the Inquiry set by the Home Secretary.[37] These were to:

(a) establish the nature and extent of allegations of sexual abuse of children in the care of the Councils and barriers to the disclosure of such abuse;

(b) analyse the institutional responses to allegations and how these have changed, with a particular focus on our case studies;

(c) reach conclusions as to what happened, holding institutions to account for past and current failings; and

(d) make recommendations as to what can improve the situation in the future.

19. After three preliminary hearings, public hearings were held over 15 days in October 2018, including seven days of hearings in Nottingham.

20. At the public hearings, we heard accounts from 12 complainants about their experiences as children who had been sexually abused in care.[38] An additional 71 complainant core participants provided written evidence of their experiences, with parts of each read into the record during the public hearings.[39]

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[33] INQ002574
[34] *Workforce perspectives on harmful sexual behaviour, Findings from the Local Authorities Research Consortium 7*, National Children's Bureau and Research in Practice, p14. Additionally, between one-quarter and one-third of all sexual offences are estimated to be committed by young people under the age of 18 (INQ002045 para. 1.2).
[35] INQ002574; INQ002577
[36] Nottinghamshire Councils investigation Definition of Scope
[37] Inquiry's Terms of Reference
[38] 2 October 2018; 3 October 2018; 4 October 2018; 5 October 2018; 26 October 2018
[39] INQ002574

21. Evidence was provided by institutional witnesses about a range of factual matters. These included: broad questions about the level of managerial scrutiny of residential homes and foster care; how the Councils conducted investigations into staff and foster carers accused of sexual abuse; whether they followed through on what the investigations revealed; and, when they did commission internal reports, how effective the Councils were in carrying out recommendations intended to protect children. Other issues included why children found it so difficult to disclose sexual abuse, what happened when they did disclose and the individual experiences of adults disclosing childhood abuse.

22. Various institutions, including the Councils, Nottinghamshire Police, the Crown Prosecution Service, Ofsted and the Department for Education, also provided corporate statements and documents.

23. The Inquiry commissioned a report from Professor Simon Hackett, an expert on harmful sexual behaviour between children. He is Professor of Child Abuse and Neglect at Durham University and, over the course of the last 20 years, has undertaken a series of research studies and written a variety of articles and books on harmful sexual behaviour. Professor Hackett was asked to provide his opinion on a number of topics, including the developing understanding of harmful sexual behaviour between children, the evolving response to the issue and the barriers to disclosure of this type of behaviour.

24. The Inquiry reviewed a large amount of witness and documentary evidence, which was disclosed to core participants where relevant. Due to the lack of evidence in relation to earlier periods, this report covers the period from the late 1960s to date.

25. References in this report such as 'NSC000102' and 'NSC000102_10' are to documents or specific pages of documents that have been adduced in evidence and can be found on the Inquiry's website. A reference such as 'Hicks 19 October 2018 142/8-23' is to the hearing transcript which is also available on the website; that particular reference is to the evidence of Rhona Hicks on 19 October 2018 at page 142, lines 8 to 23.

Part B

Context

Context

B.1: Introduction

1. Throughout this report, when referring to staff within the Councils who had a statutory responsibility for children, including children in care, we have referred to children's social care. Until 2006, this work was carried out by social services departments, and after then by new children's services departments.[40] The terms 'children's social care' or 'children's social care service' are used throughout for consistency.

B.2: Child protection issues in the early 1990s

2. In the late 1980s and early 1990s, a "*deep rift*" arose between Nottinghamshire Police and the County's children's social care service following a major child abuse investigation involving an extended family in Broxtowe.[41] The investigation led to 10 adults being charged in February 1989 with 53 offences of indecent assault, incest and cruelty against 23 children. In December 1989, a joint enquiry team of police officers and social workers warned that "*there could be a total breakdown of Police/Social Service relationships with incalculable consequences*".[42] By September 1991, the "*extent of this antagonism, and the damage ensuing from it, was … considerable*".[43]

3. In 1991, Her Majesty's Inspectorate of Constabulary (HMIC) and the Department of Health's Social Services Inspectorate (SSI) conducted a joint inspection of child abuse investigations in the County.[44] Although only seven of the 20 cases inspected concerned children in care,[45] the inspectors criticised a lack of training and made a number of recommendations, including that all child sexual abuse investigations should be undertaken by trained officers within Nottinghamshire Police's Family Support Unit (FSU), supported by specialist children's social care staff. They also said the Area Child Protection Committee (ACPC)[46] needed urgently to disseminate revised procedures and provide appropriate training to ensure implementation.

4. Between 1990 and 1995, there was a crisis in the County's child protection capability:

> **4.1.** There were more than 800 'unallocated cases' in 1990,[47] leading to the Department of Health threatening to intervene.[48] This was reduced to zero by the end of 1991.[49]

[40] NSC001235 para. 3c.i.25
[41] INQ002051 para. 37
[42] Nottinghamshire County Council Revised Joint Enquiry Report
[43] NSC000177_8
[44] NSC000184
[45] NSC000184_14
[46] ACPCs (previously Area Review Committees) were multi-agency forums bringing together social services, the police and other agencies to safeguard children. Their remit included developing and agreeing policies and procedures. ACPCs were replaced by Local Safeguarding Children Boards under the Children Act 2004 (see Area Child Protection Committees).
[47] Children for whom children's social care had opened cases but had not allocated a particular social worker (DFE000819_24-25).
[48] DFE000819_21-23
[49] DFE000965_1

4.2. There were 14 child deaths reported to the SSI between 1990 and 1992.[50] One death generated significant publicity, which intensified in December 1993 when the County decided not to start disciplinary proceedings against the social workers involved in the case, and promoted them.[51]

4.3. In 1994, two highly critical internal and external reports on child protection in the County were published.[52]

As a result, the SSI considered there was "*a serious problem*"[53] and the Health Minister had "*very great concerns about the poor performance … in the protection of children at risk*".[54]

5. The County also identified "*serious weaknesses*" in its children's social care service in 1994, with services not meeting the required standards of the Children Act 1989, weak information systems, abandoned internal training programmes, poorly kept records and inadequate recruitment practices.[55] Both David White, the County's Director of Social Services, and Joan Taylor, Chair of the Social Services Committee, subsequently resigned.[56]

6. In September 1994, an SSI inspection concluded that the children's social care service "*had not yet safely established a competent child protection service for children and families in Nottinghamshire*".[57] The SSI became directly involved in 'monitoring'[58] children's social care until August 1995, when the SSI decided that sufficient progress had been made.[59] A further SSI inspection in December 1995 commented that "*considerable efforts had been made … to transform a dismal child protection investigative service*".[60]

7. The Broxtowe investigation occupied significant time and focus,[61] and diverted attention away from child abuse investigations.[62] As a consequence, children in care were not given sufficient priority, despite the large number of investigations and prosecutions into the sexual abuse of children in residential and foster care. There was an unwarranted assumption that they were protected by the carers themselves.[63]

B.3: Governance

Management within the Councils

8. Although management structures have changed over time, staff within the children's social care service have had day-to-day responsibility for all children in care in Nottinghamshire. The Director of Children's Services within each of the Councils now has "*professional*" responsibility for the leadership, strategy and effectiveness of children's services. This includes securing the provision of services to address the needs of children

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[50] DFE000965_1
[51] DFE000965_3-4
[52] *Strong Enough To Care?* Chief Executive's Working Party, July 1994 (NSC000241); *Report of the Inspection of Nottinghamshire Social Services Department's Child Protection Service*, Social Services Inspectorate, September 1994 (NSC001160).
[53] DFE000963_3
[54] DFE000819_1
[55] NSC000241
[56] White 8 October 2018 124/1-18; INQ002051_13
[57] NSC001160_58
[58] This would happen when the SSI had particular concerns about the performance of a local authority (*The Social Services Inspectorate: A history*).
[59] CQC000007; CQC000020_1-2
[60] NSC001170_15
[61] White 8 October 2018 127/18-31/3
[62] INQ002051 para. 37
[63] White 8 October 2018 135/22-136/4; 147/24-148/5

and young people.[64] The Youth, Families and Social Work Division of the County's Children and Families Department is responsible for all children's social care within the County, including fostering and children's homes.[65] In the City, management oversight of children's homes and fostering placements is the responsibility of the Head of Service for Children in Care, who operates within the Children's Integrated Services directorate.[66]

The role of elected councillors

9. The way in which elected members have exercised governance responsibility for children in care has varied over time. Since 2004, both the County and the City have a councillor charged with specific accountability for children in care.[67] That elected Lead Member for Children's Services has political accountability for the leadership, strategy and effectiveness of children's services. This includes setting the priorities for children's services and providing support and challenge to the Director of Children's Services.[68]

10. Collectively, councillors act as the 'corporate parent' for children in care, which requires them to act in the best interests of children in care and ensure that they are kept safe.[69] Councillors also receive regular reports about children in care, including annual reports from the Fostering Service and the Independent Reviewing Officer service.[70]

Oversight of children's homes

11. The oversight of the Councils' children's homes has also developed over time:

11.1. Since the early 1990s, internal 'inspections' have been required by children's social care every month.[71] These were undertaken by children's social care managers until 2014, since when they have been undertaken by an independent person appointed by the Councils.[72]

11.2. From 1991 to 2004, children's homes were also inspected by an 'arm's length' body (structurally independent of those managers responsible for the operation of social services).[73] This involved at least two visits per year – one announced and one unannounced.[74]

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[64] This is a statutory role under s.18(1) of the Children Act 2004 which is held by Colin Pettigrew for the County and Alison Michalska for the City; *Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services*, Department for Education, April 2013

[65] NSC001235 paras 3c.i.25-3c.i.28; Children and Families Structure Chart, Nottinghamshire County Council, June 2018

[66] NCC003691 paras 3.57, 3.124

[67] NCC003691 paras 3.11, 4.5-4.7; NSC001235 para. 4a.16. In the City, this was, until May 2019, the Portfolio Holder for Early Intervention and Early Years (Councillor David Mellen) and is now the Portfolio Holder for Children and Young People (Councillor Cheryl Barnard); in the County, it is the Chair of the Children and Young People's Committee, currently Councillor Philip Owen.

[68] *Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services*, Department for Education, April 2013; *Applying corporate parenting principles to looked-after children and care leavers*, Department for Education, 2018; *Lead member role and key relationships*, Local Government Association, 2015

[69] The seven corporate parenting principles were introduced by the Children Act 1989.

[70] INQ002628 para. 23. Independent Reviewing Officers (IROs) are social workers who have a duty to ensure that care plans are legally compliant and in the child's best interests. See 'What is an IRO?'

[71] For example, see NSC000393. These visits were known as Regulation 22 visits under the Children's Home Regulations 1991, then Regulation 33 visits under the Children's Homes Regulations 2001, and are now Regulation 44 visits under the Children's Homes (England) Regulations 2015

[72] Regulation 43 Children's Homes (England) Regulations 2015

[73] Regulation 28 Children's Homes Regulations 1991

[74] Regulation 28(2)-28(4) Children's Homes Regulations 1991

11.3. Since 2000, all children's homes have been required to register with the registration authority (currently Ofsted).[75] To maintain registration, a children's home must have a statement of purpose, a children's guide and prescribed policies and procedures, as well as prescribed staffing ratios and qualifications.[76]

11.4. Elected councillors have also made visits to homes on a regular basis (called 'rota visits') since the 1970s, and have reported their findings to a committee.[77] These visits vary in their effectiveness, with witnesses describing them as "*next to useless*"[78] and "*widely perceived as a token*".[79]

B.4: Response to allegations of child sexual abuse

Policies and procedures for responding to allegations of child sexual abuse

12. The first national guidance specifically addressing child sexual abuse was in 1988, in *Working Together*.[80] This was followed by 1991 guidance accompanying the Children Act 1989, which included the sexual abuse of children in care.[81]

13. Earlier, between 1974 and 1984, the County issued a succession of memorandums, procedures and guidance for its social services, dealing with "*neglected or battered children*" and non-accidental injury.[82] The County's 1978 'Policy and Procedure Guide (Community Homes)' stated:

> "*Instances of abuse of clients coming to the notice of any member of staff must be reported immediately … The Officer-in-Charge must report all suspicions, or complaints regarding abuse of clients, to the appropriate Homes Adviser …* "[83]

When investigations into allegations of sexual abuse by staff in children's homes were conducted in the 1980s, they broadly followed the 1978 guidelines,[84] although the approach was inconsistent.[85]

14. Policies dealing with child sexual abuse developed over the years:

14.1. In 1984, new multi-agency child abuse procedures within the County included responding to allegations of child sexual abuse made against foster carers, but did not apply to residential care.[86]

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[75] Care Standards Act 2000
[76] Care Standards Act 2000, section 11; The Care Standards Act 2000 (Registration) (England) Regulations 2010; The Children's Homes (England) Regulations 2015. See also *Introduction to children's homes*, Ofsted, July 2018
[77] NSC000451_26-33; NSC001235 para. 3a.18
[78] Tipping 24 October 2018 120/17-25
[79] INQ002957 para. 3. In March 2019, the County decided to cease carrying out rota visits and replace them with a new Governance Board to oversee the County's children's homes. It will still carry out visits but under new guidance, and will consider all reports on Regulation 44 visits (Rota Visits by Elected Members).
[80] NSC000938
[81] EWM000463_35-38. Prior to that, from the 1930s, the Home Office maintained a list of people considered unsuitable to work in approved schools (HOM002409_1, 7) and this was later extended to cover Local Authority Remand Homes and children's homes. There was some Home Office guidance in place from the 1950s relating to "*allegations of indecent practices*" by staff in approved schools (EWM000463_16-17).
[82] NSC001235 paras 3c.iii.1-3c.iii.5
[83] NSC000046; INQ002007 paras 2.27-2.29; Jones 8 October 2018 57/1-58/18
[84] NSC000106; NSC000490
[85] NSC000229; NSC000105_35
[86] NSC000075

14.2. Specific guidance was issued in 1991 on responding to sexual abuse in residential care, both in the County[87] and across England and Wales,[88] following the Children Act 1989.

14.3. The 1992 Nottinghamshire ACPC procedures required an independent investigation by a senior member of staff if an allegation of abuse was made against either a member of residential care staff or a foster carer.[89] The safety of any other children in a foster care household was also to be considered.[90]

14.4. The ACPC procedures emphasised three separate strands to the investigation of allegations against staff: child protection, disciplinary proceedings and criminal proceedings. They clarified that insufficient evidence to support a prosecution "*does not mean that action does not need to be taken to protect the child, or that disciplinary procedures should not be invoked and pursued*".[91]

14.5. From the 1990s onwards, allegations against foster carers generally led to their suspension pending full investigation by children's social care. Other foster children were placed elsewhere and no further placements were made in the interim.[92] Concerns or allegations about a foster carer could lead to their deregistration, sometimes following a recommendation from the fostering panel.[93] Although allegations of sexual abuse should have triggered a review of the foster carer's suitability,[94] reviews did not always happen where the police had decided to take no further action.[95]

14.6. By 2004, the County published guidelines on conducting disciplinary investigations into staff[96] and the City began using their Local Safeguarding Children Board procedures.[97]

15. Both Councils now require all allegations of sexual abuse to be reported to the local authority designated officer (LADO), a role introduced by the Children Act 2004.[98] The LADO is responsible for overseeing the multi-agency response to allegations of abuse made against adults working with children, "*based on professional judgement on the balance of probabilities*".[99]

16. In residential care, the Interagency Safeguarding Children Procedures (which apply to both Councils) set out the steps to follow when allegations of abuse are made against staff.[100] The County[101] and the City[102] also have their own complementary procedures for

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[87] NTP001473_119-233, which were multi-agency procedures, reviewed and updated regularly. See for example 1992 (NTP001473_1-118), 1994 (NSC000077), 1997 (NSC000058) and 2001 (NSC000079).
[88] EWM000463 para. 93
[89] NTP001473_63
[90] NTP001473_63
[91] NTP001473_67
[92] Stimpson 17 October 2018 12/6-11
[93] Stimpson 17 October 2018 5/3-13. There are also examples of this process of deregistration as far back as 1983 (NSC000348_7-8).
[94] Jones 8 October 2018 27/16-23
[95] See, for example, NSC000353 and NSC000368
[96] NSC000124
[97] NCC003691 para. 3.145
[98] See section 17 of the Children Act 2004. The DfE now – following *Working Together* (2015) – uses the term 'designated officer' instead, although LADO is still used by local authorities. County: NSC001235 para. 3c.iii.13-14. City: NCC003691 paras 3.140-3.142; NCC003807 para. 4.1
[99] NCC003807 para. 4.2
[100] Allegations against staff or volunteers, updated January 2019
[101] Managing allegations/concerns in relation to adults who work with children, updated July 2018
[102] Allegations against staff and volunteers, updated November 2018

responding to allegations of abuse. These include multi-agency strategy meetings to discuss the allegations and any parallel disciplinary process or police investigation.[103] If no police investigation or social care enquiry is necessary (or once they are completed), the Councils must consider whether to take disciplinary action.

17. In foster care, all local authorities must set out the procedure to be followed in the event of any allegation of abuse or neglect against foster carers.[104] Detailed standards for handling allegations are set out in the 2011 *National Minimum Standards*.[105] The County's guidance on allegations against foster carers includes the assessment of the seriousness of the initial information, suspension of the foster carer, the continued placement of children, how to react to resignations and the holding of strategy discussions.[106] In the City, when information is received that a child in foster care is suffering or has suffered significant harm, the child's social worker will be informed, a multi-agency strategy meeting will take place and an investigation may follow that can result in the deregistration of the foster carer.[107]

18. For both Councils, the framework for responding to allegations of non-recent abuse of a child in care is broadly the same as for recent allegations, although a number of additional considerations apply.[108]

Notification to local safeguarding board or partnership

19. Between 2006 and 2018, where abuse or neglect of a child was known or suspected and the child had died or been seriously harmed, the Councils' Local Safeguarding Children Boards (LSCBs) would be notified and would make a recommendation if they decided a serious case review or some other form of review was required.[109]

20. LSCBs were, in many local authorities, replaced by Safeguarding Children Partnerships from 2018.[110] Since then, the Safeguarding Children Partnership or LSCB undertakes a "*rapid review*" and considers whether a child safeguarding practice review (the replacement for serious case reviews) is required. Because the criterion of "*seriously harmed*" must be met, not every case of known or suspected sexual abuse of a child in care will be considered by the Safeguarding Children Partnership,[111] and because of the additional criteria, even fewer will proceed to a review.

Notification to councillors

21. Historically, councillors would receive verbal reports from the Director of Social Services in relation to allegations of sexual abuse, although the extent of this varied. For example, the County's Social Services Committee received regular but limited information about disciplinary investigations of staff accused of sexually abusing children in residential care.[112]

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[103] Allegations against staff and volunteers, updated November 2018
[104] The Fostering Services (England) Regulations 2011, section 12
[105] *Fostering Services: National Minimum Standards*, Department for Education, 2011, pp44–46
[106] NSC001133; NSC001341; NSC001235 paras 3c.iii.15; 6k.8
[107] City: Allegations Against Foster Carers
[108] INQ001813_10-11; Interagency Safeguarding Children Procedures, 'Historical and Non-Recent Abuse' (updated July 2015) Historical Cases of Abuse (County, updated January 2017)
[109] The Local Safeguarding Children Boards Regulations 2006, Regulation 5; *Working Together 2015*; NSC001235 para. 3c.iv.10; NCC003691 para. 3.148
[110] Children and Social Work Act 2017, Children Act 2004 (as amended) and *Working Together* 2018
[111] Interagency Safeguarding Children Procedures, 'Child Safeguarding Practice Reviews' (January 2019)
[112] INQ001934 para. 141. They also received updates on the progress of some criminal prosecutions of staff members for the sexual abuse of children in care. They would not necessarily have learnt of allegations made against foster carers because "*in one sense, they're employees, but in another sense, they weren't*" (White 8 October 2018 137/4-7).

Within the City, until the mid-2000s, councillors were informed of serious allegations of sexual abuse of children in care, although there was no formal system in place requiring this.[113]

22. In terms of today's practice, the County introduced ("*about two weeks*" before Councillor Owen, Lead Member for Children's Services in the County, gave evidence to the Inquiry[114]) a protocol for notifying the Lead Member of relevant incidents using an incident notification form.[115] This covers all allegations against members of staff but not all allegations against foster carers or of harmful sexual behaviour[116] and, while a log is to be maintained of all notifications, the level of detail provided will be decided in each case.

23. The City's Lead Member for Children's Services until May 2019, Councillor David Mellen, received verbal reports about allegations of sexual abuse of children in care, although he was not "*involved in the detail*".[117] He thought the last such notification was about two years before our October 2018 hearings,[118] but was fairly confident that he would be told of all allegations.[119] The City did not have a written notification protocol at the time of the hearings.[120] Neither of the Councils has a process by which there has been regular reporting to the Lead Member of the number of allegations of sexual abuse of children in care and the response to those allegations.

Notification to external agencies

24. Since 2001, local authorities have been required to report 'notifiable events' to Ofsted and its predecessors, including the instigation and outcome of any child protection enquiry involving a child in residential care.[121]

25. There are now a number of notification regimes applicable to children's social care, including the following:

> **25.1.** As set out above, allegations of sexual abuse of children, including those in care, where the child "*has been seriously harmed and abuse or neglect is known or suspected*",[122] must be notified to the local Safeguarding Children Partnership or Local Safeguarding Children Board and to external agencies such as Ofsted.[123] Since 2018, the national Child Safeguarding Practice Review Panel must also be notified if a child dies or is seriously harmed and abuse is known or suspected.[124]

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[113] INQ001838 para. 5.5
[114] Owen 23 October 2018 187/2-20
[115] INQ002630; INQ002628 para. 33. Prior to this, the relevant officer would use their "*professional judgement*" as to which matters to bring to the attention of councillors (NSC001235 para. 3c.iii.26).
[116] Allegations against foster carers or of harmful sexual behaviour would only be included if the child was deemed to be "*seriously harmed*" or the case was considered "*likely to attract public interest or media attention*" (INQ002630_2).
[117] Mellen 24 October 2018 84/2-20
[118] Mellen 24 October 2018 82/17-23
[119] Mellen 24 October 2018 87/24-88/3
[120] NCC003807 para. 10.10; Mellen 24 October 2018 88/4-6. However, since then, the City has developed a written notification protocol covering all allegations against staff and foster carers (but not of harmful sexual behaviour). The protocol is still under review (https://www.iicsa.org.uk/key-documents/12159/view/NCC003812.pdf).
[121] Children's Homes Regulations 2001, Regulation 30 and Schedule 5
[122] Under *Working Together* 2015, pp74–75 and *Working Together* 2018, p82
[123] *Working Together* 2018
[124] Section 16C(1) of the Children Act 2004, as amended by the Children and Social Work Act 2017

25.2. The manager of a children's home must notify Ofsted, the Department for Education (DfE) and the local authority of "*serious events*". These include suspected involvement in sexual exploitation (including harmful sexual behaviour) and any allegation of abuse against the home or a person working there.[125]

25.3. Children's social care must notify Ofsted of various matters relating to children in foster care, including the "*instigation and outcome of any child protection enquiry involving a child placed with foster parents*".[126]

25.4. If allegations are substantiated and the perpetrator is still working with children, a referral must be made to the Disclosure and Barring Service.[127] Similarly, if the alleged perpetrator is a qualified social worker, allegations of sexual abuse must also be referred to the Health and Care Professions Council.[128] This does not apply to all residential care staff, as not all are qualified social workers.

B.5: External inspections

26. Until the 1980s, the Home Office and the Department of Health carried out occasional inspections of children's homes. Responsibility for the inspection of children's social care then varied over time.

26.1. In 1985, the SSI was established to inspect social services (including children's social care) in order to "*improve effectiveness and efficiency and to promote necessary development*". However, its focus was on the provision of social services as a whole; it rarely conducted specific inspections of individual children's homes and did not undertake dedicated inspections of fostering services.[129]

26.2. From April 2002, the National Care Standards Commission (NCSC) was responsible for registering children's homes and fostering services and then carrying out inspections after registration.[130] They carried out some,[131] but did not establish a programme of regular inspections.

26.3. The SSI and NCSC were subsumed in April 2004 into the Commission for Social Care Inspection (CSCI), bringing registration, inspection, regulation and review of all social care services (including children's homes and fostering services) under the remit of one organisation.[132] It was only from this point onwards that there were regular external inspections of children's homes and fostering services.

26.4. The CSCI and then Ofsted inspected children's homes at least twice per year.[133] From 2004 to 2013, the Councils' fostering services were subject to specific and regular inspections by the CSCI and then Ofsted, carried out against the framework of the national minimum standards.[134]

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125 Children's Homes Regulations 2015, Regulation 40(4); DFE000962 para. 109
126 Fostering Services (England) Regulations 2011 Schedule 7 and Regulation 36
127 *Managing Allegations/Concerns in Relation to Adults who work with Children*, updated July 2018, para. 9
128 Health and Care Professions Council Employer referral
129 *The Social Services Inspectorate: A History*, Department of Health, 2004, pp1, 11
130 *National Care Standards Commission Account 2001–2002*, The Stationery Office, 2003
131 Such as those carried out into Beechwood in 2002 (see Part C).
132 National Care Standards Commission Account 2001–2002
133 NSC001235 para. 8a.31-32
134 Introduced in the Care Standards Act 2000 and updated in the *Fostering Services: National Minimum Standards* (2011)

27. In April 2007, the registration and inspection of children's services became the responsibility of Ofsted.[135] Between 2007 and 2013, Ofsted conducted separate inspections of each local authority's services in relation to "*protection, care, adoption and fostering*".[136] This changed in 2013 to one single inspection framework,[137] including fostering services in a broader assessment of services for children in care.[138] This regime, criticised as an ineffective method of evaluation,[139] was replaced in 2018 with the Inspection of Local Authority Children's Services (ILACS) framework.[140] Local authorities will continue to be inspected every three years but will also receive up to two "*focused visits*" between inspections that will look at specific issues. The less positive the outcome, the greater the number of follow-up visits and inspections that take place.[141]

B.6: Police approach to allegations of child sexual abuse

National developments

28. As set out in the report by the Crime and Security Research Institute at Cardiff University, commissioned by the Inquiry, the national approach to police investigations into allegations of child sexual abuse has developed over time.[142]

28.1. From 1963, Home Office circulars referred to the need for police forces to work with local authorities in relation to children in need of care, protection and control. By 1988, sexual abuse was included in the definition of child abuse, joint working with social services was expected and the paramount consideration was the welfare of the child.

28.2. By the end of the 1990s, all forces had child protection units, which "*normally*" took primary responsibility for investigating child abuse cases. As a minimum, they were required to investigate all allegations of child abuse within the family or against a carer.[143]

28.3. In the 2000s, both the Laming and Bichard Inquiries[144] criticised HMIC for not taking a sufficiently active role in child protection through its inspections of police forces. The Laming report also recommended that police officers in child protection roles should hold senior rank and have appropriate qualifications.

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[135] NSC001235 para. 8a.32
[136] NSC001235 para. 8a.32; *The new Ofsted framework for the inspection of children's services and for reviews of Local Safeguarding Children Boards: an evaluation*, Ofsted, 2014, p4
[137] *The new Ofsted framework for the inspection of children's services and for reviews of Local Safeguarding Children Boards: an evaluation*, Ofsted, 2014, p4
[138] *Framework and evaluation schedule for the inspections of services for children in need of help and protection, children looked after and care leavers*, Ofsted, 2017, p7
[139] Multi-Agency Inspection of Child Protection: A Position Paper from ADCS, LGA and Solace (2015)
[140] *Inspecting local authority children's services from 2018*, Ofsted, 2017
[141] OFS008346 para. 58; *Inspecting local authority children's services from 2018*, Ofsted, 2017
[142] EWM000464
[143] As asserted in *Working Together* 1999 (NTP001481 para. 3.58).
[144] The Victoria Climbié Inquiry: report of an inquiry by Lord Laming (2003) followed the abuse, neglect and murder of Victoria Climbié. The Bichard Inquiry (2004) concerned child protection measures, record keeping, vetting and information sharing in Humberside Police and Cambridgeshire Constabulary, following the conviction of Ian Huntley for the murders of Jessica Chapman and Holly Wells.

28.4. Since 2010, there has been a significant increase in the volume of allegations of non-recent sexual abuse, and an HMIC thematic review of child protection in eight police forces in 2014–15[145] found that some forces were struggling to manage rising investigative demands with "*systemic weaknesses*" and high workloads.

Nottinghamshire Police

29. Practices in Nottinghamshire Police have also developed over time.

29.1. In the 1970s, allegations of child abuse were investigated by officers in its Criminal Investigation Department (CID), who would make decisions on whether to prosecute and report outcomes to children's social care.[146] Under multi-agency child abuse procedures in the County from 1984, police investigations[147] were to include regular contact with children's social care and attendance at case conferences.

29.2. The force's first specialist resource – the FSU – was established in 1988 to investigate child abuse allegations (although the CID continued to investigate some cases). It expanded over subsequent years to include a referral unit as a dedicated point of contact for all cases referred to the police by children's social care.[148] In 1994, the FSU was renamed the Child Abuse Investigation Unit (CAIU)[149] and, by 1995, according to the SSI, it had the most officers per capita of all police units in the country specialising in child protection investigations.[150]

29.3. There have been various iterations of procedures and guidance for Nottinghamshire Police on the investigation of child sexual abuse, including in 1992,[151] 1997[152] and subsequently.[153] In 2006, the force published its first specific Child Protection Investigation Procedures, which stated that a thorough investigation was required in all cases of alleged sexual abuse. The CAIU was responsible for investigating all allegations of sexual abuse of children in care by a foster carer or residential care staff member, where the complainant was still a child at the time of the allegation being made. Allegations of non-recent child abuse, where the complainant was over 18 years old at the time of the disclosure, were investigated by the CID.[154]

29.4. In 2011, Nottinghamshire Police formed a Public Protection Department, bringing together "*the various strands of police business that feature vulnerability and safeguarding*", including the CAIU, child sexual exploitation and Operation Equinox.[155]

30. However, a number of recent inspections and reviews identify serious failings concerning Nottinghamshire Police's investigations of allegations of child sexual abuse (including child sexual exploitation) and its relationship with the Councils.

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[145] *In harm's way: The role of the police in keeping children safe*, HMIC, July 2015
[146] NCC003691 para. 6.22; NTP001536 para. 22
[147] NSC000075_40-41. These procedures applied only to abuse in the home (including foster care).
[148] NSC000184_15; NTP001536 paras 24, 27
[149] NTP001536 para. 31
[150] NSC001170 para. 1.33
[151] NTP001473_1-118
[152] NTP001474
[153] NTP001536 para. 15; NSC000082
[154] NTP001536 paras 126-127; NTP001495_11-13
[155] NTP001536 para. 35

30.1. A peer review[156] of Nottinghamshire Police's child sexual exploitation capabilities in December 2014 found that "*Social care and police appear to be working well together*". However, it also noted a "*structural divide between City and County working*" which was creating barriers to joint working, and that "*Care Homes and Private providers are apparently engaged with more effectively in the City than the County, largely because of dedicated police post in the City, match-funded by social care … The County approach needs to replicate this standard.*"[157]

30.2. An HMIC report in February 2015 identified a backlog in child protection cases. For example, there were delays in investigating an allegation of sexual assault made by a 10-year-old boy in foster care. Poor investigations were attributed to a "*lack of capacity and the high volume of work*", with "*an increase in the number of historic abuse cases*". Inspectors said that "*much more needs to be done*"[158] and made a number of recommendations, including that the force (together with children's social care and other relevant agencies) carry out a review to ensure that it was discharging its statutory responsibilities.[159]

30.3. A follow-up inspection, published in February 2016, found that Nottinghamshire Police had implemented some recommendations but "*had not undertaken an audit of child abuse and sexual exploitation cases to improve standards*". It also noted that "*non-specialist staff, such as frontline officers, were investigating child protection cases without having received training in how to manage them effectively*".[160] In response, the force implemented an action plan.[161] When asked why some of the recommendations were not acted upon earlier, the Police and Crime Commissioner for Nottinghamshire, Paddy Tipping, told us:

> "*the Nottinghamshire Police didn't fully embrace the findings of the 2014 study. They thought it was unfair and misjudged and didn't pay sufficient attention to providing the reports and actions that were necessary in the three and six months that were asked for by the inspectorate*".[162]

This was ultimately an issue for the Chief Constable, who is responsible for directing and controlling the force,[163] but it is also one of the Police and Crime Commissioner's "*key roles*" to hold the Chief Constable to account.[164]

30.4. In August 2016, as part of national recommendations for forces to review each other's public protection arrangements, Lancashire Police carried out a peer review of Nottinghamshire Police. While it noted "*real strength*" within the staff and some "*positive relationships*" with social care, it also identified "*significant concern regarding the staffing levels of the public protection team*" and "*staff dealing with child protection were under pressure and managing high levels of work, comments such as 'we are waiting for something like baby P to happen' … appeared common place*".[165] This led to the creation of a multi-agency sexual exploitation panel and a cross-authority perpetrator panel,

[156] Peer reviews involve an evaluation by officers and specialists from another police force.
[157] NTP001514
[158] NTP001510
[159] NTP001510_30-31
[160] NTP001512
[161] NTP001538
[162] Tipping 24 October 2018 146/4-12
[163] The Policing Protocol Order 2011
[164] Tipping 24 October 2018 122/8-13; INQ002570 para. 14
[165] NTP001515

both attended by the "*Police, Social Care and the Charitable/Voluntary sector*".[166] The force also restructured its Public Protection Department, dividing it into three thematic portfolios – (a) children – including the CAIU, child sexual exploitation internet abuse and 'Working Together' teams, (b) adults – including rape and domestic abuse, and (c) quality, compliance and strategy – to "*Ensure the implementation of national best practices and recommendations from the various sources of scrutiny*".[167]

30.5. In 2016, the HMIC PEEL report rated Nottinghamshire Police as 'inadequate' in its effectiveness in protecting vulnerable people from harm and supporting victims, a deterioration since the previous report.[168] The 2017 PEEL report rated the force as 'requires improvement' on protecting vulnerable people (although its overall assessment was 'good').[169] The Police and Crime Commissioner told us that he was "*surprised, disappointed and more than a little irritated, in that it had been made very clear through a succession of HMIC reports that there needed to be improvements in this area.*"[170]

31. Chief Superintendent Robert Griffin of Nottinghamshire Police told us that the majority of the issues identified have now been addressed.[171] In particular, a number of the difficulties faced by the force were connected to the "*investment of resource into Public Protection. There is a lot of reference in these documents to child abuse being under-resourced, and we put that right.*"[172] The force, he said, now takes "*a much more holistic approach to vulnerability*".[173] It also tracks all HMIC[174] recommendations, under the leadership of the Deputy Chief Constable. As at September 2018, there were 44 separate ongoing 'actions' in response to recommendations, covering eight areas, including children in care, investigations, child sexual exploitation and delay.[175]

32. As at October 2018, the sexual abuse of children in care continued to be investigated by officers within the Public Protection Department, either by Operation Equinox (for non-recent abuse) or by the CAIU.[176] Nottinghamshire Police has a specific procedural guide on the investigation of sexual abuse[177] and the 'Child Abuse Investigation Procedure PD513',[178] as well as multi-agency procedures.

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[166] NTP001541
[167] NTP001539_7; NTP001536 para. 222
[168] *PEEL: Police effectiveness 2016* (INQ001036). A PEEL report is an annual assessment carried out by HMICFRS of police effectiveness, efficiency and legitimacy.
[169] *PEEL: Police effectiveness 2017* (NTP001694).
[170] Tipping 24 October 2018 149/5-9
[171] Griffin 25 October 2018 211/9-14. This is also reflected by the most recent PEEL report, published after the conclusion of our hearings in October 2018, in which Nottinghamshire Police were assessed as 'Good' for protecting vulnerable people (*PEEL: police effectiveness, efficiency and legitimacy 2018/19*, HMICFRS, 2019).
[172] Griffin 25 October 2018 207/13-208/9
[173] Griffin 25 October 2018 209/18-210/15
[174] Since 2017, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).
[175] INQ002570 para. 66
[176] INQ002371 paras 8, 13
[177] INQ001968
[178] NTP001498

B.7: Crown Prosecution Service approach to allegations of child sexual abuse

Background to the Crown Prosecution Service

33. The Crown Prosecution Service is responsible for prosecuting cases investigated by the police in England and Wales.[179] It was established by statute, which set out that its functions included taking over the conduct of criminal proceedings instituted by the police, giving advice to the police, and instituting and having the conduct of criminal proceedings where appropriate.[180] It is independent of government and, as "*an objective referral authority*", is only able to act on the information provided by the police.[181] Its role is to make "*independent and objective decisions about the prospect of a jury convicting of a criminal charge*".[182]

34. Prior to the formation of the Crown Prosecution Service in 1986, the police were responsible for investigating most crime, deciding whether to prosecute and conducting the prosecution.[183] When the Crown Prosecution Service was established, it took on responsibility for deciding whether to prosecute and for conducting the prosecution[184] after the police had decided to charge a suspect.[185]

35. Since 2004, the Crown Prosecution Service has made charging decisions[186] in all but minor cases.[187] It does so in accordance with *The Code for Crown Prosecutors* (the Code),[188] as well as its *Guidelines on Prosecuting Cases of Child Sexual Abuse*.[189] Prosecutors may authorise a charge or continue a prosecution against a suspect only where the 'Full Code Test' is passed,[190] that is:

- there is a realistic prospect of conviction and
- the public interest requires a prosecution.

Since 1986, in cases of sexual offences against children, where there is a realistic prospect of conviction then "*there will seldom be any doubt that prosecution will be in the public interest*".[191]

36. There has been concern about the low number of prosecutions resulting from Operation Daybreak. Sue Matthews (the Crown Prosecution Service reviewing lawyer for Operation Equinox) explained that every case is different and must be considered individually.[192] While it has been accused of 'cherry picking' cases to prosecute,[193] the Crown Prosecution Service "*in a sense do have to cherry pick*" as it is only those cases where the test is satisfied that can be prosecuted.[194]

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[179] CPS002848 para. 1
[180] Prosecution of Offences Act 1985
[181] CPS004657 para. 3
[182] CPS004657 para. 1
[183] Other than a small number of serious and complex cases, which were referred to the Director of Public Prosecutions (CPS004382 para. 6).
[184] Prosecution of Offences Act 1985; *The Review of the Crown Prosecution Service*, June 1998, at para. 3
[185] NSC000077_34
[186] Different phrases are used to describe the decision about whether an alleged perpetrator should be charged, including "*preferring criminal charges*" (NTP001473_156), "*charging decision*" (CPS004382 para. 127), "*prosecution decision*" (CPS004382 para. 86), and "*authorise a charge*" (CPS004382 para. 76xiv).
[187] Following the implementation of the Criminal Justice Act 2003
[188] The Code for Crown Prosecutors, CPS, 2018. The first Code was dated 1986, and the current edition is its eighth (CPS002784; CPS002790).
[189] CPS002811
[190] CPS002788
[191] CPS002784
[192] Matthews 23 October 2018 35/21-36/5; CPS002790
[193] INQ002609 para. 45; Coupland 24 October 2018 177/20-178/25
[194] CPS004657 para. 7

Decisions to prosecute

37. The factors that the Crown Prosecution Service takes into account when deciding whether to prosecute are set out in the Code[195] and in prosecution guidance.[196] Witnesses in this investigation referred to a number of considerations in cases of child sexual abuse:

37.1. Failure to disclose earlier: Ordinarily, the Crown Prosecution Service will not refuse to charge solely because a complainant has not disclosed their abuse previously. Allegations of non-recent and institutional abuse are "*common*" and there are "*good reasons*" why such cases do not come to light at the time.[197]

37.2. Complainants' previous convictions: Convictions must be disclosed to the defence and so may be used to allege that the complainant is dishonest or untruthful.[198] It is an "*essential*" part of the prosecution case to explain to the jury the circumstances behind any relevant offending by a complainant, which may be a reaction to abuse or because the complainant is under the influence of the abuser.[199]

37.3. The credibility of children: Until 1994, juries were generally warned by the judge of the risk of convicting a suspect in cases of alleged sexual abuse based on a single complainant's evidence, as the "*credibility and credit of the child will often be of limited value*".[200] However, since at least 2009, the evidence of a child has been regarded as no less reliable than that of an adult.[201]

37.4. Corroboration: Although prosecutors should consider whether there is any credible evidence suggesting a false allegation, "*prosecutors should guard against looking for 'corroboration' of the victim's account or using the lack of 'corroboration' as a reason not to proceed with a case.*"[202]

37.5. Mental health, drug and alcohol issues: The Crown Prosecution Service now recognises, in its guidance, that some complainants may have particular mental health vulnerabilities.[203] Similarly, while drug or alcohol dependency may impact on a complainant's ability to give evidence, the Crown Prosecution Service may still prosecute such a case.[204]

37.6. Previous sexual history: While it is not uncommon for records in historical cases to describe complainants as 'promiscuous', this should not now be a relevant factor in making a charging decision.[205]

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[195] CPS Code 2018
[196] CPS002802; *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018)
[197] CPS002800_12-14
[198] CPS002811 para. 61
[199] *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018) para. 62
[200] CPS002791. This practice, known as a 'corroboration warning', was abolished by the Criminal Justice and Public Order Act 1994, confirmed in R v Makanjuola [1995] 1 WLR 1348.
[201] CPS002802_4
[202] *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018)
[203] *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018) paras 57, 113
[204] Matthews 23 October 2018 46/10-19
[205] As recently as 2000, this was still used as a factor by the Crown Prosecution Service in a decision about whether to prosecute Dean Gathercole, a former residential care worker (CPS004387 para. 48), although since 1999 there has been a general prohibition on the admission of evidence of, and questions about, previous sexual history (CPS Guidance on Rape and Sexual Offences – Chapter 4: Section 41 Youth Justice and Criminal Evidence Act 1999).

37.7. Contemporaneous records: Prosecutors must ensure that complainants who have been in care are not disadvantaged by the fact that they will likely have a great deal of information recorded about them.[206] Records or the absence of records need to be treated with caution.[207] In non-recent abuse cases, records are often incomplete, though this should not be a bar to prosecution.[208]

37.8. Simultaneous civil claim: Complainants may bring a civil claim for the abuse at or around the same time that a criminal prosecution is being considered. Though the defence could question whether there is a financial motive for the disclosure, civil litigation should not impact on a charging decision unless there are substantial conflicts between the accounts given in the civil litigation and to the police.[209]

38. A decision not to prosecute (or to take no further action) does not mean that the abuse did not take place or that the Crown Prosecution Service has concluded that it did not happen. The question is whether or not the prosecutor could conclude that there was a realistic prospect of conviction, bearing in mind that the criminal standard of proof is high.[210] A second opinion may be obtained on decisions to take no further action or discontinue cases involving rape or serious sexual offences.[211]

39. After the Crown Prosecution Service decides (generally speaking) whether to authorise charges following allegations of child sexual abuse, it is the police who are responsible for informing complainants about the decision whether or not to prosecute.[212] A complainant is entitled to a review of that decision.[213]

40. It is possible for a decision to take no further action to be subsequently overturned, for example, if new evidence becomes available or if the original decision was "*obviously wrong*".[214] This decision is made by a Chief Crown Prosecutor for the relevant area or, if made as a result of a challenge under the Victims' Right to Review scheme, by a Deputy Chief Crown Prosecutor.[215] For example, the Crown Prosecution Service decided in 2006 to take no further action in relation to NO-A286's allegations against Stephen Noy but, in 2014, this decision was overturned and charges authorised because there was additional evidence relating to the complainant's mental health and another witness had come forward.[216]

B.8: Operations Daybreak, Xeres and Equinox

41. Since 2010, Nottinghamshire Police has been investigating allegations that former residents of children's homes in the City (Operation Daybreak) and County (Operation Xeres) were sexually and physically abused. These investigations were combined in 2015 into Operation Equinox.

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[206] *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018) para. 53
[207] Matthews 23 October 2018 41/18-42/15
[208] Shallow 22 October 2018 110/6-15
[209] Matthews 23 October 2018 22/4-24
[210] Matthews 23 October 2018 12/12-21
[211] CPS002802_26; *Thematic Review of CPS Rape and Serious Sexual Offences Units*, HM Crown Prosecution Services Inspectorate, 2016 – from 2006 this was a mandatory requirement but, since a Crown Prosecution Service internal review in 2016, it is now discretionary.
[212] *Code of Practice for Victims of Crime*, Ministry of Justice, 2015, p22
[213] Either under the police or Crown Prosecution Service's Right to Review Schemes (*Code of Practice for Victims of Crime*, Ministry of Justice, 2015, p23).
[214] Matthews 23 October 2018 19/7-20/6
[215] Reconsidering a Prosecution Decision, CPS Legal Guidance
[216] Matthews 23 October 2018 18/11-21/17; CPS003406; CPS003423; *The Code for Crown Prosecutors*, CPS, 2018

Operation Daybreak

42. Following receipt of two civil claims by the Councils in December 2009 and June 2010, alleging physical abuse at Beechwood,[217] a multi-agency strategy meeting was held in August 2010[218] and Nottinghamshire Police's CAIU subsequently started an investigation. Initially, limited progress was made, although alleged victims and perpetrators were interviewed.

43. In June 2011, as a result of further allegations received,[219] Nottinghamshire Police initiated Operation Daybreak, a dedicated investigation into allegations of non-recent abuse at Beechwood from the 1960s onwards. All allegations of sexual abuse were to be investigated,[220] but allegations of physical abuse were only to be pursued if the suspect still worked with children.[221] The investigation was extended in 2013 to include other City children's homes.[222] In terms of scale, there were approximately 15 allegations of sexual abuse made to Operation Daybreak in 2011, 20 in 2012, 20 in 2013 and 40 in 2014.[223]

44. However, evidence from witnesses involved in Operation Daybreak, and from reviews carried out at the time, suggest that its progress was hampered by three main issues:

44.1. The lack of a dedicated Senior Investigating Officer (SIO): Detective Inspector (DI) Yvonne Dales, the initial SIO of Operation Daybreak, retained responsibility for the CAIU at the same time.[224] The lack of a full-time SIO to supervise and control the investigation on a day-to-day basis had a negative impact[225] and it was not until January 2015 that a full-time dedicated SIO (DI Pete Quinn) was appointed.[226]

44.2. Staffing: Staffing levels were "*at a minimum*" from the outset.[227] Concerns about the impact of insufficient resources were raised as early as September 2011[228] and subsequently by team members and in independent reviews.[229] An October 2014 peer review identified "*current resources*" as "*insufficient to manage the demand*".[230] The Police and Crime Commissioner was aware that Operation Daybreak was under-resourced but was assured at the time by the Chief Constable that it was manageable.[231] However, Nottinghamshire Police now accepts that resourcing for the scale of the investigation was "*wholly inadequate*" and affected the "*pace of the investigation*".[232]

[217] Two earlier and similar claims had been made, in 2002 and 2007 (NCC000308_3).
[218] NCC003691_77-78 para. 7.33; NCC000301; NCC000302
[219] NCC000304
[220] NTP001653
[221] NTP001519_36
[222] Dales 22 October 2018 25/10-26/10; NTP001641
[223] NTP001487_2
[224] Dales 22 October 2018 59/2-19
[225] NTP001519_44-45
[226] Dales 22 October 2018 16/21-17/3
[227] NTP001650; NTP001645; NTP001653; Dales 22 October 2018 6/18-10/11
[228] NTP001653
[229] November 2012: NTP001650, December 2012: NTP001641, March 2013: NTP001645, April 2013: NTP001645, August 2013 (independent review): NTP001517, July 2014: NTP001649, October 2014 (independent review): NTP001518, May 2015 (independent review): NTP001519
[230] NTP001518
[231] Tipping 24 October 2018 123/7-125/16
[232] Griffin 25 October 2018 189/6-190/4

44.3. Attempt to scale down the investigation: Despite requests for more resources and the increasing numbers of allegations, senior officers requested in 2014 that the investigation be scaled down or even closed down.[233] An external review in October 2015 recommended that the investigation should continue.[234]

Senior officers in Nottinghamshire Police should have ensured that the investigation was prioritised and adequately resourced.

45. There was "*really, really helpful*"[235] early engagement between the police and the Crown Prosecution Service, with the reviewing lawyer also involved in providing early investigative advice such as whether to reinterview a complainant or which lines of enquiry needed to be followed.[236] There was no overall policy about how cases were to be approached; each case was judged on its own merits.[237] On completion of an individual investigation, the Operation Daybreak SIO assessed "*whether the evidence available provided a reasonable suspicion that the offence had been committed*".[238] If not, no further action was taken and the complainant was informed. If the test was passed, a comprehensive advice file was sent to the Crown Prosecution Service, which decided whether to charge based on the 'Full Code Test'.[239]

46. A number of files were passed to the Crown Prosecution Service for a decision on whether to authorise charges. However, there were no prosecutions for sexual abuse during the lifespan of Operation Daybreak.[240]

46.1. In September 2012, the Crown Prosecution Service concluded that there were too many problems with each allegation against three suspects (NO-F2, NO-F1 and NO-F10), including concerns about collusion between complainants.[241]

46.2. A single allegation against John Dent[242] did not proceed to charge in February 2013, due to inconsistencies with the dates of the alleged offence and issues of identification.

46.3. In June 2013, the Crown Prosecution Service determined there was no reasonable prospect of conviction in relation to NO-A86's allegations of serious sexual abuse by staff members, and that her allegations of rapes and murders of residents by NO-F11 were "*not true*".[243]

46.4. In June 2014, a decision was taken not to prosecute NO-F1 for sexual abuse at Beechwood and Ranskill Gardens.[244]

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[233] NTP001649_1; Dales 22 October 2018 47/13-48/9; INQ001986 para. 22; INQ002431
[234] INQ001780 paras 6.1-6.7; NTP001518
[235] Dales 22 October 2018 18/13-23
[236] CPS004386 paras 20-21
[237] Matthews 23 October 2018 35/21-36/5
[238] INQ001780 paras 3.11-3.13
[239] NTP001519_5. The full code test is outlined at paragraph 35 above.
[240] Although subsequent convictions, such as that of Andris Logins, were achieved as a result of investigative work done during Operation Daybreak.
[241] CPS002612
[242] CPS003332_24-30 – John Dent, who worked at Beechwood in the 1970s, was convicted of sexual offences against four complainants and sentenced to seven years' imprisonment (NTP001519_27; INQ001683).
[243] CPS003415
[244] CPS003386

A review by East Midlands Police in May 2015 found all of the Crown Prosecution Service decisions not to prosecute to be "*understandable*"[245] and supported most of the SIO's decisions not to proceed with cases.[246]

Operation Xeres

47. In 2014, Nottinghamshire Police received more than 10 allegations of non-recent abuse in relation to children's homes in the County.[247] In early 2015[248] the force launched Operation Xeres to investigate allegations of non-recent abuse at nine children's homes previously managed by the County.[249] However, by June 2015, Operation Xeres had also stalled due to "*staffing issues*".[250]

Operation Equinox

48. In August 2015, Operations Daybreak and Xeres were merged to form Operation Equinox,[251] in order to ensure a more consistent approach to investigating allegations and to amalgamate resources. In total, as at March 2018, 832 allegations of sexual or physical abuse had been made to Operation Equinox by 355 different complainants against 559 suspects, 63 of whom had died.[252]

49. In some cases, the police decided that no further action should be taken as the threshold for passing the case to the Crown Prosecution Service was not met.[253] In others, the Crown Prosecution Service concluded there was no realistic prospect of conviction.[254] There have been several successful prosecutions arising out of Operation Equinox.

49.1. Andris Logins was convicted in March 2016 of four counts of rape, 12 counts of indecent assault, and one count of child cruelty, related to his time as a residential care worker at Beechwood in the 1980s. He was sentenced to 20 years' imprisonment.[255] As he was a registered social worker at the time of his conviction, he was removed from the social work register.[256]

49.2. Barrie Pick, a former member of staff at Beechwood, was convicted in December 2017 of the sexual abuse of a male resident between 1976 and 1977, and was sentenced to six years' imprisonment.[257]

49.3. Dean Gathercole was found guilty in May 2018 of six counts of indecent assault and three counts of rape at Amberdale in the 1980s. He was sentenced to 19 years' imprisonment.[258]

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[245] NTP001519_13, 18, 25, 29
[246] NTP001519_30. 31, 32, 33, 45
[247] NTP001487_2
[248] NTP001542; NTP001536 para. 40
[249] INQ001876 para. 14; NTP001536 para. 40
[250] NCC000084
[251] NTP001536 para. 40; NTP001689; INQ001876 para. 15
[252] INQ001667
[253] INQ001780 paras 2.28, 3.11-3.14
[254] For example CPS003377; CPS004386; CPS003375
[255] INQ001671; INQ001682
[256] INQ001154
[257] INQ001688; CPS003381; CPS004386
[258] INQ003771

49.4. Myriam Bamkin was sentenced to 30 months' imprisonment in June 2018 after pleading guilty to having sex with a 15-year-old male resident at Amberdale in 1985. In his sentencing remarks the judge noted that, although a member of staff reported the concerns at the time, "*The head of the unit appeared to have told that member of staff to keep it to himself and it was swept under the carpet.*"[259]

49.5. Christopher Metcalfe, a former member of staff at Skegby Hall and a foster carer, was convicted in September 2018 and sentenced to two years and nine months' imprisonment for indecently assaulting two girls.[260]

49.6. David Gallop, a former social worker for the County, was sentenced in October 2018 to 21 months' imprisonment for sexually abusing a child in the 1970s when the child was placed at Hazelwood.[261]

49.7. Michael Robinson was convicted in January 2019 of sexually abusing boys at Hazelwood in the 1980s and was sentenced to eight years' imprisonment.[262]

50. In May 2018, the police carried out an analysis to try to identify whether any collusion took place between suspects or offenders whilst working at Beechwood and whether any collusion could be considered to be a "*Paedophile Ring*".[263] Six alleged or convicted offenders – John Dent, NO-F29, NO-F1, NO-F11, NO-F49 and NO-F2 – were reviewed.

> "*The combined results support the hypotheses that a small and limited level of collusion may have taken place between suspects but the evidence is not robust enough to support the existence of a Paedophile Ring.*"

As Chief Superintendent Griffin explained, some of the six suspects were working together at the same time and therefore had had the opportunity to act together. However, it was not possible to conclude that they had in fact done so.[264]

51. Operation Equinox remains ongoing.[265] Chief Superintendent Griffin told us that Nottinghamshire Police has established a dedicated non-recent child abuse investigative team which will continue beyond the lifespan of Operation Equinox.[266] It is unclear whether this will continue indefinitely or how it is to be structured.

[259] INQ003778
[260] https://www.nottinghampost.com/news/local-news/former-teacher-71-jailed-historical-2087382
[261] https://www.itv.com/news/central/2018-10-11/former-social-worker-jailed-for-sexual-abuse-40-years-ago/
[262] https://www.nottinghampost.com/news/nottingham-news/former-childrens-home-boss-locked-2471885
[263] NTP001654
[264] Griffin 25 October 2018 195/1-196/5
[265] For example, in February 2019, Nigel Pipe was charged with 27 counts relating to sexual abuse of children at Skegby Hall between 1965 and 1969, whilst he was Housemaster (*Nottingham Post* 1 February 2019).
[266] Griffin 25 October 2018 197/8-198/13

Part C

Case study: Beechwood

Case study: Beechwood

C.1: Introduction

1. The investigation's first case study concerns Beechwood Children's Home, which was comprised of four units: The Lindens, Redcot, Enderleigh and a central administration and teaching block. The case study examines institutional responses to child sexual abuse and barriers to disclosure of allegations. It also considers the changing function of the home, the environment for the children resident there, and changing internal management arrangements.

2. A large number of allegations of sexual abuse have been made against members of staff at several children's homes across the County and City over a number of years.[267] Beechwood was selected as a case study, amongst other reasons, because it had been the subject of an extensive police investigation and was also the subject of the largest number of allegations of sexual abuse by complainant core participants made to the Inquiry.

Beechwood Children's Home, mid-1980s

[267] INQ002577; INQ002574

C.2: Allegations of abuse at Beechwood

3. Five witnesses gave their accounts of being sexually abused at Beechwood at our October 2018 hearings and around 35 other complainant core participants provided statements,[268] a summary of which were read into the record. Additionally, 100 further accounts of sexual abuse were collated from police interviews, civil litigation claims and other records.[269] Nottinghamshire Police recorded 166 allegations of sexual abuse at Beechwood between 1968 and 2005, the vast majority relating to abuse in the 1970s and 1980s.[270]

4. The range of abuse alleged at Beechwood includes the following:

4.1. A79 was in Beechwood twice in the 1960s and early 1970s. During each placement, he says he was raped by a member of staff.[271]

4.2. P18 was placed for a "*few nights*" with her siblings in The Lindens between 1968 and 1970, when she was between five and 10 years old. She remembers being taken out of her bed at night by a male member of staff. She says she would be taken to another room where he would touch her all over her body and make her touch his groin. This happened several times.[272]

4.3. D10 was in Beechwood between 1971 and 1972. He alleges that he was taken from a dormitory in the middle of the night and brought to an office by a male member of staff where he was forced to the floor and raped.[273]

4.4. D7 was placed in Enderleigh for three weeks in 1977, aged 15. She says John Dent sexually assaulted her; in one incident he attempted to rape her, and in another she was digitally penetrated. Dent let D7 know that he had control over where she would go after Enderleigh, and she "*felt very alone*".[274]

4.5. C21 was placed in The Lindens for nine months in 1977, when he was aged 14. He alleges that he was raped by NO-F29 in a laundry room and indecently assaulted by him in the showers. It made him feel "*Sick, dirty and, ashamed. And fearful it might happen again.*"[275] NO-A320,[276] D22[277] and L50[278] also allege that NO-F29 indecently assaulted them. D35[279] alleges that NO-F29 was one of two members of staff who raped him. All were at Beechwood in the late 1970s and early 1980s.

4.6. L17 was placed in Redcot for almost a year in 1979, aged 11. She says she was raped by a member of staff, Colin Wallace, on "*four or five occasions*". She also alleges she was made to masturbate Wallace when other staff were in the room so she thought

[268] INQ002574
[269] INQ002577
[270] NTP001657: it is not clear whether this refers to the total number of allegations, or the total number of complainants making allegations.
[271] INQ002574
[272] P18 3 October 2018 140/17-144/18
[273] INQ002574
[274] D7 2 October 2018 67/15-103/19
[275] C21 2 October 2018 154/20-179/8
[276] INQ002577
[277] INQ002574
[278] INQ002574
[279] INQ002574

they must have known what was going on. She described the impact after she left care, saying that people in the community "*know you are damaged. So they find that it's easier to groom you, and as soon as I came out of the children's home that's what I encountered.*"[280]

4.7. N1 was placed in Beechwood in 1982 when aged 12. She was groomed and raped by Andris Logins, a member of staff.[281]

4.8. L23 alleges that in 1984, when she was placed at Beechwood aged 16, she was raped in her bedroom "*on around three occasions*" and sexually assaulted in the communal toilets by Andris Logins: "*He would pull me around, pin me down and suck my neck to give me love bites.*"[282]

4.9. L27 was in Beechwood in 1994 to 1995. He alleges that he was forced to perform oral sex on multiple occasions as well as being indecently assaulted by NO-F363 and another staff member.[283]

4.10. L29 was placed in Beechwood for four months in 2005, when he was 15 years old. NO-F61, a male member of staff, allegedly forced him more than once to perform oral sex on him. Once, when L29 resisted, NO-F61 punched him in the face.[284]

4.11. In 2005, L51 alleged that NO-F7 behaved towards her in a "*sexual manner*" by rubbing himself against her on a number of occasions at Beechwood in 1985.[285]

5. Many complainants told us that, by giving their accounts of abuse, they wanted to ensure that the same did not happen to young people now in residential care.[286]

C.3: Residential care

Introduction

6. For the purposes of this report, we use 'children's homes' or 'residential care' to refer to all residential children's homes, including observation and assessment centres.[287]

7. In England, around 40 percent of children in care in the mid-1970s were placed in residential care.[288] Numbers have continued to decline over the last 40 years, with 11 percent of all children in care in England in residential care by 2018.[289] The capacity of a children's home also reduced over time, from more than 10 in 1985 to fewer than seven by 1995. By 2016 the average was four.[290] The age of those placed in residential care has progressively increased, so that by 2012 most children were over the age of 12.[291] From

[280] L17 2 October 2018 105/22-153/20
[281] N1 3 October 2018 22/3-34/4
[282] L23 3 October 2018 148/20-152/25
[283] INQ002574
[284] INQ002574
[285] INQ002574
[286] For example, L48 (L48 4 October 2018 48/7-14) and D7 (D7 2 October 2018 102/5-6).
[287] Children's homes are more generally a subset of residential care, which has also included Approved Schools (which became Community Homes with Education), Observation & Assessment Centres (O&A Centres), Secure Units, speciality homes and others.
[288] *Residential Care in England*, Sir Martin Narey, 2016, p6
[289] Children looked after in England, year ending 31 March 2018, p7. This includes children placed in secure units, children's homes and semi-independent living arrangements.
[290] *Residential Care in England*, Sir Martin Narey, 2016, p8
[291] See *Living in Children's residential homes*, Berridge & others, 2012, p4

the 1980s, children in residential care tended to be older (over 10 years old). The policy was to place younger children in foster care.[292] These national trends are reflected in Nottinghamshire.[293]

8. In his report for the Inquiry,[294] Professor David Berridge identified a number of related themes in the development of residential care in England, including:

- the stigma of being in care and the perception that children are in residential care somehow due to their own fault;
- residential care within children's services "*receiving less attention than it requires and its deficiencies remaining unaddressed for too long*";
- the professional and social isolation of residential care workers, with a lack of professional development resulting in "*outdated, insensitive or harmful practices*";
- "*very often, local government oversight of residential homes has been inadequate*" and external oversight only gradually introduced; and
- the concentration of particularly vulnerable groups of older children and adolescents previously neglected and physically or sexually abused for "*predatory men*".[295]

These themes are apparent throughout the Councils' residential care provision, including at Beechwood.

Developments in residential care in the County and the City

9. Residential care provision by the Councils suffered from persistent problems over the years, including low staffing ratios, lack of qualifications and training, poor standards of accommodation, inadequate resources and insufficient external supervision.[296]

10. A 1975 report from the County's children's social care service found that children's homes offered low levels of supervision and support to mostly "*untrained*" staff, who were in turn isolated. There were more children in residential care than there were beds. High numbers in care were said to be due to a "*low level of preventative work*". Social workers did not have sufficient contact with children in children's homes because they believed that children were "*safe*" once they were in care. Recommendations included training for residential care staff, and increased funding for both residential care and for preventative work.[297]

11. There were more than 200 unused places in County children's homes by 1983. To reflect this fall in placements, an overall reduction in the number of residential places was proposed, including closing some homes and replacing them with specialist homes. The aim was to improve the quality of residential care by having fewer children in each home,[298] providing a more effective service for those placed.[299]

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[292] INQ004256 *Children in the Public Care*, Sir William Utting, HMSO 1991, pp28–29.
[293] See for example the County's 1984 re-evaluation of its residential care provision in the face of falling numbers (NSC000240).
[294] EWM000463: 'Children's Residential Care in England', December 2017.
[295] EWM000463_46-50
[296] See, for example, NSC000104
[297] NSC000526_7, 17, 20-21
[298] NSC000240
[299] NSC000438_1-4

12. By 1990, the County was "*in the middle of a crisis in residential care*". There was high staff turnover, an increasing use of temporary staff due to recruitment difficulties, low levels of qualified staff and low staff morale. The contraction of the residential sector had led to the grouping together of children with serious problems.[300] David White (the County's Director of Social Services from 1989 to 1994) considered that by this point residential care had been operating at an unacceptable level for some time. The County was putting its "*most vulnerable youngsters in the hands of those perhaps least qualified and able to care for them*".[301] Denis Watkins (the County's Assistant Director of Social Services in the late 1980s and early 1990s) said that in the late 1980s the County aimed to have 10 percent of residential staff trained, demonstrating its "*dire starting point*".[302]

13. Around this time there was an increasing understanding and awareness across England and Wales of the risks of sexual abuse committed by residential care staff. This was first acknowledged in national guidance *Working Together* in 1988,[303] followed by more detailed guidance in 1991 to accompany the Children Act 1989[304] and in a national review of residential care in 1991 by Sir William Utting.[305]

14. With anxiety growing among councillors, senior officers and residential care staff that existing provision of residential care was "*failing to measure up to the demands being placed upon them*", the County established a Residential Child Care Working Party[306] to review the County's residential care.[307] It produced a report in May 1992, *'As if they were our own': Raising the Quality of Residential Child Care in Nottinghamshire*,[308] which concluded that the County's residential care was of an "*unacceptable standard*" and that some young people faced "*the prospect of violence and sexual abuse within our care*".[309] If the risk of children being sexually abused by residential care staff had not been apparent to the County's children's social care service from earlier disciplinary cases, it should have been as a result of this report.[310]

15. The report made 79 recommendations.[311] A team was formed in January 1993 to implement the recommendations.[312] By March 1993 police checks before recruiting staff and procedures for complaints and reporting abuse were in place.[313] However, in January 1994, financial constraints were thought "*likely to impact on the developments in residential care*" being introduced. Despite this, plans were put in place to restructure community homes, including reducing the number of residential placements, increasing staffing ratios, and increasing investment in substitute family care.[314] A number of homes were closed by December 1994 and resources reinvested into "*residential and alternative care*".[315]

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[300] INQ001811 para. 37; NSC000438_13-27
[301] White 8 October 2018 153/18-154/7
[302] INQ002731 para. 2.2. Similar issues were identified on a national level in the 1992 Warner report, including the concentration of more challenging children in residential care and the "*largely unqualified and often untrained workforce*" (EWM000463_43).
[303] NSC000938
[304] EWM000463_35-39
[305] EWM000463_40
[306] Chaired by the County's Chief Executive and including senior officers, an Officer in Charge of a community home, a Children's Rights Officer from Leicestershire, and others (NSC000104_3, 7).
[307] NSC000438_28-33; NSC000104
[308] NSC000104; NSC001235_64-69 para. 5g
[309] NSC000104_7-9
[310] NSC000104_79
[311] NSC000104_123-127
[312] NSC001318; NSC001235 para. 3c.i.22, 5g.11-5g.19
[313] NSC000943
[314] NSC001235 paras 5g.14, 5g.16
[315] NSC001235_68-69 paras 5g.16-5g.18; NSC000943

16. From 1998, when responsibility for residential care was divided between the Councils, the City introduced its own designated training programme for those working with children, including child protection training.[316] Between 1999 and 2001, a new training programme for staff in County children's homes was introduced, including for working with children who had been sexually abused.[317]

17. Both the County and the City made efforts in the early 2000s to "*create a culture*" that encouraged children in residential care to raise concerns,[318] including a complaints process, an advocacy service, social worker visits, councillor rota visits,[319] as well as the appointment of independent visitors.[320] However, take-up of the complaints process was low, as noted by the Social Services Inspectorate (SSI):

> *"A number of young people we met said that they did not bother to complain, 'as it didn't get you anywhere' and 'nothing happened'. There was no evidence to confirm this was an accurate reflection of the situation but it is clearly a perception that the council will need to address."*[321]

18. The City introduced a multi-agency placement panel by 2011 to consider the needs of children before placement and to keep placements under review.[322] Residential care had also been reconfigured to 'small group' homes in the City,[323] leading to better outcomes for children in residential care.[324] A serious case review in 2011 (following the suicide of a 15-year-old in the care of the City, discussed in Part E) recommended a programme to address deficiencies in the "*identification, assessment and management of cases where there is emotional abuse, sexual abuse*". The "*key priority for change*" was to strengthen processes for children in care, including identification and management of safeguarding concerns, and profiling of high-risk children to ensure appropriate levels of support.[325] In November 2011, the City introduced a Children in Care Profiling Tool to identify the most vulnerable children in care.[326]

19. By 2015, the County had implemented quality standards for children's homes with improved levels of staff training, including mandatory training on child sexual exploitation.[327]

C.4: Background to Beechwood

20. The history of Beechwood demonstrates the extent to which the issues impacting on residential care more generally created an environment where vulnerable children could be and were abused, and faced difficulties in disclosing that abuse.

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316 NCC003691 para. 6.10
317 NSC000929. The training courses available to staff in the County between 1981 and 2018 are set out at NSC001241; NSC001282; NSC001274
318 NSC000913; NCC000599
319 See Part B.4.
320 NCC000019; NSCP and NCSCP Interagency Safeguarding Children Procedures
321 NSC001167_50
322 NCC003788_127-128
323 NCC003788_127-128
324 NCC003691 para. 3.120
325 NCC003788_136-138
326 NCC000399_2
327 NSC001238_6

21. Allegations of abuse at Beechwood generally began to emerge in 2010 and were the catalyst for the police initiating Operation Daybreak in 2011. In 2012, 50 former residents of Beechwood brought civil claims in respect of their allegations of non-recent abuse at Beechwood.[328]

22. Despite a large number of allegations of sexual abuse by former residents, including from those who say they reported their allegations at the time, over the 39 years Beechwood was open there are only two recorded instances of an institutional response to allegations of sexual abuse made against staff. Colin Wallace was dismissed and convicted of unlawful sexual intercourse in 1980.[329] NO-F47 resigned whilst under disciplinary investigation in 1998.[330] As a result of allegations made to the police more recently there have been three convictions of former Beechwood staff members: John Dent in 2001,[331] Andris Logins in 2016[332] and Barrie Pick in 2017.[333]

23. Records and witnesses refer to 'the Beechwood complex', 'Beechwood', and to the various individual units (Redcot, The Lindens and Enderleigh). From 1996 the official name of the home was changed to '379 (or 387) Woodborough Road'.[334] For consistency, we have referred to 'Beechwood' throughout this report.

C.5: Beechwood: 1967–1980

Composition and function

24. Beechwood opened on 1 November 1967[335] as a one-unit "*remand home for 20 boys*".[336] By 1976 it consisted of four units: The Lindens, Redcot (originally a separate children's home), Enderleigh (opened in 1967 as a remand home for 18 girls), and a central administration and teaching block.[337] Enderleigh closed in 1978,[338] leaving Beechwood with Redcot and The Lindens. In 1979, Redcot became a mixed unit,[339] whilst The Lindens continued to be for boys only.

25. Beechwood was not intended to be a children's home for long-stay or short-stay placements. It was initially a remand home,[340] then by 1974[341] an observation and assessment centre (O&A centre)[342] for children who had committed an offence and been remanded to the care of the local authority.[343] In practice, emergency family placements would also be sent to Beechwood.

328 NCC003691 paras 7.51-7.58
329 NSC001234; NSC001229
330 NCC000130
331 INQ001670
332 INQ001154_1
333 INQ001688
334 NSC000096_2
335 DFE000724
336 DFE000723_4
337 NSC000450_3
338 Following a report, discussed below, entitled 'The Future of Enderleigh' (NSC0001378).
339 NSC000463_7-8; NSC001474 para. 2c.3
340 Governed by the Remand Home Rules 1939 and Remand Homes Rules 1970
341 The Cessation of Approved Institutions (Remand Homes) Order 1973
342 Governed by the Community Homes Regulations 1972
343 Children and Young Persons Act 1969 section 23; NSC000457_3-4

Map showing location of Beechwood units

25.1. As an O&A centre, its purpose was "*to provide information as to the personality, social functioning, health, educational attainment of the child*" to decide where they should be placed.[344] At Beechwood, boys would be placed in The Lindens after being remanded from court. Following educational and psychiatric assessments and a case conference, a report would be provided to the court (ideally within six weeks), which would then decide whether to make a care order, with or without a placement decision. Boys would then be moved to Redcot, awaiting a long-term placement in a children's home or in foster care. Where no placement decision had yet been made, ongoing reviews would

[344] NSC000526_12

take place to determine the appropriate placement. If placements failed, often the child would be returned to Beechwood,[345] the effects of which, "*cannot fail to be damaging*",[346] as the County recognised in 1975.

25.2. In practice, Beechwood accommodated children on remand even after it ceased to be a remand home. It also had children placed on an emergency basis or awaiting long-term placement. This mixed cohort of children, with different challenges and needs and with ages ranging from 10 to 17 years old, produced "*further tensions resulting in difficult and sometimes very aggressive behaviour*".[347]

25.3. Mark Cope (a residential care worker at Beechwood at the time) recalled the change from remand home to O&A centre "*was really difficult … people couldn't forget the former role*"[348] and described Beechwood as a "*holding unit*" for children.[349] As a result, there was a lack of opportunity to form any nurturing relationships with children.[350] Staff at The Lindens complained to a senior manager in 1978: "*How can you properly assess a child for court or placement procedure against a background which is a threat to many types of children?*"[351]

The nature of O&A centres, such as Beechwood, created a difficult environment for vulnerable children, who had different challenges and needs. Beechwood was more like a custodial institution, rather than a children's home. It was a wholly unsuitable environment for children and young people, where sexual abuse thrived within a culture of physical violence and intimidation.

Management and governance

26. Beechwood was run by Nottingham Borough Council (the predecessor to the City) from 1967 until April 1974, when the County took over full responsibility for all children's homes under local government reorganisation. As superintendent, Jim Saul oversaw the running of Beechwood until 1981.[352] He had a deputy superintendent, a post held by Ken Rigby from 1975 to 1993. Enderleigh, Redcot and The Lindens each had a housewarden who managed the unit on a day-to-day basis.[353]

27. A Homes Advisor (later a 'Residential and Day Care Services Officer') from children's social care acted as a link between homes such as Beechwood and the local authority. Ken Rigby remembered that, throughout his time, "*I don't think we got a lot of support from … social services … We were very much left on our own*".[354]

[345] NSC001474 para. 2b.2; NSC000450_003
[346] NSC000526_15
[347] NSC000443_5
[348] Cope 17 October 2018 112/15-113/5
[349] INQ002618 para. 27
[350] Jones 8 October 2018 70/10-71/4
[351] NSC000457_3-4
[352] INQ002422 para. 7
[353] NSC000443. In the 1980s, the role became known as Officer in Charge (OIC).
[354] Rigby 9 October 2018 56/11-21

Issues

Placements

28. In 1977, the Director of Social Services noted that "*Over-accommodation is a frequent issue*" with children staying "*far longer than was appropriate or desirable*".[355]

29. Staff at The Lindens complained that their unit was being used as a placement for those rejected by other children's homes. Boys were placed:

> "*without considering the effect of such placement … for example we have a sexual offender and suspect psychopath of 16 in the same unit as a weak inadequate 11 year old boy placed by his mother … the contradictory nature of this situation is a negation of child care … What is intended for the placement of the authority's difficult children?*"[356]

30. Placement of vulnerable children alongside children who had exhibited harmful sexual behaviour without proper safeguards in place was a recurring issue at Beechwood throughout its existence.[357] Ken Rigby recalled that staff thought Beechwood was used as a "*dumping ground*", taking "*anybody that was disruptive in any sort of community home in Nottinghamshire. We had no say on who should come, and, therefore, we had to take all comers, and that could be extremely disruptive*".[358] Jim McLaughlin, a trainee residential care worker at Beechwood from 1979 to 1980, remembered separate areas had to be organised to avoid physical confrontation.[359] Mark Cope recalled that victims of sexual abuse and children exhibiting harmful sexual behaviour would be placed together, "*it was horrendous*".[360]

Staff

31. Staff at Beechwood were largely unqualified and untrained in caring for vulnerable children. Until 1979, Ken Rigby was one of only two professionally qualified residential staff.[361] Even by the mid-1990s, there was still no mandatory training programme for residential care staff.[362]

Culture

32. Many accounts of those who worked or visited Beechwood during this period were critical of its culture and environment. One member of staff thought that girls were never listened to or believed.[363] Another described The Lindens as "*strict and aggressive … the place was difficult to work at*", whereas Redcot was "*softer*" and more like a children's home.[364] Margaret Stimpson, a senior social worker at the time, found Beechwood to be "*rigid, regimented, punitive and uncaring*".[365] Rod Jones recalled Enderleigh as an "*awful place*"[366] and on one unannounced visit he found all the girls locked-in upstairs.[367]

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[355] NSC0001378
[356] NSC000457_3-4
[357] It was subsequently raised as an issue preventing admission of a child in November 1989 (NSC000444_5-6), and again arose in the 2000s.
[358] Rigby 9 October 2018 6/20-7/12
[359] McLaughlin 9 October 2018 101/7-15
[360] Cope 17 October 2018 120/18-121/10
[361] Rigby 9 October 2018 11/7-21
[362] INQ001895 para. 36b
[363] NTP001684
[364] NTP001660
[365] INQ002049 para. 17
[366] INQ002007 para. 2.16
[367] Jones 8 October 2018 72/21-73/14

33. From a resident's perspective, L17 described open violence towards residents by staff[368] and found some of the other residents to be "*highly sexual*", recalling that there was "*a lot of bullying*".[369] C21's first impression of The Lindens aged 14 in 1977 was "*fear*".[370] Others give accounts of being beaten and not having anyone to whom they could report.[371]

34. Ken Rigby did recognise, reluctantly, that "*a major part of the problem*" was staff attitudes towards the children placed in the home.[372] As Mark Cope told us: "*the way that Beechwood was managed, you were almost made to feel that they were objects … we never actually saw an individual child, it was what they'd done wrong*".[373]

Reports of and responses to allegations of sexual abuse

35. Officers working on Operation Daybreak concluded that Beechwood was "*riddled with abuse*" from the late 1960s to the late 1980s,[374] with serious sexual abuse being most prevalent in the 1970s.[375] Nottinghamshire Police recorded around 95 allegations of sexual abuse occurring at Beechwood between 1967 and 1980.[376] The abuse included rape, buggery, sexual assault, and being inappropriately touched or watched in the showers.

John Dent

36. John Dent worked at The Lindens from December 1973 to March 1975 and then as deputy housewarden at Enderleigh from March 1975 to June 1977, where he was the only male member of staff.[377] Following allegations that he had taken children to his room and caned them, Dent was investigated and he resigned in August 1978.[378]

37. In 1997, D7 reported to the police that she had been sexually abused by Dent.[379] During the police investigation that followed, 'Operation Harpoon', several other complainants alleged abuse by Dent at Enderleigh and Hillcrest. In January 2001, John Dent stood trial on 26 counts involving eight complainants, six of whom alleged abuse at Enderleigh, including D7. He was acquitted on some counts and the jury was unable to return a verdict on others. After a retrial, Dent was convicted in January 2002 of sexual abuse, including indecent assault and attempted buggery, of four complainants, mostly relating to his time at Enderleigh.[380]

38. Ken Rigby recalled finding Dent in the TV room at Enderleigh "*sitting on a settee with a girl either side of him, and he had his arms across their shoulders … he wasn't embarrassed, he made no attempt to sort of jump up … he was the only male in the room*". The girls were 14 or 15 years old. Ken Rigby's response was to warn Dent that he was "*giving mixed messages to the girls … He was very popular with the group. They liked him*".[381] He said:

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[368] L17 2 October 2018 120/11-122/1
[369] L17 2 October 2018 112/20-113/9
[370] C21 2 October 2018 158/25-159/2
[371] INQ002574: For example D36, D28, D5, L28, D35, D22.
[372] Rigby 9 October 2018 53/4-54/12
[373] Cope 17 October 2018 118/19-119/9
[374] NTP001516_3-8
[375] Dales 22 October 2018 39/11-22; INQ001780 paras 4.8-4.14
[376] NTP001657
[377] NTP000821. He went on to be OIC at Hillcrest (another children's home in Nottinghamshire) from June 1977 to August 1978.
[378] INQ002007 paras 34.12-34.13
[379] D7 2 October 2018 83/5-14
[380] NTP001654
[381] Rigby 9 October 2018 26/22-29/23

> *"Some of the girls in Redcot were very promiscuous, and to see how they operated around boys in the unit. Male members of staff had to be very careful and give the girls plenty of leeway, as I could put it."*[382]

The focus was on the risk to staff, rather than considering the welfare of the child and the risk of abuse to which they were exposed. As a senior member of staff, Ken Rigby would have been responsible, to a large extent, for the tone set for others at Beechwood.

Colin Wallace

39. Colin Wallace started working at Beechwood in 1978 as a residential care worker.[383] Some members of staff had concerns about his contact with girls at the home.[384] Mark Cope remembers seeing a resident, NO-A533, leaving a note for Wallace asking him to meet up with her. Mark Cope said he took the note to Ken Rigby, who instructed him to put it back and to keep an eye on Wallace. He again raised concerns when he saw a second note.[385] Ken Rigby denied that he was told about a note.[386]

40. NO-A533 was moved by children's social care to another home in December 1980 close to where Wallace lived. When she absconded from her new placement a few days later, she was found at Wallace's home.[387] Wallace admitted having sexual intercourse with NO-A533 and was dismissed in December 1980.[388] His dismissal was reported to councillors.[389] Wallace was charged with four counts of unlawful sexual intercourse and convicted in 1981.[390]

41. Ken Rigby said there was discussion amongst staff about how Wallace had been able to carry out his assaults but also *"as to the girl … in terms of her advancing towards Mr Wallace"*.[391] One staff member had said that NO-A533 *"sought attention from any male member of staff who was on duty at that time"*.[392] When asked what internal steps were taken to reduce risks following the conviction, Ken Rigby said:

> *"it was just reiterated once more that* [male staff] *had to be extremely careful – around young female*[s], *how they presented themselves to young female*[s], *and this was the main thing."*[393]

42. While there were no specific procedures directed at how to respond to allegations of sexual abuse against staff at the time,[394] the 1978 Policy and Procedure Guide required all suspicions or complaints regarding abuse of residents to be reported to children's social care.[395] We have seen no evidence of Mark Cope's concerns being reported to anyone within children's social care. As with the response to Dent, Ken Rigby focused on the risks to staff rather than those to children.[396]

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[382] Rigby 9 October 2018 30/21-31/2
[383] NSC001234
[384] NTP001682
[385] Cope 17 October 2018 123/11-131/6
[386] Rigby 9 October 2018 21/20-23
[387] Cope 17 October 2018 127/19-128/3
[388] NSC001234
[389] NSC001233_7
[390] NSC001229
[391] Rigby 9 October 2018 25/16-26/2
[392] Rigby 9 October 2018 23/11-17
[393] Rigby 9 October 2018 26/9-17
[394] NSC000105_35
[395] NSC000046
[396] INQ002422

Barrie Pick

43. Barrie Pick was a residential care worker at Beechwood between 1976 and 1977.[397] Mark Cope told us that he raised concerns with his manager, NO-F204, that Pick seemed attracted to the younger children in the home, but that these were not taken seriously. He felt there was generally a failure on the part of management to support staff when they raised concerns.[398] In 2017, Pick was convicted of indecent assault and gross indecency against a former resident of Beechwood, and of possessing indecent images.[399]

NO-F29

44. A police analysis in January 2018 recorded that 33 former residents made allegations of sexual abuse against NO-F29, a senior member of staff at The Lindens who worked at Beechwood from 1967 until his death in 1980.[400] The allegations included voyeurism, fondling children in the showers, digital penetration and rape.[401] Had he been alive, NO-F29 would have been the subject of serious criminal charges.[402]

45. There is no record of NO-F29 being reported to the police or investigated by children's social care during his lifetime.[403] A social worker visiting Beechwood in 1979 reported that two residents:

> "*were accusing him of homosexual activities. I interviewed* [NO-A629] *about this but all* [NO-A629] *said was that everybody knew that* [NO-F29] *was 'queer'. Mr Rigby was there as well and it was felt that there was nothing in these accusations at all apart from trying to diminish* [NO-F29's] *authority in the place. It was a very difficult time for Beechwood, the group was unsteady and* [NO-A629] *seemed to be in the middle of all the trouble that was going on.*"[404]

46. Ken Rigby said that he had heard comments about NO-F29 being "*queer*" more than once but was told by Jim Saul that they were just rumours with no foundation. He accepted this.[405] Jim McLaughlin had concerns about NO-F29 working with vulnerable children but said he would not have known who to tell given NO-F29's seniority.[406] As noted in a police report in 2015, the senior role held by NO-F29 over a long period placed him in a unique position both to abuse residents and to have influence over other staff.[407]

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397 CPS004382 para. 318
398 Cope 17 October 2018 134/24-135/17
399 INQ001688
400 NTP001654
401 INQ002574; INQ002577
402 NTP001519
403 Some complainants (such as L18) say that they told the police at the time; others (such as L50 and L24) say that they told other adults at the time (INQ002574).
404 NSC001178
405 Rigby 9 October 2018 15/3-18/17
406 McLaughlin 9 October 2018 107/13-109/4
407 NTP001519

NO-F204

47. NO-F204 held a senior role at Redcot in the mid-1970s.[408] Initially he was dismissed for, amongst other things, watching children in the shower and physically assaulting residents but this was substituted on appeal to councillors with a final written warning and NO-F204 was redeployed to Hazelwood.[409] At least six former Beechwood residents have now alleged sexual abuse by NO-F204.[410]

48. Mark Cope remembered NO-F204 standing in the shower area when children were showering rather than supervising from outside. He reported his misgivings to Jim Saul who dismissed his concerns at the time. This discouraged him from reporting "*anybody again*".[411]

Other allegations

49. The Inquiry is aware of six allegations of sexual abuse against NO-F49,[412] and allegations against NO-F52,[413] NO-F281, NO-F60 and NO-F218, all of whom worked at Beechwood between 1967 and 1980.[414] There are also numerous allegations made against perpetrators who could not be identified by complainants.[415]

50. For those residents who were able to report sexual abuse at the time, the response was generally negative. L24, NO-A451 and NO-A187 disclosed to members of staff but said nothing was done. NO-A320 alleged he was beaten by night staff after telling them that he had been sexually assaulted by a member of staff. L18 said he reported the abuse to the police but was told that they could not get involved and that he would have to report the abuse to someone else. L50 disclosed abuse to a school teacher working at the home; he recalled her simply responding "*did he?*" and that nothing then happened. L17 told us she disclosed to a staff member at her next placement but there was no response.[416]

51. A social worker visiting in the late 1970s remembered, "*there was lots of abuse reported in Beechwood and numerous complaints from children within the home. It was awful and the children often ran off to escape it.*"[417]

Barriers to disclosure

52. Other complainants who made allegations about this period were not able to disclose at the time they were abused.[418]

> **52.1.** D37 explained "*The main reason that I didn't report the abuse was that I didn't realise it was wrong … Even if I had wanted to report the abuse … who would have believed me? The staff at Beechwood were members of the community and I was just a kid.*"
>
> **52.2.** D22 said that "*The abuse I suffered has always been a source of shame and embarrassment for me. The thought of talking about it has been and still is very frightening.*"

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[408] Cope 17 October 2018 131/7-9; NSC000980_11, 13-14
[409] NSC000980_11, 13-14
[410] NTP001634_8
[411] Cope 17 October 2018 131/7-134/2
[412] NTP001654
[413] CPS003377
[414] NTP001634_5-14
[415] NTP001634_6-14
[416] INQ002574; INQ002577
[417] NTP001664
[418] INQ002574; INQ002577

52.3. D35 "*heard that it happened to others in the dorm, but we just kept our heads down and carried on. The lads just accepted what it was … I had a record of previous convictions and knew that no one would believe me. I was also scared as I knew I would get beaten if I reported.*"

52.4. A79 said that his perpetrator told him it was their "*secret*" and that, if anyone found out, he would make A79's life hell and make it "*twice as bad*" next time.

> "*There was no way I was going to tell anyone as I was scared and sure that no-one would believe me and was deeply ashamed. By this point my whole personality was being built on me being a tough guy and so I was too ashamed to tell anyone.*"

52.5. NO-A172 wanted to get a good report at Beechwood so that he did not have to stay there.

53. A number of former residents said that there was nobody to talk to about the abuse,[419] whereas others told of reporting to their social worker.[420] It never occurred to Ken Rigby that residents might want to talk to someone other than their social worker.[421]

54. Children were exposed to sexual and physical abuse and were isolated and fearful. They had no one in whom they could confide. Viewed by staff working there as a "*dumping ground*", Beechwood was neglected by senior managers, particularly Edward Culham (Director of Social Services) and Norman Caudell (Divisional Director for children's social care in the relevant local area), and councillors in both Councils.

C.6: Beechwood: 1981–1998

Composition and function

55. By 1989, Beechwood had been re-designated as a community home[422] following a recommendation in a County report into residential care in 1984.[423] It was to continue to provide 37 places, with children aged 10–18 to be placed "*normally*" for less than six months.[424] Each child was to have a designated key worker who would be "*the primary care person for the child*".[425] In line with the County's plan to reduce the number of children in residential care, The Lindens closed in 1990. From then, Beechwood consisted of only one residential unit: Redcot.[426] During the 1990s, resident numbers varied between 11 and 17.[427]

56. Beechwood was officially described in 1993 as "*a specialist children's home which takes all young people remanded from the youth court who are refused bail*", taking in children "*without notice*".[428] In reality, in addition to those on remand, it continued to take children with challenging behaviour from other homes as well as taking those in "*general welfare care*".[429]

[419] For example, D37, D36.
[420] For example, L22, P15.
[421] Rigby 9 October 2018 45/16-46/4
[422] For example, see NSC000444_1
[423] NSC000240_11
[424] NSC000240_41
[425] NSC000240_33
[426] NSC001318
[427] DFE000637
[428] DFE000637
[429] NSC001622_10

Management and governance

57. Jim Saul retired in 1981, and Jim Fenwick ran Beechwood as Principal until 1991, although he told us he had "*minimal*" contact with children in the home.[430] In around 1984, Hazel Kerr (Homes Advisor) wrote that:

> "*Beechwood is slowly evolving under the firm guidance of Jim Fenwick … It is well accepted that Beechwood will take on all-comers. They rarely, if ever reject a child.*"[431]

Jim Fenwick recalled that, when he started, Beechwood staff were "*a very much male-dominated group*" but he "*tried over a fairly long period to change this*"[432] by appointing more female staff. He said that he made staff aware of the need to use sympathy and empathy with children but recognised that he was dependent on what he was told by staff as to how children were in fact being treated.[433]

58. He also attempted to improve physical conditions at Beechwood, writing in 1989 to Denis Watkins to "*elicit … support for urgent attention to … improve the quality of life*" of children at Beechwood, adding that staff were in a state of "*desperation*".[434] He referred to a visitor who had described it as "*horrifying … how is it we can place young people in such atrocious conditions?*" Significant criticisms were still being made of physical conditions in the late 1990s and early 2000s.

59. Following Jim Fenwick's departure, Beechwood was run by a series of temporary managers before Andrew Bosworth's appointment as unit manager in 1995.[435] He considered the management culture at Beechwood prior to his arrival had been one of "*autocracy and intimidation*" and that there had been "*avoidance of issues*".[436]

60. The Inquiry has not seen evidence of any internal inspection of Beechwood during the 1980s by the County's children's social care service.

61. Annual reports into each children's home were required throughout England and Wales from 1991 onwards and within the County these were conducted by the Service Standards Unit (SSU) from 1994.[437] Although we have no SSU reports into Beechwood whilst it was run by the County, it appears that inspections were carried out.[438]

62. Also from 1991, monthly Regulation 22 inspection reports were required to be carried out by children's social care staff and reported to councillors.[439] However, as Professor Berridge noted, "*local authorities were left to their own devices about what happened to these reports, how effective were they and whether they were followed-up.*"[440] Reports on Beechwood from the early to mid-1990s regularly assessed standards of management and care as high,[441]

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[430] Fenwick 9 October 2018 122/23-123/7
[431] NSC000443_12
[432] Fenwick 9 October 2018 127/18-128/15
[433] Fenwick 9 October 2018 122/1-123/15
[434] NSC000444_3-4
[435] The job titles for those running the home changed over the relevant period (NSC000393_44-47, 56-59, 64-66; INQ001811 paras 1-2).
[436] NSC000498_19
[437] Under Regulation 28 of the Children's Homes Regulations 1991
[438] NSC000965; NSC001277
[439] NSC001235 para. 5h.13
[440] EWM000463_48
[441] NSC001619; NSC001611; NSC001616; NSC001621; NSC001617

despite poor physical conditions,[442] severe staff shortages,[443] and the criticisms from the Social Services Inspectorate (SSI)[444] and media reports. Many of the positive Regulation 22 reports were prepared by County Service Manager Paul Bohan, who had direct responsibility for the management of Beechwood.

63. Children's social care internal policy on Regulation 22 visits was revised in 1996, from that point requiring that any allegation of abuse made during the inspection be specifically recorded, and that inspection visits had to be unannounced and conducted by someone without line management responsibility for the home.[445] By mid-1996, inspection reports began to refer to some of the difficulties facing Beechwood. One noted that whilst "*great strides have been made in improving the systems and infrastructure in managing the Unit … attention needs to be given to raising the quality of child care*".[446] Another, in 1997, referred to children sharing three beds to a room "*putting them at risk*", staff standing guard "*to enable a female resident to be safe whilst using the shower*", and "*chronic*" staff shortages with the unit depending mainly on temporary staff.[447]

64. Reports also recorded the continued high numbers of children absconding each month.[448] A 1997 report recorded 73 incidents of children missing in one month, but said "*The Managers within the Unit and staff work closely with the local Police Officer … and all young people are rated as to their risk of vulnerability.*"[449]

65. From 1981 to 1998 only four reports of councillors' rota visits are available in relation to Beechwood, all of which date between 1996 and 1998.[450] No issues were identified in three of the reports.[451] A January 1998 report noted that there was "*a serious problem with safety of staff*" as well as with the safety of "*inmates*" (referring to residents).[452]

66. We have seen no evidence of the SSI, or any other external agency, carrying out an inspection into Beechwood between 1967 and 1998.[453]

Issues

Absconding

67. In late 1985 and early 1986, Beechwood attracted local and national media interest. There were reports of 400 incidents of absconding in 1985 (including 70 girls who had "*fled*" the home more than once in a year),[454] a girl's death following a fall from a window at the home[455] and a trial during which it emerged that girls at Beechwood had been working in a "*sex club*".[456]

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[442] NSC000393_4, 50, 62
[443] NSC001626; NSC001624_9-13
[444] DFE000651_2; DFE000647_2
[445] NSC001235 para. 5h.13
[446] NSC001627
[447] NSC001624_9-13
[448] NSC001612; NSC001613; NSC001614
[449] NSC001620_7-12
[450] NSC001235 paras 3b.3, 3a.18. It is unclear whether visits were carried out and not reported, or they were reported but the reports have been lost, or visits were simply not carried out.
[451] NSC001235_105 para. 6b.13
[452] NSC001622_6-10
[453] During this time there was no regime for regular inspections, but the Department of Health and SSI sometimes conducted inspections of homes (NSC001235 paras 8a.11-8a.12). Although, as discussed below, the SSI did have some oversight of the response to the death of a resident at Beechwood in 1994, no inspections were carried out.
[454] INQ0016800_1
[455] NSC000443_11
[456] INQ002407

68. This brought Beechwood to the attention of the County's Social Services Committee. Committee Chair Joan Taylor, while recognising there was a problem with absconding and the risk of sexual exploitation, suggested that "*Often girls sent to us come with a history of being involved in prostitution.*"[457]

69. Jim Fenwick did not examine the underlying reasons for absconding,[458] whilst Ken Rigby told us that girls "*absconded for all sorts of reasons*".[459] For Ken Rigby, some children at Beechwood were "*very devious in all sorts of things. Absconding was just but one of them.*"[460]

70. In March 1989, a national newspaper published an account of underage sex and drugs at Beechwood. David White reported to the Social Services Committee in April 1989 that the suggestion that there was "*extensive sexual activity amongst couples and groups of young people*" had been "*grossly exaggerated*".[461] Although a 14-year-old girl had had sex with a number of boys on different occasions, White emphasised that "*At no time did this take part against her will*". White's report was seen as a vindication of the staff: "*we were all quite delighted to receive the inquiry report and your letter that both contained a consistent underlying theme of exoneration*".[462] David White told us that he was "*ashamed by this report … in terms of the way that we, as an organisation, reported this matter … and sought to justify what we found.*"[463] The focus of the report was on the difficulties faced by the staff rather than on the vulnerability of the children.

71. Concerns arose again in June 1994 following the death of a Beechwood resident after he absconded and crashed a car.[464] The SSI criticised the high level of absconding at Beechwood, and one SSI official noted "*there could be a case for saying that Nottingham had failed to protect the welfare of the children in their care*".[465] Later that year an SSI official commented that "*It is now 4 months since* [the child] *was killed and it seems to me that nothing has been done during this period to protect the well-being of the other young people who are being looked after by Nottingham.*"[466]

Culture

72. Several complainants described physical abuse and a culture of violence at Beechwood in the 1980s and 1990s.[467] For example, N1[468] and other complainants[469] say they were made to fight one another, although Ken Rigby and Mark Cope told us that staff organised boxing matches and no child was forced to fight.[470] Some said that this culture prevented them from reporting sexual abuse either because they were scared of the repercussions[471] or because they were not believed when they reported physical abuse so did not think they would be believed about sexual abuse.[472] D33 described staff as "*very cruel*", while D34 described

[457] NSC000443_11
[458] Fenwick 9 October 2018 150/3-153/22
[459] Rigby 9 October 2018 39/20-41/12
[460] Rigby 9 October 2018 39/11-17
[461] NSC001375
[462] NSC000444_2
[463] White 8 October 2018 167/16-168/25
[464] DFE000651_3
[465] DFE000651_2
[466] DFE000647_2
[467] For example L23, L39, P12, L27, D33, D34, L22 (INQ002574).
[468] N1 3 October 2018 16/2-22
[469] INQ002574; INQ002577 – D28, D33, D36, D37, D48, D5, NO-A408, L22.
[470] Cope 17 October 2018 114/12-20; Rigby 9 October 2018 52/7-17
[471] For example D33 and L23 (INQ002574).
[472] For example D34 and L39 (INQ002574).

physical abuse as "*normal*". L22 described physical abuse from staff and other residents, and said she "*told the nice staff about the beatings and what was happening, but they didn't seem to care*".[473]

73. Concerns around the physically abusive environment at Beechwood were also raised by residents at the time. In 1987, a number of children complained to a member of the public about physical abuse at Beechwood and this came to the attention of children's social care. Jim Fenwick "*completely*" denied that staff had been taking "*children or young people into the office and slapping and knocking them around without witnesses*" and emphasised "*that this behaviour would be totally unacceptable … and does not happen*".[474] In correspondence with children's social care, Jim Fenwick defended his staff's use of "*the necessary amount of force to restrain*" one resident, whilst recognising that one member of staff had dealt with another resident "*in a manner that was not entirely necessary*". He claimed staff had "*little or no preparation or training for dealing with situations that become physical*".[475] Within children's social care, it was noted that "*residential staff are constantly vulnerable given the numbers of confrontations which take place in any working day. We are of course placed in the position of requiring appropriately to investigate any allegations made … Mr Fenwick is quite understanding of the fact that we need to fully investigate incidents that are alleged*".[476]

74. There are also recorded examples of allegations against staff of physical abuse. In 1993, NO-F3, a care worker at Beechwood, was suspended following allegations of physical assault of a resident.[477] He was charged but a prosecution was dropped in March 1994, and NO-F3 returned to work three months later.[478] In September 1995, two residents made complaints of physical abuse by staff. One said that he was physically assaulted by NO-F1, who held a senior position. Another complained that a member of staff had held his face and dragged him into the office.[479] It is not clear how these incidents were dealt with, if at all.

75. Andrew Bosworth became Unit Manager in 1995. He found that there were no restraint or incidents books kept at Beechwood, and no systems on restraint "*evident in the unit at all*".[480] He was particularly concerned about the attitudes of staff, in particular one individual who had a conviction for grievous bodily harm and who had apparently declared "*We sort people out at Beechwood*". These issues should have been picked up sooner by senior staff members and social care management.

76. Former staff denied a culture of physical violence at Beechwood. Ken Rigby said he had never had to reprimand a member of staff for their misuse of physical restraint or contact with residents in 18 years[481] and said it was children who were violent to staff and between themselves.[482] Jim Fenwick told us he never saw a member of staff being physically abusive to a child, although he remembered dealing with a complaint about a member of staff who

[473] INQ002574
[474] NSC000464_4-5
[475] NSC000464_4-5
[476] NSC000464_8-9
[477] NCC001244; NCC001246
[478] NCC001421
[479] NSC000392
[480] NSC000498_4-19
[481] Rigby 9 October 2018 54/14-24
[482] Rigby 9 October 2018 46/10-16

had threatened to hit a resident with a billiard cue.[483] For Mark Cope, the environment at Beechwood was hostile but not violent, and he recalled the home being far more relaxed in the 1980s than previously.[484]

77. However, as part of a 2011 review looking at allegations of physical and sexual abuse at Beechwood in the late 1980s, the NSPCC concluded:

> "*It is … clear from the file material that Beechwood, and particularly The Lindens, was an environment where violence, bullying and fear were common features and recording suggests that such behaviour was expected … The Lindens would certainly appear to have been an environment within which an abusing adult would be able to abuse young people successfully.*"[485]

Reports of and responses to allegations of sexual abuse

78. Police records include more than 65 allegations of sexual abuse against staff at Beechwood between 1981 and 1998.[486] Jim Fenwick told us that he was "*absolutely shocked*" at the number of allegations during his time in charge and had "*no idea*" how they could have taken place. He said that he should have known what was happening in relation to "*the abuse of children*".[487] This was a serious management failure that left children unprotected.

79. L27 said he reported being sexually abused to the police but:

> "*was told to stop lying, and that I was making it up. They just didn't seem interested at all. I don't think they believed me, but I find it hard to believe that they didn't know what was happening in the home.*"[488]

80. D4 was not able to disclose:

> "*I didn't think anyone could help me. No one had ever helped me before … Staff know you have no family and nobody cares about you and there is nobody to turn to. That's why you are there in the first place. You're vulnerable. You've got no family, so who's going to care?*"[489]

81. In 2005, NO-A93 alleged that NO-F7 sexually assaulted her in 1985. The allegations were investigated by the County under its disciplinary procedures as NO-F7 was working in education at the time of the allegations. However, the County decided that the allegations should not proceed to a disciplinary hearing against NO-F7.[490]

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[483] Fenwick 9 October 2018 144/14-146/2
[484] Cope 17 October 2018 114/21-115/24
[485] NCC000308_28 – the report does not specify what type of abuse is being referred to here.
[486] NTP001657
[487] Fenwick 9 October 2018 130/22-131/25
[488] INQ002574
[489] INQ002574
[490] It was considered that there was insufficient evidence based on interviews with witnesses and a lack of supporting records (NSC000501).

Andris Logins

82. Andris Logins, who worked in Redcot from 1980 to 1985, was convicted in 2016 of four counts of rape, 12 counts of indecent assault and one count of child cruelty in relation to four children at Beechwood from 1980 to 1984. He was sentenced to 20 years in prison. His lawyer said that Logins had been "*suckered into a regime he became part of*".[491] Logins was struck off as a social worker in April 2017.[492]

83. In 1991, charges against Logins for indecent assault of residents at another children's home, Sycamore House, were discontinued by the police. Children's social care took no further internal action and he was reinstated in October 1991[493] without any assessment of whether he posed a risk to children.[494]

84. In 2011, NO-A155 made allegations of sexual abuse against a "*Mr Logan*", but the police did not connect this to Andris Logins until 2015.[495] It was another former resident, NO-A61, who came forward in 2013 following press reports, who prompted a police investigation and others subsequently came forward.

85. Mark Cope remembered Logins being tactile with girls who would sit on his knee.

> "*That was actually done in front of management and anybody else who was around. He didn't hide what he was doing.*"

He did not report this behaviour as he felt there was no clear evidence of wrongdoing, but now realised that this could be described as grooming behaviour.[496] Ken Rigby admitted to us that a blind eye was "*probably*" turned towards the way Logins behaved, adding, "*but I have got no knowledge of that*". He grudgingly accepted that in his management role he too was responsible for what happened to children.[497]

Other allegations

86. Although Andris Logins is the only conviction in relation to this period at Beechwood, eight former residents made allegations to Operation Daybreak of non-recent sexual abuse by NO-F1 and four former residents made allegations against NO-F2, in relation to their employment at Beechwood between 1987 and 2000 and 1985 and 2002 respectively.[498] Both are also the subject of a substantial number of allegations of physical abuse.

87. NO-F11 worked at Beechwood for 19 years and died in 2012. He was the subject of allegations of sexual abuse from four former residents relating to the 1980s and 1990s.[499] We are also aware of allegations of sexual abuse against other members of staff relating to this period, including NO-F4, NO-F3, NO-F287, NO-F33, NO-F14, NO-F8, NO-F363, NO-F6 and others who could not be identified by complainants.[500]

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[491] Andris Logins jailed for Nottinghamshire children's home sex abuse 23.03.16
[492] INQ001154. The HCPC decided that his fitness to practice as a social worker was impaired following the conviction.
[493] On the basis that "*it was felt that the available evidence, despite the best efforts to clarify the situation, finally remained inconsistent and unreliable*". Logins' request to be redeployed outside the residential child care sector was rejected because there were "*no formal grounds to do so*". (NSC000488_14-15).
[494] NSC000488
[495] NTP001640
[496] Cope 17 October 2018 135/18-136/16
[497] Rigby 9 October 2018 32/13-33/16
[498] NTP001654
[499] NTP001654
[500] NTP001634; INQ002574; INQ002577

88. Despite the large number of allegations made to police and to this Inquiry in relation to this period, there are no records of allegations of sexual abuse made at the time. Several former residents say that they disclosed abuse at the time but were not believed.[501] P14 says she reported abuse to staff but was told that no one would believe her as she was regarded as a suicide risk. P12 says she reported to a member of staff at her next placement, but was told to "*piss off to bed*". NO-A188 said she told a staff member who believed her but told her that if she said anything "*you will make matters worse for yourself*".

89. Children continued to be exposed to physical and sexual abuse. There was a culture of violence and a lax attitude to absconding. Staff ignored the abuse of children by colleagues, whilst managers did not act to protect children. Senior managers clearly viewed Beechwood as a problem, in which the interests of staff were of greater concern than the protection of vulnerable children and young people.

C.7: Continuing problems under the control of the City: 1998–2006

90. The recently created City Council assumed the ownership and management of Beechwood in April 1998. Andrew Bosworth, who continued as manager during this change, felt that for a considerable period, senior staff were preoccupied with their own concerns for their future, and did not have any understanding of the unsettling effect on frontline staff.[502]

91. Around this time, the majority of placements at Beechwood, for 13 children aged 14 to 17 who had been bailed or remanded to care, were still "*unplanned*" and at short notice. Staff "*felt that young people were safe while in the unit … but felt that young people were at risk when out of the unit*".[503] However, for Margaret Mackechnie, the City's Assistant Director for Children's Services, with senior line management responsibility for the home, Beechwood reflected a "*youth justice approach … less caring … male dominated … there was a harshness about it*".[504] In spite of being aware of this at the time, Ms Mackechnie did not do enough to improve conditions at Beechwood.

92. Inspections and reviews of Beechwood were largely negative, making adverse comments about the lack of policies, procedures and training for staff and the physical conditions of Beechwood.[505] The number of children sharing rooms was "*unacceptable*", and the standard of accommodation was "*very poor*", which had been "*well documented in previous reports*".[506]

93. In the early 2000s, Beechwood faced the same problems that it had over the past 20 years. Alison Michalska, the City's Corporate Director for Children and Adults, told us that Beechwood should have been closed when the City took over ownership in 1998.[507] It continued to be over capacity and the mix of "*aggressive and loud to vulnerable and subdued*" residents was considered difficult to manage.[508]

[501] INQ002574; INQ002577
[502] INQ001895 para. 21a
[503] CQC000003_1-20
[504] Mackechnie 18 October 2018 111/2-112/20
[505] For example, CQC000003, NCC000867 and NCC001109
[506] CQC000003_2, 19
[507] Michalska 25 October 2018 96/3-20
[508] NCC001109_5

94. In 2001, the City's Registration and Inspection Unit identified 29 issues requiring attention at Beechwood, including addressing overcrowding, urgently reviewing placements to ensure they were appropriate and that children could be protected from bullying and other forms of abuse, and providing child protection training (which had also been identified in a previous review).[509]

95. Michelle Foster, a residential care worker at Beechwood between 2000 and 2002, told us that it was not "*an optimistic place*" for children to be.[510] Despite concerns raised in inspection reports about the lack of child protection training, she said that no training was provided on working with children who had been sexually abused or on dealing with sexualised behaviour.[511]

96. Although sharing bedrooms had been identified as a "*risk*" in 1997[512] and "*unacceptable*" in 1999,[513] it was still happening in 2002. Joanne Walker (who had been seconded to manage Beechwood) identified this as a "*grave concern*":

> "*I am aware of a previous incident of rape being perpetrated in another home with just such a situation, indeed, within the last week a young man who was placed in a shared room was urinated on whilst in bed! The horror of this happening is unspeakable. How can we give care to anyone who has been so abused by a system which allowed this to happen? … Sharing bedrooms is a source of constant friction between the young people resulting in unnecessary dangers. It is a disaster in the making and only a matter of time before a tragedy happens. I would go so far as to say this practise constitutes institutional abuse.*"[514]

Margaret Mackechnie disagreed that the sharing of rooms was "*institutional abuse*", but accepted that it was "*not good practice in a children's home*".[515]

Bronwen Cooper report: 2001

97. Bronwen Cooper, an Investigation Officer with the City, was asked to investigate allegations and counter-allegations concerning NO-F1, a former staff member of Beechwood now working in another home, relating to the period from the mid-1990s to 2001.[516] Ms Cooper said her remit was to consider "*the whole operation of the unit, the culture and practice … and whether children felt safe*".[517]

98. Her 2001 report revealed serious concerns of a staff culture of "*sexual banter*" and harassment at Beechwood.[518] She listed 10 specific allegations against staff, including an "*inappropriate relationship*" between NO-F1 and "*a young person in the Unit*". The report described a "'*macho' environment*", sexual and racial harassment and inappropriate behaviour between staff.

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509 NCC000867
510 Foster 18 October 2018 11/3-25
511 Foster 18 October 2018 23/6-24/6; NCC000867
512 NSC001624_9-13
513 CQC000003_1-20
514 NCC000693
515 Mackechnie 18 October 2018 133/25-134/3
516 NCC000294
517 Cooper 9 October 2018 65/22-66/19
518 NCC000294

99. Ms Cooper "*was extremely concerned that the care of the children in this situation was being neglected*" and that the behaviour of staff, particularly the sexualised behaviour, "*would have an impact on children that we knew had previously suffered physical/sexual abuse/neglect and were looking to this staff group to care for them, keep them safe and also show them appropriate boundaries*".[519] She felt that "*the whole atmosphere of the home was unsafe sexually*" making it "*very hard*" for children to be able to disclose any abuse they were suffering.[520] For Ms Cooper:

> "*there was a high level of risk of sexual abuse of residents within the home at the time of my investigation, by staff and other residents, because of the environment and culture generated by the staff group*".[521]

100. An initial draft of the report,[522] provided to Margaret Mackechnie, recommended that Beechwood be closed.[523] Closure was envisaged as temporary – while certain staff were supported and trained, and necessary disciplinary action taken against other staff[524] – but was seen by Ms Mackechnie and other managers as "*contentious*" and "*practically and politically impossible*" at the time.[525] Closure also raised "*the challenge of finding placements for children*", which was "*huge*", as well as problems with re-deploying or making staff redundant. She recognised that the behaviour of the staff was "*very concerning*" but said she had to "*balance the needs of the service and the needs of the children*".[526] Ms Cooper removed the closure recommendation from her final report, feeling "*a little pressure*" to do so. She was "*reassured*" that alternative measures would be put in place to improve the situation for residents.[527]

101. Ms Mackechnie recalled that, in response to the report, the City reduced the number of children at Beechwood and did "*the usual things you would do when there was a children's home in difficulty*".[528] Ms Michalska accepted on behalf of the City that steps taken to address problems in the home "*were wholly inadequate*".[529] Ms Cooper thought that there was a sexualised culture which created an "*unsafe environment*" for children, in which they would "*find it very hard to talk about sexual abuse*".[530] These concerns required urgent action. The response of Margaret Mackechnie and her colleagues left children in the City's care exposed to continuing risk of harm.

Events leading to closure: 2002–2006

102. In April 2002, following disclosure by a resident that she had been raped by a 21-year-old male from outside the home, National Care Standards Commission (NCSC) inspectors were notified and visited Beechwood. They recommended that Beechwood be closed "*because it was failing to safeguard and promote the welfare of the children resident there*", but within 48 hours agreed that the home could remain open provided that the number of

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[519] Cooper 9 October 2018 73/5-74/13
[520] Cooper 9 October 2018 74/14-75/9
[521] INQ001800 para. 7.1
[522] No copy of the draft report was available to the Inquiry.
[523] Cooper 9 October 2018 75/18-24
[524] Cooper 9 October 2018 75/25-76/19
[525] Cooper 9 October 2018 77/11-79/10
[526] Mackechnie 18 October 2018 125/5-128/6. In a 2002 memo referring back to this time, the City stated "*Discussions did take place … as to whether temporary closure should take place, but the difficulties that this would create in terms of placement choice were assessed to be too great a risk*" (OFS008233_9).
[527] Cooper 9 October 2018 80/3-82/17
[528] Mackechnie 18 October 2018 126/24-127/14
[529] Michalska 25 October 2018 96/8-20
[530] Cooper 9 October 2018 83/7-16

residents was reduced from 10 to eight.[531] The City disputed that any recommendation to close was ever made at this time.[532] The proposed reduction in numbers does not appear to have taken place. Michelle Foster told us that in practice the number never went below nine,[533] and the NCSC subsequently reported that the City had continued admitting young people to Beechwood over capacity, resulting "*in some young people having to sleep on couches or share bedrooms against their wishes*".[534]

103. In September 2002, the same resident who disclosed in April that she had been raped, killed herself in her room at Beechwood. The NCSC formally notified the City that it had "*reasonable cause to suspect that young people are likely to suffer significant harm. We think it incumbent upon the Local Authority to carry out immediate child protection risk assessments, as the basis for providing an informed judgement about whether young people in this children's home are safe.*"[535] The City proposed relocating children to other homes, but the NCSC was not satisfied that the City had demonstrated "*adequate and due regard to ensuring the safety and welfare*" of those children, having inspected conditions and occupancy levels at the other homes.[536]

104. The NCSC's report on the resident's death[537] was critical of the City's care for her and of its running of Beechwood. It concluded that:

> **104.1.** the City failed to respond to concerns relating to risks to the resident's welfare and to notify the NCSC of "*significant events*" including allegations of sexual abuse;
>
> **104.2.** children's social care management had been advised that the resident should not remain in residential care amidst concerns that she was sexually active with a number of boys in the home and was being sexually exploited outside the home; and
>
> **104.3.** while it might "*transpire that this was a tragedy that could not have been averted*", her life in care "*was characterised by unacceptable levels of risk, neglect and vulnerability. She was being 'looked after' by Nottingham City Council because she was considered to be in need of its care and protection. In the opinion of this Review the Local Authority failed to meet her needs in respect of the care it provided to her … young people have not been cared for … in a manner likely to safeguard and promote their welfare.*"[538]

It recommended closure of Beechwood with "*immediate effect*".

105. This was the third closure recommendation in around a year. The NCSC stated that Beechwood was only to be reopened once the City could demonstrate it was "*capable of meeting the requirements of the Children's Homes regulations and National Minimum Standards*". The City was told to undertake "*a comprehensive review of all of its children's homes*", to urgently review its procedures on notification of significant events, and to formulate a plan

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[531] Other NCSC inspectors subsequently noted that the NCSC "*should have acted on the basis of the initial evidence that the service was not up to standard*" and closed the home (OFS008229_6).
[532] OFS008233_2
[533] Foster 18 October 2018 19/19-21/3
[534] OFS008229_10-11, 20
[535] OFS008170
[536] OFS008171. The City in turn set out the steps being taken to meet the NCSC's concerns (OFS008229_14-18).
[537] OFS008229 – recipients included the City's Chief Executive and Acting Director of Social Services.
[538] OFS008229_1-18

on the suitability and relevance of its existing residential child care provision.[539] It agreed to temporary closure, declaring "*There are firm plans in place to refresh all aspects of operations at* [Beechwood] *with a view to it being reopened.*"[540]

106. Michelle Foster told us that, the day before she was due to give evidence at the inquest into the resident's death, Margaret Mackechnie made it clear that she should not do so as "*it wouldn't be good for the children if the public found out that they were taking drugs and having sex*". She was told that if she went ahead she would lose her job.[541] Ms Mackechnie did not remember specifically meeting Michelle Foster before the inquest, but did recall "*a group meeting for the staff who were going to give evidence to the inquest*". She firmly denied that she told Michelle Foster that she "*would lose her job if she said anything to the inquest*".[542]

107. Beechwood re-opened in June 2003. The City's Area Child Protection Committee (ACPC) published a 44-page overview report into the resident's death around the same time.[543] It concluded that "*no single action by a person or agency … could have prevented* [the resident's] *death*" but questioned whether "*more could have been done*" at Beechwood "*to create an environment where vulnerable young women, and men, were not liable to be sexually exploited by each other*".[544] Ms Mackechnie accepted that a similar issue had been identified in Bronwen Cooper's report two years earlier and that more could have been done.[545] There were several recommendations, including that the City develop "*Residential Care Standards, with appropriate staff development programmes, to ensure that children's homes provide a safe environment where sexual and violent behaviours … are appropriately managed*" and that the ACPC develop "*Practice Guidance and training for all agencies on assessing and working with children who have been sexually abused*".[546] Similar recommendations on the need for such guidance and training had been made as far back as 1988 and 1990.[547]

108. On receipt of the ACPC report, the Social Services Inspectorate (SSI) wrote to the City's Chief Executive highlighting the report's criticism of the lack of strategic response to incidents at Beechwood and commenting that it was very clear the child was in need of protection.[548]

109. The picture of Beechwood over the following three years, from monthly visits and external inspections, is mixed. Residents were said to present "*a high level of aggressive and challenging behaviour*"[549] and to be "*fed up with the complaints process*".[550] Some young people placed at Beechwood had "*to live with young people who are persistent offenders*", leading to attempts to coerce others into "*drug use and prostitution*".[551] On the other hand, staff were seen to be making "*concerted efforts*" to maintain positive relationships with residents, and were trained on and aware of the processes to safeguard young people.[552]

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[539] OFS008229_19-21
[540] OFS008232, which included a detailed response to the report, taking issue with many of the findings.
[541] Foster 18 October 2018 51/22-52/14. Ms Foster did in fact give evidence at the inquest and her evidence that bullying, drugs and under-age sex were rife at Beechwood was reported in the press.
[542] Mackechnie 18 October 2018 146/12-148/6
[543] NCC000297: this was a review under Chapter 8 of *Working Together* 2000.
[544] NCC000297_22, 42. The report set out some of those steps, including work by residential staff with the young people, both individually and as a group, increased staffing levels, better oversight by the Operational Manager of young people and staff, and better liaison with the field social worker.
[545] Mackechnie 18 October 2018 143/18-144/13
[546] NCC000297_43-44
[547] NSC000101_10-11; NSC000102_33
[548] OFS008244
[549] OFS008157
[550] OFS008164
[551] OFS008164
[552] OFS008166

110. By 2006, there was little evidence of positive relationships between staff and young people, and the home was still in a poor physical state.[553] The Commission for Social Care Inspection (CSCI) wrote in February 2006 to Margaret Mackechnie identifying concerns that residents were exposed to "*a variety of risks in terms of self harm and harm to each other*". The City was required "*to take immediate action to address these issues and to ensure the safety of all persons in the service*".[554]

111. Subsequent inspections record an improved picture – in September 2006, the overall rating was 'good'.[555] By the end of the year Beechwood had no residents, with a "*proposal currently being made to close the Unit*".[556] It appears to have been finally closed in late 2006 or early 2007.

Reporting of and responses to allegations of sexual abuse

112. Approximately 10 allegations of sexual abuse have been made relating to the period from 1998 to 2006 at Beechwood,[557] including from:

112.1. L43, who told staff in 2002 that he had been sexually assaulted by an older boy and the police were involved. He was told by a member of staff that if he went along with a prosecution he would be moved further away from his mother's home. He told us that he felt both very let down and unsafe, not least because for a period his abuser stayed in the home.[558]

112.2. L29, who said that he tried to tell a social worker about his abuse by a staff member in 2005, but felt like she was ignoring him as she changed the subject.[559]

113. There is evidence of only one allegation against a staff member being made at the time in relation to this period. NO-F47 was suspended in October 1998, following an allegation of an "*inappropriate relationship*" with a male resident, and resigned before the disciplinary hearing.[560] There were no documents on her file to suggest that a disciplinary investigation was concluded, despite guidance on the need to continue investigations following a resignation.[561]

114. Andrew Bosworth's understanding of the low number of allegations made at the time can be seen from a complaint he made in January 1999 about two inspectors from the City's Registration and Inspection Unit:

> "*There seemed to be a continued pursuit of trying to find some form of abuse of young people, then a denial of being allowed to make a complaint. This preoccupation had been recognised by several staff members including myself. There was simply nothing to find because we do not abuse young people or deny them the opportunity to complain about issues at any time.*"[562]

[553] Gregory 18 October 2018 175/25-176/10; NCC002170_34-36
[554] OFS008199
[555] OFS008206
[556] NCC002170_59-61
[557] NTP001657; L43 3 October 2018 54/25-90/15; OFS008182; OFS008180; NCC000351; NCC003542
[558] L43 3 October 2018 54/25-90/15
[559] INQ002574
[560] NCC000130
[561] NSC000105_50; NSC000473_4; INQ001712_11
[562] INQ000195

Andrew Bosworth said that this showed he was "*prepared to challenge issues in an open and professional manner*".[563]

115. Beechwood was allowed to carry on operating dysfunctionally. Supervision of staff was negligible. The physical environment was overcrowded and unsuitable. Children were subject to bullying and harmful sexual behaviour. Margaret Mackechnie, the City's senior manager with responsibility for Beechwood, failed to address these problems. When the City took over the management of Beechwood in 1998, it should have been closed.

C.8: Response to allegations against staff at other homes

116. From 1985 onwards, there have been several allegations of sexual abuse made against staff in residential homes other than Beechwood. Although the response to allegations developed over time in line with changes to policies and procedures (see Part B), there were persistent issues that continued to arise in the handling of such matters.

117. The Inquiry received around 60 allegations of sexual abuse against staff at homes other than Beechwood in relation to the period prior to 1980, with just under half saying that they disclosed at the time.[564] There is only evidence of one member of staff being disciplined or prosecuted for the sexual abuse of children during this period.[565]

1980–1989

118. In March 1985, Michael Preston was sentenced to nine months' imprisonment for sexually abusing a resident at Three Roofs Community Home, where he had worked as a member of care staff. At his sentencing, the judge said:

> "*It appears … that the officer in charge of the children's home and other persons in the social services, were well aware of the temptations to which you were subject, and yet they took no steps to relieve you of your responsibilities in order to protect the child … It seems to me extraordinary that you were not dismissed at a much earlier stage, and on the face of it culpable responsibility for the assault lies with your superiors as well as upon you.*"[566]

As a result, an enquiry was carried out by the County and a report sent to the Chair of the Social Services Committee in June 1985.[567] It found that the Officer in Charge (OIC) at Three Roofs had significant concerns about Preston's behaviour with the child, but they were satisfied that he had not known about Preston's attraction to the child. The OIC reported his concerns to his line manager, Tony Dewhurst, but was told he could not dismiss Preston.[568] The enquiry found that the OIC should be counselled but not disciplined. They found that his manager Tony Dewhurst had not been sufficiently perceptive when interviewing Preston and had failed to hear the "*distress signals put out*" by the OIC. As a result, the enquiry recommended that Dewhurst should undertake training on recruitment.[569]

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[563] INQ001895 para. 37
[564] INQ002574; INQ002577
[565] In 1975, Malcolm Henderson resigned from his post at Skegby Hall before being convicted of indecently assaulting a 12-year-old, for which he received a two-year probation order (NSC000204).
[566] INQ001215
[567] NSC000490; NSC001235 paras 3b.8, 5a.7-10
[568] NSC000490_9
[569] NSC000490_11

119. Amberdale was another community home for 22 children, which opened in 1975 and closed in 1996. In 1986, a formal inquiry was carried out after Gerry Jacobs, Assistant Principal at Amberdale, was dismissed and sentenced to nine months' imprisonment for indecent assault of a resident. The inquiry found that the abuse had "*finally opened Amberdale to scrutiny*";[570] it criticised the autocratic regime, supervision levels, and children's social care's management of the home. It made 29 proposals, including the introduction of a clear, explicit and easy complaints procedure for children.[571]

120. In September 1986, NO-F147 was dismissed from Wollaton House following an admitted sexual relationship with a 16-year-old resident. There was no prosecution as, until 2003, there was no criminal offence where there was 'consensual' sexual activity between a residential care staff member or a foster carer and a 16 or 17-year-old child in their care.[572] NO-F147's appeal against his dismissal was rejected by councillors, although they requested consideration of possible alternative employment within the Council.[573]

121. In 1987, David Marriott, a residential care worker at Skegby Hall, was sentenced to two years' imprisonment for four counts of indecent assault against two boys and was dismissed from his role.[574] Following this, Councillor Tom Butcher wrote to other councillors[575] that he had:

> "*identified two facts that I believe show a lack of urgency, even complacency, over the number of sexual offences by staff on children in their care. 1. Is the fact 7 members of Social Services staff have been involved in such offences over the past two years, and 2. after 14 months they appear to have failed to implement a Home Office circular intended to protect children.*"[576]

He asked for enquiries to be made "*about offences committed by … staff, the number of complaints received and how they are dealt with, etc*".[577] There is no evidence of a response by the County to the issues raised by Councillor Butcher. If a councillor removed from the detail of operational matters had such concerns, the Director of Social Services (at this time, Edward Culham) and senior officers familiar with the cases must have known something of the scale of sexual abuse in residential care.

122. In 1988, Dean Gathercole faced charges of sexual assault of girls at Amberdale, where he worked as a residential care worker. No evidence was offered at trial and Gathercole was discharged.[578] A disciplinary hearing accepted his account that the allegations against him were unfounded but concluded that his actions prior to the allegations had been inappropriate.[579] In May 2018, Gathercole was found guilty of six counts of indecent assault

[570] NSC000106
[571] NSC000566_9-13
[572] For example in the cases of NO-F151, NO-F143, NO-F159, NO-F413, NO-F46. In 2003 it became an offence for an adult to "*engage in sexual activity*" with a person under the age of 18 with whom they are in a "*position of trust*" (Sexual Offences Act 2003, sections 16-18).
[573] NSC000499; NSC001235 para. 5b.3-4. See below for a discussion of councillors' involvement in disciplinary appeals.
[574] NSC000212
[575] INQ000275_2
[576] The Home Office circular requiring checks on foster carers and staff with responsibility for children was eventually implemented with effect from 1 January 1988 (NSC000130; NSC000936).
[577] INQ000275_02
[578] NSC000202_3-4
[579] NSC000202_7

and three counts of rape against two girls at Amberdale in the 1980s. One of the victims had reported the abuse in 2000, at which point the Crown Prosecution Service had declined to authorise charges.[580] He was sentenced to 19 years' imprisonment.[581]

1990–2009

123. In the early 1990s, according to Diane Kingaby, who was responsible for managing several children's homes in the County at the time, children's social care managers were "*instructed to tell social workers that they should try anything to avoid their child coming into residential care as they were more likely to be sexually abused than not*".[582]

124. Between 1990 and 1995, five members of staff were dismissed from Amberdale following allegations of sexual abuse, although two of the dismissals were subsequently overturned on appeal:

124.1. In 1990, NO-F151, a residential care worker at Amberdale, was dismissed four days after she had allegedly sexually abused a male resident. She was not formally interviewed or suspended before her dismissal. A subsequent report concluded there was an "*error of not protecting a young person in our care, from the wholly inappropriate sexual relationship which took place*" and "*further questionable judgements*" after the nature of the relationship had been disclosed.[583] Staff suspicions about NO-F151's relationship with the child were not referred to senior management, case note entries recording concerns had been amended because it was felt they "*could possibly be libellous*", and there was insufficient supervision of both NO-F151 and the victim.[584]

124.2. In March 1992, NO-F158, a senior member of staff at Amberdale, was suspended following allegations of sexually abusing a resident. NO-F158 remained under suspension for almost three years and was eventually dismissed in February 1995. NO-F158's appeal against dismissal was rejected later that year.[585]

124.3. In May 1995, NO-F153 was dismissed for an inappropriate relationship with a female resident and for destroying her diary which contained entries relating to that relationship.[586] Another member of staff, NO-F37, was dismissed for removing the child's diary, which also included allegations against him. At the time Amberdale "*was an establishment in some crisis*"; there had been "*a breakdown of trust between management and some staff*".[587] After an appeal to councillors, NO-F37 was reinstated with a final warning.[588]

124.4. In August 1995, NO-F161 was dismissed following allegations of sexual abuse of a resident, having earlier been acquitted at trial in October 1994. Sandra Taylor, who chaired NO-F161's disciplinary, wrote to Stuart Brook (the County's Director of Social Services at the time[589]) setting out various issues "*which give me cause for grave*

[580] CPS004384
[581] INQ003771
[582] INQ002957
[583] NSC000220_19
[584] NSC000220_1-20
[585] NSC000951; NSC000512; NSC001431
[586] NSC000500
[587] NSC000231; NSC001430
[588] NSC000231
[589] Stuart Brook had only recently taken over from David White, who had resigned in July 1994 in the wake of the publication of *Strong Enough To Care?* Chief Executive's Working Party, July 1994 (NSC000241).

concern as to the welfare and safety of children in the care of the authority".[590] These included: (i) lack of knowledge and adherence to child protection procedures amongst residential care staff at all levels; (ii) lack of attention given to the wellbeing of the complainant; and (iii) the fact that although one of the complainants had disclosed abuse on three occasions previously, none of the disclosures had been properly recorded or investigated. Although there is no evidence of a formal response to Sandra Taylor's letter, steps were taken by the County over the next five years to improve its recruitment, selection and training of staff.[591] NO-F161's dismissal was later substituted for a final warning by councillors on appeal in March 1996 and he was re-employed in a different post.[592]

125. Sandra Taylor also highlighted the fractious relationship between children's social care management and trade unions. During NO-F161's disciplinary hearing, children's social care was criticised by a trade union representative for taking a positive "'*child centred' approach*" and placing the interests of the child above the interests of staff.[593] Stuart Brook described the relationship as an "*exceptionally difficult*" one.[594] He recollected that a "*culture of opposition*" lasted through the mid-1990s and "*delayed progress*".[595]

126. During the same period, following an inspection of Amberdale, an SSI report in March 1993 raised concerns about the time taken to progress disciplinary issues.[596] A "*radical change*" was sought. The SSI maintained that staff should be suspended automatically following allegations of abuse made against them, but David White, the County's Director of Social Services, thought this unrealistic "*in the light of the number and nature of allegations made*" and that with each allegation "*the Service Manager investigating will consider the appropriate manner of keeping child and staff member out of contact while inquiries are made which will include considering suspension or temporary movement to another Unit*".[597] In June 1995, the SSI conducted another inspection, concluding that young people were not at risk at the time of the inspection, but that the unit was performing very poorly.[598] The SSI recommended that Amberdale be closed. It was closed in 1996.[599]

127. Other significant cases during the early 1990s included:

127.1. In 1992, an internal enquiry was carried out by two children's social care managers after the conviction the previous year of Norman Campbell for buggery and indecent assault of children in residential care.[600] Campbell had been a residential care worker and foster carer in the County in the 1980s. The enquiry report was critical of the County's approach to a disciplinary investigation into previous allegations, in 1988. There was an apparent "*lack of understanding about the behaviour of sexual abusers and victims of sexual abuse*". Additionally, the concerns of members of staff about Campbell's behaviour and relationships with children had been dismissed.[601] The report concluded that it was "*unfortunate that the disciplinary process, as it related to Norman Campbell,*

590 NSC000189_42-49
591 INQ002480 para. 21E
592 NSC000189; NSC001433; NSC001235 para. 5j.7
593 NSC000189_48-49
594 INQ002480 paras 5.62-5.63
595 INQ002480 para. 5.63
596 NSC001162
597 NSC001162_2
598 NSC001155
599 It subsequently reopened as Clayfields in 1997.
600 NSC000506. Issues relating to foster care are addressed in Part D.
601 NSC000103_22ff

could be criticised as having the effect of protecting its senior managers and ultimately the Department from the repercussions of acting on their beliefs about him".[602] The authors suggested that lessons could be learned by a second, external, enquiry reviewing the County's management of its staff working with children in care.[603] David White decided against it, but was unable to explain to us why he did not take up the opportunity to do so.[604]

127.2. An October 1993 enquiry into events at Hazelwood Community Home during the period 1979 to 1985 found that children's social care had been "*more dedicated to the furtherance of staff employment rather than the care and protection of children*". There was an "*over-emphasis on the criminal process*" and police investigations,[605] despite procedures requiring that child protection investigations and disciplinary procedures be considered separately.[606] In particular, the report identified a failure to properly notify the Department of Health of persons deemed unsuitable to work with children[607] and a failure to follow through with disciplinary proceedings where there had been a decision not to prosecute or where an employee had resigned prior to the conclusion of disciplinary proceedings. It was noted that "*Allegations made by children towards members of staff at the moment are dealt with on an individual basis*" and there was no overall evaluation. Between June 1992 and February 1993, there had been 14 known allegations against staff of abuse in community homes which pointed to a clear need for "*rigorous Departmental oversight of these matters*".[608] The report recommended that all allegations of staff misconduct towards children needed to "*be monitored and reviewed, and that this be carried out in one place – Social Services Personnel.*"[609]

127.3. In December 1994, NO-F162, who worked at Wollaton House, resigned before the conclusion of a disciplinary hearing following alleged sexual abuse of a female resident.[610] The disciplinary process was not seen through to a conclusion, despite the need for this being highlighted in the Hazelwood report the previous year.[611]

128. Until 2010 in the City[612] and 2017 in the County,[613] appeals against disciplinary sanctions for residential care staff – including for child sexual abuse – were heard by councillors. Rod Jones (Senior Professional Officer (Child Care)) recalled that in the 1970s and 1980s successful pursuit of disciplinary proceedings was sometimes made more difficult by the councillors, who "*took a staff centred approach rather than one which put children and*

[602] NSC000103_35-36
[603] NSC000103_36
[604] NSC000154_59; White 8 October 2018 180/9-181/10
[605] NSC000105_42
[606] NTP001473_67
[607] In October 1993, the County did write to the Department of Health with a list of 10 former staff members who had been dismissed or had resigned in relation to allegations of child sexual abuse, asking for them to be entered on a file of "*persons deemed unsuitable for work with children and young people*" (Gerald Jacobs, Norman Campbell, NO-F142, NO-F143, NO-F147, NO-F148, NO-F149, NO-F150, NO-F151 and NO-F152) (NSC000234_30-34; NSC001235 para. 5h.8).
[608] It is likely (but not explicit) that this figure included allegations of physical abuse.
[609] NSC000105
[610] NSC000473
[611] NSC000105_50
[612] NCC003691 para. 7.8
[613] NSC001235 para. 5b.10, 6g.2

vulnerable people first",[614] and that such decisions had "*a marked effect on the confidence of managers to deal with errant members of staff*".[615] We have seen examples of cases in which councillors overturned dismissals for child sexual abuse and substituted a warning.[616]

129. Rod Jones told us that a culture of protecting staff "*was very much the case in the late '70s and the early '80s*", persisting until the late 1990s.[617] Helen Ryan, a County Investigative Officer in the mid-1990s, recalled how it was "*not unusual for residential managers at all levels to see protecting and supporting staff as their priority*".[618] In terms of councillors overturning disciplinary decisions on appeal, Rod Jones was "*very aware … that assistant directors would come back from disciplinaries saying, 'That was a waste of time. They're not supporting us. They're taking a personnel line'.*"[619] In the Hazelwood report, one recommendation was to review disciplinary processes to ensure that "*the personnel/employee oriented bias is addressed*".[620]

130. In 1995, the County took steps to respond to some of these matters by establishing two posts of 'Investigative Officer' to conduct staff disciplinaries and other investigations.[621] Stuart Brook acknowledged this was "*in direct response to … the increase in the number, complexity and range of investigations*", recommendations from recent reports, and the 164 staff disciplinaries[622] over the previous three years, with the majority involving alleged abuse or malpractice by staff.[623] It was hoped that the posts would provide a "*central management perspective*" on investigations.[624] Previously, disciplinaries were conducted by different service managers across the County's nine different districts, leading to "*a lack of consistency across the whole department*".[625]

131. In January 1996, following NO-F162's conviction and imprisonment for physical abuse, Rod Jones (then the County's Head of Children and Family Policy) wrote to Stuart Brook highlighting several lessons relating to NO-F162's case, including the need:

- following allegations of abuse, to "*consider whether there is a need for wider investigations*" and "*ongoing monitoring of risk to children*";
- for a managerial decision where a staff member resigns before the conclusion of a disciplinary investigation; and
- where a child retracts a serious allegation, to get a report to assess possible influences.[626]

There is no evidence of a formal response to the letter. Stuart Brook said the points raised by Rod Jones were already set out in guidance to staff at the time.[627] Further, a seminar on 'Liability, Prevention, Apologies' was held by the County in January 1998, attended by various managers within children's social care and from the County's legal, service standards and risk and insurance teams. The seminar reiterated the lessons identified in Rod Jones'

[614] INQ002007 para. 35.2
[615] INQ002007 para. 33.20
[616] NO-F204 (1979), NO-F37 (1995), NO-F161 (1996), NO-F163 (1999), NO-F46 (2000).
[617] Jones 8 October 2018 98/17-99/14
[618] INQ001799 para. 1.28
[619] Jones 8 October 2018 98/14-99/14
[620] NSC000105_50
[621] NSC000944_9-20
[622] This figure appears to relate to the whole of the County's Social Services Department and therefore would not have been limited to allegations involving children.
[623] NSC000944_9-15
[624] NSC000944_9-15
[625] Brook 24 October 2018 17/19-18/22
[626] NSC000473_1-5
[627] INQ002480 para. 30

memo from January 1996, including the need to consider wider investigations, the approach to take when a staff member resigned before the conclusion of an investigation, and the approach to retractions.[628]

132. There were several other disciplinary investigations into alleged child sexual abuse by residential care staff from 1990 to 1997, including:

132.1. The dismissal and conviction of Steven Carlisle in November 1990 on three counts of indecent assault against children in care at Woodnook. Previously, following a disciplinary hearing in September 1989, there had been no further action taken due to insufficient evidence.[629]

132.2. Five dismissals of residential staff following allegations of child sexual abuse between 1990 and 1994.[630]

132.3. Four resignations (one each in 1990 and 1991, and two in 1997) following allegations of child sexual abuse. In only one of these was the investigation concluded after the resignation.[631]

132.4. NO-F163's dismissal being substituted for a final warning on appeal in 1999.[632] He had previously been investigated in 1993, with no further action taken.

132.5. Three formal warnings (one in 1992, two in 1995) and one final written warning in 1997.[633] In the latter, NO-F413 was not dismissed because "*in 1983, there was a lack of clear guidance given to* [him] *as to the role of a houseparent*" and "*there may have been a lack of clarity about the boundaries of relationships at that time*".[634]

132.6. Two cases (in 1996 and 1997) in which no further action was taken.[635]

133. In 1997, the County produced a report on the *Safety of Children in Public Care*,[636] which noted that there was still no system in place (10 years after Councillor Butcher raised the issue, and four years on from the same recommendation in the Hazelwood report) for collating details of the number of investigations of alleged abuse concerning foster carers or residential workers.[637] Stuart Brook thought that the issue of collating investigations was addressed following investment in an *"integrated child care system*".[638] We have not seen any evidence of the collation of allegations or of steps taken to identify trends or patterns of abuse.

[628] INQ001712; INQ001714
[629] NSC000507
[630] NSC000504_4; NSC000371; NSC000508; NSC000195; NSC000485
[631] NSC000234; NSC000486; NSC001332; NSC000493; NSC000496
[632] NSC000513
[633] NSC000482; NSC000503; NSC000491
[634] NSC000491
[635] NSC000487; NSC000492
[636] This report was produced in response to the requirement of Sir Herbert Laming to review provision and safeguarding processes across the country.
[637] INQ002480 paras 6.15-6.18
[638] INQ002480 para. 6.19

134. Following the local government review in 1998, the County and the new City Council each took sole responsibility for the children's homes within their area. There were far fewer disciplinary investigations into allegations of sexual abuse in residential care than in the previous decade.[639] In five cases in which there were disciplinary investigations, there were decisions to take no further action (two in 1999, and one each in 2000, 2003 and 2006).[640]

135. In November 2000, NO-F46 was dismissed following an investigation by the City which found that he had a sexual relationship with a resident of Redtiles both in 1991 and subsequently after she had left the home. The dismissal was overturned on appeal and NO-F46 was reinstated with a final written warning.[641] There were concerns about the way in which a previous investigation into NO-F46 had been conducted by the County.[642]

136. In 2003, a report into Edwinstowe Hall Community Home[643] looked at non-recent allegations of sexual and physical abuse.[644] This is the only report prior to 2011 that had sought to evaluate the extent of abuse over a lengthy period in a children's home. It concluded that there had been no pattern of abuse at the home and that the number of allegations was no higher than would have been found in any establishment over a 30-year period. A disciplinary investigation into non-recent allegations of sexual and physical abuse against a member of staff there, NO-F41, concluded with a decision to take no further action.[645]

2010 onwards

137. In May 2011, NO-F1, who previously worked at Beechwood and Ranskill Gardens, was dismissed for a relationship with a former resident, then aged 23, including sending her sexually explicit text messages.[646] An allegation that NO-F1 had sex with the young person when she was in the care of the City was not upheld.[647]

138. In 2014, NO-F190 (a support worker at a privately run children's home) was dismissed following allegations of child sexual abuse.[648] In September 2015, NO-F190 was acquitted on all of the charges against him.[649]

139. One of the recent convictions arising from Operation Equinox was of Myriam Bamkin in June 2018 for abuse whilst she was a residential care worker at Amberdale in the late 1980s. When the allegations were made in 2016, Ms Bamkin still worked for the County, but held the role of Fostering Team Manager, from which she was then suspended. During that suspension, in May 2017, Ms Bamkin resigned.

140. Contrary to the Council's own guidance since the 1990s, no disciplinary investigation was carried out and no conclusion reached, either prior to Ms Bamkin's resignation or after her conviction. At least, after she was convicted, the County should have come to a formal

[639] This may be due to a lower residential care population. For example, in 1990 there were 380 children in residential care in the County (NSC000438_019), whereas in 2005 the County only had 14 places in residential care (NSC000702_3). It may also be due to improvements in vetting and the recruitment of staff (NSC001235 paras 6a.18-6a.27).
[640] NCC000125; NSC000214; NCC000332_2-3; NSC000209; NSC000175; NSC000174_5-6
[641] NCC000610; INQ002438_10-11
[642] NCC000610_1-3
[643] This operated as a residential care unit for children of mixed ages from 1967 to 1994 (NSC000108_3).
[644] NSC000108
[645] NSC000489
[646] It was noted that the City had responsibility for young people up to the age of 25.
[647] NCC000127; NCC002300
[648] NCC000189; NCC000190
[649] CPS004382 paras 552-556

conclusion that if she had not resigned, she would have been dismissed for gross misconduct. This approach was taken by the County as far back as 1990 (NO-F142)[650] and 1997 (NO-F164).[651] The County referred Ms Bamkin's case to the Health and Care Professions Council (HCPC) in 2016. As at April 2019, the HCPC had not yet made a determination about her fitness to practice.

141. Although there have been far fewer reported cases in recent years, the author of a 2011 serious case review into the death of a young person in the care of the City echoed the evidence of David White about the County's approach in the early 1990s:[652]

> "*The assumption cannot be made that because a child is Looked After by the Local Authority that they are safe or that their needs are being fully met … Professionals, including carers themselves, need to be prepared to think the unthinkable, and recognise that Looked After Children may be abused whilst in care and are very unlikely to disclose such abuse.*"[653]

City Council Historical Concerns Project

142. In an example of a recent attempt to look broadly at allegations of abuse against staff, in November 2014, the City initiated a Historical Concerns Project to review the employment records of current and former employees (and so not foster carers) who had worked with vulnerable groups "*to identify patterns of behaviour that may be of concern*".[654] Alison Michalska said that when she took up her appointment, she was uncomfortable not knowing who might historically have posed a risk to a child or who might currently be a risk to a child.[655]

143. The final report,[656] published in June 2016, noted:

143.1. 75 current employees and 60 former employees were rated as high or medium risk;

143.2. four current employees and 24 former employees were the subject of allegations or concerns about sexual abuse of children;[657] about 15 related to children in care (one current employee and about 14 former employees);

143.3. 14 current employees received disciplinary sanctions to "*better safeguard service users*", some of which took into account previous misconduct where this suggested a pattern of inappropriate behaviour;

143.4. 12 former employees were referred to the Disclosure and Barring Service and a number were subject to police enquiries and were progressed for investigation by the City; and

143.5. that "*as a result of the review of historical employment records, the Council should have a high degree of confidence that appropriate action has been taken in respect of individuals that have and potentially could cause harm to vulnerable service users*".

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650 NSC000504
651 NSC000493
652 White 8 October 2018 147/24-148/-5
653 NCC003788_105, 136
654 NCC000340
655 Michalska 25 October 2018 80/6-11
656 NCC000340
657 NCC003708

144. This review was a positive step to have taken and appears to have provided some reassurance that alleged perpetrators did not simply evade scrutiny because of bad practice applied at the time.

145. The level of abuse at Beechwood was serious and prolonged. Sexual abuse of children in residential care was also widespread in the Councils' other children's homes, particularly in the 1980s and 1990s. The abuse was never properly addressed by the Councils.

Part D

Case study: Foster care

Case study: Foster care

D.1: Introduction

1. The investigation's second case study examines the institutional responses to allegations of child sexual abuse in foster care in the Councils as well as the barriers to disclosure of those allegations.

2. Fostering is the provision of care in a family home to a child unable to live with their own parents. For many years, it has been regarded as the preferred placement for the majority of children in care. It can take many forms, including emergency, short and long-term placements, short breaks, family and friends (kinship) care,[658] fostering for adoption, and specialist therapeutic care.[659] A local authority placing a child with foster carers has a continuing statutory duty to safeguard and promote the child's welfare.[660] Where a child is in foster care but not in the care of the local authority, this is generally known as 'private fostering'.[661]

D.2: Allegations of abuse

3. Over the last 40 years, 10 foster carers in Nottinghamshire have been convicted of sexual abuse against children in their care,[662] whilst four have been acquitted and several others deregistered following allegations. The Inquiry has received 75 individual accounts of sexual abuse in foster care in Nottinghamshire over this period, primarily drawn from statements and interviews given to the police and from investigations by the Councils.[663] Additionally, 23 complainant core participants made allegations of sexual abuse in foster care,[664] five of whom gave evidence at the public hearings.

4. The Inquiry received a number of accounts about abuse in foster care, including:

> **4.1.** P2 was in foster care in the 1960s. She was raped by her foster father on two separate camping holidays with her foster family.[665]
>
> **4.2.** P7 described regular sexual abuse by NO-F277 in a private foster placement from the age of eight until she left the home aged 26. She came to accept that the sexual abuse – which included rape – was part of her life.[666]

[658] Formal kinship care is when a child in the care of the local authority is placed with a relative or another adult connected to the child. This can include grandparents, siblings, godparents or close family friends.
[659] http://www.gov.uk/foster-carers/types-of-foster-care
[660] Children Act 1989, section 22
[661] Private fostering is where a child is cared for by someone who is not their parent or relative and is arranged between a parent and a carer. It has been subject to regulation by local authorities under the Foster Children Act 1980 and subsequent statutory regulations in 1991 and 2005. It has been subject to *National Minimum Standards* since 2005.
[662] Bernard Holmes, Michael Chard, NO-F141, Norman Campbell, NO-F64, Douglas Vardy, Patrick Gallagher, NO-F77, Stephen Noy and Christopher Metcalfe. There have also been three foster carers convicted of sexual offences against children not in care (NO-F106, William Boden and Raymond Smith), and two relatives or friends of foster carers convicted of sexually abusing children in foster care (NO-F119 and Robert Thorpe).
[663] INQ002575
[664] INQ002574
[665] INQ002574
[666] P7 4 October 2018 112/18-122/22

4.3. L45 was sexually abused in foster care by NO-F57 in the late 1970s when she was around 10. She was also abused by Robert Thorpe, a friend of the foster family, both in the foster home and when she was moved to Beechwood, aged 14. She disclosed the abuse to staff, but despite this he continued to visit her and to rape her. Thorpe was convicted in 2009 of four counts of indecent assault and five counts of unlawful sexual intercourse against her, and sentenced to five years' imprisonment.[667]

4.4. During her foster placement in the 1970s, L47 was regularly indecently assaulted by her foster father, NO-F276.[668]

4.5. P13 was sexually abused by the 21-year-old brother of his foster mother when he was in foster care between 1979 and 1981. He forced P13 – then aged 11 – to masturbate him and perform oral sex on him, and on other occasions he lay behind P13 and simulated sex.[669]

4.6. F37 was sexually and physically abused by NO-F235, her foster carer, in the 1970s and 1980s from when she was a young child until she was 15. NO-F235 regularly touched F37 indecently and went on to rape her.[670]

4.7. L48 was aged six when he and his brother were placed with NO-F275 and NO-F358. In addition to regular physical abuse, L48 was made to touch NO-F275's penis.[671] In his next foster placement, aged 11, L48 was indecently assaulted by NO-F276, culminating in attempted anal rape.[672]

4.8. L35 was in foster care in the 1980s. Her foster carer NO-F116 would touch her between the legs. She added: "*He never forced himself onto me but would make me touch his penis, and him touch me. NO-F116 would hit me with the belt if I refused to do so.*"[673]

4.9. L37 was placed with a foster family in 1986. One of the foster carers, NO-F36, digitally penetrated her in the bath. Two sons of NO-F36 digitally penetrated her, inserted objects into her anus and raped her.[674]

D.3: Background

5. Since the 1950s and until at least 1990 the County had a consistently higher percentage of children in foster care than comparable local authorities.[675] In 1975, 40 percent of the 2,082 children in the care of the County were in foster care[676] and by 1999 this had risen to 64 percent of children in care.[677] This rose further to 86 percent in 2003[678] but reduced to

667 INQ002574
668 INQ002574
669 INQ002574
670 F37 3 October 2018 94/20-139/8
671 L48 4 October 2018 10/14-11/8
672 L48 4 October 20/21-21/19
673 INQ002574
674 INQ002574
675 NSC000438_23 para. 20; NSC001235 para. 3c.ii.2
676 NSC000914_12
677 NSC000920_1
678 NSC001167 para. 3.8

63 percent in 2018.[679] In the City, 69 percent of children in care were placed in foster care in 2004,[680] rising to 73 percent in 2018.[681] The same proportion (73 percent) are in foster care across England.[682]

6. Both Councils have used independent fostering agencies (IFAs, ie private and voluntary providers of foster care)[683] since the 1990s to supplement local authority foster carers. By 2018, 43 percent of children in foster care in the County and 52 percent in the City were placed with IFAs.[684] Foster carers working with IFAs are subject to the same levels of assessment, supervision and training as local authority foster carers.[685]

D.4: Developments in foster care

7. The County undertook its first significant review of fostering services in 1975. The review recommended a co-ordinated approach across the County, an 'examination' of the recruitment and selection process of foster carers and of the level of support given to existing foster carers, and the introduction of a professional foster carer scheme.[686] The County subsequently created a dedicated fostering unit,[687] to recruit, train and support foster carers and to match children to carers. This was followed by guidance in 1979 on 'The recruitment, selection and support of foster parents'.[688]

8. During the 1970s and 1980s, the County provided group home fostering, in which foster carers would care for up to 19 children at a time,[689] even though the 1975 review cautioned against reliance on such homes.[690] One witness characterised these as "*unregulated and unofficial children's homes*".[691] In 1989, a joint police and children's social care report in the County recommended that, "*wherever possible*", children who had been abused should not be placed together and that the use of family group foster homes should therefore cease.[692] Between 1975 and 1989, at least two group home foster carers were subject to allegations of sexual abuse.[693]

9. In May 1996, the County examined the provision of alternative family care services, including fostering and adoption. It concluded that "*the current system is not working well enough … no change is not an option*";[694] there was a need for "*consistent good practice from all child care teams*".[695] However, a "*significant number of recommendations*" had not been implemented by the time of a follow-up review in 1999.[696]

679 NSC001235 para. 1.3; NSC001474 para. 4f.1
680 Children looked after at 31 March by placement, 2004 to 2006 (Table 4)
681 NCC003691 para. 3.135
682 Children looked after in England, year ending 31 March 2018, p7
683 INQ002431 para. 91
684 NSC001474 para. 4f.1; NCC003807 para. 3.9
685 Fostering Social care common inspection framework (SCCIF): independent fostering agencies
686 NSC000526_1; 17-19
687 NSC000447_3-5
688 NSC001235 para. 6k.2
689 NSC001235 paras 3c.ii.7-8; NSC000521_80-86
690 NSC000526_1; 17-19
691 INQ002608 para. 6(c); Jones 8 October 2018 32/11-33/6
692 Joint Enquiry Team Report part 5, recommendation 11
693 NSC000371 (F141); NSC000432 (F116 and F117).
694 NSC000931_4-5
695 NSC000931_7
696 NSC000920_1-7; NSC000945

10. Until 2000, the County devolved fostering services to a number of localities,[697] resulting in apparently differing responses to allegations across the County.[698] For instance, there are examples in Newark of a more child-centred approach,[699] whilst in Mansfield the approach taken in some cases appeared to be more focused on the interests of the foster carers.[700] In 2000, the management of the County's fostering teams was centralised within the County's Regulated and Corporate Parenting Services.[701]

11. Following the 1998 local government reorganisation, many carers living in the City area chose to continue to work with the County, creating for the City an "*immediate shortage of placement availability and choice for children in care*".[702]

12. From 2002, the Councils were subject to national minimum standards relating to their management of fostering services.[703] New national fostering service regulations came into force in 2002 and 2011,[704] as did regulations on statutory visits.[705] A new external inspection regime was also introduced, as discussed below.

Recruitment

13. From the late 1970s onwards, prospective foster carers applied to the County in writing, with references. Their assessment over three months included a series of interviews. Two social workers prepared assessment reports, the relevant fostering panel made a recommendation and a senior manager made the final decision on approval.[706] If successful, foster carers would be 'registered', usually with placement criteria recorded such as the age range of children, their previous history (for example, in some instances foster carers would specify that they would not want to take children who had been sexually abused) and the length of placement. In some cases, selection criteria and standards were not followed.[707]

14. In the last 20 years closer scrutiny has been applied to applicants' background history and to their motivation for fostering.[708] Reference checks became more wide ranging, including interviews with ex-partners and children formerly cared for by the applicants. It is now standard to explore with prospective foster carers the possible motivation for wanting access to children as well as the extent of empathy towards abused and vulnerable children.[709] After approval, a risk assessment is carried out to identify the child's needs and match them with foster carers. Where a child has been abused or has previously abused others, children's social care will try to obtain a lone placement to reduce risk.[710]

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[697] From 1974, 13 areas (six in the City and seven in the County) – NSC001235 paras 3c.i.7, 3c.i.9, 3c.i.10 – then from 1992 to 1998, nine Districts – INQ002007 para. 1.11.
[698] INQ002007 paras 27.8-27.10
[699] For example, NO-F111 (NSC000433_1-25, 40-48).
[700] For example, with NO-F108 and NO-F77 (Austin 19 October 2018 117/8-118/25).
[701] NSC000003_13-14
[702] INQ001984 para. 2.2
[703] *Fostering Services: National Minimum Standards* (2002)
[704] The Fostering Services Regulations 2002; The Fostering Services (England) Regulations 2011
[705] The Care Planning, Placement and Case Review (England) Regulations 2010 and The Care Planning and Fostering (Miscellaneous Amendments) (England) Regulations 2015
[706] NSC000447_3-5; NSC000002_67; NSC000351. This is now done by a countywide fostering panel and the final decision is made by an 'Agency Decision Maker' (NSC000972 para. 30; Blackman 17 October 2018 151/18-152/6).
[707] NSC000526_1; 17-19
[708] NSC000003 para. 133; NSC000002 paras 325-326: see also NSC000002_67-70
[709] NSC000002_67-70
[710] Austin 19 October 2018 108/2-18

Training and standards

15. By the mid-1980s, training was offered to foster carers but it was not mandatory.[711] There was a reluctance to engage in training by some foster carers who were subsequently found or alleged to have sexually abused children in their care.[712] Even in the 2000s, a reluctance to take up training was not a bar to continuing to foster, particularly if foster carers were experienced.[713]

16. All foster carers must now undergo induction training, meet certain standards within 12 months of approval and undertake ongoing training, which includes keeping children and young people safe from harm.[714] Sonia Cain, the City's Fostering Service Manager, thought that there should be more mandatory training.[715]

17. Since 2000, there has been a career pathway for approved foster carers in the County with increased payments according to evidence of learning and skill. The City has an accreditation scheme to support improved training and reward those foster carers who accommodate children requiring higher levels of skill or support.[716]

18. Since the Care Standards Act 2000, foster carers have been subject to national minimum standards.[717] These require "*the child's welfare, safety and needs*" to be at the centre of all decisions regarding their care.[718] When Jayne Austin became the County's Fostering Service Manager in 2002, she found instead an emphasis on the carer's needs.[719] By contrast, when inspecting the County's fostering services in 2004, the Commission for Social Care Inspection (CSCI) noted the then "*child-centred*" approach of its fostering panel.[720]

Supervision and review of foster carers

19. In the 1970s, a child's social worker would supervise both the child and their foster carers. As the social worker's primary concern was the child's welfare, this often resulted in foster carers feeling unsupported.[721] By the late 1980s, foster carers were allocated a separate fostering support worker (or 'supervising social worker') who provided support for the foster carers as well as scrutinising their skills and practice. Since 2002 there has been mandatory professional supervision of foster carers[722] and supervising social workers have been required to conduct at least one unannounced visit to foster homes each year.[723]

20. All foster carers have been subject to an annual review by the Councils since 1991,[724] which initially consisted of a team manager's review of the supervising social worker's report.[725] Since 2002, reviews have included a meeting between the carers and fostering team managers.[726] Annual reviews have been carried out since 2016 by a fostering

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711 NSC000002_71-72. Between 2002 and 2011 it was "*expected*" (NSC000002_30).
712 For example, Patrick Gallagher (see NSC000002_27), NO-F127, NO-F111.
713 NSC000002_71-73
714 Fostering Services (England) Regulations 2011, Regulation 17; *Fostering Services: National Minimum Standards*; *Training, Support and Development Standards for Foster Care*
715 Cain 19 October 2018 30/11-31/7
716 INQ001984 para. 13.4
717 The current standards being set out in *Fostering Services: National Minimum Standards*, Department for Education, 2011.
718 DFE000962_13; *Fostering Services: National Minimum Standards*, Department for Education, 2011
719 Austin 19 October 2018 100/21-102/18
720 NSC000967
721 NSC000357_8
722 NSC000003_13; NSC000002_70
723 *Fostering Services: National Minimum Standards*, Department for Education, 2011 – see standard 21(8).
724 Foster Placement (Children) Regulations 1991, Regulation 4.
725 Austin 19 October 2018 103/15-104/4
726 NSC000002_118-119

independent reviewing officer[727] (with further reviews if any allegations are made). Children's views of placements – including the foster carers' biological children – form part of the annual review.[728]

Visits to children in foster care

21. From 1955, social workers were required to visit foster homes once every two months in the first two years of placement, and every three months thereafter.[729] This was the primary check on the quality of care that children were receiving. However, several complainants, who were in foster care in the 1960s, 1970s or 1980s, told us that they were not visited on a regular basis, if at all.[730] Social workers were also required to carry out reviews of the child's welfare every six months.[731]

22. From 1991, the frequency of social work visits increased, with an initial visit after one week, and then every six weeks for the first year and every three months thereafter.[732] The expectation was that social workers would speak to the child alone, without the foster carers present, to give the child the opportunity to raise any issues. Team managers would check whether this had been done.[733]

23. Steve Edwards (the County's Service Director for Youth, Families and Social Work) and Sonia Cain were confident that social workers now see children alone in the County and City.[734] Since 2010, regulations have required that a child in care must be visited every six weeks unless the placement is long term.[735] In long-term placements, visits need only to be every three months (or every six months, after the first 12 months in the placement, if the child consents to this).[736] The Councils' visiting standards go slightly further than the six-week minimum required by regulations, requiring more frequent visits for long-term placements.[737]

Out-of-area placements

24. The use of out-of-area placements – where a child in the care of one local authority is placed within another authority's geographical area – is widespread across England and Wales and is subject to DfE statutory guidance.[738] Placements should be as close to the original local authority as possible, so that greater support can be provided.[739] In the past, where a child was placed in an out-of-area foster home it was common for the authority in which the child was placed to be asked to visit the child, but this is now less frequent. Under

[727] A fostering independent reviewing officer works for the local authority, but without line management responsibility for the supervising social worker or the foster carer (Edwards 23 October 2018 137/6-15; Cain 19 October 2018 34/21-35/5; NSC001235 para. 3c.iii.19).
[728] Cain 19 October 2018 32/10-35/5; Austin 19 October 2018 106/15-21
[729] From the Boarding-Out of Children Regulations 1955, which remained in force until they were replaced by the Boarding-out of Children (Foster Placement) Regulations 1988
[730] F37 3 October 2018 95/19-96/19; L48 4 October 2018 9/19-22; INQ002574 (L47, P1, L49); INQ002575 (NO-A184). The Gallagher Serious Case Review found that children did have opportunities to see professionals on their own in the 1990s and 2000s, but these professionals frequently changed (NSC000002_84 para. 422).
[731] Boarding-Out of Children Regulations 1955, Regulation 22; Boarding-out of Children (Foster Placement) Regulations 1988, Regulation 8
[732] Foster Placement (Children) Regulations 1991
[733] Cain 19 October 2018 8/1-9/24
[734] Edwards 23 October 2018 145/9-21; Cain 19 October 2018 8/1-9/24
[735] Those children in a placement in which they are expected to remain until the age of 18.
[736] The Care Planning, Placement and Case Review Regulations 2010 – see regulation 28.
[737] NCC003807 para. 3.3; Michalska 25 October 2018 65/9-66/21; Nottinghamshire County Council – Social Worker Visits to Looked After Children
[738] Out of Authority placement of looked after children: supplement to the Children Act 1989, DfE, July 2014
[739] Cain 19 October 2018 19/23-22/23

current practice, the child will retain their social worker, who will continue to conduct the required regular visits. Sonia Cain told us that fostered children who move out of the City may not be visited "*as frequently as they should*".[740]

25. When City foster carers move to another area,[741] the City notifies the relevant local authority and will discuss support and training for the foster carer with that authority's fostering team.[742]

D.5: External inspections

26. Until 2013, fostering services were inspected independently of other children's services and against national minimum standards set out in legislation.[743] Between 2004 and 2011, the Councils' fostering services received broadly positive assessments from these external inspections.

26.1. CSCI's inspection of the County in 2004[744] was positive. It found "*clear lines of management*" and the use of risk assessments to keep young people safe and minimise risk. A guide for children in placements, including a section on how to raise concerns, was "*excellent*". The County kept a "*centrally collated management system of numbers and outcomes of allegations of neglect or abuse of a child in foster care*".[745] Serious incidents and child protection issues had, where required, been notified to the National Care Standards Commission (NCSC). Foster carers found training to be "*excellent*".

26.2. The City's fostering service received a similarly positive report from the CSCI in 2005,[746] meeting all eight standards concerning the welfare of children in foster care. All foster carers had completed child protection training prior to approval.

26.3. In 2006, the County was found to have met the majority of the standards on which it was assessed.[747] Assessment and reviews of foster carers were completed to "*a high standard*" and there were increasing training opportunities (including on safeguarding and caring for abused children). However, recording of information by carers was "*wholly inappropriate*".[748] The City was advised to ensure all foster carer placements had been adequately assessed and approved, and to provide better support to carers located outside Nottinghamshire.[749]

26.4. In 2008, the County's service was rated 'satisfactory' by Ofsted, but with concerns raised about record keeping and record management. The fostering panel was now independent and there were risk assessments in relation to bedroom-sharing arrangements for young people who had been abused or had abused others, alongside "*robust*" initial risk assessments for all children placed with foster carers.[750] The City's

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[740] Cain 19 October 2018 23/17-25/14
[741] We did not hear specific evidence from the County on this point, as we did not receive any allegations of recent sexual abuse in out-of-County foster placements.
[742] Cain 19 October 2018 19/23-22/23
[743] *Fostering Services: National Minimum Standards* (2002), published under sections 23 and 49 of the Care Standards Act 2000 and alongside the Fostering Services Regulations 2002
[744] NSC000967
[745] Introduced following the Children Act 2004 – see Austin 19 October 2018 114/9-19. We have not seen evidence of the existence of this management system.
[746] OFS008047. Of the 21 national minimum standards assessed, they met 14, partially met five and did not meet two.
[747] NSC000956_29. They met or exceeded 18 out of 22 of the national minimum standards assessed.
[748] NSC000956_28
[749] OFS008049; OFS008050
[750] NSC000964

service was rated as 'good', with new policies on managing allegations, although central records relating to allegations and complaints did not contain sufficient detail. For example, dates of allegations and outcomes of investigations were not recorded.[751]

26.5. By 2011, the County's fostering service had improved to 'good'. Allegations were being taken seriously and placement planning, risk assessments and safe caring policies were 'good'.[752] The City's fostering service was also rated as 'good'.[753]

27. Since 2013, Ofsted has inspected children's services as a whole, rather than fostering services as a separate function.[754]

27.1. In 2014, the City was rated 'requires improvement' overall. Specific criticisms of its fostering service included insufficient information provided to foster carers about children being placed with them, and a need to ensure "*there is sufficient technical knowledge and expertise*" within its fostering and adoption service.[755]

27.2. The County's 2015 inspection[756] found most children to be living in stable placements and cared for by skilled foster carers. The fostering panel was "*effective*", with members receiving annual appraisals and performance development plans.

27.3. In November 2018, shortly after the conclusion of the Inquiry's public hearings, the City was rated as 'requires improvement' across its children's social care services.[757] In relation to fostering, Ofsted found that "*A small group of very young children have been left vulnerable in unsuitable private fostering arrangements*" with insufficient management oversight. Children's needs were said generally to be met, but those with complex needs experienced too many moves before finding stability. Plans to increase the range of local foster carers were progressing well, but decisions on matching them with children were not well recorded. By contrast, foster carers were supported well and were assessed to be of a high quality. Carers valued their supervising social workers and the quality of training and support provided.

27.4. A 2019 inspection of the County was a 'focused visit' and therefore did not look at fostering services.[758]

D.6: Responses to abuse

1970–1979

28. In the 1970s, the County had no policy or procedure in place for responding to allegations of sexual abuse against foster carers. The Inquiry has evidence of only three examples of institutional responses to allegations of sexual abuse in foster care, all of which show serious failings by children's social care:

[751] OFS008048
[752] NSC000003_14 para. 47; OFS008045
[753] OFS008034
[754] *The new Ofsted framework for the inspection of children's services and for reviews of Local Safeguarding Children Boards: an evaluation*, Ofsted, 2014
[755] OFS008020
[756] OFS007990
[757] Nottingham City Council, Inspection of children's social care services (2018)
[758] Focused visit to Nottinghamshire County Council children's services (2019)

28.1. Foster carer NO-F106 pleaded guilty to indecent assault of his two nieces, aged 8 and 11, and was given a three-year probation order in October 1976. Two foster children were returned to NO-F106 the following month. For at least two years, foster child NO-A272 and the foster carers were left "*without proper monitoring and advice*". NO-A272 subsequently made allegations of sexual abuse in relation to this period.[759]

28.2. F37 alleged she was abused by NO-F235 and told not to speak to social workers. After she ran away in 1974, she told a social worker "*how unfair*" NO-F235 was. She did not disclose the sexual abuse at the time because she did not think she would be believed.[760] NO-F235 denied the abuse when questioned in 1975 by children's social care following F37's later disclosure. No further action was taken.[761] By the time F37 disclosed to the police in 2015, NO-F235 had died.

28.3. In 1978, a "*meeting at County Hall*" considered allegations that foster carer NO-F234 had sexually abused a child in his care, aged 10, but was inconclusive in light of the foster carer's denial. The social worker's view was that "*a more searching enquiry could only be destructive*" to the foster carers and the complainant. No further girls were to be placed with the foster carers. It was noted that NO-F234 "*should in future take care*".[762]

29. In other instances of alleged sexual abuse in foster care during this period, complainants felt unable to disclose. For example, while in the City's care in 1972, L48 moved to Cheshire with his foster carers where he was sexually abused by his foster carer, NO-F275. L48 felt unable to disclose the abuse as he was not seen alone by a social worker. L48 was then sexually abused by his next foster carer, NO-F276, in 1975. L48 was again unable to disclose the abuse as he was worried he would not be believed and the abuse had made him question his own sexuality.[763]

1980–1989

30. From 1984, there were procedures governing child sexual abuse in foster care within the County.[764] They were not consistently applied:

30.1. In October 1985, NO-F138, a County residential care worker and foster carer, admitted indecently assaulting a foster child, NO-A325, from the age of 14. The abuse had been reported three months earlier, but the allegations were initially regarded as "*malicious*" by children's social care. The 1984 multi-agency child abuse procedures were not applied by either the police or children's social care until NO-F138's admission, despite three prior opportunities to investigate (including two reports of abuse of another child, NO-A326, in 1984). As a result, children were left at risk of abuse. Following his admission, NO-F138 was dismissed in March 1986 for "*a serious violation of trust*" and "*putting his sexual needs before those of a child entrusted in his care*".[765] Inexplicably, he was given 10 weeks' notice "*in view of the unfortunate background*".[766] An inquiry into this case in 1986, commissioned by Edward Culham, the Director of Social

[759] NSC000357_8
[760] F37 3 October 2018 94/20-139/8
[761] INQ002414
[762] NSC000367
[763] L48 4 October 2018 1/6-48/24. He added that when he eventually did disclose in 1985, he was not believed.
[764] NSC000075
[765] NSC000229_6
[766] NSC000229_7

Services, concluded that "*no officers who had been involved had got a grip of the situation*" and that "*close relationships*" between senior officers and NO-F138 had "*impaired judgements*".[767] In reality, the County's response was biased in favour of the perpetrator and protection of their own staff. The police only cautioned NO-F138 for his abuse of NO-A325, taking no action in relation to the abuse of NO-A326.[768]

30.2. The police failed to apply the procedures in 1986 when NO-A257, then aged 15, alleged that her foster father NO-F97 had sex with her when she was "*half asleep*", leaving money by her bed. She ran away and disclosed the abuse to her social worker. Given NO-A257's "*history of prostitution*", the police considered the abuse as her "*plying her trade rather than being harmed*". After "*considerable delay*", no further action was taken. Children's social care noted the delays and raised concerns at the police "*ridicule*" of NO-A257, recording that "*the needs of children rather than* [NO-F97's] *must be uppermost in our minds*". NO-F97 and his wife were removed from the list of specialist foster providers, but the couple were still to be considered for short-term placements.[769]

30.3. Procedures were followed when in March 1988 a foster carer (NO-F129) was deregistered and later that year stood trial but was acquitted.[770] He had been charged in late 1987 with the sexual abuse of two foster children. Following the acquittal, Rod Jones (then Principal Assistant – Child Care) gave a statement to the press saying that children's social care believed the girls and that, notwithstanding the acquittal, they would not be placing any more children with NO-F129.[771]

31. In 1989, a significant case of abuse by a foster carer was prosecuted, leading to an internal report and a considered response from the County. The internal report was prepared for David White, the Director of Social Services, in advance of the trial of Michael Chard. Chard was charged with sexually abusing a child in foster care over several years in the late 1980s. The report identified a number of failures by children's social care, including:[772]

31.1. Chard was allowed to foster children on his own from 1978, without proper assessment or sufficient scrutiny of his suitability to do so.

31.2. As well as being sexually abused by Chard, one child in his care, NO-A242, was also regularly sexually abused by her respite carer (NO-F88)[773] despite a social worker raising concerns about NO-F88's behaviour with children's social care in 1977, and recommending that no further children be placed with him.

David White acknowledged an "*increasing need to accept that the sexual abuse of children is a significant problem and that assessment practices and subsequent proceedings will need to be continuously improved.*"[774] In August 1989, Chard was convicted and sentenced to three years' imprisonment.[775]

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[767] NSC000229_10-15; NSC001235 paras 3c.iii.7, 5c.5
[768] NSC000229_4, 11, 13, 18
[769] NSC000352_1-20
[770] NSC000375
[771] INQ002007 paras 2.84; 12.1
[772] NSC000360_10
[773] Police believed NO-A242's complaints about this in 1988 but NO-F88 was not prosecuted because of his ill-health (NSC000360_9-12; NSC000344). The children remained in the placement because, although the children's social care believed that NO-F88 abused the children, it was felt that his wife would be more protective than ever.
[774] NSC000985_47
[775] NSC000360_13-17

32. Following this investigation and the cases which led to it, children's social care circulated a memorandum to senior managers in March 1989. Managers were asked to ensure that "*there is no doubt in the minds of your senior officers*" that child abuse procedures applied to all children in care, with "*no exception*".[776] Detailed investigation guidelines relating to abuse in foster care were also prepared.[777] These specified that carers' registration was to be reviewed after any investigation and, following a case conference, a senior manager would decide whether a placement could continue, whether other children were at risk, or any other necessary action.[778] Training was to be provided to foster carers on how their behaviour might be interpreted by a child, as well as on dealing sensitively with abused children placed with them.[779]

33. Rod Jones also reminded all foster carers of the risks and responsibilities involved in foster care:

> *"Any person with reason to believe that a child has been abused should bring this to the attention of the Area social worker … In the few occasions when this happens within foster care, the child still gets first consideration …* "[780]

1990–1999

34. Approximately six months after Chard's conviction, in February 1990, another foster carer, NO-F141, was charged with sexual offences against three foster children. Over 25 years he had fostered 400 children, including a large number of teenage girls who had previously been sexually abused. NO-F141 admitted offences against one child, but denied the others, calling the girls "*liars*". The 10 children then placed with NO-F141 were moved.[781]

35. A number of investigations of abuse in adoption or foster families prompted children's social care[782] to prepare an internal monitoring report (the Davis report).[783] It was widely circulated, including to David White, the Chair of the Social Services Committee (Joan Taylor) and one other councillor.[784] Rod Jones described the extent of abuse in foster care set out in the Davis report as "*considerable*".[785] It recorded 10 allegations of sexual abuse between April 1989 and March 1990.[786] Some led to prosecution or deregistration, but in others there was no formal action or the outcome was unknown. While the report noted positive steps taken by children's social care over the previous 18 months (including a revised policy and procedure guide, training strategies and a monitoring process),[787] it highlighted concerns about what had happened in practice. This included staff dismissing allegations by prejudging the complainant or inappropriately taking the side of the accused foster carer. Recommendations included introducing an improved code of practice on investigation of allegations, increased training of foster carers, and a requirement to have an ongoing

[776] NSC000944_1
[777] NSC000985_10-12; NSC000985_48-49
[778] NSC000985_49 para. 6; NSC000985_12
[779] NSC000985_49 para. 7
[780] NSC000944_2
[781] NSC000985_8-9; NSC000371_1_3
[782] NSC000985_17-18
[783] NSC000977_101-118
[784] NSC000977_102
[785] INQ002007 para. 2.88
[786] NSC000977_112-118 including some explored above.
[787] NSC000977_103-104

and monitored central record of allegations of carer abuse.[788] We have seen no evidence that these recommendations were implemented, other than a brief section on foster care included in the 1992 ACPC Child Protection Procedures.[789]

36. When asked about his views on the level of abuse in foster care at this time, David White (the County's Director of Social Services from 1989 to 1994) explained that he had had no direct involvement in the day-to-day running of the fostering service.[790] Abuse in foster care was not an area he had focused on because it had not been brought to his attention as frequently as other matters.[791]

37. Rod Jones thought there was a misplaced belief that foster carers were "*exceptional carers*"; consequently abuse was more likely to remain undetected. Barriers such as shame and threats from perpetrators prevented foster children from disclosing abuse.[792]

38. Similar issues to those identified in the Davis report were raised by the case of Norman Campbell, a residential care worker who was approved as a foster carer in 1987.

38.1. At the time of his approval as a foster carer, concerns were raised by two children's social care staff about Campbell's close relationship with NO-A197, a child who he was seeking to foster. These concerns were known by those considering his application. Campbell dismissed the concerns as "*racist*". A meeting was held, at which the staff members who had raised the concerns were left feeling "*belittled*" and "*chastised*" by the response of children's social care managers Tony Dewhurst and Paul Bohan.[793] In May 1988, another child (NO-A198) alleged that he had been sexually abused by Campbell. There were no applicable child protection procedures at that time as NO-A198 was regarded as a "*child outside the home*".[794]

38.2. Following a police investigation, the Crown Prosecution Service did not prosecute and disciplinary proceedings found NO-A198's allegations "*not proven*"[795] but both the County's Child Protection Officer and the police believed NO-A198's account. Campbell returned to residential social work as deputy officer in charge of a children's home. The fostering panel relied on a previous positive assessment in deciding that Campbell should be allowed to continue to foster.

38.3. Further children alleged sexual abuse by Campbell in 1990 and in the following year he was sentenced to six years' imprisonment for sexual abuse of three children, including NO-A197.[796] Tony Dewhurst now accepts that he and others had not been "*sharp enough*" to realise what was happening.[797]

39. David White notified the Social Service Inspectorate (SSI) in 1991 about the Campbell case, drawing attention to the steps that had been taken since and to the fact that guidance on sexual abuse by non-family members was now included in the ACPC procedures.[798] The

[788] NSC000977_108-111; Jones 8 October 2018 41/7-20
[789] NTP001473_63
[790] INQ001934 para. 74
[791] White 8 October 2018 135/1-136/4; INQ001934 paras 73-76. (Although he acknowledged that he was sent a copy of the Davis report: NSC000977_101-118)
[792] INQ002007 para. 29.13
[793] NSC000103_8-13, 27-28
[794] NSC000103_22
[795] NSC000103_21
[796] NSC000154_22-26; INQ001220; INQ002406
[797] INQ002731 para. 17.4
[798] NSC000164_1-2

SSI suggested an enquiry be carried out by an external "*consultant*".[799] An internal review was instead undertaken and in July 1992 made numerous recommendations, including that any allegation involving a foster carer should prompt a formal review of both the carer and the placement (noting that this had already become children's social care policy in the County) as well as more rigorous assessment and approval of foster carers. Echoing the Davis report in 1991, the review recommended a central monitoring system of allegations against foster carers (and children's social care employees).[800]

40. As at September 1994,[801] the ACPC Child Protection Procedures referred to a "*monitoring process for alleged carer abuse*".[802] The system was to be operated by a specific member of staff with details of allegations of abuse against foster carers and the outcome centrally recorded. An annual report was to be supplied to a senior manager detailing "*numbers, outcomes and trends in carer abuse*". Despite this, other than the Davis report in 1991 and one monitoring sheet from 1992,[803] we have no evidence of central monitoring of allegations until 2004.[804] Had the model of the Davis report in 1991 been followed, this would likely have increased the understanding of the scale of sexual abuse in foster care, the steps needed to address it and improved the institutional response. Even this would not have been sufficient. There should have been monthly reports on numbers and outcomes to senior managers, councillors and the ACPC, and a system allowing for proper scrutiny of that information.

41. Following the Campbell case, there is evidence that children's social care was aware of 11 further instances of allegations of sexual abuse in foster care in the County over the next six years.[805] In many of these cases, action was taken by the County in response (such as moving the child or deregistering the foster carer). In one case, however, a foster carer was allowed to return to his employment working with children without further assessment after an investigation could not substantiate the allegations.[806] Only two of the 11 cases led to convictions of foster carers,[807] although children's social care or the police had serious concerns or thought abuse had occurred in several others.[808] In one case, in which Douglas Vardy was convicted of sexually abusing three foster children, it was identified that one victim, NO-A256, had been removed from her family because of abuse and then been sexually abused in each of her three foster placements.[809]

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[799] NCC003089
[800] NSC000103
[801] NSC000077_162-167
[802] NSC000077_166-167
[803] NSC000977_15-16: this listed allegations against County childminders and carers, including six allegations of sexual abuse in foster care in 1991. None had the outcome or comments recorded.
[804] Introduced following the Children Act 2004 – see Austin 19 October 2018 114/9-19
[805] NO-F64 (NSC000373); NO-F196 (NSC000977_22-46); NO-F118 (NSC000370; NSC000474); NO-F130 (NSC000376); NO-F126 (NSC000358); NO-F109 (NSC000362); NO-F116 and NO-F117 (NSC000432); Douglas Vardy (NSC000351); NO-F108 (NSC000368); NO-F98 and NO-F99 (NSC000353); NO-F111 (NSC000433).
[806] NSC000368_27; Stimpson 17 October 2018 25/1-26/18
[807] NO-F64 (NSC000373); Douglas Vardy (NSC000351). There was also one conviction of the son of foster carers (NO-F119 – NSC000370; NSC000474).
[808] NO-F196 (NSC000977_22-46); NO-F118 (NSC000370; NSC000474); NO-F130 (NSC000376); NO-F126 (NSC000358); NO-F111 (NSC000433).
[809] NSC000351_10

2000–2009

42. The allegations received during this period primarily concerned non-recent sexual abuse. Under procedures at the time, allegations of non-recent abuse were to be responded to in the same way as contemporary allegations, including prompt referral to social services, discussion with the police if appropriate and a strategy meeting to plan the way forward.[810]

43. Between 2002 and 2006, there were at least seven cases in which allegations of sexual abuse of children by their foster carer were reported to police and investigated but did not lead to conviction.[811] Crown Prosecution Service guidance at the time, which has since been revised, required prosecutors to consider the relevance of previous sexual history[812] or the possible motive for making allegations.[813] In one case where a foster carer was acquitted, one of the complainants had disputed the accuracy of entries in records about him being happy with the alleged perpetrator and this was considered to fatally undermine his credibility.[814]

44. In 2002, NO-F114 and NO-F115 were arrested following allegations relating to sexual abuse in the late 1970s. Two complainants had disclosed the abuse in 1983, but no further action had been taken despite children's social care at the time believing the allegations. It was noted in 1983:

> "*Presumably therefore, what* [NO-A91] *says* [NO-F114] *did with her is true. It was agreed that neither girl should know about today's discussion, and that there would be no point in pursuing it further.*"[815]

A strategy meeting in 2002 concluded that there was no attempted "*cover up*" by children's social care employees who had known of the disclosures at the time. No action was taken against them. The response in 1983 had allowed NO-F114 to continue fostering, exposing children to further risk. Following an initial decision to prosecute in 2002, the case was ultimately discontinued due to "*insufficient evidence*".[816] The reasons are unclear.

45. In 2004, the Crown Prosecution Service decided not to charge NO-F191 with sexually abusing her former foster child, NO-A394. The allegations were considered to be "*substantially undermined*" as NO-A394:

- had made previous allegations which were referred to children's social care but did not repeat the allegations when interviewed by the police;[817]
- admitted sexually abusing other children in the placement;[818] and
- would likely be accused of making the allegation to seek revenge on NO-F191 for ending contact with him.[819]

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[810] NSC000079_180
[811] There was one conviction of a foster carer, William Boden, in 2002, for offences over a 20-year period against children not in care (INQ001673).
[812] CPS002792: the Crown Prosecution Service Prosecution Manual 1996 states that "*The character of the complainant cannot be ignored when considering an alleged sexual offence. Such evidence may be relevant to the question of consent.*"
[813] CPS002787_5 para. 5.3e: the Code for Crown Prosecutors 2000 required consideration of the witness's background, including whether they may have any motive or relevant previous convictions.
[814] NSC000365; NTP001636_21-25
[815] NSC000369 4
[816] NTP001636_11-15
[817] Police investigators thought that he had been "*primed*" not to say anything, but would, in any event, be cross-examined on the basis that he had made "*previous unproven allegations*" (NTP001178_1).
[818] NTP001178_1
[819] NO-A394 was not happy in the foster placement and was placed elsewhere, but NO-F191 decided to stop fostering and end all contact with NO-A394 (NTP001178_1).

Although these features were not uncommon, Sue Matthews (a Senior Crown Prosecutor) said that they would still cause her concern today if she were advising on the case.[820] NO-F191 resigned from fostering following the allegations but children's social care continued with their own investigations. NO-F191 was deregistered in 2005 following a unanimous recommendation from the fostering panel.[821]

46. In 2003 and 2005, the Crown Prosecution Service concluded that there was insufficient evidence to prosecute Raymond Smith for alleged sexual abuse of two fostered children (aged 10 and 13), due to undermining evidence in social services records and from other witnesses.[822] Smith had privately fostered over 100 children during the 1980s before becoming a local authority approved foster carer in the 1990s.[823] He was deregistered as a foster carer by the City in 2004,[824] but no documents are available regarding the response to these allegations. It does not appear that any wider enquiries were carried out by the City at that time,[825] nor was the matter reported to the NCSC as required.[826]

47. In 2014, further allegations of non-recent abuse were made against Raymond Smith. In response, Smith "*minimised the allegations*" by saying that one complainant "*had been 15 years old at the time and that he was a man and enjoyed it*".[827] It also emerged that in 1981, Smith had been found in bed with a 15-year-old boy by his ex-wife.[828] Strategy meetings recorded that "*During their tenure as foster carers, allegations were made against Ray Smith by a number of young people of a sexual nature*" and "*it is uncertain why Mr and Mrs Smith were approved as long-term carers*".[829] This was a serious failure. Ultimately, in 2016, Smith pleaded guilty to indecent assault of a different child (who was not in care) and received a two-year suspended sentence.[830] We have not seen any evidence of the City, as required, notifying their Local Safeguarding Children Board (LSCB) about the case,[831] nor of consideration given by the LSCB as to whether the case should be subject to a serious case review or internal practice review into how Smith had been approved as a foster carer and had remained approved for so long. An independent review should have been carried out.

48. In 2006, NO-A286 again disclosed (having retracted her initial allegations, made in 1988) that she had been abused in the late 1980s by her foster carer, Stephen Noy, who was no longer fostering. A series of strategy meetings concluded that the allegations remained unproven.[832] The Crown Prosecution Service decided not to prosecute due to concerns about NO-A286's credibility, partly on the basis of her poor behaviour as recorded in her social care records.[833] In 2013 another complainant came forward alleging abuse by Noy, who was then charged in respect of both. Noy was convicted and sentenced to 17.5 years'

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[820] Matthews 23 October 2018 10/20-13/10
[821] NTP001178; NSC000910
[822] INQ001780_17-18
[823] NCC000594_2
[824] NCC003691 paras 7.22-7.26
[825] Relevant procedures required those undertaking investigations into allegations of abuse to be *"alert to any sign or pattern which suggests that the abuse is more widespread or organised than it appears at first sight"* (NSC0000079_178).
[826] Fostering Services Regulations 2002, Schedule 8
[827] NCC000594_3
[828] NCC000594_8
[829] NCC000594_4, 13
[830] NCC000594; NCC003691 paras 7.22-7.26; CPS004382 para. 523
[831] The Councils were required to notify Ofsted and their LSCB of notifiable incidents.
[832] NSC000372_1-17, 36-59
[833] CPS004382_87 para. 548; Crown Prosecution Service guidance now advises greater scepticism about such records and states that children who have been in care should not be disadvantaged by the extent to which their behaviour is recorded (*Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated Nov 2018) para. 53).

imprisonment in 2015.[834] Again, we have not seen any evidence that the County notified Ofsted or their LSCB of the case, nor of whether consideration was given to a serious case review or internal practice review by the County's LSCB. Such a review should, at the very least, have been considered.

49. In 2006, following allegations against foster carer NO-F70 of harassment and child sexual abuse which were not pursued by the IFA responsible for the foster carers,[835] NO-F70 and his wife moved to the Isle of Wight[836] with D6, then aged 10 and in the care of the City (although he had been placed in Yorkshire). Once on the Isle of Wight, D6 was physically, psychologically and sexually abused by NO-F70. Visits by City social workers became sporadic and were regularly cancelled. D6 was eventually removed from the foster placement in 2009, after others made allegations of sexual abuse against NO-F70. There was no investigation by the City into whether D6 had been abused, nor strategy meetings held to consider whether any other children placed with the foster carers might have been abused. D6 disclosed the abuse to Nottinghamshire Police in 2017, who mistakenly thought the abuse had occurred in Yorkshire so passed the case on to that force and ceased contact with D6. Chief Superintendent Robert Griffin commented this was "*not good enough*".[837] This is true of the response of both the City and the police.

2010–2018

50. This period is marked by two significant cases in the County – Patrick Gallagher and NO-F77 – each involving sexual abuse of foster children by their foster carers. Both cases led to reviews of practice. Over the same period, there were also a number of other allegations of sexual abuse against foster carers which show problems with the Councils' institutional responses.

51. Patrick Gallagher and his wife were respite foster carers for the County from the late 1980s.

51.1. In 2006, a child who had been placed with them disclosed to his permanent foster carer that Gallagher made him watch pornography. There was no prosecution but, following a children's social care investigation, the Gallaghers wrote to children's social care to say they wanted to resign from fostering. Children's social care refused to accept the resignation and instead decided to formally deregister the Gallaghers in the same year, following the fostering panel's recommendation.[838]

51.2. Further allegations emerged in November 2010 following Mrs Gallagher's death. Patrick Gallagher quickly admitted offences in the face of overwhelming evidence, including video tapes.

[834] CPS004382_88 para. 551
[835] INQ002785; INQ002784. See paragraph 6 above.
[836] INQ002785; INQ002784
[837] Griffin 25 October 2018 202/22-203/7
[838] NSC000380_1-11; 113-116

51.3. In May 2011, Patrick Gallagher pleaded guilty to 55 sexual offences, including rape, committed against 16 boys between 1998 and 2010.[839] Gallagher received 13 life sentences and was to serve at least 28 years. He abused young boys on an "*unprecedented scale*" and did "*incalculable*" damage.[840] None of the abuse was detected over this 12-year period.

51.4. A serious case review was commissioned, written by Peter Maddocks,[841] and published in December 2011.[842] It focused on the seven children who had been in the County's care when abused by Gallagher, aged between eight and 14 at the time of the abuse. In addition to identifying significant barriers to disclosure faced by the children, key findings included:

- The initial assessment of the Gallaghers as foster carers was more rigorous than required by the standards of the time, although there would be greater scrutiny now.[843]
- The Gallaghers were consistently reluctant to undergo training.[844] This would not be accepted now and should not have been accepted at the time, at least not after the introduction of national minimum standards in 2002.[845]
- In 2006, the police were insufficiently involved and children's social care proceeded without focusing on the allegations from a child protection perspective, but these failures made no difference to the outcome.[846]
- In hindsight, there had been a failure to recognise and respond to the potential significance of behaviour exhibited by some children and of Gallagher's behaviour. Both highlighted the importance of training and the need for specialist social workers and police officers to be involved in discussions about the significance of behaviour displayed by children and adults.[847]
- Social workers often did not see the children in placement at the Gallaghers.[848] Much of the social work case-recording had focused on the physical environment rather than more complex information such as the child's views, wishes and feelings.[849]

The serious case review recommended more therapeutic and support services for victims and survivors.[850] Phil Morgan, the County's Fostering Team Manager for the Mansfield District at the time, thought that children's social care "*got off the hook*" with the serious case review. He thought that children's social care should have acknowledged their failures in safeguarding, fostering and not identifying the abuse at any time over 12 years.[851] We agree.

[839] CPS002694; CPS004382_39; NSC001235_84 para. 5n.2
[840] https://www.bbc.co.uk/news/uk-england-nottinghamshire-13527480
[841] Peter Maddocks was appointed in June 2011 as the "*independent author*" (NSC000002_17).
[842] NSC000002
[843] NSC000002_66 para. 308
[844] NSC000002_27 para. 110
[845] DFE000962_13; NSC000003_13
[846] NSC000002_76-82
[847] NSC000002_59 para. 296.cc
[848] NSC000002_88 para. 449
[849] NSC000002_88 para. 451
[850] NSC001235_86 para. 5n.10
[851] Morgan 17 October 2018 93/10-94/9

51.5. Additional complainants came forward after Gallagher's conviction; he received a police caution as the Crown Prosecution Service decided it was not in the public interest to pursue another prosecution given that he was never going to be released.[852] Chief Superintendent Griffin thought Gallagher should have been charged with those additional offences as it would have made a positive difference for the complainants.[853]

52. NO-F77 and his wife NO-F76 were foster carers from 1988 until 2012, fostering over 30 children in that time.[854]

52.1. In 1995 and 1998 reports of sexual abuse and sexualised behaviour were made to NO-F76 about NO-F77 regarding two children in their care (NO-A203 and NO-A200). NO-F76 passed the allegations to their supervising social worker Mrs Chris Middleton, who failed to take any action in response.[855]

52.2. In 2000, NO-A200 reported to a care worker that he had been sexually abused by NO-F77. This led to a multi-agency investigation. Phil Morgan urged colleagues to keep an "*open mind*" about whether NO-A200 may have fabricated the allegation, and that four incidents involving NO-F77 and NO-F76 over a long period as foster carers was "*not bad going*".[856] Although he told us that he regretted this almost immediately,[857] these phrases, taken together, amounted to inappropriate language for a professional to use in a formal meeting about sexual abuse and indicated a presumption against the child's truthfulness. Such comments are likely to have prejudiced a proper consideration of NO-A200's allegation from the outset.[858]

52.3. NO-A200 did not retract his allegation, despite being given the opportunity to "*change or retract his story*",[859] but the police took no further action due to concerns about NO-A200's credibility.

52.4. The strategy meetings concluded that "*the allegations cannot be substantiated nor can they be dismissed*".[860] The "*differing professional views*" as to whether the abuse was likely to have taken place should have been resolved.

52.5. Mrs Middleton felt it would be unfair for NO-F77 and NO-F76 to have to stop fostering,[861] but failed to raise at the strategy meeting that allegations had been made against NO-F77 in 1995 and 1998. She and Mr Morgan concluded they had "*no doubt*" that NO-F77 did not abuse NO-A200 and in a report for the fostering panel "*strongly*" recommended they were reapproved as foster carers.[862] Although Kathy Swift, chair of the strategy meetings, expressed "*reservations*" about NO-F77 and NO-F76 continuing as foster carers in a letter to the fostering panel,[863] the views of Mrs Middleton and Mr Morgan were given precedence over a thorough investigation.[864]

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[852] NTP001696. DC Hicks agreed with this decision (Hicks 19 October 2018 161/1-7).
[853] Griffin 25 October 2018 191/9-193/9
[854] NSC000003_4
[855] Morgan 17 October 2018 59/13-61/11; NSC000003_20-23
[856] NSC000434_1-10: this included allegations of physical abuse.
[857] Morgan 17 October 2018 64/16-65/1
[858] Morgan 17 October 2018 62/3-63/21
[859] NSC000434_13
[860] NSC000434_14-17
[861] NSC000434_16
[862] NSC000434_27-34; Morgan 17 October 2018 71/10-73/13
[863] NSC000434_35-36
[864] Morgan 17 October 2018 80/1-17

52.6. The fostering panel was convened, with Mr Morgan as a voting member even though this was a conflict of interest given his previous involvement.[865] Mrs Middleton presented the case in favour of NO-F77 and NO-F76's continued registration, and no one presented the opposing view.[866] The panel agreed unanimously that NO-F77 and NO-F76 should be reapproved. No consideration was given to reassessment of NO-F77's continued suitability to foster,[867] although the couple were to receive training on "*sexual safety*".[868]

52.7. In 2012, NO-F77 was witnessed exposing himself to a five-year-old foster child and another fostered child then disclosed that she had been sexually abused by him. By this time, NO-F77 and NO-F76 had fostered over 30 children. NO-F77 was suspended from fostering by the County and multi-agency strategy and planning meetings were held.[869]

52.8. An internal practice review was carried out in October 2012 and was critical of the County's response.[870]

- The supervision of NO-F77 and NO-F76 was undertaken by the same social worker (Mrs Middleton) from 1988 until 2010:

  > *"The relationship … was much too focused on support to the carers and when allegations were made the response was to defend the carers … there was intolerance to receiving information that contradicted accepted and long established beliefs about the competence and capacity of the carers".*[871]

- Safeguarding procedures should have been invoked on a number of occasions, but the supervision of NO-F77 and NO-F76 by children's social care was poor.[872]
- There was a general assumption that once a carer was approved, they would be trusted. This approach presented a "*risk of abuse to children*".[873]
- There was a need for children in care to have access to systems for raising concerns and complaints.

  > *"The strongest measure for safeguarding children is to ensure that every looked after child understands how to raise concerns, is given access and support to talk to people and can have confidence that their concerns will be treated seriously irrespective of their history and background."*[874]

- Much of the file records concentrated on the difficulties children were presenting to the carers, rather than any challenge to the foster carers or focus on what they were doing.[875]

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[865] Morgan 17 October 2018 73/14-75/7
[866] Morgan 17 October 2018 75/8-25
[867] Morgan 17 October 2018 77/16-78/5. In 2000, there was no requirement to conduct a full reassessment following allegations (NSC000077_164), but this was identified in the Internal Practice Review in 2012 as something that should happen going forward (NSC000003_40, 42).
[868] NSC000434_37-41
[869] NSC000434_42-104
[870] NSC000003 – by the same author as the serious case review into Patrick Gallagher.
[871] NSC000003_33-34 paras 140-141
[872] NSC000003_35 para. 149
[873] NSC000003_35 para. 153
[874] NSC000003_40 para. 187
[875] NSC000003_32 para. 133

- The fostering panel's decision in 2000 was "*flawed and unwise*". The panel were provided with imbalanced information, influenced by the "*defensive alliance*" supporting NO-F77 and NO-F76.[876]

The report made six recommendations,[877] including to ensure independent oversight of the management of complaints and concerns, and to bring forward proposals for rotating supervision of foster carers. The County considered the feasibility of the latter recommendation in October 2012 and concluded that instead of automatic rotation of supervising social workers, there should be routine consideration of a supervising social worker's involvement with foster carers.[878]

52.9. The findings of the internal practice review were regarded as "*extremely concerning*" by senior managers in children's social care.[879] We would have expected Phil Morgan's conduct to have been subject to a disciplinary investigation, as should that of Mrs Middleton had she still been employed.

53. The case of NO-F77 illustrated a culture within certain fostering teams that the interests of foster carers outweighed those of the children placed in their care. In NO-F77's case, it meant that he was allowed to go on to abuse other fostered children.

54. These examples highlighted significant failures in practice. Although it ultimately led to the two foster carers being deregistered and convicted, no action was taken against the supervising children's social care staff. In response to the Gallagher and NO-F77 cases, in 2012 the County sought to evaluate its approach to its foster care practice by commissioning an external independent audit of 19 cases of allegations against foster carers, of which six cases caused "*some concern*".[880] The audit concluded there was a lack of robust management within the fostering service. It also identified cases in which procedures were not followed, recording was inadequate and there were unexplained delays in responding to allegations.

55. Subsequent audits were then carried out into randomly selected foster carer files in January 2013. The audits recorded good adherence to most policies, procedures and national minimum standards, but noted there were some problems with supervision visits and a lack of unannounced visits.[881] Jayne Austin (Fostering Service Manager) responded to the audit reports' criticisms in a report in May 2013, pointing out what she considered as good practice that was ongoing.[882]

56. In June 2013, NO-F77 and NO-F76 were deregistered following the unanimous recommendation of the fostering panel.[883] The panel noted that had full information been provided in 2000 (for example the allegations in 1995 and 1998) the outcome would have been different at that time. In January 2014, NO-F77 was sentenced to eight months' imprisonment.[884]

[876] NSC000003_39 paras 174-180
[877] NSC000003_40-42
[878] NSC001349
[879] Morgan 17 October 2018 83/5-85/19
[880] INQ001812
[881] NSC001348
[882] NSC001352; Austin 19 October 2018 137/10-17
[883] NSC000434_113-116
[884] NSC000434_96-104

57. In 2016, further allegations against NO-F77 were made, this time by NO-A302.[885] The Crown Prosecution Service decided not to prosecute,[886] but strategy meetings found the allegations substantiated. There was a delay in informing NO-A302 of this due to concern about conflict between the County's safeguarding process and perceived risks of civil claims.[887]

58. In 2011 and 2012, there were two cases in which the County's fostering service and fostering panel considered there to be too much risk for them to allow the foster carers to continue fostering. This was different from the approach of the Independent Review Mechanism (IRM) panel, which focused more on the consequences of any decision for the foster carer and whether the allegations could be substantiated.[888]

58.1. In August 2010, allegations of sexual abuse in foster care were made against NO-F165. The police and children's social care agreed that the allegations were credible, but in December 2010 the Crown Prosecution Service decided not to prosecute. In June 2011, NO-F165 was deregistered following the unanimous recommendation of the fostering panel.[889] In response to NO-F165's appeal against deregistration, in October 2011, the IRM panel recommended that his approval to foster should continue, having found that the County had disregarded the views of an experienced social worker who knew the carers well and that there were "*serious flaws in the child protection investigation*". It concluded that the reason for refusal appeared to have been based on children's social care's best interests, rather than their "*duty of care*" to NO-F165. The IRM panel did not refer to risk, which should have been the primary concern when considering safeguarding.[890] In light of the IRM's recommendation, the County's 'Agency Decision Maker'[891] decided that NO-F165 and his wife were suitable to continue as foster carers, although training and careful supervision were required.[892]

58.2. Following harmful sexual behaviour between two children in different foster families in 2012, the foster carers of the child exhibiting harmful sexual behaviour were deregistered due to their failure to properly assess the risk posed by the child exhibiting harmful sexual behaviour. In 2013, the IRM panel again recommended that the decision be reversed, and that the foster carers be allowed to continue fostering.[893] This recommendation was rejected; the deregistration was upheld on the grounds of flawed management of risk, lack of trust and "*serious failure to safeguard both your own looked after child and another looked after child in spite of knowing the risks posed, resulting in serious harm*".[894]

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[885] NO-A302 had formerly been fostered by NO-F77's brother-in-law (NSC000434_120-159).
[886] CPS003412
[887] Morton 23 October 2018 94/20-95/15
[888] Since 2009, foster carers who are deregistered can appeal to the Independent Review Mechanism – a statutory body currently run by Coram Children's Legal Centre on behalf of the DfE. IRM panels will include a minimum of five members, who have professional or personal expertise in adoption or fostering (Independent Review of Determinations (Adoption and Fostering) Regulations 2009).
[889] NSC000378_1-26; 45
[890] NSC000378_27-35
[891] An Agency Decision Maker is someone employed by a fostering service provider (such as a local authority) to make the final decision about whether to approve or continue to approve a foster carer (and if so, on what terms) following a recommendation by the fostering panel (INQ001853 paras 2-5).
[892] NSC000378_27-40, 46-49. The Agency Decision Maker is required to take the recommendations into account, but can come to their own view.
[893] On the basis that: they had shown long-term commitment to, and understanding of, children in care; they had shown willingness to reflect and learn from their practice; they were experienced carers who had shown the ability to meet the needs of challenging young people; and they had remained child-focused throughout their fostering career (NSC001607).
[894] NSC001602; NSC001589

59. Following these cases, there were a number of other allegations of sexual abuse in foster care. The responses showed failures in joint working, including inconsistent approaches to decision-making, cases not being passed by the police to the Crown Prosecution Service for a charging decision, cases not always being referred to the fostering panel, and apparent failures to notify Ofsted or councillors.

59.1. In 2012, NO-A161 disclosed that she was sexually abused by her foster carer, NO-F35. The police considered there was insufficient evidence to pass the case to the Crown Prosecution Service and the multi-agency strategy meetings concluded that the allegation was "*unfounded*". NO-F35 was able to continue fostering without the required referral to the fostering panel to assess his continued suitability.[895] Further allegations against NO-F35 were made by NO-A160 in 2014. By this time there were around 10 allegations of sexual abuse against him (including those by NO-A159 in 2007[896]). The police considered the allegations to be unsubstantiated and decided to take no further action without referral to the Crown Prosecution Service. Despite this, the City took a thorough approach to evaluating the risk posed by NO-F35, and commissioned the NSPCC to carry out an independent investigation and risk assessment. This concluded in March 2015 that NO-F35 posed an unacceptable level of sexual risk and should not be allowed to care for vulnerable children.[897] In August 2015, further allegations of sexual abuse against NO-F35 were made by NO-A159 and NO-A163. These allegations were regarded as credible and the Crown Prosecution Service decided to charge NO-F35.[898] In May 2016, the fostering panel unanimously recommended termination of NO-F35's registration as a foster carer.[899] In 2017, he was acquitted of all charges.

59.2. In May 2015, a child in foster care (NO-A779) with the City disclosed to her teacher that she had been in a sexually abusive relationship with a 27-year-old male when she was aged 15.[900] Her foster mother was aware of the sexually abusive relationship but decided not to report it as she had wanted to deal it with 'like a "normal" family'. It was decided that the foster carer was suitable to continue as a foster carer, and that it was in NO-A779 and her sister's best interests to continue in the placement given the need for stability. The matter was never referred, as recommended in the foster carer review, to the fostering panel to consider the carer's continued approval.[901] This was questioned by the fostering panel following the foster carer's resignation in January 2017.[902]

59.3. In December 2016, NO-A104 alleged to children's social care that he had been sexually abused by his former foster mother, NO-F80, in the 1980s.[903] The Crown Prosecution Service received legal advice from external counsel that NO-F80 was unlikely to be convicted, despite the complaint being credible, because NO-A104 had previous convictions, a troubled background, mental health issues and had made a

[895] NCC000593_1-16
[896] NCC000593_3
[897] NO-F35 had said, as part of the assessment, that sexually abused children could prevent the abuse from happening, that some were capable of leading adults on and that some make up allegations for attention (NCC000316_1-11; NCC000593_48-55).
[898] NCC000593_56-94; CPS003393
[899] NCC000593_95-101
[900] NCC000293_18-40
[901] NCC000293_18; NCC000293_25
[902] NCC000293_37-38; NCC003811 para. 11
[903] NSC000361

number of allegations. Sue Matthews, the Crown Prosecutor, decided not to charge NO-F80.[904] The County's subsequent decision that the allegations were unsubstantiated had not, it was said, been influenced by the Crown Prosecution Service decision.[905]

59.4. In September 2017, allegations of sexual abuse were made by a child placed in 2015 against his previous foster carers, NO-F423 and NO-F424.[906] There was an initial failure to hold an emergency strategy meeting and, although contact was made with the police and the complainant was interviewed, children's social care told the foster carers about the allegations two days before the police saw them. Following a meeting of the fostering panel in May 2018, NO-F423 and NO-F424 were deregistered as foster carers. In February 2019, the Crown Prosecution Service decided not to charge the alleged perpetrators. We have no evidence as to whether the case has been considered for a child safeguarding practice review or if a notifiable incident form was sent to Ofsted. Councillor David Mellen was not formally notified but was told by Alison Michalska during a meeting which was not minuted.[907]

59.5. In December 2017, NO-A626 alleged that he had been sexually abused by his foster carer, NO-F292. The allegations were considered to be unsubstantiated following a multi-agency strategy discussion and a joint police and children's social care investigation. Notwithstanding this conclusion, in February 2018, the County followed the serious incident notification process by notifying Ofsted, and the fostering panel was to review NO-F292's approval as a foster carer.[908]

60. The extent of sexual abuse in foster care in the 1970s and 1980s was compounded by poor decison-making in those cases where disclosure had been made. Some known perpetrators were permitted to remain as foster carers and then went on to abuse again. Despite the County's assessment of the prevalence of sexual abuse for children in foster care in the early 1990s, David White, the Director of Social Services, failed to take any effective action.

[904] Matthews 23 October 2018 41/12-42/15
[905] Morton 23 October 2018 102/6-8
[906] NCC000293_4-17
[907] NCC003811 para. 16.1
[908] OFS008121

Part E

Case study: Harmful sexual behaviour

Case study: Harmful sexual behaviour

E.1: Introduction

1. The investigation's third case study examines the institutional responses to, and barriers to disclosure of, allegations of harmful sexual behaviour between children in the care of the Councils.[909] The Inquiry has been assisted with these issues by Professor Simon Hackett, Professor of Child Abuse and Neglect at Durham University, an expert on harmful sexual behaviour between children.[910]

2. In this report, we use the term 'harmful sexual behaviour' to refer to sexual abuse between children, whether children of different ages or children of a similar age. This reflects Professor Hackett's view that this behaviour may be harmful to others but also to the child responsible for that harm, and it is therefore less stigmatising than other terms.[911]

E.2: Allegations of harmful sexual behaviour in Nottinghamshire

3. The Inquiry has received 95 accounts[912] of harmful sexual behaviour, including:

3.1. P16 was sexually abused, including rape, by another child in a children's home "*some decades ago*". He ran away, becoming a victim of child sexual exploitation.[913]

3.2. P7 was sexually abused by another child in her foster home in the 1970s, who threatened to disclose that she was being abused by the foster father. P7 was scared that this would lead to her being taken away from her two siblings.[914]

3.3. P3 was sexually assaulted by a male resident at a children's home in 1978. She described the continuing effects of the abuse: "*Sometimes when I meet men, they know I've been abused and they ask me if I have been a prostitute. They assume that I have because I have been abused. This makes me feel really confused; as if my abuse has made me worthless*".[915]

3.4. A76 was raped twice by one older boy and sexually assaulted by another in a children's home in the 1970s and 1980s.[916]

[909] Notice of Determination on Selection of Case Studies, 28 February 2018
[910] Hackett 25 October 2018 1/22-48/19; INQ002045
[911] Hackett 25 October 2018 6/16-8/20; INQ002045_8-9
[912] INQ002576; INQ002574; and oral evidence from P7, P16, D31 and L43.
[913] P16 26 October 2018 3/22-4/23
[914] P7 4 October 2018 124/15-125/3
[915] INQ002576; INQ002574
[916] A76 5 October 2018 113/10-121/12

3.5. P5 gave an account of being sexually abused by two of her brothers in the 1970s and 1980s. This included forced oral sex and sexual touching, at the children's home where she lived and when they would go home at the weekend.[917]

3.6. P1 was sexually assaulted by the son of his foster carers in the 1980s, including forced oral sex.[918]

3.7. L46 was sexually assaulted by a female resident at a children's home in 1987, who inserted her finger into L46's anus in the course of bullying her. This was recorded in her social services records.[919]

3.8. D31 was sexually abused on around five different occasions by older boys at Greencroft Community Home between 1989 and 1991, including sexual assault and rape.[920]

3.9. D46 was sexually abused by two older boys at a children's home in the 1990s.[921]

3.10. L43 was sexually abused at Beechwood in 2002, by another resident who was one year older than him. This included attempted anal rape and sexual touching. He reported the abuse but felt unsafe and confused. He described the impact of the abuse as "*everlasting*".[922]

E.3: Understanding harmful sexual behaviour

4. Professor Hackett's expert view was that there are a number of key points to assist in understanding harmful sexual behaviour:

4.1. A child presenting with harmful sexual behaviour is likely to act it out to varying degrees over a period of time. That behaviour might range from normal and "*developmentally appropriate*" on the one hand and "*highly abnormal and violent*" on the other. Understanding this range can help professionals to respond appropriately to the risk presented by that behaviour.[923]

4.2. Though in each case intervention is needed,[924] it is important to distinguish between: (i) 'abusive' sexual behaviours that are manipulative or coercive where the victim is unable to give informed consent and (ii) 'problematic' sexual behaviours that have no intended victim but which may have a developmental impact on the children exhibiting the behaviour or cause them rejection or distress, or increase the risk of their victimisation.[925]

4.3. Harmful sexual behaviour exhibited by younger children should be approached differently to that exhibited by adolescent children. Younger children's behaviour is more likely to be a direct consequence of having been abused.[926]

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[917] P5 3 October 2018 156/11-159/22
[918] P1 5 October 2018 103/24-109/10
[919] L46 5 October 2018 97/12-101/9
[920] D31 5 October 2018 11/10-19/18
[921] D46 5 October 2018 101/10-103/23
[922] L43 3 October 2018 67/18-90/5
[923] Hackett 25 October 2018 3/13-4/13; INQ002045 _6-8, 10
[924] Hackett 25 October 2018 5/24-6/15
[925] INQ002045_8
[926] Hackett 25 October 2018 17/12-19/4; INQ002045_35

4.4. A history of having been sexually abused is one of several possible pathways which may lead to harmful sexual behaviour. Around half of those children exhibiting harmful sexual behaviour have themselves previously been sexually abused.[927] However, of children who are victims of all kinds of abuse, the vast majority do not go on to sexually abuse others, and victims should not be labelled as potential abusers. Trauma, suffered through other experiences as well as sexual abuse, is a key indicator and causal factor for many children exhibiting harmful sexual behaviour.[928] Another pathway is general anti-social attitudes and beliefs which can link with sexual bullying.[929] There are examples where harmful sexual behaviour appears to have been part of a culture of bullying and inappropriate behaviour.[930]

4.5. Most children exhibiting harmful sexual behaviour no longer do so by their mid-twenties. Previous assumptions about adolescent sexual offending being 'addictive' are not borne out by recent studies.[931]

4.6. Children abused by their peers are more likely to be abused by a group than by an individual. One incident of being abused by a group may lead to "*a kind of chain effect*" of further abuse by other members of the group.[932]

4.7. The fact that children have exhibited, or been the victims of, harmful sexual behaviour may be identified by adult perpetrators who "*pick out*" those vulnerabilities and use them to abuse the child.[933]

The prevalence of harmful sexual behaviour

5. It is generally accepted that up to two-thirds of allegations of child sexual abuse are made against young people under the age of 18.[934] Figures from 2017 show almost 30,000 reports of harmful sexual behaviour over the previous four years in England and Wales, with annual figures almost doubling in that time.[935] The "*overwhelming majority*" of cases of children exhibiting harmful sexual behaviour do not result in a prosecution or caution.[936] Around half of sexual abuse cases in residential care are of harmful sexual behaviour.[937]

6. However, these numbers are likely to be an under-representation of the true scale. This is a result of the barriers to reporting, the variable ways of recording harmful sexual behaviour, and because the issue has only relatively recently been acknowledged and understood.[938] In Professor Hackett's view, there is a "*high likelihood that peer sexual abuse in care has been downplayed by professionals who have seen it as exploratory adolescent sexual behaviour*".[939]

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[927] Hackett 25 October 2018 20/19-25/2; INQ002045 45-48. Around two-thirds have experienced some form of abuse, including physical, sexual and emotional abuse.
[928] Hackett 25 October 2018 22/19-25/2; INQ002045 _43-44
[929] Hackett 25 October 2018 19/8-20/18; INQ002045 _37-38; INQ003565_62-63 paras 228-238
[930] For example, the abuse of NO-A89 (NSC000103) and L46 (5 October 2018 97/12-101/9).
[931] Hackett 25 October 2018 20/19-21/6; INQ002045_39-40
[932] Hackett 25 October 2018 45/16-46/7
[933] Hackett 25 October 2018 46/8-20
[934] *Workforce perspectives on harmful sexual behaviour, Findings from the Local Authorities Research Consortium 7*, National Children's Bureau and Research in Practice. Additionally, between one-quarter and one-third of all sexual offences (of children and adults) are thought to be committed by young people under the age of 18 (INQ002045 para. 1.2).
[935] INQ002045_20-21
[936] Only 26 percent of these cases resulted in criminal justice interventions (see INQ002045 para. 4.4).
[937] INQ002045_58
[938] Hackett 25 October 2018 2/23-3/12; INQ002045_4
[939] INQ002045_58-59 at para. 7.25

7. Many accounts of abuse reviewed by this Inquiry were given in interviews during Operations Daybreak, Xeres and Equinox or in disciplinary cases, none of which focused on allegations of harmful sexual behaviour.

Harmful sexual behaviour in relation to children in care

8. Harmful sexual behaviour between children in care has not been extensively researched, despite a large number of children exhibiting such behaviours subsequently entering the care system.[940] In Professor Hackett's view, the mistaken belief that most children who commit sexual offences will continue to do so through adolescence and into adulthood has led to an "*overly risk-averse approach*" to children coming into care who had previously exhibited harmful sexual behaviour.[941] The "*developing sexuality and sexual behaviour*" of children in care is often subject to scrutiny in a way in which children in the family home is not, so there can be an assumption that they are more prone to exhibiting harmful sexual behaviour.[942] However, for some children, coming into care can stop further harmful sexual behaviour, as they will have been removed from an abusive or sexualised home environment.[943] This does not remove the need for a robust risk assessment when making placement decisions and formulating care plans in all cases in which a child has exhibited harmful sexual behaviour.[944]

9. Professor Hackett has produced a model showing the relevance of the care environment and the attitudes and responses of staff in understanding harmful sexual behaviour.

E.4: Policy and practice developments in Nottinghamshire

10. The Councils' understanding of and approach to harmful sexual behaviour mirrors, to a large extent, the national picture. In 1990, the County was aware that a significant number of children known to be exhibiting harmful sexual behaviour were in its children's homes.[945]

1970s and 1980s

11. The County's first Policy, Procedure and Practice Guide for Community Homes in April 1978 included guidance on responding to children in care suspected of involvement in unlawful sexual intercourse.[946] Rod Jones, Senior Professional Officer (Child Care), clarified the guidance later that year:

> "*Clearly where this is experimental horseplay (for want of better words) there is no question of the Police needing to be involved … Where a child has been the subject of U.S.I. or serious homosexual or other activity and the staff have good reason to believe that an offence has been committed – then the policy is that the Area Director should consider informing the Police immediately. As I understand it, the policy also states that only the Divisional Director has the power to agree to withhold information from the Police.*"[947]

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[940] Hackett 25 October 2018 26/4-22; INQ002045_53. Around one-third of those referred to specialist services between 1992 and 2000 after exhibiting harmful sexual behaviour were then placed into care (Hackett, S., Phillips, J., Masson, H. and Balfe, M., 2013. 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child abuse review* 22(4), pp232-245).
[941] Hackett 25 October 2018 27/23-28/6; INQ002045_54
[942] Hackett 25 October 2018 29/1-22; INQ002045 _55
[943] Hackett 25 October 2018 26/23-27/14
[944] INQ002045 paras 9.18-9.20
[945] At a meeting on the issue of "*Kids being abused by kids*" (NSC001228_9).
[946] NSC000046_107. 'Unlawful sexual intercourse', in this context, involved sexual activity between a male aged 16–18 and a female aged 13–16 (Sexual Offences Act 1956, section 6).
[947] NSC001331

Derived from the work of Firmin and Hackett, 2018

A context continuum model of care settings and harmful sexual behaviour

12. Following an internal inquiry into an allegation of harmful sexual behaviour at Amberdale Secure Unit in 1988 (discussed further below), a multi-agency Adolescent Sex Offenders Group was created and met from October 1989 "*to develop services designed to address the risks presented by male adolescent sex offenders*".[948]

1990s and 2000s

13. Between March and September 1990, the Adolescent Sex Offenders Group undertook a range of work regarding harmful sexual behaviour and made a number of findings:

13.1. An increasingly high level of reporting of sexual offences carried out by adolescents,[949] as shown for example by a snapshot[950] of 380 children resident in children's homes in Nottinghamshire on one particular day in June 1990. This found:

- 32 children (8 percent) had been sexually abused by other residents (of those 26 had also been sexually abused before entering care and six were sexually abused for the first time by other residents);
- out of 79 children (21 percent) who had been sexually abused before entering care, 16 had gone on to sexually abuse other residents;
- 23 children (6 percent) had been placed in care having already committed sexual offences; and
- 15 children (4 percent) committed a first sexual offence whilst in care.

David White, the County's then Director of Social Services, was "*astounded to find the number who had been subjected to abuse … However we're probably not untypical of Departments generally.*"[951]

13.2. A "*lack of departmental and multi-professional guidelines and resources*" which meant that "*what happens in each case is a matter of chance*".[952]

The group proposed setting up a new unit to work with adolescent sex offenders and sought the implementation of guidelines for staff,[953] and joint police and children's social care investigations in response to allegations of harmful sexual behaviour.[954] Although the placement of abused children alongside children exhibiting harmful sexual behaviour was common practice across England and Wales in the 1990s,[955] the group recommended in 1990 that "*adolescent sex offenders should no longer be housed with other children without very careful consideration of the risks*". It also provided a definition of "*sexual abuse by juveniles*" and identified an "*urgent*" need to develop treatment services for young offenders.[956]

[948] INQ002764_3. The group included David Fisher (a member of staff at Amberdale), Judy Holloway-Vine (as she was known then, a social worker), a member of the Community Health Team, and an educational psychologist. See also DFE000707_4-7
[949] DFE000707_9
[950] NSC000102_27-29
[951] INQ002642_6
[952] DFE000707_9
[953] DFE000707_10-11. The same recommendation, regarding the development of practice guidelines, was made to senior management and councillors two years earlier, in the 1988 Amberdale report (NSC000101_11), but it had not been implemented.
[954] DFE000662_2-5
[955] Hackett 25 October 2018 34/6-35/9; INQ002045 _61-62
[956] DFE000662_2-5

14. The 1991 Area Child Protection Committee (ACPC) procedures in Nottinghamshire appear to have drawn on the group's work (as well as on the national *Working Together* guidance in 1991, which referred for the first time to harmful sexual behaviour[957]). The procedures included guidance on 'Abuse between children and young people'. Those exhibiting harmful sexual behaviour were to be seen as children who may have been abused, and placement decisions had to take into account the risks they posed to other children. Joint investigation procedures were to apply to allegations of harmful sexual behaviour in children's homes.[958]

15. A "*landmark*" National Children's Home report about harmful sexual behaviour in England, Wales and Scotland, published in 1992, considered for the first time on a wide scale the issue of children and young people who sexually abuse other children.[959] It noted "*an absence of policy, practice or ethical guidance to assist practitioners*" with young people demonstrating harmful sexual behaviour, and that much sexually abusive behaviour went unreported or unrecognised, or was simply not formally dealt with by the criminal justice system. A model was proposed to establish the range of sexual behaviours which a child could demonstrate.[960]

16. The 1991 ACPC procedures highlighted the need to consider risks around placement because of concern about harmful sexual behaviour between children in residential care.[961] Despite this, in 1992, a County working party report entitled *'As if they were our own': Raising the Quality of Residential Child Care in Nottinghamshire* concluded that a failure to monitor admissions into residential care had led to:

> "*young people who have been sexually abused being placed at risk by being accommodated with young people who have committed sexually abusive acts*".[962]

It found that 80 percent of sexual abuse within community homes was committed by young male residents against young female residents.[963]

17. The report noted that the work of the Adolescent Sex Offenders Group in monitoring those exhibiting harmful sexual behaviour and providing them with treatment had "*helped to project Nottinghamshire as a lead Authority in recognising and responding*" to their needs.[964] The working party recommended an additional "*systematic and informed service*" for adolescent sex offenders, but funds were withdrawn three weeks before the service was due to start.[965] This was despite the report's warning that:

> "*In the absence of such a service the problem continues to increase with real cost to the young people, both offenders and victims, and the possibility of the County Council being held liable for claims of compensation becomes more concerning.*"[966]

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[957] INQ002045 para. 3.11 – although the phrase 'harmful sexual behaviour' was not used until very recently.
[958] NTP001473_136-137
[959] AFC000067; Hackett 25 October 2018 10/9-11/1; INQ002045_15-16
[960] AFC000067. The model is explained by Professor Hackett's more recent diagram.
[961] NTP001473_137
[962] NSC000104_19. This report was produced at a senior level, with the working party led by the County's Chief Executive, Michael Lyons.
[963] NSC000104_104
[964] NSC000104_79
[965] NSC001380_2
[966] NSC000104_79

18. By this point, two years on from the 1990 survey,[967] *'As if they were our own'* included some statistics on the 285 children in residential care:

- 90 children (32 percent) had been sexually abused before coming into care;
- 11 children (4 percent) had been placed in care as having been abused and were subsequently abused by other residents whilst in care; and
- five children (2 percent) had been sexually abused for the first time by other residents whilst in care.[968]

19. In 1997, an ACPC project on 'Children who sexually abuse other children' reviewed 57 alleged incidents of harmful sexual behaviour in the County over a six-month period, four of which involved children in residential care.[969] Responses to harmful sexual behaviour remained inconsistent.[970] Although most cases had been referred for investigation, in some child protection procedures had not been followed. It proposed "*further briefing or training*".[971] In a March 1997 progress report to the ACPC, the Project Manager drew attention to the fact that "*the scale of the problem*" of harmful sexual behaviour was "*bigger than initially thought*", and that there was "*no consistent approach for dealing with these children*". She proposed setting up a panel with the aim of diverting children away from the criminal justice system.[972] By 1998, "*both the City and the County each had established their own respective panels*" (subsequently known as assessment and early intervention panels),[973] to which the majority of cases were referred, usually by the police or children's social care.[974]

20. The County's Child Protection Practice Guidance was also updated in 1997, in relation to responses and support to both victims of and children exhibiting harmful sexual behaviour. It also included guidelines on what was 'normal' sexual experimentation and what was abusive.[975] However, this does not appear to have been accompanied by training for residential care staff or foster carers.[976]

21. National interagency procedures and a practice framework for assessing children and young people with harmful sexual behaviour (Assessment Intervention and Moving On (AIM)) were introduced in 2000.[977] The framework became best practice and was in use by the Councils by the mid-2000s.[978]

22. By 2005, the County was carrying out risk assessments of children exhibiting harmful sexual behaviour,[979] which were provided to the foster or residential home where the child was being placed.[980] The County's process changed in 2006,[981] from local individual assessment and early intervention panels to a strategy meeting approach with multi-

[967] NSC000102_27-29
[968] NSC000104_107
[969] NSC001325_6
[970] NSC001380
[971] NSC001325_10
[972] NSC001328_9-10
[973] NSC001474 para. 3b.8
[974] NCC003792; NSC001326
[975] NSC000058_137-148
[976] INQ002434 paras 4.6, 11; INQ001895 para. 29a
[977] Hackett 25 October 2018 11/25-12/12
[978] INQ002045 paras 4.32-4.37; NSC001474 para. 3c.2
[979] See, for example, NSC001438_10-18
[980] Edwards 23 October 2018 150/7-152/17
[981] Following work done by the County's Child on Child Abuse Steering Group between 2003 and 2006 (NSC001596).

agency planning and assessment. The assessment evaluated the level of risk posed by children exhibiting harmful sexual behaviour to other children in the same household or establishment including younger or more vulnerable children.[982]

23. Over the next few years, the City funded a part-time post in relation to harmful sexual behaviour[983] and sought to intervene early to prevent future incidents.[984] In practice, a large number of children arrested for sexual offences in the City were still not being referred to the assessment and early intervention panel. There was substantial delay in referring cases and, where cases were referred, the panel often had little or no information about the victim or the impact of abuse.[985] The panel could only recommend, rather than direct, that children's social care take decisions, including the placement of children exhibiting harmful sexual behaviour.[986] Although police attendance was "*a useful and effective process ensuring best outcomes for victims and alleged young perpetrators*",[987] it was infrequent.[988]

24. Since 2007, the Councils' safeguarding boards have produced cross-authority guidance on 'Children who display sexually harmful behaviour'.[989]

Recent developments and present day

National developments

25. In 2013, a Criminal Justice Joint Inspection[990] identified concerns about the effectiveness of multi-agency working with children and young people who had committed sexual offences. It found little evidence of oversight, gaps between policy, procedures and practice, and no evidence that implementation of procedures had been monitored or reviewed.[991]

26. Professor Hackett referred to 2014 research which suggested that victims of sexual abuse and children exhibiting harmful sexual behaviour were still being placed together, even though placement providers had become more aware of the need to "*look very carefully*" at risks presented by young people when making placement decisions.[992]

27. In 2015, following unsuccessful attempts to formulate a national strategy, the National Society for the Prevention of Cruelty to Children (NSPCC) developed, in conjunction with some local authorities,[993] an Operational Framework[994] for harmful sexual behaviour to help

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[982] The new approach was set out in the County's 2006 'Practice Guidance on Children and Young People who Sexually Harm' (NSC001151; NSC001586).
[983] INQ001984 para. 14.2
[984] NCC003792
[985] NCC003794
[986] INQ002434 paras 10.2-10.3
[987] NCC003793
[988] NCC003793; NCC003790
[989] NSC000084_59-60. This was updated in 2014 (NSC000092) and then again most recently in January 2019 (Interagency Safeguarding Children Procedures – 'Harmful Sexual Behaviour (HSB)').
[990] *Examining Multi-Agency Responses to Children and Young People Who Sexually Offend*, Criminal Justice Joint Inspection, 2013: a joint inspection of the effectiveness of multi-agency work with children and young people in England and Wales who have committed sexual offences and were supervised in the community.
[991] Hackett 25 October 2018 37/16-38/7; INQ002045_28-29. These findings appear to reflect the position within the Councils. Between 2007 and 2013, we saw no evidence of steps taken by the County to monitor its own practice or the implementation of its procedures. The City's AEIP produced annual reports but none appeared to consider or evaluate the effectiveness of policies and procedures.
[992] Hackett 25 October 2018 34/6-35/9; INQ002045 para. 7.38 _62
[993] Including the City (INQ001981 para. 6.2).
[994] Hackett, S., Holmes, D. and Branigan, P. 2016. *Operational framework for children and young people displaying harmful sexual behaviours*, NSPCC, London. This was recently updated with a second edition: Hackett, S., Branigan, P. and Holmes, D. 2019. *Operational framework for children and young people displaying harmful sexual behaviours*, second edition, NSPCC, London

local authorities structure their interagency response to the issue.[995] Professor Hackett considered this a "*really important step forward*", giving local agencies the ability to audit their harmful sexual behaviour practice against the Framework and promote standard practice in assessment, in the availability of intervention services and in training.[996]

28. Guidance and advice on harmful sexual behaviour have been published in recent years by the National Institute for Health and Care Excellence[997] and by the Department for Education,[998] and awareness and procedures have improved. However, "*there is still no national strategy*" or model for local authorities to use in addressing harmful sexual behaviour.[999] In Professor Hackett's view, there is a need for an "*overarching strategy that actually brings together some of these principles in an overarching national framework*".[1000]

The County

29. Chris Few, chair of the County's Local Safeguarding Children Board,[1001] recognised that the County's approach to harmful sexual behaviour, as at October 2018, was not as he would wish.[1002] Nevertheless, in recent years, the County has taken steps to audit its practice, quality assure its work and develop multi-agency responses to harmful sexual behaviour cases. The 2016 audit (using the NSPCC framework) found that residential staff and foster carers were trained and able to support children exhibiting harmful sexual behaviour, but that the County had no overall picture of the scale of harmful sexual behaviour or the efficacy of its response. Recommendations included setting up an annual data return on children who sexually harm, a multi-agency audit on harmful sexual behaviour practice and the introduction of the Brook Sexual Harm Traffic Light Tool.[1003] The Traffic Light Tool is a step-by-step guide to assist professionals in understanding whether behaviour is abusive, problematic or appropriate, and to inform the appropriate interventions.[1004]

30. A multi-agency audit in May 2018 examined 10 cases of harmful sexual behaviour in the County, two of which involved children in residential care. This found delays in identifying and responding to harmful sexual behaviour, inconsistent advice given to children and their carers, an over-dependence on police decision-making, and a lack of understanding of the purpose and use of the AIM assessment. Recommendations included aligning practice across agencies, reworking local guidance and developing a model to quality-assure cases involving harmful sexual behaviour.[1005] Chris Few assured us that the County's Harmful Sexual Behaviour Panel[1006] was working on the audit's recommendations and the issues it had raised.[1007] At the time of our hearings, an action plan was still being implemented to respond to the 2016 and 2018 audit recommendations. While a number of actions had been completed (including the introduction of the Brook Sexual Harm Traffic Light Tool), annual

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[995] INQ002045 para. 3.23. The framework is directed across five aspects: responses, prevention, assessment, intervention and workforce development.
[996] Hackett 25 October 2018 14/21-15/17; INQ002045_18
[997] INQ002045_19; 32; 81-82; Harmful sexual behaviour among children and young people, NICE guideline (2016)
[998] DFE000962_27-28
[999] INQ002045 para. 3.25. This was also reflected in *Workforce perspectives on harmful sexual behaviour, Findings from the Local Authorities Research Consortium 7*, National Children's Bureau and Research in Practice, 2016
[1000] Hackett 25 October 2018 40/7-14
[1001] Now called the 'Nottinghamshire Safeguarding Children Partnership'.
[1002] Few 22 October 2018 173/16-17
[1003] NSC001373
[1004] Brook Traffic Light Tool; NSC001474 para. 3d.2
[1005] NSC001587
[1006] This was a change from its strategy-meeting-based approach, and it met for the first time in June 2018 (NSC001604; NSC001391; NSC001591_1-5; 28-34).
[1007] Few 22 October 2018 173/18-174/12

data on children who had been sexually harmed had yet to be collated and the development of new procedures and protocols was still ongoing.[1008] The County held training in 2019 on harmful sexual behaviour for all practitioners working directly with children and young people and the training team were *"overwhelmed with interest"*.[1009]

31. As of October 2018, the County notifies incidents of harmful sexual behaviour to the Service Director[1010] and the Lead Member for Children's Services,[1011] as well as Ofsted, local safeguarding partners and the national Child Safeguarding Practice Review Panel.[1012] However, on some occasions in the past the notification process was not followed.[1013]

The City

32. As at October 2018, the City's Assessment and Early Intervention Panel – renamed the Assessment of Sexual Harm Arrangements (ASHA) panel in 2014[1014] – met monthly.[1015] Its remit, since 2017, has broadened to include those whose behaviour suggested they might sexually harm other children as well as those who had done so.[1016] Although Clive Chambers (the City's Head of Service for Children in Care) told us that the City's approach mirrors the NSPCC's framework,[1017] we have not seen evidence to support this or of steps taken to understand the extent of harmful sexual behaviour exhibited by or carried out against children in the care of the City or to audit their practice.[1018]

33. The City's Lead Member for Children's Services until May 2019, Councillor David Mellen, thought that it was less likely he would be informed of a case of harmful sexual behaviour, in contrast to other sexual abuse,[1019] and he had no sense of the scale of harmful sexual behaviour in the City.[1020]

E.5: Institutional responses

34. There is little information now available about the approach adopted by children's social care or the police towards harmful sexual behaviour for much of the 1970s and early 1980s. Some incidents were recorded in children's social services files but treated as behavioural problems or adolescent exploration.[1021] As Professor Hackett commented, while even good carers and professionals may not have understood harmful sexual behaviour at this time, they should still have been concerned about the sexual wellbeing and behaviour of children in care.[1022]

[1008] NSC001609. We understand that since the Inquiry's hearings, revised policy, practice and procedural guidance on harmful sexual behaviour has been completed and circulated to staff in the County.
[1009] Minutes of the NSCB Full Board Meeting 12 December 2018, p4
[1010] Edwards 23 October 2018 152/18-153/9
[1011] Owen 23 October 2018 186/12-24
[1012] DFE000962_32
[1013] Edwards 23 October 2018 153/10-155/2; 157/6-158/2
[1014] INQ002405 para. 4.3
[1015] NCC000424; NSC001337
[1016] Michalska 25 October 2018 99/3-101/10; INQ001792 para. 5.3
[1017] Which the City worked to develop, alongside seven other local authorities and the NSPCC (INQ001792 para. 5.4).
[1018] INQ001792 para. 5.4
[1019] Mellen 24 October 2018 82/12-90/19
[1020] Mellen 24 October 2018 97/20-98/14
[1021] For example D47, L46, A76, and supported by Professor Hackett (INQ002045_63-64 para. 7.42).
[1022] Hackett 25 October 2018 42/6-14; INQ002045_83 paras 10.1-10.4

35. The County accepted that it had "*let down*" a number of children who had been sexually abused by other children.[1023] To explore the institutional response, we have reviewed five internal enquiries, carried out between 1988 and 1995, into allegations of harmful sexual behaviour at different community homes in the County.

Harmful sexual behaviour in residential care

Amberdale (1987–1988)

36. In December 1987, two female residents of Amberdale alleged that they had been forced into oral sex by a male resident, aged 15. Their allegations were investigated by the police.[1024] In January 1988 the same male resident attempted to sexually assault another female resident, and three further allegations of harmful sexual behaviour followed over the next few days. As a result, there were "*real fears for the safety and security of females in the unit*".[1025] Despite this, no steps were taken by residential staff or social care managers to address the immediate risk of sexual abuse of other children and the harmful sexual behaviour was regarded as simply part of a pattern of disruptive behaviour.[1026] In March 1988, the child was removed from the unit and placed outside of Nottinghamshire.[1027]

37. In 1988, NO-A117, a 13-year-old male resident at Amberdale, made allegations of rape and oral sex against another male resident of the same age.[1028] The child alleged to be exhibiting harmful sexual behaviour had been admitted to Amberdale following allegations that he had committed buggery and murder. As children in the secure unit were closely supervised, no special arrangements had been considered necessary to separate children exhibiting harmful sexual behaviour from other residents.[1029]

38. NO-A117's allegations were escalated to children's social care, the placing local authority for each child, the police, councillors and the Department of Health Inspectorate. The child alleged to be exhibiting harmful sexual behaviour had allegedly threatened to kill NO-A117 if he told anyone of the abuse. Steps were taken to divide the unit to separate the two children. This proved to be unsustainable and the child alleged to be exhibiting harmful sexual behaviour was moved.[1030] Despite supportive medical evidence and a consistent statement from NO-A117, the police concluded there was insufficient evidence to proceed "*in the absence of any corroborative evidence*".[1031] The internal enquiry commenced in December 1988. In interview, staff said that they did not believe NO-A117. The investigation concluded that "*the truth will probably never be known*", but that children's social care's response had been "*appropriate*" and "*in keeping with good child care practice, embracing important principles guiding work with sexually abused children*".[1032] Recommendations included training and guidelines "*to assist residential staff when they have to deal with allegations of sexual abuse between children and young people in residential care*".[1033] Although the findings and recommendations were endorsed by councillors,[1034] they were not passed on to

1023 NSC001657 para. 144; 26 October 2018 84/8-85/9
1024 NSC000533_2
1025 NSC000533_3
1026 Fisher 18 October 2018 73/19-74/6
1027 NSC000533_4
1028 NSC000101
1029 Fisher 18 October 2018 75/13-76/20
1030 NSC000101
1031 NSC000101_3-5
1032 NSC000101_9-10
1033 NSC000101_11
1034 NSC001235 para. 5d.7

Amberdale staff.[1035] Recommended training did not take place[1036] and guidelines were only introduced in 1991[1037] (by which time further harmful sexual behaviour cases in residential care had been reported).

Greencroft Community Home (1990)

39. In May 1990, children's social care management and residential staff from Greencroft Community Home (which could accommodate up to 12 children, up to 17 years old)[1038] met to discuss "*kids being abused by kids*".[1039] They discussed possible ways to protect children, including the need for ongoing counselling, for children's inductions to include a discussion about sex and sexuality, and the deployment of waking night staff.

40. In July 1990, at which point eight of the nine Greencroft residents had been sexually abused previously,[1040] two incidents of harmful sexual behaviour, three weeks apart, were reported. The first incident involved a 15-year-old male resident allegedly sexually abusing four girls aged between seven and 16 in one night.[1041] The police were involved and recommended charging the male resident.[1042] The second incident involved one of the same four girls being sexually assaulted by a different male resident.[1043]

41. One of the victims, D31 (then aged 12), told us that these were just two of a series of five incidents of harmful sexual behaviour to which she was subjected by the same male residents and others.[1044] She had been placed at Greencroft with much older children[1045] which, along with a failure to monitor risks posed by other children and a lack of guidance for staff,[1046] left her at risk of abuse.

42. An internal enquiry reported, in September 1990, that "*widespread changes*" were needed across all children's homes to contain "*the problem of child abuse*" and give children "*the protection and help they need*".[1047] Children's social care were "*overburdened*" and responses to child sexual abuse had "*fallen far short of what is needed*".[1048] It was "*unacceptable*" and dangerous to mix together sexually abused children with children exhibiting harmful sexual behaviour,[1049] and there was no guidance on how to deal with either group.[1050] More generally, advice on the response to abuse was "*based on a premise of trained, skilled professional staff, whereas less than 10% of the staff are trained and many are temporary and inexperienced*".[1051] The report made 20 recommendations, including that:[1052]

[1035] Fisher 18 October 2018 74/7-75/12; INQ001895 para. 10(a)-(b)
[1036] Fisher 18 October 2018 84/25-85/11; INQ001895 para. 10(c)-(d)
[1037] NTP001473_136-137
[1038] NSC000102_4 para. 9
[1039] NSC001228_9
[1040] NSC000102_7
[1041] NSC000102_8-10
[1042] NSC000102_12 para. 41
[1043] NSC000102_22-23. The report does not address any police investigation into the second incident.
[1044] D31 5 October 2018 11/10-20
[1045] D31 5 October 2018 12/9-12
[1046] NSC000102
[1047] NSC000102_27
[1048] NSC000102_28
[1049] NSC000102_20
[1050] NSC000102_21
[1051] NSC000102_26 para. 77. Steve Edwards, County Service Director, agreed that there was a disconnect between policy and how individuals performed on a day-to-day basis (Edwards 23 October 2018 146/19-147/9).
[1052] NSC000102_32-34

42.1. steps be taken to "*separate abused children and perpetrators*" and "*priority … given to providing separate Homes for abused and abusers*"[1053] and

42.2. children's social care issue guidance to residential staff on dealing with harmful sexual behaviour[1054] and establish a system for monitoring and evaluating sex offenders in residential homes.

The Social Services Committee approved separating victims of sexual abuse and children exhibiting harmful sexual behaviour, with one community home to be designated for work with children exhibiting harmful sexual behaviour and another exclusively for sexually abused girls.[1055] These recommendations were not fully implemented by the County.[1056]

Sandown Road Community Home (1990–1991)

43. In 1990, in the course of a police investigation, two residents at Sandown Road Community Home admitted sexually assaulting and raping other residents at the home. One was cautioned and the other was given a supervision order.[1057] One of their victims (NO-A120) had also been anally raped by a different resident six months earlier. A safe and secure placement for the victims could only be found outside the County.[1058]

44. The County failed to prevent or respond appropriately to widespread sexual abuse at Sandown Road. A 1991 internal enquiry into the quality of child care at Sandown Road by senior social workers from the County found that children's social care staff:

> "*were very concerned by the sense of inevitability that any child admitted was subject to sexual abuse or involved in inappropriate sexual activities. In one 12 month period, every child admitted was involved in sexual abuse incidents whether they had been previously abused or not. This does not appear to have been a problem since April of this year.*"[1059]

Staff had reported concerns about the management of disclosures, that staff meetings had not addressed how to manage abused children and "*the needs of the individual children in terms of counselling and protection were forgotten*".[1060] Social workers were concerned that "*staff had not been able to prevent*" the "*high levels of sexual abuse*".[1061] Requests for training and support for staff had not been responded to by Paul Bohan, Senior Professional Officer within the County at the time.[1062]

45. Sandown Road was temporarily closed that year, in line with the report's recommendations. Although the Social Services Committee were informed of the closure, there is no record of how much they were told of the abuse suffered by some of the children and staff concerns.[1063]

[1053] NSC000102_20, 32. This echoed a similar recommendation made by the Adolescent Sex Offenders Group earlier that year.
[1054] This suggests that the same recommendation from the 1988 Amberdale report had yet to be implemented.
[1055] NSC000438_13-27
[1056] AFC000068 paras 3.2-3.4; 3.11; AFC000060; AFC000069; NSC000104_78-79
[1057] NSC001495
[1058] NSC001495_8-10
[1059] NSC001502_3
[1060] NSC001502_3
[1061] NSC001502_5
[1062] NSC001502_3
[1063] NSC001494

46. There is no evidence of anyone within children's social care considering this report alongside the Greencroft and Amberdale reports despite those reports raising similar issues. Co-author of the Sandown Road report, Sue Gregory (Senior Social Worker at the time), told us that when writing the report, she was unaware of the similar issues that had been raised in the Greencroft report the previous year.[1064] This lack of information sharing was poor practice.

Hazelwood Community Home (1991–1994)

47. A former resident of Hazelwood (another community home), NO-A89, alleged in 1991 that he had been raped by three other residents at the home in 1985.[1065] The other residents were aged between 11 and 15 years old.[1066] It was known to staff in 1985 that NO-A89 had suffered serious physical abuse by other residents "*with potentially sexual content*".[1067] At the time, the other residents had remained at Hazelwood and staff were not warned of the risk they posed to other children.[1068]

48. Tony Dewhurst (a children's social care manager in the County, whose role at the time included supervision of and advice to management at Hazelwood) was said to have been aware of the rape according to NO-A89's social worker at the time,[1069] although Mr Dewhurst told us that he could not remember being informed about it.[1070] Mr Dewhurst had also allegedly described one incident involving NO-A89 as "*normal adolescent behaviour*",[1071] however it is unclear whether this related to the rape or to physical abuse suffered by NO-A89. He did notify the Social Services Inspectorate (SSI) of the allegation in November 1991, saying that "*lessons … have been learnt*". The SSI responded that "*The general question of whether community homes in Nottinghamshire are safe places in which children can live is clearly the most important factor.*"[1072]

49. In 1992, NO-A89's social worker and his key worker at the time of the 1985 assaults voiced their "*extreme concern*" to David White, the Director of Social Services, about the abuse and the response to it, including the disappearance of files, the failure to investigate staff and children's social care's failure to take responsibility for the harm caused to young people in the care system.[1073]

50. At a meeting in August 1992 between County legal and insurance officers and a children's social care manager, they agreed that:

> "*there was basically no discipline in this particular home, no action was taken against the perpetrators, there was no psychological help for* [NO-A89] *and the records of all the incidents have since been destroyed*".

It was agreed that a working party within the County should consider various issues, including "*segregation of abusers and abused or males/females*" and the reporting of incidents of abuse[1074] but no such group was set up.

[1064] Gregory 18 October 2018 169/7-171/5
[1065] NSC000983_5-7
[1066] NSC000105_4
[1067] NSC000976_1-7
[1068] NSC000980_20
[1069] NSC000105_2, 27-28
[1070] INQ002731
[1071] NSC000976_4-5; NSC000980_30; NSC000105_27-29
[1072] NSC000983_9-11
[1073] NSC000980_19-21
[1074] NSC000440_41-43

51. One of the three residents was convicted in 1992 and sentenced to five years' imprisonment. The judge commented that "*if the home had been run better by social services the offence could not have been committed*".[1075]

52. An internal enquiry was ordered by David White. Its report concluded, in 1993, that it was not possible to determine whether senior staff had been aware of the harmful sexual behaviour incidents at the time due to a lack of records.[1076] However, it concluded that insufficient control had been exerted by staff, so that "*powerful boys*" had created a culture of "*intimidation and violence*".[1077] The report also identified failures by staff to take action to prevent the abuse by responding to persistent and serious bullying of NO-A89 and to respond appropriately afterwards. Its recommendations did not address harmful sexual behaviour in community homes but did recommend training on the support needs of children who had suffered abuse and their vulnerability to abuse from other children. This was implemented.[1078]

Farmlands Community Home (1995)

53. In March 1995, a fifth enquiry was carried out, following a complaint that a resident at Farmlands Community Home, D46, was at risk. It concluded that "*particularly difficult children some with problems of sexually abusive behaviour have tended to end up in Farmlands*"[1079] and there were a number of complaints of sexual abuse between residents. The report identified a failure to move D46 and one of the children exhibiting harmful sexual behaviour, despite this being recommended by case conferences and the police. It concluded that the County failed to protect D46 by exposing him to both physical and sexual abuse. There was:

> "*no strategy dealing with the sexualized behaviour of adolescent boys. No consistent therapeutic approach and there are limitations to the service that is provided at the moment … The Child Protection Policy within residential care is both inadequate and unclear. Therefore it is recommended that a clear procedure be laid down and staff be made aware of these.*"[1080]

This was compounded by there being "*no overall strategy across the County*".[1081]

54. The Service Standards Unit annual report for Farmlands that year commented:

> "*resident/resident abuse has occurred and the inspecting officers were very concerned about child protection issues in their widest sense. These concerns have been the subject of a confidential document sent to the Director of Social Services.*"[1082]

We have not seen this document nor any documents setting out the children's social care response to the report into D46.

[1075] NSC000983_17
[1076] NSC000105_34
[1077] NSC000105_19
[1078] NSC000980_26
[1079] NSC001644
[1080] NSC001644_6
[1081] NSC001644_5
[1082] OFS008178_17

Wider consideration of these investigations

55. While each investigation covered different institutions and raised its own issues, they were all commissioned by the County's children's social care service about children in their care in their establishments. However, children's social care do not appear to have considered these investigations together or their wider implications. There is no record of the Sandown Road report or the Farmlands report being considered by senior managers within children's social care or by the Social Services Committee. Knowledge and learning were not shared across the County; each report was considered, if at all, in isolation, with no reference to the findings or recommendations in the preceding reports.

56. There was also no apparent attempt to disseminate those findings or recommendations to staff in children's social care. For example, Margaret Stimpson (the County's Children's Service Manager in the early 1990s, responsible for a number of other residential homes) was unaware of the risk to children in care of harmful sexual behaviour and was never briefed about events at Amberdale, Greencroft, Hazelwood and Sandown Road or the reports.[1083]

Other cases of harmful sexual behaviour in residential care

57. Between 2001 and 2005, there was a series of disclosures of harmful sexual behaviour in children's homes that were by that time the responsibility of the City:

57.1. In 2001, NO-A483, a resident at Beckhampton Road[1084] disclosed to staff that he had been raped by his roommate, who was then arrested and remanded to secure accommodation.[1085]

57.2. In 2002, L43 alleged that another resident at Beechwood had indecently assaulted him.[1086] L43 told staff but felt like he was "*talking to a brick wall*", and was discouraged from pursuing the matter with the police.[1087] He told us that sexual activity between children at Beechwood happened "*pretty much daily*" and staff did nothing about it.[1088] L43 was seen as a "*management problem*" for staff.[1089]

57.3. The same year, the National Care Standards Commission (NCSC) concluded that Beechwood was "*an environment where vulnerable young women, and men, were liable to be sexually exploited by each other*".[1090] Michelle Foster (a staff member) told us that there was no guidance or training on harmful sexual behaviour.[1091] Understaffing meant they could only manage and monitor sexual activity.[1092]

57.4. In late 2003, NO-A479, a Beechwood resident, disclosed that she had twice been pressured into having sex with a male resident and thought she might be pregnant. The male resident should have been supervised closely by staff, having committed sexual offences against young children, but this had not been possible because of staff

[1083] Stimpson 17 October 2018 41/2-42/22
[1084] The name given to Redtiles from May 1996.
[1085] NCC003543
[1086] NCC000349; NCC000350; L43 3 October 2018 67/18-68/12
[1087] L43 3 October 2018 69/6-72/3
[1088] L43 3 October 2018 65/8-17
[1089] NCC003799_2
[1090] NCC000297_22
[1091] Although at this point, staff in City children's home should have been following the 2001 cross-authority child protection procedures (see NSC000079_182-183).
[1092] INQ002673 paras 25, 46; Foster 18 October 2018 16/21-17/5

shortages. The NCSC were notified[1093] and visited Beechwood.[1094] The Assessment and Early Intervention Panel assessed the ongoing risk posed by the male resident as "*very high*" and supported a prosecution "*should there be sufficient evidence*".[1095]

57.5. In October 2003, NO-A480, a resident of Beechdale Road, disclosed he had been forced to perform oral sex and masturbation by two other residents. There was a joint investigation.[1096] One of the children allegedly exhibiting harmful sexual behaviour was removed, but the other remained in the home despite a recommendation to reconsider this by the Assessment and Early Intervention Panel. No charges were brought against the two residents[1097] and the one who remained at Beechdale Road was subsequently involved in another "*very similar incident*" with a different victim, which also did not proceed to charge.[1098]

57.6. In 2004, strategy meetings were held amid concern about sexualised behaviour of 10 children in City children's homes, including allegations of rape.[1099] The meetings were "*to try and establish whether the incidents constituted child-on-child sexual abuse, and if so who were the victims and who were the perpetrators*".[1100] Two of the children had been charged with sexual offences against children, but there had previously been separate strategy meetings for the individual children, so only "*assorted information*" had come to light. It was concluded that intensive sex education was needed for all children, and that all of the City's children's homes needed to liaise with each other regarding the children's activities.

However, it does not appear that any steps were taken to address these cases at a senior management or political level.

58. Staff lacked sufficient guidance or training on harmful sexual behaviour.[1101] Glynis Storer, the City's Practice Manager for Young People who Sexually Harm in the 2000s, said she never trained residential staff on harmful sexual behaviour.[1102]

Harmful sexual behaviour in foster care

59. Few studies have been conducted on harmful sexual behaviour in foster care.[1103] Research shows a lack of information provided to foster carers about allegations of harmful sexual behaviour made against children placed with them, and the risks associated with their behaviour. This has impeded foster carers' ability to identify or respond to harmful sexual behaviour.[1104]

60. We received evidence of four cases of alleged harmful sexual behaviour in foster care between 2002 and 2007: one in the City and three in the County. These involved multiple rapes, sexual assault and forced oral sex. There was a significant difference in age between the children allegedly exhibiting harmful sexual behaviour and the complainants in most of

[1093] OFS008182
[1094] OFS008180
[1095] NCC000351
[1096] NCC003537; NCC003538; NCC000352
[1097] INQ002434 paras 10.2-10.3
[1098] INQ002434 paras 10.2-10.3
[1099] NCC003544; NCC003536; NCC003539
[1100] NCC003536_9
[1101] Hackett 25 October 2018 29/23-30/16; INQ001984 para. 14.4
[1102] INQ002434 para. 11.1
[1103] Hackett 25 October 2018 32/3-9; INQ002045_59
[1104] Hackett 25 October 2018 41/1-42/1; INQ002045_80

the allegations. We have seen no documentary evidence relating to the response to any earlier instances of harmful sexual behaviour in foster care, but the absence of records does not mean that earlier abuse did not occur.

61. In each of the four cases, the police were notified. In three of them, steps were taken to reduce the risk of further abuse, either by ensuring no unsupervised contact[1105] or by moving the child allegedly exhibiting harmful sexual behaviour.[1106]

62. However, in one case an alternative placement could not be found for a child allegedly exhibiting harmful sexual behaviour so he remained in the same placement as the complainants.[1107] In another, the police did not pursue allegations of harmful sexual behaviour in one foster home until the same complainant made allegations relating to another child two years later. By this time the complainant did not want to pursue her original complaint.[1108] In that case, the City also failed to properly assess the risks posed or support needed by the child allegedly exhibiting harmful sexual behaviour, despite procedures at the time requiring them to do so.[1109]

Recent years and ongoing issues

63. Since 2010, a number of cases have raised issues about the way in which the Councils respond to allegations of harmful sexual behaviour. In the City, a serious case review in 2011 highlighted the need for clear governance in addressing incidents. The review also called into question the effectiveness of its Assessment and Early Intervention Panel. In the County, the variable responses to allegations showed a continuing lack of understanding amongst residential care staff of the complexities in individual cases, and the challenge in knowing what to do in practice, despite the guidance and procedures in place.

64. The 2011 serious case review followed the suicide of a child in the care of the City[1110] who had suffered sexual assaults by other residents and had displayed harmful sexual behaviour himself. It described children who sexually offend as "*one of the most vulnerable groups of children*", who needed "*robust processes*" to assess their "*levels of need, vulnerability, risks posed and appropriate interventions*".[1111] It recommended that the process of assessment should be reviewed and strengthened:

> "*to ensure that these children have a full assessment and intervention plan that supports their own vulnerability and safeguarding needs. This will include the development of clear governance and performance management arrangements*".[1112]

In spite of these recommendations, in the 2013 annual review of the Assessment and Early Intervention Panel, it was noted that meetings of the group responsible for overseeing the work of the City's AEIP had "*not taken place for some time*".[1113]

[1105] A609 – NSC001438
[1106] A607 – NSC001440; NTP001561; A610 – NSC001442
[1107] NTP001579
[1108] NCC003783; NCC003784
[1109] NSC000079_182-183
[1110] NCC003788
[1111] NCC003788_117
[1112] NCC003788_137
[1113] NCC003797

65. In 2012, the County failed in its response after a four-year-old in foster care with the County, NO-A605, was forced to perform oral sex on a 13-year-old child in care who was visiting the foster home.[1114] The AIM assessment was delayed due to a lack of trained social workers. The chair of the series of strategy meetings said that the County's response "*could be seen as negligence*".[1115] When an assessment finally did take place,[1116] it identified that the 13-year-old had been involved in an earlier incident of harmful sexual behaviour with another child which was not investigated. It was agreed that children's social care should complete a learning review into the case, but there is no evidence of what, if any, lessons were actually taken forward.[1117]

66. There were also failings by the County in 2014, when a resident in a County children's home, NO-A588, was subjected to forced oral sex and masturbation by another resident.[1118] This led to an internal investigation, carried out by an independent investigator under the County's complaints procedure following a complaint made on behalf of NO-A588,[1119] which found that "*staff at the care home failed in their duty of care*".[1120] There had been no assessment prior to placement of whether the victim would be safe at the home, and staff had not been informed about the known risks posed by the child exhibiting harmful sexual behaviour. Following the abuse, risk assessments were carried out, the complainant was moved to ensure his safety and the child exhibiting harmful sexual behaviour was closely supervised before moving to a therapeutic placement.[1121] However, the investigation found that it was unclear "*how well the incident … was investigated and how seriously it was taken in respect of lessons that could be learned from what happened*".[1122] Although it was recommended that the County acknowledge their failings and consider an apology and appropriate redress to NO-A588, it was not until 18 months later that the County made an "*unreserved apology*" for the failings which resulted in him being abused.[1123]

67. In November 2016 and May 2017, allegations of harmful sexual behaviour were made at a children's home run by a private company, Homes2Inspire.[1124] Homes2Inspire had its own safeguarding policy specific to harmful sexual behaviour.[1125] This required any concerning behaviour to be referred to social workers and other relevant agencies.[1126] Staff were only to conduct an internal investigation if the local authority gave permission and the allegation either did not meet the threshold for police involvement or the police had concluded their enquiries.[1127] In practice, whilst the Deputy Manager at the home was clear that staff would not question children, he was confused as to the distinction between an investigation and how this differed from initial fact finding.[1128]

[1114] NTP001550; NSC001435
[1115] NSC001435_29-35
[1116] NSC001435_55-58
[1117] NSC001435_101
[1118] NSC001478_1-4
[1119] NSC001478_6-13, 68-70
[1120] NSC001478_71-127
[1121] NSC001478_30-42; 48-66. In December 2014, the child exhibiting harmful sexual behaviour was sentenced to an 18-month detention centre order (NSC001478_67).
[1122] NSC001478_127 para. 7
[1123] NSC001478_129-135, 139
[1124] NCC003778; INQ000773; INQ000758; INQ000759
[1125] INQ002421_27; Yates 19 October 2018 53/10-55/13
[1126] Yates 19 October 2018 47/14-48/5
[1127] Yates 19 October 2018 50/4-6
[1128] INQ002420 para. 26; Yates 19 October 2018 64/19-65/4; 79/3-10

68. NO-A136 alleged, in October 2016, that she had been sexually abused in her previous foster placement by the foster carers' son.[1129] At the time, she was 11 years old and the alleged perpetrator 21. Nonetheless, the Deputy Manager noted that NO-A136 "*hasn't stated if this was consented or not*"[1130] despite the fact that consent would have been irrelevant.[1131]

69. Allegations of sexual abuse made against NO-A136 by a male resident in November 2016[1132] and by NO-A136 against another male resident in May 2017 were handled appropriately. In the former case, the police decided it was not in the public interest to proceed;[1133] in the latter, they concluded NO-A136's complaint was "*a hoax*". In any event, proactive steps were taken to protect the children and a detailed safety plan was put in place. This included increased supervision, extra staff, sex education, a sexualised behaviour tracking log, preventing children from going into each other's rooms and trying to ensure a family atmosphere in the home.[1134] Staff also received specific training on harmful sexual behaviour and sexualised behaviours as a result of the second incident.[1135]

E.6: Nottinghamshire Police and Crown Prosecution Service approach to non-recent harmful sexual behaviour

Nottinghamshire Police

70. Although Nottinghamshire Police had a specialist team dealing with cases of child sexual abuse from 1988 onwards,[1136] allegations of harmful sexual behaviour were excluded from its remit and were instead dealt with by its Criminal Investigation Department (CID).[1137] This was because harmful sexual behaviour does not involve a perpetrator with care of or control over the victim.[1138]

71. From 2006,[1139] certain cases of harmful sexual behaviour were dealt with by the CAIU and others by the CID, depending on the severity of the alleged offence. In any event, all harmful sexual behaviour cases should have been discussed with the CAIU, given its role in advising and monitoring the conclusions of harmful sexual behaviour investigations to ensure a consistent and appropriate response.[1140] Since 2011, all allegations of harmful sexual behaviour should be referred to the CAIU.[1141]

72. We have not seen any guidance or policy specific to the investigation of allegations of harmful sexual behaviour by Nottinghamshire Police.[1142] We were told that "*generally these cases are dealt with in a way that is similar to other cases of abuse*".[1143] Child Abuse Investigation procedures simply state that where the suspect is a child, "*this will not prevent a crime from being investigated*".[1144]

[1129] INQ000763
[1130] INQ000764
[1131] As accepted in evidence by Daniel Yates (Yates 19 October 2018 62/4).
[1132] INQ000776; INQ000773
[1133] Yates 19 October 2018 77/6-25
[1134] INQ002421_42-51
[1135] Yates 19 October 2018 91/19-92/22
[1136] The Family Support Unit (FSU) from 1988 to 1994, and then the Child Abuse Investigation Unit (CAIU) thereafter.
[1137] See, for example, NSC001497_12
[1138] Hicks 19 October 2018 141/14-142/3
[1139] NTP001495
[1140] NSC001590; NSC001608
[1141] NTP001536 para. 128
[1142] Nor is there any Operation Hydrant guidance on investigating harmful sexual behaviour.
[1143] INQ001970 para. 82
[1144] NTP001498 para. 4.8

The Crown Prosecution Service

73. Since 2009, all harmful sexual behaviour allegations must be referred to the Crown Prosecution Service for it to authorise charges.[1145]

74. The Crown Prosecution Service's approach has changed over time as it has become more aware of issues in relation to the vulnerability of both victims and children exhibiting harmful sexual behaviour, consent, adolescent relationships and public interest criteria. From 1986, when deciding whether to institute proceedings the Crown Prosecution Service was required to take into account the relative ages of the complainant and alleged perpetrator, and whether there was any element of "*seduction or corruption*".[1146] Specific guidance relating to the prosecution of harmful sexual behaviour cases was first included in the 2009 guidelines on prosecuting cases of child abuse, which required all such cases to be reviewed by a youth prosecutor.[1147]

75. More recently, Youth Offenders Guidance[1148] set out some of the unique considerations for prosecutors dealing with harmful sexual behaviour cases, which primarily affect the public interest test. It is emphasised that the overriding public concern is to protect children, rather than punish them unnecessarily.[1149] Factors to consider include: the relevant ages and the sexual and emotional maturity of the parties, the views of other agencies involved, the likely impact of any prosecution on the parties, and whether there is any element of exploitation, coercion, threat, deception, grooming, seduction, manipulation or breach of trust in the relationship. A distinction is drawn in relation to children under the age of 13:

> "*There is a fine line between sexual experimentation and offending and in general, children under the age of 13 should not be criminalised for sexual behaviour in the absence of coercion, exploitation or abuse of trust.*"[1150]

Allegations of non-recent harmful sexual behaviour

76. More than 50 complainants who were in the care of the Councils allege non-recent harmful sexual behaviour, but few have reported their allegations to the police. For those who did report to the police, some allegations have led to a decision by the police or Crown Prosecution Service to take no further action,[1151] whilst investigations into others were still ongoing as at October 2018.[1152] We are aware of only one prosecution for non-recent harmful sexual behaviour, which took place in the early 1990s and related to harmful sexual behaviour at Hazelwood in 1985.

77. L43 contacted the police recently regarding harmful sexual behaviour in 2002. He was told that there was nothing that the police could do because he did not press charges at the time.[1153] Chief Superintendent Robert Griffin confirmed that a complainant's earlier decision not to proceed with allegations would not be a bar to the police now taking his complaint forward, and that on the face of it there should have been an investigation into

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[1145] And all other allegations of sexual or physical abuse involving under 18s (CPS002804_6).
[1146] CPS002784 para. 8(vi)
[1147] CPS002804_6
[1148] CPS003476
[1149] CPS003476_14-17; CPS002805_64-69
[1150] CPS003476_16
[1151] For example, P4, L46, A76, D38 and L22 (INQ002574). In the case of NO-A94, the police decided not to speak to the alleged perpetrator (who had been a child at the time of the alleged abuse, but was an adult at the time of the allegation) on the basis that there was no corroborative evidence and she had been a victim of sexual abuse (NTP001632_1-4).
[1152] NSC000345; NTP001636_6-10; P16 26 October 2018 3-6; NTP001632_11-14, 21-24
[1153] L43 3 October 2018 86/16-87/18

L43's allegations.[1154] Despite the police not pursuing an investigation in this case, Chief Superintendent Griffin had not sensed any reluctance in general to investigate non-recent allegations of harmful sexual behaviour.[1155]

78. At present, allegations of non-recent harmful sexual behaviour in care (made by adults no longer in care) are generally investigated by the adult team within Nottinghamshire Police's Public Protection Unit. If a complainant alleges non-recent abuse in care by staff and also alleges they were abused by a child, it will be investigated by Operation Equinox.[1156]

79. Neither the police nor the Crown Prosecution Service appear to have specific guidance on the prosecution of cases of non-recent harmful sexual behaviour. This means that there is no specific guidance on some of the difficult issues in these cases, such as the extent to which someone should be held responsible for offences carried out many years ago whilst he or she was a child in care, the impact of a child exhibiting harmful sexual behaviour having been abused themselves, and how the question of consent should be approached. Instead, these matters are left to individual police officers and prosecutors to consider.

80. The understanding of and response to harmful sexual behaviour between children has developed significantly over the past three decades. There had been a focus on the issue in the County in the late 1980s and early 1990s, with five enquiries into harmful sexual behaviour in children's homes, the formation of an Adolescent Sex Offenders Group, and the development of policies and procedures. Whilst the enquiries established that harmful sexual behaviour was widespread in its children's homes, the County did not address the prevalence of harmful sexual behaviour or take sufficient action to prevent and respond to incidents. More recently, however, the County has taken steps to evaluate and improve its response to harmful sexual behaviour, to better understand its scale, and to develop new approaches to its prevention.

[1154] Griffin 25 October 2018 199/22-201/1
[1155] Griffin 25 October 2018 187/22-188/9
[1156] Griffin 25 October 2018 188/13-189/1

Part F

Cross-cutting themes

Cross-cutting themes

F.1: Barriers to disclosure

1. One key issue relevant to the three case studies in this investigation, and beyond, is why so many people do not report abuse. Research indicates that up to two-thirds of children do not disclose abuse during childhood,[1157] and only around 25 percent of those who are abused disclose when they reach adulthood.[1158] For those who do disclose, it takes them on average around 24 years to do so from the time of the abuse.[1159] Older children who do disclose will most frequently do so to their peers.[1160]

Barriers for children

2. Complainant core participants, other complainants who have given interviews to the police and some of the institutional witnesses who gave evidence to us identified the barriers to disclosure they had seen or experienced. These fall into a number of broad categories:[1161]

2.1. Fear of not being believed, or of being told by the perpetrator that they would not be believed.

2.2. Being scared, threatened with violence by the perpetrator or told by them not to tell anyone.

2.3. Having no one to whom they felt able to disclose, which may be due to a lack of trust, a feeling of isolation, a lack of opportunity to speak to a social worker on their own, or not having the same social worker for a sustained period.

2.4. Feeling embarrassed, ashamed or guilty, including because of grooming.

2.5. Not understanding what was happening at the time or seeing the abuse as normal, possibly due to grooming or past abuse.

2.6. Thinking that disclosure was not worthwhile, including due to a negative response to previous disclosure or because staff were involved or implicated in some way in the abuse.

2.7. Fear of being separated from family.

2.8. Inhibition by shock, trauma or mental health problems caused by the abuse.

[1157] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, sections 4–6
[1158] NSC000002_22 para. 84
[1159] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, p22
[1160] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, pp37–38
[1161] INQ002574; INQ002575; INQ002576; INQ002577; INQ001875_19-23; INQ001876; INQ001960 para. 41; INQ001951 paras 214-221; INQ002007 paras 28.1-28.2; INQ001981 para. 8.1; INQ002480 para. 56.11; INQ002039 paras 66-70; INQ001807 paras 16.1-16.4; INQ002628 para. 60; INQ001964 para. 119; MacKechnie 18 October 2018 149/8-150/1; INQ001983; INQ001787; INQ001758; INQ001792; INQ001806; INQ001895 paras 5-7; INQ001984 paras 15.1.4-15.1.5; INQ001987 para. 19; INQ002405 para. 11.1; INQ001799 para. 150

2.9. Fear that disclosure would affect their next placement.

3. Other barriers identified by professionals[1162] included children having other priorities,[1163] feeling that they have found some stability or having an affection for the perpetrator or their family member,[1164] and fearing that they will lose control of the process once they disclose.[1165] There may also be practical issues such as disability or language and cultural differences.[1166] Having suffered neglect or abuse in the past, leading to attachment difficulties, may also inhibit disclosure.[1167]

4. A large number of complainants of sexual abuse in care have come forward as adults to this investigation or to Nottinghamshire Police but, for others, barriers to disclosure remain. These barriers may be continuations of those listed above, such as a fear of not being believed,[1168] a feeling of shame or guilt,[1169] a lack of trust in authority[1170] or fear of the perpetrator.[1171] Adult survivors may also be frightened that disclosure might have a negative impact on their relationships or that their own child might be removed by social services.[1172] They may also think that the support available will not be good enough[1173] or they may have lost faith in the strength of their claim after, for example, being unable to access their records.[1174]

5. There is little evidence available on specific barriers to disclosure of harmful sexual behaviour.[1175] Professor Hackett's view was that children were probably less likely to disclose harmful sexual behaviour than adult-perpetrated sexual abuse, in part because public education campaigns have largely focused on risk from adult perpetrators.[1176]

6. Even if a child makes an initial disclosure of abuse, the barriers to reporting discussed above may lead them subsequently to retract their disclosure.[1177] Professionals need to deal with retractions cautiously and consider the possible reasons behind them.[1178]

Impact of relationship with perpetrator or type of placement

7. The type of placement, and the relationship between the complainant and the perpetrator, can have an impact on the barriers that arise in any individual case.[1179] As a result, barriers to disclosure for children abused in care may require different considerations from those for children abused in the family home or in a religious or school setting.

[1162] Including in a 2011 Serious Case Review into Patrick Gallagher (NSC000002).
[1163] INQ001875_22
[1164] INQ001875_22-23; INQ001983; INQ001758; INQ001895 paras 5-7
[1165] Fisher 18 October 2018 101/7-102/4
[1166] INQ001875_23; INQ002480 para. 56.11; *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, p43
[1167] NSC000002_24, 58-59
[1168] D46, L25 (INQ002574).
[1169] L28 (INQ002039 para. 71).
[1170] D44, D48 (INQ001984 para. 15.1.5).
[1171] Coupland 24 October 2018 158/20-159/1
[1172] For example L52 (Coupland 24 October 2018 159/4-160/8; NSC000002_61).
[1173] Coupland 24 October 2018 160/25-161/17
[1174] D6 5 October 2018 73/23-79/20
[1175] INQ002045_70 para. 8.13
[1176] Hackett 25 October 2018 43-44
[1177] INQ001813 para. 151; NSC000507
[1178] NSC000473_1-5, as was the advice in the County since at least 1996.
[1179] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, p40

8. Evidence suggests that children in care can be more vulnerable to abuse than other children, which may be due to their experiences prior to coming into care. For example, the impact of neglect may make it more difficult for children in care to distinguish between appropriate behaviour from trusted people and harmful relationships or activities.[1180] Particular barriers for children in care include:

8.1. Children may be less likely to know what abuse is, if carers feel that it is an inappropriate topic to discuss.[1181]

8.2. Those who may be best placed to provide an avenue for reporting, such as social workers, are often the same people who have removed them from their family (or other source of harm), which may make it difficult to establish trust.[1182]

8.3. Children who do disclose often do so to a relative (most likely mothers[1183]) or a friend. Those in care are away from their families and may well not be in settled placements or schools. As a result, the opportunity for, and likelihood of, disclosure is reduced.[1184]

8.4. Children may fear that if they do disclose their placement will break down, necessitating another new placement, or that they will be separated from their peers or siblings.[1185]

9. Some particular factors relevant to residential care may include:

9.1. The institutional environment has an inherent power imbalance, increasing the vulnerability of the child and making it more difficult for them to speak out.[1186]

9.2. There may be a sexualised culture within the home, including amongst staff, leading to a lack of appropriate boundaries and an unsafe environment in which children would find it difficult to talk about sexual abuse.[1187]

9.3. Physical abuse, including by staff, may inhibit disclosure by children through fear of retributive violence.[1188]

10. Specific factors affecting those in foster care may include:

10.1. Vulnerable children who experience apparent kindness and attention from a foster carer, which they may not have previously had at home, may then have conflicted feelings about disclosing abuse by the foster carer.[1189]

[1180] NSC000002_23 para. 86
[1181] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 12, Contemporary out-of-home care, p179
[1182] NSC000002_22 para. 85
[1183] *'No one noticed, no one heard': a study of disclosures of childhood abuse*, NSPCC, 2013, p24
[1184] NSC000002_43 para. 216, 58-59 para. 296 b
[1185] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 12, Contemporary out-of-home care, pp183–184
[1186] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, p40; INQ001895 para. 32; INQ001984 para. 15.1.2
[1187] Cooper 9 October 2018 91/11-24
[1188] For example, see the evidence of P8, D28, D33, D48, L28, A76 (INQ002574).
[1189] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 12, Contemporary out-of-home care, p183; INQ001875_23

10.2. Some foster carers become trusted by social workers and other professionals, perhaps because of the length of time they have been foster carers or the number of children they have fostered.[1190] Their reputation can then make children in their care feel less likely to be believed if it is their word against the foster carer's.

10.3. Long-term foster care will often involve care of a child over many years beginning from a young age. The depth of the ensuing relationship may act as a barrier – research suggests that the type of abuse least likely to be disclosed is long-term abuse by a carer or trusted adult which starts at a very young age.[1191]

Reducing barriers to disclosure

11. A number of steps towards reducing barriers to disclosure are set out in the Councils' Inter-Agency Safeguarding Procedures, including:

- ensuring that children feel valued and respected, and listening and responding to their concerns;
- training staff and foster carers to be alert to children's vulnerabilities;
- giving children ready access to a trusted adult outside their placement and making them aware of independent visiting and advocacy services;
- having clear, effective and accessible complaints procedures for children;
- having clear procedures for staff to raise concerns about other staff or carers, such as a whistleblowing policy; and
- ensuring that if a child goes missing, guidance is followed and steps are taken to understand the reasons.[1192]

12. In terms of the response to children, as far back as 1984, multi-agency procedures in the County stated:

> *"Almost all allegations by children of sexual abuse are true and it is important to communicate to the child at the outset that they are believed … The victim needs to hear that full responsibility for the offences rests with the offender."*[1193]

13. There are other steps which already form part of recognised good childcare practice[1194] and which may also reduce barriers to disclosure:

13.1. Children having the same social worker whom they are able to see alone on a regular basis and with whom they can establish a relationship.[1195]

13.2. Placements being regularly reviewed during unannounced visits.[1196]

[1190] NSC000002_23 para. 87, 122 para. 675 b
[1191] NSC000002_54 para. 279 b
[1192] Interagency Safeguarding Children Procedures of the Nottinghamshire Safeguarding Children Partnership (NSCP) and the Nottingham City Safeguarding Children Partnership (NCSCP) 2019
[1193] NSC000075_11
[1194] Fostering Services (England) Regulations 2011; Children's Homes (England) Regulations 2015; Interagency Safeguarding Children Procedures of the Nottinghamshire Safeguarding Children Partnership (NSCP) and the Nottingham City Safeguarding Children Partnership (NCSCP) 2019
[1195] INQ001758; INQ001951 para. 227
[1196] INQ001960 para. 42; INQ001807 para. 16.3; INQ001942 para. 9.5

13.3. Ensuring social workers, residential care staff and foster carers are able to "*think the unthinkable*".[1197]

13.4. Providing support and counselling services to children from their first disclosure of an allegation.[1198]

13.5. Providing children with age-appropriate information which sets out that some behaviour, whether from adults or peers, is unacceptable and may constitute sexual abuse, and educating them about what they should do if a friend tells them they are being abused.[1199]

13.6. Ensuring that residential staff, foster carers, social workers, children's social care managers and police officers are aware of the barriers to disclosure and of the need to take proactive steps to elicit disclosures.

> "*Professionals need to be alert to a child's attempts to begin to disclose. The information children share may be piecemeal and not necessarily evidential. What children say must also be viewed in the context of their behaviours and professional concerns in order to formulate a clear assessment of risk and plan of protective action.*"[1200]

14. Following recognised practice will assist the Councils to reduce the barriers to disclosure for children in the future.

F.2: Recent responses to complainants

15. Once complainants come forward and do disclose sexual abuse, they have then to engage with various institutions, including the police, the Councils and the Crown Prosecution Service. In this they face numerous challenges, such as interviews and investigations, giving evidence in criminal trials, obtaining their social service records, commencing legal claims for compensation, establishing contact with the Councils, and accessing support and therapy.

16. Complainants have expressed concern about the level and quality of support received during Council or police investigations, or during any criminal trial that arises, and after an investigation has concluded. Some complainants become so critical of the support that they no longer want to engage with these mechanisms,[1201] while others say they received no support and had to find it for themselves.[1202]

Responses from the Councils

17. In early 2015, the County formed a Historical Abuse Team of social workers to work with adults making allegations of non-recent abuse. This team is responsible for the County's children's social care service's enquiries into allegations[1203] and for supporting any police investigation. The team also works with the Support for Survivors Group[1204] and supports

[1197] A message currently being delivered to social workers and others in the County by three victims of non-recent abuse (INQ001951 para. 227).
[1198] INQ001983; INQ001964 paras 124-125
[1199] NSC000002_128 paras 708-709; INQ001942 para. 9.5; Dales 22 October 2018 58/12-22; INQ002045_75-76 paras 8.26-8.27
[1200] NCC003788_126
[1201] Including D10, P9, D4, D42, D5, D26, D20, L51, P1, P8, P3 (INQ002574).
[1202] D7 2 October 2018 94/22-95/25; L17 2 October 2018 149/24-151/7
[1203] Historical Cases of Abuse, Nottinghamshire County Council (updated January 2017)
[1204] Edwards 23 October 2018 126/6-14; INQ001951 para. 27

complainants, providing referrals to specialist services and producing chronologies of complainants' time in care based on the records.[1205] Although this constitutes a dedicated resource providing personalised support to complainants, it was developed "*a little late*".[1206] Funding has now been secured until at least March 2020.[1207]

18. The City has one social worker supporting police investigations, and allows the police full access to child care records. Alison Michalska (the City's Corporate Director for Children and Adults) was of the view that adults making complaints of non-recent abuse needed advice and support from adult social workers and adult specialists; she did not think that children's social workers were the right people to be involved. The City also has a single point of access for all complainants: this then signposts them to the City's support services as well as health and other services.[1208]

19. The Councils also have various partnerships[1209] which offer opportunities for survivors to share experiences, such as a therapeutic recovery service for children who have been sexually abused or exploited which has information on external support services.[1210] The City's Lead Member for Children's Services until May 2019, Councillor David Mellen, said that counselling and support "*will always be a priority … to make sure that people who have been let down are not let down again*".[1211] However, the City's view was that some counselling is better provided through the health service.[1212]

Responses from Nottinghamshire Police

Support

20. From the early stages of Operation Daybreak until at least 2013, if the police came into contact with a complainant who they felt needed support, they would direct them to their GP.[1213] DI Yvonne Dales (former Senior Investigating Officer of Operation Daybreak) accepted that this may not have been the "*best approach*", and reflected that provision of support for victims as well as directing them to appropriate support were not prioritised early enough in the investigation. There was no specific training on providing support to complainants.[1214] Since 2014, Paddy Tipping, the Police and Crime Commissioner, has been responsible for commissioning support services to which the police will direct complainants.[1215]

[1205] INQ001951 paras 20-34; Morton 23 October 2018 71/18-76/25; INQ001942 para. 4.9
[1206] Edwards 23 October 2018 122/9-13
[1207] https://www.nottinghampost.com/news/local-news/county-council-set-spend-another-2657522
[1208] Michalska 25 October 2018 67/8-69/8
[1209] For example, between 1998 and 2012, the City commissioned Action for Children to provide specialised support to children who had been sexually abused. Since then, support has been provided as part of the City's Children and Adolescent Mental Health Services for Children Looked After (CAMHS CLA) to all children in care who have suffered forms of trauma, including sexual abuse (NCC003691 paras 7.101-7.103).
[1210] NSC001235 para. 7a.12
[1211] Mellen 24 October 2018 102/7-14
[1212] Michalska 25 October 2018 76/21-77/16
[1213] NTP001517; INQ001780 para. 5.14
[1214] Dales 22 October 2018 46/3-47/5
[1215] INQ002570 paras 23-31

Contact

21. Several complainants were dissatisfied with their contact with the police during Operations Daybreak, Xeres and Equinox.[1216] This included the initial method of contact,[1217] the frequency of contact[1218] and communication during investigations,[1219] whilst some disliked the way in which they were told that no further action would be taken.[1220] However, Mandy Coupland, co-founder of the Child Sexual Abuse Survivors Group, was positive about current Chief Superintendent Robert Griffin's approach; he didn't "*butter things up*" and his way of communicating with complainants was "*helpful*".[1221]

22. Since 2005, complainants should be updated regularly by the police until an investigation is closed.[1222] During Operation Daybreak, there was no protocol on approaching potential victims. DI Dales introduced logs to record contact with complainants.[1223] DC Julie Balodis's view was that the individual officer would give the initial contact "*careful consideration*", based on the information available, although she acknowledged that "*we don't always get it right*".[1224]

23. The police are responsible for informing complainants of a decision not to prosecute and of the reasons why this decision was made,[1225] which DI Dales told us would "*ideally*" be done in person.[1226] Evidence from complainants suggests that this did not happen in each case.[1227] Since 2013, victims have had a right to request a review of a Crown Prosecution Service decision not to prosecute or to terminate proceedings.[1228]

24. In our Interim Report, we recommended that a joint inspection of compliance with the Code of Practice for Victims of Crime be commissioned.[1229] A cross-government Victims Strategy was subsequently published in September 2018, which "*commits to hold agencies to account for compliance with the Victims' Code through improved reporting, monitoring and transparency on whether victims are receiving entitlements*".[1230]

[1216] INQ002574: including P4, P5, D28, D4, P15, D5, D9, L25, L28, L31, P2, D20, P6, L22 and L51. By contrast, others thought the police had been good at keeping in contact and providing support and advice (D22 3 October 2018 148/7-10; L23 3 October 2018 151/19-22; L29 3 October 2018 155/4-6; D26 4 October 2018 168/17-169/1).
[1217] For example, arriving at a complainant's house unannounced, leaving a card asking them to contact the police, or arriving and saying that they had come about allegations of child sexual abuse (P4 4 October 2018 160/15-24).
[1218] P1 5 October 2018 108/6-13; INQ002574
[1219] For example, whether by email, text messages, voice messages or face-to-face contact (INQ002574; Coupland 24 October 2018 175/3-10).
[1220] INQ002574
[1221] Coupland 24 October 2018 176/16-177/5
[1222] Guide for Victims 2005; Balodis 22 October 2018 94/18-95/3. The most recent version is the *Code of Practice for Victims of Crime* (October 2015) which is not clear on the regularity of contact required but notes that this should be agreed at the outset in the case of child complainants (p73). For adult complainants, they should be told at the outset how often they will receive updates from the police, following a discussion about it (p19). The Code of Practice is due to be updated again; the Government's 2018 *Victims Strategy* states it will "*Provide timely and clear information to victims. We will give victims more choice in how they are communicated with, whether they want to speak to another person or communicate by email or text message. We will make sure that information is accurate and timely and we will clarify the role and responsibility of criminal justice agencies in the updated Victims' Code.*"
[1223] Dales 22 October 2018 37/24-38/6
[1224] Balodis 22 October 2018 99/23-100/25
[1225] *Code of Practice for Victims of Crime* (2015), p22
[1226] Dales 22 October 2018 37/8-11
[1227] INQ002574
[1228] CPS004382 paras 84-88
[1229] *Interim Report of the Independent Inquiry into Child Sexual Abuse*, April 2018, p53
[1230] *Government response to the Interim Report by the IICSA*, p6, para. 15

Other support

25. There are several independent survivor support groups in Nottinghamshire. The Support for Survivors Group provides a forum for survivors and their representatives to meet with local safeguarding boards, the Councils, clinical commissioning groups, Nottinghamshire Healthcare NHS, the Police and Crime Commissioner and the police.[1231] The CSA Survivors Group in Nottingham seeks "*justice for survivors*" and directs people to the correct services.[1232]

26. Whilst these groups are clearly of benefit to complainants, waiting lists for counselling and other treatment (particularly in crisis teams) are still too long, insufficient empathy is still sometimes shown by the authorities towards complainants[1233] and, in the view of one survivors group, some police officers remain untrained to deal with complainants.[1234]

Apologies

27. In the 1990s, children who had been sexually abused received apologies from the County in a small number of cases following convictions, critical findings in inquiry reports or civil claims which had been settled.[1235] More generally, however, the County was cautious about apologies, which were considered "*dangerous*" as they could amount "*to an admission of legal liability which can open up the department to legal claims*".[1236] Given the number of cases in the late 1980s and 1990s in which staff were convicted of or the subject of disciplinary sanction for sexual abuse of children, the County should have apologised and learned lessons.

28. More recently, the Councils have been willing to apologise in some individual cases where there has been a conviction, or where they are satisfied that there was abuse. For example, the County apologised to NO-A588 in 2017[1237] and the City apologised to the children in the NO-F35 case, despite his acquittal.[1238]

29. The County has apologised to those who suffered abuse while in its care. In March 2016, the Leader of the County Council made an unreserved apology to the victims and survivors of Andris Logins; while the apology acknowledged the County's failure to protect vulnerable children, it only came after Logins' conviction.[1239] In January 2018, the County apologised to all those who had suffered abuse while in its care and made a pledge about how it would act in the future.[1240] The County's public apology has been received positively by many victims and survivors.[1241] However, as acknowledged by Colin Pettigrew,[1242] the County does not always meet the terms of its pledge, in its approach to civil claims.

30. In the City, as recently as February 2018, Councillor Mellen reported the Leader of the City as saying "*we will apologise when there is something to apologise for*".[1243] It was suggested that this did not represent the attitude of the City at the time,[1244] but Councillor Mellen

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1231 NCC000337; NCC000614; NCC003652
1232 Coupland 24 October 2018 154/14-155/1
1233 Coupland 24 October 2018 160/18-165/12
1234 Coupland 24 October 2018 172/21-177/10
1235 For example, NSC000440_2, 26
1236 NSC001610_4
1237 NSC001478_129-135
1238 Michalska 25 October 2018 88/8-22
1239 INQ001682
1240 NSC001283; NSC001235_2 para. 1.5
1241 INQ002609 para. 50; Coupland 24 October 2018 184/5-185/7
1242 Pettigrew 25 October 2018 158/4
1243 NCC003688_4
1244 Mellen 24 October 2018 103/22-107/2

signed off the minutes of the relevant meeting. Councillor Mellen accepted that this was offensive to those who were abused while in the City's care. Alison Michalska explained that the thinking was that an apology would be made when there was a conviction of an employee, ex-employee or foster carer from the City.[1245] The City did make a public apology two weeks before our October 2018 hearings.[1246] However, this apology was viewed with cynicism by some complainants and was rejected.[1247]

31. In June 2018, following an interview by the *Nottingham Post*,[1248] Alison Michalska was quoted as saying that no evidence had appeared of disclosure not being acted on and thought they had "*learnt the lessons*" from cases up to and including the 1980s. Ms Michalska disputes the accuracy of the article, but the *Nottingham Post* has maintained its position.[1249] The City should have apologised for the sexual abuse of children in its care a long time ago.

Civil litigation

32. There have been approximately 200 civil litigation claims against the County. Of these, 41 were ongoing as at July 2018 and only one had gone to trial.[1250] As at May 2018, the City had received 37 claims since 2009, of which 18 had been settled.[1251] The handling of these claims has caused further difficulties for complainants.

33. In the early 1990s, there was some dispute within the County about the extent to which staff should co-operate with claimant solicitors. There were concerns that the County's duties to children "*were in danger of being overridden by those seeking to defend the County Council from costs … There had been no overall liaison or drawing lessons to be learnt*."[1252] In response, in 1993, the County formed a Risk Management Group (made up of representatives of social services, the County solicitor and the Risk & Insurance Officer[1253]) to respond to claims received.[1254] As learning points arose, the group met with children's social care managers to discuss those lessons, and subsequently disseminated them more widely by holding a seminar.[1255]

34. However, there remained a wariness about apologising, because of financial consequences, and staff were not authorised to admit liability.[1256] L24 said that an "*apology would mean more to me than any amount of money*" and that recognition and acceptance from the Councils would have been the "*only thing that would really help*".[1257]

[1245] Michalska 25 October 2018 89/8-25
[1246] City Council 2 October 2018 44/8-45/19
[1247] P7 4 October 2018 150/1-9; C21 2 October 2018 177/6-9; D6 5 October 2018 78/17-25
[1248] NCC003803
[1249] Michalska 25 October 2018 91/13-93/2; NCC003802; *Nottingham Post* 25.10.18
[1250] NSC001235 para. 1.4
[1251] NCC003691 para. 7.4. The City has limited or no information in relation to claims received before 2009.
[1252] INQ002007 para. 2.109
[1253] NSC000440_7
[1254] INQ002007 paras 11.12-11.13
[1255] Jones 8 October 2018 85/7-86/24
[1256] Jones 8 October 2018 89/8-18
[1257] L24 5 October 2018 130/2-10. We understand that the City has, since our hearings in October 2018, changed its policy towards apologies and that a letter of apology, along with a meeting with Ms Michalska if desired, is now sent to every claimant when their claim is resolved.

35. Some complainants were surprised that the Councils resisted their claims. L46 was "*shocked*" that the County would deny liability for sexual assault as the incident is recorded in her records.[1258] L17 told us that reliance on 'limitation' arguments (that claims could not proceed because they were out of time) made her "*really angry*".[1259]

36. The delay in settling claims also caused concern. L17's case took six years to conclude; she described the process as "*hell*" and felt that "*they were just hoping I would go away*".[1260] Delays can of course be caused by either side[1261] and it is important not to settle too quickly, before the impact of the abuse on the complainant can be assessed.[1262] However, we note that the Councils have made efforts to reduce delay for complainants, with the County reducing the time to reach a settlement from an average of 12 years in 2005 to eight months in 2017.

37. Concerns were also raised about the level of settlement offers. L43 said that the offer made to him was "*insulting*", describing it as "*like offering me a £10 note and telling me to go home and shut up*".[1263] However, how litigation is conducted is typically decided by the Councils' insurers.[1264]

38. The Inquiry will consider the approach to civil litigation, apologies and other issues related to the justice system in greater detail in its Accountability and Reparations investigation,[1265] the report on which will be published later in 2019.

Care records

39. For those in care during their childhood, the records made by social workers and residential care staff are often their only available means of understanding their past. However, there are issues surrounding the quality of records, the extent of their retention and the access given to them for those formerly in care.

40. Under national legislation and regulations, residential care staff were required to keep records from 1951 onwards.[1266] These included registers of admission and discharge and records of each day the child was resident, as well as "*events of importance connected with the home*". The most recent regulations in 2015 set out in extensive detail the information that must be provided in a child's case records.[1267] Similarly, since 1955, local authorities have been required to maintain records on children in care in foster placements.[1268] Social workers are also required to keep and maintain detailed records on the children in their caseload, most recently under 2010 regulations.[1269]

[1258] L46 5 October 2018 99/11-23
[1259] L17 2 October 2018 147/23-148/3
[1260] L17 2 October 2018 149/10-150/18
[1261] Pettigrew 25 October 2018 178/6-7
[1262] Pettigrew 25 October 2018 158/9-159/1
[1263] L43 3 October 2018 88/1-9
[1264] Pettigrew 25 October 2018 155/8-156/15
[1265] Accountability and Reparations for Victims and Survivors of Abuse
[1266] The Administration of Children's Homes Regulations 1951; Children's Homes Regulations 1991; Children's Homes Regulations 2001
[1267] The Children's Homes (England) Regulations 2015
[1268] The Boarding-Out of Children Regulations 1955; The Boarding-out of Children (Foster Placement Regulations) 1988; Fostering Services (England) Regulations 2011
[1269] Children Act 1989 Guidance and Regulations, Volume 2: Care planning, Placement and case review; Care Planning, Placement and Case Review (England) Regulations 2010 (as amended)

41. In Nottinghamshire, from 1978 onwards, County and multi-agency procedures and guidance set out the records to be kept by residential staff, foster carers and social workers in various circumstances, including when allegations of abuse were made.[1270] These were set out most recently in interagency procedures for both Councils[1271] and in the Councils' individual procedures.[1272]

Quality of care records

42. The majority of complainant core participants were in care from the 1970s to the 1990s, several of whom gave evidence of their concerns about the quality of the records kept about them during their time in care.[1273] Similar concerns were raised by children's social care management and councillors over the past four decades. For example:

42.1. We were told about poor record-keeping occurring as early as the mid-1970s, with residential staff at Beechwood failing to record events in logbooks and incident sheets.[1274]

42.2. A 1979 memo from the County's Divisional Director to senior staff at Beechwood noted: "*the full account of that incident should have been recorded in the logbook … will you please ensure that the logbooks in the Lindens and in Redcot are at all times kept fully and accurately and in particular, regard is had to the child's behaviour and the response of staff to that behaviour.*"[1275]

42.3. In 1987, County Councillor Tom Butcher wrote to the Director of Social Services expressing concern that "*records are 'not kept within the department' in relation to children in care involved in sexual offences/acts. I consider it to be an important part of managerial monitoring of problems facing children in care*".[1276] We have seen no response.

42.4. A County investigation into child sexual abuse in foster care and Wollaton House in 1992 reported that recording and organisation of residential and fostering files were poor, and that this had been happening over many years. Records were not properly organised, but also were not being kept in the first place. The authors emphasised that, "*staff should be clear that children cannot be protected if vital information is omitted, and that records are a part of the history of a child's life during any time they spend in a 'looked after' placement.*"[1277]

42.5. During the course of a disciplinary investigation in 1995, most of the records kept by Amberdale were found to be "*shoddy, partial and contained little substance to aid professional social work decision making on the children concerned*".[1278]

[1270] NSC000046_29-31; NSC000075_32; NTP001473_119; NTP001473_1-118; NSC000077
[1271] Allegations Against Staff or Volunteers, section 6 (updated January 2019)
[1272] County: Case Management and Recording; Managing Allegations/Concerns in Relation to Adults who work with Children; Children's Homes; Fostering, sections 12.6, 12.13, 12.17
City: Case Management, Recording and Supervision; Looked After Services; Allegations Against Foster Carers
[1273] INQ002574
[1274] Rigby 9 October 2018 43/6-16; Cope 17 October 2018 117/9-16; INQ002673 paras 35-37
[1275] NSC000455_2
[1276] INQ000275_3
[1277] NSC000103_6
[1278] NSC000189_47

Retention of records

43. From 1955 onwards, a local authority was required to retain the records of a child in foster care until their 21st birthday.[1279] Until 1991, the retention of child protection files or social services records for a child in residential care was at the discretion of the record keeper.[1280] Since then, records for each child in care have had to be retained until their 75th birthday.[1281] This remains the current retention period[1282] and has been applied by the City since 1998.[1283]

44. In the County, keeping "*historic records*" was viewed historically by some children's social care staff as "*the lowest priority*".[1284] During an internal reorganisation in 1985, there was "*an awful lot of weeding and destruction of files*", which led to the loss of certain information which could have been considered "*essential to keep*".[1285]

45. Similarly, most of the City's documents relating to the provision of social services before 1974 have been destroyed. Only those which the City was required to keep have survived from this period, such as admissions registers, logbooks and medical records.[1286]

Access to records

46. Access to care records is vital for individuals to understand their childhood experiences, the reasons for being taken into care and what happened to them during their time in care.[1287] For those who allege abuse during their time in care, being unable to see their records can compound the sense of being let down by the Councils.

47. Since 1998, the primary methods of obtaining records for those formerly or currently in care have been via a subject access request[1288] or disclosure in civil court proceedings.[1289]

48. On at least some occasions, the Councils have not responded appropriately to requests for access to records, particularly given their legal obligations set out above. For some complainants, the search for records and the lack of communication and explanation have been difficult and upsetting.[1290] In particular:

> **48.1.** D6 (a care leaver) submitted his first subject access request to the City in May 2015. After a long wait, he felt compelled to disclose to the City that he was a core participant in this investigation, and he only received his records days before the hearings in October 2018.[1291] The City told us that D6's first subject access request was received by the wrong part of the City, that he had not provided the necessary proof of identity and that the City had to wait for permission to release the records of

[1279] Boarding-Out Of Children Regulations 1955
[1280] NSC001235 para. 1.11
[1281] INQ002946_3; Arrangement for the Placement of Children Regulations 1991, Regulation 9, unless they died before the age of 18, in which case they must be kept for 15 years after death.
[1282] County Children's Services – Retention of Records
[1283] NCC003704_002
[1284] Jones 8 October 2018 77/6-15
[1285] NSC000980_10
[1286] NCC003691 para. 1.9; Michalska 25 October 2018 81/21-82/19
[1287] Coupland 24 October 2018 180/23-181/4; Leigh 24 October 2018 190/10-16
[1288] Data Protection Act 1998, section 45
[1289] Civil Procedure Rules 1998, Part 31
[1290] A79 5 October 2018 110/19-113/9; INQ002574: L51, P18, Q1, Michael Summers
[1291] D6 5 October 2018 73/23-79/20

D6's birth family at the same time as his own.[1292] The procedural hurdles appear to take no account of the significance to the applicant of the records, nor do they allow for prioritisation. This was an unacceptable delay.

48.2. A79 described spending "*30-odd years*" trying to get his records, making numerous subject access requests and being told that his records no longer existed. In 2000, he eventually received eight pages of information typed up by an investigation officer from the County, but did not understand how they were produced.[1293]

49. Further changes to the process have been made recently. Since 2015, the County's Historic Abuse Team have been assisting those formerly in care to access their records.[1294] Around the time of the investigation's October 2018 hearings, the City agreed to establish a new role "*dealing wholly with the provision of social care records*".[1295] Further improvements to processes are clearly required, as we identified in the Inquiry's Interim Report.[1296]

F.3: External inspections of children's social care in the Councils

50. Although local authorities should not be relying solely on external inspections to understand if their services are performing adequately, they provide an insight into changing performance.

51. The County has received variable Ofsted assessments since 2008:

- 2008: Services for children in care and the quality of residential care were rated as 'good'.[1297]
- 2010: Whilst services for children in care were 'adequate', safeguarding services were 'inadequate', with significant weaknesses in staffing and failures to protect children, resulting in an improvement notice for safeguarding.[1298]
- 2011: The County's safeguarding service was rated 'adequate' and some aspects 'good'. As a result, the improvement notice was lifted.[1299]
- 2015: Overall, the County was rated 'good', with positive comments about arrangements for the management of allegations against staff:

  "*Individual cases are managed and planned well, with timely and effective work carried out to ensure risks to individual children are assessed and addressed, as well as investigation of the adults concerned.*"[1300]

- June 2018: Ofsted commented that the County's self-evaluation of its children's social care had highlighted strengths in practice as well as areas for improvement.[1301]

[1292] Michalska 25 October 2018 84/2-85/9
[1293] A79 5 October 2018 110/19-113/9
[1294] Pettigrew 25 October 2018 161/5-7
[1295] NCC003807 para. 7.5
[1296] *Interim Report of the Independent Inquiry into Child Sexual Abuse*, April 2018, p72
[1297] OFS008002
[1298] OFS007988 (see also https://www.gov.uk/government/collections/improvement-notices).
[1299] OFS007987
[1300] OFS007990
[1301] OFS008126

- February 2019: After a 'focused visit' assessing the County's arrangements for children potentially at risk or in need of support, Ofsted's report was generally positive[1302] but it did not cover children in care.

Since 2011, the County's children's social care service appears to have shown significant improvement. It is now in 'Pathway One' under the new ILACS framework, so that it receives a short inspection about three years after the previous inspection.[1303] However, we note there has been no general Ofsted inspection of the County's children's social care service since 2015.[1304]

52. The inspections of the City have been mixed:

- 2007: The City was rated as 'adequate' by Ofsted overall, with social care services improving (including in placement choice and residential homes, which now met national standards).[1305]
- 2011: The City received a 'good' rating for safeguarding and services for looked after children. The dedicated police officer for looked after children was described as "*an outstanding example of effective support*".[1306]
- 2014: The City's children's social care service was rated as 'requires improvement' overall, including for services for children in need and children in care overall.[1307] There were too many changes of allocated social worker, inadequate supervision, poor planning and poor record keeping. However, there were positive findings in relation to the placement of children outside of the City, social worker visits to children in care and the response to allegations of abuse or mistreatment of children by professional staff and carers. Young people had access to an independent advocacy service and knew how to make complaints.
- 2017: Ofsted rated children's social care services 'good' but the progress of children in care and care leavers 'requires improvement'.[1308] The City did not always fully understand the reasons why children went missing and therefore did not always provide them with the necessary support; the City told us its practice in this regard was not yet good enough.[1309]
- May 2018: Based on a self-evaluation, Ofsted observed that "*the sense is of a strong authority continuing to manage well in a difficult environment*".[1310]
- November 2018: The City was rated as 'requires improvement' for all its children's social care services.[1311] Its self-assessment did not "*accurately identify all the shortfalls found during this inspection*". While there were areas of good practice (such as the management of allegations against staff and the identification of children at risk of child sexual exploitation), there were insufficient social workers, poor systems to support the education of children in care, delays in placing children appropriately and insufficient priority for securing adequate emergency accommodation.

1302 Focused visit to Nottinghamshire County Council children's services, letter 1 February 2019
1303 ILACS framework and evaluation criteria p7
1304 Nottinghamshire County Council: Activity, reports and ratings
1305 OFS008024
1306 OFS008019
1307 OFS008020
1308 OFS008274
1309 Michalska 25 October 2018 106/1-109/1
1310 OFS008123
1311 Nottingham City Council, Children's services inspection (2018)

Part G

Conclusions and recommendations

Conclusions and recommendations

G.1: Conclusions

1. Most institutions referred to in this report failed children who were sexually abused whilst in the care of Nottinghamshire County and Nottingham City Councils, to a greater or lesser extent. These included elected members, senior managers, frontline social work and residential staff and foster carers within both of the Councils, and Nottinghamshire Police.

Nature and extent of allegations of child sexual abuse

2. The sexual abuse of children in the care of the Nottinghamshire Councils was widespread in both residential and foster care during the 1970s, 1980s and 1990s. It included repeated rapes and other sexual assaults, as well as physical abuse. Allegations have been made against a range of perpetrators, including senior and junior residential care staff, foster carers, and children exhibiting harmful sexual behaviour.

3. Around 350 complainants have made allegations of sexual abuse whilst in the care of the Councils from the 1960s onwards but the true number is likely to be considerably higher.

Conclusions in respect of the Councils

4. Neither of the Councils learned from their mistakes despite decades of evidence of failure to protect children in care. Successive reviews, both internal and external, identified weaknesses in policy and practice relating to the protection of children in residential care, in foster care and in the area of harmful sexual behaviour. Many of these reviews included recommendations for change which were accepted but rarely acted upon.

5. Over the last 30 years, the Councils have produced policies and procedures on responding to allegations of sexual abuse of children in care. However, these policies were not generally made known to staff nor was there a checking process in place to verify implementation.

6. The County acknowledged that there was a crisis in children's social care in the early 1990s when the root cause of this crisis was the failure to recruit sufficient numbers of qualified social workers. This was not unusual at that time, but the Inquiry heard nothing of any strategies put in place to address the problem. The focus was on child protection on the misplaced assumption that children in care were sufficiently protected by the carers themselves. In the same period, there was a "*deep rift*" between children's social care and Nottinghamshire Police.

7. In the late 1980s and early 1990s, a significant number of residential care staff in the County faced disciplinary investigations for the sexual abuse of children. This should have prompted an assessment, at a senior level, of the scale of abuse, why it was happening and how the risk of abuse could be addressed. Despite occasional attempts to consider the issues more broadly, the County failed to address the risk of abuse to children in their care.

8. When proper disciplinary action was taken by the County about alleged misconduct relating to sexual abuse, some council officers expressed extreme frustration that on occasion, councillors would overturn their decisions on appeal.

9. Only qualified social workers are required to be registered with the Health and Care Professions Council. Therefore, allegations of sexual abuse are only referred to an external regulator if the alleged perpetrator residential care staff member is also a qualified social worker. As set out in the Inquiry's Interim Report, residential child care staff should be registered with an independent professional regulatory body.

10. The various chief executives of the Councils may not have been informed by their Directors of Children's Services of the seriousness of the sexual abuse occurring on their watch. Nevertheless, as heads of paid service, the chief executives should have been alert to their statutory responsibilities for the welfare of children in their care and taken a proactive leadership role.

11. There have been positive efforts by the Councils, including:

11.1. The City's Historical Concerns Project reviewed the employment records of current and former employees to identify any concerns about the risks posed to children. This provided some reassurance that alleged perpetrators did not evade scrutiny.

11.2. The County's ongoing Historical Abuse Team provides support for complainants, follows up on allegations and works with survivors groups, while the City has a single point of access for all complainants which signposts support services. This kind of engagement with survivors groups can provide clear channels of communication which reduces the risk of misunderstanding and may improve relationships with victims and survivors.

12. Provision and consistency of support and counselling for those who have suffered sexual abuse in care remain an issue. More needs to be done by the Councils, and the police need to continue to be receptive to complainants' needs. Support services are now commissioned by the Police and Crime Commissioner and the NHS also has a duty to provide such support.

13. The Councils have taken different approaches to apologising for non-recent abuse and their past failure to protect children in their care. Whilst the County have made a public apology, the City have been guarded and slow to appreciate the level of distress felt by complainants. Their approach has caused understandable upset and anger, which could have been avoided.

14. Access to records for those formerly in care has not been well handled. For some, their search for records and the lack of communication or explanation from the Councils has been distressing. For others, the procedural hurdles seem to have taken little account of the importance of these records to the complainants, with no provision for fast-tracking the process.

Residential care

15. Residential care across England was characterised, from the late 1970s to the early 1990s, as poorly resourced and managed, with residential care staff who were predominantly unqualified and received little, if any, training.

16. This is reflected by the Beechwood case study, in which we saw untrained and unqualified staff, insufficient resources and, increasingly, older children exhibiting multiple behavioural problems. In these respects, Beechwood was not an exception. However, it demonstrates the extent to which these underlying issues create and maintain an environment in which vulnerable children are at risk of abuse.

17. A significant number of children were sexually abused whilst resident at Beechwood. For example, John Dent and NO-F29 were able to commit abuse in the knowledge that children would be too frightened to speak out, or would think that, if they did, they would not be believed. Similarly, Andris Logins was able to sexually abuse residents at Beechwood because it was an environment where sexualised behaviour was tolerated or overlooked. Some staff raised concerns about the behaviour of colleagues but were not taken seriously; others witnessed colleagues acting inappropriately towards children but did nothing.

18. Despite the high number of allegations of sexual abuse against staff at Beechwood, there are only two examples of disciplinary action taken in response, both of which were inadequate.

19. During the 1960s, 1970s and 1980s, the staff were often viewed as vulnerable rather than the children, with some girls seen as creating a particular risk for male staff. During this period, Beechwood was not a safe environment for vulnerable children. Staff were both threatening and violent, physical abuse was commonplace and children were frightened. The children placed at Beechwood were not protected and supported as they should have been.

20. The reasons for high levels of absconding in the mid-1980s to the 1990s were not explored by Beechwood staff, who saw absconding as an example of "*devious*" behaviour. The risks faced by these children and their vulnerabilities were not addressed.

21. Until the early 1990s, there was a lack of sustained attention given to residential care by staff and senior managers in the County's children's social care service. The most vulnerable children were left in the hands of staff who were not qualified to care for them. From 1992, the County recognised these challenges and took steps to address them.

22. When the City took over the running of Beechwood in 1998, the staff environment had not improved and children and young people were still at risk of sexual abuse. This was not helped by overcrowding. Between 1998 and its eventual closure in 2006, there were several opportunities for the City to close Beechwood and it should have done so earlier.

Foster care

23. For the last 40 years, foster care has been the most common placement for children in the care of the Councils. The County re-organised its fostering service in the mid-1970s. For some time afterwards, recruitment, assessment, support, supervision and deregistration of foster carers was inconsistent.

24. By the beginning of the 1990s, the County's response improved, but this was not followed through. There were long-standing tensions between social workers for foster carers and social workers for the individual children who were alleged to have been abused. This is not an unfamiliar problem but what was troubling was the extent to which the support for foster carers in such situations continued over many years without any independent assessment of individual allegations. So often, the prevailing assumption was that the foster carer must always be guiltless.

25. The Norman Campbell case, which involved the sexual abuse of children in residential and foster care between 1982 and 1990, was an example of poor practice by County fostering management. Campbell's approval did not follow the established process, legitimate concerns about his motivation were ignored and he was not subject to re-approval as he should have been. His abuse of children might have been prevented had processes been followed.

26. There continues to be weakness in current foster care practice in both Councils despite improvements. These include poor joint-agency working, inconsistent decision-making, and failure to refer cases to the fostering panel or to notify Ofsted or councillors. Examples of good practice in response to allegations include the use of independent risk assessments and child-centred approaches to de-registration.

Harmful sexual behaviour

27. Between 1988 and 1995, there were enquiries into harmful sexual behaviour in five County community homes. While a multi-agency group was set up leading to the development of policies and procedures on the issue, the work of the group was largely squandered. Issues raised in individual reports were not considered more broadly or together; similarly, lessons were not learnt and recommendations not pursued.

28. Recent cases of harmful sexual behaviour in residential and foster care show problems remain with the institutional responses. There is a lack of clear governance in the City. In the County, there are still not enough social workers trained to carry out assessments of children exhibiting harmful sexual behaviour. In some instances, full investigations have not been carried out, managers have not been notified, and children not safeguarded.

29. The County has taken positive steps to audit its practice and develop multi-agency responses to harmful sexual behaviour, although their most recent audit in 2018 showed that there is still some way to go. By contrast, we have not seen evidence of the City taking steps to evaluate its practice in recent years and they did not refer to the issue of harmful sexual behaviour in their oral or written closing submissions to the investigation, despite it being one of three selected case studies.

30. There is no clear process within the Councils for ensuring elected councillors are made aware, in confidence, of serious allegations of harmful sexual behaviour by children in care.

31. Despite increasing awareness and understanding of the issue of harmful sexual behaviour across the country, there is no national strategy or overarching framework for investigating, auditing, responding to, and preventing harmful sexual behaviour (including, but not limited to, children in care). The Inquiry is carrying out further research on this issue.

Barriers to disclosure

32. There were particular barriers to disclosure for children in both residential and foster care. With regard to residential care, these included the institutional setting, a sexualised and physically abusive staff culture, and abuse being perpetrated by staff in senior positions. Specific factors affecting those in foster care included the complex relationship that can develop between the child and the foster carer, and the fear of not being believed because the perpetrator foster carer was established and trusted by professionals.

Conclusions in respect of governance

33. Despite being regularly informed of disciplinary action taken against staff (but not foster carers) following investigations into sexual abuse of children in residential care during the late 1980s and 1990s, the County councillors responsible for oversight of children's social care did not question the scale of sexual abuse or what action was being taken. This was a serious failure of scrutiny and governance.

34. County councillors are now briefed on some allegations of sexual abuse of children in care. A recently introduced protocol requires that the Lead Member for Children's Services be briefed on all allegations of sexual abuse against members of staff, but only some allegations of sexual abuse against foster carers or other children. At the time of our hearings in October 2018, the City had no written protocol on when the Lead Member should be notified of allegations of sexual abuse of children in care.

35. Continuing to the present day, neither the County nor the City has had a process by which there has been regular reporting of the number of allegations and the response to those allegations. This has meant that knowledge of the scale of allegations of sexual abuse of children in care and the response to those allegations has been limited and inconsistent.

Conclusions in respect of Nottinghamshire Police and the Crown Prosecution Service

36. Nottinghamshire Police's investigation into allegations of non-recent sexual abuse of children in residential care (Operation Daybreak) was not adequately resourced or supported from its formation in 2011 until 2015. Given the increasing number of allegations of abuse and the criticisms from internal and external reviews, senior police officers should have done more to support the operation. The police did not treat the allegations with sufficient seriousness.

37. Since 2015, when Operation Daybreak was subsumed into Operation Equinox, there have been a number of prosecutions and there now appears to be greater confidence in the force's commitment amongst complainants.

38. However, Nottinghamshire Police has consistently shown a lack of urgency and failed to address the weaknesses identified and the recommendations made in recent inspections and reviews concerning its approach to investigating child sexual abuse. Responsibility for this rests primarily with the force itself. These failings had consequences for the children involved. The most recent assessment report indicates some improvements.

39. Complainant experience of engagement with the police and the Crown Prosecution Service has been mixed. The police have had to improve how they communicate with complainants following criticisms, including the means of initial contact with complainants, the irregularity of subsequent contact, and issues with the notification that an investigation has been closed.

G.2: Matters to be explored further by the Inquiry

40. The Inquiry will return to a number of issues which emerged during this investigation, including but not limited to:

40.1. Harmful sexual behaviour.

40.2. The barriers to disclosure of sexual abuse by children, including those in care, and proactive steps to reduce those barriers.

40.3. The approach to civil litigation, including the role of insurers.

G.3: Recommendations

The Chair and Panel make the following recommendations, which arise directly from this investigation and the case studies of Beechwood, foster care and harmful sexual behaviour in Nottinghamshire and are specific to the County and the City. Other local authorities should consider the issues identified in this report and take action as appropriate to their own circumstances.

Nottingham City Council and Nottinghamshire County Council should publish their response to these recommendations, including the timetable involved, within six months of the publication of this report.

Recommendation 1:

Nottingham City Council should assess the potential risks posed by current and former foster carers directly provided by the council in relation to the sexual abuse of children. They should also ensure that current and former foster carers provided by external agencies are assessed by those agencies. Any concerns which arise should be referred to the appropriate body or process, including the Disclosure and Barring Service, the local authority designated officer (LADO) or equivalent, the fostering panel and the police.

Nottinghamshire County Council should assess the potential risks posed by current and former residential care staff and foster carers, which are directly provided by the council, in relation to the sexual abuse of children. They should also ensure that current and former staff in residential care provided by external agencies, and current and former foster carers provided by external agencies, are assessed by those agencies. Any concerns which arise

should be referred to the appropriate body or process, including the Disclosure and Barring Service, the relevant regulatory body, the local authority designated officer (LADO), the fostering panel and the police.

Recommendation 2:

Nottingham City Council and its child protection partners should commission an independent, external evaluation of their practice concerning harmful sexual behaviour, including responses, prevention, assessment, intervention and workforce development. An action plan should be set up to ensure that any recommendations are responded to in a timely manner and progress should be reported to City's Safeguarding Children Partnership.

Annexes

Annex 1

Overview of process and evidence obtained by the Inquiry

1. Definition of scope for the case study.

This investigation is an inquiry into the nature and extent of, and the institutional responses to, allegations of sexual abuse of children in the care of the Nottinghamshire Councils.

The scope of the investigation is as follows:

> *"1. The Inquiry will investigate the nature and extent of, and institutional responses to, the sexual abuse of children in the care of Nottingham City and Nottinghamshire County Councils ('the Councils'), including those cared for in children's homes and by foster carers and/or 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 Councils, and will investigate:*
>
> *2.1. the nature and extent of allegations of child sexual abuse of children in the care of the Councils during the relevant period;*
>
> *2.2. the nature and extent of the failures of the Councils to protect such children from sexual abuse;*
>
> *2.3. the appropriateness of the response of the Councils, law enforcement agencies, prosecuting authorities and other public authorities to reports of child sexual abuse involving children cared for by the Councils, and/or reports of child sexual abuse by individuals who were employed by or contracted by the Councils, with access to children;*
>
> *2.4. the extent to which the Councils sought to investigate, learn lessons, implement changes, and/or provide support to victims and survivors, in response to:*
>
> *a) allegations that individuals with access to children cared for by the Councils had sexually abused children;*
>
> *b) criminal investigations and prosecutions and/or civil litigation in relation to alleged sexual abuse of children within the care of the Councils;*
>
> *c) reports, reviews and inquiries into child sexual abuse and/or safeguarding; and/or*
>
> *d) other external guidance.*

2.5. the adequacy of the policies and practices adopted by the Councils during the relevant period 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 made allegations of sexual abuse 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 Councils which inhibited the proper investigation, exposure, prevention of, and reparation for, child sexual abuse; and

2.8. the adequacy of the inspection regimes applicable throughout the relevant period.

3. To investigate the issues set out in paragraph 2, the Inquiry may identify a number of case studies.

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."[1312]

2. Core participants and legal representatives

Counsel to this investigation:

Patrick Sadd
Paul Livingston
Imogen Egan
Olinga Tahzib

Complainant core participants:

D3, D4, D5, D6, D7, D9, D10, D11, D12, D13, D18, D19, D20, D22, D23, D25, D26, D28, D31, D33, D34, D35, D36, D37, D38, D42, D44, D46, D47, D48, D51	
Counsel	Caoilfhionn Gallagher QC, Megan Hirst, Mary-Rachel McCabe, Nick Brown
Solicitor	Jon Wakefield (Bhatia Best)
A73, A74, Dale Davey, A76, A79	
Counsel	Caoilfhionn Gallagher QC, Megan Hirst, Mary-Rachel McCabe
Solicitor	Kim Harrison (Slater & Gordon)
P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, P14, P15, P16, P17, P18, P19	
Counsel	Caoilfhionn Gallagher QC, Megan Hirst, Mary-Rachel McCabe
Solicitor	Debbie Heath (Instalaw)

[1312] Nottinghamshire Councils Investigation Definition of Scope

L17, L18, L19, L20, L21, L22, L23, L24, L25, L26, L27, L28, L29, L30, L31, L32, L33, L34, L35, L36, L37, L38, L39, L40, L43, L44, L45, L46, L47, L48, L49, L50, L51, L52	
Counsel	Stephen Simblet, Laura Profumo
Solicitor	Christopher Ratcliffe (Uppal Taylor)
F37, F38, F39, F40, F46, Michael Summers	
Counsel	Christopher Jacobs
Solicitor	David Enright (Howe + Co)
C21	
Counsel	Christopher Jacobs
Solicitor	David Greenwood (Switalskis)
Q1	
Counsel	Aidan O'Neill QC
Solicitor	Jessica Gladstone (Clifford Chance)
N1	
Counsel	Christopher Jacobs
Solicitor	Jonathan Bridge (Farleys)

Other individual core participants:

David Hollas	
Counsel	Not legally represented
Solicitor	Not legally represented
John Mann	
Counsel	Aidan O'Neill QC
Solicitor	Jessica Gladstone (Clifford Chance)

Institutional core participants:

Nottinghamshire Police	
Counsel	Sam Leek QC, Alice Meredith
Solicitor	Craig Sutherland (East Midlands Police Legal Services)
Nottinghamshire County Council	
Counsel	Andrew Sharland QC, Christopher Parkin
Solicitor	Geoffrey Russell (Nottinghamshire County Council)
Nottingham City Council	
Counsel	Steven Ford QC
Solicitor	Sarah Molyneux, Malcolm Townroe (Nottingham City Council)

Crown Prosecution Service	
Counsel	Edward Brown QC
Solicitor	Alastair Tidball (Government Legal Services)
Ofsted	
Counsel	Sarah Hannett, Alice de Coverley
Solicitor	James Fawcett (Ofsted)
Department for Education	
Counsel	Cathryn McGahey QC
Solicitor	William Barclay (Government Legal Department)

3. Evidence received by the Inquiry

Number of witness statements obtained:
173
Organisations and individuals to which requests for documentation or witness statements were sent:
A73
A74
A76
A79
Action for Children
Allan Breeton (Nottinghamshire Police)
Andrew Bosworth (former manager of Beechwood Children's Home – Nottinghamshire County Council)
Andrew Gowan (Nottinghamshire Police)
Anna Sains (Manager within children's social care – Nottinghamshire County Council)
Anthony May (Director within children's social care – Nottinghamshire County Council)
Brian Doohan (Nottinghamshire Police)
Bronwen Cooper (children's social care – Nottingham City Council)
C21
Carol Smith (social worker – Nottinghamshire County Council)
Carolyne Willow (Director of Article 39 charity)
Cath Carrie (Crown Prosecution Service)
Chris Cook (Chair of Nottingham City Safeguarding Board)
Chris Few (Chair of Nottinghamshire County Safeguarding Board)
Clive Chambers (Manager within children's social care – Nottingham City Council/Nottinghamshire County Council)
Crown Prosecution Service

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Daniel Yates (children's social care – Nottinghamshire County Council)
David Fisher (children's social care – Nottinghamshire County Council)
David Mellen (Councillor – Nottingham City Council)
David Philip Morgan (Manager within children's social care – Nottinghamshire County Council)
David Taylor (Nottinghamshire Police)
David White (former Director of Social Services – Nottinghamshire County Council)
Dawn Godfrey (children's social care – Nottinghamshire County Council)

Denis Watkins (Assistant Director within children's social care – Nottinghamshire County Council)
Department for Education
Derek Brewer (Nottinghamshire Police)
F37
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F39
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F46
Michael Summers
Geoff Ward (Department Head within children's social care – Nottinghamshire County Council)
George Norman Hanson (senior management within children's social care – Nottinghamshire County Council)
Glynis Storer (children's social care – Nottingham City Council)
Helen Blackman (Director of Children's Social Care – Nottingham City Council)
Helen Chamberlain (Nottinghamshire Police)
Helen Ryan (Director within children's social care – Nottinghamshire County Council)
James Fenwick (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Jayne Austin (Manager within children's social services – Nottinghamshire County Council)
Jenny Street (Nottinghamshire Police)
Jim McLaughlin (former employee at Beechwood Children's Home – Nottingham City Council)
Joan Taylor (Chair within children's social care – Nottinghamshire County Council)
John Mann MP (MP for Bassetlaw)
John Stocks (Chair within children's social care – Nottinghamshire County Council)
Joyce Bosnjak (Chair within children's social care – Nottinghamshire County Council)
Joyce White (children's social services – Nottinghamshire County Council)
Judy Holloway-Vine (children's social services – Nottinghamshire County Council)
Julie Balodis (Nottinghamshire Police)
Kenneth Rigby (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Kevin Flint (Nottinghamshire Police)
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Malcolm McBride (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Mandy Coupland (Co-founder of the Nottingham CSA Survivors Group)
Margaret Mackechnie (Director within children's social care – Nottingham City Council)
Margaret Stimpson (Manager within children's social care – Nottinghamshire County Council)
Mark Cope (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Maxine Leigh (Founder of Support for Survivors)
Mike Morris (Director within children's social care – Nottinghamshire County Council)
Nottingham City Council
Nottinghamshire County Council

Nottinghamshire Police
NSPCC
Ofsted
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Paddy Tipping (Police and Crime Commissioner for Nottinghamshire)
Paul Bohan (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Paul Snell (Director within children's social care – Nottingham City Council)
Peter Maddocks (Independent Reviewer for Nottinghamshire Safeguarding Children Board)
Philip Owen (Councillor – Nottinghamshire County Council)
Q1
Rachel Morton (children's social care – Nottinghamshire County Council)
Rhona Keenan (Nottinghamshire Police)
Rob McKinnell (Nottinghamshire Police)
Rod Jones (former Head of Children and Families Policy – Nottinghamshire County Council)
Sallyanne Johnson (Director within children's social care – Nottingham City Council)
Sam Shallow (Crown Prosecution Service)
Sandra Brothwell (former employee at Beechwood Children's Home – Nottingham City Council)
Sarah Palmer (Nottinghamshire Police)
Sharon Wilkinson (children's social care – Nottinghamshire County Council)
Sheila Place (Chair within children's social care – Nottinghamshire County Council)
Shelley Nicholls (children's social care – Nottingham City Council)
Sonia Cain (Manager within children's social care – Nottingham City Council)

Steve Edwards (Director within children's social care – Nottinghamshire County Council)
Steve Freeman (Nottinghamshire Police)
Stuart Brook (Director within children's social services – Nottinghamshire County Council)
Sue Matthews (Crown Prosecution Service)
Susan Gregory (Director within children's social care – Nottingham City Council)
Susan Hawkesford (Manager with children's social care – Nottinghamshire County Council)
Tony Dewhurst (children's social care – Nottinghamshire County Council)
Yvonne Dales (Nottinghamshire Police)

4. Disclosure of documents

Total number of pages disclosed: 40,316	
Investigation material	38,793
Publicly available material	1,546

5. Public hearings including preliminary hearings

Preliminary hearings	
1	11 May 2017
2	31 January 2018
3	19 July 2018
Public hearings	
Days 1–5	1–5 October 2018
Days 6–7	8–9 October 2018
Days 8–10	17–19 October 2018
Days 11–15	22–26 October 2018

6. List of witnesses

Forename	Surname	Title	Called / Read	Hearing day
	D7		Called	2
	L17		Called	2
	C21		Called	2
	N1		Called	3
	L43		Called	3
	F37		Called	3
	P18		Read	3
	D22		Read	3
	L23		Read	3
	L29		Read	3

Forename	Surname	Title	Called / Read	Hearing day
	L48		Called	4
	L45		Called	4
	P7		Called	4
	L35		Read	4
	P4		Read	4
	D38		Read	4
	D26		Read	4
	D31		Called	5
	D6		Called	5
	P3		Read	5
	L46		Read	5
	D46		Read	5
	P1		Read	5
Rod	Jones	Mr	Called	6
David	White	Mr	Called	6
Kenneth	Rigby	Mr	Called	7
Bronwen	Cooper	Ms	Called	7
Jim	McLaughlin	Mr	Called	7
James	Fenwick	Mr	Called	7
Margaret	Stimpson	Ms	Called	8
David Philip	Morgan	Mr	Called	8
Mark	Cope	Mr	Called	8
Helen	Blackman	Ms	Called	8
Michelle	Foster	Ms	Called	9
David	Fisher	Mr	Called	9
Margaret	Mackechnie	Ms	Called	9
Susan	Gregory	Ms	Called	9
Sonia	Cain	Ms	Called	10
Daniel	Yates	Mr	Called	10
Jayne	Austin	Ms	Called	10
Rhona	Hicks	Ms	Called	10
Yvonne	Dales	Detective Inspector	Called	11
Julie	Balodis	Detective Constable	Called	11
Sam	Shallow	Ms	Called	11
Chris	Few	Mr	Called	11

Forename	Surname	Title	Called / Read	Hearing day
Sue	Matthews	Ms	Called	12
Rachel	Morton	Ms	Called	12
Steve	Edwards	Mr	Called	12
Philip	Owen	Councillor	Called	12
Stuart	Brook	Mr	Called	13
David	Mellen	Councillor	Called	13
Paddy	Tipping	Commissioner	Called	13
Mandy	Coupland	Ms	Called	13
Maxine	Leigh	Ms	Read	13
Simon	Hackett	Professor	Called	14
Alison	Michalska	Ms	Called	14
Colin	Pettigrew	Mr	Called	14
Robert	Griffin	Chief Superintendent	Called	14
	P16		Called	15

7. Restriction orders

On 23 March 2018, the Chair issued an updated restriction order under section 19(2)(b) of the Inquiries Act 2005, granting general anonymity to all core participants who allege they are the victim and survivor of sexual offences (referred to as 'complainant core participants'). The order prohibited:

(i) the disclosure or publication of any information that identifies, names or gives the address of a complainant who is a core participant; and

(ii) the disclosure or publication of any still or moving image of a complainant core participant.

This order meant that any complainant core participant within this investigation was granted anonymity, unless they did not wish to remain anonymous. That order was amended on 23 March 2018, but only to vary the circumstances in which a complainant core participant may themselves disclose their own core participant status.[1313]

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.

[1313] Restriction Order, 23 March 2018

9. Redactions and ciphering

The material obtained for the investigation was redacted and, where appropriate, ciphers were applied, in accordance with the Inquiry's Protocol on the Redaction of Documents.[1314] 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; 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 would be 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."[1315]

In accordance with rule 13, warning letters were sent as appropriate to those who were covered by the provisions of rule 13. The Chair and Panel considered the responses to those letters before finalising the report.

[1314] Inquiry Protocol on Redaction of Documents
[1315] http://www.legislation.gov.uk/uksi/2006/1838/article/13/made

Annex 2

Glossary

CID	Criminal Investigation Department, a branch of the police which investigates serious crimes
CSCI	Commission for Social Care Inspection, responsible for the registration and inspection of children's social care services between 2004 and 2007
DfE	Department for Education
Director of Children's Services	The officer within each local authority who has statutory professional accountability for all children's services, including education and social care
HMIC	Her Majesty's Inspectorate of Constabulary: until 2017 the name of the body responsible for assessing the effectiveness and efficiency of police forces
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services: from 2017 the name of the body responsible for assessing the effectiveness and efficiency of police forces and fire & rescue services
LADO	Local Authority Designated Officer, an officer in each local authority's children's social care service to whom allegations or concerns about the protection of children are reported. Responsible under statute for investigating such complaints
Lead Member for Children's Services	The councillor within each local authority who has statutory political accountability for all children's services, including education and social care
LSCB	Local Safeguarding Children Board, a multi-agency body set up in each local authority, with an independent chair, to safeguard and promote the welfare of children in the area. From 2018, replaced by Safeguarding Children Partnerships
NCH	National Children's Home
NCSC	National Care Standards Commission, responsible for registering children's homes and fostering services and then carrying out inspections between 2002 and 2004
NSPCC	National Society for the Prevention of Cruelty to Children
Ofsted	Office for Standards in Education, Children's Services and Skills, responsible for inspections of children's social care since 2007
PEEL assessment	An annual assessment of police forces conducted by HMICFRS
Social Services Committee	A local authority committee, primarily consisting of councillors, which was politically responsible for children in care until 2000
SSI	Social Services Inspectorate, established in 1985 to improve effectiveness and efficiency of social services and to promote necessary development, including in children's social care

The City	Nottingham City Council
The Councils	Collective reference to both Nottinghamshire County Council and Nottingham City Council
The County	Nottinghamshire County Council
The police	Nottinghamshire Police

Annex 3

List of convictions

There have been various convictions for sexual offences against children over the period covered by this investigation. Convictions of residential care staff for sexual abuse of children in residential care and convictions for child sexual abuse in foster care are listed below. Where the conviction was for non-recent abuse, the timeframe of the abuse is listed along with the year of conviction. Where the conviction was for recent abuse, only the year of conviction is listed. Convictions for harmful sexual behaviour are not listed because, by their nature, those who were convicted were children at the time of the offence.

The Sexual Offences Act 1956[1316] included offences of rape, unlawful sexual intercourse with girls under 16 and indecent assault of children.

The Indecency with Children Act 1960[1317] introduced the offence of gross indecency with a child under the age of 14.

The Sexual Offences Act 2003[1318] made provisions about new sexual offences and the protection of children from harm from sexual acts and incidents connected with sexual acts.

Table of convictions of residential care staff for sexual abuse of children in residential care

Name	Nature of the offence(s)	Year of conviction	Sentence received
Malcolm Henderson	Indecent assault of two girls at Skegby Hall	1975	Two-year probation order
Colin Wallace	Four counts of unlawful sexual intercourse against a child in care	1981	Unknown
Michael Preston	Two counts of indecent assault against a resident at Three Roofs Community Home	1985	Nine months' imprisonment
Gerald Jacobs	Indecent assault of a resident at Amberdale Secure Unit	1986	Nine months' imprisonment
David Marriott	Four counts of indecent assault against two residents at Skegby Hall	1987	Two years' imprisonment
Steven Carlisle	Three counts of indecent assault against residents at Woodnook Community Home	1990	Unknown
Norman Campbell	Four counts of buggery and three counts of indecent assault against children in residential and foster care	1991	Six years' imprisonment

[1316] Sexual Offences Act 1956
[1317] Indecency with Children Act 1960
[1318] Sexual Offences Act 2003

Name	Nature of the offence(s)	Year of conviction	Sentence received
John Dent	11 counts, including rape and indecent assault of children at Beechwood and Hillcrest in the 1970s	2002	Seven years' imprisonment
Paul Wheater	16 counts of indecent assault against two residents at Risley Hall Approved School in the 1970s	2002	Six years' imprisonment
Andris Logins	Four counts of rape, 12 counts of indecent assault and one count of cruelty against children at Beechwood in the 1980s	2016	20 years' imprisonment
Barrie Pick	Two counts of indecent assault and two counts of indecency with a child resident at Beechwood in the 1980s	2017	Six years' imprisonment
Dean Gathercole	Six counts of indecent assault and three counts of rape of two residents at Amberdale in the 1980s	2018	19 years' imprisonment
Myriam Bamkin	Indecent assault of a resident at Amberdale in 1985	2018	30 months' imprisonment
Christopher Metcalfe	Indecent assault of two girls in foster care and at Skegby Hall in the 1970s	2018	33 months' imprisonment
Michael Robinson	Five counts of indecent assault and one count of taking an indecent photograph of a child in relation to residents at Hazelwood in the 1980s	2018	Eight years' imprisonment
David Gallop	Two counts of indecent assault against a resident at Hazelwood in the 1970s	2018	21 months' imprisonment

Table of convictions for child sexual abuse in foster care

Name	Nature of the offence(s)	Year of conviction	Sentence received
NO-F106	Indecent assault of two children not in care	1976	Three-year probation order
Bernard Holmes	Four counts, including unlawful sexual intercourse, indecent assault and gross indecency, against two children in his care	1987	30 months' imprisonment
Michael Chard	Four counts of indecent assault against two children in his care	1989	Three years' imprisonment
NO-F141	Indecent assault of a child in his care	1990	Unknown
NO-F119	Adult son of foster carer convicted of rape of a child in foster care	1991	30 months' imprisonment

Name	Nature of the offence(s)	Year of conviction	Sentence received
Norman Campbell	Four counts of buggery and three counts of indecent assault against children in residential and foster care	1991	Six years' imprisonment
NO-F64	Indecent assault of two girls in his care	1991	Three months' imprisonment
Douglas Vardy	Sexual abuse of three children in his care	1993	Unknown
William Boden	Indecent assault of four girls from the 1960s to the 2000s who were not in care	2002	10 years' imprisonment
Robert Thorpe	Friend of foster carers convicted of four counts of indecent assault and five counts of unlawful sexual intercourse with a girl under 13 in foster care	2009	Five years' imprisonment
Patrick Gallagher	55 counts of sexual abuse, including rape and sexual assault, against 16 children (seven of whom were in his care) between 1998 and 2010	2011	13 life sentences with a minimum term of 28 years
NO-F77	Two counts of sexual assault and one count of exposure against two girls. One had been in his care and the other had been in foster care with another family	2013	Eight months' imprisonment
Stephen Noy	Eight counts of indecent assault and two of unlawful sexual intercourse against two girls, one of whom was under his foster care	2015	17.5 years' imprisonment
Raymond Smith	Indecent assault of a child not in care	2016	Two years' imprisonment, suspended for two years
Christopher Metcalfe	Indecent assault of two girls in foster care and at Skegby Hall in the 1970s	2018	33 months' imprisonment

The following amendment was made to this report on 1 August 2019:

Pages 146 and 149: The core participant Michael Summers, formerly ciphered as F52, has previously waived his anonymity and references have been updated.

Accountability and Reparations

Investigation Report
September 2019

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

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Contents

Executive Summary

The law of England and Wales affords a variety of ways for perpetrators of child sexual abuse to be held to account under criminal law and in civil law. Many victims seeking reparations for child sexual abuse have found the experience of the legal processes sometimes hostile, baffling, frustrating and futile.

One witness (ciphered as AR-A21) described his experience of giving evidence in civil proceedings:

> *"At the time, I thought – and the way the trial proceeded, it just felt like another case of somebody saying, 'Well, are you sure you're telling the truth?', sort of thing, and it's that feeling of, 'Well, is it really pointless – is there really any point carrying on?' … It's embarrassing, and it was like reliving again everything that had gone on. It's something that – I think a lot of people would be reluctant to do it to relative strangers, and that's what makes it difficult … "*

The accountability and reparations public hearing took evidence from 40 witnesses over a period of 15 days between November 2018 and January 2019.

Victims and survivors described child sexual abuse and its aftermath spanning a period of nearly 60 years from the 1960s to the present day in five case studies: Forde Park Approved School in Devon, Stanhope Castle Approved School in County Durham, St Leonard's children's home in Essex, North Wales children's homes, and St Aidan's Approved School in Widnes, Cheshire and St Vincent's Approved School in Merseyside. Each witness gave evidence of their experience of seeking accountability and reparations for the abuse suffered.

The redress which a victim or complainant may seek can include punishment of the perpetrator, compensation from an individual or institution, acknowledgement that the abuse occurred, an apology, an explanation of how the abuse was allowed to happen, an assurance of non-recurrence, and counselling or other support.

A crime report to the police may lead to a Criminal Injuries Compensation Authority (CICA) award, prosecution, conviction and imprisonment of the perpetrator and/or a criminal compensation order (CCO). A criminal complaint must be proved to a high standard – beyond reasonable doubt – but there is no time limit for the complaint to be made.

A complaint via civil law is, by contrast, usually for compensation from an institution which has legal responsibility for the perpetrator. The civil law complaint may be proved to a lower standard – the balance of probabilities – but must usually be brought within a limited time period of three years from the abuse or the 18th birthday of the complainant. The complainant will often find out after initiating a civil law claim that the opposing party is not the named institution but is substituted by the institution's public liability insurer.

The criminal law route to a conviction of the perpetrator and the civil law route to compensation for the victim are distinct legal processes each with its own intricacies. Complexity is added when, as is often appropriate, the two processes – civil and criminal – are pursued concurrently and in parallel. Further complication is caused when the law, practice and procedure are altered during the course of proceedings.

Witnesses who sought redress for child sexual abuse at one or more of the institutions considered in this part of this investigation described the variety of bafflement and distress they endured in attempting to attain their remedies at law: they became embroiled in litigation which spanned decades; their cases had been brought against the wrong defendant; they felt they were treated unfairly in court; they had successfully proved their case on the facts but they could have no remedy due to the operation of the law of limitation.

This investigation spans the period from the 1960s to the present day. During that time, the law, practice and procedure for the conduct of sexual abuse cases in the criminal courts and in the civil courts has evolved in important respects. On this we heard evidence from legal and other professional witnesses, including: barristers, solicitors, senior police officers from the local police forces that investigated the relevant institutions, insurance companies, the Association of British Insurers, the Ministry of Justice, the CICA and charities that provide support to victims of sexual violence. From them, we heard their experiences of some systemic failings and recommendations for improvement.

Some of the failings which were identified are already addressed by recommendations made by the Inquiry in our Interim Report of April 2018.

Some proposals are still under consideration and are due for further consideration by the Inquiry later this year. One such proposal is a redress scheme to enable victims and survivors of child sexual abuse to obtain accountability and reparations. Another proposal under consideration is for the law of limitation in civil proceedings to be reformed to make it easier for victims and survivors to bring civil claims for non-recent child sexual abuse.

Our approach to this investigation has been to examine the evidence we heard for areas in the legal processes where the experience of, and outcomes for, victims and survivors of child sexual abuse may be made fairer and more effective.

The evidence which has been heard in this investigation leaves no doubt that none of the avenues for redress which we have examined – civil justice, criminal compensation (CCOs and CICA awards) or support services – is always able to adequately provide the remedies which are sought as accountability and reparations for victims and survivors of sexual abuse.

Peter Robson, a survivor who waived anonymity at our hearing, told us:

> *"I feel I need a lifetime of help … I don't like myself. There's times I hate myself … "*

In this report, we make recommendations for: revision of the Victims' Code to improve signposting of civil and criminal compensation; revision of the civil justice system so that the Local Government Association and the Association of British Insurers must produce codes of practice (aimed at eliminating unneccessary distress to claimants) to be followed throughout civil claims for child sexual abuse; revision of criminal justice compensation to increase the use of CCOs; and provision of a code to enhance access to therapy and support for victims and survivors through the litigation process.

Pen portraits

AR-A1 (North Wales)

AR-A1[1] was 12 years old when he was taken into care and sent to the Bryn Alyn Community, a group of privately run children's homes in North Wales. He told us that he suffered sexual, physical and psychological abuse and neglect at the hands of John Allen, a member of staff, and another child.

AR-A1's life has been "*blighted by the effects of the abuse; perhaps even more than the abuse itself*". He explained that he has never been able to trust people, which has also impacted on his children. He has felt suicidal and without value or self-worth. For many years, he was trapped in a cycle of seeking support which "*never really worked*", and which re-traumatised him, affecting his ability to work, parent and carry on. He was finally able to break this cycle and obtain the support he needed due to a combination of factors, including family support and self-education, which was "*the beginning of the healing process that has worked*".

AR-A1 did not join the group litigation against Bryn Alyn. He said he was trying to avoid anything to do with Bryn Alyn and there "*was the idea of this dirty money that I had in my mind*".

In 2014, AR-A1 gave evidence in the criminal trial of John Allen, who was convicted of a number of offences against him, including rape, and sentenced to life imprisonment.

Police officers put him in touch with Victim Support and a telephone counselling service. Although he attempted to use the telephone counselling service, he said he was never really going to be helped on the telephone. He was also informed about the Criminal Injuries Compensation Authority (CICA). Having previously said "*I don't want the dirty money*", he finally decided he wanted to get some compensation for his family as well as "*acknowledgement*". He received £22,000 but found the process "*demeaning and confusing and traumatic*". He thought that the award had only been made in respect of abuse committed by John Allen and unsuccessfully reapplied in respect of the other abuse.

AR-A1 is still seeking accountability and reparations through a civil claim against the local authority which placed him at Bryn Alyn.

> "*What we want generally – it's not like a lottery where we win money. What we want is, recognise that this stuff happened, recognise it didn't need to happen. We need to hold to account the systems, if not the people, that the systems failed us. If we can all achieve that, and if, as I mentioned earlier on, we can also recognise that the adversities that are caused in these circumstances are lifelong in their effect and generationally they affect so many people, if there is a recognition of all of that, then perhaps these organisations will be far more careful in the future, and hopefully prevent it from happening again and again and again.*"

[1] AR-A1 gave evidence to the Inquiry on 27 November 2018 63/19-106/1

AR-A41 (Forde Park)

AR-A41[2] was taken into care when he was 11 years old and was eventually sent to Forde Park Approved School. He told us he was sexually assaulted and raped by several teachers there over a number of years.

For a long time, he struggled to tell anyone about the abuse:

> *"Nobody ever believed us at the time. Who was going to believe us then? You know, I was still, with what happened to me, that little boy, petrified, afraid to bring this sort of thing out."*

He was eventually encouraged to speak to the police and gave evidence at two criminal trials, an experience he found extremely stressful, despite receiving support from the police.

AR-A41 brought a civil claim against Devon County Council. He wanted retribution, payment for the damage that had been done to him and a real, sincere apology from the Council and the Home Office.

He struggled to understand the litigation process and felt overwhelmed by being part of a group. He remembers that he was told by his lawyers how much his claim was likely to be worth and the claim was settled for much less than he was expecting. He could not comprehend how a value could be placed on the lifelong effects of the abuse he suffered.

> *"The ordeal of the trials completely re-traumatised me in more ways than one."*

He told us that he is still looking for proper psychiatric support because, even after 55 years, his mental anguish remains.

> *"What it does to your head is just horrendous."*

Paul Connolly (St Leonard's)

Paul Connolly[3] was at St Leonard's, a children's home, for 12 years from the age of seven. He told us that he resisted attempted rapes by staff members and saw other children being sexually assaulted by staff. He would hide under a bed with a knife to avoid being taken from his dormitory and abused at night.

Mr Connolly gave a statement to the police for a criminal prosecution but felt that justice had not been done in the criminal cases.

He joined a group of victims and survivors bringing a civil claim against Tower Hamlets London Borough Council in 2002. He saw it as *"another chance to get some kind of justice and … some kind of recognition … not just for myself, but for the families and the kids that … I grew up with"*. His claim was settled before trial for £16,000. He said he was not interested in the money and had really hoped for his *"day in court"*.

Mr Connolly came to give evidence to the Inquiry to *"insist that Tower Hamlets apologise for the tragedy of St Leonard's, to me and my family, and especially to my friends who have not survived and their families"*.

[2] AR-A41 gave evidence to the Inquiry on 30 November 2018 1/7-51/4
[3] Paul Connolly gave evidence to the Inquiry on 4 December 2018 1/7-29/10

AR-A87 (St Aidan's)

AR-A87[4] was sent to St Aidan's, an approved school which later became a community home providing education, when he was about 13 or 14 years old. He was only there for around a year but he told us that he was sexually abused on three occasions by a teacher. After he left, he was so ashamed that he could not tell anyone, not even his wife when he was an adult. He first disclosed the abuse to the police in the 1990s but did not give evidence in any criminal proceedings.

AR-A87 brought a civil claim against Nugent Care, the organisation responsible for St Aidan's. He was not seeking money but justice, and wanted his abusers convicted for their crimes. He also wanted his day in court.

> *"That was the most important thing, to actually have my day in court. I wanted to face my abusers and to be believed by the court that what happened to me did happen."*

The litigation process for AR-A87's claim lasted 12 years and his claim was the subject of two trials. At each trial, the judge accepted that he was abused.

> *"at the end of the day, that's all I wanted: I wanted to be able to stand there, give my evidence and for somebody to turn around and say … 'I believe you … '. That, to me, was everything."*

Ultimately though, the court rejected AR-A87's claim on the basis that it was brought too late. He said that, if he had his time again, he would not bring a civil claim. It took away many years of his life and at the end he was just abandoned, with nobody to care for him. He said that the pressure of repeated court hearings made him ill and tore his family apart.

AR-A87 also made a claim to the CICA but this too was rejected,[5] as was his application for a review of that decision.[6] Because no action was taken when the police first investigated, and a subsequent criminal prosecution was stayed on a legal technicality, the CICA could not say whether AR-A87 had been the victim of an assault.[7]

Peter Robson (Stanhope Castle)

Peter Robson[8] went into care in 1963, when he was 11 years old, and was placed at Stanhope Castle Approved School from 1963 to 1967. He told us that an older boy in the next bed repeatedly raped him within his first year. He was also caned across his bare bottom by a schoolmaster. He suspects he suffered further sexual abuse which he has blocked out from his memory.

Mr Robson only managed to speak to the police about the abuse in 2015. Over the years, he has had mental health issues, including feeling suicidal. He has tried to access support services but these always felt insufficient. He felt that he needed *"a lifetime of help"* following the abuse he suffered. The police were supportive but they could not trace his abuser.

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[4] AR-A87 gave evidence to the Inquiry on 5 December 2018 101/16-122/3
[5] INQ002651_027
[6] INQ002651_010
[7] INQ002651_010
[8] Peter Robson gave evidence on 10 December 2018 1/8-32/2

The police directed him to counselling and to make a claim to the CICA. His claim was refused due to a lack of corroborating evidence. He was upset by this, mainly because he felt he had not been believed. However, with the assistance of his lawyers, he applied for a review of the decision, which was reversed, and he was awarded £22,000.

Part A

Introduction

Introduction

A.1: Background to the investigation

1. This investigation examined the extent to which the systems of civil justice, criminal compensation and support services provide effective accountability and reparations to victims and survivors of child sexual abuse. It arose out of concerns that those systems may be failing to result in satisfactory reparation to victims and survivors of child sexual abuse.

A.2: Scope of this investigation

2. The first part of the investigation's work comprised the publication of issues papers on the civil justice system and on criminal compensation in August 2016. Following the receipt of responses to these papers, the Inquiry held seminars in November 2016 and February 2017, to explore the two issues in more detail. The Inquiry subsequently made a number of recommendations in its Interim Report, published in April 2018.[9]

3. The Inquiry also selected five case studies, through which to examine these issues: North Wales children's homes; Forde Park Approved School; St Leonard's children's home; St Aidan's Approved School and St Vincent's Approved School; and Stanhope Castle Approved School. The case studies were selected in order to obtain as broad a range of evidence as possible on the system of civil justice. They generally included group actions where there were a large number of potential victims and survivors, from whom the Inquiry could also obtain evidence on their experiences of criminal compensation processes and support services.

4. We are grateful to all those victims and survivors who provided us with their evidence, some of whom died during the course of this investigation. We also understand that there were many victims and survivors involved who, for personal reasons, did not wish to provide evidence to us.

5. We wish to make clear at the outset of this report that the accountability and reparations investigation is not making findings in respect of individual allegations of child sexual abuse, the broader operation of the criminal justice system or the professional conduct of the lawyers involved in the civil litigation in each of the case studies. Instead, its purpose and that of the case studies is to provide an insight into how the systems of civil justice, criminal compensation and support services operate.

6. To this end, the Inquiry has sought evidence of past and present practices from a large number of witnesses, including lawyers, insurers and police officers, in order to obtain a clear picture of how those systems and services function, and to allow us to consider recommendations for how they may be improved in the future. Any issues that require further, more detailed, consideration will be examined in public hearings in November 2019.

[9] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018

A.3: The meaning of accountability and reparations

7. The words 'accountability' and 'reparations' mean different things to different victims and survivors of child sexual abuse. Through the evidence that we heard, a number of key elements emerged.

7.1. Punishment of offenders: Many victims and survivors wanted perpetrators brought to justice and punished – that is, prosecuted in the criminal courts, convicted and imprisoned.

7.2. Holding institutions to account: Victims and survivors wanted the institutions they saw as responsible for the abuse held to account for any failures that had allowed the abuse to occur.

7.3. Acknowledgement and recognition: We heard that acknowledgement and recognition of the abuse was important to victims and survivors. For some victims and survivors, this meant having their 'day in court'. They wanted to explain in public what had happened to them and for there to be recognition of the abuse that they had suffered. Some, but not all, also wanted the opportunity to face their abusers.

7.4. Apologies and explanations: The majority of victims and survivors we heard from wanted apologies from the institutions and bodies that they thought had failed them, rather than from the abusers themselves. The importance of a genuine and effective apology was made clear, with some people saying that it should be face-to-face and not a simple 'sorry' on a piece of paper. Victims and survivors stressed the importance of those in authority acknowledging the abuse and explaining why it had been allowed to happen.

7.5. Assurances of non-recurrence: Many victims and survivors wanted assurances that other children would be protected in the future. They felt that listening to and recognising the abuse they had suffered might help prevent it from happening again.

7.6. Redress: Some victims and survivors told us that no amount of money could ever compensate them for what they had been through. Others did want financial compensation and hoped that the money might go some way towards helping them to achieve the things that they had been unable to because of the effects of the abuse. However, victims and survivors made clear that reparation was not just about financial compensation. Several spoke of a lost education and the inability to live fulfilled lives.

7.7. Support: Many victims and survivors told us that the provision of support was an important form of reparation.

8. The importance attached to each of these elements varies between different victims and survivors, and individuals' opinions about their significance may also change over time. This makes it impossible for any one system, whether civil justice, criminal compensation or support services, to satisfy everyone.

9. More fundamentally, none of these systems is designed to deliver all of these elements. For example, prosecutions of offenders can only occur through the criminal justice system. The settlement of civil claims may occur without any admission of liability being made by the institutions and without any 'day in court' for victims and survivors. Even where institutions are held legally liable for the abuse, this may not amount to an acceptance of responsibility

for the abuse where the claims are based upon vicarious liability. Awards by the CICA are not accompanied by any findings of wrongdoing by the perpetrators or the institutions in which they have abused children.

10. Even where these systems can potentially deliver some elements of accountability and reparations, most obviously financial compensation, we heard evidence that difficulties may arise from the way in which these systems operate for victims and survivors of child sexual abuse. Civil justice in England and Wales is adversarial and governed by the legal principles and procedures applicable to all personal injury litigants, not just those who have suffered child sexual abuse. Victims and survivors of child sexual abuse are often left re-traumatised by the process, including the experience of the 'day in court' that so many of them seek. Criminal compensation orders (CCOs) are rarely made by the courts in child sexual abuse cases. Victims and survivors may be prevented from receiving awards from the CICA due to criminal offending, even where the offending is attributable to the abuse they suffered.

11. The Inquiry cannot redesign the systems of civil justice and criminal compensation in order that each and every element of accountability and reparations identified above is deliverable to victims and survivors of child sexual abuse. However, it can consider improvements to the operation of these systems for those victims and survivors of child sexual abuse who continue to seek accountability and reparations through them. The question of whether or not there could be more fundamental change or an alternative to these systems, although raised in this report, will be considered further in the next phase of this investigation.

A.4: Procedure adopted by the Inquiry

12. The procedure 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 five groups of victims and survivors, four individual victims and survivors[10] and 11 institutions and other interested parties. The Inquiry held several preliminary hearings between 2016 and 2018, and substantive public hearings over 15 days between 26 November 2018 and 14 December 2018, with an additional hearing day on 15 January 2019.

13. We heard accounts from nine victims and survivors about their experiences of child sexual abuse at the institutions in the five case studies and their attempts to obtain accountability and reparations. An additional 32 victims and survivors provided written evidence of their experiences, with the majority of this evidence being read into the record either in full or by way of summary.

14. The Inquiry heard evidence from witnesses involved in the civil proceedings and criminal investigations that occurred in the case studies, including lawyers, insurers, police officers and local authorities. We also heard from the Ministry of Justice and from national organisations such as Rape Crisis, the Survivors Trust, the National Police Chiefs' Council, the College of Policing and the Crown Prosecution Service.

15. Two core participants died during the course of this investigation: AR-A28 died in 2016 and AR-A6 died just before the hearings. AR-A27 was too ill to travel to give evidence.

[10] AR-A20 was de-designated as a core participant in this investigation by the Chair on 14 December 2018 upon his request

A.5: Terminology

16. The Inquiry recognises that some people who have been sexually abused as children identify as victims, and others as survivors, of sexual abuse. Throughout this report, unlike in other reports, we use the phrase 'victims and survivors' rather than 'complainants' when referring to witnesses who have told us that they have been sexually abused. We use the phrase neutrally, without making any findings of fact in any specific cases. As stated above, making such findings is not within the scope of this investigation.

17. References in the footnotes of the report such as 'XXX000001' are to documents that have been adduced in evidence or published on the Inquiry website. A reference such as 'Philip Marshall 20 November 2018 66/10-17' is to the hearing transcript which is also available on the website; that particular reference is to the evidence of Philip Marshall on 20 November 2019 at page 66, lines 10 to 17.

Part B

Case studies

Case studies

B.1: Introduction

1. This investigation included the examination of five case studies. For each, we outline the allegations of child sexual abuse and summarise the police investigations and civil litigation that then ensued. The themes that arise in the case studies are considered in the following chapters on civil justice, criminal compensation and support services.

B.2: North Wales children's homes

2. Allegations of child sexual abuse in North Wales children's homes first emerged in the 1970s and have been the subject of numerous police investigations, inquiries and litigation. This included children's homes run by two local authorities, Clwyd County Council and Gwynedd County Council. Child sexual abuse was also prevalent among private children's homes run by individuals or companies in North Wales. In particular, we focus on the experiences of the victims and survivors who suffered sexual abuse at the Bryn Alyn Community, a group of privately run children's homes set up in 1969 by John Allen, who went on to be convicted of multiple counts of sexual abuse of children in his care.

Allegations of sexual abuse

3. Victims and survivors of abuse at children's homes in North Wales described the sexual abuse and rape they suffered at the hands of Allen, other members of staff and older residents at the homes.[11] Many were sexually abused on multiple occasions over the course of a number of years and all were left traumatised and vulnerable.

3.1. AR-A1 was physically, psychologically and sexually abused by Allen and two other perpetrators at Bryn Alyn over the course of three years.[12]

3.2. AR-A78 described being slapped repeatedly on the bottom by Allen and being sexually abused by AR-F28 so many times he could not put a number on it.[13]

3.3. Numerous victims and survivors were anally raped by Allen, including AR-A19,[14] AR-A26[15] and AR-A30.[16]

3.4. Other abuse included having genitals fondled,[17] attempted anal rape[18] and oral penetration.[19]

[11] See, for example, AR-A21 27 November 2018 1/22-24; AR-A24 27 November 2018 53/7-23; AR-A23 27 November 2018 32/24-33/3; AR-A1 27 November 2018 64/3-18; AR-A78 29 November 2018 111/17-112/2; Robert Balfour 29 November 2018 116/4-7; AR-A19 3 December 2018 129/7-8; AR-A20 3 December 2018 131/25-132/2; AR-A26 3 December 2018 135/13-18; AR-A30 3 December 2018 145/10-14
[12] AR-A1 27 November 2018 64/3-18
[13] AR-A78 29 November 2018 111/17-112/2
[14] AR-A19 3 December 2018 129/7-8
[15] AR-A26 3 December 2018 135/13-18
[16] AR-A30 3 December 2018 145/10-14
[17] Robert Balfour 29 November 2018 116/4-5; AR-A26 3 December 2018 135/13-18
[18] AR-A78 29 November 2018 111/17-112/2
[19] AR-A30 3 December 2018 145/10-14

4. Survivors of this abuse have lived with guilt and shame,[20] anxiety and depression,[21] and drug and alcohol dependency.[22] AR-A24 used alcohol to "*numb the thoughts of the abuse and the pain*".[23] Many have serious issues trusting people, in particular men and those in positions of authority,[24] which has impacted on professional, personal and family relationships.[25]
For AR-A1:

> "*The impact for me has been a life blighted by the effects of the abuse; perhaps even more than the abuse itself … I have never been able to trust people, and trusting people is an essential part of being a productive adult*".[26]

Many remain "*highly vulnerable and disadvantaged even when they are adults*".[27]

Police investigations

5. Between 1976 and 2003, North Wales Police conducted several individual investigations and four major investigations into sexual abuse at children's homes in North Wales,[28] which led to a number of convictions.

5.1. Six men were convicted of various sexual offences in children's homes after separate investigations between 1976 and 1984.[29]

5.2. From 1988 to 1990, there were a number of convictions for sexual offences at children's homes in Gwynedd and Clwyd.[30]

5.3. In July 1994, Peter Howarth, the former Deputy Principal at Bryn Estyn, one of the North Wales children's homes, was convicted of seven offences of indecent assault against boys committed between 1972 and 1983, for which he was sentenced to 10 years' imprisonment.[31]

5.4. In February 1995, Allen was convicted of six indecent assaults against boys at Bryn Alyn between 1972 and 1983 and sentenced to six years' imprisonment. He was acquitted of four other counts of indecent assault.[32]

6. In 2012, the BBC broadcast an interview with a former resident of a children's home in North Wales who alleged a culture of physical and sexual abuse. This prompted further reports of abuse and a new police investigation, Operation Pallial, which was directed and controlled by the National Crime Agency.[33] It reviewed all previous investigations into child sexual abuse in North Wales and investigated new allegations.[34] As a result, in 2014,

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[20] AR-A23 27 November 2018 46/6-15; AR-A24 27 November 2018 54/2-8
[21] AR-A24 27 November 2018 54/16-18; AR-A1 27 November 2018 66/6-8
[22] AR-A24 27 November 2018 54/25-55/3; AR-A1 27 November 2018 66/11-12
[23] AR-A24 27 November 2018 55/1-3
[24] AR-A23 27 November 2018 46/16-20; AR-A24 27 November 2018 54/9-16; AR-A1 27 November 2018 65/18-23
[25] AR-A23 27 November 2018 46/24, 47/12-16; AR-A24 27 November 2018 54/10-16, 55/12-13; AR-A1 27 November 2018 65/24-66/5
[26] AR-A1 27 November 2018 65/18-23
[27] AR-A78 29 November 2018 115/4-6
[28] INQ003620_005-007
[29] INQ003620_005
[30] INQ003620_005-006
[31] INQ003620_006
[32] INQ003620_006
[33] NCA000310_002. Even if an allegation was made against a deceased offender so a prosecution was not possible, it would still be investigated by the National Crime Agency (NCA) to provide some closure for victims and survivors (Philip Marshall 28 November 2018 84/5-10; see, for example, MMI000079_001). North Wales Police set up Operation Jowter to run risk assessments and support victims alongside the NCA investigation (INQ003620_007).
[34] Philip Marshall 28 November 2018 64/12-23

Allen was prosecuted again. He was found guilty of seven counts of buggery or attempted buggery, 25 counts of indecent assault and one count of indecency with a child. He was sentenced to life imprisonment with a recommended minimum of 11 years.[35]

7. Operation Pallial continues today. By December 2018, 375 complainants had alleged abuse at 31 children's homes by 146 identified suspects, across North Wales, between 1953 and 1995. Although 41 suspects had died, 23 had been arrested and a further 42 interviewed under caution. Of 18 people charged, 11 were convicted of a total of 106 offences, ranging from possession of indecent images through to buggery. The prosecutions of 81 additional offences were not successful.[36] Operation Pallial had stopped investigating new complaints by the time of our hearings, but there are ongoing criminal proceedings. Four further matters are listed for trial and others are under consideration by the Crown Prosecution Service.[37]

8. In his evidence to the Inquiry, Temporary Assistant Chief Constable Neill Anderson apologised to all of the participants in the Inquiry who, in the past, had not received the service from North Wales Police that he would expect by today's standards.[38]

Other inquiries

9. In addition to police investigations, a number of other independent inquiries have examined the scale of, persistence of and response to child abuse in children's homes across North Wales, such as the Jillings and Waterhouse inquiries.

9.1. The Jillings Inquiry: This was an internal independent review commissioned by Clwyd County Council of allegations of sexual abuse of children in its care and the failings that allowed the abuse to continue undetected for so long. The inquiry ran from 1994 to 1996 and was chaired by John Jillings (former Director of Social Services for Derbyshire).[39] It concluded that there had been extensive abuse of children in care in Clwyd from 1974 to 1995.[40] It made numerous critical findings of various organisations, including the County Council, the Welsh Office and North Wales Police, and found that the response to the indications of abuse were inadequate.[41] However, the report was never fully published, in part because the Council's insurer, Zurich, indicated that publication of the report might invalidate their insurance cover.[42]

9.2. The Waterhouse Inquiry: In 1996, Sir Ronald Waterhouse (a retired High Court judge) was appointed by the Secretary of State for Wales to chair a tribunal of inquiry into the abuse of children in care in Gwynedd and Clwyd since 1974.[43] Many victims and survivors gave evidence of the abuse they suffered to the tribunal. Its report, *Lost in Care*,[44] made 72 detailed recommendations about continuing areas of concern.[45] In relation to Bryn Alyn, it concluded that Allen's convictions were "*merely a sample of*

[35] NCA000311_001
[36] Philip Marshall 28 November 2018 65/3-66/8
[37] Philip Marshall 28 November 2018 66/10-17
[38] Neill Anderson 28 November 2018 3/15-22. This was an extension of the apology made in 2016 by the Chief Constable of North Wales Police for the harm caused by Gordon Anglesea, who was convicted of historic sexual abuse committed whilst a serving police officer.
[39] INQ002923_001, 023
[40] FCC000001_001, 010; FCC000002_080
[41] FCC000002_080-082
[42] David Nichols 29 November 2018 143/6-145/21
[43] INQ003620_006-007
[44] INQ002923_001
[45] INQ003620_007

his overall offending"[46] and that there was inadequate management and supervision, instruction and training for staff.[47] At Bryn Estyn, two of the most senior members of staff were "*habitually engaged in major sexual abuse of many of the young residents without detection"*[48] and physical violence was "*endemic*".[49]

Litigation

10. In the late 1990s,[50] a large number of claims for damages for sexual abuse at children's homes in North Wales were issued in the High Court.[51] The claims were known as the North Wales Children's Homes Litigation[52] and were split into three tranches: claims against Clwyd County Council; claims against Gwynedd County Council; and claims against Bryn Alyn Community and other organisations.[53]

11. Most of the claims against Clwyd and Gwynedd were settled.[54] In 2000, 11 claims against Clwyd went to trial[55] but the abuse was mostly admitted and liability was undisputed. The main issues were causation and quantification of damages.[56] All of the claimants succeeded and were awarded damages of between £2,000 and £35,000.[57] An appeal by the Council was dismissed.[58]

12. The focus of this Inquiry's investigation is a group of between 50 and 60 claims[59] arising from abuse within the Bryn Alyn Community. This litigation took many years to resolve and was complicated by disputes over whether Royal & Sun Alliance (RSA) and another insurer, Eagle Star, were obliged to indemnify the company for the abuse that had taken place.

12.1. In January 1998, a number of claims were brought against Bryn Alyn Community (Holdings) Ltd, the holding company to which the assets and liabilities of the trading company, Bryn Alyn Community Ltd, had been transferred in 1996.[60]

12.2. Upon receipt of the statements of claim, RSA, the company's insurer, informed the claimants that there was a potential conflict of interest between themselves and the company. One of the reasons for this was the existence of a clause in the insurance policy that excluded liability for any deliberate acts of the insured. It was therefore necessary for RSA to be added as a second defendant in the claim.[61] In December 1998, Bryn Alyn Community (Holdings) Ltd was wound up, so it played no part in the proceedings.[62]

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[46] INQ002923_317
[47] INQ002923_342
[48] INQ002923_095
[49] INQ002923_151
[50] There were a number of claims contemplated in the early 1990s, although some were issued but not pursued because lawyers advised that they would not succeed on the basis of limitation (AR-A20 3 December 2018 133/17-134/5), or were stayed pending criminal investigations and the Waterhouse Inquiry (Alistair Gillespie 29 November 2018 24/5-11).
[51] ZUI003210
[52] ZUI003207_001-003. It was also at times called the North Wales Child Abuse Litigation (ZUI003210).
[53] ZUI003207_001-003
[54] ZUI003222_017, 018, 020, 021, 027, 028; ZUI003196_003
[55] ZUI003196_001, 003
[56] ZUI003196_003
[57] ZUI003196_093-094
[58] INQ003605_001, 015
[59] ZUI003222_020; RSA000110_015, 025
[60] RSA000110_006-007
[61] RSA000051_008; Alistair Gillespie 29 November 2018 24/17-25/21
[62] RSA000110_010

12.3. In August 2000, RSA confirmed that it was prepared to indemnify the company where the alleged abuse occurred from the date on which the company commenced trading, 1 July 1973, despite a lack of documentation prior to 1982. This confirmation was given subject to the provisions of the exclusion clause.[63]

12.4. The first stage of the litigation determined the liability of Bryn Alyn. In early 2001, 14 lead claims went to trial in the High Court. Many issues were disputed by RSA, including limitation, negligence, causation of injury and the amount of money claimed (quantum).[64] With the exception of AR-A23, all of the claimants were successful in 2001.[65] Both sides then appealed to the Court of Appeal on various issues, including limitation, vicarious liability and the quantification of the damages.[66] Save for AR-A23, the claimants were ultimately successful in early 2003 and their damages were increased.[67]

12.5. In the second stage of the litigation, the claimants issued fresh proceedings in June 2003 to enforce the judgment against RSA,[68] which resisted the claim under the exclusion clause in the insurance policy.[69] In January 2006, the High Court determined that the exclusion clause was not engaged.[70] However, the court also considered evidence about when RSA started to insure the company and concluded that it did not do so until August 1976.[71] Claimants who were abused prior to that date were therefore unable to recover damages from RSA.

12.6. The Court of Appeal then ruled that the exclusion clause meant that RSA was not liable for the abuse perpetrated by Allen between 1976 and 1981, and the abuse by other directors and senior managers from 1981 onwards.[72] This prevented further claimants from recovering damages from RSA.

12.7. The third and final stage of the litigation began in 2007, when the remaining claimants issued proceedings against Eagle Star,[73] which was thought to be the insurer for the period before August 1976.[74] This was eventually conceded by Eagle Star.[75] By January 2009, the remaining issues were the scope of the exclusion clause, the amount of the damages and the apportionment of liability between RSA and Eagle Star.[76] In December 2010, settlement terms were agreed with Eagle Star, excluding any injuries suffered as a result of the abuse by Allen.[77] The remaining claims against RSA were then settled following a meeting in August 2011.[78]

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[63] RSA000051_077-078
[64] ZUI003197_001-002
[65] RSA000110_015-016
[66] ZUI002361_001, 004. AR-A21 was the only claimant who did not appeal the quantification of his claim (AR-A21 27 November 2018 18/16-25).
[67] ZUI002361_001, 114
[68] RSA000091_177
[69] RSA000110_019-020
[70] RSA000070_025, 043-045
[71] RSA000070_025, 034
[72] ZUI000300_001, 023
[73] ZUI000182_002-003
[74] ZUI003222_021
[75] ZUI003205_001, 003
[76] ZUI003222_019, 023
[77] ZUI003222_025
[78] RSA000110_026

13. For many victims and survivors, the journey towards obtaining accountability and reparations took many years. For those abused by Allen, it was around 20 years before he was first convicted in 1995, and around 40 years until his further convictions in 2014. It took more than 12 years for the civil claims of some victims and survivors to be concluded.

B.3: Forde Park

14. Forde Park Approved School[79] was set up and supervised by the Home Office from 1940 until April 1973, when it became a community home[80] under the control of Devon County Council until its closure in 1985.

Allegations of sexual abuse

15. Victims and survivors described widespread sexual abuse at Forde Park. We heard evidence from 12 former residents, who told us that children resident there were repeatedly sexually assaulted and raped, often over many years, and by different members of staff.[81]

15.1. When he was 11 and 12 years old, AR-A41 was sexually assaulted and raped by several staff members, including Derek Hooper, a gardener/voluntary worker,[82] at Forde Park. AR-A41 said "*it was just evil*".[83]

15.2. For two years after he was sent to Forde Park at age 12, AR-A13 was raped by Hooper once or twice a week.[84]

15.3. AR-A6 was sexually abused by older boys and once raped by Hooper while at Forde Park. He lived in constant fear of sexual abuse.[85]

16. The impact of these traumatic experiences was profound. AR-A41 felt that the abuse had made him a "*bitter, twisted little boy*". He was ashamed and petrified to speak about the abuse, even as an adult.[86] AR-A13 told us that he still had not come to terms with being raped at 12 years old. He relies on medication to cope, but told us "*I'm an old man … I don't want chemical enhancement. I'd like to know what peace of mind is*".[87] AR-A6 spent the majority of his damages from a civil claim on drink and drugs, "*to block out my feelings*".[88] AR-A9 said: "*I will always be haunted by the memories of Forde Park*".[89]

[79] An approved school was a residential institution for "*education and training*", to which children could be sent by a court for a variety of reasons (including for their own protection or as punishment for criminal behaviour). The Home Secretary or a junior minister was able to "*approve*" schools for such purposes under section 79(1) of the Children and Young Persons Act 1933. In the late 1960s, approved schools began to be abolished and replaced by community homes (Children and Young Persons Act 1969, s 46(1)) and by 1 October 1973 they had all gone (Cessation of Approved Institutions (Approved Schools) (No 2) Order 1973, SI 1974/1552).
[80] Cessation of Approved Institutions (Forde Park School) Order 1973, SI 1973/509.
[81] See also AR-A27 30 November 2018 82/5-21; AR-A3 30 November 2018 108/14-18; AR-A9 30 November 2018 113/16-22; AR-A11 30 November 2018 116/22-117/6; AR-A14 30 November 2018 122/15-18; AR-A31 30 November 2018 124/12-18; Paul Sinclair 30 November 2018 140/6-13; AR-A7 30 November 2018 110/10-14; AR-A44 30 November 2018 136/22-25
[82] JNQ004422_001-002
[83] AR-A41 30 November 2018 2/3-11, 9/24-10/6
[84] AR-A13 30 November 2018 52/14-53/1
[85] AR-A6 30 November 2018 98/21-24
[86] AR-A41 30 November 2018 3/13-22, 9/11-13
[87] AR-A13 30 November 2018 56/4-15, 70/16-71/9
[88] AR-A6 30 November 2018 101/8-15
[89] AR-A9 30 November 2018 114/2-6

17. During our hearings, a representative of Devon County Council said that it was deeply sorry for the abuse suffered by the former residents of Forde Park.[90] In addition, in a letter to the solicitor for some of the victims and survivors of Forde Park, the Home Office said that the government deeply regretted the suffering they and others had endured in institutions in the past. It said that ministers recognised the importance of acknowledging when institutions have not done what they should have done. However, despite being responsible for Forde Park from 1940 to 1973, the Home Office did not make a direct apology for the abuse that occurred there during that period, stating that "*it is also important that apologies properly reflect the actions and responsibilities of those involved*" and that "*the inquiry hearing is the proper forum for consideration of these matters*".[91]

Police investigations

18. From 1999 to 2002, investigations into allegations of sexual abuse at Forde Park were managed under an overarching investigation known as Operation Lentisk.[92] Around 100 former pupils at the school made allegations and the police took almost 1,300 statements.[93] Although a significant number of alleged abusers had died by the time of the investigation,[94] the majority of allegations of abuse at Forde Park were against Hooper and John Ely.[95]

18.1. Hooper was initially involved at Forde Park on a voluntary basis. From 1971 to 1973, he was employed there as a gardener, before returning to a voluntary role. On 21 September 2000, Hooper was convicted of 28 counts of indecent assault on a male, seven counts of attempted buggery, three counts of buggery and two counts of incitement to commit buggery. All but one of the counts were for crimes against children at Forde Park. On appeal, he was sentenced to 14 years' imprisonment.[96]

18.2. Ely was a housemaster at Forde Park between 1967 and 1979. In 2001, he was convicted of 18 counts of indecent assault, seven counts of buggery and one count of attempted buggery. These crimes were committed against children who were pupils at Forde Park and at another institution where he had also been a housemaster. He was sentenced to 12 years' imprisonment.[97]

Litigation

19. Over 100 claimants brought civil claims against Devon County Council, the Home Office, or both, seeking damages for physical and sexual abuse at Forde Park. The majority of these claims commenced in around 1999.[98]

[90] Letter from Jo Olsson, Chief Officer for Children's Services at Devon County Council, as read by Paul Greatorex 3 December 2018 94/7-95/18
[91] Letter from Sir Philip Rutnam, Permanent Secretary to the Home Office, as read by Neil Sheldon 12 December 2018 162/13-166/5
[92] OHY005912_001; Deborah Marsden 3 December 2018 20/16-21/2
[93] Deborah Marsden 3 December 2018 21/6-13
[94] OHY005912_003
[95] Deborah Marsden 3 December 2018 21/14-23
[96] INQ004422_001-002, 004
[97] INQ004421_001-002, 031
[98] Emily Wilkins 3 December 2018 39/25-40/4; Christian Papaleontiou 3 December 2018 98/7-99/4; Penelope Ayles 15 January 2019, 50/22-51/14; ZUI003198_001-002

20. During the litigation, the defendants raised the issue of limitation and applied unsuccessfully (including appealing to the Court of Appeal)[99] for it to be heard as a preliminary issue.[100] A dispute also arose between the Home Office and the Council as to who should be liable for any claims of abuse in the period prior to April 1973. Although this issue did not directly concern the claimants, and it was eventually resolved in the Home Office's favour,[101] it appears to have prolonged the time it took to resolve their claims.[102]

21. During the course of the litigation, the parties identified a group of lead cases to be heard by the court. The trial of these cases was due to take place in 2001. However, many of the claims were settled before the hearing or shortly after the trial began.[103] Devon County Council's records show that, of the approximately 100 claims it received, 46 were settled (six of which were progressed to court but settled before judgment), five were repudiated and 23 were discontinued. The outcome for the remaining 26 is unknown as records have not been updated.[104]

B.4: St Leonard's

22. St Leonard's was a children's home in Essex operated by Tower Hamlets London Borough Council (Tower Hamlets) from the late 1960s until it closed in the early 1980s. It comprised a series of family cottages, run by a house father and house mother together with other members of staff.[105]

Allegations of sexual abuse

23. Paul Connolly told us that children at St Leonard's were often "*snatched*" from their dormitories and raped.[106] It was "*a brutal environment in which sexual and physical abuse were ever present*".[107] He had fought off attempts to snatch him:

> *"if I had not hidden under the bed most nights with my wooden-handled kitchen knife, I would have been raped, as well as the other boys"*.[108]

When the police contacted Mr Connolly in the course of their investigations into abuse at St Leonard's, he found out that six of the eight boys with whom he had shared a dormitory had died. He told us that each had taken their own lives, "*in one way or another*", by drug overdose and suicide.[109] He believes that his mental and physical scars will never leave him. He still chooses to sleep on the floor downstairs and feels that he will never be able to sleep in a bed again.[110]

[99] Christian Papaleontiou 3 December 2018 104/7-13
[100] Christian Papaleontiou 3 December 2018 103/15-104/2
[101] Christian Papaleontiou 3 December 2018 104/14-22
[102] Rod Luck 3 December 2018 62/20-63/13; Penelope Ayles 15 January 2019 52/21-25
[103] Elizabeth-Anne Gumbel and Henry Witcomb 15 January 2019 24/6-25/8, 41/9-42/1
[104] Emily Wilkins 3 December 2018 43/15-20
[105] ZUI003200_001
[106] Paul Connolly 4 December 2018 1/20-3/21, 26/15-17
[107] Paul Connolly 4 December 2018 25/23-24
[108] Paul Connolly 4 December 2018 1/20-3/21, 26/15-17
[109] Paul Connolly 4 December 2018 5/13-6/8, 26/2-5
[110] Paul Connolly 4 December 2018 27/13-19

24. AR-A15 gave evidence that, while at St Leonard's, he was made to sit on a priest's lap and could feel his erection. Haydn Davies, who worked at St Leonard's, forced him into mutual masturbation, drugged and raped him.[111] AR-A15 told us that, as a result of the abuse, he has sought help all his life but that therapy has been no help.[112]

25. During the course of the hearings, a representative of Tower Hamlets gave an apology on behalf of the Council to all victims and survivors, and thanked them for their courage in coming forward to seek justice.[113]

Police investigations

26. In 1995, a former resident informed the Director of Social Services at Tower Hamlets that he had been sexually abused whilst at St Leonard's. As a result, the Metropolitan Police, in Operation Hamoon, interviewed a number of former residents and sent a file about the investigation to the Crown Prosecution Service. Four residents made allegations that Alan Prescott and Davies, who both worked at St Leonard's in the 1970s, committed acts of indecent assault, buggery and indecency with children. The Crown Prosecution Service declined to prosecute.[114]

27. The same former resident complained about a lack of action in 1996. Internal enquiries continued at Tower Hamlets and the Director of Social Services asked the police to undertake an investigation into inappropriate behaviour by staff at St Leonard's.[115]

28. Operation Mapperton commenced in 1998. The Metropolitan Police and Tower Hamlets first sought to identify former residents and find out whether any wished to disclose allegations of abuse. A police inquiry team then set about gathering witness evidence and progressing criminal investigations into the men identified as abusers.[116] The police investigations resulted in two successful convictions:

- In 2001, Prescott, who had run St Leonard's from 1968 to 1984,[117] pleaded guilty to four counts of indecent assault and was sentenced to two years' imprisonment.[118]
- William Starling, a former house parent,[119] was convicted of 19 counts of abuse of 11 residents, including a number at St Leonard's, and sentenced to 14 years' imprisonment.[120]

Proceedings against Davies were stayed by the court, as evidence from previous criminal investigations into him was missing.[121]

Litigation

29. In total, 58 claimants brought civil claims against Tower Hamlets for the abuse they suffered at St Leonard's. Solicitors were first instructed in 2000, before the criminal trials. In March 2002, the court made a group litigation order which arranged the management of

[111] AR-A15 5 December 2018 98/20-24
[112] AR-A15 5 December 2018 100/18-21
[113] Richard Baldwin 4 December 2018 81/19-82/9, 108/5-109/15
[114] OHY006384_004; OHY006739_002
[115] OHY006739_002; OHY006749
[116] OHY006739_002; OHY006749; see also Daniel O'Malley 4 December 2018 33/8-19
[117] INQ002530
[118] OHY006748_001
[119] INQ002530
[120] OHY006748_002
[121] OHY006748_001-002; Daniel O'Malley 4 December 2018 33/23-35/17

the claims. In March 2003, Tower Hamlets admitted liability, subject to the issue of limitation and to individual claimants proving that they suffered injuries and resulting losses. Between 2002 and September 2003, settlements were negotiated in all but one of the cases. The final claim was eventually resolved in 2005. The civil cases settled for £1.3m in damages.[122]

B.5: St Aidan's and St Vincent's

30. St Aidan's and St Vincent's were approved schools which later became community homes providing education on the premises. They housed children in Widnes in Cheshire and Formby in Merseyside. They were owned and managed by a Roman Catholic organisation known as Catholic Social Services and then as Nugent Care Society. St Aidan's closed in 1982 and St Vincent's in 1989.[123] Some former residents of St Aidan's and St Vincent's endured well over a decade of litigation in the civil courts. A focus of our investigation in this case study was, therefore, the long process of civil litigation and how it impacted on the experiences of victims and survivors.

Allegations of sexual abuse

31. Victims and survivors told us that children at St Aidan's and St Vincent's were repeatedly subject to sexual abuse, including groping, anal sex, oral sex and masturbation, as well as other abuse.

31.1. AR-A87 told us that he was indecently assaulted three times by a teacher when he was around 13 or 14 years old.[124]

31.2. AR-A36, who was at St Aidan's, was indecently touched and then raped on several occasions by Colin Dick,[125] a housemaster.[126]

31.3. AR-A79 described that he was sexually assaulted by more than one person, including Dick. He believes he has suppressed his memories of other abuse.[127]

31.4. AR-A2 was sexually abused by other residents and members of staff. He was groomed by AR-F1 and forced by him into anal sex, oral sex and masturbation.[128]

32. This abuse and its aftermath prompted feelings of shame[129] and lasting psychological damage.[130] AR-A36 told us that he could never forget the abuse.[131] AR-A2 said that it had destroyed his childhood and most of his social life.[132]

33. During our hearings, a lawyer representing Nugent Care read a message from the chair of trustees, Father Michael Fitzsimons. He said that the trustees "*are deeply sorry that former residents suffered under the abuse at the hands of individuals who were employed by our charity and committed appalling crimes*". The trustees acknowledged the hurt and trauma

[122] ZUI003200
[123] INQ003633_001-002; Normandie Wragg 6 December 2018 37/20-38/6
[124] AR-A87 5 December 2018 101/19-102/8
[125] AR-A36 5 December 122/13-123/4
[126] INQ003356_001, 036
[127] AR-A79 5 December 2018 144/2-7
[128] AR-A2 5 December 2018 146/10-14
[129] AR-A87 5 December 2018 102/9-20
[130] AR-A87 5 December 2018 113/22-114/18
[131] AR-A36 5 December 2018 127/14-20, 139/15-21
[132] AR-A2 5 December 2018 146/23-147/8

experienced by residents, and offered to signpost and facilitate contact with support and counselling. The chair of trustees also offered to meet former residents to listen to their experiences and to offer a personal and organisational apology.[133]

Police investigations

34. In 1994, Cheshire Constabulary launched Operation Emily to investigate allegations of abuse against children at St Aidan's. A number of suspects had died, but four abusers were eventually convicted.[134] These included Dick, who pleaded guilty to indecent assault and buggery of children at St Aidan's between 1978 and 1981 and was sentenced to four years' imprisonment.[135]

35. There have been further investigations into alleged abuse at St Aidan's and Cheshire Constabulary informed us that an investigation into allegations made by one individual is ongoing.[136]

36. Merseyside Police investigated abuse at St Vincent's and other children's homes (known as Operation Van Gogh and later Operation Care) after allegations were made by 45 victims and survivors against 20 suspects. Some of these suspects had died and some had no further action taken against them, whilst two progressed to trial and at least one was convicted.[137]

Litigation

37. The St Aidan's and St Vincent's litigation lasted from 1997 to 2010.[138] The claims were part of a group of cases known as the North West child abuse litigation. The defendant in the St Aidan's and St Vincent's claims was Nugent Care Society, whose insurer was RSA.[139]

38. The other claims in the group arose from child sexual abuse at Danesford, Greystone Heath and Dyson Hall. Danesford was a children's home run by the National Children's Home, who were insured by the Methodist Insurance Company. Greystone Heath and Dyson Hall were children's homes in Liverpool, run by Liverpool City Council.[140]

39. Shortly after the litigation started in 1997, the defendants sought to strike out[141] the whole of the litigation on the technical basis that the claimants had not identified themselves openly in the court documents, in order to preserve their anonymity. This was unsuccessful. The defendants sought permission to appeal, but in June 1998 the Court of Appeal refused their application.[142]

40. By the end of January 1999, claims arising from abuse at Danesford began to settle, and in April 2000 the defendant withdrew from the group. Between April 2003 and May 2004, claims in relation to Greystone Heath and Dyson Hall were settled in a series of meetings between the parties.[143]

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[133] Jonathan Hough 12 December 2018 1/8-3/1
[134] OHY006311_003
[135] INQ003356_001, 036-037, 041
[136] OHY006311_004; Darren Martland 6 December 2018 11/13-12/1
[137] Serena Kennedy 6 December 2018 21/10-22/24; Deputy Chief Constable Kennedy provided these figures based on a review of the paperwork that her force had been able to find.
[138] See INQ003530, a chronology of legal events prepared by Peter Garsden.
[139] Stephen Bellingham 7 December 2018 15/25-16/8
[140] Peter Garsden 6 December 2018 44/14-46/6
[141] The court has the power to 'strike out' and end a claim, for example if it determines that the claim is an abuse of process (CPR 3.4).
[142] INQ003530_002; Peter Garsden 6 December 2018 73/11-78/8
[143] INQ003530_002-004; Peter Garsden 6 December 2018 66/20-67/11

41. In the early years of the litigation, various attempts were made to settle the Nugent Care claims, including an unsuccessful mediation in 2004.[144] A number of trials and appeals followed.

41.1. Three test cases were heard in November 2006. One case was allowed to proceed, but two failed on limitation grounds, including the claim of AR-A87.[145]

41.2. The two unsuccessful claimants appealed, asking the Court of Appeal to reconsider the decision by the judge to refuse to extend the limitation period in their claims. This appeal was delayed to await the outcome in the case of *A v Hoare*, which was decided by the House of Lords in January 2008 and held that the extendable three-year limitation period for personal injury claims should apply to all sexual abuse claims.[146]

41.3. The decision of *A v Hoare* enabled the group of claimants to amend their case to allege vicarious liability for assault,[147] which was a simpler way of arguing liability (discussed in Part C).

41.4. In June 2008, the Court of Appeal allowed the appeal in the test cases and asked the High Court to reconsider its decision.[148]

41.5. In January 2009, the High Court reconsidered the two cases, alongside two other claims. In two of the four claims, including one of the original test cases, the judge decided to exercise his discretion and let the case continue. In the other two claims, including AR-A87's, the judge declined to allow the case to proceed as it was outside the limitation period.[149]

41.6. The cases were appealed, but the judgment of the Court of Appeal in July 2009 did not alter the High Court's decision on which claims could proceed. For AR-A87, the rejection of his appeal meant his claim had ended.[150]

42. By October 2009, the High Court had ordered trials of several further lead claims. Three were heard in early 2010. Two claimants were awarded damages and one failed for limitation reasons.[151]

43. We were told that, of 120 claimants from St Aidan's and St Vincent's, 71 were successful and 49 unsuccessful.[152] However, as with the Bryn Alyn litigation, it took more than 12 years for the claims to be concluded.

B.6: Stanhope Castle

44. Stanhope Castle, in County Durham, was set up in 1941 as an approved school under the control of the Home Office. In 1973, following the abolition of approved schools, it became a community home and was transferred to Teesside County Borough Council.

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[144] Peter Garsden and Paul Durkin 6 December 2018 96/8-97/14, 137/1-138/19; Stephen Bellingham 7 December 2018 42/13-43/12
[145] INQ003624_001, 005, 010-011, 013-014, 016
[146] INQ003530_004; RSA000111_015; *A v Hoare* [2008] UKHL 6, [2008] 1 AC 844
[147] Peter Garsden 6 December 2018 92/18-21; the amendment was made on 15 July 2008 (INQ003530_004).
[148] INQ003632_001, 003
[149] INQ003356_001, 030, 033, 035-036, 042, 048
[150] INQ003633_001, 016, 018, 022
[151] INQ003368_001, 020, 031, 041
[152] INQ003530_006

When Teesside County Borough Council was abolished in 1974, responsibility for the school transferred to Cleveland County Council. The school closed in 1981. When Cleveland County Council was abolished in 1996, its liabilities – including in respect of Stanhope Castle – were transferred to four unitary authorities[153] and administered by one of those authorities, Middlesbrough Council.[154]

Allegations of sexual abuse

45. Victims and survivors told us about the sexual abuse they suffered at the hands of teachers, staff and other pupils, which included forced masturbation, oral sex and anal rape.

45.1. AR-A5 was forced to perform oral sex and was anally raped.[155]

45.2. James (Thomas) Harding was watched whilst naked in the shower and whipped on his bare bottom.[156]

45.3. Peter Smith was repeatedly sexually abused by numerous older students over a period of six years. He was forced to masturbate them, perform oral sex and was subjected to attempted anal rape.[157]

45.4. AR-A96 was repeatedly forced to perform oral sex and masturbate two teachers.[158]

46. The sexual abuse was accompanied by physical abuse and brutality. Colin Watson said that the daily physical abuse and the threat of violent abuse was used to make him compliant and to remain silent about sexual abuse.[159]

47. Several witnesses told us that they received beatings after reporting the abuse to members of staff and social workers.

47.1. AR-A25 was forced to masturbate AR-F17, a member of staff, when he was 12 to 14 years old. He reported this to the matron of the school. He believes that the matron told AR-F17, as he then received a "*savage beating*" from AR-F17, who said that he had been spreading lies. The sexual abuse then ended, but the physical abuse continued.[160]

47.2. AR-A34, who was physically and sexually abused, said that the day after he told his social worker about the brutality at Stanhope Castle, he "*had his first smashed-in skull*".[161]

48. Victims and survivors had difficulties disclosing the abuse for many years. After his first disclosure to his social worker, AR-A34 said that he "*couldn't tell anybody*" and he kept it a secret for "*years and years*".[162] AR-A25 said that he suppressed his experiences, although they were always at the back of his mind.[163]

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[153] Middlesbrough Borough Council (known as Middlesbrough Council), Langbaurgh Borough Council, Stockton on Tees Borough Council and Hartlepool Borough Council.
[154] MDC000015_001-002; James Bromiley 10 December 2018 82/17-83/2
[155] AR-A5 10 December 2018 32/14-18
[156] James Thomas Harding 10 December 2018 35/24-36/4
[157] Peter Smith 10 December 2018 39/8-14
[158] AR-A96 10 December 2018 51/17-20
[159] Colin Watson 10 December 2018 46/10-12
[160] AR-A25 7 December 2018 126/24-127/20
[161] AR-A34 7 December 99/20-100/25
[162] AR-A34 7 December 2018 100/13-101/12
[163] AR-A25 7 December 2018 128/3-7

49. The Inquiry heard the extent to which the abuse has had an impact on the lives of victims and survivors. They spoke of a lost education which, as AR-A34 put it, *"affected my chances in life"*.[164]

49.1. AR-A25 said *"I was a very damaged person when I left Stanhope. I spent the next 20 years in and out of detention centres and prisons, mainly for assaults"*.[165]

49.2. Peter Robson said the abuse happened *"56 years ago. And I'm still suffering and I'm still trying to cope with it now"*.[166]

49.3. AR-A5 said the *"abuse I suffered as a little boy at Stanhope Castle has blighted my whole life"*.[167]

49.4. Mark Gray said *"I have struggled with depression all my life"*.[168]

50. On behalf of Middlesbrough Council, James Bromiley, Strategic Director for Finance, Governance and Support Services, began his evidence to the Inquiry by expressing the *"deepest sympathy and apologies for any abuse that took place at Stanhope Castle"*.[169] However, at the end of his evidence, he said he was unable to answer whether or not sexual abuse had taken place, stating that *"as I said at the very start, if sexual abuse did occur, then I have a huge sympathy for that"*.[170]

Police investigations

51. Unlike the other case studies, there have been no prosecutions arising out of the physical or sexual abuse at Stanhope Castle.[171]

52. In 1999, a report of child sexual abuse was made to Durham Constabulary but, as they accepted in their evidence, it was not properly investigated.[172] In 2013, Operation Midday was set up and, by the end of 2016, Durham Constabulary had received allegations in respect of 14 victims and survivors. Many of these allegations were passed to the police by Watson Woodhouse Solicitors, who were representing the victims and survivors in a number of civil claims. The total number of victims eventually rose to 28, in respect of which there were 59 offences recorded, of which 31 were sexual. The Inquiry understands that the investigations are continuing.[173]

Litigation

53. At the time of the public hearings, 33 civil claims had been brought against Middlesbrough Council for physical and sexual abuse suffered at Stanhope Castle.[174]

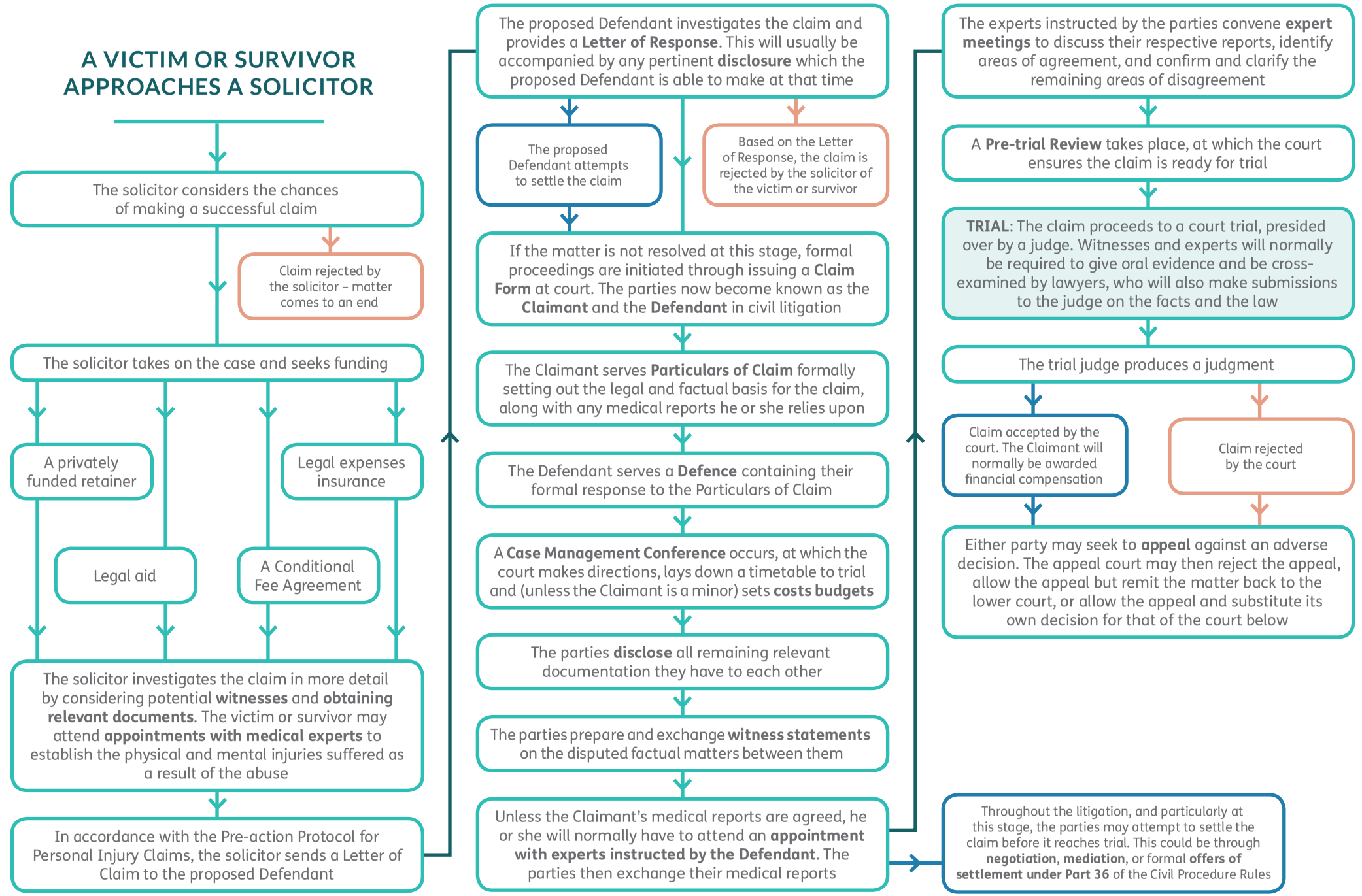
[164] AR-A34 7 December 2018 123/22-23; see also Peter Robson 10 December 2018 27/23-25
[165] AR-A25 7 December 2018 127/22-24
[166] Peter Robson 10 December 2018 27/16-18
[167] AR-A5 10 December 2018 33/3-4
[168] Mark Gray 10 December 2018 45/1
[169] James Bromiley 10 December 2018 80/10-19
[170] James Bromiley 10 December 2018 99/14-20
[171] For a summary of the results of the investigations, see David Orford 10 December 2018 69/7-21
[172] David Orford 10 December 2018 66/16-67/14
[173] David Orford 10 December 2018 67/15-68/23; OHY006312_016-017
[174] James Bromiley 10 December 2018 90/13-19. This was the number of claims of which Mr Bromiley was aware.

54. The majority of the claims proceeded in two tranches. The first tranche was brought in the early 2000s and focused on physical abuse only.[175] Those claims were insured and handled by Municipal Mutual Insurance (MMI)[176] and were eventually settled for modest sums in 2010.[177] The second tranche included claims for sexual abuse in addition to physical abuse. The sexual abuse claims commenced in around 2014 and included uninsured claims and MMI-insured claims, with the latter handled by Zurich.[178] Those claims never progressed beyond the stage of pre-action correspondence, primarily due to a lack of corroborating evidence (including criminal convictions) and difficulties in respect of limitation.[179]

[175] Rod Luck 10 December 2018 103/9-18
[176] James Bromiley 10 December 2018 91/20-23. There was no insurance cover for the period before 1 April 1973. From 1 April 1973 until the school's closure in 1981, MMI provided insurance to Teesside, and once that was abolished, then Cleveland (MDC000015_004). Zurich usually handles claims for MMI unless MMI chooses to handle them, as it did with this tranche (ZUI003222_005-006, 042).
[177] James Bromiley 10 December 2018 90/22-91/7; Rod Luck 10 December 2018 105/15-24, 110/20-111/1
[178] Rod Luck 10 December 2018 112/8-15; MDC000015_007-013; ZUI003222_042-043
[179] See Part C. One of the claims for physical abuse also commenced in around 2014 and was settled (MDC000015_015-016).

Part C

Civil justice system



Overview of the litigation process

Civil justice system

C.1: Introduction

1. The civil justice system aims to resolve disputes between individuals and organisations, and provide remedies for injured parties, often in the form of compensation. Disputes can concern anything from unpaid bills or unfulfilled contractual terms to problems between landlords and tenants, construction-related claims, or defective products. Legal claims arising from child sexual abuse are dealt with as personal injury claims, the purpose of which is to put the complainant back in the position they would have been if the injury had not occurred, through the award of compensation.

2. Civil claims in England and Wales are adversarial. This means that the court adjudicates the dispute between the individuals or organisations involved, known as the parties, who are pitted against each other. The parties instruct their own legal representatives and are responsible for investigating the claims and finding the relevant evidence. If a claim proceeds to trial, the parties' advocates (or, in some cases, the parties themselves) will present the evidence and make submissions to a judge, who will determine the issues and produce a judgment.

3. The litigation process is governed by the Civil Procedure Rules (CPR), which were introduced in 1998. An overview of the litigation process for non-recent sexual abuse claims is included above.

4. The overriding objective of the CPR is to help the court to deal with cases justly and at proportionate cost.[180] The court must further this objective by actively managing cases – which includes encouraging the parties to cooperate with each other – fixing timetables and generally controlling the progress of the case.[181]

5. The CPR also encourages early settlement of claims. There are a number of pre-action protocols which set out the steps that the court expects claimants and defendants to take before commencing proceedings, including setting out and responding to the allegations in pre-action correspondence.[182] There are different protocols for particular types of civil claims; although there is no specific pre-action protocol for sexual abuse cases, these are covered by the protocol for personal injury claims.[183]

6. If the parties are not able to settle the claim pre-action, a claimant may decide to commence the claim formally at court. This can result in a trial before a judge in a public courtroom. However, it remains open to the parties to settle at any point up until, or during, a trial.

[180] CPR 1.1
[181] CPR 1.4; see also CPR Part 3 – The Court's Case Management Powers
[182] CPR, Practice Direction – Pre-Action Conduct and Protocols. Compliance with the protocols is not mandatory, but it is expected and non-compliance may result in the court imposing costs penalties.
[183] This is directed at straightforward personal injury claims worth £25,000 or less. However, parties in more complex and high-value claims are encouraged to follow the spirit of the protocol (Pre-Action Protocol for Personal Injury Claims; CPR 26.6).

7. The Inquiry heard evidence that the adversarial civil justice system is inherently unsuitable for providing accountability and reparations to victims and survivors of child sexual abuse, particularly in non-recent cases. Many witnesses told us that the litigation process was emotionally challenging and that it compounded the trauma they had already suffered as children. They also felt dissatisfied with the outcome, either because their claims had failed or because they had succeeded, usually by accepting a settlement offer, but they had never received any explanation or apology for what had happened to them and did not feel that justice had been done.

C.2: Knowledge and awareness

8. Some victims and survivors who gave evidence at our hearings had not brought civil claims against the institutions in which they were abused because they were unaware that they could do so.

> **8.1.** AR-A14 said "*I did not make a claim at any point because I have not heard or understood what to do.*"[184]
>
> **8.2.** AR-A96 said "*I had not made a civil claim previously because I had simply tried to forget all that had happened to me and did not want to revisit it. I was not fully aware of the process to make a civil claim and, in any case, I did not want to explore it, but rather try to just forget my experiences.*"[185]

9. Victims and survivors who report allegations of sexual abuse to the police may choose not to bring a civil claim. On the other hand, they may not be aware of the option or know that they should bring one promptly in order to avoid having their claim rejected by the court as being too late.

10. The police do not always actively signpost victims and survivors to seek legal advice about potential civil claims.[186] This is partly because the police have not seen it as their responsibility to do so, but it also results from a concern that any criminal proceedings against the abusers may be undermined by accusations that the victims and survivors have fabricated allegations to obtain compensation.[187] AR-A23 said that, at the trial of John Allen in 2014, she was "*repeatedly asked whether or not I was lying for money*".[188]

11. Approaches towards this issue varied between the police forces we heard from. Some forces – such as North Wales Police[189] and Durham Constabulary[190] – have no guidance or policies on signposting the possibility of civil claims; whether or not they do so is left to the discretion of individual officers. Other forces – for example Cheshire Constabulary[191] – train their officers specifically to provide such signposting. Civil claims are not signposted in the College of Policing's Authorised Professional Practice, which is the official source of professional practice on policing.[192]

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[184] AR-A14 30 November 2018 123/15-16
[185] AR-A96 10 December 2018 51/22-52/4
[186] OHY005933_017; Serena Kennedy 6 December 2018 22/24-24/20, 29/11-30/1
[187] Neill Anderson 28 November 2018 36/24-37/24; OHY005933_017; Craig Turner 4 December 2018 68/22-69/12
[188] AR-A23 27 November 2018 43/15-22
[189] Neill Anderson 28 November 2018 37/11-38/10
[190] David Orford 10 December 2018 64/11-25
[191] Darren Martland 6 December 2018 19/7-22
[192] OHY006397

12. Melissa Case, Director of Criminal and Family Justice Policy at the Ministry of Justice, said that the police should inform victims and survivors of their right to claim compensation in the civil courts.[193] This does not appear to occur at present at a national level. The Inquiry was shown a Ministry of Justice leaflet, produced for victims of crimes, which refers to the Criminal Injuries Compensation Authority but does not mention compensation in the civil courts.[194] Similarly, the existence of such a right is not publicised and explained in the Code of Practice for Victims of Crime (the Victims' Code), which came into effect in 2006 and was revised in 2013 and 2015.[195]

C.3: Aims and objectives

13. Not all victims and survivors we heard from chose to bring civil claims. For those who did not initiate any litigation, the main theme was the concern that they would not be believed. AR-A1 said he was trying to avoid anything to do with Bryn Alyn, where he was abused, but he also thought that *"no-one was going to believe us anyway, why go through all the trauma"*.[196] Similarly, AR-A79, who was abused at St Aidan's, said he did not bring a civil claim because he assumed that he would not be believed.[197]

14. Those victims and survivors who decided to bring claims all had several different reasons, or combinations of aims and objectives. Such objectives did not always align with the more fundamental purpose of a civil claim, which is to obtain financial compensation. Although financial compensation was an important objective for some, it was rarely the primary motivation.

15. AR-A78 wanted compensation but *"the important part for me was not the compensation, but the fight for truth and justice itself"*.[198] AR-A2 wanted compensation to *"get help"* and to open up opportunities he had been deprived of by the effects of abuse.[199] He felt that those institutions that had been responsible for his care *"but who had instead destroyed my childhood and most of my social life, had a responsibility to make amends"*.[200] Financial compensation also represented accountability, or even retribution. AR-A41 said:

> *"I was hoping to achieve retribution for what had happened to me … They should pay. They should be made to pay for what damage they've done to me."*[201]

Others expressly did not want compensation. AR-A87 said: *"All I was after was justice. I was after no monetary reward."*[202]

[193] Melissa Case 12 December 2018 100/4-101/22
[194] OHY006390
[195] INQ003556
[196] AR-A1 27 November 2018 101/4-13
[197] AR-A79 5 December 2018 145/13-22
[198] AR-A78 29 November 2018 112/4-16
[199] AR-A2 5 December 2018 146/20-147/3. See also AR-A78 29 November 2018 112/6-14; AR-A23 27 November 2018 34/1-5
[200] AR-A2 5 December 2018 147/3-7
[201] AR-A41 30 November 2018 15/6-11
[202] AR-A87 5 December 2018 107/6-108/2

16. The desire for some form of justice was articulated or experienced in different ways. Some wanted the truth about the abuse to come out. Others also wanted recognition that they were abused, to be believed, or to be vindicated for being called a liar for many years.[203] AR-A24 said:

> *"I was hoping that I'd get some recognition for what had happened to me, hoping that I would be vindicated for being called a liar all these years and that finally someone would listen to me … "*[204]

17. Many victims and survivors wanted their day in court.[205] AR-A29 said this was so he could "*tell everyone about what happened to me during my childhood. I wanted it all out in the open and I wanted those responsible held accountable*".[206] AR-A13 wanted his day in court "*to talk out loud and feel … fairly confident that I was being believed, because I'd gone all these years without being believed*".[207] For AR-A87, a day in court was also important:

> *"I needed to be believed. That was the most important thing, to actually have my day in court. I wanted to face my abusers and to be believed by the court that what happened to me did happen … I was looking forward to looking at my abusers and saying to them, 'I'm not a child no more'."*[208]

18. Several victims and survivors even wanted their abusers to be prosecuted, despite this only being possible in the criminal courts. AR-A87 said that he wanted to see the abusers brought to court and convicted, although he understood that this was not possible in the civil courts.[209]

19. Many wanted an apology from the relevant institution, which is a theme we discuss further below.[210] AR-A27 wanted an apology but also assurances that children in care would be protected in the future.[211]

20. It is likely that the victims and survivors we heard from are not alone in their views. We heard evidence from a number of experienced claimant lawyers about what victims and survivors want from the civil claims process.

20.1. Paul Durkin, a solicitor who represented claimants in the St Aidan's and St Vincent's litigation, said that:

> *"the vast majority, if not all, wanted a voice, they wanted to be believed, they wanted to get their account out there … Very, very frequently, they say the money is secondary, it is not about the money, 'What happened to me was wrong and I want justice. I want things to be put right', and it's a very amorphous thing they want, but compensation isn't a primary motivator, in my experience."*[212]

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[203] AR-A23 27 November 2018 34/1-5; AR-A29 3 December 2018 141/5-8; AR-A36 5 December 2018 126/2-11
[204] AR-A24 27 November 2018 59/16-22
[205] AR-A7 30 November 2018 110/23-25; Paul Connolly 4 December 2018 10/6-18; Tracey Storey 5 December 2018 26/12-23; AR-A15 5 December 2018 99/10-12
[206] AR-A29 3 December 2018 141/5-8
[207] AR-A13 30 November 2018 61/1-13
[208] AR-A87 5 December 2018 108/21-109/19
[209] AR-A87 5 December 2018 107/6-23
[210] AR-A41 30 November 2018 15/16-16/17; AR-A13 30 November 2018 61/21-62/14; AR-A27 30 November 2018 89/25-90/4; AR-A11 30 November 2018 117/24-118/1, 118/22-24; AR-A31 30 November 2018 125/10-13; AR-A2 5 December 2018 146/20-22
[211] AR-A27 30 November 2018 89/25-90/4
[212] Paul Durkin 6 December 2018 54/13-55/11

20.2. Tracey Storey, a solicitor who represented claimants in the St Leonard's litigation, said that clients will come to her expecting more from the civil process than is always possible:

> "*They will expect to feel better. They will expect people to be punished. They will expect there to be accountability. And it doesn't necessarily flow. You can use a civil process for apologies, for other forms of redress, but it doesn't necessarily flow from it*".[213]

20.3. Peter Garsden, another solicitor who represented claimants in the St Aidan's and St Vincent's litigation, said that victims and survivors are seeking truth and justice:

> "*Often they want to have their abuser prosecuted if they haven't been prosecuted through the criminal courts, and we have to explain we can't do that, that's for the police. But often when they have failed prosecutions, they go to the civil process to try and get some justice … "*[214]

20.4. Billhar Singh Uppal, the lead solicitor for the claimants in the Bryn Alyn litigation, was asked how many of those who went through the Bryn Alyn litigation were satisfied. He said:

> "*Very few. I can probably say that since 1994 I could probably count on the fingers of two hands those that have truly emerged out of this totally – I wouldn't say unscathed, but positive, that have emerged out of this – out of the whole civil process having achieved absolutely everything that they wanted to achieve.*"[215]

When asked why clients persist with civil claims after having been warned about the process, he said:

> "*Often because they have no other option available to them. They have exhausted all previous options. They are not – the vast majority of claimants, issuing proceedings and getting compensation is not anywhere near their first port of call. They are corralled down an avenue that leads them to that inevitable conclusion. Along the way, some will fall down and simply not get back up, but the ones that arrive in the civil litigation arena arrive there because they have tried absolutely everything else.*"[216]

C.4: Legal basis for claims against institutions

21. Child abuse claims are governed by an area of civil law known as the law of tort. A civil claim of assault and battery (also known as trespass to the person) can be brought directly against an abuser. This covers acts which, in criminal proceedings, would be sexual assault or rape. However, an individual abuser typically does not have sufficient funds to be able to pay damages. As a result, claims are usually brought against the institution in which the abuse took place or against those responsible for that institution, for example a local authority or private body.

[213] Tracey Storey 5 December 2018 24/11-25/1
[214] Peter Garsden 6 December 2018 56/10-15
[215] Billhar Singh Uppal 28 November 2018 159/4-16
[216] Billhar Singh Uppal 28 November 2018 159/17-160/6

22. Historically, the law did not permit claimants in sexual abuse claims to bring cases on the basis of vicarious liability, the legal principle which may make institutions liable for their employees, even where the institution itself is not at fault. This was because the courts considered that sexual abuse was always outside the scope of the abuser's employment.[217] Instead, the law required victims and survivors to prove that their abuse resulted from the negligence of a particular institution, for example, in failing to stop the abuse. These cases were known as systemic negligence cases because they involved examining the whole system operating at an institution. Alistair Gillespie, a defendant lawyer who acted for Royal & Sun Alliance (RSA) in the North Wales litigation, explained that having to bring claims based on systemic negligence was very challenging for claimants. They had to prove that there was a breach of duty according to the standards at the time, and they had to obtain sufficient evidence of what systems and operations were in place at the time.[218]

23. It is now easier for claimants to bring claims of non-recent abuse based on vicarious liability.[219] This is due to two major judgments by the House of Lords. First, a decision in 2001 that employers could be vicariously liable for sexual assault.[220] Second, a decision in 2008 that the extendable three-year limitation period should apply to all sexual abuse claims[221] (see below).

24. However, Peter Garsden told the Inquiry that this shift meant that there was now more focus on whether or not the abuse took place and an examination of the credibility of the claimants.[222]

C.5: Proving abuse and the resulting damage

Evidence of abuse

25. Unless a defendant admits that the claimant was sexually abused, the onus is on the claimant to satisfy the court that it is likely (on the balance of probabilities) that the abuse took place. This is known as the burden and standard of proof and it will ordinarily be discharged by the presentation of one or more of the following types of evidence.

25.1. Criminal convictions for child sexual abuse: In civil claims, the fact that a person has been convicted by a criminal court in the United Kingdom can be used as evidence that he committed the offence.[223] The court will consider that the offender committed that offence unless he can prove that he did not.[224]

25.2. Witness evidence: The claimant will be expected to provide a written statement and give oral evidence at trial. On its own, this evidence may not be sufficient, and the claimant may also rely on the evidence of other witnesses to support his or her case. These may be people who saw the abuse, or heard about it at the time or some time

[217] The present test for vicarious liability requires the court to consider (1) the relationship between the individual perpetrator of the wrongdoing and the defendant institution and (2) the connection between their relationship and the wrongdoing by the individual (*Various Claimants v Catholic Child Welfare Society and Others* [2012] UKSC 56, [2013] 2 AC 1).
[218] Alistair Gillespie 29 November 2018 4/1-20
[219] Alistair Gillespie 29 November 2018 17/2-18/8; Billhar Singh Uppal said that "*we can judge liability in a much more concrete, certain way from the outset of the claim*" (Billhar Singh Uppal 28 November 2018 129/15-130/3).
[220] *Lister v Hesley Hall* [2001] UKHL 22, [2002] 1 AC 215
[221] *A v Hoare* [2008] UKHL 6, [2008] 1 AC 844 in relation to the application of the Limitation Act 1980, ss.2, 11
[222] Peter Garsden 6 December 2018 92/18-93/5
[223] Civil Evidence Act 1968, section 11(1)
[224] Civil Evidence Act 1968, section 11(2)

later. Defendants are not obliged to call any witnesses, but if they wish to do so they may rely on evidence from alleged perpetrators or other people who may support the defendant's defence or undermine the claimant's case, if such evidence is available.

25.3. Documents: As in all civil claims, documentary evidence is important. However, it is rare that documents confirm that sexual abuse took place at an institution. Billhar Singh Uppal said that, in "*the vast majority of cases, it isn't recorded, although, surprisingly, at times we have seen where it is*".[225] It is necessary to look at "*the whole span of records, so that one can peer through the window of the home 20/30 years after the event*".[226] However, searching and reviewing large volumes of documents is a time-consuming exercise for which the costs may not always be recoverable.

26. In cases of non-recent child sexual abuse, the evidence available to both claimants and defendants may be significantly limited. Witnesses may be dead, untraceable, or unable or unwilling to give evidence. Documents may have been lost or destroyed. In many cases, there may also have been no successful criminal prosecutions, and the only evidence of abuse is that of the claimants themselves. As the burden of proof is on the claimants, this can make it difficult or impossible for them to pursue their claims, even where their accounts are credible.

27. The Stanhope Castle claims exemplify these problems.

27.1. There were no criminal prosecutions in relation to the alleged sexual (or physical) abuse. Alistair Smith, who acted for several claimants, told us that successful prosecutions would have made a significant difference to the ability to pursue the sexual abuse claims.[227]

27.2. Almost all of the alleged perpetrators were dead or could not be found.[228]

27.3. No documentary evidence was found to support the allegations of sexual abuse.[229] This was one of the factors that Rod Luck, the Claims and Reinsurance Manager at Municipal Mutual Insurance (MMI), said led the defendant to reject the claims.[230] This position may be contrasted with an earlier tranche of non-recent claims for physical abuse, which MMI settled in part because of a 1979 government report about complaints of physical abuse made between 1974 and 1977.[231]

Challenges to the allegations of abuse

28. Institutional defendants are only able to deny that the abuse itself took place if they have factual evidence upon which to base such a denial, such as testimony from the alleged perpetrator. Alistair Gillespie said that a positive challenge is made by an institutional defendant in no more than 5 percent of the cases that he deals with. He acknowledged that challenging the allegations can re-traumatise claimants, but said that it is appropriate to do this when there is evidence to support it.[232]

[225] Billhar Singh Uppal 28 November 2018 118/5-14
[226] Billhar Singh Uppal 28 November 2018 118/14-20
[227] Alistair Smith 11 December 2018 23/20-24/13
[228] Alistair Smith 11 December 2018 21/7-11; INQ002704_001
[229] INQ002704_001
[230] Rod Luck 10 December 2018 112/16-113/11
[231] Rod Luck 10 December 2018 106/12-108/15, 109/2-25
[232] Alistair Gillespie 29 November 2018 18/9-19/9

29. Even if institutional defendants do not positively deny that the abuse took place, this does not mean that they will make a legal admission that it did. Instead, they may require claimants to prove that the abuse took place. For example, in the Bryn Alyn litigation, RSA (the defendant's insurer) required the claimants to prove the abuse suffered,[233] even where there had been a criminal conviction of John Allen for abuse against the claimant concerned.[234] Stephen Bellingham, Technical Claims Manager in RSA's UK Legacy unit, explained that, as RSA was disputing its liability to indemnify the defendant, it was not in a position to make any admissions in respect of the abuse and in any event such matters were outside of its direct knowledge.[235] However, claimants may find it difficult to understand such an approach, regardless of the legal basis for it. AR-A23, whose claim was based on abuse by Allen, said "*this surprised me, given the number of allegations made against John Allen and the fact he was a convicted child abuser by this time*".[236]

30. It can also be distressing for claimants if defendants question the credibility of their accounts. AR-A36 told us that he was abused by Colin Dick at St Aidan's and Keith Sutton at another institution. He gave evidence at the trial of Sutton, who was convicted. Dick was convicted of offences at St Aidan's against other children.[237] AR-A36 brought a claim after the initial group action in St Aidan's and St Vincent's. In a letter, the defendant stated that the 32-year period of delay had impacted the cogency and credibility of the evidence.[238] It also identified what they saw to be inconsistencies in AR-A36's description of the abuse and whether or not it was carried out by Sutton at the other institution or Dick at St Aidan's.[239]

31. Stephen Bellingham made clear that the letter did not call AR-A36 a liar.[240] He pointed out that there were "*fundamental*" inconsistencies which involved "*the time and the location and the identity of the assailant*". He said that the judicial system is required to:

> "*make positive evidential facts on all stages in order to attribute blame, liability and damages. So it would look to make positive assertions as to what happened, where, how and by whom, in order to establish whether the defendant is legally liable for those actions; then to look at the impact of those actions in relation to any injury that has occurred, and then to attribute damage. So it needs to make positive factual conclusions at each stage, and the judicial system, if it doesn't feel able to do that, will not do it.*"[241]

32. One of the difficulties for AR-A36 was that Sutton was convicted in relation to abuse at another institution and his claim, in part, was based on abuse perpetrated by Dick at St Aidan's. However, as far as AR-A36 was concerned, he simply did not understand how he could be believed in the trial of Sutton and "*called a liar*" in the civil system.[242]

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[233] ZUI003197_001-002, 039; see, for example, INQ002552_006-007, 017. In one of the claims RSA argued that the abuse had not occurred.
[234] ZUI003197_001-002, 035, 037
[235] RSA000110_013-014
[236] AR-A23 27 November 2018 34/12-24
[237] AR-A36 5 December 2018 122/24-124/14; RSA000021_001
[238] RSA000021_053
[239] RSA000021_055
[240] Stephen Bellingham 7 December 2018 57/16-58/15
[241] Stephen Bellingham 7 December 2018 60/5-21
[242] AR-A36 5 December 2018 135/18-136/19

Causation of injury

33. Claimants must satisfy the court that the abuse has injured them. In cases of child sexual abuse, this usually involves proving that the abuse occurred and that it has caused them to suffer a physical or recognisable psychiatric injury. This issue is known as causation.

The role of expert witnesses

34. Child sexual abuse claimants are typically assessed by two psychiatric experts, one instructed by their solicitors and one by the defendants' solicitors. The experts then produce reports setting out their views on the psychiatric effects of the abuse, the claimants' present psychiatric conditions, and their prognoses with or without some form of treatment (such as psychotherapy).

35. Tracey Storey warns her clients that one of the most difficult things that they will have to do during their claims is to undergo psychiatric assessment.[243] Individuals respond differently. She remembered claimants from St Leonard's who said that they found talking to a psychiatric expert a "*liberating experience that helped them make sense of what they'd been through*". However, one of her clients in another case "*went into crisis*" after seeing the psychiatrist.[244] She questioned whether the experiences of abuse can be encapsulated in one session with a psychiatrist and whether there could be a more sophisticated method for assessing the damage caused.[245]

36. Victims and survivors varied in their views about experts.

36.1. AR-A21, who was abused at Bryn Alyn, found it a "*great help*" to hear the expert instructed on his behalf say that he was significantly injured by the abuse.[246]

36.2. AR-A26, also abused at Bryn Alyn, said that the psychiatrist instructed on his behalf was "*sympathetic*" but the defendant's psychiatrist was "*not so nice*". The "*negative*" report left him "*upset, distressed*" and feeling "*suicidal*".[247]

36.3. AR-A6, who was abused at Forde Park, said that he was sent to a psychiatrist who he had never met before and had a rushed meeting for no more than an hour. This made it impossible for him to disclose details of his abuse.[248]

37. It is also a feature of the adversarial system of civil justice that the views of claimants' and defendants' experts will often be in opposition. Billhar Singh Uppal said "*more often than not, the other side's expert's opinion will be diametrically opposed. It will be all to do with something else, very little to do with the abuse*".[249] Carolyn Mackenzie, Complex Claims Director at RSA, agreed that "*more often than not, there seems to be a real polarisation of view between experts*".[250] To counter this, single joint experts could be used, subject to an agreed protocol.

[243] Tracey Storey 5 December 2018 48/7-21
[244] Tracey Storey 5 December 2018 64/21-65/7
[245] Tracey Storey 5 December 2018 64/15-19
[246] AR-A21 27 November 2018 9/20-10/12
[247] AR-A26 3 December 2018 137/19-25
[248] AR-A6 30 November 2018 101/3-7
[249] Billhar Singh Uppal 28 November 2018 126/11-21
[250] Carolyn Mackenzie 7 December 2018 93/14-24

38. In many cases the critical issue for the experts – and for the court – will be the extent to which any psychiatric disorders were caused, not by child sexual abuse, but by other adverse life experiences in childhood or adulthood. As Alistair Gillespie said:

> *"it can sadly be the case that an individual can have suffered abuse in more than one establishment and the expert, or experts, face a very difficult job indeed in trying to disentangle that and understand what proportion of responsibility from a causation perspective lies with one institution or perpetrator rather than another."*[251]

39. Even with expert assistance, causation may still be a difficult issue for the court to determine. In the Bryn Alyn litigation, the trial judge recognised that most of the claimants had "*been through a traumatic series of damaging experiences before being placed in the care of the defendants*" so were likely to have suffered difficulties in later life in any event.[252] He concluded that "*in no case have I felt that it would be doing justice to the defendants to condemn them for the whole of the psychiatric injury suffered to date by any claimant*".[253] In the same litigation, the Court of Appeal recognised the difficulties faced by judges in apportioning damage, but decided that they should adopt a principled and logical approach[254] and that a wrongdoer should only pay for the proportion of harm he has caused.[255]

40. However, several claimant solicitors made the point that the courts should also consider the fact that children went into care, even with prior adverse life experiences, expecting to be protected rather than harmed further.[256] As Billhar Singh Uppal said:

> *"psychological injury is not linear. So to say that the individual who had suffered, let's say, parental bereavement prior to arriving at Bryn Alyn, may, absent any other abuse, emerge into adulthood with issues of trust, perhaps a caution to love, perhaps inability to engage with their own children … Layer on top of that, then, abuse, serious abuse that they have not experienced before, not just simply a bit more of what they had at home, and it is like throwing two pebbles in a pond. The ripples are not going to be the same on every single occasion."*[257]

C.6: Limitation

41. The Limitation Act 1980 imposes time limits, known as limitation periods, within which claimants must bring their claims. The purpose of limitation periods is to strike a balance between the rights of claimants to bring claims and the interests of defendants in not having to defend historic cases when, for example, it may be difficult to establish what happened due to the passage of time. The imposition of limitation periods is also in the general public interest, as it allows individuals and institutions to arrange their affairs (including, for example, in taking out insurance or destroying documents), without the fear of facing litigation at some indeterminate time in the future.

[251] Alistair Gillespie 29 November 2018 19/24-20/17
[252] ZUI003197_001, 005
[253] ZUI003197_001, 005
[254] ZUI002361_001, 052
[255] ZUI002361_001, 051
[256] Tracey Storey and Malcolm Johnson 5 December 2018 13/19-14/21
[257] Billhar Singh Uppal 28 November 2018 123/15-124/17

42. For many years, the courts considered that sexual abuse was a deliberate act to which a fixed, six-year limitation period applied. Some but not all claimants were able to avoid the application of this period by arguing that their abuse was the result of systemic negligence, to which a three-year limitation period applied that was extendable.

43. This distinction between the limitation periods for deliberate assaults and negligence led to unfair outcomes. In AR-A23's claim against Bryn Alyn, for example, the judge accepted that she had been sexually assaulted by John Allen. However, he did not accept that any negligence had occurred and so rejected her claim on the basis that she was outside the non-extendable limitation period of six years.[258]

44. The Court of Appeal subsequently dismissed AR-A23's appeal,[259] although one of the appeal judges commended the proposal of the Law Commission in 2001[260] that all claims for personal injuries, whether negligence or assault, be subject to the same extendable limitation period of three years. The judge commented that "*statutory implementation of it would obviate much arid and highly wasteful litigation turning on a distinction of no apparent principle or other merit*."[261]

45. The Law Commission's proposal was never implemented by Parliament. However, the law did finally change in 2008, when the House of Lords decided in *A v Hoare* that the extendable three-year limitation period for personal injury claims should apply to all claims of sexual abuse.[262] This period runs from either the date when the injury occurred or the date of knowledge[263] of the individual claimant. However, in all cases involving children, the limitation period does not start to run until the claimant reaches adulthood at the age of 18. All claimants therefore have until at least the age of 21 to commence legal proceedings.[264]

46. Despite these developments in the law, the Inquiry heard that one of the most challenging legal issues for victims and survivors of non-recent child sexual abuse remains the limitation period. Very few victims and survivors of child sexual abuse bring their claims before the age of 21.[265] Consequently, if the defence of limitation is raised by the defendant,[266] they must ask the court to exercise its discretion under section 33 of the Limitation Act to allow their claims to proceed.

Section 33 factors

47. In deciding whether or not to exercise its discretion, the court must consider all of the circumstances of the individual case, and in particular:

- the length of, and reasons for, the delay in bringing a claim;
- the extent to which the evidence is less cogent than if the claim had been brought within time;

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[258] AR-A23 27 November 2018 36/15-25; ZUI003197_001, 030
[259] ZUI002361_001, 114
[260] Limitation of Actions (2001) (Law Com No 270)
[261] ZUI002361_001, 043
[262] *A v Hoare* [2008] UKHL 6, [2008] 1 AC 844 in relation to the application of the Limitation Act 1980, sections 2, 11
[263] A claimant's knowledge may comprise actual knowledge of various matters, including the fact that the injury was significant, which may not always be apparent to those who have suffered sexual abuse during their childhood. It may also comprise constructive knowledge that a claimant 'might reasonably have been expected to acquire' if he or she had tried to do so, in some cases with the help of medical or other appropriate expert advice (Limitation Act 1980, section 14).
[264] Limitation Act 1980, sections 28(1), (6), 38(2)
[265] Alistair Gillespie estimated that he dealt with around 1–2 percent (Alistair Gillespie 29 November 2018 59/25-60/7).
[266] Limitation is a procedural defence, meaning that claims are not automatically time-barred but instead defendants must actively raise the issue of limitation in response to receiving a claim.

- the conduct of the defendant after the claim was brought;
- the duration of any disability[267] of the claimant;
- the extent to which the claimant acted promptly and reasonably once they knew that there was a possibility of bringing a claim; and
- any steps taken by the claimant to obtain medical, legal or other expert advice, and the nature of any such advice.[268]

48. Defendant representatives emphasised the importance of being able to have a fair trial (which includes consideration of whether the evidence is less cogent due to any delay). Alistair Gillespie said limitation:

> *"is a question of whether the court can conduct a fair trial in relation to the issues in the claim … It's not simply a question of whether the abuse can be proved or not; it's actually a question of whether delay in bringing the claim has prejudiced the defendant's ability to investigate."*[269]

49. Philippa Handyside, General Counsel of the Association of British Insurers (ABI), thought that in the civil justice system there is *"a requirement of natural justice that parties should be able to defend themselves and that serious allegations ought to come up to a certain standard of evidential proof."*[270]

50. The issue of whether or not a fair trial will be possible years later is clearly important, as was recognised by the House of Lords in *A v Hoare*:

> *"Whether or not it will be possible for defendants to investigate these sufficiently for there to be a reasonable prospect of a fair trial will depend upon a number of factors, not least when the complaint was first made and with what effect. If a complaint has been made and recorded, and more obviously still if the accused has been convicted of the abuse complained of, that will be one thing; if, however, a complaint comes out of the blue with no apparent support for it (other perhaps than that the alleged abuser has been accused or even convicted of similar abuse in the past), that would be quite another thing. By no means everyone who brings a late claim for damages for sexual abuse, however genuine his complaint may in fact be, can reasonably expect the court to exercise the section 33 discretion in his favour. On the contrary, a fair trial (which must surely include a fair opportunity for the defendant to investigate the allegations – see section 33(3)(b)) is in many cases likely to be found quite simply impossible after a long delay."*[271]

51. However, the courts have made it clear that whether a fair trial can take place is not the only issue to be taken into account. They must also, for example, consider why the claimant has delayed in bringing a claim.[272] Many victims told us how hard it is for them to disclose details of their sexual abuse as children, and how it can take many years to be able to do so.[273] Witnesses spoke of feeling ashamed, guilty, distrustful and angry,[274] of trying to forget

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[267] For the purposes of the Act a person is treated as under a disability while he or she is a child or lacks capacity to conduct legal proceedings (Limitation Act 1980, section 38(2)).
[268] Limitation Act 1980, section 33
[269] Alistair Gillespie 29 November 2018 11/9-12/8
[270] Philippa Handyside 12 December 2018 59/7-60/4
[271] *A v Hoare* [2008] UKHL 6, [2008] 1 AC 844, para 86
[272] *RE v GE* [2015] EWCA Civ 287, paras 77–79
[273] AR-A23 27 November 2018 34/25-35/8; AR-A29 3 December 2018 143/11-13
[274] AR-A24 27 November 2018 54/3-4; AR-A23 27 November 2018 49/18-21; AR-A27 30 November 2018 84/17-22

or block out the memories[275] and of having previously been let down by adults in positions of authority when they tried to disclose abuse as children.[276] They found it difficult to accept that they were expected to bring claims earlier.[277]

52. These are all factors that the courts do take into account when considering a delay in bringing a claim. Tracey Storey told us that the courts are "*more generous on time with sexual abuse because of the fear, shame and humiliation involved in sexual abuse*".[278] However, whilst there was an "*increasing understanding of the dynamics of sexual abuse*", she did not think "*our court system is particularly set up to understand the dynamics*".[279]

53. A number of claimant representatives felt that the law of limitation was unfair to victims and survivors of child sexual abuse, and that it should be changed.

53.1. Paul Durkin said "*I'm not convinced the judiciary is, at the moment, capable of dealing with these cases properly … I'm not sure that section 33 is the correct instrument to deal with these claims in a compassionate way*". He also said that without "*legislative change … we're relying upon the commercial necessities of an insurance company … I don't think we can trust the insurance industry to do the right thing*".[280]

53.2. Peter Garsden said "*to punish a victim of abuse for delaying, when psychologically, they're unable to deal with the thing, because they're so traumatised by it, is like punishing a victim twice*".[281] He told us:

> "*I have come to the conclusion that we should replace it and do something with it, but we have to be very careful what we replace it with to make sure that we don't open the door to more technical defences.*"[282]

53.3. Henry Witcomb QC, one of the counsel who represented the claimants in the Forde Park litigation, said that there should be a suspension of limitation:

> "*so that people can just bring their claims, and if they're good claims, they are good claims, and if they're bad claims, they're bad claims, and they should be then tried, and we can then attempt to have some closure on what has been a disgraceful period in our history*".[283]

54. However, this view was not shared by all claimant representatives. Billhar Singh Uppal said:

> "*I don't think there is anything about child sexual abuse cases that in itself should prompt us into having a different period. I'm sure there would be lots of other groups out there who would say, 'Well, we should be just as deserving'.*"[284]

[275] AR-A27 30 November 2018 84/10; AR-A3 30 November 2018 115/14-16
[276] AR-A21 27 November 2018 29/8-30/2; AR-A1 27 November 2018 73/8-74/14; AR-A25 7 December 2018 126/24-127/20; AR-A34 7 December 99/20-101/12
[277] AR-A20 3 December 2018 134/7-10; Peter Smith 10 December 2018 40/8-10; AR-A41 30 November 2018 36/16-37/11
[278] Tracey Storey 5 December 2018 38/3-23
[279] Tracey Storey 5 December 2018 43/3-13
[280] Paul Durkin 6 December 81/12-82/16, 119/19-120/16
[281] Peter Garsden 6 December 2018 80/8-12
[282] Peter Garsden 6 December 2018 120/17-121/3
[283] Henry Witcomb 15 January 2019 46/12-47/5
[284] Billhar Singh Uppal 28 November 2018 115/14-20

He was also unsure that "*by tinkering or disposing of the limitation periods, as has been advocated, it's going to solve the problem*". He told us that "*we are all lawyers, there are going to be ways around it*".[285]

55. Carolyn Mackenzie told the Inquiry that the "*biggest area of divergence*" between claimant and defendant representatives is over the question of whether there should be "*a complete removal of limitation as a defence*". She explained that defendants still see limitation as an "*equitable defence*",[286] which is borne out by the evidence we heard on the extent to which it is raised by defendants (discussed further below).

C.7: The initial stages of a claim

Legal representation and funding

56. Victims and survivors who wish to make a civil claim will usually need to instruct solicitors to prepare and manage the litigation. When deciding whether to take on a case, solicitors will consider the merits of the claim, including the quality and nature of the available evidence and, if the claim is non-recent, the strengths and weaknesses of any limitation arguments. There may also be practical issues, such as the means of the defendant and whether it has insurance cover to pay compensation and legal costs if the claim is successful (see below).

57. There may be funding issues for claimants, many of whom do not have the means to pay their own costs or those of the defendants if their cases are lost. Without some form of litigation funding, they are unlikely to be able to pursue their claims. Some claims are funded by legal expenses insurance, if available, or by public funding from the Legal Aid Agency. However, Billhar Singh Uppal told us that the means test for public funding is now "*very, very restrictive*"; he said one of his Bryn Alyn clients who qualified for legal aid in 1994 would not do so now.[287] Peter Garsden made a similar point in the context of the North West child abuse litigation.[288]

58. Most claims now proceed under a conditional fee agreement (CFA) backed by an insurance policy. In those cases, the claimants' lawyers will only be paid if the claims succeed. If the claims fail, the defendants' costs will be paid by the insurers. If insurance cannot be obtained, claimants must fund the claims themselves if they want to proceed, including paying for the lawyers' time and disbursements such as medical reports.[289]

59. Solicitors will also consider the potential value of a claim compared to the likely legal costs, which may be substantial in complex cases. If the costs of pursuing a low-value claim are high, some or all of those costs may not be recoverable at the end of the litigation, even if the case succeeds. There are a limited number of insurance companies that offer policies protecting claimants against losing their claims. Those insurers will only offer policies to those claimants whose cases are likely to succeed and, even then, the premiums may be unaffordable. As a result, some victims and survivors find that solicitors are unable or unwilling to pursue their claims.

[285] Billhar Singh Uppal 28 November 2018 115/25-116/11
[286] Carolyn Mackenzie 7 December 2018 94/17-95/10
[287] Billhar Singh Uppal 28 November 2018 161/3-13
[288] Peter Garsden 6 December 2018 53/1-54/12
[289] Alistair Smith 11 December 2018 9/4-10/10, 12/4-14/3, 25/12-26/15

The defendant's means and insurance

60. A claimant's solicitors will consider whether the defendant has the means to pay any damages and costs arising from a claim. If the defendant is a large, solvent institution, such as a local authority, this will not be an issue. But if the organisation is small, insolvent or no longer exists, the solicitors will want to confirm that there is (or was) insurance in place.

61. Public, private and charitable institutions usually have public liability insurance to meet any legal liabilities for injuries and losses suffered by members of the public. This may include liability for claims of child sexual abuse, although historically such insurance policies may not have included specific provisions for such claims. Even where there is an insurance policy in place, it may contain clauses excluding liability for deliberate acts of abuse by the person who took out the insurance policy, as was the case in Bryn Alyn.

62. Public liability insurance policies will ordinarily stipulate a minimum amount, known as the deductible, that the policyholder must contribute to a claim before the insurer adds its contribution. They will also set the insurance limit, ie the maximum amount that the insurer will pay towards any covered claim.

63. Some potential defendants are uninsured and so are responsible for the financial risks of any litigation. Where uninsured defendants may not have the resources to pay compensation or legal costs, it may be pointless or difficult to bring claims against them.

64. Difficulties can arise in the identification of the correct insurer for the relevant periods, especially in historic litigation. This can be seen in the protracted North Wales litigation concerning Bryn Alyn.

> **64.1.** Although, originally, RSA was prepared to indemnify Bryn Alyn Community (Holdings) Limited from 1 July 1973,[290] it was confirmed several years later that RSA was not liable for the period prior to 22 August 1976.[291] This was a result of new evidence found in searches conducted by RSA. These searches were not undertaken until 2004, which Alistair Gillespie acknowledged was a mistake.[292]
>
> **64.2.** Similarly, there was then a delay before the claimants' solicitors themselves conducted further searches and, in October 2008, discovered a letter from 1973 which showed that Eagle Star was the relevant insurer.[293] The court agreed that this delay was caused by the failures of the claimants' solicitors.[294]

65. This might have been avoided if a public liability register had been in place, recording the defendant's insurers throughout the relevant periods. As regards the benefit of such a register, David Nichols, UK Chief Claims Officer at Zurich, said:

> *"I think you can see examples of where you can speed up an understanding of the coverage that exists, and over multiple years, which is of course something that we need to be mindful of, and indeed understanding where the cover may have been held, it does fast track some scenarios."*[295]

[290] RSA000051_077
[291] Billhar Singh Uppal 28 November 2018 150/5-12; RSA000070_025, 034
[292] Alistair Gillespie 29 November 2018 45/16-46/11
[293] ZUI003205_001, 003; Billhar Singh Uppal 28 November 2018 150/20-152/24
[294] ZUI003205_001, 016-018
[295] David Nichols 29 November 2018 122/6-16

The pre-action protocol

66. If a prospective claimant is able to secure legal representation, their solicitor will take preliminary steps to investigate the claim, including obtaining documents such as medical records. While this is taking place, or once it has concluded, the solicitor will write a letter of claim to the defendant. This will summarise the nature of the claim, including the allegations of sexual abuse and any consequential damage and losses.

67. Letters of claim are one of the steps required by the Pre-action Protocol for Personal Injury Claims, which applies to child sexual abuse claims. The protocol's objectives are to encourage the exchange of early and full information, early investigation, settlement before proceedings and the efficient management of any proceedings. It requires a claimant to include sufficient information in the letter of claim for the defendant to assess the merits of the case and its potential value. The defendant is then required to produce a letter of response that admits or denies the claim, with reasons if necessary. Disclosure is also encouraged in order to help clarify or resolve issues in dispute.[296]

68. There is currently no pre-action protocol specifically for child sexual abuse claims. However, with the assistance of Master McCloud (a judge), a group of representatives for both claimants and defendants have each prepared a draft of a pre-action protocol for non-recent abuse claims. These drafts have now been supplied to the Civil Procedure Rule Committee (which makes the rules) for review.[297]

69. Defendant representatives told us that they hoped a new protocol would improve the procedures governing letters of claim from claimants (which may be too vague) and the early disclosure of records by both sides.[298] However, aside from documents such as the claimant's employment and medical records, we were told that it is often the defendant that is in possession of the documents relating to the claimant's time at an institution.[299]

C.8: The approaches of defendants and insurers to claims

Claims handling

70. Institutional defendants to child sexual abuse claims include local authorities, charities, religious organisations and private companies. Uninsured defendants will be responsible for meeting the costs of the litigation themselves and are therefore likely to manage the cases themselves. Where a defendant is insured, the responsibility for taking decisions during the litigation may depend on several factors, including: the attitudes and policies of the defendant's management towards child sexual abuse claims; the defendant's relationship with its insurer; the defendant's means and financial obligations; the number and value of the claims; the size of the insurance policy deductibles; and the limits of the insurance cover.

71. It is clear that non-recent child sexual abuse claims often raise difficult issues, such as proving abuse, limitation and causation. Much like the decision to initiate a claim, the decision to defend one will depend in part on the strength of the available evidence. However, the resolution of a claim may also depend on a defendant's or insurer's approach to it, which may be informed by wider considerations than the legal defences available, such as

[296] Pre-Action Protocol for Personal Injury Claims, para 7.1.1
[297] Alistair Gillespie 29 November 2018 50/16-51/18
[298] Rod Luck 3 December 2018 88/25-89/22; Sarah Erwin-Jones 5 December 2018 91/9-14; Carolyn Mackenzie 7 December 2018 91/9-20; Philippa Handyside 12 December 2018 51/21-52/21
[299] Sarah Erwin-Jones 5 December 2018 91/15-22; Billhar Singh Uppal 28 November 2018 120/5-9

a defendant's ongoing safeguarding responsibilities. This may mean that some claimants face fewer hurdles in achieving accountability and reparations than others, depending on which defendant they are claiming against.

72. Different approaches appear to have been taken in the case studies by the defendants and their insurers, as the following examples show.

72.1. The "*key decisions*" taken in respect of the St Aidan's and St Vincent's claims "*were made by Nugent's insurers with the benefit of legal advice*".[300] The claims in the other tranches of the North West child abuse litigation settled much earlier. Lawyers representing the claimants across the whole group told us that they did not see any difference between the strength of the cases that settled and those that did not. They thought that the difference lay in the attitude of the defendants.[301]

72.2. Paul Durkin said that the alternative "*would have been to take a compassionate approach – the defendants don't have to do that, but to take a compassionate approach, see the modest financial value of the claims, settle them, save the harm and suffering to the claimants, and save a lot of legal costs*".[302]

72.3. Stephen Bellingham explained that a decision was taken relatively early on that there were "*material and strong grounds on which to defence the allegation of negligence on the part of Nugent Care, and the tactics I think reflected that*".[303] He made the point, however, that it was open to Nugent Care to choose not to invoke their insurance policy and to settle the claims, or to liaise with their insurer to discuss options for the settlement of the claims.[304]

72.4. In contrast to the St Aidan's and St Vincent's claims, the response of the London Borough of Tower Hamlets (insured by MMI) to the claims of abuse at St Leonard's was seen as instrumental in reaching settlement of that litigation. Malcolm Johnson, solicitor for the claimants, considered that the admission of liability in the defence was made because "*London Borough of Tower Hamlets realised that something had gone horribly wrong on their watch and that they needed to make amends*".[305] Sarah Erwin-Jones, the solicitor instructed by MMI, agreed that Tower Hamlets' approach was "*a very significant feature*", and referred to an officer in the Council, John Thesiger, playing a significant role in instructing the defendant solicitors and enabling them to reach the strategic decisions that they did.[306]

73. When asked about the approaches that different insurers might take, Alistair Gillespie told the Inquiry that:

> "*I think these matters are so fact-specific that it is difficult to generalise any further, and particular insurers may have different approaches, depending upon the type of organisation that they insured at the time. What might be an appropriate approach for a local authority, for example, faced with a multitude of claims might be very*

[300] Normandie Wragg 6 December 2018 38/12-38/17
[301] Peter Garsden and Paul Durkin 6 December 2018 66/15-68/24
[302] Paul Durkin 6 December 2018 110/8-16
[303] Stephen Bellingham 7 December 2018 22/1-23/6
[304] Stephen Bellingham 7 December 2018 16/15-18/10; see also Carolyn Mackenzie 7 December 2018 97/6-99/5
[305] Malcolm Johnson 5 December 2018 33/1-13
[306] Sarah Erwin-Jones 5 December 2018 72/4-19

different to an approach faced by an insurer in respect of an isolated claim against an isolated organisation, and RSA's portfolio does not include … very many local authority risks at all."[307]

74. Some insurance companies have developed guidance over the years to assist their claims handlers in dealing with child sexual abuse claims.

74.1. Zurich insure about 40 percent of the UK's local authorities.[308] David Nichols said their practices were informed by the need to make their products appeal to local authorities.[309] The Inquiry was told that, while Zurich's guidance and training for claims handlers used to focus on the legal position, it is now more focused on understanding the circumstances of individual claimants.[310] The guidance makes clear that a limitation defence should not automatically be applied to claims, and permits apologies where appropriate (both of which are discussed further below).[311]

74.2. RSA does not have any specific child sexual abuse guidance. Stephen Bellingham had seen Zurich's external guidelines and said "*the statements they make are similar in their construct to what we undertake in practice, but we don't have external published guidelines ourselves at this point*".[312] Carolyn Mackenzie said that child sexual abuse claims are governed by RSA's policies and "*technical best practice*", which applies to all claims. However, having heard the evidence given at the Inquiry, she accepted that there would be "*value in putting some written guidance and best practice together internally*".[313]

75. Both RSA and Zurich told the Inquiry that if a policyholder wanted to settle claims they would listen to their proposal. Carolyn Mackenzie said that the engagement of policyholders varies but that it is open for defendants to ask to be involved and that there can be dialogue between them as to how to proceed with claims.[314] Stephen Bellingham said it was difficult to say what would have happened if Nugent Care had said they wanted to settle the claims but gave a recent example of a school which reached an agreement with RSA that they settle some child sexual abuse claims "*as they saw fit and then return at a later date to discuss what contribution the insurer might make*".[315]

76. David Nichols said that child sexual abuse claims represent only a small part of a local authority's exposure and therefore would not be "*likely to trigger huge changes in their premium base*". He said that if a local authority wished to settle a large group of claims, then Zurich would listen to their proposal and work through the cases.[316] He did not consider that there was a conflict between local authorities' safeguarding obligations towards children and any obligations they may have to defend claims of child sexual abuse.[317]

[307] Alistair Gillespie 29 November 2018 53/21-54/16
[308] David Nichols 29 November 2018 151/5-8
[309] David Nichols 29 November 2018 125/11-126/17, 133/11-134/3
[310] David Nichols 29 November 2018 131/13-133/7
[311] ZUI003202_001, 008, 024, 030, 031; David Nichols 29 November 2018 134/4-140/22. As the claims handler for Municipal Mutual Insurance (MMI), Zurich's guidance documents usually apply to MMI's claims handling as well (Rod Luck 3 December 2018 48/16-49/10).
[312] Stephen Bellingham 7 December 2018 51/18-23
[313] Carolyn Mackenzie 7 December 2018 71/5-18
[314] Carolyn Mackenzie 7 December 2018 81/15-85/6
[315] Stephen Bellingham 7 December 2018 17/6-18/10
[316] David Nichols 29 November 2018 151/16-153/7
[317] David Nichols 29 November 2018 149/14-150/16

77. None of the four local authorities we heard from – Flintshire County Council, Tower Hamlets, Devon County Council and Middlesbrough Council – have written policies or guidance in place for handling claims of child sexual abuse.[318]

78. Richard Baldwin, Divisional Director of Children's Social Care for Tower Hamlets, said "*my position would be that safeguarding trumps any other consideration and what is right for the young person has to be our primary focus*".[319] He said that he would be involved with legal colleagues in the discussions about how to respond to claims and that he would expect his views to be taken into account.[320] He had not "*come across or worked in a local authority where … financial constraints have trumped the needs of safeguarding*".[321] When asked whether this approach should be adopted as a matter of policy, he said:

> "*I think, if you are saying to me that there feels as though there's inconsistency between local authorities, then certainly some kind of policy that sets a minimum standard for that would sound as though it would be a sensible way forward, yes.*"[322]

The use of the limitation defence

79. One of the most contentious issues we heard about was defendants' use of the limitation defence (see above for a discussion of the law), which must be actively raised if they wish to rely upon it. Claimant solicitors told us that defendants will routinely do so.

79.1. Billhar Singh Uppal said "*I have never come across a claim that has been notified to a defendant where limitation has not featured as a defence.*"[323]

79.2. Alistair Smith said it is "*always advanced*" which "*makes life very difficult, because you have to get over, quite often, an initial hurdle before you can get to the next stage*". He also explained that it is "*appallingly difficult*" for claimants to understand this.[324]

79.3. Peter Garsden said it "*is still used as often as possible to defeat cases*".[325]

79.4. Paul Durkin said that limitation is raised in "*each and every case I have*".[326]

79.5. Tracey Storey said that, in otherwise strong cases, insurers are more likely to concede limitation. They were more likely to raise it where there are other unresolved issues in the case.[327] However, she also said:

> "*I think it is really unfair when the corporate parent loses documents or people and relies on that for a limitation defence. That is very difficult to explain to a layperson, that that's going to scupper the ability to get civil justice.*"[328]

80. Several of the defendant representatives who gave evidence told us that limitation does continue to be raised routinely in defences to non-recent cases.

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[318] Gareth Owens 28 November 2018 103/2-5; Richard Baldwin 4 December 2018 101/20-102/15; LBT000259_008; Emily Wilkins 3 December 2018 38/21-39/10; MDC000015_006
[319] Richard Baldwin 4 December 2018 97/6-23
[320] Richard Baldwin 4 December 2018 97/24-99/2
[321] Richard Baldwin 4 December 2018 101/7-19
[322] Richard Baldwin 4 December 2018 101/20-102/15
[323] Billhar Singh Uppal 28 November 2018 132/24-133/13
[324] Alistair Smith 11 December 2018 22/22-23/8
[325] Peter Garsden 6 December 2018 120/1-6
[326] Paul Durkin 6 December 2018 120/1-7
[327] Tracey Storey 5 December 2018 38/3-39/4
[328] Tracey Storey 5 December 2018 41/23-42/2

80.1. Alistair Gillespie said that it was for defendant organisations and their insurers to decide, as a matter of policy, if they want to rely on a legally valid defence.[329] However, he acknowledged that limitation "*will invariably be raised as a potential defence, yes, because, as a matter of fact, the claim is out of time*".[330] He did, however, state that he regularly agrees what is known as a moratorium on limitation, which is where limitation is suspended.[331]

80.2. Stephen Bellingham said that "*it is good practice to simply put on the record that the claim is outside of the primary limitation period and, depending upon the results of our investigations, it may well be that there is material prejudice*".[332]

80.3. Carolyn Mackenzie agreed that it was right to raise limitation at the outset as at "*that point, you don't know whether it is a material issue*".[333]

81. However, this is not the universal approach across insurers.

81.1. During the hearings, David Nichols told us that Zurich recognises that victims and survivors of child sexual abuse may not make claims until years after the events. Zurich may have formerly "*hit limitation as a … primary defence*", but its claims handling internal guidance now advises that claims handlers should "*at least try and understand the facts and the knowledge before you get there*"[334] and claims handlers seek "*only to apply limitation in appropriate claims*".[335]

81.2. Since the hearings, Zurich has made further changes to its approach to limitation in recognition of the evidence given by victims and survivors to the Inquiry. It told us:

> "*the position that Zurich is looking to put forward is that, where Zurich has handling authority in relation to a claim, limitation should only be raised as a defence where, following reasonable enquiries, it is considered that a fair trial would not be possible. In circumstances where Zurich does not have full handling authority, such as where an insured customer has a significant deductible or another insurer bears the larger proportion of the claim, Zurich will seek their agreement to Zurich's approach, which it believes is both a responsible one and one that recognises the particular limitation issues in child sexual abuse claims.*"[336]

81.3. The Inquiry also heard that Ecclesiastical Insurance has 'Guiding Principles' which state that limitation should be pleaded as a defence sparingly in relation to physical and sexual abuse claims, and should be considered and approved only at a senior level.[337]

[329] Alistair Gillespie 29 November 2018 53/21-55/24
[330] Alistair Gillespie 29 November 2018 15/2-8
[331] Alistair Gillespie 29 November 2018 16/16-21
[332] Stephen Bellingham 7 December 2018 52/18-53/7
[333] Carolyn Mackenzie 7 December 2018 75/23-77/6
[334] David Nichols 29 November 2018 134/22-135/21
[335] ZUI003202_001, 024
[336] ZUI003275_006
[337] ABI000003_027

82. We were also told that, although defendants may raise the issue of limitation in the early stages of a claim, this does not necessarily mean that they will continue to use it at the trial. Carolyn Mackenzie said that RSA will seek to remove the issue of limitation, where possible:

> *"if we can remove it actively, we can. I think much more likely, in reality, it becomes not much of a discussion point. If you move quickly to resolution of your claim, it's really not talked about a great deal after that. You just are into the stage of negotiating a settlement."*[338]

It is unclear whether, in reality, defendants do actively tell claimants that they are no longer relying on a limitation defence. If their cases proceed, as Alistair Gillespie accepted, limitation may weaken the claimants' position in any settlement negotiations.[339]

83. We also heard evidence that, in some cases, defendants will seek to have the courts adjudicate on a limitation defence as a preliminary issue before the main trial.[340] Peter Garsden and Paul Durkin told us that it is easier for defendants to try and strike out claims on limitation, because it prevents them from having to bring the abusers to give evidence and directly accuse claimants of being liars.[341] Stephen Bellingham did not accept this as a general premise.[342] Alistair Gillespie told us that there were a number of cases, following the decision in *A v Hoare*,[343] where applications for limitation to be tried as a preliminary issue were refused by the court. He said:

> *"the mood music we have from the courts at the moment is that they don't readily entertain applications for limitation to be heard as a preliminary issue".*[344]

A recent example: Stanhope Castle

84. The second tranche of Stanhope Castle litigation exemplifies the difficulties that claimants face in bringing child sexual abuse claims decades after the events.

84.1. Around 2014, Alistair Smith sent letters of claim to Middlesbrough Council. In response, the Council wrote back raising limitation as a defence and stating that it would be prejudiced under section 33 of the Limitation Act in relation to a number of evidential issues. It notified the claimants that it would seek to try limitation as a preliminary issue.[345]

84.2. Alistair Smith was advised by specialist counsel that the claims were unlikely to succeed, due to the evidential and limitation difficulties. As a result, he felt unable to proceed with the claims. His firm could not afford to fund the litigation and he could not obtain litigation insurance for the claimants, as their cases were too risky.[346]

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[338] Carolyn Mackenzie 7 December 2018 76/18-77/6
[339] Alistair Gillespie 29 November 2018 15/2-17
[340] Peter Garsden 6 December 2018 88/8-89/4
[341] Peter Garsden and Paul Durkin 6 December 2018 85/10-20, 86/1-16, 87/24-88/7
[342] Stephen Bellingham 7 December 2018 32/25-34/6
[343] *A v Hoare* [2008] UKHL 6, [2008] 1 AC 844
[344] Alistair Gillespie 29 November 2018 57/8-22
[345] MDC000015_007-013; see, for example, MDC000007_012, 014, 031, 032, 061; Alistair Smith 11 December 2018 29/8-35/12; MMI000032_005, 015, 016; James Bromiley 10 December 2018 93/2-95/13
[346] Alistair Smith 11 December 2018 20/7-21/11, 24/25-26/15, 36/13-37/8, 42/25-43/10, 51/6-12; INQ002704_001

> **84.3.** Alistair Smith therefore made an attempt to settle some of the cases by offering to accept modest sums of damages from the Council. However, these offers were not accepted by the Council and he was forced to write to his clients explaining that there was nothing more he could do for them.[347]

It is difficult to know whether any of the Stanhope Castle claims would ultimately have succeeded if Alistair Smith had been able to proceed further with them. The absence of any criminal convictions and the lack of supportive documentary evidence created real difficulties for the claimants.

85. Rod Luck of MMI (which provided insurance for Middlesbrough Council) said that "*there was clearly a very strong limitation defence to these cases*". However, he thought that the "*claims did not really come through very strongly following our initial repudiation*" and the claimants went away before he expected. He said that the defendant did not receive a full response to the issues it had raised and that the claimants' low offers of settlement indicated that their solicitors did not think the claims were viable and were simply trying to get some sort of payment.[348]

86. Alistair Smith accepted that the claimants' offers indicated this. However, he explained that the only alternative was to do nothing. He also thought it was "*easy*" for Rod Luck to say what he said about the offers at this point. He said that there had been nothing stopping MMI from making a goodwill payment and the defence to these claims had been "*extremely robust*".[349] Rod Luck acknowledged that, based on the evidence that the Inquiry had heard about child sexual abuse at Stanhope Castle, "*there may be seen to be an unfairness in the system here*" but, if that was the case, it was "*a system issue*".[350]

87. James Bromiley, Strategic Director of Finance, Governance and Support Services at Middlesbrough Council, said that it was appropriate for the Council to rely on limitation as a defence, referring to the "*need to have a legitimate justification … to settle any claims*".[351] We accept that, when faced with a group of claims by victims and survivors of Stanhope Castle, the Council was obliged to consider the financial implications of the litigation. However, insufficient consideration was given to the role of the Council as a corporate parent with past and present child safeguarding responsibilities. It was always open to the Council to settle the claims rather than defend them on the grounds of limitation. Not doing so is even more difficult to understand given that, on the evidence available to us, the Council had the means to pay.[352] The attitude of Middlesbrough Council, as presented by James Bromiley, compares poorly with that of Tower Hamlets, as presented by Richard Baldwin.

[347] MDC000015_007-013; see, for example, MMI000032_003; James Bromiley 10 December 2018 95/14-96/10; Alistair Smith 11 December 2018 42/25-43/24
[348] Rod Luck 10 December 2018 113/12-117/19
[349] Alistair Smith 11 December 2018 38/18-41/25
[350] Rod Luck 10 December 2018 117/20-119/9
[351] James Bromiley 10 December 2018 87/5-98/1
[352] James Bromiley 10 December 2018 99/21-100/1

C.9: Resolving the claim

Case management

88. If the parties are not able to settle the claim pre-action, a claimant may decide to start proceedings by issuing a claim form at court. Once claims have been issued the court has extensive powers to manage cases under the CPR.[353] Judges routinely use these powers to direct the parties to exchange witness and expert evidence, to order the disclosure of documents, to determine which issues may be considered in the litigation, to hold hearings of any preliminary issues (see above on limitation) and to set the timetable for trial.

89. Defendants may try and defeat the claim before it reaches full trial. One way in which they can do this is to strike out the claim, for example if there are no reasonable grounds for bringing the claim or if there was a failure to follow a rule, practice direction or order.[354] One example of this was the unsuccessful application made by Nugent Care to strike out the St Aidan's and St Vincent's claims on the basis that the claimants had breached the rules by issuing claims using letters in place of their own names.

90. Peter Garsden said that this was a "*technical point*" which wasted "*two years of the litigation*" and was "*typical of litigation at the time*".[355] Stephen Bellingham agreed that such an application would now be considered to be "*aggressive*". He told us that it would not now be appropriate to strike out an entire claim on such a basis, and that modern procedure would make such an application unnecessary.[356] Peter Garsden accepted that it would not be raised now but said if he was being "*truly cynical, I would say that if it was allowed, then those points would still be taken*". He also acknowledged that this was an "*adversarial process and I can't blame defendants for taking whatever points they can*".[357]

The trial process

91. Where the facts of a claimant's sexual abuse, or its effects, are in dispute, the claimant will ordinarily be called to give evidence at trial. The claimant's own version of the facts will be set out in a written statement. With the judge's permission, this may be supplemented by oral evidence in response to questions from the claimant's own barrister, known as examination-in-chief. The claimant will then be questioned by the barrister for the defendant (or in some cases the defendant perpetrator himself). During this process, known as cross-examination, the claimant will usually be challenged on all of those parts of the evidence that the defendant does not accept.

92. The civil courts, unlike the criminal courts, do not have special rules governing the questioning of vulnerable witnesses such as victims of child sexual abuse. Claimants are treated like any other personal injury claimant. They may therefore be questioned robustly and in detail about their experiences before, during and after their abuse, with the intention of undermining some or all of their accounts.

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[353] CPR Part 3
[354] CPR Part 3.4
[355] Peter Garsden 6 December 2018 75/21-76/21. Mr Garsden's chronology of legal events shows that the period between the application to strike out and the dismissal of the issue by the Court of Appeal was in fact around one year between June 1997 and June 1998 (INQ003530).
[356] Stephen Bellingham 7 December 2018 26/3-29/1
[357] Peter Garsden 6 December 2018 77/12-23

93. Although a number of victims and survivors told us of their wish to give evidence at trial, the actual experience of doing so is invariably very difficult for them. As Paul Durkin said:

> *"Some clients say they want their day in court, but I know that they don't want their day in court because it's such a rigorous forensic process. It's probably the last thing that they want to face, in reality."*[358]

94. AR-A87 was abused at St Aidan's. In 1998 he brought a claim against Nugent Care Society and later became one of the lead claimants in the North West Children's Homes litigation. He told us that he prayed for his day in court when he could tell the judge what had happened to him.[359] That day, he said, was:

> *"important because I needed to be believed. That was the most important thing, to actually have my day in court. I wanted to face my abusers and to be believed by the court that what happened to me did happen … I was looking forward to looking at my abusers and saying to them, 'I'm not a child no more'".*[360]

95. The trial judge ultimately rejected AR-A87's claim on the grounds of limitation. But AR-A87 said that he still felt happy because "*the judge himself turned around and said in court that he believed every word I said … it was a small win on my behalf because the judge himself believed me*".[361] The judge recognised this in his judgment, commenting on "*the satisfaction of being heard and believed*".[362]

96. Following a successful appeal,[363] AR-A87's claim was reheard before a different judge. Again, the judge accepted that he was sexually abused but, for different reasons, also rejected his claim on the grounds of limitation.[364] This time, the Court of Appeal upheld the judge's decision on limitation.[365]

97. AR-A87 told us that the pressure of repeated court hearings about his abuse made him ill. He said that he did not realise it at the time, but he was suffering with mental health problems, and that the pressure tore his family apart and nearly ended his marriage.[366] However, although his claim failed, AR-A87 still believed that:

> *"It was a valuable experience because I came out of those two courts and I was literally ecstatic because both the judges believed my story and, at the end of the day, that's all I wanted: I wanted to be able to stand there, give my evidence and for somebody to turn around and say, 'I believe you … '. That to me was everything."*[367]

[358] Paul Durkin 6 December 2018 59/25-60/4
[359] AR-A87 5 December 2018 101/19-102/5, 108/21-109/2
[360] AR-A87 5 December 2018 109/3-19
[361] AR-A87 5 December 2018 110/9-111/13
[362] INQ003624_001, 021
[363] INQ003632_001, 003
[364] INQ003356_001, 035
[365] INQ003633_001, 016, 018
[366] AR-A87 5 December 2018 112/24-113/21
[367] AR-A87 5 December 2018 114/19-115/4

98. AR-A23, who was a lead claimant in the Bryn Alyn group action, also lost her case despite the trial judge accepting that she had been abused. But she too said that the recognition of the abuse was more important:

> "*The judge had found that I was abused by John Allen. This was a great relief for me. Finally, I had been believed. It was recognition that I had been abused and also vindication for being disbelieved for so many years and no-one listening.*"[368]

99. However, the experience of AR-A23 and other claimants in the Bryn Alyn litigation also exemplifies how difficult it can be for victims and surviviors of child sexual abuse to give evidence in the civil courts.

100. The Bryn Alyn claims proceeded to trial in early 2001. The defendant's insurer, RSA, did not advance a positive case in relation to the fact of the abuse (except in one case) but conceded very few issues and still required each claimant to prove every element of their claim.[369] This made AR-A23 feel like she was "*being abused all over again*" as she had to "*relive everything, in intimate detail*".[370]

101. The claimants were cross-examined about the issue of causation, namely factors other than their abuse that may have caused their psychiatric injuries.[371] Claimants were also questioned about their credibility,[372] their disclosure of the abuse,[373] their date of knowledge (for the purposes of limitation)[374] and the management of the school.[375]

102. While AR-A21 now feels that the experience was therapeutic, at the time the prospect of giving evidence was "*daunting*".[376] The psychiatrist in the case noted that AR-A21 got more agitated as the trial approached and AR-A21 himself explained that this was because giving evidence required him to re-open painful memories:

> "*You're sort of reliving that thing over and over again, and each time it became more painful to do so.*"[377]

103. Those claimants who gave evidence explained how it felt to have to speak about their experiences. AR-A23 and AR-A29 both said it was "*horrible*".[378] AR-A21 said that it was "*embarrassing, and it was like reliving again everything that had gone on*".[379]

104. Some felt the thrust of the questions was that they were lying about the abuse. Even though the question of whether the abuse occurred was not actually disputed, the process of giving evidence exposed and re-ignited a fear of not being believed.[380]

105. Lord Faulks QC, the barrister representing RSA, sought to explain the parameters within which an advocate can challenge whether or not the abuse took place. He stated that, if a defendant witness denies the abuse took place, it should be put to the claimant. Where

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[368] AR-A23 27 November 2018 36/15-25
[369] ZUI003197_001-002, 039
[370] AR-A23 27 November 2018 35/9-22
[371] Lord Faulks 29 November 2018 78/14-85/5
[372] Lord Faulks 29 November 2018 101/23-102/18
[373] Lord Faulks 29 November 2018 100/3-25
[374] Alistair Gillespie 29 November 2018 36/8-37/6
[375] Lord Faulks 29 November 2018 81/17-82/8, 100/10-25
[376] AR-A21 27 November 2018 12/3-20
[377] AR-A21 27 November 2018 11/5-15
[378] AR-A23 27 November 2018 35/23-36/2; AR-A29 3 December 2018 143/17-23
[379] AR-A21 27 November 2018 14/6-16/1
[380] AR-A21 27 November 2018 14/6-17/2; AR-A23 27 November 2018 35/23-36/25; AR-A29 3 December 2018 143/24-144/4

there is no such denial it may be appropriate to "*put in issue whether it took place*" but it has to be done "*carefully and with appropriate circumspection, because you have no positive case to put*".[381] He also agreed with Alistair Gillespie[382] that claimants may need to be challenged directly on what effect the abuse has had on them, so that the issue is not simply determined on the basis of expert medical evidence.[383]

106. When asked about the Bryn Alyn litigation, Lord Faulks pointed out that there were no objections to his questions from the experienced High Court judge or the barristers representing the claimants.[384] He said he was obliged as a matter of fairness to put these issues to the claimants in cross-examination in order for the defendant to make the arguments in their closing submissions.[385] Nevertheless, he recognised the experience of cross-examination would not have been pleasant[386] and that, when challenged about events in their past, a claimant might feel that they were being accused of lying.[387] He also suggested that it may actually be the whole experience of litigation, rather than the trial alone, which was traumatic for claimants – having to repeatedly tell and relive their experiences on numerous occasions.[388]

107. Looking at the present day, Lord Faulks stated that, as the law is now more straightforward, fewer people have to give evidence. When asked about the possibility of changing the way in which claimants are questioned, he cautioned against preventing defendants from challenging cases through a "*more traditional approach*".[389]

108. A number of other witnesses, on both the claimant and defendant side, supported looking at adopting special measures for vulnerable witnesses in civil claims.

108.1. Peter Garsden said that the civil claims process was "*out of date*" in this regard and it needed to change.[390]

108.2. Stephen Bellingham stated that "*it's something that absolutely we should be actively looking into*".[391]

108.3. Carolyn Mackenzie said that she endorsed replacing traditional cross-examination and replacing it with another approach.[392]

109. Melissa Case explained that, although the family courts were following behind the criminal courts in relation to the treatment of vulnerable witnesses, the civil courts had some way to come. She told the Inquiry that the Master of the Rolls (the most senior civil judge in the Court of Appeal) had asked the Civil Justice Council to look at the issue of provisions regarding vulnerable claimants and that the Ministry of Justice would support any recommendations. She was also open to the need for legislation, but warned of the time that this could take.[393]

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[381] Lord Faulks 29 November 2018 76/7-78/1
[382] Alistair Gillespie 29 November 2018 20/18-21/4
[383] Lord Faulks 29 November 2018 79/12-80/10
[384] Lord Faulks 29 November 2018 85/17-86/3
[385] Lord Faulks 29 November 2018 84/12-85/5
[386] Lord Faulks 29 November 2018 85/6-16
[387] Lord Faulks 29 November 2018 103/18-104/4
[388] Lord Faulks 29 November 2018 87/4-15
[389] Lord Faulks 29 November 2018 85/17-86/15
[390] Peter Garsden 6 December 2018 102/17-103/1, 104/11-105/6
[391] Stephen Bellingham 7 December 2018 65/1-66/17
[392] Carolyn Mackenzie 7 December 2018 90/23-91/5
[393] Melissa Case 12 December 2018 104/7-105/25

Settlement

110. The CPR encourages early settlement of claims.[394] Parties may make written offers of settlement to each other at any time during the litigation process. The process of settlement may take many forms and the CPR encourages the use of alternative dispute resolution methods, which may include discussion and negotiation or mediation.[395] The CPR also provides a written mechanism for settlement, known as a Part 36 offer. A party who rejects a Part 36 offer may face financial penalties, including additional legal costs, if the amount of compensation they ultimately receive at trial is less than the sum previously offered.

111. Settlement removes the risk of a claim being rejected by the courts and avoids victims and survivors having to suffer the stress and trauma of a contested trial. But claimants may still be left dissatisfied by both the process of settlement and its outcome, ie the payment of compensation without judgment and accountability. This can be seen in the Forde Park and St Leonard's litigation, where the views of the lawyers instructed by the claimants contrasted deeply with the experiences of a number of victims and survivors who gave evidence.

Settlement of the Forde Park claims

112. The lead solicitor and counsel who acted for the claimants in the Forde Park litigation explained to us the complex process by which the claims were settled. This involved detailed consideration of the value of each claim and the risks that the litigation might be unsuccessful, both on generic issues and on factors specific to each case.[396] Elizabeth-Anne Gumbel QC, leading counsel for the claimants, told us that despite the risks in proceeding to trial, for example losing on limitation, the settlement figures achieved were "*more or less on the basis of full liability*", and that they compared very favourably with awards in the North Wales litigation.[397]

113. Nevertheless, some but not all victims and survivors were unhappy with the amount of compensation that they were awarded.[398] For example, AR-A41, who received in the region of £50,000, compared his compensation to the amount expected for a broken leg.[399] Penelope Ayles, the lead solicitor for the claimants, said such unhappiness was unsurprising, "*because how can you put a figure on something that devastated their childhood and changed their whole lives*".[400] Elizabeth-Anne Gumbel and Henry Witcomb, junior counsel for the claimants, agreed that the levels of damages are generally too low in child sexual abuse claims, but the former observed that "*we can only work within the system in place*".[401]

114. The claimants' legal team told us that they provided advice to individual claimants as to the potential value of their claims and the risk that they might receive less at trial. They also explained to them the process of offers and counter-offers.[402] However, a number of victims and survivors said that they did not understand how their settlements had been reached

[394] Practice Direction: Pre-Action Conduct and Protocols, paras 3(d), 8-11; Pre-Action Protocol for Personal Injury Claims, para 2.1(c)
[395] Mediation involves a third party facilitating a resolution. Other options for alternative dispute resolution include arbitration, where a third party decides the dispute and early neutral evaluation, where a third party gives an informed opinion on the dispute (Pre-Action Protocol for Personal Injury Claims, para 9.1).
[396] Elizabeth-Anne Gumbel 15 January 2019 29/22-30/5, 31/5-24, 43/20-44/18; Henry Witcomb 15 January 2019 41/6-16; Elizabeth-Anne Gumbel and Henry Witcomb 15 January 2019 41/17-42/16
[397] Elizabeth-Anne Gumbel 15 January 2019 31/8-24, 43/20-44/18
[398] AR-A44 30 November 2018 138/16-139/1, 139/16-23; AR-A11 30 November 2018 119/11-17
[399] AR-A41 30 November 2018 20/5-21/1
[400] Penelope Ayles 15 January 2019 72/16-73/2
[401] Elizabeth-Anne Gumbel and Henry Witcomb 15 January 2019 42/17-44/18
[402] Penelope Ayles 15 January 2019 71/1-73/24; Elizabeth-Anne Gumbel and Henry Witcomb 15 January 2019 37/22-40/20

and that they were not given explanations.[403] Penelope Ayles told the Inquiry that she was "*very sorry*" that the claimants were unhappy with the communication but that she did the best she could to explain the process. She acknowledged that the concepts in litigation are difficult to understand and that some time had passed since the settlements were reached.[404]

115. Some of the claimants' feelings about the lack of explanation may have been compounded by what was described as a 'take it or leave it' approach to the offers of settlement.[405] Penelope Ayles said that although she might not have used those terms, "*in reality, that's where you ended up if they weren't prepared to take the offer*". She explained that, as the claims were publicly funded, if an offer was made that the claimant's lawyers thought was reasonable, they would have to tell the Legal Aid Board (now the Legal Aid Agency), which would stop funding the claim.[406]

116. A number of victims and survivors were left disappointed that they had not had their "*day in court*".[407] However, as Elizabeth-Anne Gumbel explained, as with all civil cases, although clients may want their 'day in court', when appropriate levels of damages are offered it is not possible to go to court just to fight the claim.[408]

117. Finally, as with victims and survivors in the other case studies, many had brought civil proceedings hoping for an apology, an explanation and acceptance of responsibility.[409] However, the claims were settled without an admission of liability and the lawyers told us that, in such circumstances, it would have been difficult to obtain an apology from the defendant through the civil claims process.[410] A number of victims and survivors were, and continue to be, extremely disappointed by this.

118. It is clear from the evidence that we heard that the claimants' legal team worked hard to secure favourable settlements for all of their clients. That some victims and survivors nevertheless felt dissatisfied with the process and its outcome illustrates how the civil justice system cannot always provide satisfactory accountability and reparation for claimants.

Settlement of the St Leonard's claims

119. There was a relatively fast resolution to the 58 civil claims arising from child sexual abuse at St Leonard's. A central factor in the speed of resolution was the early admission by Tower Hamlets that, subject to any defence of limitation, it was liable for any personal injury that the claimants suffered as a result of abusive treatment or neglect while resident at St Leonard's. Malcolm Johnson noted that the defendant seemed to have made the decision to pay the claims, and then did so at speed.[411]

[403] AR-A41 30 November 2018 29/22-30/14; AR-A31 30 November 2018 127/19-21; Paul Sinclair 30 November 2018 144/5-8
[404] Penelope Ayles 15 January 2019 77/3-78/7
[405] AR-A41 30 November 2018 33/14-34/7; AR-A31 30 November 2018 125/20-23
[406] Penelope Ayles 15 January 2019 73/11-24
[407] See, for example, AR-A27 30 November 2018 89/19-24; AR-A6 30 November 2018 104/20-105/1; AR-A7 30 November 2018 110/23-25
[408] Elizabeth-Anne Gumbel 15 January 2019 26/17-27/17
[409] AR-A41 30 November 2018 15/20-25; AR-A13 30 November 2018 61/21-62/14; AR-A27 30 November 2018 89/25-90/4; AR-A6 30 November 2018 100/10-21; AR-A11 30 November 2018 117/24-118/12, 118/22-24; AR-A31 30 November 2018 125/10-13, 128/1-7; Paul Sinclair 30 November 2018 142/1-22
[410] Henry Witcomb 15 January 2019 9/5-18; Penelope Ayles 15 January 2019 52/10-20
[411] Malcolm Johnson 5 December 2018 62/5-10

120. From the outset, the parties' solicitors worked constructively together and sought ways to quickly resolve the claims.[412]

121. Tracey Storey considered that St Leonard's had proved a useful model for the resolution of complex claims.[413] She was pleased to have avoided protracted proceedings, which some of her clients did not have the resilience to face, and the risk of losing on what her clients might see as technical causation or limitation arguments.[414]

122. Malcolm Johnson agreed that the speed with which the claims resolved was "*enormously helpful*".[415] He stated that civil litigation can be:

> "*enormously damaging because it's adversarial and, therefore, it recreates many of the elements of the abuse in itself because people are being told, 'Well, you could be lying', and this is what happened to them when they were children.*"[416]

He added that "*the single-most important thing about child abuse compensation claims is that they should be resolved with as little adversarial process … as possible*".[417]

123. However, two of the claimants in the St Leonard's litigation, Paul Connolly and AR-A15, said that the settlement of their cases prevented them from having their day in court. For Paul Connolly, the "*whole point*" of the litigation was "*to have our day in court, because we didn't have it in the criminal court*".[418] Tracey Storey said that this opportunity was lost early in the litigation as the defendant accepted liability. She observed:

> "*So there was never going to be a full examination of how St Leonard's happened, what led to – what made it happen, what made it so horrible, who failed whom. That was never going to be examined in this litigation. I think that was very disappointing for a lot of people.*"[419]

124. Tracey Storey said that clients need to be made aware that there will be pressure to settle cases, so that they know they will have to make difficult decisions.[420] When asked whether he understood that the case might settle out of court, Paul Connolly said that was "*never the intention*".[421]

125. Peter Garsden, who was not involved in the St Leonard's claims, sought to explain why some victims and survivors may be disappointed by the settlement process:

> "*what we have heard a lot from all the survivors of abuse is that they feel completely disengaged with the civil judicial process. Even those that have got damages go away feeling disenchanted and unhappy, and I think the reason is that they're not engaging properly – sorry that's not their fault, it's our fault. They are not being engaged as much as they should be in the settlement process, so they don't feel that they have – they are part of it.*"[422]

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[412] Malcolm Johnson 5 December 2018 29/3-17
[413] Tracey Storey 5 December 2018 60/21-61/6
[414] Tracey Storey 5 December 2018 33/23-34/12
[415] Malcolm Johnson 5 December 2018 62/2-63/1
[416] Malcolm Johnson 5 December 2018 65/17-22
[417] Malcolm Johnson 5 December 2018 66/10-13
[418] Paul Connolly 4 December 2018 10/6-18; see also AR-A15 5 December 2018 99/23-100/7
[419] Tracey Storey 5 December 2018 26/12-23
[420] Tracey Storey 5 December 2018 25/1-8
[421] Paul Connolly 4 December 2018 10/19-11/1
[422] Peter Garsden 6 December 2018 131/24-132/7

He suggested that mediation may be one solution:

> *"With mediation, at least they would go to the mediation, they would be able to look the defendant in the eye, they would take ownership of the settlement process, they would feel part of it and it would perhaps be a more satisfying experience than simply getting a letter with a cheque."*[423]

Length of time to resolve proceedings

126. The length of time to conclude claims can vary depending on a number of factors such as whether the claims proceed to trial, the number of issues in dispute and the level of case management by the court. The Bryn Alyn claims and the St Aidan's and St Vincent's claims are examples of particularly protracted litigation. In both cases, the litigation first began in the late 1990s and did not conclude until around 2010.

The Bryn Alyn claims

127. The Bryn Alyn claims raised a number of legal issues such as causation, limitation and the proper approach to the quantification of damages. The litigation was further complicated by insurance issues – in particular, whether RSA or Eagle Star were obliged to indemnify the company for the abuse that had taken place, and the terms of the exclusion clause of the insurance policy provided by RSA (see above).

128. Another effect of the exclusion clause was to create a conflict between Bryn Alyn (the insured) and RSA (the insurer). This resulted in RSA being joined as a separate defendant, rather than conducting the litigation in the shoes of Bryn Alyn.[424] As a consequence, there were two stages of the litigation against RSA – first determining the liability of Bryn Alyn and then enforcing the judgment against RSA under the insurance contract.[425] The claimants' solicitor said that RSA forced them to have a trial on the underlying issue of the liability of Bryn Alyn before they dealt with the insurance policy.[426] However, he subsequently agreed with RSA that the enforcement of the insurance policy did need to be determined after Bryn Alyn's liability to the claimants had been established.[427]

129. Alistair Gillespie told us that the Court of Appeal's judgment on the terms of the exclusion clause is now a precedent for cases where similar exceptions might arise. He also said that the problems that arose with insurance in the Bryn Alyn claims do not normally arise in civil litigation.[428]

130. By the time the outstanding Bryn Alyn claims finally settled, some claimants just wanted an end to the matter, even if they felt that the damages they were being offered were inadequate. For example, AR-A24, whose claim settled for £21,000 some 12 years after his first disclosure, said:

> *"This was not enough for what I had been through, but by this point in my life I had had enough of fighting and just wanted to bring matters to an end."*[429]

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[423] Peter Garsden 6 December 2018 132/13-18
[424] Alistair Gillespie 29 November 2018 25/16-26/6
[425] Alistair Gillespie 29 November 2018 30/3-31/5
[426] Billhar Singh Uppal 28 November 2018 145/23-146/20
[427] Billhar Singh Uppal 28 November 2018 147/12-148/14. Mr Gillespie said that the insurance policy could not be determined in a "*vacuum*" (Alistair Gillespie 29 November 2018 30/3-15).
[428] Alistair Gillespie 29 November 2018 33/2-8
[429] AR-A24 27 November 2018 61/24-62/5

St Aidan's and St Vincent's

131. Paul Durkin told us that he felt his clients were "*confused as to why the litigation took so long*", and said that from a claimant's perspective "*it was a very, very difficult claim*".[430] AR-A87, who was a lead claimant, told us that the process of repeated hearings and appeals was "*very, very difficult, not just for me, but for my family, because I ended up ill due to all the repetitive information that I had to give about my abuse*".[431] In retrospect, he would not have joined the group litigation:

> "*the reason for that being … the amount of time that it took for these court procedures to take place. It took approximately 12 to 13 years of my life away*".[432]

132. Some of the delays in the resolution of the claims were beyond the control of the parties, including problems with the availability of judges.[433] It is also clear that the law at this time was in flux, particularly during the period of almost three years between the trial of the original test cases and the resolution of the law following the decision in *A v Hoare*.[434] Paul Durkin told us that, by this stage:

> "*I think that it would be fair to say that finally the defendant and the claimants' lawyers had an understanding of lines of engagement, and there was a tacit understanding that we should look at settling claims and discontinuing claims. Because this was at the end of a long process: two courts of appeal, three trials. The law was more settled. We were looking at vicarious liability. There was more understanding of limitation.*"[435]

133. However, the decision by the defendant, Nugent Care, not to settle the claims early on also inevitably contributed to their duration. Stephen Bellingham and Alistair Gillespie told us that most child sexual abuse claims conclude without the need for a trial. Alistair Gillespie said that only about 10 percent of claims in which his firm are instructed enter litigation in the first place and that 90 percent are resolved between the parties without the need to resort to litigation,[436] which should be a last resort.[437] However, he was unable to say how many of the 90 percent "*fade away*", ie are discontinued.[438]

134. We also heard that the time to resolve child sexual abuse claims is now significantly shorter than previously. David Nichols said that the average duration of a case, not necessarily involving a trial, is about 1.8 years, which is slightly longer than in other personal injury claims.[439] Malcolm Johnson agreed that the process of settlement had sped up.[440] Tracey Storey was not convinced that this was the case but agreed that more conversations are now being had between the parties.[441]

[430] Paul Durkin 6 December 2018 108/6-14
[431] AR-A87 5 December 2018 112/24-113/11
[432] AR-A87 5 December 2018 120/10-15
[433] INQ003530_004
[434] *A v Hoare* [2008] UKHL 6, [2008] 1 AC 844
[435] Paul Durkin 6 December 2018 105/7-22
[436] Alistair Gillespie 29 November 2018 14/13-18; see also Stephen Bellingham 7 December 2018 53/16-55/23
[437] Pre-Action Protocol for Personal Injury Claims, para 9.1.1
[438] Alistair Gillespie 29 November 2018 14/19-15/1
[439] David Nichols 29 November 2018 155/5-21
[440] Malcolm Johnson 5 December 2018 68/14-69/5
[441] Tracey Storey 5 December 2018 69/6-70/7

C.10: Compensation

135. Personal injury claims are brought for financial compensation. This can include general damages for the pain, suffering and loss of amenity experienced by the claimant, and special damages for past and future financial losses, such as earnings and the costs of care and therapy.

Quantification of general damages

136. General damages are presently awarded for the sexual abuse itself and for any physical or psychiatric injuries resulting from the abuse.

137. When considering the appropriate level of award to make, the court will ordinarily compare the claimant's case with that of other claimants whose cases have been reported. It will also consider the Judicial College (formerly Judicial Studies Board) *Guidelines for the Assessment of General Damages in Personal Injury Cases* (Guidelines).[442] These Guidelines do not contain a freestanding section on injuries caused by sexual abuse. But they do provide some guidance on how to quantify the psychiatric damage that may result from such abuse.

138. At the time the North Wales Children's Homes Litigation commenced, except for the 1996 case arising from the physical and sexual abuse of children in care by Frank Beck (an employee of Leicestershire County Council), there were very few reported cases for judges to consider when assessing general damages.[443] Nor did the Guidelines make any mention of sexual abuse cases.

139. The February 2001 Court of Appeal judgment in the claims against Flintshire County Council, which were part of the initial tranche of North Wales claims, was therefore the first major appellate decision on compensation for institutional child sexual abuse.[444] An important aspect of that decision was that the court doubted the applicability of the Guidelines to child sexual abuse cases, recognising that abuse in care fell into a "*wholly different category from psychiatric damage that follows other personal injuries*".[445]

140. In June 2001, the High Court gave its judgment in the Bryn Alyn litigation, having considered the Beck case and the Court of Appeal's decision in the Flintshire claims.[446] In 2003, the Court of Appeal heard the appeals in the Bryn Alyn claims and gave clear guidance on how the courts should quantify general damages for child sexual abuse. In particular, it said that:

- Awards in child sexual abuse cases should "*take account of the nature, severity and duration of the abuse itself and of its immediate effects, as well as any long-term psychiatric harm that it may have caused*".[447]
- Although the then Guidelines did not directly address the issues in the claims and were "*not capable of rigid application*", they provided "*some sort of signpost to the general level of damages that a judge ought to be considering in a case of this kind*".[448]

[442] At the time of writing the Guidelines are in their 14th edition, published 14 September 2017.
[443] INQ003776_003
[444] INQ003605_001. This was followed in 2003 by the judgment of the Court of Appeal in the Bryn Alyn litigation (ZUI002361_001).
[445] INQ003605_001, 012
[446] ZUI003197_001, 005
[447] ZUI002361_001, 049
[448] ZUI002361_001, 054

141. Malcolm Johnson said that one of the most important things that the Court of Appeal said in Bryn Alyn was that it was necessary to look at both the short and long-term effects of abuse. He said that that was "*still good law today*" and that the courts continue to follow this approach.[449]

Quantification of special damages

142. Some special damages claims are easy to calculate, such as the cost of therapy or counselling. But other claims, especially loss of earnings, may be much more complex. Claimants who are abused as children have no pre-injury earnings upon which to base such a calculation. They may also have had a difficult family life, few educational opportunities, or have themselves committed criminal offences, sometimes as a consequence of their neglect or abuse. These factors can be very difficult for the courts to disentangle.

The adequacy of damages

143. Some victims and survivors, though not all,[450] expressed dissatisfaction with the amount of damages they had received for their civil claims.

143.1. AR-A41, who was abused at Forde Park, received in the region of £50,000:

> "*when you think a broken leg is the same as what's happened to me for 55 years of my life since it happened, if you think the pathetic amount they paid me – because I think it's pathetic. I earned more than that in 12 months, you know, when I was in business, and it should have been life changing, not the pennies that they offered. Ridiculous.*"[451]

143.2. AR-A2, who was abused at St Vincent's, accepted compensation of £17,500. As an adult who has spent many years suffering from mental health issues since being abused as a child, AR-A2 calculated that this amounted to compensation of under £6 a week. He asked, "*can someone tell me the fairness in this?*"[452]

144. Malcolm Johnson told the Inquiry that claimants are "*getting far more for very serious abuse than they were, say, ten years ago*".[453] Other claimant lawyers felt that the awards were still too low.

144.1. Tracey Storey said "*personally, I don't think that we compensate people who have been abused in childhood. I don't think we really get to understand the impact upon a developing child of those experiences*". She compared their cases with those claimants who have suffered serious physical injuries, such as brain damage. She did not think "*we are there yet with compensating people who have been through these events and who have carried it around with them into adulthood*". Although she accepted that child sexual abuse cases were complicated by the pre-care and pre-abuse experiences of victims and survivors, she still thought the awards she sees regularly were "*pretty low*".[454]

[449] Malcolm Johnson 5 December 2018 56/17-58/11
[450] See for example AR-A11 who was content with damages of £55,000, albeit that he felt under pressure to accept the offer (AR-A11 30 November 2018 119/11-15).
[451] AR-A41 30 November 2018 20/20-21/8
[452] AR-A2 5 December 2018 146/10-148/14, 148/22-152/3
[453] Malcolm Johnson 5 December 2018 58/2-23
[454] Tracey Storey 5 December 2018 59/14-60/20

144.2. Henry Witcomb and Elizabeth-Anne Gumbel both agreed that general damages in cases of child sexual abuse are too low. However, the latter made the point that the general damages for all personal injury claimants are too low and the sums awarded for severe sexual abuse have to be seen in the context of the current system.[455]

145. One of the reasons for this may be that, when assessing general damages, the courts tend to focus on specific incidents of abuse and their psychiatric consequences, and may not make awards simply for the experience of living for a protracted period in an abusive and neglectful environment.

146. Paul Connolly, who was brought up in an "*absolutely appalling*" environment at St Leonard's,[456] was awarded £16,000 in his claim.[457] Tracey Storey observed that "*the court system hasn't really recognised the full extent of emotional abuse and the impact it has on the developing personality of a child who has to go through those events. I mean, no child should have to do that*".[458] She explained that they did attempt to argue that, in Paul Connolly's case, the abusive experiences had limited his educational attainment and other opportunities. She said that the issue was raised in negotiation to increase the value of the claim, but "*typically, those arguments aren't getting anywhere*".[459]

147. Sarah Erwin-Jones agreed that it was difficult but not impossible for claimants to claim for the overall experience. She referred to a 'failure to remove' case in which the damages awarded reflected the experience of being in a harsh and uncaring environment. However, she did also acknowledge that there were a number of differences between that case and the cases of non-recent sexual abuse based on vicarious liability.[460]

148. Some claimants in the Forde Park litigation wanted to pursue claims for loss of education. Elizabeth-Anne Gumbel explained that claims simply based on the quality of education have not, to her knowledge, succeeded as personal injury claims.[461] However, that loss of education clearly continues to be an important issue for many victims and survivors. Nigel O'Mara, a counsellor, called for an educational trust to help them obtain qualifications later in life.[462]

C.11: Apologies, explanations and assurances

149. The primary purpose of civil claims for child sexual abuse is to obtain financial compensation. The courts cannot order defendants to give apologies or explanations for the abuse or assurances that it will not happen again. Billhar Singh Uppal said that, by the time litigation is commenced, it is too late for an apology.[463]

150. Nevertheless, victims and survivors repeatedly emphasised the importance of receiving genuine and meaningful apologies from the institutions they saw as responsible for their abuse.

[455] Henry Witcomb and Elizabeth-Anne Gumbel 15 January 2019 44/19-45/19
[456] Tracey Storey 5 December 2018 16/16-18
[457] Paul Connolly 4 December 2018 26/22-25
[458] Tracey Storey 5 December 2018 16/16-17/11
[459] Tracey Storey 5 December 2018 17/12-18/11
[460] Sarah Erwin-Jones 5 December 2018 90/2-91/4
[461] Elizabeth-Anne Gumbel 15 January 2019 13/15-14/13
[462] Nigel O'Mara 11 December 2018 83/8-84/5
[463] Billhar Singh Uppal 28 November 2018 160/7-161/2

150.1. AR-A41 said "*I wanted an apology. I want bloody Devon County Council and the Home Office to say sorry for what they've done to me, and mean it; not just say the word. Anybody can say the word, but really mean it. Really, really mean it. Not falsely.*"[464]

150.2. AR-A36 said the value of an apology would depend "*where and how the apology came about to be honest. Words are meaningless.*" He explained that the apology had to come from the "*top of Nugent Care Society who run the homes and it's got to be meant. Words are easy to say, but to actually mean it, and after so long … an apology needs to be a proper apology, face-to-face apology, not on a piece of paper. Anyone can say 'I'm sorry' on a piece of paper.*"[465]

150.3. AR-A5 said he wanted "*someone in authority to acknowledge that what happened at Stanhope Castle did happen. I want it to be acknowledged that many, many children were sexually, physically and psychologically abused. I want an explanation for why no-one looked into what was going on at the time and why there has never been a proper investigation of the abuse of boys at Stanhope Castle. I want a real, genuine apology.*"[466]

151. For some victims and survivors, apologies were said to be more important than compensation.

151.1. AR-A24 said "*I now realise that an apology or acceptance for what I had been through is worth more than any amount of compensation.*"[467]

151.2. Similarly AR-A6 said "*I was not at all satisfied with the civil process or the outcome of the case. There was a payment of damages; however, there was no apology and my abusers were not held to account.*"[468]

152. Some victims and survivors wanted more than just an apology. For example, AR-A27 said, of his civil claim, "*I was not happy with the outcome as I received no apology or acceptance of liability or responsibility.*"[469] He also told us:

> "*The main thing I wanted was to receive an acknowledgment from Devon County Council that they had failed us boys and to have an apology for what we had been put through. I also wanted to get assurances that children in care would be protected in the future.*"[470]

153. Although insurers told us that they are generally supportive of apologies being made by institutions, concerns remain as to the timing of such an apology and whether it might amount to an admission of liability.

153.1. David Nichols explained that the insurance perspective back in the 1990s would have been that an apology made by a local authority "*could lead to admission of liability*" and "*would not therefore have been supported*".[471] However, Zurich now supported apologies being made by local authorities at the outset of a claim. Its guidance permits

[464] AR-A41 30 November 2018 15/20-25
[465] AR-A36 5 December 2018 136/20-137/8
[466] AR-A5 10 December 2018 33/3-14
[467] AR-A24 27 November 2018 61/21-62/18
[468] AR-A6 30 November 2018 100/18-21
[469] AR-A27 30 November 2018 94/12-16
[470] AR-A27 30 November 2018 89/19-90/4
[471] David Nichols 29 November 2018 129/7-14

its policyholders to make apologies which do not amount to admissions of liability.[472] He said he had no experience of making the apology conditional, for example "*we are very sorry if abuse has occurred*", but could not say that never happened.[473]

153.2. Alistair Gillespie said that sometimes an apology is mentioned in the first letter from a claimant but not thereafter. He said that requests for apologies are made in only around 5 percent of cases. His insurance clients "*have never stood in the way of an apology being made*" in circumstances where a payment of money was also being made but "*an insurer, in those circumstances, would have to flag up as a matter of caution that if any apology did amount to an admission, then there may have to be a further discussion between the insurer and the policyholder*".[474]

153.3. Alistair Gillespie also said that, on a limited number of occasions, he had been able to facilitate meetings between claimants and defendant institutions so that assurances can be provided about how those organisations now operate. However, he cautioned that with non-recent claims the institution in question will have transformed out of all recognition since the abuse took place.[475]

153.4. Rod Luck said that MMI "*don't have a problem with apologies*" made by the local authority or the insured institution. However, he said MMI suggest that they work with their own legal advisers on the nature of the apology, and made clear that there "*may be certain occasions and certain points in time when an apology can't at that stage be offered*".[476]

153.5. Philippa Handyside, General Counsel at the Association of British Insurers (ABI), stated that ABI's guidance made clear that if an organisation wanted to do or say something that might amount to an admission of liability, they should liaise with their insurers. She acknowledged it was a difficult issue for organisations but thought it should be possible for them "*to agree a sensible way forward that gives as much as can be given*". She accepted that a conditional apology was far from ideal; "*A lawyer's apology is not welcome*".[477]

154. The Compensation Act 2006 affords defendants the opportunity to make apologies without necessarily compromising their defence of personal injury claims. The Act states that an apology, an offer of treatment or other redress shall not of itself amount to an admission of negligence or breach of statutory duty.[478]

155. However, the Act only refers to negligence or breach of statutory duty, and not to vicarious liability, which is the main basis upon which child sexual abuse claims are now brought. David Nichols said that Zurich interpreted its provisions as extending to vicarious liability[479] but other defendant witnesses such as Carolyn Mackenzie and Philippa Handyside said that this issue needed to be clarified.[480]

[472] David Nichols 29 November 2018 139/10-140/11; ZUI003202_001, 031
[473] David Nichols 29 November 2018 156/7-15
[474] Alistair Gillespie 29 November 2018 66/10-67/9, 68/25-69/15
[475] Alistair Gillespie 29 November 2018 67/10-68/10
[476] Rod Luck 3 December 2018 89/23-90/13
[477] Philippa Handyside 12 December 2018 49/19-51/19
[478] Compensation Act 2006, section 2
[479] David Nichols 29 November 2018 159/5-16
[480] Carolyn Mackenzie 7 December 2018 85/7-86/13; Phillipa Handyside 12 December 2018 48/11-49/18

156. The Inquiry heard that none of the victims and survivors in the case studies ever received apologies during the civil claims process from the institutions or those responsible for them.

156.1. In the Bryn Alyn litigation, the company that ran the homes was in liquidation by the time of the litigation.

156.2. In the Forde Park litigation, Penelope Ayles explained that because the defendants did not admit liability she could not secure an apology.[481]

156.3. In the St Leonard's litigation, Tracey Storey said that the only explanation given for the abuse came in the form of an admission of liability in the defence.[482] It appears that Tower Hamlets made a statement expressing regret at what had happened and an intention to make amends but no formal apology.[483]

156.4. In the North West Children's Homes litigation, it is unclear whether any request for an apology was made by victims and survivors from St Aidan's and St Vincent's. Whilst Peter Garsden recalled making such a request in the early stages and being refused,[484] Stephen Bellingham said that, from his review of the papers, he could see no evidence that a request for an apology was ever made of Nugent Care.[485]

156.5. In relation to Stanhope Castle, we have not seen any evidence that an apology was sought by or provided to the claimants in the sexual abuse claims brought against Middlesbrough Council.

157. However, during the Inquiry's hearings, apologies were made by Devon County Council, Tower Hamlets, Nugent Care Society and Middlesbrough Council, although the representative of the latter, James Bromiley, was unable to say whether or not sexual abuse had taken place at Stanhope Castle.

[481] Penelope Ayles 15 January 2019 52/10-20
[482] Tracey Storey 5 December 2018 26/24-27/6
[483] Malcolm Johnson 5 December 2018 27/23-28/16; Richard Baldwin 4 December 2018 81/19-25
[484] Peter Garsden 6 December 2018 132/22-133/7
[485] Stephen Bellingham 7 December 2018 68/16-69/2

Part D

Criminal compensation

Criminal compensation

D.1: Introduction

1. Victims and survivors of child sexual abuse can obtain financial reparation outside the civil justice system, through awards of compensation by the criminal courts or by the Criminal Injuries Compensation Authority (CICA).

D.2: Criminal compensation orders

2. A criminal compensation order (CCO) requires a person convicted of an offence to pay money to the victim of that offence for personal injury, loss or damage arising from it.[486] The underlying purpose of a CCO is that offenders pay for the damage that they have caused, as a form of reparation.[487]

3. Recent data provided by the Ministry of Justice show that only around 0.02 percent of CCOs relate to child sexual abuse cases.[488]

Table 1: Ministry of Justice data about criminal compensation orders (CCOs)

	Total number of CCOs	Number of child sexual abuse offenders	CCOs in child sexual abuse cases
2017	124,835	6,861	26
2016	146,789	7,155	28
2015	147,982	5,822	29
2014	147,292	4,956	28
2013	150,372	4,356	30

The courts' powers

4. The criminal courts have had the power to make CCOs since 1973.[489] This power is now governed by sections 130 to 134 of the Powers of Criminal Courts (Sentencing) Act 2000 (the Act). Under the Act, the court must consider making a CCO where it has the power to do so, and must give reasons if it does not. It is not necessary for an application to be made by the prosecution on behalf of the victim.[490]

[486] Powers of Criminal Courts (Sentencing) Act 2000, section 130(1)
[487] Melissa Case 12 December 2018 69/24-70/25
[488] MOJ000859
[489] Criminal Justice Act 1972, section 1(1)
[490] Powers of Criminal Courts (Sentencing) Act 2000, section 130. This was originally a discretionary power under the Criminal Justice Act 1972 and then the Powers of Criminal Courts Act 1973. However, since 2000, the court must provide reasons if it does not make an order where it is able to do so (section 130(3)). In 2012 the 2000 Act was amended so that the court now must consider making a CCO where it has such a power, and must continue to give reasons if no such order is made (section 130(2A), inserted by section 63(1) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012).

5. CCOs are intended to provide *"a convenient and rapid means of avoiding the expense of resort to civil litigation when the criminal clearly has means which would enable the compensation to be paid"*.[491]

6. The courts have made clear that CCOs should only be used in simple and straightforward cases, where the amount of compensation can easily be calculated.[492] This practice is also reflected in the guidance given in the Adult Court Benchbook, which is used in the Magistrates' Courts.[493] The court should not embark on a detailed inquiry into the extent of any injury, loss or damage. If such an inquiry is necessary, it may be more appropriate for the victim to bring a claim in the civil courts where proper medical reports can be considered.[494] As the court can only consider submissions made by the prosecution and offender – not the victim – it is not considered appropriate to have complex compensation proceedings determining the entitlements of the victim.[495]

7. The courts have also made clear that CCOs should not be made if there is no realistic possibility of compliance. This might be, for example, because the offender has very limited means[496] or because he or she is serving a custodial sentence and will not have the resources to pay within a foreseeable period of release[497] and may be encouraged to commit further offences in order to do so.[498]

The process of making a CCO

8. CCOs are dealt with during the sentencing process, and the prosecution is to assist the court by making it aware of all relevant information. The prosecutor is obliged to draw the court's attention to its powers to award compensation and invite it to make an order, where appropriate.[499]

9. The Sentencing Council's guidelines for the Magistrates' Courts state that compensation should benefit, not inflict further harm on, the victim. It advises that assumptions should not be made as to whether or not a victim wants compensation from the offender, and that the victim's views should be obtained by the police or witness care unit. If the victim does not want compensation, this should be made known to the court and respected.[500]

10. If a victim or survivor does want a CCO to be made, the prosecutor should seek supporting evidence from the police.[501] The police should therefore draw the possibility of compensation to a victim's attention and gather the necessary information.[502] Factors relevant to compensation may be included in the Victim Personal Statement,[503] and in the MG19 compensation form provided to victims, in which the basis of a claim for

[491] *R v Inwood* (1974) 60 Cr App R 70
[492] *R v Donovan* (1981) 3 Cr App R (S) 192; *R v Kneeshaw* [1975] QB 57; *R v Stapylton* [2013] 1 Cr App R (S) 12
[493] *Adult Court Bench Book*, Judicial College, August 2017, p25, para 118
[494] *R v Stapylton* [2013] 1 Cr App R (s) 12; *R v Cooper* (1982) 4 Cr App R (S) 55; *R v Welch* (1984) 6 Cr App R (S) 13
[495] *R v Bewick* [2008] 2 Cr App R (S) 31
[496] *R v Webb* (1979) 1 Cr App R (S) 16
[497] *R v Grafton* (1979) 1 Cr App R (S) 305
[498] *R v Wilkinson* (1979) 1 Cr App R (S) 69; *R v Panayioutou* (1989) 11 Cr App R (S) 535
[499] *Sentencing – Ancillary Orders* (see 'The Role of the Prosecutor in Compensation Applications'), CPS Legal Guidance, as at July 2019
[500] *Magistrates' Courts Sentencing Guidelines*, Sentencing Council, Introduction to Compensation, as at July 2019
[501] *Sentencing – Ancillary Orders* (see 'The Role of the Prosecutor in Compensation Applications'), CPS Legal Guidance, as at July 2019
[502] Melissa Case 12 December 2018 71/16-23
[503] *Sentencing – Ancillary Orders* (see 'Compensation for Personal Injury'), CPS Legal Guidance, as at July 2019; OHY006397_001

compensation can be set out and provided to the court.[504] The College of Policing's guidance (issued in 2013) states that the police should supply the MG19 compensation claim form as soon as possible after a defendant has been charged.[505]

11. If the court is considering making a CCO, it should first indicate that it is minded to do so and then give a provisional figure of compensation.[506] It is not the responsibility of the prosecution to establish the defendant's means and the court will usually look to the defence counsel to provide information about the means of the defendant.[507]

12. The Magistrates' and Crown Courts have procedures for establishing the financial means of defendants. In the Magistrates' Courts, a defendant must provide such information in a form known as the MC100, which states that it is an offence to make a false statement or knowingly fail to disclose material facts.[508] In the Crown Court, the judge can direct a defendant to provide a statement as to his or her financial means and, if necessary, order disclosure of relevant documents.[509]

13. Where the court is not satisfied that it has been given sufficient, reliable information, the court is entitled to draw reasonable inferences as to the defendant's means and ability to pay a CCO.[510]

14. A compensation order may be made where the defendant has to borrow money in order to pay it. However, there must be sufficient material before the court to conclude that there are sound prospects that the defendant can repay the loan.[511] A CCO may be appropriate even where its effect is to force the sale of the matrimonial or family home.[512]

Amounts of compensation

15. In determining whether to make a CCO and the amount under such an order, the court should consider the offender's means so far as they appear, or are known to the court.[513] The amount of compensation is what the court considers appropriate, having regard to any evidence and representations made by, or on behalf of, the offender or the prosecutor.[514]

16. There is no limit to the compensation that can be ordered, except where the Magistrates' Court is dealing with an offender under the age of 18.[515] However, the compensation should not exceed the sum that would be awarded by a court in civil proceedings.[516]

17. The Sentencing Council's guidelines for the Magistrates' Courts[517] state that courts should consider two types of loss:

[504] OHY006397_003
[505] OHY006397_003
[506] *R v Phillips* (1988) 10 Cr App R (S) 419; *R v Stanley* (1989) 11 Cr App R (S) 446
[507] *R v Johnstone* (1982) 4 Cr App R (S) 141; *R v Phillips* (1988) 10 Cr App R (S) 419
[508] Melissa Case 12 December 2018 76/19-77/3; MOJ000018_005; MOJ000017
[509] MOJ000018_005; *Criminal Practice Directions 2015* as at July 2019, pp176–177, paras Q4, Q6
[510] MOJ000017_001; *Criminal Practice Directions 2015* as at July 2019, p177, para Q6; see also *R v Bolden* (1987) 9 Cr App R (S) 83
[511] *R v Carrington* [2014] 2 Cr App R (S) 41
[512] *R v McGuire* (1992) 13 Cr App R (S) 332
[513] Powers of Criminal Courts (Sentencing) Act 2000 section 130(11)
[514] Powers of Criminal Courts (Sentencing) Act 2000 section 130(4)
[515] Powers of Criminal Courts (Sentencing) Act 2000 section 131
[516] *R v Flinton* [2008] 1 Cr App R (S) 96
[517] *Magistrates' Courts Sentencing Guidelines*, Introduction to Compensation, Sentencing Council, as at July 2019

17.1. Financial loss sustained as a result of the offence, for example, any loss of earnings or medical expenses.

17.2. Pain and suffering caused by the injury, which should be assessed in light of all factors that appear to the court to be relevant, including any medical evidence, the victim's age and their personal circumstances. This can include distress and anxiety, although sums in respect of this alone are likely to be modest.[518]

The guidelines include starting points for some offences arising out of physical and sexual abuse, in line with the Criminal Injuries Compensation Authority tariff. For example, the starting point for non-penetrative sexual acts over clothing is £1,000.[519]

18. However, most cases of this type will be dealt with in the Crown Court, which may consider the tariffs set out in the guidelines for Magistrates' Courts.[520]

19. If a victim or survivor later makes a civil claim in respect of any injury, loss or damage previously compensated by a CCO, the resulting damages will be reduced by the amount of the CCO that has been paid.[521] If a victim or survivor makes a CICA claim, their compensation will be reduced where the court has made a CCO, even if it is never in fact paid.[522]

Enforcement

20. CCOs can be paid in instalments, but the full compensation must be paid within a reasonable time. This will ordinarily be up to three years, although there is no strict limit.[523]

21. There is no data on whether the sums awarded in CCOs are ever in fact paid.[524] However, Melissa Case, Director of Criminal and Family Justice Policy at the Ministry of Justice, acknowledged that there may be issues of enforcement.[525]

22. Generally, CCOs are enforced in the same manner as any financial penalty imposed by the court, ie by a collection order. Non-payment of CCOs is dealt with in line with any other default on a criminal financial imposition.[526] Penalties may include a period of imprisonment.[527]

The use of CCOs in child sexual abuse cases

23. None of the victims and survivors from whom we heard in this investigation told us that they received CCOs at the conclusion of criminal proceedings arising from their abuse.

[518] See for example *Bond v Chief Constable of Kent* [1983] 1 All ER 456
[519] *Magistrates' Courts Sentencing Guidelines*, Suggested Starting Points for Physical and Mental Injuries, Sentencing Council, as at July 2019
[520] *The Crown Court Compendium, Part II: Sentencing*, Judicial College, December 2018, S7-1, para 8
[521] Powers of Criminal Courts (Sentencing) Act 2000, section 134
[522] Criminal Injuries Compensation Scheme 2012 para 85(1)(d); Melissa Case 12 December 2018 81/15-24
[523] *R v Olliver* (1989) 11 Cr App R (S) 10; *R v Anthony Patsalos* [2016] EWCA Crim 768; *R v Ganyo* [2012] 1 Cr App R (S) 108. The Adult Court Benchbook advises that it is common practice to look to the defendant to pay the total financial penalty within 12 months (p25, para 120). The *Magistrates' Courts Sentencing Guidelines*, Introduction to Compensation, state that the court may allow it to be paid over a period of up to three years (para 9).
[524] MOJ000018_004
[525] Melissa Case 12 December 2018 82/2-16
[526] Melissa Case 12 December 2018 82/2-16; MOJ000018_005
[527] Magistrates' Courts Act 1980, section 76 and Schedule 4

23.1. There were no applications for CCOs at the conclusion of John Allen's trial in 2014.[528] The Crown Prosecution Service told us they were unable to ascertain whether compensation was applied for by the prosecutor, following conviction.[529] Some victims and survivors said, in retrospect, that they would have wanted the court to make a CCO even if it was never going to be paid.[530] AR-A1 did not recall being asked whether he wanted a CCO, but thought one should have been made:

> *"I know that John Allen may have been considered at that time as a man of straw, but for me, if he'd have owned a gold watch, then he should have sold it and gave it to the 19 of us. It was about the principle of him being held to be accountable to us in some way."*[531]

23.2. During Operation Pallial, only one CCO was made. This was against an individual who was convicted of child cruelty and not given a custodial sentence. The order was for £500. Philip Marshall, a Senior Investigating Officer for the National Crime Agency, said that, in all the other cases, following contact with the Crown Prosecution Service and the prosecution, decisions were taken not to apply to the courts for CCOs because the offenders were receiving significant custodial sentences.[532]

23.3. Temporary Assistant Chief Constable Deborah Marsden, of Devon and Cornwall Police, told us that the manager of her witness care unit had no recollection of a CCO being made for sexual offences by the courts in her force's area.[533] Some victims and survivors from Forde Park reported that they did not give evidence during the criminal trials and they therefore could not have received a CCO.[534]

23.4. There were no CCOs made in the prosecutions arising from Operation Mapperton. Daniel O'Malley, a former detective inspector with the Metropolitan Police Service and Senior Investigating Officer with the Paedophile Unit at New Scotland Yard, could not recall any instance in his experience as a police officer in which a CCO had been made.[535]

23.5. Paul Connolly, a victim and survivor of St Leonard's, could not recall any mention of getting a CCO against any abuser. He reflected that he would not want such compensation now but at the time he might have accepted it. He would have needed it, even if he had not wanted it.[536]

23.6. The police officers who gave evidence to us about the investigations into abuse at St Aidan's and St Vincent's did not know whether CCOs had ever been made. Acting Deputy Chief Constable Darren Martland of Cheshire Constabulary had no specific knowledge of CCOs in child abuse cases and did not know whether such data were

[528] Philip Marshall 28 November 2018 74/25-75/10
[529] Gregor McGill 12 December 2018 30/1-19
[530] AR-A23 27 November 2018 44/1-8; AR-A19 3 December 2018 129/15-19
[531] AR-A1 27 November 2018 99/24-100/21
[532] Philip Marshall 28 November 2018 74/25-75/10
[533] Deborah Marsden 3 December 2018 15/20-16/5
[534] AR-A31 30 November 2018 126/5-8; Paul Sinclair 30 November 2018 141/6-14, 142/23-143/1; AR-A3 was unaware of any prosecutions arising from Forde Park until recently, AR-A3 30 November 2018 109/21-25; AR-A6 30 November 2018 100/6-9
[535] Daniel O'Malley 4 December 2018 29/24-30/4, 50/14-51/5. Daniel O'Malley was a police officer for 27 years until 2003.
[536] Paul Connolly 4 December 2018 21/22-22/19

kept.[537] Deputy Chief Constable Serena Kennedy of Merseyside Police did not have information on the use of CCOs and could not recall assisting the Crown Prosecution Service with a CCO.[538]

23.7. There were no criminal prosecutions arising out of the abuse at Stanhope Castle and so there were no CCOs.

24. Witnesses told us that there were a number of possible reasons for the low numbers of CCOs in child sexual abuse cases.

24.1. Melissa Case acknowledged that there might be a lack of awareness on the part of victims and survivors.[539] We note that there is no mention of CCOs in the Victims' Code.

24.2. Melissa Case also said that there might be a lack of awareness or training on the part of the judiciary. She commented that further investigation was needed to see "*whether there's something else going on*", for example whether decisions not to make orders are due to the offender's lack of means[540] (some offenders will be given custodial sentences) or reflect a lack of specialist knowledge of torts or damages.[541]

24.3. The Crown Prosecution Service's view is that applications for CCOs are normally based on loss or damage that is easily quantifiable, such as theft or criminal damage. This point was also made by Temporary Assistant Chief Constable Neill Anderson of North Wales Police.[542] By contrast, convictions arising out of child sexual abuse are less likely to lead to CCOs because they are more difficult to quantify and a remedy is more likely to come from other avenues, such as civil claims or the CICA.[543] As a result of this, North Wales Police now focus on advising victims about the CICA.[544] Assistant Chief Constable David Orford of Durham Constabulary also acknowledged the perception that child sexual abuse cases were different from other types of cases.[545]

24.4. There may also be a lack of awareness among police officers.[546] Even where police officers are aware of CCOs, they may consider that CCOs are not suited to cases of child sexual abuse. The MG19 form used for setting out the details of a compensation claim focuses on personal losses such as stolen or damaged property rather than damage caused by abuse.[547] Deborah Marsden told us that the form did not invite police officers to consider its application to child sexual abuse cases.[548] The same point was made by Detective Chief Superintendent Craig Turner of the Metropolitan Police.[549] Melissa Case noted that there is minimal guidance in the criminal courts equivalent to that in the civil courts to assist in the compensation process.[550]

[537] Darren Martland 6 December 2018 17/14-19/6
[538] Serena Kennedy 6 December 2018 24/21-25/22
[539] Melissa Case 12 December 2018 80/11-17
[540] Melissa Case 12 December 2018 80/18-81/1
[541] Melissa Case 12 December 2018 75/11-23
[542] Neill Anderson 28 November 2018 33/7-23
[543] CPS004656_003
[544] Neill Anderson 28 November 2018 33/10-36/3
[545] David Orford 10 December 2018 62/22-64/10
[546] Melissa Case 12 December 2018 80/11-17
[547] Melissa Case 12 December 2018 71/25-72/4
[548] Deborah Marsden 3 December 2018 14/12-15/15
[549] Craig Turner 4 December 2018 68/17-21
[550] Melissa Case 12 December 2018 74/1-25

D.3: The Criminal Injuries Compensation Authority

25. The CICA is an independent executive agency funded by central government, with responsibility for making awards of compensation to victims of violent crime.

26. Applications for compensation are considered under the Criminal Injuries Compensation Scheme (the scheme). The first scheme was set up in 1964 and was administered by the Criminal Injuries Compensation Board. The Criminal Injuries Compensation Act 1995 created the CICA and placed the scheme on a statutory footing. The scheme has since been updated in 2001, 2008 and 2012.

27. Awards by the CICA differ from CCOs. They are publicly funded, rather than paid for by convicted perpetrators, and may be made to victims whether or not there has been a successful criminal conviction.[551] They are only made where compensation is not available by other means.[552] They may also be significantly lower in value than the compensation payable in successful civil claims.

28. In September 2018, the government announced a review of the scheme in order to improve access to compensation and consider how the scheme might better serve victims, especially victims and survivors of child sexual abuse. The review is expected to report in 2019 with recommendations for reform.[553]

Knowledge and awareness

29. A number of victims and survivors in the case studies told us that they were unaware of the availability of criminal compensation under the scheme.

29.1. AR-A194, who told us that he had not previously disclosed his abuse to anyone, never made a claim for criminal compensation. He explained that he was totally unaware of the scheme's existence.[554]

29.2. AR-A3, who was unaware that there had been criminal convictions arising from Forde Park until 2017, also said that he did not know that the scheme existed.[555]

Publicity of the scheme

30. In recent years the government has attempted to improve the support and services offered to victims of crime.

31. The Victims' Code makes clear that victims are entitled to apply for compensation under the scheme, and provides information on how to do so.[556] However, it is not clear that the Victims' Code has improved awareness of the scheme amongst victims and survivors. Melissa Case told us that awareness of the Victims' Code is "*pretty low*" and that it is "*perhaps for a layperson not terribly accessible*". As a result of this, the government published the Victims Strategy in September 2018. Its aims include improving the accessibility and awareness of the Code.[557]

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[551] Criminal Injuries Compensation Scheme 2012 para 9
[552] MOJ000018_011-012
[553] *Justice Secretary announces victim compensation scheme review, scraps unfair rule*, Government Press Release, 9 September 2018. The announcement also referred specifically to victims of terrorism.
[554] AR-A194 5 December 2018 153/20-23, 154/3-5
[555] AR-A3 30 November 2018 109/21-110/1
[556] INQ003556_001, 005, 044-046
[557] Melissa Case 12 December 2018 85/22-86/23; MOJ000858

32. Information about the CICA and the scheme is also available online at GOV.UK and the Victims' Information Service. Linda Brown, Chief Executive of the CICA, also told the Inquiry that the CICA works with stakeholders in various victims' organisations to help promote the scheme and educate them about it so that they can help victims and survivors.[558]

Police signposting

33. Victims and survivors also rely on the police to signpost their entitlement to compensation under the scheme. This is particularly important given that the police may be the first, and sometimes the only, recipients of reports of abuse, and given there are time limits for making applications to the CICA.

34. One of the issues that arose in the case studies was the consistency with which the police raised awareness of the scheme with victims and survivors, particularly in the 1990s and early 2000s when several of the criminal investigations took place.

> **34.1.** Neill Anderson said that, based on the recollections of retired North Wales Police officers and the limited documentation now available, it appeared that officers did not proactively mention compensation to victims and survivors in the 1990s. However, if asked about it, they would indicate that it could be discussed at the conclusion of the criminal case.[559]
>
> **34.2.** Serena Kennedy said that the policy of Merseyside Police during the St Vincent's investigations that concluded in 2003[560] was that officers should not discuss CICA or civil compensation with victims and survivors. A helpline card was provided to victims but she was not able to identify whether the helpline gave information on the compensation available.[561]

35. It appears that, as with civil compensation, there may have been concerns in the past that any criminal proceedings could be undermined by accusations that the victims and survivors had fabricated allegations to obtain compensation. Daniel O'Malley said:

> *"My view about this was very simple: we would do what we could at the end to assist claimants to go through the process of CICA applications. We would not offer it up at the outset. If they asked, we wouldn't be dishonest with them, we would tell them that it existed, but I was conscious of trying to put it … 'on the back burner' … I didn't want to run the risk, the potential for undermining the very reason that my part of the inquiry existed, which was to give effect to a proper and thorough criminal investigation."*[562]

36. These past practices may have changed since the publication of national guidance in 2013 by the College of Policing.[563] This guidance is not mandatory but it is taken into account by police forces.[564] It makes clear that applications to the CICA for awards should not be delayed until the conclusion of a criminal investigation or trial. However, the guidance assumes that victims are already aware of the scheme; it does not require police officers to be proactive in raising the scheme's existence.[565]

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[558] Linda Brown 12 December 2018 110/13-111/9
[559] Neill Anderson 28 November 2018 20/11-23/13, 51/11-52/8; OHY005933_011
[560] OHY006027_001
[561] Serena Kennedy 6 December 2018 22/24-24/20
[562] Daniel O'Malley 4 December 2018 42/11-43/7
[563] OHY006397
[564] CPO000001_004
[565] OHY006397_003-004

37. The Ministry of Justice also published a leaflet entitled *Information for Victims of Crime*[566] in 2013 for use by police forces in the delivery of entitlements under the Victims' Code.[567] The current version of the leaflet tells victims that they may be eligible for compensation from the CICA and provides information on how to apply. The CICA also works with police forces to ensure that they advise victims and survivors about the time limit for applications to the CICA, and that they should not wait until the conclusion of criminal proceedings to apply.[568]

38. The Victims' Code states that victims and survivors are entitled to receive written information on what to expect from the criminal justice system, such as the *Information for Victims of Crime* leaflet. Victims and survivors should usually be provided with written information on how to seek compensation from their first contact with the police, or within five working days thereafter.[569]

39. The six police forces involved in the case studies, and the National Crime Agency, said that they do now generally signpost the issue of criminal compensation to victims and survivors. However, there remains some variation in when and how this may be done, either verbally or in writing by, for example, letters or leaflets.[570] This may reflect the autonomy of local forces and their ability to develop their own policies and guidance to reflect the needs of their local communities.[571]

40. Emma Barnett, Assistant Chief Constable of Staffordshire Police and Lead for Victims and Witnesses in the National Police Chiefs' Council, accepted that there is variation in how police forces approach referrals for criminal compensation. She told us that this is dependent on the relationships and discussions between police officers and victims.[572] She also acknowledged that there may still be some concern among police officers that the issue of compensation may be used to undermine a victim's credibility at the criminal trial.[573]

Decisions to make applications

41. A number of victims and survivors were not sure about the process of making a CICA claim, or doubted whether they could be successful.

> **41.1.** AR-A31 said that his former solicitors may have given him advice about the possibility of making an application but that he did not know what the process involved and was not sure that any application would be successful.[574]

[566] OHY006390_001_002
[567] MOJ000018_009
[568] CIC000061_007
[569] INQ003556_001, 005, 011-012, 27, 48-49
[570] Neill Anderson 28 November 2018 23/18-24/3, 25/14-29/8, 30/14-31/7; Philip Marshall 28 November 2018 72/13-73/25; Craig Turner 4 December 2018 61/11-64/15; Darren Martland 6 December 2018 14/7-16/5; David Orford 10 December 2018 60/6-62/9, 71/20-73/16; OHY006694_001-002; Serena Kennedy 6 December 2018 25/23-26/11; Deborah Marsden 3 December 2018 10/13-11/18, 12/9-23
[571] CPO000001_004
[572] Emma Barnett 12 December 2018 11/19-12/17
[573] Emma Barnett 12 December 2018 16/4-20
[574] AR-A31 30 November 2018 126/9-24

41.2. AR-A2 said that he had not been informed about the availability of CICA compensation during the criminal trial. His solicitors in the civil claim made him aware of the scheme and it was also mentioned to him by police investigating an unrelated matter. He said that he did not make an application due to a lack of knowledge about the CICA scheme.[575]

41.3. AR-A79 did not make an application for criminal compensation. He was not sure how to make such a claim and was sceptical that he would be believed.[576]

42. Some victims and survivors may not want compensation. For example, AR-A9 told us that he has not sought any form of compensation as he does not believe that money could compensate for:

> *"the lives we lost whilst in care and the psychological and physical scars we still carry with us. I will always be haunted by the memories of Forde Park and compensation will not make them go away."*[577]

Others declined CICA compensation as they had already received larger sums in civil compensation.[578]

Time limits

43. There is a general two-year time limit from the date of the incident of sexual abuse to make an application to the CICA. Under the current scheme, this may be extended where:

- the applicant did not apply earlier due to exceptional circumstances;
- the evidence supplied means that the application can be determined without the need for further extensive enquiries; and
- the claims officer decides to exercise their discretion to extend.[579]

44. Many victims and survivors feel unable to report that they were sexually abused when they were children, and will therefore exceed the time limit. Linda Brown said that the CICA "*are respectful*" of the issues around disclosure of non-recent child sexual abuse "*wherever we can*", and referred to guidance on making exceptions to the two-year rule. She told us that, over the 18 months prior to the hearings, the CICA have done more work with their staff to "*help educate them around the experience of victims of historic child sexual abuse*", in order to "*try and help educate our staff to be more confident in exercising the discretion they have around the two-year rule*".[580]

45. Victims and survivors may also be late making applications as the police do not always inform them of their right to criminal compensation while criminal investigations and trials are ongoing. This contributes to the risk of applications being made out of time.

46. During Operation Mapperton, Daniel O'Malley recognised this risk and took the initiative of agreeing with the CICA that the time limits would not be automatically imposed.[581] Craig Turner called this agreement a gold standard but explained that it

[575] AR-A2 5 December 2018 148/15-21
[576] AR-A79 5 December 2018 145/6-11
[577] AR-A9 30 November 2015 113/25-114/6
[578] AR-A13 30 November 2015 66/13-67/22; AR-A27 30 November 2015 90/12-16
[579] CIC000061_007
[580] Linda Brown 12 December 2018 111/14-113/4
[581] Daniel O'Malley 4 December 2018 43/18-46/9; OHY006747_002; OHY006783_002

probably would not be made today as the Metropolitan Police now adhere to the College of Policing guidelines. He also pointed out that there is a distinction between large, complex investigations such as Operation Mapperton and individual cases which should be dealt with on a case-by-case basis.[582]

47. Emma Barnett was asked whether or not it would be sensible for the police to agree a policy with the CICA, so that the time limit is suspended whilst active investigations are ongoing. She said that it could be discussed with the CICA, although she referred to the discretion to extend the time limits as happened "*from time to time*".[583] Linda Brown and Melissa Case agreed that the current review of the scheme provided the opportunity to look at the "*exceptional circumstances*" provision again.[584] While Linda Brown did not have experience of the Operation Mapperton moratorium, she said this was something that could be considered.[585]

Difficulties during the application process

48. Applications were originally made in writing, on a form obtainable from the CICA. It is now possible to make the application online or on the phone.[586] There is no public funding available to assist applicants either to make an application or to appeal against a decision.[587] Melissa Case told the Inquiry that the process is relatively straightforward, guidance is available and the CICA is able to provide assistance where required.[588] Assistance with applications may be available from solicitors (who will ordinarily be paid if an award is made), charitable organisations such as Citizens' Advice, the police or local independent sexual violence advisers (ISVAs)[589] who provide support, advice and help to victims and survivors of sexual violence.[590]

49. AR-A26 told us that the application paperwork seemed straightforward.[591] However, Peter Robson said that he found the process difficult.[592] So too did AR-A1: it "*felt very matter of fact, very disengaged to what I was experiencing, because it was just all facts and figures*".[593] Linda Brown reported feedback from applicants more generally that they do not always understand the questions put to them. She said that the CICA was in the process of reviewing and simplifying the application form.[594]

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[582] Craig Turner 4 December 2018 65/4-66/5
[583] Emma Barnett 12 December 2018 15/7-20
[584] Linda Brown and Melissa Case 12 December 2018 132/9-133/3
[585] Linda Brown 12 December 2018 133/4-22
[586] Criminal Injuries Compensation Scheme 2012 para 91(a); MOJ000018_009; Linda Brown 12 December 2018 117/15-118/4; CIC000061_002
[587] MOJ000018_010
[588] MOJ000018_010
[589] *The Role of the Independent Sexual Violence Adviser: Essential Elements*, Home Office, September 2017
[590] North Wales Police ISVAs will fill in the form for victims if necessary (Neill Anderson 28 November 2018 31/8-32/16). Devon & Cornwall Police's Victim Care Unit and ISVAs support victims in the completion of the form (Deborah Marsden 3 December 2018 10/13-11/9). In Merseyside Police, the ISVAs assist victims with applications (Serena Kennedy 6 December 2018 26/12-27/2).
[591] AR-A26 3 December 2018 136/18-22
[592] Peter Robson 10 December 2018 18/23-19/13. Peter Robson accepted that Dawn Clarke, a Detective Constable with Durham Constabulary, would have helped him had she known he was struggling: "*Dawn has said, you know, if she'd known I was having trouble, she would have helped me, and I believe that as well. I believe she would have*" (Peter Robson 10 December 2018 19/6-13).
[593] AR-A1 27 November 2018 88/19-89/13
[594] Linda Brown 12 December 2018 116/18-117/2

50. There did not appear to be a consistent, national, police policy on providing direct assistance to victims and survivors. Philip Marshall said that the National Crime Agency does not help with filling in forms,[595] although he recognised that more support could be given.[596] Deborah Marsden told us that Devon and Cornwall Police's Victim Care Unit and ISVAs may provide support completing the CICA form.[597] Neill Anderson and Serena Kennedy both also referred to assistance provided by ISVAs.[598] Craig Turner said that, at some point during criminal investigations, Sexual Offence Investigation Technique officers would take victims through the forms.[599] David Orford said that he would expect all of the officers in Durham Constabulary to help with the forms in circumstances where it becomes apparent that the applicant is having difficulties.[600]

51. A small number of victims and survivors said that they would have benefitted from some assistance at the review or appeal stage. For example, Robert Balfour said that he felt unable to challenge his award because of lack of advice:

> *"A free specialist legal advice service and access to medical experts to write clinical reports would have vastly improved my experience of CICA."*[601]

Similarly, AR-A23 made a claim with the assistance of Citizens' Advice, although she did most of the application herself. She was awarded £6,000, which she did not think was enough. With the benefit of hindsight, she wishes she had received more advice and had applied for a review or appealed the decision.[602]

Decision-making

52. The decision to make an award is made by a CICA claims officer, who considers whether, on the balance of probabilities,[603] the evidence makes it more likely than not that a compensatable crime has occurred. That decision is then set out in writing,[604] which provides a "*gist*" of the evidence on which it is based.[605]

53. An applicant can apply for a review of this decision,[606] which is then carried out by a different claims officer.[607] If an applicant is dissatisfied with the outcome of a review, they can appeal the decision to the First-tier Tribunal (Criminal Injuries Compensation), previously the Criminal Injuries Compensation Appeals Panel, which is administered independently by Her Majesty's Courts and Tribunals Service.[608]

54. Peter Robson told us how difficult it can be for a victim of non-recent child sexual abuse to bring a successful CICA claim. He applied for an award based on his account that he had been repeatedly raped at Stanhope Castle by a fellow pupil.[609] His application

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[595] Philip Marshall 28 November 2018 74/1-3
[596] Philip Marshall 28 November 2018 74/11-21
[597] Deborah Marsden 3 December 2018 10/13-11/9
[598] Neill Anderson 28 November 2018 31/8-32/16; Serena Kennedy 6 December 2018 26/12-27/2
[599] Craig Turner 4 December 2018 64/16-65/3
[600] David Orford 10 December 2018 73/17-74/13
[601] Robert Balfour 29 November 2018 117/25-118/13
[602] AR-A23 27 November 2018 48/21-49/10
[603] MOJ000018_019
[604] Criminal Injuries Compensation Scheme 2012 para 99
[605] This is a legal obligation following the decision in *R v Criminal Injuries Compensation Authority, ex p Leatherland* [2001] ACD 13. See also CIC000061_003
[606] Criminal Injuries Compensation Scheme 2012 para 117
[607] Criminal Injuries Compensation Scheme 2012 para 121
[608] Criminal Injuries Compensation Scheme 2012 para 125
[609] CIC000151_003; CIC000130_007

was rejected, as the alleged perpetrator had not been found and, based on the available evidence, it was not possible to say that he had been a victim of abuse.[610] This occurred despite Detective Constable Dawn Clarke of Durham Constabulary telling the CICA that the lack of corroborating evidence did not mean that he had not been abused.[611] He told us he was very upset that he had not been believed by the CICA.[612] He asked for a review of the decision. Upon review, it was decided that there was sufficient evidence to come to a different conclusion, and he was awarded £22,000 shortly before he gave oral evidence to the Inquiry. He told us that he did not care how much the award was. He was just happy finally to be believed.[613]

55. Linda Brown told us that this case illustrated the evidential difficulties in such cases. She explained that there is "*a degree of subjectivity*" in relation to the balance of probability test, "*no matter how hard we try to establish certain lines of consistency*". She accepted that, sometimes, the CICA "*get the balance of probability decision wrong*", and explained that the review process provided a safeguard. In this case, she explained that a review of the evidence, together with Peter Robson's request to review the decision, was sufficient to come to a different decision.[614]

56. Linda Brown stated that, since the Inquiry's Interim Report[615] (discussed further below), the CICA has "*formed a number of partnerships with third sector victims' organisations to help build awareness about victim experience and help our people shape their service in a way that supports them better*". She referred to training provided to the CICA's operational staff by the police and Rape Crisis.[616]

Refusals and reductions

57. The CICA may refuse to make an award to an applicant if:

- the incident giving rise to the criminal injury has not been reported to the police as soon as reasonably practicable[617] or
- the applicant has not cooperated as far as reasonably practicable in bringing the assailant to justice.[618]

58. Awards may also be withheld or reduced if:

- the applicant fails to give reasonable assistance to the CICA or other body regarding their application, for example, through repeated failure to respond to letters;[619]
- the applicant's conduct or character makes it inappropriate to make an award or full award;[620] or
- the applicant has unspent criminal convictions (which we address further below).[621]

[610] Peter Robson 10 December 2018 18/23-21/11; CIC000668_007-008
[611] CIC000130_007
[612] Peter Robson 10 December 2018 22/13-23/10
[613] Peter Robson 10 December 2018 24/21-26/1
[614] Linda Brown 12 December 2018 155/10-158/6
[615] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018
[616] Linda Brown 12 December 2018 112/17-113/4, 121/5-122/11
[617] Criminal Injuries Compensation Scheme 2012 para 22
[618] Criminal Injuries Compensation Scheme 2012 para 23
[619] Criminal Injuries Compensation Scheme 2012 para 24
[620] Criminal Injuries Compensation Scheme 2012 paras 25–28
[621] Criminal Injuries Compensation Scheme 2012 para 26

59. In its Interim Report, the Inquiry considered another rule – known as the same-roof rule – that prevented applicants who were abused before 1 October 1979 from receiving compensation when they were living under the same roof as their assailant.[622] We concluded that this rule was unfair and recommended that the Ministry of Justice revise the CICA rules so that all applicants who previously applied for compensation in relation to child sexual abuse but were refused solely due to the 'same-roof' rule should be entitled to reapply for compensation and have their claim approved by the CICA. The government has subsequently introduced legislation which abolishes the rule and implements the Inquiry's recommendation.

Criminal convictions

60. The CICA does not make awards to applicants who have unspent convictions (convictions which have not been removed from an offender's criminal record due to the passage of time) which resulted in a custodial sentence, a community order, a youth rehabilitation order or equivalent sentences.[623]

61. Previous schemes gave the CICA discretion to make full or reduced awards to applicants with certain criminal convictions.[624] This discretion was removed in the 2012 scheme, based on government policy that people who have themselves committed crimes should not benefit from a publicly funded scheme.[625]

62. Several victims and survivors told us that they considered the rule on previous convictions and non-cooperation with the police to be unfair.

62.1. AR-A20 said his claim was rejected on the basis of his previous convictions. He said: "*This was absurd. My convictions related to my experiences whilst in care.*"[626] He ultimately gave evidence to the CICA and was awarded £8,500. He said that applicants should not be penalised for non-cooperation with the "*criminal justice authorities*", and that rejecting claims for criminal convictions "*unfairly prejudices victims of sexual abuse who often fall into harmful patterns of behaviour as a result*".[627]

62.2. Similarly, AR-A26's claim was refused on the basis of his previous convictions. He said: "*I couldn't understand how I could be denied compensation when the things they used against me were as a result of what he had done to me.*"[628]

62.3. AR-A78 did not make a claim because he understood that it would be rejected on the grounds of his previous convictions. He said: "*I think it is deeply unfair to penalise victims of child sexual abuse with CICA claims for having a criminal record, when having a criminal record is often a direct result of having been abused.*"[629]

[622] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, p55
[623] Criminal Injuries Compensation Scheme 2012 Annex D, para 3
[624] See, for example, Criminal Injuries Compensation Scheme 2008 para 14(3)
[625] MOJ000018_018
[626] AR-A20 3 December 2018 132/15-21
[627] AR-A20 3 December 2018 132/22-25, 133/3-10
[628] AR-A26 3 December 2018 136/23-137/7
[629] AR-A78 29 November 2018 113/7-17

62.4. Paul Sinclair said he did not make an application as he believed that any award would be reduced due to him having a criminal record. He said:

> *"I do not understand why my having a criminal record has anything to do with me being abused in care as a child. I think it is very unfair that an award for being sexually abused as a child in care is reduced because a person goes on to have a criminal record. I believe that children who are abused in care often go on to offend because of the abuse that they suffered."*[630]

62.5. AR-A36 applied for a CICA award, but the CICA assessed that his damages of £6,000 for abuse from Colin Dick and £6,000 for abuse from Keith Sutton should be reduced by half, due to his own criminal convictions. AR-A36 explained to us that he ran away from abuse in care and stole jewellery from a travelling family because he "*needed to survive*". He was delighted when he got some compensation because he felt that "*it proved a point*", that the CICA agreed that the crimes against him had been proven.[631] He considered, however, that the CICA should be reformed to reflect that some children only offend because they have suffered abuse whilst in the care of the authorities.[632]

63. Melissa Case accepted that the case of AR-A36 was "*a stark example*" of where offending is related to the abuse. She also said that there had been other examples that witnesses had raised, and that "*very powerful evidence*" had been put before the Inquiry.

> *"It is now one of the key tenets that we are going to look at under the review the Secretary of State announced and obviously the evidence from this inquiry will be part of that … I think we have to think about whether our understanding of the impact of child sexual abuse particularly has moved on. I mean, I think there are, in the whole field of offending, we know a lot more about the causes and reasons for offending, so I think the other thing we need to bear in mind is that there are probably a significant amount of other examples of where it could be said that the state failed people and that led to their offending. And potentially, opening up this eligibility criteria starts to open up a much wider set of questions, so all of those, in public policy terms, need to be balanced."*[633]

Awards

64. The CICA awards compensation for sexual abuse based on a tariff, set out in the scheme.[634] (There are also additional categories of loss allowed under the rules, such as financial losses.)

65. There is a range of tariffs for sexual offences against children, based on the seriousness of the offence and the impact on the victim. The levels of awards have increased over the years, but they are still modest. The current level extends from £1,000 for minor, non-penetrative, sexual, physical act(s) over clothing, to £11,000 for one incident of non-consensual penile penetration of the vagina, anus or mouth (with an increase for

[630] Paul Sinclair 30 November 2018 143/2-15
[631] AR-A36 5 December 2018 137/9-138/21
[632] AR-A36 5 December 2018 141/9-17
[633] Melissa Case 12 December 2018 135/15-137/17
[634] Criminal Injuries Compensation Scheme 2012 paras 32–41, Annex E: Tariff of Injuries

repeated incidents up to £22,000). Where the abuse results in serious mental and physical illness, awards can go up to £44,000.[635] For separate criminal injuries, an award is made up of the full tariff of the highest value injury and 30 percent of the tariff for the next injury.[636]

66. The scheme includes provision for damages for other losses, including loss of earnings and expenses incurred as a consequence of the injury. The loss of earnings calculations contain stringent rules which only arise after 28 weeks out of work and require the applicant to have no capacity for work,[637] calculated by reference to statutory sick pay rather than actual earnings.[638] Previous schemes allowed loss of earnings payments by reference to industrial standards which were more generous to applicants.[639] There is also an overall maximum compensation cap of £500,000, a figure that has remained the same since 1996, without any allowance for inflation.[640]

67. Melissa Case told us that there was presently no political appetite for increasing the levels of awards available from the CICA. However, she did acknowledge that these would be looked at as part of the comprehensive review of the scheme that was taking place.[641]

[635] Criminal Injuries Compensation Scheme 2012 Annex E: Tariff of Injuries – Part B: Sexual and Physical Abuse and Other Payments, pp70–71
[636] Criminal Injuries Compensation Scheme 2012 para 37
[637] Criminal Injuries Compensation Scheme 2012 para 43
[638] Criminal Injuries Compensation Scheme 2012 paras 47–48
[639] Criminal Injuries Compensation Scheme 1996 paras 30–34; Criminal Injuries Compensation Scheme 2001 paras 30–34; Criminal Injuries Compensation Scheme 2008 paras 30–34
[640] Criminal Injuries Compensation Scheme 2012 para 31. This is the same cap imposed by earlier schemes: Criminal Injuries Compensation Scheme 1996 para 23; Criminal Injuries Compensation Scheme 2001 para 24; Criminal Injuries Compensation Scheme 2008 para 24
[641] Melissa Case 12 December 2018 131/8-132/2

Part E

Support: civil proceedings and criminal investigations

Support: civil proceedings and criminal investigations

E.1: Introduction

1. Many victims and survivors of child sexual abuse find that they need support services during the often traumatic experience of seeking accountability and reparations. By support services, in this context, we refer to any specialist advocacy services, medical services, mental health services and therapeutic services, in either the state, private or voluntary sectors.

2. During the hearings we heard consistently that victims and survivors of child sexual abuse struggle to access the right support at the right time.[642] The availability and effectiveness of support services nationally and locally continues to be an important issue for victims and survivors. It has featured across a number of other strands of the Inquiry's work and is an issue that we continue to examine.[643]

3. The focus of this chapter is on the particular issue of the provision of support to victims and survivors during and through civil proceedings and criminal investigations.

E.2: Support services

4. Support services are provided by the public, private and voluntary sectors.[644] Although this chapter focuses on the arrangement of support services for victims and survivors during criminal investigations and civil proceedings, we heard that, in practice, victims and survivors used multiple routes to access support and would do so at various points during their lives. Often, this was through their GPs,[645] but victims and survivors also sought support from or with the assistance of their families,[646] police officers, prison officers[647] and local support groups.[648]

[642] AR-A13 30 November 2018 56/20-57/12, 64/18-66/12, 67/20-68/9, 69/22-70/4; AR-A41 30 November 2018 9/14-12/18, 25/11-26/10, 27/19-28/25; AR-A1 27 November 2018 69/4-73/1; AR-A25 7 December 2018 130/9-132/4; AR-A87 5 December 2018 113/2-114/18; AR-A6 30 November 2018 99/5-99/21; Colin Watson 10 December 2018 50/4-51/14; James Thomas Harding 10 December 2018 38/13-39/1

[643] The Inquiry has heard a range of evidence, information and views about the adequacy of support services, including numerous first-hand accounts from victims and survivors of child sexual abuse. We have heard consistently that services are unable to cope with rising demand, and that many victims and survivors struggle to access the right support at the right time. The Inquiry has also been told that complex commissioning processes and short funding cycles do not facilitate long-term planning or investment in support services, and pose particular challenges for voluntary sector organisations seeking sustainable funding. See Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, pp73–74; Criminal Justice Seminar: An Update Report, August 2018, p10; INQ003533_004-013

[644] The general nature, commissioning and funding of support services is summarised in the Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, pp73–74.

[645] AR-A1 27 November 2018 70/8-20

[646] AR-A1 27 November 2018 71/1-73/1

[647] AR-A78 29 November 2018 115/11-14

[648] AR-A24 27 November 2018 57/18-58/2

5. There was variation in the availability and type of support services in the case studies, and in whether victims and survivors could or did use them. Generally, there is a 'postcode lottery' in the provision of local services,[649] and a gap between the need for support services and the ability of those services to meet the need.[650] Funding issues inevitably played a critical role in whether support was available.[651]

6. Most victims and survivors who gave evidence in the case studies were men who had been sexually abused while they were children in care but we heard there were difficulties with the provision of support services for men. Nigel O'Mara, a counsellor, said that the development of services for men has occurred more recently than those for women, and the result was that there was a lack of coverage and organisation within male services.[652] Melissa Case, Director of Criminal and Family Justice Policy at the Ministry of Justice, said that there may be a need for funding to catch up with the increased numbers of cases reported by men, and that male survivors may wish to access different services. Nigel O'Mara agreed that such differences do occur. Melissa Case explained that this was an area that the Ministry of Justice was continuing to look at.[653] Over time, there has been improvement on this issue.[654]

7. Fay Maxted, Chief Executive Officer of the Survivors Trust, observed that the vast majority of their member services[655] do offer comparable services to male victims and survivors.[656] Lee Eggleston, a member of the board of trustees of Rape Crisis England & Wales,[657] described improvement on this issue, with the recent formation of the Male Survivors Partnership. Both agreed that the problem is that there are not enough services for everyone.[658]

8. In its Interim Report, the Inquiry established that one of the challenges to understanding systemic issues in relation to the provision of support services is the lack of accurate information on current expenditure levels. The Inquiry recommended that the UK and Welsh governments work to establish current levels of expenditure, and the effectiveness of that expenditure, on services for child victims and adult survivors of child sexual abuse in England and Wales.[659] The recommendation has been accepted by the UK and Welsh governments. Furthermore, the Sexual Assault and Abuse Services (SAAS) Partnership Board, which is responsible for governance of the government's Strategic Direction for Sexual Assault and Abuse Services,[660] has agreed to supervise the implementation of this recommendation in England, with a view to presenting its findings to the Inquiry later in 2019.[661] The Inquiry awaits the outcome of this work with interest.

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[649] Fay Maxted and Lee Eggleston 11 December 2018 121/15-123/1; RCE000002_007, 014; Nigel O'Mara 11 December 2018 69/19-70/3, 74/15-75/2
[650] Melissa Case 12 December 2018 94/10-95/11
[651] Fay Maxted and Lee Eggleston 11 December 2018 109/10-112/17. Understanding the basis on which support services are funded is hampered by a lack of available data (Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, p74).
[652] Nigel O'Mara 11 December 2018 69/16-71/24
[653] Melissa Case 12 December 2018 95/12-96/4
[654] Nigel O'Mara 11 December 2018 70/18-70/21
[655] Member Agencies of the Survivors Trust provide a range of therapy, counselling, emotional support, training and clinical supervision services (INQ003533_004-005).
[656] Fay Maxted 11 December 2018 91/19-92/11
[657] A core part of the work of Rape Crisis Centres is counselling, therapeutic support (Lee Eggleston 11 December 2018 93/19-94/6).
[658] Fay Maxted and Lee Eggleston 11 December 2018 92/12-17
[659] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, pp74–75
[660] Strategic Direction for Sexual Assault and Abuse Services, 12 April 2018
[661] Government response to the Interim Report by the Independent Inquiry into Child Sexual Abuse, December 2018, para 64

E.3: Support: civil proceedings

9. The need for adequate psychological support and counselling during civil claims was raised by many of the victims and survivors who gave evidence. Remembering and reliving the experiences of abuse in order to provide evidence in a civil claim is inevitably a painful experience.[662] AR-A23 warned that he believed that many people do not come forward and discuss their experiences of abuse in part because of the inadequacy of support services.[663] Peter Garsden, a lawyer representing claimants, told the Inquiry that his clients often cannot take the process any further and discontinue claims due to the stress of the litigation. With psychological support, he believed, he could keep his clients engaged in the litigation.[664] AR-A13 told the Inquiry: "*Some of us can never fully heal. But counselling goes a long way towards being able to deal with life after a childhood filled with abuse.*"[665] AR-A41 said: "*we should have been wrapped in cotton wool and helped … to ease the torments that we go through*".[666]

10. The experience of victims and survivors in terms of accessing therapeutic support during civil claims was generally poor. Many went through the process with no professional therapeutic support.[667] AR-A13 found the civil process to be relentless and found that "*when it got to the point of sheer blind panic, there was no-one to turn to*". He had no one he felt he could tell that he needed "*time out*" from the litigation.[668] AR-A2 also felt that he had no support whatsoever during his civil claim. His solicitor advised him to see his GP but he was left feeling that "*there had been no thought for the psychological well-being of the claimants going through the claims process*".[669]

11. Not all victims and survivors wanted therapy, and some worried whether they could cope with it. Malcolm Johnson, a lawyer representing claimants, told us that in his experience the majority of child abuse survivors are "*remarkably robust*". His view is that therapy is a "*difficult area*" and he told us about instances where psychiatrists have warned that therapy would not help or might even harm his clients. He explained that meetings between solicitors on the issue of rehabilitation concluded that getting rehabilitation is very difficult, as many victims and survivors will not or do not want to engage in it.[670] AR-A21 told us that he did not pursue therapy or counselling during his civil claim as it was too traumatic to engage further about his experiences.[671] He said that he felt "*pretty miserable*" after court, and in hindsight he believed that counselling or therapy during the civil claims would have helped him with the process.[672] Sarah Erwin-Jones, a defendant solicitor, believed that the take-up of counselling was "*not particularly high*" but that it was important for a lot of claimants for it to be there as an option.[673]

[662] For example, AR-A21 27 November 2018 11/05-15
[663] AR-A23 27 November 2018 50/3-8
[664] Peter Garsden 6 December 2018 65/10-16
[665] AR-A13 30 November 2018 80/7-10
[666] AR-A41 30 November 2018 26/6-10
[667] For example, AR-A24 27 November 2018 62/19-24
[668] AR-A13 30 November 2018 67/21-68/22
[669] AR-A2 5 December 2018 152/22-153/5
[670] Malcolm Johnson 5 December 2018 49/20-51/12. See also Edward Faulks 29 November 2018 87/11-25
[671] AR-A21 27 November 2018 10/13-25; AR-A1 also told us that he was in two minds about support *"because support means talking; talking means revisiting; revisiting means being traumatised"* (AR-A1 27 November 2018 89/22-25).
[672] AR-A21 27 November 2018 17/6-15, 26/14-27/1
[673] Sarah Erwin-Jones 5 December 2018 94/7-95/5

12. Lawyers representing victims and survivors told us that very little support is available in the civil process.[674] They reiterated that they are lawyers, not counsellors, and they identified a clear difference between providing legal advice and therapeutic support. Tracey Storey, a claimant solicitor, told us that she tells her clients from the outset that, as a solicitor, she is not there to provide counselling or emotional support. Instead, she would ask whether they have support, at home or through therapy, to help them with the litigation process.[675] She explained that, as a lawyer, she has to tell her clients things they may not want to hear, requiring very clear boundaries.[676] Peter Garsden also emphasised the need to carefully signpost clients to appropriate services and to remember to make sure that "*we are lawyers and we are not trying to be counsellors as well*".[677] Peter Robson, a victim and survivor, touched on this when he explained that his lawyer at this Inquiry was "*not a psychiatrist, he can't deal with me*".[678]

13. We heard from victims and survivors who believe that the defendants or their insurers should provide for counselling services during claims.[679] Elizabeth-Anne Gumbel QC, a claimant barrister, explained the importance of this:

> "*One of the things I feel strongly about is that there should be funding for private therapy as soon as people have made complaints and litigation has started, that there should be – possibly like the Rehab Code in relation to head injuries, that therapy should be provided, even without admissions of liability, at private costing, because the delays in getting therapy to waiting until you've settled the case, is just causing more damage.*"[680]

14. The 2015 Rehabilitation Code[681] is published by the Rehabilitation Working Party, which includes representatives from the International Underwriting Association of London, the Association of British Insurers, Lloyd's, primary insurers, legal groups, care providers and the NHS. Its purpose is to "*help the injured claimant make the best and quickest possible medical, social, vocational and psychological recovery*".

15. The Pre-Action Protocol for Personal Injury Claims, at paragraph 4, requires that parties should consider as early as possible, and throughout the period of the protocol, whether the claimant has reasonable needs that could be met by medical treatment or other rehabilitative measures. It states that the Rehabilitation Code is likely to be helpful in considering how to identify the claimant's needs and how to address the cost of providing for those needs.[682]

16. It is possible for a claimant with a good claim in the civil process to obtain an interim payment that could fund expenses such as psychotherapy or counselling. Tracey Storey told us that defendants have become more amenable to requests for interim funding in strong cases. Typically, she would receive interim funding from the defendant to help her clients access private treatment.[683] Malcolm Johnson did not have the same experience; for various reasons, only a minority of his clients would access therapy during the civil

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[674] Paul Durkin 6 December 2018 63/5-9
[675] Tracey Storey 5 December 2018 47/17-48/4
[676] Tracey Storey 5 December 2018 48/22-49/1
[677] Peter Garsden 6 December 2018 61/19-62/5
[678] Peter Robson 10 December 2018 15/17-18
[679] AR-A23 27 November 2018 35/11-16, 36/9-14; AR-A26 3 December 2018 139/10-17; AR-A13 30 November 2018 80/17-22
[680] Elizabeth-Anne Gumbel 15 January 2019 47/6-48/6
[681] https://www.iua.co.uk/IUA_Member/Publications/Rehabilitation_Code.aspx
[682] Pre-Action Protocol for Personal Injury Claims, para 4
[683] Tracey Storey 5 December 2018 49/8-18

claims.[684] Paul Durkin, a claimant solicitor, and Peter Garsden, also told us that in their experience defendants do not make interim payments for therapy[685] – although the former had an experience of defendants voluntarily making interim 'ex-gratia' payments, which are payments made out of goodwill and not because of legal liability.[686]

17. Rod Luck, the Claims and Reinsurance Manager at MMI, acknowledged that where the need for psychiatric support and treatment of a claimant is identified during litigation, that could be dealt with by an interim payment before the end of the litigation, although it could not be done on a "*blanket*" basis when claims came in due to the need for medical evidence.[687] The Inquiry was told that Ecclesiastical Insurance has offered support including therapy for some claimants during child abuse litigation against parties it has insured.[688]

18. At the end of their civil claims, victims and survivors can feel abandoned. For example, AR-A6 felt "*cut adrift without any support at all*" at the end of his claim. The case had reawakened suppressed memories, and he turned to drink and drugs to block out his feelings.[689]

19. The payment of compensation to settle a civil case does not necessarily lead to claimants accessing support services, even if they need them. One reason for this is that it is for claimants to choose how to spend their compensation. They are under no obligation to use it in any particular way, even if some of it has been paid for specific purposes such as psychotherapy.[690] We heard from victims and survivors that the payment of compensation did not always lead to treatment. AR-A21 felt that counselling would re-open his trauma.[691] AR-A41 received compensation but did not know that he was expected to use it to fund therapy.[692] Sarah Erwin-Jones noted that although a settlement sum may include a sum for therapy and support, "*we have no idea whether that is used for therapy and support and we have no right to ask*".[693]

E.4: Support: criminal investigations

Evolving provision of services

20. Over the last 20 years there have been significant changes in the provision of support during criminal investigations, with a welcome movement by police forces towards prioritising the needs of victims and survivors.

21. Darren Martland, Acting Deputy Chief Constable of Cheshire Constabulary, told the Inquiry about a significant cultural change in policing. He explained that when he started his policing career in the early 1990s there was a focus on investigations and the conviction of offenders, with a lower emphasis on the care and support of victims. Any arrangements with

[684] Malcolm Johnson 5 December 2018 49/20-50/2
[685] Peter Garsden and Paul Durkin 6 December 2018 63/10-64/12
[686] Paul Durkin 6 December 2018 65/23-66/14
[687] Rod Luck 3 December 2018 85/24-88/20
[688] Peter Garsden 6 December 2018 62/5-9; Paul Durkin 6 December 2018 63/1-4, 65/23-66/14
[689] AR-A6 30 November 2018 101/8-15
[690] Sarah Erwin-Jones 5 December 2018 94/7-16
[691] AR-A21 27 November 2018 10/13-11/4
[692] AR-A41 30 November 2018 25/11-24
[693] Sarah Erwin-Jones 5 December 2018 94/7-16

social services, counselling organisations and therapeutic organisations were much more informal than is presently the case. He told us that victims are now put at the forefront of the investigation and that victim support and safeguarding is now a primary concern.[694]

22. This trend towards greater focus on the support of victims and survivors was evident in the earlier police investigations covered by the case studies. A number of these started before the provision of support was regulated by the Victims' Code, which first came into effect in 2006 and is explained later in this section.

22.1. Evidence from North Wales Police was that policing culture prior to Operation Pallial,[695] which began in 2012, focused on evidential outcomes and not primarily on victim support and wellbeing.[696] There was some limited guidance in place. A staff briefing for an investigation in 1991 reportedly told staff to approach victims in a confidential manner, provide details of an NSPCC helpline and not pursue them overzealously to engage with the enquiry.[697] Strategies, such as they existed at the time, focused simply on supporting the victim to court.[698] Police would have relied on social services to provide support for the welfare of victims.[699] Neill Anderson, Temporary Assistant Chief Constable of North Wales Police, explained that the situation nationally was similar, as there was very little or no victim care contact in the senior investigating officer programme in the 1980s and 1990s.[700]

22.2. In the Operation Mapperton investigation into abuse at St Leonard's,[701] the issue of assistance to victims and survivors was a matter of concern for Detective Inspector Daniel O'Malley, the senior investigating officer, from early on in the investigation.[702] He assigned individual officers to complainants from the outset so as to avoid the negative experience of seeing multiple officers throughout the investigation and prosecution process.[703] He also asked the Crown Prosecution Service for guidance on the provision of counselling and psychiatric support for the victims and survivors called as witnesses.[704]

22.3. Tower Hamlets Social Services also arranged and funded a system of support for victims and survivors of St Leonard's. This was provided independently by the Tavistock Clinic in London.[705] The scheme was put in place to support witnesses in the criminal trials, and a number of claimants in the civil process also accessed its services.[706] Tracey Storey said that one client particularly benefited from it.[707] A review by the Tavistock Clinic reported their view that some patients really benefited from the service.[708]

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[694] Darren Martland 6 December 2018 3/1-4/2
[695] North Wales Police conducted investigations earlier into child sexual abuse in children's homes in North Wales from 1976.
[696] OHY005933_011; INQ003620_003-004
[697] OHY005933_011
[698] Neill Anderson 28 November 2018 4/8-21
[699] Neill Anderson 28 November 2018 5/5-13
[700] Neill Anderson 28 November 2018 6/8-20; OHY005933_011
[701] Operation Mapperton started in August 1998 (OHY006739_002).
[702] Daniel O'Malley 4 December 2018 37/11-14
[703] There is evidence that this measure was effective. When the court stayed Haydn Davies' prosecution, Daniel O'Malley asked his officers to meet privately with the complainants and explain what had happened 'face to face'. Paul Connolly recalled that two policewomen assigned to his case came to see him in person to explain that vital evidence had gone missing in Davies' prosecution. They apologised to him. Paul Connolly recalled that he was grateful for the visit, "*they were decent people who came to see me and explain things in person*" (Daniel O'Malley 4 December 2018 35/9-36/14; Paul Connolly 4 December 2018 20/18-21/7).
[704] Daniel O'Malley 4 December 2018 38/18-39/8; OHY006740
[705] Daniel O'Malley 4 December 2018 40/15-41/3; LBT000386_002
[706] ZUI003200_004
[707] Tracey Storey and Malcolm Johnson 5 December 2018 44/6-19
[708] LBT000386_004

Richard Baldwin, the present Divisional Director for Children's Social Care, London Borough Council of Tower Hamlets, told the Inquiry that he considered the arrangement between Tower Hamlets and the Tavistock Clinic to support survivors was "*very forward thinking*".[709]

22.4. Devon and Cornwall Police records state that Operation Lentisk,[710] the investigation that covered abuse at Forde Park, had to create a system of witness care and support that was progressed by the senior investigating officer and two victim liaison officers. A network of support was used, with services provided by, among others, social services, counsellors, community psychiatric nurses, GPs, psychologists, prison liaison officers and the NSPCC. Operation Lentisk also required minimum qualifications for counsellors.[711]

23. Before the Victims' Code, there was wide variation in practice in the provision of support between police forces investigating crimes. The provision of support could depend on decisions made by the individual police officers involved.

24. More recently, there have been efforts to ensure that the support needs of victims and survivors are provided for consistently across the criminal justice system. The minimum standards for services that must be provided to victims of crime in England and Wales are now set out in the Victims' Code, which applies to a range of organisations, including Police and Crime Commissioners and all police forces in England and Wales.[712] The Victims' Code identifies the kind of support that a victim of crime can expect, including access to information on the range of services available.[713] Victims of child sexual abuse fall within the definition of victims of the most serious crime and of both vulnerable and intimidated victims. They therefore have enhanced entitlements under the Victims' Code, in respect both of support during the criminal process and the arrangements for giving evidence.[714]

25. From first contact with police, victims of crime must be offered information on where and how to get advice or support, including access to medical support and any specialist services (such as psychological support).[715] Victim support services are defined as "*organisations providing emotional and practical support services to victims of crime*".[716] Victims of sexual offences are entitled to be referred to a specialist organisation where appropriate and available, and to receive information on pre-trial therapy and counselling, also where appropriate.[717] Police must seek explicit consent from victims of sexual offences before sending their details to victim support services.[718]

26. Detective Chief Superintendent Craig Turner, Operational Command Unit Commander for the Child Abuse Sexual Offences Command of the Metropolitan Police, told us that an adult alleging that they were abused as a child would be offered support from their initial contact with police and throughout the investigation.[719]

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[709] Richard Baldwin 4 December 2018 87/13-23
[710] Operation Lentisk began in 1999 (OHY005912_001).
[711] OHY005912_004; Deborah Marsden 3 December 2018 25/5-27/24
[712] INQ003556_010
[713] INQ003556
[714] INQ003556_021-022
[715] INQ003556_005, 011-012, 027-028, 048-049
[716] INQ003556_101
[717] INQ003556_028, 048-049
[718] INQ003556_027, 049
[719] Craig Turner 4 December 58/18-60/2

27. The Victims' Code requires police to conduct an assessment of needs and vulnerability.[720] Melissa Case explained that this had two aspects: first, asking what a person needs to help them cope with, and recover from, the criminal injury they have suffered; second, asking what a person needs to cope with the criminal process itself.[721] In terms of the 'cope and recover' aspect of support, she identified that the Ministry of Justice would expect to see an assessment of what a victim of crime needs and signposting to specialist services, rape support and others, if they had not already been signposted there. They might also be sent to Sexual Assault Referral Centres (SARCs) if it was a recent incident of sexual abuse.[722]

28. There is flexibility in how the Victims' Code is applied. Assistant Chief Constable Emma Barnett, the National Police Chiefs' Council lead for victims and witnesses, explained that provision and funding of victim support services are arranged by local Police and Crime Commissioners and described a "*whole catalogue … of support services in a local area*".[723]

29. The variation in provision of support services by forces was explained to us by officers[724] from the investigating forces involved in the case studies.

29.1. Support services within Operation Pallial are, in general terms, provided by the National Crime Agency.[725] The investigation entered into partnership arrangements with social services and a local authority, and appointed social workers to assist with finding documents and also signposting services for support.[726] Where a victim and survivor needed or wanted counselling support, the initial interviewing officer was responsible for making a counselling referral to a dedicated social worker.[727] The officer interviewing the victim and survivor was also the victim care officer, and would be their long-term point of contact after the interview.[728]

29.2. Assistant Chief Constable Deborah Marsden of Devon and Cornwall Police informed us that, since 2015, a Victim Care Unit has existed to provide a gateway to access multiple services commissioned by the Police and Crime Commissioner or voluntary services. Further, victims of sexual offences will be allocated a sexual offences liaison officer who performs both an investigative and support function, and they may also be allocated an independent sexual violence adviser employed by a SARC.[729]

29.3. Operation Midday, the investigation into abuse at Stanhope Castle, has a victim strategy drafted by the senior investigating officer. It is designed to show all staff the tone and support to be offered to victims throughout.[730] Under the strategy, "*the needs of the Victim will come above anything else*". It requires that an Adult Abuse Investigation Team will offer support and counselling during their initial meeting with a victim or witness. All victims are to be provided with the details of the NSPCC for support, and

[720] INQ003556_016, 027
[721] Melissa Case 12 December 2018 87/24-88/21
[722] Melissa Case 12 December 2018 88/9-21
[723] Emma Barnett 12 December 2018 7/9-8/16. For example, she referred to Rape Crisis, counselling services, Sexual Assault Referral Centres, Victim Support, Citizens Advice, and independent domestic violence and sexual violence advisers.
[724] See also, in respect of Cheshire Constabulary, Darren Martland 6 December 2018 4/3-6/24
[725] Neill Anderson 28 November 2018 44/8-46/23; Philip Marshall 28 November 2018 63/12-64/7. The National Crime Agency is an agency set up to tackle serious and organised crime and may take over nationally significant investigations.
[726] Philip Marshall 28 November 2018 67/24-69/4
[727] Philip Marshall 28 November 2018 71/14-24
[728] Philip Marshall 28 November 2018 71/14-72/12
[729] Deborah Marsden 3 December 2018 2/10-8/4
[730] David Orford 10 December 2018 70/5-15. Operation Midday was set up in 2013.

referred to services where appropriate. If support is needed over and above that which can be provided by a victim's GP, then the strategy requires that a referral should be made to the Victim Suite which will coordinate support services.[731]

Review of the Victims' Code

30. The Victims' Code is under review by the government. The Victims Strategy, published in September 2018, aims to set out the government's intention to update, make more accessible and increase awareness of the Victims' Code.[732] Melissa Case said that, although there was a statutory code in place through the Victims' Code, there is not a robust framework for compliance with that Code. She said: *"it's a code we might characterise as wanting people to abide by the spirit of it but having no means of enforcing that or even checking what's happening"*.[733]

30.1. As noted in Part D, Melissa Case told us that awareness of the Victims' Code is low and it is not "*terribly accessible*" for a layperson.[734] She observed that our investigation had heard evidence from police forces that awareness of the needs assessment or its provision is not what it should be. She told us that the Ministry of Justice is working with the College of Policing and others on guidance about the questioning of victims by police, including the way in which they can signpost specialist services.[735]

30.2. Melissa Case also described the challenges posed by the fragmented commissioning of care, with services commissioned by various bodies such as Police and Crime Commissioners, NHS England and the Ministry of Justice.[736] She observed that victims are not provided with a joined-up experience,[737] and described the risk of victims going through the system *"on a wild goose chase from agency or service to service"*.[738]

30.3. HM Government acknowledges that victims may not always receive the entitlements contained in the Victims' Code and also that there is a lack of data to evidence where the key issues are.[739] Melissa Case also explained that the Ministry of Justice considers that the monitoring of statutory agencies meeting the Code should be via the Police and Crime Commissioners, as they have local oversight of the criminal justice system. Data from those Commissioners is received by the Criminal Justice Board, whose members include the Home Secretary and the Secretary of State for Justice.[740]

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[731] OHY006320_003-004
[732] The Victims Strategy states that it sets out a criminal justice system wide response to improving the support offered to victims of crime and incorporates actions from all criminal justice agencies, including the police, Crown Prosecution Service and courts. It identifies that victims need professional, targeted victims' services and notes that victims find it helpful if their primary point of contact is a trained professional with good knowledge of the criminal justice system and the compassion and empathy to provide moral support. The Victims Strategy recognises that entitlements in the Victims' Code may not always be delivered. A number of issues regarding availability, access and quality of victims' services are addressed (MOJ00858_008, 013, 018, 026).
[733] Melissa Case 12 December 2018 89/2-10
[734] Melissa Case 12 December 2018 85/22-86/23; MOJ000858_018
[735] Melissa Case 12 December 2018 87/9-23
[736] Melissa Case 12 December 2018 90/15-91/3. The Ministry of Justice directly commissions 97 sexual violence services, but is working in some areas to test devolution of those services.
[737] Melissa Case 12 December 2019 92/17-93/4; see also MOJ000858_022, 026
[738] Melissa Case 12 December 2019 95/2-11
[739] MOJ000858_021
[740] Melissa Case 12 December 2018 89/11-21

Part F

Redress schemes

Redress schemes

F.1: Introduction

1. The Inquiry has heard evidence that a redress scheme would be a possible alternative to the existing systems of criminal[741] and civil[742] compensation. This would enable victims and survivors of child sexual abuse to obtain compensation for the abuse they have suffered. It may also have the flexibility to facilitate apologies, fund or direct victims and survivors to support services, and avoid the difficulties of civil litigation.

2. A redress scheme is generally an independent, non-adversarial forum in which applications for financial compensation are considered. It is usually administered on the basis of paper applications alone but may include psychiatric assessments.

3. Redress schemes have been used internationally as a model to address child sexual abuse. They have been set up by Lambeth London Borough Council, the Irish Government, the Jersey Government and the Australian Government, and one is also being established in Scotland.[743] Schemes may be publicly funded, or paid for wholly or in part by the institutions responsible for the abuse (or their insurers). However, they are different from the types of settlement schemes that may be used to compensate groups of claimants who have initiated civil claims against individual perpetrators and defendant institutions.[744]

F.2: The justification for a redress scheme

4. Some victims and survivors told the Inquiry that they were satisfied with the outcome of civil claims for damages or their applications for compensation through the Criminal Injuries Compensation Authority (CICA). However, the majority of those who provided evidence to the Inquiry said that both civil claims and the CICA are not suitable for victims and survivors of child sexual abuse and can have a damaging impact.

5. Several claimant solicitors, together with a defendant insurer, recognised that an alternative to the civil justice system may benefit victims and survivors who are seeking redress.[745] Billhar Singh Uppal – the lead claimant lawyer in the North Wales litigation – said:

> *"the civil litigation process is not really fit for this particular purpose. There are too many hurdles, too many ways that claims can be defeated on technicalities that victims and survivors simply do not understand."*[746]

[741] Criminal compensation orders (CCOs) and compensation awards made by the Criminal Injuries Compensation Authority (CICA), discussed in Part D.
[742] The civil justice system, discussed in Part C.
[743] In April 2019, the Scottish Government opened an Advance Payment Scheme, ahead of the planned legislation for a statutory redress scheme (https://www.gov.scot/news/redress-for-historical-abuse-survivors/).
[744] Such a settlement scheme was used in the litigation arising from the sexual abuse by Jimmy Savile (Alistair Gillespie 29 November 2018 65/14-66/9).
[745] Paul Durkin 6 December 2018 117/7-17; Tracey Storey 5 December 2018 64/4-20; Stephen Bellingham 7 December 2018 67/3-9, 67/25-68/2
[746] Billhar Singh Uppal 28 November 2018 162/18-22

In his view, most of his clients resort to civil litigation because they have tried all other options.[747] His experience of redress schemes is that:

> *"they have been a better experience. Victims have emerged from the process less bruised, wholler. Their trust in society restored – not totally restored, but you've got to start somewhere."*[748]

6. Similarly, Alistair Smith, the solicitor for a number of the Stanhope Castle victims and survivors, criticised both the civil justice system and the CICA scheme:

> *"The system that we have got … just doesn't work … I would like some kind of non-litigation, a sort of non-adversarial type of system."*[749]

F.3: Components of a redress scheme

7. We heard evidence about a number of different schemes that operate to provide redress for victims and survivors of child sexual abuse.

8. The Lambeth Children's Homes Redress Scheme was established by Lambeth London Borough Council to operate between 2 January 2018 and 1 January 2020.[750] It is designed so that the standard of proof, the elements for establishing liability and the valuation of claims are the same as the civil justice system.[751] Applications are made on a written application form, reasonable legal costs are covered[752] and applications are determined by members of the Council's Redress Team or the scheme solicitors.[753]

9. The scheme offers more than just financial recompense to victims and survivors of abuse. Those eligible are entitled to:[754]

- a written apology acknowledging what has happened, providing an acceptance of responsibility and an assurance that measures have been taken to prevent any further repetition;
- a meeting with a senior representative of the Council, so the victim and survivor can feel heard and acknowledged by the Council;
- a payment of up to £10,000 to reflect the experience of living in an environment which caused them to fear immediate physical or sexual abuse (where the scheme's criteria are met);
- appropriate counselling or other therapeutic, psychological or psychiatric support;
- specialist advice, support and assistance to obtain housing, appropriate welfare benefits, access to further education and suitable employment; and
- a compensation payment in accordance with the terms of the scheme.

[747] Billhar Singh Uppal 28 November 2018 159/17-160/6
[748] Billhar Singh Uppal 28 November 2018 162/23-163/3
[749] Alistair Smith 11 December 2018 57/5-21
[750] Lambeth Children's Home Redress Scheme paras 3.1–3.2
[751] Lambeth Children's Home Redress Scheme paras 2.14–2.17; Paul Durkin 6 December 2018 126/10-11
[752] Lambeth Children's Home Redress Scheme paras 23.1–23.4
[753] Lambeth Children's Home Redress Scheme paras 2.3, 5.2. Disputes about eligibility or the amounts of any payments, legal expenses or costs are adjudicated on by members of a three-person multi-disciplinary Independent Appeal Panel (paras 17.1–17.4).
[754] Lambeth Children's Home Redress Scheme para 7.2(i)–(vi)

10. Paul Durkin, a solicitor who represented claimants in the St Aidan's and St Vincent's litigation, was also involved with the Residential Institutions Redress Board in the Republic of Ireland. He described that scheme as a "*fair, compassionate scheme providing speedy redress to people who have been abused at qualifying institutions in Ireland*".[755]

11. Witnesses told us that there are a number of potentially important components to an effective redress scheme.

11.1. Compensation: Although many victims and survivors have said that money was not their primary motivation,[756] it seems that this is a key aspect of any redress or compensation scheme. It is an important feature of the recognition of wrongdoing by an institution and of compensating for an injury.

11.2. The facilitation of apologies and an acknowledgement of failure: An apology by the relevant institution and an acknowledgement of failure is a primary desire of many of the victims and survivors who gave evidence to the Inquiry.[757] Paul Durkin told us that key ingredients of such a scheme are:

> *"an acknowledgement by the institution that the people have been wronged; the facility for an apology and understanding that they were let down".*[758]

11.3. Prevention of continuing abuse: Some want to ensure that future children do not suffer the abuse they received.[759] To that end, reassurance that steps have been taken to prevent abuse occurring may be a welcome feature.

11.4. Counselling or other treatment: Some victims and survivors continue to struggle with the effects of the abuse they suffered, and hoped for more support than they got in their civil claims or CICA applications.[760] Paul Durkin and Alistair Smith both said that counselling and assistance with social needs could be a key ingredient of a redress scheme.[761]

11.5. A non-adversarial system: Civil litigation is an adversarial system, which – in particular through cross-examination – can be traumatic, difficult and demoralising.[762] Any challenge to the credibility of a victim and survivor of child sexual abuse can re-traumatise them through the fear of not being believed.

11.6. Speed: Civil litigation and CICA applications can both be protracted processes which can be hard for victims and survivors.[763] A more timely remedy may be an important factor in ensuring that victims and survivors feel believed and acknowledged.

[755] Paul Durkin 6 December 2018 125/15-20
[756] See, for example, AR-A78 29 November 2018 112/13-16; AR-A34 7 December 2018 104/2-6; AR-A25 7 December 2018 132/8-19; AR-A87 5 December 2018 107/6-13
[757] See, for example, AR-A41 30 November 2018 15/21-25; AR-A13 30 November 2018 61/24-62/6; AR-A27 30 November 2018 89/25-90/4; AR-A31 30 November 2018 125/10-13; AR-A2 5 December 2018 146/20-22; AR-A5 10 December 2018 33/3-14
[758] Paul Durkin 6 December 2018 139/9-13; see also Alistair Smith 11 December 2018 58/17-59/3
[759] AR-A27 30 November 2018 90/3-4
[760] See, for example, AR-A13, 30 November 2018 67/21-68/22; AR-A2 5 December 2018 152/22-153-5
[761] Paul Durkin 6 December 2018 139/14-15; Alistair Smith 11 December 2018 58/23-59/3
[762] Alistair Smith 11 December 2018 54/22-55/11
[763] Alistair Smith 11 December 2018 55/12-20

11.7. Parity with civil damages: As we have seen, numerous victims and survivors have applied for CICA awards and brought civil claims.[764] A redress scheme may not be an adequate alternative if victims and survivors still feel they need to bring civil claims to ensure that they receive adequate damages.

12. It may be difficult for a single national redress scheme for victims and survivors of child sexual abuse to deliver all of these objectives. In particular, the facilitation of apologies and the acknowledgement of failure, and the prevention of continuing abuse, are matters that require the engagement of the institutions where the abuse took place. This may not be forthcoming if particular institutions no longer exist or are unwilling to engage with the redress process.

F.4: Advantages and disadvantages

13. There are a number of potential advantages and disadvantages to a redress scheme.

Advantages

14. The advantages include: avoiding a contentious, adversarial process; the flexibility to facilitate apologies and acknowledgements of wrongdoing; assurances that steps have been taken to prevent further abuse; and the provision of support services.

15. Removing the compensation process from the civil justice system will avoid claimants suffering the stress and emotional trauma of adversarial litigation, the purpose of which is limited to obtaining financial compensation. Billhar Singh Uppal warned that, even if the civil justice system was changed to make it easier for claimants to succeed, the "*corrosive, defensive approach*" of denying any fault can be very damaging for claimants.[765]

16. Richard Baldwin, Divisional Director for Children's Social Care at Tower Hamlets London Borough Council, recognised that a single unified system may be beneficial:

> "*I can certainly see the value of bringing something together so that there is just one claims system … So anything that brings together that process into one system sounds very sensible to me.*"[766]

17. Such a scheme may also cater for the specific needs of victims and survivors of child sexual abuse. While the rules concerning criminal convictions may be justified for CICA applications generally (see Part D), a redress scheme may avoid these potentially inappropriate limitations.

18. However, several lawyers, local authorities and insurance companies told us they were more circumspect about the benefits of redress schemes. For example, Alistair Gillespie – formerly a partner at Hill Dickinson, the law firm instructed by Royal & Sun Alliance in the North Wales litigation and the St Aidan's and St Vincent's litigation – said "*It's very difficult, sitting here, to know what a redress scheme would look like that would actually improve the situation*".[767]

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[764] See, for example, AR-A23 27 November 2018 33/24-25, 48/21-49/1; AR-A24 27 November 2018 59/10-11, 60/24-25; AR-A27 30 November 2018 90/12-16
[765] Billhar Singh Uppal 28 November 2018 163/15-164/3
[766] Richard Baldwin 4 December 2018 105/21-106/2
[767] Alistair Gillespie 29 November 2018 65/1-3

Disadvantages

19. There are a number of possible disadvantages to a redress scheme that should be taken into account.

20. A redress scheme may not balance the interests of participants justly or investigate claims with the same degree of rigour as the civil justice system, which Rod Luck, Claims and Reinsurance Manager at Municipal Mutual Insurance, said is *"a process which does mean that both sides to the claim are able and entitled to have cases properly investigated and assessed"*.[768] A redress scheme may also not afford victims and survivors the opportunity to have their 'day in court',[769] which some witnesses, including AR-A21, told us they found beneficial.[770]

21. A redress scheme may have the same drawbacks as the CICA scheme. A tariff-based approach may feel limited and impersonal to those who have suffered abuse.[771] Indeed, the structure of the scheme and the way it is funded – for example by government rather than the institutions – may prevent victims and survivors from feeling they have achieved accountability.

22. A key factor to consider is the funding and duration of such a scheme.

22.1. Many witnesses told us that redress schemes fail to achieve longevity or are limited by their funding.[772] Peter Garsden, a solicitor who represented victims of abuse at St Aidan's and St Vincent's, who was involved with a redress scheme in Jersey, noted that the scheme, like others, was time limited.[773] The Lambeth scheme, similarly, will come to an end on 1 January 2020.[774] By contrast, statutory compensation schemes such as the CICA may not conclude after a fixed period, so do not disadvantage those who for whatever reason delay coming forward.

22.2. The source of the funding may be important. If the scheme is funded by the government, it may have few differences from the CICA scheme. Also, victims and survivors may not feel that the process is holding the relevant institution to account. It may therefore be important to involve local authorities, private and voluntary children's homes, and insurance companies.

22.3. Richard Baldwin sounded a note of caution about the funding of redress schemes falling on the shoulders of local authorities. When large groups of survivors come forward, this may cause significant financial difficulties.[775] In his view, *"it would be up to the local authorities, either individually or collectively, to make a decision about where those resources and where those finances best sit in terms of how they're best spent"*.[776]

[768] Rod Luck 3 December 2018 81/3-6
[769] See, for example, Alistair Smith 11 December 2018 54/24-55/1
[770] AR-A21 27 November 2018 11/16-13/11
[771] Stephen Bellingham 7 December 2018 67/10-16
[772] For example, Stephen Bellingham 7 December 2018 67/6-9
[773] Peter Garsden 6 December 2018 127/23-128/6
[774] Lambeth Children's Home Redress Scheme paras 3.1–3.2
[775] Richard Baldwin 4 December 2018 106/10-14
[776] Richard Baldwin 4 December 2018 106/14-18

22.4. Peter Garsden suggested that a redress scheme could potentially cover lower value cases, or those that fall foul of limitation.[777] While that might seem a sensible solution, it may risk treating victims and survivors differently. Those who are more seriously affected by abuse may then have to go through the traumatic experience of a civil claim.

23. Some insurers told us that they were reluctant to commit to how they might engage with a redress scheme – whether voluntarily or through obligation – and how it might impact them, without knowing more details.[778] This was understandable. Their considerations are primarily financial and they cannot offer apologies or commitments for the future.[779] As Philippa Handyside of the Association of British Insurers explained, the compensation that insurers pay is not discretionary, it is based on a legal liability within the civil justice system to indemnify institutions.[780]

[777] Peter Garsden 6 December 2018 129/5-12
[778] Rod Luck 3 December 2018 81/13-18
[779] Stephen Bellingham 7 December 2018 68/3-13, 69/6-10
[780] Philippa Handyside 12 December 2018 62/15-63/16

Part G

Conclusions and recommendations

Conclusions and recommendations

G.1: Conclusions

1. Accountability and reparations for child sexual abuse takes many different forms – including punishing offenders, holding institutions to account, acknowledging abuse and providing apologies, explanations and assurances of non-recurrence, redress (including financial compensation) and support.

2. None of the systems under examination in this investigation – civil justice, criminal compensation or support services – is designed to deliver all of these objectives. However, the operation of those systems could be improved so that they become more effective at delivering accountability and reparations for victims and survivors.[781]

Conclusions in respect of signposting compensation

3. The Victims' Code is intended to set out the services to be provided to victims of crime. The Code raises awareness of the entitlement to apply for awards from the Criminal Injuries Compensation Authority (CICA). But it does not signpost the rights of victims and survivors to bring claims for compensation in the civil courts. Nor does it signpost the possibility that they may receive financial compensation in the form of a criminal compensation order (CCO) by the criminal courts.

4. The Inquiry has previously heard from victims and survivors that they had not consistently received the level of service they were entitled to under the Victims' Code.[782] In its Interim Report, dated April 2018, the Inquiry recommended that the Ministry of Justice, the Home Office and the Attorney General's Office commission a joint inspection of compliance with the Victims' Code in relation to victims and survivors of child sexual abuse. It also recommended that the Victims' Commissioner be consulted on this work.[783]

5. In December 2018, the government published its response to the Inquiry's recommendation. The response noted that it will discuss the possibility of a joint inspection with the Criminal Justice Joint Inspection (CJJI)[784] once its work to ensure compliance with the Victims' Code has formally commenced later in 2019.[785] According to the government's latest progress update, published in July 2019, a draft compliance framework based on five of the entitlements contained in the Code is now in place at a local level. The first report on this framework will be ready in early 2020.[786]

[781] In these conclusions, as throughout this report, we use the phrase 'victims and survivors' neutrally, without making any findings or assumptions that such persons have or have not suffered child sexual abuse.
[782] *The Criminal Justice System*, Independent Inquiry into Child Sexual Abuse
[783] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, p53
[784] The CJJI brings together four Inspectorates: HM Inspectorate of Constabulary and Fire & Rescue Services, HM Crown Prosecution Service Inspectorate, HM Inspectorate of Prisons and HM Inspectorate of Probation.
[785] Government response to the Interim Report by the Independent Inquiry into Child Sexual Abuse, December 2018, para 16
[786] Government response to the Interim Report by the Independent Inquiry into Child Sexual Abuse, Progress Update, July 2019, p5

6. Nevertheless, we remain concerned that the Inquiry continues to see evidence of victims and survivors of child sexual abuse not receiving their entitlements under the Victims' Code. We will therefore want to see the extent to which the new framework implemented by the government addresses our concerns.

7. In the meantime, we consider that the Code requires revision to ensure that victims and survivors are made fully aware of their rights to compensation within the civil and criminal justice systems. It is important that victims and survivors do not lose the opportunity to initiate civil claims or make CICA applications whilst criminal investigations and prosecutions are ongoing. Police forces need to be consistent and proactive in the way that they signpost these entitlements. Normalising the expectation that they will provide this signposting will also negate the risk that criminal trials are compromised by allegations that victims and survivors have fabricated allegations to obtain compensation.

Conclusions in respect of the civil justice system

8. The civil justice system is governed by laws and procedures that apply to all claimants and defendants. Some of its practices – such as the adversarial trial process – are essential components of our system of justice. So too is the law of limitation, which we heard operates unfairly in the context of child sexual abuse litigation, and which we intend to consider further in the next phase of our work (see below).[787]

9. Individual and institutional defendants have the right to defend themselves in accordance with these laws and procedures. However, there is a compelling need for claims by victims and survivors of child sexual abuse to be treated differently from other forms of personal injury litigation.

10. The effects of child sexual abuse on victims and survivors can be lifelong and devastating. Defendants, including local authorities and insurers, must take this into account when responding to civil claims, together with the fact that claimants may struggle to disclose details of their abuse and to initiate and engage with the process of litigation. Claimants should be treated with sensitivity and defendants should recognise that the provision of explanations, apologies, reassurance and access to specialist therapy and support may be as important (or more important) to them than the receipt of financial compensation.

11. Defendant institutions must be able to make apologies, offers of treatment and other redress to victims of child sexual abuse, without undermining their ability to defend civil claims. The Compensation Act 2006 is intended to facilitate this but cannot do so if defendant insurers consider that its wording may not apply to claims involving allegations of vicarious liability for the actions of individual abusers.

12. Victims and survivors should not have their claims prolonged or undermined by not knowing if the defendants have public liability insurance in place to pay for successful claims. In the Inquiry's Interim Report, we recommended that the Association of British Insurers (ABI) consider whether a register could be introduced to assist claimants in this respect. The ABI formally responded to this recommendation in April 2019, raising a number of questions

[787] We are grateful to the Association of British Insurers for indicating that in response to the evidence given by victims and survivors during the Inquiry's hearings they now support a change in the law of limitation as it relates to claims of child sexual abuse (letter to the Inquiry 5 June 2019). We look forward to receiving further assistance from the ABI in relation to this issue.

about the merits of such a register and the challenges that may be faced by its introduction. Having heard the evidence in the case studies, we are satisfied that the benefits of a register for victims and survivors outweigh any potential difficulties it may cause.

13. The quantification of awards of compensation for claims of child sexual abuse is a matter for the courts. However, the general damages that claimants receive must more fully reflect the physical, emotional and psychiatric injuries that they have suffered, together with the impact on their long-term quality of life, including on relationships and their ability to work. The Judicial College is best placed to provide guidance on these matters for the courts and it needs to revise its Guidelines accordingly.

14. In its Interim Report, the Inquiry recommended that the Ministry of Justice provide in primary legislation that victims and survivors of child sexual abuse in civil court cases, where they are claiming compensation in relation to the abuse they suffered, are afforded the same protections as vulnerable witnesses in criminal court cases. In addition, we recommended that the Civil Procedure Rules be amended to ensure that judges presiding over cases relating to child sexual abuse consider the use of these protections.[788]

15. In its responses, the government confirmed that a subcommittee of the Civil Justice Council (CJC) has drafted a consultation document to share with members of the CJC and will produce a final report in autumn 2019. It has also stated that the Ministry of Justice will liaise with the Civil Procedure Rule Committee to explore whether any other provision about protections is appropriate.[789]

16. The practice during civil litigation of claimants having their psychiatric, psychological and physical injuries assessed by two or more medical experts – their own and defendants' – can cause unnecessary distress to victims and survivors of child sexual abuse and may worsen rather than resolve the disputes between the parties. This could be avoided if it were the norm rather than the exception that single experts were jointly instructed by claimants and defendants in such cases.

Conclusions in respect of criminal compensation

17. CCOs are a valuable form of reparation. However, they are not being made in sufficient numbers following successful prosecutions for child sexual abuse. The precise reasons for this are unclear from the case studies, not least because many of the events under consideration occurred many years ago, and many perpetrators received long prison sentences. Further investigation of the present position by the Ministry of Justice is required so that the use of CCOs can be improved.

[788] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, p57
[789] Government response to the Interim Report by the Independent Inquiry into Child Sexual Abuse, December 2018, para 29; Government response to the Interim Report by the Independent Inquiry into Child Sexual Abuse, Progress Update, July 2019, p9

18. The Ministry of Justice is presently conducting a full review of the Criminal Injuries Compensation Scheme.[790] The Inquiry welcomes this review, during which we expect consideration to be given to:

- the Inquiry's finding in its Interim Report that the current CICA rules fail to recognise the impact of child sexual abuse and, specifically, that abuse may have directly contributed to instances of offending[791] and
- the Inquiry's recommendation that the Ministry of Justice revise the rules so that applications are not automatically rejected in circumstances where an applicant's criminal convictions are likely to be linked to their sexual abuse as a child.[792]

19. In the Interim Report, we also welcomed the steps that the CICA has taken to increase the knowledge and understanding of its staff in relation to child sexual abuse, but recommended that more should be done. We raised concerns that applications for compensation relating to child sexual abuse are handled by the general pool of CICA caseworkers. The Inquiry recommended that the CICA ensures that claims relating to child sexual abuse are only considered by caseworkers who have specific and detailed training in the nature and impact of child sexual abuse.[793] In its response, the government stated that all CICA operational staff are given training on child sexual abuse cases, and caseworkers are given specific training on handling child sexual abuse cases.[794]

Conclusions in respect of support

20. Support and therapy are a vital form of reparation for victims and survivors. Within the civil justice system, the Rehabilitation Code is designed to assist personal injury claimants to access the help that they need. A new code is needed, or a revision of the existing Rehabilitation Code, to ensure that this also happens for victims and survivors who are bringing claims of child sexual abuse.

21. In November 2017, the Inquiry held a two-day seminar to explore how institutions in the criminal justice system respond to child sexual abuse.[795] We heard directly from victims and survivors that they had not consistently received the level of service they were entitled to under the Victims' Code. As noted above, in its response to the Inquiry's Interim Report, the government stated that it will discuss the possibility of a joint inspection with the CJJI once its work to ensure compliance with the Victims' Code has formally commenced later in 2019.[796]

22. One of the entitlements in the Victims' Code that must be improved in its implementation is the signposting of support services. Specialist support services for victims and survivors of child sexual abuse vary according to where they live. The police should be aware of what is available in their local area and should take responsibility for ensuring that those services are clearly signposted.

[790] http://data.parliament.uk/DepositedPapers/Files/DEP2018-1283/terms_of_reference_CICS_Review.pdf
[791] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, p54
[792] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, p54
[793] Interim Report of the Independent Inquiry into Child Sexual Abuse, April 2018, p54
[794] Government response to the Interim Report by the Independent Inquiry into Child Sexual Abuse, December 2018, para 21
[795] *The Criminal Justice System*, Independent Inquiry into Child Sexual Abuse
[796] Government response to the Interim Report by the Independent Inquiry into Child Sexual Abuse, December 2018, para 16

G.2: Matters to be explored further by the Inquiry

23. Two important issues arose during the case studies which, in our view, require further investigation:

23.1. Whether the law of limitation should be reformed to make it easier for victims and survivors to bring claims in respect of non-recent child sexual abuse.

23.2. The potential for a redress scheme to offer accountability and reparation to victims and survivors of child sexual abuse.

We will hear more evidence about both of these issues at a further public hearing in November 2019.

G.3: Recommendations

The following recommendations arise directly from the evidence given in the five case studies in this investigation.

Those mentioned in these recommendations should publish their response to each recommendation, including the timetable involved, within six months of the publication of this report.

Signposting civil and criminal compensation

Recommendation 1:

The Ministry of Justice should revise the Victims' Code to make clear that victims and survivors of child sexual abuse must be advised by the police that:

1. They are entitled to seek civil compensation through the civil courts and, if they wish to do so, should seek legal advice – they should be signposted to specialist lawyers identified by the Ministry of Justice.
2. They are entitled to assistance completing any application to the CICA, should they require it. Such assistance should be provided by independent sexual violence advisers or other suitably qualified and trained persons.
3. At the conclusion of any criminal proceedings, the court may make orders for the payment of criminal compensation by convicted offenders to their victims.
4. They are entitled to be referred to organisations supporting victims of sexual abuse. They should be signposted to the support services available in their local area.

The College of Policing should make changes to its guidance (currently Authorised Professional Practice) to require police officers to provide oral and written information on each of these matters.

The Ministry of Justice should also provide further information on how the new compliance framework, and any other developments, will improve compliance with the Code for victims and survivors of child sexual abuse.

The civil justice system

Recommendation 2:

The Local Government Association and the Association of British Insurers should each produce codes of practice for responding to civil claims of child sexual abuse.

The codes should include recognition of the long-term emotional and psychiatric or psychological effects of child sexual abuse on victims and survivors, and acknowledgement that these effects may make it difficult for victims and survivors to disclose that they have been sexually abused and to initiate civil claims for that abuse.

The codes should also include guidance that:

1. claimants should be treated sensitively throughout the litigation process;
2. the defence of limitation should only be used in exceptional circumstances;
3. single experts jointly instructed by both parties should be considered for the assessment of the claimants' psychiatric, psychological or physical injuries; and
4. wherever possible, claimants should be offered apologies, acknowledgement, redress and support.

Recommendation 3:

The government should introduce legislation revising the Compensation Act 2006 to clarify that section 2 facilitates apologies or offers of treatment or other redress to victims and survivors of child sexual abuse by institutions that may be vicariously liable for the actions or omissions of other persons, including the perpetrators.

Recommendation 4:

The Department for Work and Pensions[797] should work with the Association of British Insurers to introduce a national register of public liability insurance policies. The register should provide details of the relevant organisation, the name of the insurer, all relevant contact details, the period of cover, and the insurance limit. These requirements should apply to policies issued and renewed after the commencement of the register, and those against which a claim has already been made.

The Financial Conduct Authority[798] should make the necessary regulatory changes to compel insurers that provide public liability insurance to retain and publish details of all current policies.

Recommendation 5:

The Judicial College should revise its *Guidelines for the Assessment of General Damages in Personal Injury Cases* to include a freestanding section on the damages that may be appropriate in cases of child sexual abuse.

[797] The Department for Work and Pensions is responsible for matters related to workplace compensation and insurance in the UK. It consulted on the introduction of the Employers' Liability Tracing Office (ELTO) in 2010.
[798] The Financial Conduct Authority is responsible for regulating the financial services industry in the UK, including insurance.

This new section of the guidelines should advise the court to take into account the nature and severity of the abuse itself, any short-term and long-term physical, emotional and psychiatric or psychological injuries, and the general effect of the abuse on the claimant's capacity to function throughout their life. The latter may include the ability to sustain personal and sexual relationships, to benefit from education and to undertake paid employment.

Criminal compensation orders (CCOs)

Recommendation 6:

The Ministry of Justice should consult with the Sentencing Council, the Judicial College, the Crown Prosecution Service and other relevant bodies, in order to increase the use of CCOs, where appropriate, in cases involving child sexual abuse by, among other things, implementing guidance for the judiciary and prosecutors in the Crown Courts and Magistrates' Courts.

Support through civil proceedings

Recommendation 7:

The International Underwriting Association of London should take the lead in the production of a code for the benefit of claimants who are bringing civil claims for child sexual abuse. The aim should be to produce a code, comparable to the Rehabilitation Code or for inclusion in that code, with the objective of ensuring that victims and survivors of child sexual abuse are able to access the therapy and support they need as soon as possible.

Annexes

Annex 1

Overview of process and evidence obtained by the Inquiry

1. Definition of scope for the investigation

This investigation is an inquiry into the extent to which existing support services and available legal processes effectively deliver reparations to victims and survivors of child sexual abuse and exploitation.

The scope of this investigation is as follows:[799]

> *"1. The Inquiry will investigate the extent to which existing support services, compensation frameworks and the civil justice system are fit to deliver reparations to victims and survivors of child sexual abuse. 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 in relation to the delivery of reparations to the victims and survivors of child sexual abuse.*
>
> *2. The Inquiry will consider the experiences of victims and survivors of child sexual abuse and investigate:*
>
> *2.1. what amounts to adequate reparation in the case of child sexual abuse, including a consideration of what weight should be attached to the right to an independent and impartial investigation, the right to truth, accountability, compensation, guarantees of nonrecurrence, and support services;*
>
> *2.2. to what extent support services, the civil justice system, and/or alternative compensation frameworks (including the criminal courts and the Criminal Injuries Compensation Authority) have delivered each of these elements to victims and survivors of child sexual abuse, including consideration of:*
>
> *a. the adequacy of support services provided by public, private and charitable organisations;*
>
> *b. the extent to which the current civil litigation framework may have obstructed the delivery of some or all elements of reparation;*
>
> *c. the extent to which the current model of insurance, and/or the practice of insurance companies, may have obstructed the delivery of some or all elements of reparation;*
>
> *d. the extent to which other factors may have obstructed the delivery of some or all elements of reparation;*
>
> *e. the extent to which any of the factors above may also have obstructed the implementation of effective safeguarding measures by institutions.*

[799] https://www.iicsa.org.uk/investigations/reparations-for-victims-and-survivors-of-child-sexual-abuse?tab=scope

3. *To investigate the issues set out above the Inquiry will identify case studies including, but not limited to, the experience of victims and survivors of sexual abuse at Forde Park Approved School and children's homes in North Wales.*
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."*

The scope for the case studies is as follows:[800]

"1. *The description of scope for the Inquiry's investigation into accountability and reparations states that it will examine two specific case studies: North Wales children's homes and Forde Park Approved School.*
2. *The Inquiry has decided to add three further case studies in order to obtain as broad a range of evidence as possible. The additional case studies are: St Leonard's children's home, St Aidan's & St Vincent's children's homes and the Stanhope Castle Approved School. The selection of these case studies does not prevent the inclusion of additional case studies at a later date.*
3. *The accountability and reparations investigation focuses on the aftermath of child sexual abuse. The Inquiry is limited by its terms of reference to considering experiences of child sexual abuse. It is not able to examine other forms of child abuse.*
4. *We will be seeking evidence on the following issues …*
    a. *The process of making a civil claim for damages;*
    b. *Criminal compensation schemes (criminal compensation orders; Criminal Injuries Compensation Authority (CICA), formerly Criminal Injuries Compensation Board (CIBA) awards); and*
    c. *Support services for victims and survivors who have disclosed child sexual abuse, whether or not they were involved in a criminal or civil case.*
5. *The investigation will not examine or resolve disputed factual issues relating to the underlying allegations of child sexual abuse."*

2. Core participants and legal representatives

Counsel to this investigation:

Peter Skelton QC
Lois Williams
Tim Cooke-Hurle
Gideon Barth

[800] https://www.iicsa.org.uk/investigations/reparations-for-victims-and-survivors-of-child-sexual-abuse?tab=scope

Complainant core participants:

AR A31, AR A7, AR A6 (deceased 2018), AR A9, AR A11, AR A28 (deceased 2016), AR A27, AR A13, AR-A5, AR-A34, AR-A25, AR-A3, AR-A194, AR-A36, AR-A79, AR-A96, AR-A14, AR-A41, AR A44, AR A15, AR A78, Peter Smith, Paul Connolly, Colin Watson, James (Thomas) Harding, Paul Sinclair, Mark Gray, Nigel O'Mara, Forde Park Survivor Group and Stanhope Castle Survivor Group	
Counsel	Christopher Jacobs
Solicitor	David Enright, Howe and Co Solicitors
Peter Robson	
Counsel	N/A
Solicitor	David Greenwood, Switalskis Solicitors
AR-A23, AR-A21, AR-A24, AR-A26, AR-A29, AR-A30, AR-A46	
Counsel	Stephen Simblet
Solicitor	Billhar Singh Uppal, Uppal Taylor Solicitors
AR-A1, AR-A19, AR-A2	
Counsel	N/A
Solicitor	Alan Collins, Hugh James Solicitors
Robert Balfour	
Counsel	N/A
Solicitor	Tamsin Allen, Bindmans
AR-A87	
Counsel	Aswini Weereratne QC
Solicitor	Peter Garsden, Simpson Millar
Karen Gray (Not legally represented)	
Counsel	N/A
Solicitor	N/A
AR A20 (De designated as a core participant 14 December 2018)	
Counsel	Alan Barker
Solicitor	Sarah McSherry, Imran Khan and Partners

Institutional core participants:

Chief Constable of Devon and Cornwall Police	
Counsel	Jason Beer QC
Solicitor	Tara Harrop, Joint Legal Services
Devon County Council	
Counsel	Paul Greatorex
Solicitor	Jan Shadbolt, Devon County Council Solicitor
Chief Constable of Durham Constabulary	
Counsel	Alan Payne QC
Solicitor	Stephen Mooney, Deputy Force Solicitor
Commissioner of Police of the Metropolis (MPS)	
Counsel	Jason Beer QC
Solicitor	Metropolitan Police Services' legal services directorate
Chief Constable of Merseyside Police	
Counsel	Graham Wells
Solicitor	Caroline Ashcroft, Force Solicitor
Middlesbrough Council	
Counsel	Steven Ford QC
Solicitor	Michael Pether, BLM
Municipal Mutual Insurance	
Counsel	N/A
Solicitor	Chris Webb-Jenkins, Weightmans LLP
Ministry of Justice	
Counsel	Neil Sheldon QC
Solicitor	Judith Cass, Government Legal Department
Chief Constable of North Wales Police	
Counsel	Graham Wells
Solicitor	Philip Kenyon, Force Solicitor
Royal & Sun Alliance	
Counsel	Jonathan Hough QC
Solicitor	Alistair Gillespie, Keoghs LLP
Zurich Insurance PLC	
Counsel	Nigel Pleming QC
Solicitor	Andrew Lidbetter, Herbert Smith Freehills

3. Evidence received by the Inquiry

Number of witness statements obtained:
121
Organisations and individuals to which requests for documentation or witness statements were sent:
All victim and survivor core participants listed in 2 above
Alistair Gillespie, Keoghs LLP
Alistair Smith, Watson Woodhouse Solicitors
Andrea Ward, DAC Beachcroft
Anglesey County Council
Association of British Insurers
Billhar Singh Uppal, Uppal Taylor
Browne Jacobson
Cheshire Constabulary
Cheshire West & Chester Council
Criminal Injuries Compensation Authority
Crown Prosecution Service
Daniel O'Malley
David Knapp
Detective Constable Dawn Clark, Durham Constabulary
Devon & Cornwall Police
Devon County Council
Durham Constabulary
Elizabeth-Anne Gumbel QC
Flintshire County Council
Graham Needs
Gwynedd County Council
Henry Witcomb QC
Home Office
Kevin Daymond
The Law Society
London Borough of Havering
London Borough of Tower Hamlets
Lord Faulks QC
Malcolm Johnson, Hudgells Solicitors
Merseyside Police
Metropolitan Police Service

Michael Pether, BLM
Middlesbrough Council
Ministry of Justice
Municipal Mutual Insurance
National Crime Agency
NHS England
Nicholas Fewtrell
Nigel O'Mara
North Wales Police
Paul Durkin, Switalskis Solicitors
Penelope Ayles (now District Judge Penelope Taylor)
Peter Garsden, Simpson Millar Solicitors
Rape Crisis England & Wales
Royal & Sun Alliance
Salford City Council
Sarah Erwin-Jones, Browne Jacobson
Simon Bailey, National Police Chiefs' Council
Simpson Millar Solicitors
Solicitors Regulation Authority
The Survivors Trust
Therese Classon, WBW Solicitors
Tracey Storey, Irwin Mitchell
Watson Woodhouse Solicitors
WBW Solicitors
Zurich Insurance

4. Disclosure of documents

Total number of pages disclosed: 25,751

5. Public hearings including preliminary hearings

Preliminary hearings	
1	29 July 2016
2	28 March 2017
3	8 May 2018
4	25 September 2018
Public hearings	
Days 1–5	26–30 November 2018
Days 6–10	3–7 December 2018
Days 11–14	10–14 December 2018
Day 15 – additional hearing day	15 January 2019

6. List of witnesses

Forename	Surname	Title	Called/Read	Hearing date
AR-A21			Called	27 November 2018
AR-A1			Called	27 November 2018
AR-A24			Read	27 November 2018
AR-A23			Read	27 November 2018
Charlotte	Ramsden	Ms	Read	27 November 2018
Neill	Anderson	Temporary Assistant Chief Constable	Called	28 November 2018
Phillip	Marshall	Mr	Called	28 November 2018
Billar	Singh Uppal	Mr	Called	28 November 2018
Gareth	Owens	Mr	Read	28 November 2018
Alistair	Gillespie	Mr	Called	29 November 2018
Edward	Faulks	Lord, QC	Called	29 November 2018
David	Nichols	Mr	Called	29 November 2018
Robert	Balfour	Mr	Read	29 November 2018
AR-A78			Read	29 November 2018
AR-A13			Called	30 November 2018
AR-A41			Called	30 November 2018
AR-A27			Read	30 November 2018
AR-A6			Read	30 November 2018
AR-A31			Read	30 November 2018
AR-A14			Read	30 November 2018
Paul	Sinclair	Mr	Read	30 November 2018
AR-A44			Read	30 November 2018

Forename	Surname	Title	Called/Read	Hearing date
AR-A11			Read	30 November 2018
AR-A3			Read	30 November 2018
AR-A7			Read	30 November 2018
AR-A9			Read	30 November 2018
Deborah	Marsden	Temporary Assistant Chief Constable	Called	3 December 2018
Rod	Luck	Mr	Called	3 December 2018
Emily	Wilkins	Ms	Read	3 December 2018
Christian	Papaleontiou	Mr	Read	3 December 2018
AR-A19			Read	3 December 2018
AR-A20			Read	3 December 2018
AR-A30			Read	3 December 2018
AR-A29			Read	3 December 2018
AR-A26			Read	3 December 2018
Paul	Connolly	Mr	Called	4 December 2018
Daniel	O'Malley	Mr	Called	4 December 2018
Craig	Turner	Detective Chief Superintendent	Called	4 December 2018
Steven	Tinkler	Mr	Read	4 December 2018
Richard	Baldwin	Mr	Called	4 December 2018
Malcolm	Johnson	Mr	Called	5 December 2018
Tracey	Storey	Ms	Called	5 December 2018
Sarah	Erwin-Jones	Ms	Called	5 December 2018
AR-A87			Called	5 December 2018
AR-A36			Called	5 December 2018
AR-A15			Read	5 December 2018
AR-A79			Read	5 December 2018
AR-A2			Read	5 December 2018
AR-A194			Read	5 December 2018
Darren	Martland	Acting Deputy Chief Constable	Called	6 December 2018
Serena	Kennedy	Detective Chief Constable	Called	6 December 2018
Peter	Garsden	Mr	Called	6 December 2018
Paul	Durkin	Mr	Called	6 December 2018
Normandie	Wragg	Ms	Read	6 December 2018
Stephen	Bellingham	Mr	Called	7 December 2018

Forename	Surname	Title	Called/Read	Hearing date
Carolyn	McKenzie	Ms	Called	7 December 2018
AR-A34			Called	7 December 2018
AR-A25			Read	7 December 2018
Peter	Robson	Mr	Called	10 December 2018
David	Orford	Assistant Chief Constable	Called	10 December 2018
James	Bromiley	Mr	Called	10 December 2018
Rod	Luck	Mr	Called	10 December 2018
AR-A5			Read	10 December 2018
James Thomas	Harding	Mr	Read	10 December 2018
Peter	Smith	Mr	Read	10 December 2018
Mark	Gray	Mr	Read	10 December 2018
Colin	Watson	Mr	Read	10 December 2018
AR-A96			Read	10 December 2018
Alistair	Smith	Mr	Called	11 December 2018
Nigel	O'Mara	Mr	Called	11 December 2018
Lee	Eggleston	Ms	Called	11 December 2018
Fay	Maxted	Ms	Called	11 December 2018
Emma	Barnett	Assistant Chief Constable	Called	12 December 2018
Philippa	Handyside	Ms	Called	12 December 2018
Melissa	Case	Ms	Called	12 December 2018
Linda	Brown	Ms	Called	12 December 2018
Gregor	McGill	Mr	Read	12 December 2018
Penelope	Ayles (now known as Taylor)	District Judge	Called	15 January 2019

7. Restriction orders

On 15 August 2016, the Chair issued a restriction order under section 19(2)(b) of the Inquiries Act 2005, granting general anonymity to all core participants who allege they are the victim and survivor of sexual offences (referred to as 'complainant CPs'). The order prohibited (i) the disclosure or publication of any information that identifies, names or gives the address of a complainant who is a core participant and (ii) the disclosure or publication of any still or moving image of a complainant CP. The order meant that any complainant CP within this investigation was granted anonymity, unless they did not wish to remain anonymous. That order was amended on 23 March 2018 but only to vary the circumstances in which a complainant CP may themselves disclose their own CP status.

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.[801] 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. 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 would be 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."*[802]

[801] https://www.iicsa.org.uk/key-documents/322/view/2018-07-25-inquiry-protocol-redaction-documents-version-3.pdf
[802] http://www.legislation.gov.uk/uksi/2006/1838/article/13/made

Annex 2

Glossary

2015 Rehabilitation Code	A voluntary code for claimants and compensators produced by the Rehabilitation Working Party, effective from 1 December 2015. Its objective is ensuring that injured people receive the rehabilitation they need to restore quality of life and earning capacity. While voluntary, the Pre-action Protocol for Personal Injury Claims provides that use of the Code should be considered for all types of personal injury claims.
Approved School	A residential institution approved by the Secretary of State under section 79(1) of the Children and Young Persons Act 1933 to which children could be sent by a court for reasons such as protection or punishment. They were brought to an end by the Cessation of Institutions (Approved Schools) (No 2) Order 1973.
Balance of probabilities	The standard of proof which must be met by a party bearing the burden of proof in a civil case. The standard means that one must prove that their allegation is more likely to be true than not.
Breach of statutory duty	A cause of action in the law of tort, in which one party (A) claims compensation from another party (B) on the basis that A has suffered injury and/or losses because B breached a duty imposed upon them by statutory law.
Burden of proof	The legal phrase used to refer to the onus to prove any particular allegation. Generally, in bringing a claim, it is for the claimant to prove their case.
Civil Justice Council	A non-departmental advisory public body, sponsored by the Ministry of Justice and established under the Civil Procedure Act 1997. It is responsible for overseeing and coordinating the modernisation of the civil justice system, and for that purpose provides advice to the Lord Chancellor, the Judiciary and the Civil Procedure Rules Committee.
Civil justice system	The legal system in which an adversarial process overseen by the courts is used by individuals and organisations to determine matters of a non-criminal nature, including claims for personal injury arising from instances of sexual abuse.
Civil Procedure Rules	A detailed set of rules governing the conduct of civil claims in the courts of England and Wales, introduced in 1998 and regularly updated. The rules provide the courts with extensive case management powers, and cover matters such as how to initiate a claim in the courts, the evidence that must be exchanged, application hearings and the running of final trials.
Claim form	A document setting out brief details of a claimant's claim, which must be filed with and issued by the court, triggering the formal commencement of civil proceedings.
Claimant	The party bringing a claim in the civil justice system.

Code of Practice for Victims of Crime	Also known as the Victims' Code. Statutory guidance on the support and services that victims of crime are entitled to receive from criminal justice agencies in England and Wales, from the point of reporting a crime to after the conclusion of a criminal trial.
Collection order	A method of enforcing financial penalties, including criminal compensation orders, imposed by the courts pursuant to the provisions of the Courts Act 2003.
College of Policing	A professional body established in 2012 for those working in the police service in England and Wales. It sets standards in policing for forces and individuals, and supports the training and education of personnel.
Conditional fee agreement	An agreement with a legal representative which provides for their fees and expenses, or any part of them, to be paid only in certain circumstances – usually only if the client wins the case. From 1 April 2013, pursuant to sections 44 and 46 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 and the Conditional Fee Agreements Order 2013, clients have to pay any success fee and any 'after the event' insurance premiums from their damages.
Criminal compensation order	A form of order which the courts have had the power to issue in the criminal courts since 1973, now governed by sections 130 to 134 of the Powers of Criminal Courts (Sentencing) Act 2000. These orders require a person convicted of an offence to pay money to the victim of that offence, to compensate them for any personal injury, loss or damage arising from it.
Criminal Injuries Compensation Authority	An independent executive agency which deals with compensation claims from people who have been physically or mentally injured because they were the victim of a violent crime in England, Scotland or Wales. Replaced the Criminal Injuries Compensation Board.
Criminal Justice Board	An entity chaired by the Lord Chancellor and comprising senior leaders from across the criminal justice system, such as the Director of Public Prosecutions, the Metropolitan Police Commissioner and the Attorney General. It is responsible for maintaining oversight of the criminal justice process and addressing challenges facing the system.
Criminal Justice Joint Inspection	A collaborative effort between the four criminal justice inspectorates (Constabulary, the Crown Prosecution Service, Prisons and Probation), formalised under the Police and Justice Act 2006, with the objective of providing the ability to consider and address issues which cut across the criminal justice system.
Cross-examination	The term used for questioning an opposing party's witness, characterised by the asking of 'closed' questions which are intended to test, challenge and/or undermine the witness's evidence. Unlike examination-in-chief (see below), cross-examination remains a fundamental part of a trial in civil proceedings.

Crown Prosecution Service	Independent agency headed by the Director of Public Prosecutions that is responsible for deciding whether to prosecute, and prosecuting, criminal cases that have been investigated by the police and other investigative organisations in England and Wales.
Defence	A factual and legal response to a claim which disputes all or part of the claim. Where court proceedings have been commenced, this word can refer to the defendant's formal pleading in response to the claimant's case, which will have been previously set out in a formal document entitled 'particulars of claim'.
Defendant	The party defending a claim brought by a claimant in the civil justice system.
Ex-gratia payment	In civil proceedings, a payment of money made by a defendant to a claimant prior to final determination of the claim at trial, as a good-will gesture. It is inherent in such payments that there is no acknowledgment of actual or likely liability.
Examination-in-chief	The term used for questioning a litigating party's own witness, characterised by the asking of open questions which do not suggest or hint at any particular answer. Examination-in-chief rarely occurs in civil proceedings, as witnesses usually rely on a written statement before answering questions from the other party to the case.
First-tier Tribunal	Part of the United Kingdom court system, established under the Tribunals, Courts and Enforcement Act 2007. It is a first-instance court with seven chambers dealing with different types of legal disputes.
General damages	A form of compensation to address losses which have not crystallised in such a way as to allow for precise quantification. The term is frequently used to refer to compensation for pain, suffering and loss of amenity.
Group action	A group of civil claims that share common or related issues of fact or law and which are litigated together against one or more defendants.
Group litigation order	An order which can be made by the courts in England and Wales under Part 19 of the Civil Procedure Rules, providing for claims to be managed together where they raise common or related issues of fact or law. It involves setting up a register under which the claims subject to the group litigation order will be managed.
Independent sexual violence advisers	People who provide support, advice and help to victims and survivors of sexual violence.
Insurance policy deductible	Sometimes referred to as an excess, this is a minimum amount that an insurance policyholder must contribute to a claim before the insurer adds its contribution.
Insurance policy limit	The maximum amount that the insurer will pay towards any covered claim.
Interim payment	In civil proceedings, a payment of money made by a defendant to a claimant prior to final determination of the claim at trial, in recognition of an established or likely legal liability to pay compensation at the conclusion of the litigation.

Judicial College guidelines	A set of guidelines promulgated by the Judicial College providing indicative ranges of general damages for a wide range of types of personal injury. These guidelines are frequently used by parties' legal representatives and the courts as the first step in addressing general damages for personal injury.
Legal aid	Financial assistance provided in accordance with set criteria to those who cannot afford legal assistance and representation whilst engaged with the court system.
Legal Aid Agency	Executive agency sponsored by the Ministry of Justice responsible for considering applications and administering legal aid. Replaced the Legal Aid Board.
Legal expenses insurance	An insurance policy which can be purchased by individuals or businesses to cover the legal costs associated with certain types of legal actions. Depending on the circumstances, it can be purchased on a 'before the event' or 'after the event' basis.
Letter of claim	A letter to a proposed defendant in civil proceedings, which should set out the basis of the proposed claim and the remedy that is sought. Required under various pre-action protocols in England and Wales, a letter of claim is frequently the first time a claimant will formally engage with the defendant in a litigation context.
Letter of response	The defendant's response to the letter of claim sent by the claimant, setting out their position in relation to the matters raised.
Limitation	A legal term used to refer to a statutory defence which can be invoked by a defendant to defeat a claim because it has been brought outside the legal time limit (ie after the end of the statutory limitation period). In personal injury claims, the normal position is that a claim must be brought within three years of the act or acts causing injury, unless that time is extended by the court.
Male Survivors Partnership	A national umbrella agency for member organisations providing support specifically for male victims and survivors of sexual violence and abuse.
Master of the Rolls	The most senior judge in the Civil Division of the Court of Appeal of England and Wales.
MC100	A form to be provided by a defendant in the Magistrates' Court setting out their financial means.
Mediation	An alternative means of resolving litigation prior to going to trial, usually involving a process of negotiation facilitated by a neutral mediator.
MG19	A form that can be used to set out the basis of compensation claimed by a victim in the criminal courts, which can be taken into account when the court is considering the making of a criminal compensation order.
National Crime Agency	A non-ministerial government agency whose role is to counter organised and serious crime, including modern slavery, human trafficking, and the sexual abuse and exploitation of children. It does so by providing support to local police forces, as well as undertaking investigative activities itself.

National Police Chiefs' Council	An organisation established under section 22A of the Police Act 1996 with a range of functions and objectives, including considering and developing coordinated police force responses to widespread problems of crime. It is also the representative body for British police chief officers.
Negligence	A cause of action in the law of tort, characterised by the payment of compensation by one party (A) to another (B) where A has breached a duty of care owed to B, causing the latter to suffer injury or loss.
NSPCC	National Society for the Prevention of Cruelty to Children. United Kingdom charity with statutory powers that is dedicated to the protection of children. Established in 1889 and incorporated by Royal Charter in 1995.
Operation Emily	A Cheshire Constabulary operation investigating allegations of abuse at St Aidan's Approved School (subsequently a community home).
Operation Gogh	A Merseyside Police operation, later named Operation Care, investigating allegations of abuse at St Vincent's Approved School (subsequently a community home).
Operation Hamoon	A 1995 Metropolitan Police operation investigating allegations of sexual abuse at St Leonard's Children's Home in Essex.
Operation Lentisk	A multi-agency investigation into allegations of sexual abuse at Forde Park Approved School (subsequently a community home).
Operation Mapperton	A 1998 Metropolitan Police operation investigating allegations of sexual abuse at St Leonard's Children's Home in Essex.
Operation Midday	A Durham Constabulary operation investigating allegations of abuse at Stanhope Castle Approved School (subsequently a community home).
Operation Pallial	An ongoing National Crime Agency operation reviewing all previous investigations into child sexual abuse in North Wales, and investigating new allegations.
Part 36 offer	An offer to settle a civil claim, made under Part 36 of the Civil Procedure Rules. These offers need to meet a number of formal requirements as set out in the rules, and their rejection can have significant costs consequences for the parties, depending on the outcome of the claim at trial.
Parties	A term used to refer generally to individuals and institutions who are claimants and defendants in the civil justice system.
Pre-action protocol	A set of steps approved by the Master of the Rolls and annexed to the Civil Procedure Rules which the courts expect claimants and defendants to take before commencing proceedings. The courts take any failure to comply with pre-action protocols into account when considering their approach to sanctions imposed as part of the litigation, for example in relation to legal costs.
Preliminary issue	A point of law or dispute of fact which arises in litigation which is appropriate for determining prior to the final substantive trial. The determination of a preliminary issue can occur immediately before (ie at the start of) a trial, or at a prior hearing specially convened for that purpose.

Public liability insurance	An insurance policy which is commonly held by public, charitable and private institutions to cover any legal liabilities arising from injuries and/or losses suffered by members of the public.
Public liability register	As proposed in this report, a register containing the details of public liability insurance held by institutions having responsibility for children, over time. It is recommended that such a register contain the name of the institution, the name of the insurer, the period of cover and the insurance limit.
Rape Crisis England & Wales	An umbrella agency for a network of independent member rape crisis centres across England and Wales which seek to support female victims and survivors of sexual violence and abuse.
Rehabilitation Working Party	Entity responsible for publishing the Rehabilitation Code. It includes representatives from the International Underwriting Association, the Association of British Insurers, Lloyd's, primary insurers, legal groups, care providers and the NHS.
Sexual assault referral centre	A provider of specialist medical, forensic and support services to victims and survivors of rape and sexual assault, irrespective of whether or not they choose to report the matter to the police. Commissioned by NHS England, together with Police and Crime Commissioners.
Special damages	A form of compensation to address losses that can normally be calculated with precision. In claims for personal injury, it frequently encompasses compensation for lost earnings and the cost of medical treatment.
Strike out	A legal mechanism which can be used to bring court proceedings to an end without having to proceed to a full trial. It is most commonly used in circumstances where, due to legal or factual weaknesses in the party's case, the claim or defence is deemed to be hopeless.
The Survivors Trust	A national umbrella agency for around 130 specialist member organisations providing support for those affected by sexual violence or abuse.
Tort	A branch of civil law most commonly characterised by the payment of monetary compensation for established wrongdoing, rather than the imposition of any criminal sanction.
Vicarious liability	A form of legal liability under which one entity or individual can be held liable for the wrongdoing of another, in certain circumstances.
Victims' Code	Also known as the Code of Practice for Victims of Crime. Statutory guidance on the support and services that victims of crime are entitled to receive from criminal justice agencies in England and Wales, from the point of reporting a crime to after the conclusion of a criminal trial.
Victims' Information Service	A service operated by Victim Support which provides information to victims of crime about the support services available to them, as well as information about the criminal justice system, the Victims' Code and the Witness Charter.

Victims Strategy	A cross-government strategy published in 2018 setting out the intended response of the criminal justice system to the issues facing victims of crime. It incorporates a range of actions to strengthen and improve the support provided to victims, involving all criminal justice agencies, including the police, the Crown Prosecution Service and the courts.
Victim Support	An independent charity dedicated to supporting victims of crime and traumatic incidents in England and Wales, in particular as they interact with the criminal justice system.

The Roman Catholic Church

Case Study: English Benedictine Congregation

1. Ealing Abbey and St Benedict's School
2. Ampleforth and Downside: update

Investigation Report
October 2019

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

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Contents

Part 1

Ealing Abbey and St Benedict's School

Executive Summary

Ealing Abbey is an English Benedictine monastery, established in 1897 by monks from Downside Abbey. Ealing Priory, as it was then called, became independent from Downside in 1947. Eight years later it achieved Abbey status, becoming the first Benedictine Abbey in Greater London since the Reformation. The monastery is home to 14 monks who live under the care of the Abbot, the spiritual leader of the community. The Abbot is assisted by his Prior, who acts as his principal adviser, and by his Council.

St Benedict's School, Ealing is the only Benedictine day school in England and is situated adjacent to Ealing Abbey. Although it started as a boys' school, it became fully co-educational in 2008 and accepts children from nursery age to 18 years old. The junior and senior schools (the middle school having been absorbed some years ago) have their own headmasters, although since 2006 the headmaster of the senior school has overarching responsibility for the junior school. The number of monks teaching at the school has varied over the years from nine in 1980 to just one in 2018, and none now, in 2019. As well as serving as teachers, monks act as chaplains and lead religious services.

Child sexual abuse at St Benedict's School was extensive. Since 2003, two monks (Laurence Soper and David Pearce) and two lay teachers (John Maestri and Stephen Skelton) have been convicted of multiple offences involving the sexual abuse of over 20 children between at least the 1970s and 2008. In 2016 another teacher, the deputy head Peter Allott, was convicted of offences relating to the possession of indecent images of children. We have also received evidence of at least 18 further allegations against these men and eight other monks and teachers. Material we have seen suggests that the number of complainants is likely to be higher than the figures set out here.

The St Benedict's School of the 1970s was described to us as a "*Cold, grim, forbidding*" and "*beastly*" place.[1] The atmosphere was sadistic and predatory, and we heard that for many children "*coming to school was terrible*".[2] There was a culture of excessive corporal punishment. Physical abuse in many cases was used as a platform for sexual gratification, and a means by which to instigate sexual abuse. Corporal punishment was also used to punish boys who sought to protect themselves and others from sexual abuse, such as RC-A8.

Laurence Soper and David Pearce

A particularly startling aspect of the sexual abuse perpetrated at the school was that very senior figures at the school or Abbey were abusers. David Pearce was the head of the junior school and then bursar; Laurence Soper was head of the middle school, bursar, Prior then Abbot. This created particular problems for those who wished to report sexual abuse – not only the victims, but also others, such as members of staff who heard rumours or observed

[1] RC-A8 4 February 2019 129/1, 148/24
[2] RC-A8 4 February 2019 134/21

behaviour that caused concern. Reporting such matters was therefore made more difficult by the seniority of those against whom the complaint would have been made. Staff members have described the atmosphere as feeling "*like the mafia*" and chose not to risk their jobs.[3]

Pearce was a serial abuser of boys. At least 14 pupils have complained to the statutory authorities of being sexually abused by him. Their allegations span a 32-year period from 1976 to 2008. In October 2009, Pearce was sentenced to eight years' imprisonment (reduced to five years on appeal in May 2010) for various sexual offences against five of these pupils. That was not the end of the matter, however, and in 2011 Pearce faced a further trial relating to indecent assaults against another pupil but was acquitted. In relation to the eight other boys, there was either no complaint made to the police or a decision made by the police/ Crown Prosecution Service not to proceed.

It appears that many in the school and Abbey – teachers and monks alike – were aware of Pearce's behaviour but were seemingly powerless to do anything about it. Gossip amongst the boys and staff was rife and complaints, including from parents, failed to trigger any action by the school or, in the rare event that information was communicated externally, by the statutory authorities. Staff were afraid that by speaking up they would lose their jobs. Pearce may well have been emboldened by this inertia as his abuse became less secretive, filming the boys at the swimming pool, lining them up naked and committing sexual assaults with apparent impunity. Unsurprisingly, Pearce was protected by Soper, but other Abbots and headmasters throughout this period also failed to act to protect children under their care.

Soper is known to have abused at least 10 children at St Benedict's between 1972 and 1983, including multiple rapes. Many of the assaults were committed during acts of corporal punishment apparently inflicted on the slightest of pretexts. Soper's predilection for caning boys was well known amongst the boys and staff at the school. He was told to stop by a previous headmaster at some point in the late 1970s or early 1980s. This had no effect, and he continued to cane and sexually assault boys on many occasions.

His campaign of sexual abuse was allowed to continue because of the inaction of those who had the power to do something to stop it or bring him to justice. By 2002 – two years after he had resigned as Abbot – Soper had been appointed general treasurer for the International Benedictine Conference in Rome, residing in Sant'Anselmo. Whilst on police bail in 2011, he left Sant'Anselmo, purportedly returning to London. He absconded and a European Arrest Warrant was issued. Some five years later he was located in Kosovo and extradited. In 2017, he was sentenced to 18 years' imprisonment – over 40 years had elapsed since his offending began.

The role of Abbots

There were significant opportunities to stop abusers in the school which were not acted upon. When Abbot Martin Shipperlee took over as Abbot from Soper in 2000, many were hopeful that a "*new broom*"[4] had arrived. Indeed, some improvements to child protection were made. He commissioned a number of independent reports from experts.

[3] MPS002950_001; MPS002946_003
[4] MPS002959_002

David Tregaskis, a clinical criminologist with extensive experience of providing risk assessments, provided a report about the risk Pearce posed to children. He concluded that there was a "*major concern*" and "*clear boundaries*" should be placed upon him.[5] Although restrictions were placed upon Pearce, they were not monitored properly. In 2006, the sexual abuse committed by Pearce was established in a civil trial brought by one of his victims. Mr Justice Field said he found Pearce's account "*extremely unconvincing*"[6] and the allegations were found proven. There were no changes to the restrictions already placed upon Pearce, although there could have been no doubt about the risk he posed. In the same year as the civil trial, Pearce started to sexually abuse a 16-year-old boy who was working in the monastery.

There were also limitations to the advice Abbot Shipperlee received from the Diocese of Westminster Child Protection Team. In particular, the advice provided in respect of imposing restrictions upon Pearce and others failed to give any guidance on how compliance with those restrictions should be enforced and monitored. The Child Protection Officer failed to keep the risk posed by Pearce and the restrictions in place under review, particularly following the successful civil claim. Pearce should have been required to leave Ealing Abbey – particularly given its proximity to the school.

When Pearce was convicted in 2009, Abbot Shipperlee commissioned a further review by Philip Wright, the safeguarding coordinator for the diocese of Brighton and Arundel and John Nixson, an independent child protection specialist. Despite the mounting child protection concerns against Soper and another monk, the review was confined to Pearce. There was no consideration of the underlying material. The whole exercise was limited to two days' work. John Nixson in his written evidence to the Inquiry stated: "*with the benefit of further reflection, it is now evident to me that Abbot Martin presented the existing concerns and findings about individual members of the religious community in a minimal manner*".[7]

The Abbot President of the English Benedictine Congregation in the period from 2001 to 2017, Dom Richard Yeo, did not significantly contribute to the response of Ealing Abbey to the allegations of child sexual abuse made in that period. During his 2007 Visitation he did not inquire into the restrictions upon Pearce and gave no consideration to issues of risk management. In his report to the monastic community, there was no express recognition of the fact that the judge in the civil proceedings in 2006 had found Pearce to be an unconvincing witness. He conceded that, in retrospect:

> "*I should probably have suggested at the 2007 Visitation that it was too serious a risk to allow … Pearce to continue to live in the monastery*".[8]

Throughout this time, public pressure was mounting. A series of articles appeared in *The Times*, the Charity Commission published a critical report, public disquiet gained momentum through Jonathan West's blog, the Independent Schools Inspectorate had published a follow-up report which was critical of Trustees, and the Minister of State for Schools was seeking "*assurance that all ISI's recommendations will be implemented*".[9]

[5] BNT001208_011-12
[6] BNT001206_019
[7] INQ003916_004-005
[8] BNT006991_028
[9] INQ003858_071

In the light of these pressures, Lord Carlile of Berriew QC was commissioned in 2010 to prepare a report. Abbot Shipperlee submitted five principles for reform which Lord Carlile accepted. He firmly stated, however, that reforms could not take place under the auspices of a single trust and recommended the creation of two separate charitable trusts – in effect separating the school from the Abbey. St Benedict's School became truly independent of Ealing Abbey on 1 September 2012.

During the Inquiry's investigation into Ealing Abbey, Abbot Shipperlee resigned. He admitted to the Inquiry *"as has been serially revealed, my administration of safeguarding is of insufficient standard"*.[10]

The role of headmasters

Headmasters as well as Abbots played a significant role in managing child protection issues. Christopher Cleugh, during his time as headmaster of the school between 2002 and 2016, repeatedly minimised questions of child sexual abuse to teachers and to external institutions and parents, to the point of materially misrepresenting significant facts. Although he told the Independent Schools Inspectorate that one of the monks had been charged with an assault on a pupil doing work experience in the monastery, he did not tell them that Pearce had been under restrictions at the time, nor did he tell them about the successful civil action against Pearce. He did not address safeguarding issues openly and proactively; when answers were given, he was defensive. One former teacher, Peter Halsall, said the previous culture of cover-up and denial at the school was *"followed … by passing the buck"*.[11]

Andrew Johnson, who was appointed headmaster in 2016, described a number of improvements to safeguarding, including record-keeping and vetting, compulsory reporting to Ealing Social Services, safeguarding training for staff, information for students and parents, and the operation of the safeguarding sub-committee. He also outlined that he had commissioned an audit report from Philip Threlfall, an independent safeguarding consultant, who concluded that the school was committed to safeguarding and that the *"right things are in place"*.[12] In order for these changes to have a long-term impact, it will now be for those in responsibility at the school to remain vigilant so as to ensure that safeguarding remains a priority.

The role of external agencies

The Metropolitan Police made mistakes in how some of the early allegations against Pearce and Soper were investigated. For example, in 2001, one of the victims told the police that Pearce had forcibly grabbed his trousers and pants and looked down into his pants, and that Pearce had put his hands down the swimming trunks of another boy, *"for a couple of seconds having a feel around"*.[13] In July 2002, the police decided to take that case no further, the investigating officer concluding *"I have been unable to find evidence of any criminal offences"*.[14] This approach was unreasonable. Commander Neil Jerome, in his evidence to us, agreed.

[10] Abbot Martin Shipperlee 7 February 2019 68/25
[11] MPS002946_003
[12] BNT007148
[13] OHY006649_016
[14] MPS003014_043-044

There were also failures in respect of the investigation into the allegations against Pearce in respect of another boy, including a failure to provide all relevant information to the Crown Prosecution Service when a prosecution decision was sought.

The Crown Prosecution Service shares some responsibility for the fact that neither Pearce nor Soper were prosecuted in 2004, when serious allegations were made by two victims against them. It was not until 2009 and 2017 that Pearce and Soper were convicted of the abuse. In the Crown Prosecution Service decision regarding one victim's allegations against Pearce, the reviewing lawyer wrongly adopted a requirement for corroboration. Likewise, in the decision concerning another victim's allegations against Soper, the Crown Prosecution Service lawyer took the view that a victim's word against a perpetrator was insufficient to found a prosecution instead of considering whether the victim's account could be supported by other evidence or whether Soper's account could be undermined.

There were also deficiencies in the consideration of the situation at Ealing Abbey and St Benedict's School by those external bodies charged with regulating the management of charities (the Charity Commission) and inspecting independent schools (the Independent Schools Inspectorate). The Charity Commission was undertaking a statutory inquiry into Ealing Abbey's handling of Pearce at the very time when he was committing further child sexual abuse. The Commission's conclusion at the time, that appropriate steps were being taken, was based on assurances given by Ealing Abbey, which were not scrutinised or tested. Likewise, the Independent Schools Inspectorate oversaw an inspection in 2009 which concluded that the child protection policy was compliant with statutory guidance, and that an independent review into Pearce's offending had been conducted and its advice fully implemented: both conclusions were wrong. The 2009 report was withdrawn in April 2010 and an unannounced, non-routine further inspection was carried out, resulting in a critical report of August 2010. But for the fact that members of the public drew the deficiencies of the 2009 report to the Commission's attention, there may have been no such rectification of the position.

It is notable that in 2010 the Department for Education did not have the statutory power to enforce a recommendation made by the Independent Schools Inspectorate to the effect that monks who had been the subject of allegations should not reside at Ealing Abbey. As a result, the Minister for Schools wrote to the Charity Commission in October 2010 to see if the Charity Commission might be able to use its powers to enforce compliance in this regard. The position is now different. From January 2015 changes to the statutory standards by which independent schools are judged have rectified this gap in the Department's powers.

The role of the Holy See

Prior to the hearing, the Inquiry sought a witness statement and documentation from the Holy See, initially through a voluntary request to its diplomatic representative in the United Kingdom, the Apostolic Nuncio, who is covered by diplomatic immunity. The request included asking what steps were taken after Soper's disappearance that might have assisted in locating him. The Holy See has confirmed that it does not intend to provide a witness statement but has provided some documentation which is being reviewed and may be considered further, if necessary, during the hearings we are holding in October and November 2019.

Recommendations

This report on the Ealing Abbey and St Benedict's School case study forms part of the Inquiry's wider investigation into the Roman Catholic Church. As part of that investigation, as set out above, there will be a hearing in late 2019 following which a further report including any recommendations will be published.

Pen portraits

RC-A622

RC-A622[15] attended St Benedict's in the 1960s and 1970s, between the ages of eight and 15. He was sexually abused by Laurence Soper, then Abbot of Ealing, from the age of 12. At first, Soper fondled and stroked his genitals; however, the abuse quickly escalated. Soper made RC-A622 watch him while he masturbated and forcibly masturbated RC-A622. He caned and anally raped him on several occasions, sometimes ejaculating inside him and sometimes on the child's body. Once, during a school trip, Soper fondled RC-A622's genitals and then put RC-A622's penis into his mouth. He told the boy to keep these incidents a secret, threatening him with severe punishments or expulsion.

Soper's abuse had a devastating impact on RC-A622. He went from being a happy child who enjoyed school and aspired to become a veterinarian or a pilot to playing truant, stealing and drinking excessively. He said:

> *"I was drinking to numb the pain of what Soper was doing to me … To this day, I can still smell the aroma of the dirty habit that Soper wore and the smell of the leather on the desk that I was made to bend over. I don't think these smells will ever leave me. I feared going to school once the abuse started."*[16]

His relationship with his parents broke down.

As an adult, RC-A622 was unable to hold down a job or maintain personal relationships. He described falling into depression, losing contact with his two children and becoming homeless as a result of his excessive drinking. He attempted suicide several times and was sectioned because of his mental health problems. He said:

> *"I often wonder what my life would have been like if I hadn't been abused … I feel like I am still in a black hole and just can't climb out of it. I don't think I can ever put down in words fully what [Soper] has done to me. He has damaged me for life and I am afraid that that damage will never go away."*[17]

RC-A8

RC-A8[18] attended St Benedict's in the 1970s, from the ages of 13 to 16. He had already been sexually abused by a family friend by the time he joined the school.

During the three years he spent at St Benedict's, RC-A8 was physically and sexually abused by Soper. Soper would regularly cane RC-A8, including on one occasion so severely that he drew blood. RC-A8 described two further incidents where Soper fondled his bottom and tried to probe his anus with his fingers, over clothing. RC-A8 told us that Soper would

[15] RC-A622 8 February 2019 83/1-87/18
[16] RC-A622 8 February 2019 84/10-14
[17] RC-A622 8 February 2019 86/12-13, 87/3-4, 10-12
[18] RC-A8 4 February 2019 126/4-149/8

regularly "*feel up*" the boys and that this was "*full-on highly intrusive groping … the aim of it was sexual gratification for Soper and sexual humiliation for me*".[19]

RC-A8 became "*the most beaten, the most caned boy*"[20] in the school, after he tried to protect one of his friends from abuse. He told us that:

> *"refusing these men led to being singled out … . Each master/cleric, lay or clergy, had their own coterie of boys … these were boys who might be past their sell-by date sexually, but were still under the spell of these predators … we are not talking about a bit of push and shove in the playground, we are talking about football-hooligan-level violence, we are talking about serious beatings in the street on the way home. That sort of thing. So you had official punishments – canings on all sorts of made-up pretexts … And then you had the other, the other victimisation, the physical violence. In a nutshell, I'd say that boys like me who resisted could look forward to having their educations derailed and wrecked … It was as if these men were following an instruction manual they'd learned by rote: grooming, accusation, persecution."*[21]

RC-A596

RC-A596 was a pupil at St Benedict's from the mid 1970s to the early 1980s. He was summoned by Father David Pearce, a monk of Ealing Abbey, to his office two to three times a week. Pearce would touch his legs, bottom and genitals, expose himself and force RC-A596 to masturbate him through his robes. Pearce told RC-A596 that this was "*okay*" and "*normal*".[22] The abuse went on for approximately three years,[23] when RC-A596 was between 10 and 14 years old.[24]

He was left with many psychological problems, including depression and anxiety, and attempted suicide on a number of occasions. He struggled with drug and alcohol addictions and had trust issues and difficulties forming relationships.[25]

Pearce's abuse had a devastating impact on RC-A596. As he told the Metropolitan Police in 2009:

> "*He destroyed the foundations of mental, emotional and psychological wellbeing and stability which, for most, are the basic ingredients for a happy and productive existence. His despicable conduct robbed me of the ability to trust other*[s], *destroying my capacity to form loving and lasting relationships. Instead, I found myself seemingly intent on self-destruction, the result of unbearable mental and emotional suffering. The self-loathing and self-hatred his crimes engendered in me saw me go through a lifetime of self harm, beginning at the age of 15 ... I was repeatedly confined to psychiatric institutions over the next 25 years. I found myself unemployable and homeless, incapable of pulling out of the negative spiral that is substance abuse and dependence, a direct result of Pearce's crimes ... He still appears in my nightmares ... his crimes are woven into the very fabric of my existence.*"[26]

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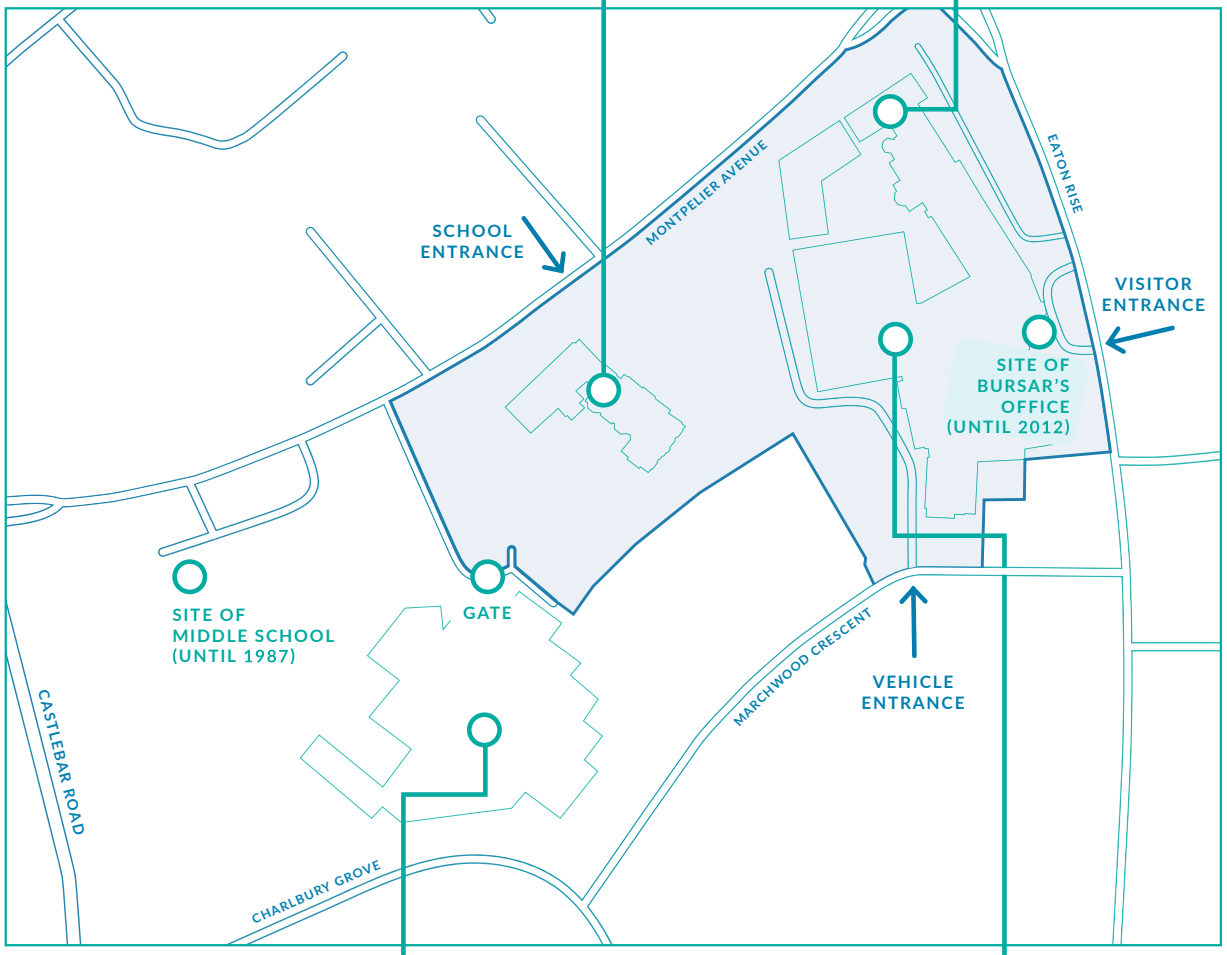
[19] RC-A8 4 February 2019 134/3-4, 7-11
[20] RC-A8 4 February 2019 138/6
[21] RC-A8 4 February 2019 131/7-25; 132/1-3; 137/19-21
[22] BNT001228_015, 030-033; BNT001190_013-014
[23] BNT001228_007-008, 018, 029-030
[24] BNT001190_013
[25] BNT000816_003
[26] MPS004245

Part A

Introduction

ST BENEDICT'S JUNIOR SCHOOL

ST BENEDICT'S SCIENCE BLOCK (PRINCIPALLY USED BY THE SENIOR SCHOOL)



EALING ABBEY WITH MONASTIC ACCOMMODATION (LEFT)

ST BENEDICT'S SENIOR SCHOOL

Ealing Abbey and St Benedict's

Chronology of abbots and headmasters

Abbots of Ealing Abbey	
Rupert Hall	1955–1967
Francis Rossiter	1967–1991
Laurence Soper	1991–2000
Martin Shipperlee	2000–2019
Dominic Taylor	2019–present

Headmasters of St Benedict's School	
Senior School	
Father Bernard Orchard	1945–1960
Father George Brown	1960–1965
Father Bernard Orchard	1965–1969
Father George Brown	1969–1977
Father Anthony Gee	1978–1985
Father Gregory Chillman	1985
Dr Anthony Dachs	1986–2001
Mr Christopher Cleugh	2002–2016
Mr Andrew Johnson	2016–present
Junior School	
Father David Pearce	1985–1993
Father Martin Shipperlee	1993–2000
Mr Denis McSweeney	2000–2005
Mrs Catherine Nathan	2005
Mr Robert Simmons	2005–2008

Introduction

A.1: The background to the investigation

1. The Inquiry's investigation of Ealing Abbey and St Benedict's School (St Benedict's) is our second case study concerning the English Benedictine Congregation (EBC). Our first case study concerned Ampleforth and Downside Abbeys and their respective schools and we published our report in August 2018.[27] It was necessary to consider Ealing separately because relevant criminal proceedings in respect of Laurence Soper, former Abbot of Ealing, were ongoing at the time of the earlier review.[28] This report should therefore be read in conjunction with our Ampleforth and Downside report.

2. The child sexual abuse perpetrated against pupils at St Benedict's between at least the 1970s and 2008 was extensive. During his evidence to our inquiry on 7 February 2019, Abbot Martin Shipperlee, abbot since 2000, said of his own handling of child sexual abuse allegations at Ealing during his abbacy that:

> *"as has been serially revealed, my administration of safeguarding is of an insufficient standard … I have made at least one extraordinary – a very serious mistake which isn't creditable [sic] to me and that my brethren who have offended have done serious wrong. I can only apologise for what I've done wrong … "*[29]

The following day, Abbot Shipperlee's resignation was announced by the Abbot President of the EBC at the outset of his evidence to us. Abbot President Christopher Jamison said:

> *"in the light of what I heard during the hearing, and in the light of his own self-assessment, I have accepted his resignation".*[30]

3. Subsequently, on 8 February 2019, Abbot Shipperlee made the following press statement:

> *"As the IICSA hearings have shown, there has been a series of serious failings in safeguarding and some of those failings have been mine. Much has been achieved to correct this in recent years and I have confidence in the present structures and policies. However this does not take away from the seriousness of what went before. In order for the Abbey to look forward with confidence new leadership is now needed and so I have resigned as Abbot so that this may be possible."*[31]

4. Our investigations into these three EBC-related institutions, taken together, have provided insight into the nature of the institutional failures, the challenges faced by the EBC, and the efforts made to comply with the recommendations of previous reviews, including the Carlile Review in 2011. This insight in turn will inform the investigation into the wider Roman Catholic Church.

[27] Ampleforth and Downside Investigation Report
[28] Chair's decision 8 June 2017
[29] Abbot Martin Shipperlee 7 February 2019 68/25, 69/1-3
[30] Abbot President Christopher Jamison 8 February 2019 63/12-23
[31] https://www.thetablet.co.uk/news/11346/abbot-of-ealing-abbey-resigns-over-failure-to-report-abuse

5. There are also a number of areas of potential overlap with other investigations, such as the Anglican Church, Residential Schools, and Accountability and Reparations. Therefore, some topics and themes may echo those in other investigations by the Inquiry.

A.2: The scope of the investigation

6. Since 2003, two monks (Laurence Soper and David Pearce) and two lay teachers (John Maestri and Stephen Skelton) have been convicted of multiple offences involving the sexual abuse of children perpetrated between at least the 1970s and 2008. Another teacher, deputy head Peter Allott, was convicted in 2016 of offences relating to the possession of indecent images of children. The Inquiry also received evidence of at least 18 further allegations against these five men and eight other monks and teachers (RC-F41, RC-F46, RC-F122, RC-F191, RC-F282, RC-F310, RC-F311, RC-F312).

7. The accounts that we have heard have encompassed a wide spectrum of behaviour, including severe physical chastisement (sometimes for sexual gratification and sometimes as a precursor to further sexual abuse), grooming, fondling of genitalia, and oral and anal penetration. The true scale of sexual abuse of children in the school over more than 40 years is unknown.

8. The issues that we have sought to address in this investigation are derived from the Terms of Reference set by the Home Secretary[32] and the definition of scope for the EBC investigation.[33] Having considered the evidence received in respect of Ealing Abbey and St Benedict's, we identified a number of issues which have formed the core focus of our considerations. These included:

- the extent to which children at St Benedict's were sexually exploited by monks and others associated with those two institutions;
- whether children were sexually abused by individuals against whom allegations had previously been made and not properly acted upon;
- whether adequate safeguarding structures were put in place, or whether these were merely a box-ticking exercise, absent any real desire to implement change and leading to a culture of complacency;
- whether there was a culture of 'victim blaming' or a suggestion that because a child had not made formal complaint it was less serious than claimed;
- whether the first instinct was to protect the perpetrator rather than to safeguard the child, or to consider the perpetrator's wellbeing over that of the child;
- whether decisions were taken with a view to the protection of the reputation of the Church above the safety of children;
- whether any events were deliberately hidden or covered up;
- whether the general attitude was one of minimisation of allegations;
- the background to the review conducted by Lord Carlile of Berriew QC, his report in 2011, and the response of Ealing Abbey and St Benedict's to it;
- what steps the EBC now plans to take to address the safeguarding of children.

[32] https://www.iicsa.org.uk/terms-reference
[33] https://www.iicsa.org.uk/key-documents/584/view/CHILDSEXUALABUSEINTHEROMANCATHOLICCHURCH amended.pdf

A.3: Procedure adopted by the Inquiry

9. 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 23 complainants and victims and nine other individuals or institutions. The Inquiry held preliminary hearings on 5 June 2018 and 1 November 2018. The Inquiry held its substantive public hearings in this investigation over five sitting days between 4 and 8 February 2019.

10. In our first report into the EBC, Ampleforth and Downside, we provided a brief explanation of the EBC, its structure and how it fits within the wider Roman Catholic Church together with a summary outline of the relevant legislation, reports and guidance.[34] We also considered the background of the Nolan and Cumberlege reviews extensively in our Ampleforth and Downside report, together with the efforts made by the EBC to implement Nolan (and to a lesser extent to pay regard to Cumberlege), and so do not consider these matters here.

11. The Inquiry heard a brief Opening Statement from Counsel to the Inquiry on 4 February 2019, and Closing Statements from all core participants on 8 February 2019. Witnesses who gave evidence to the Inquiry included complainant core participants, who gave accounts of the sexual abuse they suffered. The Inquiry received evidence orally, in writing and through disclosure of documents from a number of corporate witnesses, including on behalf of Ealing Abbey and St Benedict's School, the Metropolitan Police, the Crown Prosecution Service, the Diocese of Westminster, Independent Schools Inspectorate and Charity Commission.

12. We have also heard further evidence from the EBC in respect of its response to allegations of child sexual abuse within its institutions. In addition to hearing again from Dom Richard Yeo, Abbot President of the EBC from 2001 to 2017, we also heard from his successor Abbot President Christopher Jamison, who gave evidence as to the EBC's acknowledgment of the many failings identified in our report into Ampleforth and Downside, the action taken to address these, and the efforts that he told us are being made to improve safeguarding within its institutions. Many of these are still in their infancy, so we have found ourselves unable to address the question of how effective they may prove to be in the future.

13. We have sought evidence from the Holy See, initially through a formal request made to the Apostolic Nuncio, its diplomatic representative in London, and subsequently to the Holy See directly. The Holy See has provided some documentation in response to the Inquiry's request but aspects remain outstanding. As a result we are unable to fully assess the role that the Holy See may have played in events concerning the EBC. It is likely therefore that the position of the Holy See will be considered further in the Inquiry's investigation into the response of the Catholic Church as a whole, by which point we expect to have some answers.

14. Finally, there have been a number of developments at Ampleforth and Downside since our report was published. These are summarised in Part 2 of this report.

[34] Ampleforth and Downside Investigation Report

A.4: Terminology

Ealing, Ampleforth and Downside

15. In drafting this report we have used the term Ealing to refer jointly to Ealing Abbey and St Benedict's. Similarly, where we refer to Ampleforth and Downside, this relates to both the abbeys and the schools.

Modes of address

16. When discussing a monk, we have referred to him as Father. When speaking of someone who was Abbot at the time we are considering we have called him Abbot. Once he ceases to hold that position, we have referred to him as Dom.

Ciphering

17. Some of the accused we consider within this report have not been convicted of any offence, and some are deceased. The allegations against them are nonetheless relevant because there may have been institutional failings in responding to them. In such cases we have applied ciphers, such as 'RC-Fxx', to the names of those accused, and sought to prevent their identification through other means, such as not revealing the dates and subject that they may have taught. In some instances, however, the position that they held in the school or Abbey is relevant to an issue – for example, why a child may not have sought to complain at the time the abuse was taking place. In these instances we have ciphered the name as described, but included any other necessary information.

18. The names of complainants, victims and survivors are also ciphered, unless they have specifically waived their right to anonymity. The term 'complainant' is used to indicate someone who has made an allegation of abuse that has not yet been proved. We have also removed details that might lead to identification through other means, such as specific personal characteristics and the house within the school they attended.

References

19. References in the footnotes of the report such as 'ANY001234' are to documents that have been adduced in evidence or posted on the Inquiry website. A reference such as 'Jane Smith 5 February 2019 110/9' is to the witness, the date he or she gave evidence and the page and line reference within the relevant transcript. Hearing transcripts are also available on the Inquiry website.

Part B

Context

Context

B.1: History and establishment

1. Ealing Abbey is an English Benedictine monastery, set up in 1897 by monks from Downside Abbey.[35] Ealing Priory, as it was then called, became independent from Downside in 1947.[36] It achieved abbey status in 1955,[37] becoming the first Benedictine Abbey in Greater London since the Reformation. The Roman Catholic Parish of St Benedict, Ealing, is under the care of Ealing Abbey and does not form part of the Archdiocese of Westminster. The monastery is home to 14 monks under the care of their abbot,[38] the spiritual leader of the community, who oversees the various works they undertake. The abbot is assisted by his prior, who acts as his principal adviser and deputises for him.[39]

2. St Benedict's School, Ealing (St Benedict's) – previously known as Ealing Priory School – is an independent day school and the only Benedictine day school in England.[40] It was founded in 1902 by the Downside monks and began as a boys' school. St Benedict's is now mixed[41] and accepts boys and girls from nursery age to 18 years old. It has approximately 1,000 pupils in a junior and a senior school. Both schools have lay headmasters. Since 2006 the headmaster of the senior school has also had overarching responsibility for the junior school.[42]

3. St Benedict's is situated adjacent to Ealing Abbey. Monks from the abbey may serve as teachers and chaplains, and lead religious services. The number of monks teaching at St Benedict's has varied over the years. Historically, nearly all junior monks were given an opportunity to participate in school life and to do some teaching. In 1980, nine monks were working as teachers at St Benedict's. By 2000, there were only four, which reduced to one monk teaching at St Benedict's in 2018.[43] As at September 2019, the school's website lists no monks among the teaching or support staff.[44]

4. Dom Francis Rossiter was abbot between 1967 and 1991,[45] followed by Dom Laurence Soper between 1991 and 2000, and Dom Martin Shipperlee from 2000 to 2019.[46]

5. As outlined in our introduction, Abbot Shipperlee resigned after giving evidence to our Inquiry. His prior, Father Dominic Taylor, served as monastic superior between February and July 2019. On 9 July 2019, he was elected Abbot of Ealing Abbey.[47]

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[35] See the English Benedictine Congregation case study report concerning Ampleforth and Downside
[36] BNT007139_003 para 1.2
[37] AAT000807_003 para 2
[38] Abbot Martin Shipperlee 6 February 2019 56/19
[39] BNT007139_003 para 2.1
[40] AAT000807_003 para 1
[41] There was previously also a middle school for boys aged 12 and 13 (years 7 and 8), but the evidence that we received suggests that this was subsumed into the main school sometime in the 1990s (MPS002965_003; MPS002951_002). In 1972, girls were admitted into the sixth form for the first time. The junior and senior schools became co-educational in 2007 and 2008 respectively (BNT007139_006 paras 7.1, 7.2).
[42] BNT007139_007 para 8.1
[43] BNT007139_009-010 paras 14, 15
[44] St Benedict's staff list
[45] BNT007139_004 para 3.1
[46] Abbot Martin Shipperlee 6 February 2019 57/2-3
[47] https://ealingmonks.org.uk/dominic-taylor/

B.2: Governance

6. Before 1 September 2012, St Benedict's was wholly owned by the Abbey.[48] Both the school and the Abbey were governed by the Trust of St Benedict's Abbey Ealing (the trust).[49] The trust was chaired by the Abbot of Ealing. Its trustees were Ealing Abbey monks.[50]

7. St Benedict's first lay headmaster, Dr Anthony Dachs, was appointed in 1986. In the same year, a lay advisory board (the Board of School Advisers) was created to assist the trust with the governance and management of the school.[51] Abbot Shipperlee and Christopher Cleugh, the headmaster between 2002 and 2016,[52] told us that, in practice, the trust generally accepted and followed the advice of this advisory board. However, control and governance of St Benedict's remained in the hands of the monks of Ealing Abbey.[53] The advisory board had no executive powers, so any recommendations made were subject to ratification by the trust.[54] The chair of the board of advisers has not always been a lay member; Abbot Shipperlee, for example, served as chair between 2007[55] and 2012.

8. In August 2009, David Pearce, a monk of Ealing Abbey, pleaded guilty to the sexual abuse of five St Benedict's pupils. One of the pupils had been abused while Pearce was under restricted ministry.

9. As a result,[56] in September 2009, Abbot Shipperlee approached the Catholic Advisory Safeguarding Service (CSAS) for help in improving the Abbey's safeguarding policies and procedures. In turn, CSAS asked John Nixson, a social worker and independent consultant, and Philip Wright, the safeguarding coordinator for the Diocese of Arundel, to liaise with Abbot Shipperlee to conduct a review of safeguarding at Ealing Abbey. This review, which was provided to the Abbot in November 2009, was limited, however, as it was conducted over just two days and considered only the Abbey's management of the risk posed by Pearce.[57] It did not include detailed consideration of the safeguarding arrangements at St Benedict's.[58]

10. In August 2010, Dr Kevin McCoy CBE, a child and social care consultant, was instructed by Abbot Shipperlee to carry out an audit of the Abbey's records and archives in order to identify any matter giving rise to a child protection concern, to report any previously unidentified child protection issues to the abbot, and to make recommendations.[59]

11. Thereafter, there was significant criticism from statutory agencies (including the Charity Commission, Independent Schools Inspectorate and the Department for Education[60]) and other individuals over Ealing Abbey's and St Benedict's handling of child sexual abuse allegations. As a result, Abbot Shipperlee asked Lord Carlile of Berriew QC to conduct an independent review into safeguarding and child protection arrangements at St Benedict's.[61]

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[48] Abbot Martin Shipperlee 6 February 2019 62/18-19; BNT007139_007 para 10.1
[49] CYC000210_016
[50] BNT007139_001, 004
[51] Abbot Martin Shipperlee 6 February 2019 63/3-4l, 62/19, 63/21-23
[52] Christopher Cleugh 7 February 2019 115/10-12
[53] Abbot Martin Shipperlee 6 February 2019 66/11-14, 68/19-24
[54] Christopher Cleugh 7 February 2019 121/5-10
[55] Christopher Cleugh 7 February 2019 121/2-10; 125/1-4, 122/7
[56] Abbot Martin Shipperlee 7 February 2019 28/20-25; 21/1
[57] INQ003916_001; INQ003560_001-002; BNT001114_001 and see Part D of this report.
[58] INQ003916_004 para 25
[59] BNT007139_038 para 57.6; BNT003761_001
[60] CYC000255; ISI000019; INQ003857
[61] Abbot Martin Shipperlee 7 February 2019 50/20-25; 51/1-4

One of those who complained was Mr Jonathan West, a member of the public who had become interested in events at St Benedict's as a result of his son having been a pupil there, though not himself a victim of abuse.[62]

12. Lord Carlile published his report in November 2011. In relation to governance, he said:

> *"I have come to the firm conclusion … that the form of governance of St Benedict's School is wholly outdated and demonstrably unacceptable. The Abbot himself has accepted that it is 'opaque to outsiders'. It does not have the appearance of allowing for independent scrutiny of the ongoing relationship between the Abbey and School … In a school where there has been abuse, mostly (but not exclusively) as a result of the activities of members of the monastic community, any semblance of a conflict of interest or lack of independent scrutiny must be removed."*[63]

13. Lord Carlile made a number of recommendations, the most significant of which was that a separate educational charity should be established to govern St Benedict's independently from Ealing Abbey.[64] This recommendation was accepted and, in September 2012, ownership of St Benedict's and responsibility for it was transferred to a newly created charitable trust, St Benedict's School Ealing.[65] This trust is governed by a memorandum and articles of association, which stipulate that St Benedict's governing body must always have a lay majority and that 75 percent of the governors, out of a maximum of 20, must be of the Catholic faith.[66]

14. There are currently 15 governors, of whom 12 (including the chair) are lay. The other three governors are the abbot and two members of the monastic community selected by him. The current headmaster, Andrew Johnson (who has been in that post since 2016), reports directly to the chair of governors.[67]

[62] INQ004176_001 para 1
[63] AAT000807_012 para 25
[64] BNT007137_003
[65] CYC000210_016; BNT007137_003
[66] BNT001116_010 para 10.5
[67] BNT007137_003 para 3.2; BNT001116_009 para 10.2

Part C

Nature and extent of abuse

Nature and extent of abuse

C.1: Introduction

1. There have been a number of allegations of child sexual abuse at St Benedict's School (St Benedict's) over the past 50 years. Precisely how many complaints were made during this period is unclear, as record-keeping and the reporting of incidents have been inconsistent and incomplete. However, since 2003, five men connected with St Benedict's have been convicted of multiple offences involving the sexual abuse of more than 20 children, from the 1970s.

- Father David Pearce was convicted in 2009 of offences against five children perpetrated between 1976 and 2008.
- Abbot Laurence Soper was convicted in 2017 of offences against 10 children perpetrated between 1972 and 1983.
- John Maestri, a former lay teacher at the school, was convicted in 2003, 2005 and 2009 of offences against four children in the mid 1970s and mid 1980s.
- Stephen Skelton, another lay teacher, was convicted in 2011 of offences against two children, one a St Benedict's pupil in 1983.
- Peter Allott, the school's former deputy headmaster, was convicted in March 2016 of downloading and distributing indecent images of children.

(Further details of the abuse follow below. A summary of the criminal convictions is set out in Annex 4.)

2. In addition, the Inquiry received evidence of at least 18 further allegations against these men and eight other monks and teachers (RC-F41, RC-F46, RC-F122, RC-F191, RC-F282, RC-F310, RC-F311, RC-F312).

3. The allegations received by the Inquiry cover a wide spectrum of behaviour, ranging from corporal punishment (in many cases for sexual gratification) to grooming, fondling of genitalia, masturbation, and oral and anal rape.

C.2: Physical and emotional abuse (1970s and 1980s)

4. The St Benedict's of the 1970s was described to us by one former pupil as a "*Cold, grim, forbidding*" and "*beastly*" place, with a culture of severe corporal punishment.[68] The impression given by some pupils was of an atmosphere that was sadistic and predatory.

5. Physical abuse was widespread and we heard that, for many children at the time, "*coming to school was terrible*".[69]

> **5.1.** RC-A8 told us that physical abuse "*happened to all of us*" and was "*commonly talked about and commonly discussed*" amongst the pupils.[70]

[68] RC-A8 4 February 2019 129/1; 148/24; 132/19-22
[69] RC-A8 4 February 2019 134/21-22
[70] RC-A8 4 February 2019 133/12-14

5.2. RC-A24 said "*there were particular teachers whose reputation was that they were almost deranged in their pursuit of corporal punishment*".[71]

6. Several witnesses told us that Soper in particular was a terrifying figure, "*the scariest of the monks there*"[72] and a "*disciplinarian*"[73] who "*everyone saw … as someone best to avoid*".[74] Pearce was also known to use corporal punishment. In 2009, he was convicted of indecently assaulting RC-A594, a boy he would regularly call to his office to receive beatings with a cane and then sexually abuse.

7. The evidence we received shows that, in many cases, physical violence was used as a pretext for sexual gratification. Corporal punishment was also used to punish boys who sought to protect themselves and others from sexual abuse, such as RC-A8.[75]

8. The prevalence and severity of the violence, coupled with the general atmosphere at the school, meant that children did not feel comfortable reporting sexual or other abuse. As RC-A645 said:

> "*I feel quite strongly that the atmosphere of extreme violence, menace and severe corporal punishment was part of what allowed sexual abuse to take place on such a wide scale. When most of the pupils are perpetually in a state of fear and often terror (and I choose my words carefully and I believe accurately here) then teachers can get away with just about anything. It is notable that some of those teachers who were convicted of sex offenses [sic] at school were also amongst the most violent members of staff.*"[76]

9. We agree that children who are intimidated are less likely to report abuse. An atmosphere which is physically violent and threatening is also one where sexual abuse is more likely to occur. The true scale of the physical and the sexual abuse at St Benedict's is therefore likely to be much higher.

C.3: Sexual abuse (1970s to 2000s)

David Pearce

10. David Pearce was born in 1941 and attended St Benedict's as a child. He joined Ealing Abbey in 1969 and was ordained as a priest in 1975.[77] Pearce taught at St Benedict's from 1976 to 1992. Between 1984 and 1992, he was the headmaster of the junior school. He was then appointed Bursar of Ealing Abbey, St Benedict's and Ealing Abbey Parish, remaining in that post until 1999. From 1999 until 2004 or possibly 2006,[78] Pearce was Novice Master, in charge of the education and training of junior monks.[79] He was also a trustee of the Trust of St Benedict's Abbey Ealing (described in Part B) until 2004.[80]

[71] RC-A24 4 February 2019 158/10-13
[72] INQ001661_008
[73] INQ001661_008
[74] RC-A24 4 February 2019 162/11-12
[75] RC-A8 4 February 2019 133/12-14
[76] INQ003561_002 para 9
[77] BNT001146
[78] The precise date is unclear (BNT003761_006; BNT001146).
[79] BNT007139_005 para 4.2
[80] BNT000885_002

11. Following his conviction in 2009 for sexually abusing a number of pupils, and while he was in prison, Pearce requested a dispensation from his monastic vows and the obligations of the priesthood, including celibacy. This request was granted by the Congregation of the Doctrine of the Faith in July 2011, at which point Pearce ceased to be a priest.[81]

Allegations of sexual abuse against Pearce

12. It was well known amongst teachers and pupils that the children at St Benedict's called Pearce 'Gay Dave'. We heard that this was understood by some members of the community[82] to be a reference to Pearce's general manner and sexuality,[83] but used by the pupils also to refer to his sexual interest in boys.[84]

13. At least 14 pupils have complained of being sexually abused by Pearce, either to the police or statutory authorities. The alleged abuse spans a 32-year period from 1976 to 2008.

13.1. In August 2009, Pearce pleaded guilty to indecent assault and gross indecency against five of these pupils: RC-A596, RC-A6, RC-A621, RC-A597 and RC-A594.[85] In October 2009 he was sentenced to eight years' imprisonment;[86] this was reduced to five years on appeal in May 2010.[87]

13.2. In July 2011, Pearce faced a further trial in respect of allegations of indecent assault against RC-A599.[88] RC-A599 said that Pearce had beaten him on his bare buttocks in the late 1970s after he reported Maestri's abuse to Pearce.[89] On other occasions, RC-A599 said that Pearce made him undress, touched his thighs and pulled down his underwear to see if the boy had any pubic hair.[90] Pearce was acquitted.[91] (RC-A599 also made allegations of sexual abuse against John Maestri, who was a lay teacher at St Benedict's at that time,[92] dealt with below.)

13.3. Of the eight remaining allegations of abuse made during this period, there was either no police complaint (RC-A631, RC-A419, RC-A592, RC-A593) or the police or the Crown Prosecution Service made the decision not to proceed with the allegations (RC-A11, RC-A418, RC-A632, RC-A595).

14. The nature of the sexual abuse perpetrated by Pearce took a number of different forms, including exposing himself, filming the boys in the showers and sexually assaulting them over and under clothing. It was also alleged that he masturbated in front of them.

[81] BNT003323; BNT001147; BNT006991_013 para 66
[82] Dom Richard Yeo 7 February 2019 89/1-24
[83] INQ003108_001; Abbot Martin Shipperlee 6 February 2019 89/5-13
[84] Jeremy Harvey 4 February 2019 153/23-25; RC-A24 4 February 2019; RC-A6 5 February 2019 58/21-23
[85] CYC000004_007
[86] BNT001165_002, 014
[87] INQ003069
[88] OHY006752_004
[89] BNT001154_002
[90] MPS002991_033
[91] BNT007139_032 para 55.14.1
[92] MPS002991_032

RC-A594

15. RC-A594 joined St Benedict's in the early 1970s, aged only seven or eight. He said that he would be summoned to Pearce's office, made to take off his clothes, beaten on his bare buttocks, and struck on his knuckles with a cane. Pearce would laugh and smile as he caned him, then make RC-A594 sit on his knee afterwards.[93]

16. RC-A594 told his parents about the abuse. They complained to St Benedict's but no action was taken.[94] RC-A594 contacted the school in 2007[95] and his details were passed to the Metropolitan Police.[96] In August 2009, Pearce was convicted of indecently assaulting RC-A594.[97] Subsequently, in April 2011, RC-A594 received £35,000 in damages in civil proceedings.[98]

RC-A595

17. RC-A595 was a pupil at St Benedict's during the 1990s. His allegations appear to be the first to have been investigated by the police, in the early 1990s.

18. According to RC-A595, in June 1992, when he was 11 years old, Pearce called him into his study, locked the door and made him remove his shorts and underwear.[99] Pearce then rubbed RC-A595's buttocks and inserted a finger into his anus.

> *"His finger went into my bottom about 1 cm. This went on for about three minutes. I then walked away and pulled my shorts and pants up. He then told me 'It's best if we keep this our secret for now'. I wasn't quite sure what was going on. I felt really strange."*[100]

19. RC-A595 told his family what had taken place and the matter was reported to the Metropolitan Police.[101] RC-A595 made a statement within two weeks of the incident occurring.[102] The police took the view that RC-A595 was an honest witness[103] and pursued the investigation. Matters were complicated however by suggestions that the allegation might have been fabricated by RC-A595's family[104] in retaliation for Pearce having reported RC-A595's father to social services for child abuse.[105] The Crown Prosecution Service took this into account, as well as the absence of corroboration and of medical evidence, and in 1992 declined to prosecute Pearce.[106]

20. In November 2010, RC-A595 (whose case had been considered in the civil case of RC-A6 against Pearce and Ealing Abbey, dealt with below) made a formal complaint to the trustees of St Benedict's Ealing Abbey about Pearce's abuse. The claim was handled by the charity's insurers and was settled out of court for £24,400.[107] In March 2011, RC-A595's mother also

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[93] MPS003091_006-007
[94] OHY005919_003
[95] Abbot Martin Shipperlee 6 February 2019 160/10-16
[96] OHY005919_003
[97] BNT001190_003-004
[98] BNT000819
[99] RC-A595 5 February 2019 21/7; 17/4-20
[100] MPS003066_031
[101] MPS003066_024
[102] MPS003066_027-032
[103] MPS003066_025
[104] MPS003066_007; MPS003066_019, 066
[105] MPS003066_042
[106] MPS003529
[107] BNT000819; BNT007055; BNT000813_003

wrote to Abbot Martin Shipperlee. She said that her son had endured an unhappy life and asked for a return of his school fees.[108] Abbot Shipperlee arranged for an ex-gratia payment of £10,000 to be made to RC-A595's mother, without an admission of liability.[109]

RC-A418, RC-A632, RC-A631

21. In 1997, another boy came forward with allegations. RC-A418, a pupil at St Benedict's between the early 1980s and the late 1990s, said that he had attended swimming lessons supervised by Pearce. He said that Pearce liked to check if the boys were *"dry"*[110] after swimming lessons by touching their backs, buttocks and genitals. If a boy lost his swimming pool locker key, Pearce would put his hands down his swimming trunks on the pretext of checking if the key was there.[111] We also heard that Pearce watched and filmed the boys when they were in the shower.[112] A number of other former pupils have made similar allegations.[113]

22. RC-A418 also said that, in the early 1990s when he was around 10 years old, he was sent to Pearce's office because he had a rash on his upper body. Pearce insisted on examining his genital area, despite RC-A418 telling him that the rash did not go below his waist.[114] RC-A418 said that Pearce's behaviour made him feel uncomfortable and he eventually told his mother that he did not want to attend any more swimming lessons, so she wrote to St Benedict's and he stopped attending.[115]

23. In 1997, during his final year at St Benedict's, RC-A418 spoke to Katherine Ravenscroft, a lay teacher at the school, about Pearce. Ms Ravenscroft told us that she felt unable to take any action at the time as St Benedict's *"felt a bit like a mafia"*.[116] It was only in 2000, once Soper had resigned as Abbot, that Ms Ravenscroft felt able to act.[117] In October 2001,[118] she contacted RC-A418 and a meeting was arranged between him and the new abbot, Martin Shipperlee.[119] Abbot Shipperlee referred RC-A418's complaint to Father Sean Carroll, the Diocese of Westminster's child protection coordinator at that time, who in turn contacted the Metropolitan Police.[120]

24. Between November 2001 and July 2002, the Metropolitan Police investigated the allegations. RC-A418 was interviewed. Other ex-pupils and their parents were contacted and gave corroborative evidence of his account.[121] In particular, RC-A632, who was a contemporary and friend of RC-A418, said that when he was eight or nine years old, Pearce had put his hand down his swimming trunks after a swimming lesson to *"check"* if the boy's lost locker key was there.[122]

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[108] BNT001149
[109] INQ004172_019 para 38
[110] OHY006649_016-017
[111] OHY006649_016-017; MPS003014_025; MPS003014_030; OHY005919_001
[112] RC-A6 5 February 2019 61/9-21; OHY005919_001
[113] OHY005919_001; OHY006649_016, 017; MPS003014_034; MPS003014_035; MPS003014_036
[114] OHY006649_017
[115] OHY006649_017
[116] MPS002950_001
[117] MPS002950_002
[118] MPS003014_025
[119] OHY006649_018
[120] MPS003014_025; BNT000885_002
[121] MPS003014_034; MPS003014_035; MPS003014_036
[122] MPS003014_036

25. During the course of their 2001/2002 investigation, the Metropolitan Police identified another potential victim, RC-A631. The police learned that the parents of RC-A631, who was a pupil at St Benedict's in the 1990s, had written in 1998 to the then headmaster, Dr Anthony Dachs, to raise concerns about Pearce. Shortly after, Soper, then abbot, met with RC-A631's parents. They wanted assurances that Pearce would no longer have any contact with the junior school.[123] Soper informed them that the school would deal with the matter.[124] In 2017, both Ms Ravenscroft and Father Alban Nunn told the police (as part of the investigation into Soper) that Soper had promised RC-A631's family that Pearce would no longer have any contact with the children.[125]

26. We have seen no evidence to suggest that Pearce was ever challenged by Soper, who was also later revealed to have abused pupils. Instead, Pearce was allowed to remain in his post. No disclosure was made to the statutory authorities, nor does it appear that RC-A631's parents contacted the police directly.[126]

RC-A6

27. In January 2004, another former St Benedict's pupil, RC-A6, told Abbot Shipperlee[127] and then the Metropolitan Police[128] that Pearce regularly abused pupils when he took them to the local baths for swimming lessons. RC-A6 attended St Benedict's in the 1980s and 1990s.[129] He said that after swimming lessons, Pearce would insist that he needed to "*check if the boys were dry*" and would use this as an excuse to fondle and rub their buttocks and genitals.[130] According to RC-A6:

> "*The days when he took us swimming were known as 'gay days' … We all used to rush to change at the end of the swimming lessons as quickly as possible because we all felt uncomfortable being stared at by Pearce and we did not want to be selected to be dried by him … One of the occasions when Pearce 'dried me' he touched my genitals with his bare hands under the towel … I felt very uncomfortable … but obviously I had no choice but to obey him as he was both a priest and the headmaster.*"[131]

28. Pearce also abused RC-A6 on two separate occasions in 1990 or 1991, when RC-A6 was ill in the infirmary. On the first occasion, Pearce removed RC-A6's underwear and stared at his genitals for a few minutes. On the second occasion, he fondled the boy's penis, rubbing the foreskin backwards and forwards.[132] RC-A6 found these incidents deeply distressing and he tried to commit suicide when he was just 10 years old.[133]

29. RC-A6's allegations were investigated by the Metropolitan Police in 2004. On the advice of the Crown Prosecution Service reviewing lawyer, Senior Crown Prosecutor Azra Khan,[134] no charges were brought.

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[123] OHY005917_002
[124] MPS003014_034
[125] MPS002950_001; MPS002959_001
[126] OHY005917_002
[127] BNT001206_008
[128] MPS002970_029
[129] OHY006649_015
[130] RC-A6 5 February 2019 59/7-9
[131] RC-A6 5 February 2019 59/24-25; 60/7-10, 16-17, 25; 61/1-2
[132] RC-A6 5 February 2019 63/2-25
[133] BNT001206_005
[134] MPS003091_009

30. RC-A6 subsequently filed a civil claim against Pearce and the trustees of Ealing Abbey, in October 2004. During the course of the hearing in January 2006, RC-A6 relied upon the allegations of sexual abuse previously made by X (RC-A418, above), Y (RC-A595, above) and Z (RC-A419, below) as similar fact evidence.[135] The judge, Mr Justice Field, decided to exclude RC-A595's account. We do not know what or how much evidence was placed before him, but it seems that he considered it likely that the boy had been induced by his family into making a false claim against Pearce. He did however accept the allegations involving RC-A418 and RC-A419 (Pearce having admitted the latter allegation) and considered that both were probative of the facts alleged by RC-A6 as they showed that Pearce had a sexual interest in boys. Mr Justice Field accordingly found in favour of RC-A6 and awarded him £43,000 in damages in January 2006.[136]

31. The Metropolitan Police were not aware of this judgment in 2006. It was not until 2008 that a series of events led them to seek advice from the Crown Prosecution Service about whether to reopen RC-A6's case.[137] First, in January 2008, Pearce was arrested at Ealing Abbey over a complaint made by another boy, RC-A621.[138] Second, during the course of this arrest, the Metropolitan Police searched Pearce's room and found correspondence from another pupil, RC-A597, that gave rise to concern.[139] Third, following Pearce's arrest, three further victims (RC-A11, RC-A594 and RC-A596) came forward between February and November 2008.[140] In light of these mounting allegations, in November 2008 the Crown Prosecution Service advised that it was appropriate to charge Pearce in relation to RC-A6, as well as to the other new complainants.[141] Pearce was eventually convicted in August 2009 for abusing RC-A6.[142]

RC-A419

32. In summer 2004, a few months after RC-A6 had come forward with his allegation, another complaint against Pearce was made by RC-A419. He attended St Benedict's in the 1970s.[143] RC-A419 said that, when he was a pupil in the late 1970s, Pearce had befriended his mother and visited their home. He took advantage of this friendship to abuse RC-A419 upstairs in his bedroom by touching his penis on the pretext of "*naming body parts*".[144] (RC-A419 also said that he was abused by Maestri during this period, as discussed below.)

33. RC-A419 first disclosed this incident to the Diocese of Westminster's child protection team.[145] The Inquiry understands that RC-A419 did not wish to make a formal police complaint.[146] However, Pearce admitted the allegation during RC-A6's 2006 civil trial.[147]

[135] BNT001206_011
[136] BNT001206_003, 011-018, 026
[137] OHY006751_012 para 47; Neil Jerome 5 February 2019 79/25, 80/1-2
[138] OHY005919_002
[139] MPS003091_006
[140] OHY005919_002-003
[141] OHY006751_012 para 49
[142] BNT001165_002
[143] BNT001208_006
[144] BNT001208_006; BNT001208_007
[145] BNT003761_009
[146] BNT003761_009
[147] BNT001206_015

34. It was at this stage in 2005 that, in light of the allegations made by RC-A419, RC-A6, RC-A595 and RC-A418, Abbot Shipperlee instructed a clinical criminologist to conduct a risk assessment of Pearce.[148] Later he decided to place Pearce under restrictions[149] on the basis of this assessment[150] and the recommendations of the Diocese of Westminster.[151]

RC-A621, RC-A597

35. While under restrictions, Pearce groomed and abused another child, RC-A621. He was a 16-year-old pupil at St Benedict's who, in 2006, worked at Ealing Abbey on weekends.[152] Although complaints had by this point been made against Pearce and the civil court had awarded damages to RC-A6, Abbot Shipperlee had allowed him to remain in the monastery.

36. During our hearing Abbot Shipperlee was asked what he told the community and staff about Pearce and the restrictions he was under.

> *"A. I talked to the council about it. And I talked to at least some members of the community about it.*
>
> *Q. Some? Not all?*
>
> *A. They know he's under restriction.*
>
> *Q. Did they know what they were?*
>
> *A. They know he can have no public ministry. They know that he cannot minister directly regarding children.*
>
> *Q. There are five restrictions listed in the letter. Did they know all the restrictions?*
>
> *A. It is possible they didn't, although monks are very good at not knowing what you think you've told them. But it's a serious matter and –*
>
> *Q. 'Monks are very good at not knowing … '?*
>
> *A. All the things you have told them. You make an announcement and someone will say, 'You didn't tell me that. I didn't hear that'. I didn't give them a piece of paper telling them all that, for sure. Clearly, I could have been – I should have been clearer about what I was saying."*[153]

It is therefore unclear whether monks and staff in the monastery and associated areas knew of the restrictions on Pearce or the reasons for them. Whether or not they were aware, Pearce was able to visit the kitchens and form a relationship with RC-A621.

37. RC-A621 was, at that time, interested in becoming a monk, and was seeking spiritual guidance. Pearce befriended him, giving RC-A621 his mobile telephone number and arranging private meetings, during which he touched RC-A621 on his buttocks and upper thigh, and tried to kiss him. He asked RC-A621 to send him nude photographs and, although reluctant, RC-A621 did eventually send a picture of himself naked from the waist up. Pearce also heard RC-A621's confession – which was in breach of the restrictions on his ministry.

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[148] Abbot Martin Shipperlee 6 February 2019 7/1-4
[149] BNT007139_016 para 22.19
[150] BNT001208_012
[151] BNT000829
[152] BNT001201_002
[153] Abbot Martin Shipperlee 6 February 2019 145/25, 146/1-19

While he did so, Pearce pulled RC-A621 onto his own body, an act that was plainly sexual in nature. He also arranged to meet secretly with RC-A621, away from the abbey, in 2007 when RC-A621 was attending a church-run retreat in Ireland.[154]

38. Although RC-A621 was uncomfortable with Pearce's behaviour, he felt unable to stop it until January 2008 when, aged 17, he complained to St Benedict's.[155] RC-A621 was subsequently interviewed by the Metropolitan Police.[156] In late January 2008, Pearce was arrested. The police searched his room at Ealing Abbey, during the course of which some correspondence from another ex-pupil (RC-A597), who had also been groomed for several years by Pearce, was found.[157]

39. RC-A597 was spoken to by the Metropolitan Police in April 2008.[158] He explained that he joined St Benedict's in the mid 1980s, aged nine. Pearce took an immediate interest in him. He treated him differently from the other boys, letting RC-A597 know that he was "*special*[159] and regularly calling him to his office for private meetings.[160] Pearce kissed him on the lips when they met in private. He gave RC-A597 money, letters, notes, sweets and chocolate, which he would place in RC-A597's underwear, touching the boy's genitals with his hands both over and under his clothing as he did so. He called this "*posting*".[161] Pearce also wrote him letters in which he said that he was sexually aroused by RC-A597, but he asked him to destroy the letters after he read them.[162] Pearce asked RC-A597 to join him in the bath on several occasions, and also filmed him whilst he was bathing. RC-A597 said that when Pearce referred to these encounters he would call them their "*special meetings*".[163]

40. As RC-A597 moved up in the school, Pearce gained the trust of his parents, frequently visiting them at home, where he would film RC-A597 in the bath and touch his genitals.[164] In 1989, RC-A597's father found one of Pearce's letters to RC-A597, in which he referred to filming RC-A597 while he was naked in the bath and to seeing "*all*" of the boy.[165] His father asked RC-A597 about the letter but his son became very distraught and did not answer.[166] He was unable to tell him the truth about what was happening. Pearce's infatuation with RC-A597 continued for 13 years, even after he left school for university in 1995. Pearce would write to him, sending money and visited him at university approximately once a term. When they met he would kiss RC-A597 on the lips. Things only came to an end in 1999, when RC-A597 graduated from university and was finally able to put a stop to it.[167]

41. In 2009, Pearce was convicted of sexually assaulting RC-A621 and indecently assaulting RC-A597.

42. RC-A597 also took civil action in respect of these matters. The Abbey paid £70,000 in damages in November 2012 and RC-A597's court costs.[168]

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[154] MPS003091_004-005; BNT001201_003
[155] BNT001188_002
[156] OHY006751_011 para 43
[157] MPS003091_008
[158] OHY005919_003
[159] MPS003091_005
[160] BNT001162_002, 003; BNT001162_004
[161] BNT001162_002, 003; BNT001162_004
[162] BNT001162_003; MPS004225
[163] BNT001162_003
[164] BNT001162_003
[165] MPS003091_005; MPS004225
[166] MPS004225
[167] BNT001162_004; MPS003091_006
[168] BNT007055

RC-A11, RC-A596

43. The publicity generated by Pearce's arrest in January 2008 led other victims to come forward,[169] including RC-A11 and RC-A596.

44. RC-A11 was a pupil at St Benedict's from the mid 1970s until the early 1980s, approximately from the ages of six to 13.[170] He contacted the Metropolitan Police in February 2008 and said that Pearce would masturbate under his cassock in front of pupils during lessons. (RC-A11 also made allegations against Soper and Maestri.) Pearce would also force RC-A11 and other boys to sit on his lap while they were in class, so that he could touch their legs and genital area over their shorts.[171]

45. RC-A11 said that Pearce used his position as head of the Cadet Force to meet with pupils in the sheds by the school playground. More than once, he saw Pearce go inside the sheds with a boy who would come out 45 minutes to an hour later, crying and pulling up his trousers. He also said that he knew that Pearce was having sex with two pupils at St Benedict's.[172]

46. Pearce was charged with indecent assault and gross indecency against RC-A11[173] but it appears that ultimately the charges did not proceed.

47. RC-A11 subsequently pursued a civil claim against Ealing Abbey[174] which was resolved without a court hearing. In a letter of apology to RC-A11 dated March 2012, Abbot Martin Shipperlee said "*I am deeply sorry that you suffered abuse when you were a pupil*".[175] The Abbey paid RC-A11's court costs and £15,000 in damages in January 2013.[176]

48. RC-A596 was a pupil at St Benedict's in the mid 1970s to the early 1980s. He was abused by Pearce for approximately three years, between the ages of 10 and 14. Pearce touched his bottom and genitals, and is alleged to have exposed himself and forced RC-A596 to masturbate him. He told RC-A596 that this was "*okay*" and "*normal*".[177]

49. RC-A596 was interviewed at Northwood police station in September 2008 and disclosed Pearce's abuse.[178] (He also alleged that he had been abused by Maestri during the same period.[179]) Pearce pleaded guilty to abusing RC-A596 in August 2009.

50. RC-A596 pursued a civil claim against Ealing Abbey. In 2010, he received £30,000 in compensation and payment of his legal costs.[180]

RC-A593, RC-A592

51. Following Pearce's conviction in August 2009, two other victims came forward, RC-A593 and RC-A592.

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[169] OHY005919_002
[170] BNT001231_003-005
[171] OHY005919_002; MPS003091_007
[172] MPS003091_007
[173] OHY006751_012 para 49
[174] BNT001160
[175] BNT000812_005
[176] BNT007055_003
[177] BNT001228_015, 030-033; BNT001190_013-014
[178] BNT001228_002
[179] BNT001228_028, 046
[180] BNT007055

52. RC-A593 attended St Benedict's in the late 1970s. In December 2010, he wrote to Abbot Shipperlee, alleging inappropriate behaviour and sexual assaults by Pearce, though he did not provide further details of the alleged abuse. RC-A593 demanded that St Benedict's reimburse his school fees, in light of the abuse he had suffered as a pupil. He also asked whether any legal claims were being pursued by Pearce's other victims. The abbot responded to this letter in March 2011, stating that St Benedict's could not return his school fees. He did, however, confirm that some former pupils were pursuing claims and gave him the names of the law firms involved.[181] No further action was taken by RC-A593 after receiving this letter.[182]

53. RC-A592 attended St Benedict's between the early 1980s and the early 1990s. He claimed that he was indecently assaulted by Pearce during a school trip to the Lake District. The incident is alleged to have taken place in the summer of 1984, when RC-A592 was 10 years old. In 2011, RC-A592 sought compensation from Ealing Abbey and St Benedict's but subsequently abandoned his claim.[183]

Laurence Soper

54. Laurence Soper was born in September 1943.[184] Like Pearce, he attended St Benedict's as a child. They were almost direct contemporaries; Soper is two years younger than Pearce, but their time at school and later as novice monks would have overlapped.

55. Following a short career in banking, Soper entered Ealing Abbey in 1964 and was ordained in 1970. Between 1972 and 1984, he taught at St Benedict's. During this time, he held a number of significant positions, both at the school and the abbey, including as head of the middle school (1978–1984), bursar (1975–1991) and prior (1984–1991).[185] While at the middle school, Soper was also the master in charge of discipline (from 1979 to 1983) and, by his own admission, used corporal punishment.[186] In 1991, he was elected Abbot of Ealing Abbey.[187]

56. Soper also held roles outside of Ealing Abbey that brought him into contact with children. He served as Catholic Chaplain at Feltham Young Offender Institution (from 1989 to 1991)[188] and also for a period at Harrow School.[189] After resigning as Abbot of Ealing in 2000, he took up a position as Chaplain at an army base in Cambridgeshire for approximately one year.[190] In 2002, he was appointed general treasurer for the International Benedictine Conference in Rome. He resided at the Benedictine headquarters in Sant'Anselmo until his disappearance in 2011.[191]

57. Soper is known or alleged to have sexually abused at least nine children at St Benedict's between 1972 and 1983. Like Pearce, many of the sexual assaults were committed under the pretext of corporal punishment. The abuse included sexual touching, sexual assault and rape.

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[181] BNT000812
[182] BNT007055
[183] BNT000811; BNT007055
[184] MPS002955
[185] MPS002955
[186] MPS003072_036
[187] BNT007139_004 para 3.1
[188] MPS003067_002 para 1.4
[189] MPS002926_002
[190] BNT006991_006-007 para 29; BNT007139_021 para 36.4
[191] INQ001661_001 para 3

58. While he was living in Sant'Anselmo, Rome, Soper returned to the UK on three occasions (in 2004, 2009 and 2010) to be interviewed by the Metropolitan Police in relation to allegations that had been made against him by former St Benedict's pupils (RC-A622, RC-A11, RC-A601, RC-A600). On each occasion the police released him without charge, bailing him to return at a later date. Soper was due to return for a further interview in March 2011, and left Sant'Anselmo saying that he was on his way to London. He failed to surrender to his bail. He was reported missing by the Prior of Sant'Anselmo[192] and in November 2011 a European Arrest Warrant was issued for him.[193] On 9 January 2012 Soper was dismissed from the order of the English Benedictine Congregation.[194]

59. Soper was on the run for over five years and was eventually located in Kosovo in May 2016. He was extradited and arrested on his arrival in the UK in August 2016. He was charged with a number of offences against nine victims (RC-A622, RC-A11, RC-A8, RC-A610, RC-A611, RC-A609, RC-A591, RC-A601, RC-A600) and was convicted in December 2017. He was sentenced to 18 years' imprisonment.[195] On 6 June 2019 he was dispensed from the clerical state.[196]

RC-A622

60. RC-A622 attended St Benedict's in the 1960s and 1970s, between the ages of eight and 15. As described in Part A, Soper began to abuse RC-A622 when he was only 12 or 13, initially by using physical chastisement as a pretext for fondling and stroking the child's penis and testicles.[197] The abuse did not stop there. Soper made RC-A622 watch him while he masturbated, and he forcibly masturbated RC-A622. On multiple occasions, Soper caned and then anally raped RC-A622, usually over his desk.[198]

61. During a school trip when RC-A622 was 14 or 15 years old, Soper came into the hostel room where RC-A622 and other boys were sleeping on bunk beds. Soper went to RC-A622's bed and fondled the boy's genitals through the opening in his pyjamas. He then put RC-A622's penis into his mouth and tried to kiss him.

62. He also anally raped RC-A622 on "*3 to 4 occasions*".[199] Soper told RC-A622 to keep these incidents a secret, and threatened severe punishments, or expulsion, if he spoke of them.[200]

63. RC-A622 did not report the abuse at the time. He said that he didn't feel able to tell his parents about what was happening to him because "*their faith was so strong, they never would have believed it from a priest*".[201]

64. In January 2004, RC-A622 formally reported the abuse to Peter Turner, the Diocese of Westminster child protection officer. At the time of this disclosure, RC-A622 was receiving psychiatric treatment.[202] Mr Turner contacted the Metropolitan Police and RC-A622 was interviewed in February 2004. In July 2004, Soper voluntarily returned to the UK from Rome. He was arrested and interviewed by the police. He admitted to having caned pupils

[192] OHY006751_016 paras 61–72
[193] MPS002937_002
[194] BNT001098_002
[195] MPS003065_032-034
[196] BNT007157
[197] INQ001661_004
[198] BNT001094_003; MPS003524_010; MPS003524_015; MPS003524_019-020
[199] BNT001094_003
[200] INQ001661_004-005
[201] MPS002972_002
[202] OHY005919_010

in the 1970s but denied the rape and sexual assault allegations. He was released without charge and bailed to return in October 2004. Thereafter, the police referred the matter to the Crown Prosecution Service which advised that there was insufficient evidence to charge and prosecute Soper.

65. In 2007, RC-A622 contacted the police again with a view to having the allegations re-investigated but the police once more told him that they could not proceed with the matter.[203]

66. RC-A622 has said that the decisions taken in 2004 and 2007 not to prosecute Soper had a "*detrimental effect on his health*" and led him to have a "*mental breakdown*".[204]

> "*I felt completely devastated. I felt let down and thought no-one believes me, I had always been brought up to tell the truth and I don't tell lies … I continued to mentally suffer as a result*".[205]

67. In June 2012, RC-A622 brought a civil claim against the Trust of St Benedict's Abbey, Ealing.[206] An out-of-court settlement was reached and RC-A622 was paid £135,000 in compensation by the Trust, as well as his legal costs. In addition, RC-A622 received a written letter of apology from the trustees.[207]

68. In December 2017, Soper was convicted of multiple counts of buggery, indecency with a child and indecent assault relating to his abuse of RC-A622.[208]

RC-A11

69. As outlined above, RC-A11 was interviewed by the Metropolitan Police in February 2008 in relation to Pearce.[209] He also made allegations against Maestri (detailed below) and Soper, who he described as a "*sexual sadist*".[210]

70. RC-A11 said that Soper caned him every week during a two-year period, for no good reason. He told police that Soper would often make him remove his trousers and underwear on the pretext of searching for a hidden book, after which he would rub and fondle his buttocks.[211] Like some of the other accounts, RC-A11 said that if he did not remove his lower clothing Soper would threaten him with six strikes of the cane rather than three.[212]

71. On one particularly brutal occasion, RC-A11 had just returned to school following the summer holidays, during which his mother had died. He would have been especially vulnerable at that time, but Soper had him come to his office on his first day back at school, where he caned him for no reason.[213]

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[203] MPS002981_002; OHY005919_010; MPS003065_17, 024-025
[204] MPS002981_001
[205] MPS002981_002
[206] BNT001097
[207] MPS002981_003; BNT007055
[208] OHY006752_002
[209] BNT001231_002
[210] BNT001231_053
[211] BNT001231_060-062
[212] BNT001231_062
[213] BNT001231_054-055

72. In light of these allegations, Soper returned to the UK from Rome, for the second time, in June 2009. On this occasion, he was not placed under arrest but was interviewed under caution by the Metropolitan Police. He denied the allegations and was allowed to return to Rome.[214]

73. Soper was convicted of multiple counts of indecent assault against RC-A11 in December 2017.[215]

RC-A601, RC-A600, RC-A591

74. In June 2010, RC-A601 and RC-A600 contacted Northwood police station to make allegations against Soper.[216]

75. RC-A601 attended St Benedict's in the early 1980s, when he was between 11 and 15 years old. He described one incident in Soper's study when he was made to lie across Soper's lap while Soper spanked him over his clothing. RC-A601 said that Soper's breathing changed as he was spanking him and that he seemed to become excited. Afterwards, Soper ordered him to pull down his trousers and touched his backside. RC-A601 told his parents about the abuse at the time, but they did not report it.[217]

76. RC-A600 attended St Benedict's for two years, in the late 1970s and early 1980s, between the ages of 11 and 13. He was caned by Soper approximately once a fortnight for matters that seemed insignificant. The first time, Soper insisted that he remove his trousers and underwear, supposedly so that he could check for padding. Soper then stroked and rubbed the boy's bare bottom. After this he told RC-A600 to pull up his trousers and bend over the desk. He then caned him with such force that black and blue welts were left on his skin. Following the beating Soper stroked the boy's buttocks to "*comfort*" him. Soper did not check for padding on any subsequent occasions, but the routine was otherwise the same.[218] RC-A600 told his sister about the beatings at the time, but did not mention that there was a sexual element to them. He said that he could not bring himself to reveal the full truth to his family because they were devout Catholics.[219]

77. Following these two police complaints, Soper was contacted in Rome and returned, once again, to the UK in September 2010.[220] He was arrested on arrival. He denied the allegations and was bailed until March 2011.[221]

78. In January 2011, while Soper was still in Rome, RC-A591 made a complaint of sexual abuse against him to the Metropolitan Police.[222] RC-A591 attended St Benedict's from the mid 1970s until the mid 1980s, between the ages of eight and 16. When RC-A591 was around 11, he went to Soper's office to report another boy who had kneed him in the thigh. Soper made RC-A591 remove his trousers and began to stroke the boy's leg. He then pushed his fingers into his underwear and touched his genitals, while at the same time cupping and squeezing his buttocks.[223]

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[214] INQ001661_018
[215] OHY006752_003
[216] MPS002937_002
[217] INQ001661_015-016; OHY005919_011
[218] OHY005919_011; INQ001661_012
[219] INQ001661_012
[220] OHY005919_011
[221] MPS002937_002
[222] OHY005919_011
[223] MPS004217; OHY006752_005

79. Soper was eventually prosecuted and convicted of indecent assault against RC-A600, RC-A601 and RC-A591 in 2017.[224]

80. RC-A591 also brought civil proceedings against Ealing Abbey in 2011. His claim was settled out of court and he was paid £5,900 in compensation, as well as his legal costs.[225]

RC-A610, RC-A609, RC-A8

81. After Soper's disappearance from Sant'Anselmo, Rome, complainants continued to come forward between 2011 and 2016, including RC-A610, RC-A609 and RC-A8. RC-A610 and RC-A609 also made allegations about Soper using caning as a pretext to touch, rub and fondle their buttocks.[226]

82. RC-A610 was a pupil at St Benedict's in the 1970s. In November 2011, he told the Metropolitan Police that when he was around 13 or 14 years old, he was in the school grounds and took a short cut along a route that was out of bounds. He was encountered by Soper who confronted him and chastised him for being out of bounds. Soper told him to report to his office later that day, which he did. Once in his office, Soper told RC-A610 that he would have to beat him for what he had done. He made the boy lie across his lap, put his hand inside the top of the waistband of his trousers and touched the top middle part of his buttocks.[227] RC-A610 said that Soper's hands "*were moving all over the place*".[228] Soper then hit RC-A610 and asked him "*Did that hurt?*" and when RC-A610 replied that it did, Soper said "*Okay, I'll do it harder*" and then hit him another four times with a cane.[229]

83. RC-A609 attended St Benedict's in the 1980s. In October 2014, he told the Metropolitan Police about how he had been sent to Soper's office for a minor infraction. Once in his office, Soper pulled open a large desk drawer inside of which were canes, a cat-o-nine-tails whip and a leather strap. Soper instructed RC-A609 to pull down his trousers, which he did. He kept on his underwear. Soper then made him lean across his lap. At this point, RC-A609's penis was touching Soper's thigh. Soper then tapped RC-A609 on his backside, leaving his hand resting on his bottom in between pats. He did this a couple of times. RC-A609 said that he felt no pain but thought that the incident was odd. Soper told him that the next time, he would use the cane.[230] Over the course of the year, RC-A609 was beaten a number of times by Soper. He told police that these incidents were different, in that Soper did not ask him to lie across his lap and used a cane instead of his hand.[231]

84. RC-A8 was a pupil at St Benedict's in the mid 1970s. In May 2016, he contacted the Metropolitan Police and said that he had been physically and sexually abused by Soper during his time at the school.[232] RC-A8 was sexually abused on at least two occasions. The first occasion was in 1975, when RC-A8 was around 14 years old. He got into trouble with a group of other boys for "*horsing*" around. All were sent to Soper's office for punishment. Once there, Soper told RC-A8 to bend over, for caning, which RC-A8 did. Soper rubbed his hands up and down RC-A8's buttocks and down to the beginning of his crotch, over his clothes. RC-A8 formed the impression that Soper was trying to probe his anus. After

[224] OHY006752_005
[225] BNT007055
[226] INQ001661_009-011
[227] INQ001661_009
[228] INQ001661_009
[229] INQ001661_009
[230] INQ001661_011
[231] INQ001661_011
[232] INQ001661_006

this, Soper proceeded to cane him.[233] A second similar incident took place just over a year later, during RC-A8's final year of school. Soper touched his buttocks and then pushed his fingers towards his anus. Soper used more force on this occasion, causing RC-A8 to stumble forwards. He was then violently beaten.[234] In addition to the sexual abuse, Soper subjected RC-A8 to violent physical abuse. On one occasion, when RC-A8 was 16 years old, he caned him so forcefully that he drew blood. RC-A8 attempted to defend himself and punched Soper. He was later expelled.[235]

85. In 2017, Soper was convicted of indecently assaulting RC-A8.[236]

RC-A608, RC-A611, RC-A24

86. In June 2016, shortly before Soper's arrest (after being on the run for over five years), RC-A608 contacted the Metropolitan Police.[237] RC-A608 was a pupil between the mid 1970s and the early 1980s. He told the police that it was well known among the pupils that, when administering punishments, Soper would offer them a choice of being caned three times across their bare buttocks or six times over their clothing. This happened to RC-A608, who said that he always chose the first option and was caned across his buttocks at least half a dozen times.[238] On other occasions, Soper would stroke and rub his back and bottom, sometimes over his clothing and sometimes with his clothes off.[239]

87. RC-A24, who attended St Benedict's between the late 1960s and the early 1980s, also described being offered this choice when he was 13 or 14 years old.[240]

> *"I fully understood – and given Soper's behaviour, anyone in the school would have understood – that Soper was giving me a choice of either six canings on the bottom or being sexually assaulted."*[241]

RC-A24 told us that he was able to convince Soper that the punishment was unjustified and that he did not deserve a caning. In the end, Soper did not discipline him and the boy managed to leave his office, unharmed.[242]

88. In August 2016, the Metropolitan Police was contacted by RC-A611, who had learned of Soper's arrest.[243] RC-A611 was a pupil at St Benedict's from the mid 1970s until the mid 1980s.[244] He described Soper visiting him in the infirmary, when he was 11 or 12 years old,

[233] INQ001661_007
[234] INQ001661_007
[235] INQ001661_008
[236] OHY006752_008
[237] MPS002937_003; MPS002937_004
[238] INQ001661_008
[239] INQ001661_008; INQ001661_009
[240] RC-A24 4 February 2019 157/1; 162/13
[241] RC-A24 4 February 2019 163/10-14
[242] RC-A24 4 February 2019 163/15-19
[243] MPS002937_003; MPS002937_004
[244] MPS002940_001

after he had sustained a minor injury while playing in the playground.[245] He rubbed his buttocks in an aggressive and sexual manner for several minutes, on the pretext of inspecting his injury.[246] RC-A611 said:

> *"I felt confused and I didn't understand what was happening to me. I remember staring at the wall and I was too scared to move."*[247]

RC-A611 said that he did not report the abuse at the time because he did not want to upset his parents, who were devout Catholics.[248]

89. Soper was convicted of the indecent assaults of RC-608 and RC-A611 in 2017.[249]

RC-A618, RC-A615

90. RC-A618 was a pupil at St Benedict's in the 1980s. He said that, on one occasion, Soper summoned him to his office for punishment. Once there, Soper made RC-A618 remove his trousers and underwear, and stared at his exposed genitals. This continued for a few minutes, after which he told RC-A618 to leave his office and say nothing about what had happened.[250] RC-A618 disclosed the abuse to his father but he told RC-A618 that he did not believe that Soper had done anything wrong.[251]

91. RC-A618 wrote to St Benedict's in August 2016, two days after Soper's arrest, claiming that he had also been abused by Soper. (He had first complained to St Benedict's in 2014 in relation to Maestri.) He was interviewed by police in December 2016.[252] Although he told the police that he had contacted a firm of solicitors in order to pursue a civil claim against St Benedict's,[253] we have not seen any evidence of civil proceedings or their outcome.

92. RC-A615 said that Soper had punished him on one occasion in the early 1980s, by caning him. According to RC-A615, before using the cane, Soper had stroked his buttocks, over his clothing. RC-A615 was contacted by the Metropolitan Police in September 2016, and the matter was referred to the Crown Prosecution Service.

93. The police and Crown Prosecution Service ultimately considered that the allegations disclosed by RC-A618 and RC-A615 did not amount to a criminal offence, and no further action was taken.[254] They considered that the stroking of RC-A615's backside was an isolated incident and there was no evidence that Soper's actions were of a sexual nature.[255]

RC-F46

94. RC-F46 taught at St Benedict's for almost 40 years, from the 1950s to the early 1990s.[256]

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[245] MPS002940_001
[246] MPS002940_001-003
[247] MPS002940_003
[248] MPS002940_003-004
[249] OHY006752_008-009
[250] MPS002941_001; MPS002941_002-003
[251] MPS002941_003
[252] OHY006752_007, 009
[253] MPS002941_005
[254] OHY006752_009
[255] OHY006752_009
[256] BNT007139_025 para 48.1

95. In April 2010, RC-A423 contacted the Metropolitan Police. He had been a pupil at St Benedict's in the 1970s. A police report records that he complained of three matters involving RC-F46, two of which potentially involved sexual abuse. After an incident at school when RC-A423 was about 13 years old and had been kicked in the groin by pupils from another school, RC-F46 had "*examined his private parts*"[257] but did not touch him. RC-A423 also said that on another occasion during a school trip abroad RC-F46 had insisted that he join him in his room, told him to remove his clothes and to get into RC-F46's bed. RC-A423 however had refused and returned to his own room.[258] The police decided to take no further action. The crime report states:

> "*the behaviour of the suspect is perhaps inappropriate and would breach safeguarding principles as they exist today, however in the absence of any physical contact between the 2 or any incitement … no crimes have been committed in this case*".[259]

John Maestri

96. John Maestri was born in November 1938,[260] and worked as a lay teacher at St Benedict's from 1971 until 1984.[261]

97. He is known to have sexually abused at least four St Benedict's pupils while he was employed at St Benedict's: RC-A623, RC-A626, RC-A625 and RC-A11, the latter also having been abused by Soper and allegedly by Pearce. Further allegations were also made by RC-A624 and RC-A419 but never tried. RC-A599, who alleged abuse against Pearce, also made similar allegations against Maestri. In addition to these, we are aware that complaints were made by two others in 2000 and 2002, relating to events in the 1960s when they were children, before Maestri joined St Benedict's.[262]

RC-A624, RC-A419, RC-A623, RC-A626

98. Three brothers – RC-A624, RC-A419 and RC-A623 – made allegations against Maestri. He had befriended their mother in the 1970s,[263] becoming "*like a big brother*"[264] to the children.

99. RC-A624 said that on one occasion, when he was 11 or 12 years old, Maestri kissed him whilst they were sitting on the sofa in RC-A624's home watching television.[265]

100. RC-A419 said that Maestri came into his bedroom and kissed him and touched his penis.[266]

101. The third brother, RC-A623, also described being abused by Maestri in the early 1980s. When RC-A623 was 11 years old, he attended Maestri's flat on the weekends for extra tuition. Maestri would force him to the floor, kiss him and masturbate him.[267]

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[257] MPS003017_028-029
[258] MPS003017_028-029
[259] MPS003017_029
[260] OHY005919
[261] MPS004177
[262] MPS004218
[263] MPS003532_001
[264] MPS003532_001
[265] MPS003532_001-002
[266] OHY006752_001; MPS003006_037
[267] OHY005919_006

102. The Metropolitan Police first became aware of the allegations relating to RC-A623, RC-A624 and RC-A419 in early 2003, after being contacted by RC-A623.[268] Maestri was arrested and interviewed in April 2003. He admitted kissing RC-A623 and rubbing his thighs but denied masturbating him. He also denied all the allegations made by RC-A624 and RC-A419.[269]

103. Maestri did however admit that he had been asked to leave St Benedict's for kissing another pupil, RC-A626.[270] The police were able to locate RC-A626 and in July 2003 he gave a statement in which he described how, in the mid 1980s, when he was around 12 years old, Maestri made him sit on his lap and kissed him on the mouth. He then took RC-A626 into a bedroom, undressed him down to his underwear and made him lie on the bed. He again kissed him on the mouth and touched his body. After a few minutes RC-A626 began to cry and Maestri stopped.[271]

104. Maestri was indicted with five counts of indecent assault. He pleaded guilty to the indecent assault offences against RC-A623 and RC-A626, and was sentenced in December 2003 to 30 months' imprisonment, placed on the sex offenders' register and banned for life from working with children.[272] The counts relating to RC-A419 and RC-A624 were ordered to lie on the file (ie the judge agreed with the prosecution that, while there was enough evidence for the matter to go to trial, a trial would not be in the public interest given that Maestri had pleaded guilty to the other substantial offences).[273]

RC-A11, RC-A625

105. Maestri also sexually abused RC-A625 and RC-A11 when giving them private lessons at his home address.

106. RC-A625 was a pupil at St Benedict's in the 1980s. He had been given private tuition by Maestri in the summer of 1982, when he was around 11 years old. During the lessons, Maestri put his arms around him and sat him on his lap. On one occasion, he took RC-A625 to his bedroom, made him lie on the bed and fondled his genitalia.[274] In December 2003, RC-A625's mother contacted the police to report the abuse against her son. Maestri was produced from prison and further charged with indecent assault. He pleaded guilty and, in June 2005, received a non-custodial sentence of a rehabilitation order for a period of two years.[275]

107. RC-A11, whose abuse by Soper and allegedly by Pearce is outlined above, said that in the early 1980s Maestri made him sit on his lap, kissed him on the mouth, forcibly masturbated him and tried to insert his finger into RC-A11's anus.[276] RC-A11's allegations came to light in February 2008.[277] Maestri was charged with indecent assault in September 2008 and pleaded guilty in January 2009. He received a two-year suspended sentence of imprisonment.[278]

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[268] MPS003006_028
[269] MPS003006_038
[270] MPS003006_038
[271] MPS003530
[272] MPS002971_028
[273] MPS004242
[274] MPS002971_028-029
[275] OHY005919_005-006
[276] MPS003084_004
[277] MPS003084_004
[278] MPS002977_023

RC-A599

108. In June 2010, Maestri faced further allegations of abuse made by RC-A599, who had joined St Benedict's in the mid 1970s and said that he was abused over an eight-month period in 1976. Maestri caned him on his buttocks and then rubbed them with his hand to make him feel "*better*", while masturbating himself. RC-A599 said that he told Pearce about the abuse[279] but, instead of taking any action, Pearce also began to abuse him. Maestri and Pearce were jointly tried. Both were acquitted in July 2011.

RC-A618 and RC-A641

109. In October 2014, further allegations were made by RC-A618, who attended St Benedict's in the mid 1980s. He described one incident when Maestri touched his penis over his clothing while asking him if he wanted to play table tennis for the school. RC-A618 said that the incident did not last very long.[280]

110. RC-A618 told the Metropolitan Police that he believed another pupil, RC-A641, had also been abused by Maestri. Maestri was interviewed by the police in 2014 and, although he denied the allegations made by RC-A618, he admitted to sexually assaulting RC-A641.[281]

111. RC-A641 attended St Benedict's in the early 1980s.[282] Maestri admitted to the police that, on one occasion, he had removed the boy's tracksuit bottoms, cuddled him and touched his thigh while they were lying in bed together.[283]

112. In respect of RC-A618, the Metropolitan Police decided that there was insufficient evidence to charge Maestri with a criminal offence, and although RC-A641 confirmed that he had been sexually abused by Maestri, he said that he did not wish to provide a witness statement or to attend court.[284]

113. Maestri died in 2016.[285]

Stephen Skelton

114. Stephen Skelton was born in July 1948 and was employed as a lay maths teacher at St Benedict's in the early 1980s. He gave private maths lessons at his home, and is known to have used these occasions to abuse at least one pupil, RC-A604. During the lessons, Skelton gave RC-A604 sweets, made him sit on his lap and played with his hair. In the third and final lesson, Skelton began rubbing RC-A604's stomach under his shirt, before kneeling in front of him with his face close to RC-A604's groin. RC-A604 was very scared and made an excuse to leave. Skelton initially refused to let him go, but eventually did.[286]

115. In December 2011, Skelton was convicted of two counts of indecent assault, in respect of RC-A604 and another child at a different school.[287] He was given a six-month prison sentence (suspended for two years), a lifelong sexual offences prevention order, placed on the sex offenders' register and made subject to notification requirements for seven years.[288]

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[279] MPS002991_032-033
[280] MPS004219
[281] MPS004221; OHY005917_002; OHY005917_003
[282] MPS004220
[283] OHY005919_008; OHY006752_007
[284] MPS004221; MPS004222
[285] MPS002973
[286] BNT001066_001-002; MPS002985_004
[287] MPS002985_006
[288] MPS002987_006-007

RC-F41

116. RC-F41 taught at St Benedict's between the 1960s and late 1980s.

117. During a school trip to Italy in 1984, RC-A421, who was 11 years old at the time, had been suffering from constipation and stomach pains and had gone to RC-F41 for help. RC-F41 asked the boy to remove his trousers, put Vaseline on his finger and inserted it into RC-A421's anus on the pretext of checking for a blockage. RC-F41 told the child not to tell anyone. In April 2005, RC-A421 made a complaint to Mr Turner, who in turn reported it to the police. Mr Turner also spoke to RC-F41, who admitted that he had "*realised immediately what he had done was wrong and sinful*".[289] In a subsequent risk assessment, he said "*the fact I felt guilty means perhaps there was (sexual desire)*".[290]

118. The police first became aware of this allegation in April 2005.[291] Although RC-F41 admitted to touching RC-A421,[292] the police could not charge him because the incident had taken place overseas and predated the changes in legislation[293] which would later allow for a prosecution in these circumstances (the Sex Offenders Act 1997).

119. In October 2005, RC-A421 made a further allegation against RC-F41. He said that, when he was 12 or 13 years old, after receiving his confession, RC-F41 forced him to perform oral sex on him. RC-A421 did not tell anyone about this incident at the time.[294] RC-F41 was charged with indecent assault but was acquitted in April 2007.[295]

Peter Allott

120. Peter Allott was born in March 1979.[296] He was the lay deputy headmaster of St Benedict's between 2012 and 2015.[297]

121. In December 2015, Allott was arrested for downloading and distributing indecent images of children, found on his phone and a hard drive found in his office at St Benedict's.[298] No images were found on the school computer itself.

122. Allott was found guilty in March 2016 of making and distributing indecent photographs of children. He was also found guilty of possession of extreme pornographic images involving animals and possession of Class A drugs. He received a sentence of 33 months' imprisonment and a 10-year sexual harm prevention order. He was also placed on the sex offenders' register for an unlimited term.[299]

123. Allott committed suicide in April 2018.[300]

[289] BNT000825_003
[290] BNT001026_007
[291] BNT001024_002
[292] BNT000825_003
[293] BNT001018_003
[294] BNT001024_002-003
[295] BNT001022_003
[296] BNT001248_045
[297] BNT001248_046
[298] OHY005919_014
[299] MPS004223
[300] MPS004223

Part D

Response of Ealing Abbey and St Benedict's School to allegations of abuse

Response of Ealing Abbey and St Benedict's School to allegations of abuse

D.1: Introduction

1. The institutional responses of Ealing Abbey and St Benedict's School (St Benedict's) to the allegations of sexual abuse made by pupils fall into three key periods:

- **1970 to 2000**, during Dom Francis Rossiter's abbacy, when there was extensive child sexual abuse at St Benedict's, much of which was perpetrated by David Pearce and Laurence Soper, who himself became abbot in 1991.
- **2000 to 2010**, covering the first 10 years of Abbot Martin Shipperlee's leadership. (This followed Soper's resignation in 2000 and coincided with structural changes in child protection that resulted from the Nolan report in 2001, after which Ealing Abbey aligned itself with the Diocese of Westminster child protection team.) During this time there was an increasing number of complaints against monks in the Abbey, and Pearce was able to re-offend against RC-A621 despite being under restrictions. Following concerns among the public, media and external institutions, Ealing Abbey instructed Lord Carlile of Berriew QC in August 2010 to undertake an inquiry.
- **2010 to the present**, the period after the publication of Lord Carlile's report, when structural changes were implemented to make St Benedict's independent of Ealing Abbey, during which better efforts were finally made to address safeguarding issues.

D.2: 1970 to 2000

2. Between 1970 and 2000, extensive child sexual abuse was perpetrated by monks and teachers at St Benedict's, in particular by Soper, Pearce and John Maestri. Much of this abuse was known or suspected by other monks, teachers and staff, yet almost nothing was done.

Response to Pearce's abuse

3. There was widespread awareness and gossip among pupils, staff and monks that Pearce behaved inappropriately towards a number of boys at St Benedict's.

3.1. RC-A645, a pupil at the middle school in the late 1970s, said:

> "[Pearce] *was known throughout the school as 'gay Dave'. This was how he was referred to by literally all the children, he was known universally by this moniker. He seemed actually to revel in this description. His general technique was to be*

> *constantly moving his hand over some part of your body; the shoulder, the leg, the thigh. It was generally quite subtle; he would touch you and his hands would linger on your flesh for just a little too long."*[301]

3.2. Father James Leachman, monk and teacher, referred to there being, in the 1980s, "*gossip about him touching children in the showers and photographing them*".[302]

3.3. Katherine Ravenscroft, who joined the school as a teacher in 1990, told the Inquiry that it was common knowledge among staff that there were rumours about Pearce.[303] She noted:

> "*It was spoken about quite freely amongst the boys in the school that Father David Pearce would oversee swimming whilst they were in the Junior school and that he would line the boys up naked after swimming to feel them in order to check that they were dry."*[304]

3.4. Father Timothy Gorham, another monk who taught at the school, recalled pupils talking in 1995 about Pearce saying things like "*Sit on my lap little boy*". He said "*these things were already mentioned amongst the monks at the abbey. I think everybody knew about it."*[305]

4. Abbot Shipperlee has accepted that he knew of at least some gossip in the 1980s and of "*recurrent stories*" about Pearce. He told us:

> "*I am aware that certainly, by the time I arrived in the junior school the story of the filming – or stories of the filming were referred to."*[306]

It is, however, clear that the filming was not the only aspect of Pearce's abuse that was known, as a number of teachers raised concerns internally about his behaviour, without any result.

5. Peter Halsall, a teacher at St Benedict's for 40 years, "*made complaints about both PEARCE and MAESTRI but they didn't go anywhere and it definitely harmed my career. At times it felt like the mafia, like ramming your head against a brick wall."*[307] He also said:

> *"effectively Soper and Pearce held sway in the Abbey and school and it is my belief they colluded to block any investigation by Tony Dachs. There was no one anyone could complain to until Soper resigned as Abbot."*[308]

Mr Halsall also spoke at one stage to a former pupil, then a fairly senior police officer, who said that "*unless ex pupils were willing to come forward nothing could be done*".[309]

6. Ms Ravenscroft said that "*if anybody complained or said anything about PEARCE, Laurence SOPER would protect him … to complain meant putting your job on the line*".[310]

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[301] INQ003561_002
[302] MPS002939_002
[303] INQ003777_004
[304] INQ003777_002
[305] MPS002963_002
[306] Abbot Martin Shipperlee 6 February 2019 95/1-97/11 (Father Shipperlee started teaching in the junior school in 1987; Abbot Martin Shipperlee 6 February 2019 86/3S)
[307] MPS002946_003
[308] INQ003774_002
[309] INQ003774_002
[310] MPS002950_001

7. There were monks who raised concerns internally, but who found no support before 2000. In 1999, Father Alban Nunn and other monks in the Abbey (Father Andrew Hughes and Father Thomas Stapleford) were "*all very concerned about the way these complaints were being dealt with*".[311] This was not revealed to police until 2017, when Father Nunn spoke to them and told them that he felt Soper as abbot and Soper's Council (upon which the abbot relied for advice, and on which both Pearce and Father Shipperlee sat[312]) had not dealt with the problem properly and that Soper and the Council should have gone to the police.[313]

8. Accountability for inaction primarily rests on those in charge during this period. They were the Abbots of Ealing Abbey (Francis Rossiter and Soper) and the headmasters of St Benedict's (Father George Brown, Father Anthony Gee and Dr Anthony Dachs).

9. We did not hear any evidence directly from Dom Rossiter, Abbot from 1967 to 1991, who was too infirm to provide a statement to the Inquiry. However, his approach can be seen in a letter written in 2001, when as Abbot President of the English Benedictine Congregation (EBC), he responded to serious concerns about Pearce raised by a monk at Ealing Abbey, Father Peter Burns. Abbot Rossiter warned Father Burns, saying:

> "*someone's good name is at stake, hence one needs substantial evidence. Remarks passed by third parties … would to my mind be wholly insufficient information to pass on to officials outside the monastery*".[314]

He also denied knowing of any concerns about Pearce in the period to 1991, saying "*When I left office in 1991* [Pearce] *was doing a good job as Headmaster and I had no complaints about him from anyone*". He must at the very least have known of concerns about Pearce.

10. The next Abbot of Ealing Abbey was Soper. In June 1992, when RC-A595 complained to police that Pearce had abused him in his study, Soper responded by giving Pearce his "*full support as headmaster*". He did not suspend him and said that this was:

> "*partly because the timing of the allegation in my eyes and the eyes of those I consulted, appeared to be a smokescreen for the alleged activity of the father and partly since Father David has been in the community for 22 years at least 16 of them as a school teacher in the senior or junior schools without any allegation of impropriety of any sort against him.*"[315]

As set out above, there was widespread awareness that Pearce was acting improperly towards boys. It is not clear whether the decision to replace Pearce as head of the junior school in 1993 was because of this incident, but that move did not prevent Pearce from continuing to have unrestricted access to pupils. He was able to move around the school as he wished. We were told that he was known to have pupils come to his office on a Friday afternoon, when he would shut the door and cover its glass window with paper so nobody could see in.[316] When, in 1998, the parents of RC-A631 complained of sexual abuse by Pearce, Soper again did not challenge him about his behaviour.[317] It seems clear that, as Abbot, Soper protected Pearce from further scrutiny.

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[311] MPS002959_002
[312] Abbot Martin Shipperlee 6 February 2019 109/21-23
[313] MPS002959_002
[314] BNT002587_001
[315] MPS003060_002
[316] Evidence of Father Nunn, Harsha Mortemore and RC-A597, as cited Abbot Martin Shipperlee 6 February 2019 110/6-113/13
[317] MPS003014_034

11. Dr Dachs was the lay headmaster of St Benedict's senior school between 1986 and 2002. During this time Pearce was head of the separate junior school. As such, Pearce was not under Dr Dachs authority, however like Abbot Rossiter and Soper, Dr Dachs was aware of the complaints about Pearce. For example, on 19 October 1998, the parents of RC-A631 complained by letter to him.[318] Dr Dachs did not raise those concerns with any external authority.

12. Harsha Mortemore, senior accounts assistant at St Benedict's, stated that when she raised her concerns with Dr Dachs he warned her "*If you know what's good for you, keep your head down and do your job.*"[319] Dr Dachs has denied this.

13. Father Shipperlee replaced Pearce as headmaster of the junior school in 1992 and was a member of the Abbot's Council, before becoming Abbot. He admitted that he had been aware of ongoing concerns in respect of Pearce, including the fact that as bursar Pearce continued to have contact with children at the school, but he did nothing.[320] He gave us two answers to why he did not complain. First he said "*Now, obviously, I can/could have complained. But at this stage, I'm aware of a lot of stories about him … "*,[321] the suggestion being that "*stories*" were not enough. Later in his evidence to us, Abbot Shipperlee said that he did not raise concerns when he was head of the junior school "*Because by that stage* [Pearce] *is now out of – well, he is out of the school.*"[322]

14. Pearce should not have been allowed to remain bursar or to retain an office in the school which enabled him to continue to come into contact with pupils.

Response to Soper's abuse

15. Much of the abuse perpetrated by Soper was committed under the pretext of corporal punishment. His predilection for physical chastisement was well known by boys and staff.

15.1. Mr Halsall said that he heard boys:

> "*talking about being caned and that Laurence would offer them six with the cane with trousers on but three on their bare backside with trousers off … I heard the boys talking about 'PD', which was the 'pants down' policy expounded by Laurence*".[323]

15.2. Leo Hopley, a parent of a boy at St Benedict's during the late 1970s and a teacher at St Benedict's in the 1980s, told police in 2018 that in the 1970s:

> "*Several of the parents told me that Laurence would offer the boys six strokes with their pants up or 3 strokes on their bare backsides. I thought this was rather deviant, but I thought it was for those parents to make a complaint and I thought that 'the higher ups' at the school and the Abbey would deal with it.*"[324]

[318] MPS003014_034
[319] MPS002957_002
[320] Abbot Martin Shipperlee 6 February 2019 93/1-8; 95/1-6
[321] Abbot Martin Shipperlee 6 February 2019 97/25-98/2
[322] Abbot Martin Shipperlee 6 February 2019 98/2, 99/3
[323] MPS002946_002
[324] MPS002962_002

15.3. Father Gee was the headmaster while Soper was teaching at St Benedict's, from 1973 to 1984. He told the police that:

> *"A member of staff … approached me and stated that Soper had resumed the 'old tradition of 'PD'' or pants down. This was apparently having the boys pull down their pants to be beaten on their bare behinds. This apparently had been the policy of the monks at Downside to ensure boys hadn't put a book down their trousers … I spoke to Soper and told him that he must stop doing this, he agreed to do so … At the time I think that I was rather naive and whilst I thought what SOPER was doing was very unpleasant and humiliating, it never occurred to me that it was sexual. In hindsight I now wonder."*[325]

16. Corporal punishment involving 'pants down' was unacceptable and should have signalled to staff that there may have been a sexual element.

17. Dr Dachs told the police that the use of corporal punishment was terminated when he became headmaster in 1986.[326]

Response to abuse by others

18. In 1984, Maestri became head of the middle school. Shortly afterwards, RC-A626 complained that Maestri had abused him during tuition at Maestri's flat. Abbot Rossiter went to meet RC-A626's parents, and later recalled to the police:

> *"I remember being relieved that the incident wasn't more serious, I think it involved cuddling or something of that nature. If it had been more serious I think I would have remembered what it was."*[327]

No investigation was undertaken to identify other victims. The authorities were not informed. Abbot Rossiter told Maestri that it was not possible for him to remain at the school (although he did not leave immediately).[328] The school magazine stated that he tendered resignation due to ill health.[329] Abbot Rossiter subsequently wrote a testimonial in support of his obtaining a further teaching position.[330]

19. There was a similar response to another lay teacher, Stephen Skelton. The parents of RC-A604 informed the school that he had sexually abused their son. They apparently received a letter from someone at the school but were not happy with the response and so a meeting was arranged with Abbot Rossiter and RC-F41 (Dom Rossiter, who was too unwell to attend our hearing, has said that he has no recollection of this). They were told that RC-A604 would be removed from Skelton's class and that the matter would be dealt with. Skelton did leave, but not immediately.[331] Skelton told police that the reason for his departure was because his year's probation was up.[332] He too was given a reference (he

[325] MPS002961_002
[326] MPS002951_002
[327] MPS004177
[328] MPS004177
[329] MPS004176
[330] MPS004177
[331] MPS003008_041
[332] MPS004236_001

could not recall by whom)[333] and again no report was made to the authorities. Skelton obtained a position at another school and in the 1990s he went on to abuse a boy who was a pupil at a school in Hampshire, for which he was convicted.[334]

20. The action taken against Maestri and Skelton was inadequate. Although both were made to leave the school, no report was made to external authorities and references were provided. This was a blatant failure to consider the risk to other children. Maestri and Skelton were therefore free to abuse elsewhere, and Skelton did so. It is notable that when the perpetrators were lay teachers they were forced to leave St Benedict's, but this did not happen when the perpetrators were monks.

D.3: 2000 to 2010

21. Martin Shipperlee was elected Abbot of Ealing Abbey in March 2000, following the resignation of Soper. As Abbot Shipperlee has now acknowledged, there were serious shortcomings in his response to allegations and handling of child protection concerns.

22. It is important to note the wider context at this time. Following the Nolan report in 2001, Dom Richard Yeo, then Abbot President of the EBC, had set up a working party "*to propose a common framework of procedures for Child Protection in the houses of the Congregation in the light of* [its] *recommendations*".[335] Abbot Shipperlee was a member of this working party, which went on to recommend that the EBC "*take advantage of the Diocesan structures and especially the Diocesan CPC* [Child Protection Coordinators]".[336] It also recommended that *"all disclosures, allegations and suspicions, including historic ones be immediately referred to the relevant Diocesan CPC"*.[337]

23. Ealing Abbey did align itself with the Diocese of Westminster child protection team. Abbot Shipperlee consulted the team, and in particular Peter Turner, the Child Protection Officer (later entitled Safeguarding Advisor), extensively during this period, and brought allegations to his attention. However, there were weaknesses in the advice provided by the Diocese of Westminster child protection team (discussed in Part E), which compounded deficiencies in Abbot Shipperlee's leadership.

Response of Abbot Shipperlee to Pearce

24. When Martin Shipperlee became Abbot in 2000, at least one monk, Father Nunn, considered that he would be "*a new broom*" who would support taking concerns about Pearce to the police.[338] He and another monk, Father Stapleford, encouraged staff to come forward.[339] It proved a false dawn. Based upon the evidence we heard, Abbot Shipperlee's responses were frequently inadequate, ineffective and ill-judged.

25. In December 2000, Father Burns told Abbot Shipperlee that Pearce was hearing confessions in St Benedict's junior school at the invitation of Father Gorham. Abbot Shipperlee agreed that Pearce should not have been asked to hear confessions,[340] but Father Burns was not satisfied with the response. He took his concern to the then Abbot President,

[333] MPS004175_001
[334] OHY005919_010
[335] BNT002382_007
[336] BNT002382_007
[337] BNT002382_007-008
[338] MPS002959_002
[339] INQ003774_003
[340] BNT002592

Francis Rossiter. Abbot Shipperlee told us that he had a conversation with Father Gorham; "*If I remember rightly, we talked and decided it would not be wise to involve him*" in hearing confessions.[341] That was the extent of his action.

26. Father Nunn also spoke to Abbot Shipperlee about Pearce, and remembered that Abbot Shipperlee's response was "*What can I do? He is my friend.*"[342] While not remembering whether he did say this, Abbot Shipperlee told us:

> *"in that situation … I felt it was difficult to act. You might think that was a rather strange conclusion to come to, but that was my honest reaction at the time … it was wrong."*[343]

27. Father Nunn and Ms Ravenscroft, hopeful that Abbot Shipperlee's appointment would bring about change, contacted RC-A418 and invited him to come forward with his complaints against Pearce.[344] In 2001, he did so. The allegations included putting his hands down boys' swimming trunks and filming them in the showers. Abbot Shipperlee referred the matter to the Diocese of Westminster child protection coordinator (then Father Sean Carroll[345]), who referred it to the police. Abbot Shipperlee subsequently told the police that Pearce was in no position to have any contact with children[346] but he did not consider putting him under any restrictions.

> *"I wasn't looking – I admit this, I was not looking at what he might choose to do or want to do."*[347]
>
> *"It looks like perhaps there is ample evidence that should be persuading me to do something more. But I have, at this point, taken the matter to the police, which is quite a step against … someone you live with. I understand perfectly well that that's not a very, perhaps, creditable way of considering things.*
>
> *Q. As abbot, who exactly were you waiting for advice from?*
>
> *A. Well, the police or the diocese. Never having been in this situation before – and I admit that this is not a strong answer and not a very good defence of what I did at the time … well, in retrospect, something much more did need to be done and I wasn't doing it."*[348]

28. Abbot Shipperlee also allowed Pearce to remain a trustee of the Trust of St Benedict's Abbey Ealing, which oversaw both the school and the abbey. Abbot Shipperlee admitted to us that "*In retrospect, I should have acted earlier.*"[349] He evidently found it difficult to take action against another monk.[350] Abbot Shipperlee was not proactive. He failed to take further steps of his own volition, choosing instead to wait for guidance from others.

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[341] Abbot Martin Shipperlee 6 February 2019 121/25
[342] MPS002959_002
[343] Abbot Martin Shipperlee 6 February 2019 128/9-16
[344] INQ003777_004
[345] MPS003014_025
[346] MPS003014_033
[347] Abbot Martin Shipperlee 6 February 2019 131/7-8
[348] Abbot Martin Shipperlee 6 February 2019 134/9-22
[349] Abbot Martin Shipperlee 6 February 2019 136/8
[350] Abbot Martin Shipperlee 6 February 2019 134/9-22

29. In 2003, when Abbot President Yeo conducted his first visitation on Ealing Abbey, several monks told him of their concern about Pearce. They complained that he was "*not being reined in as he should have been*"[351] and gave examples of how Pearce would pass through the school "*in order to reach some offices*".[352] The concern presumably being that Pearce could engineer access to children under this pretext.

30. In 2004, further complainants came forward. For example, RC-A6 alleged abuse by Pearce while in the school infirmary and elsewhere, and RC-A419 alleged an incident of abuse while Pearce was visiting his home. In response, Pearce was placed on "*administrative leave*" in April 2004[353] while the police investigated. Following a decision not to prosecute in October 2004, and in keeping with Catholic Office for the Protection of Children and Vulnerable Adults (COPCA) guidance and Mr Turner's advice, Abbot Shipperlee instructed an expert, David Tregaskis, to prepare a child protection risk assessment report on Pearce. Mr Tregaskis was a clinical criminologist with extensive experience in providing risk assessments in respect of sex offenders for criminal and civil courts, and for other bodies including the NSPCC, dioceses and religious orders.[354] In his letter of instruction, Mr Tregaskis was informed of the allegations of RC-A419 and RC-A6 as well as RC-A595 and RC-A418. He was not however told of the allegation of RC-A631 (despite Abbot Shipperlee being aware of it[355]). In any event, Mr Tregaskis concluded that there was "*a major concern*" in respect of Pearce and that "*clear boundaries*" (ie restrictions) should be placed on him.[356]

31. On 19 April 2005, Mr Turner, having discussed Mr Tregaskis' report with his manager Monsignor Harry Turner (the Diocese of Westminster Child Protection Coordinator), wrote to Abbot Shipperlee recommending that five restrictions be placed upon Pearce.[357]

> "*1. That Fr. David has no public ministry with the Parish setting.*
>
> *2. That Fr. David is only allowed to say mass in private or within the monastery, and with no members of the public present.*
>
> *3. That Fr. David is allowed to continue in a non-executive role within the Monastery as long as that does not bring him into contact with Children and Young Persons;*
>
> *4. That Fr. David continues to serve as Chaplain to other Religious Communities as long as this does not bring him into contact with Children and Young Persons, and provided that the person in charge of such Communities is made aware of these conditions;*
>
> *5. That if Fr. David visits families within the Parish, he does so only on condition that he does not wear clerical dress and that the families are bonafide families/friends.*"

Mr Turner concluded his letter by asking that "*the recommendations be formally recognised in a formal letter to me*", but this was never done.

[351] BNT003122_003 (as recorded by Dom Yeo)
[352] BNT003122_003
[353] BNT001208_005
[354] BNT001208_003-004
[355] MPS003014_027
[356] BNT001208_011-012
[357] BNT000829

32. Abbot Shipperlee accepted that he failed to do this, and had also failed to keep any record over and above Mr Turner's letter.[358] This inaction and lack of record-keeping contributed to subsequent confusion about the details of the restrictions (for example, the subsequent Charity Commission report only referred to three restrictions, so they may not have been made aware of all five).[359]

33. Mr Turner's letter was insufficient. It did not give any guidance to Abbot Shipperlee as to how compliance with these restrictions should be enforced and monitored. We address this further in Part E.

34. Abbot Shipperlee also failed to ensure that action was taken. Instead of putting a formal safeguarding mechanism in place, he appears to have relied upon three factors.

- **Pearce living alongside him:** Abbot Shipperlee told us that "*I'm living with him a lot of the time*",[360] the suggestion being that he was therefore able to monitor Pearce's activities. He should have recognised that this had been the case since the 1980s and had not prevented Pearce abusing children in the care of St Benedict's.
- **Compliance by Pearce:**[361] Abbot Shipperlee said that Pearce "*now knows how he is meant to be – the scope of his activity. His work is in the monastery and nowhere else.*"[362] This repeats the mistaken assumption that because Pearce *should* not have contact, he would not have contact. It ignored Mr Tregaskis' clear advice that Pearce's denial of any inappropriate behaviour was itself a risk factor.[363] It was not appropriate to deal with a significant risk to children by relying on the word of the person accused of abusing them.
- **Other monks would tell the abbot if there were breaches:**[364] There is no documentary evidence of what monks at Ealing Abbey were told about Pearce's restrictions. The later review carried out by Philip Wright and John Nixson observed that the extent of knowledge within the community was unclear.[365] If the monks did not know what the restrictions were, they could not help to police them. When Abbot Shipperlee was questioned about this, he initially seemed to lay blame at the door of his community, saying "*monks are very good at not knowing what you think you've told them*", although he accepted that he:

  > *"didn't give them a piece of paper telling them all that, for sure. Clearly, I could have been – I should have been clearer about what I was saying."*[366]

35. The failings in respect of restrictions upon Pearce went further. Abbot Shipperlee said of his failure to act that he was:

> *"plainly not thinking the right way around … I was looking at what he [Pearce] couldn't do. I really wasn't concentrating anywhere near enough on what he might do, and, in that sense, clearly, I'm not thinking first about the safety of children, and that's a mistake … "*[367]

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[358] Abbot Martin Shipperlee 6 February 2019 145/10
[359] CYC000255_008
[360] Abbot Martin Shipperlee 6 February 2019 147/7
[361] Abbot Martin Shipperlee 6 February 2019 148/7
[362] Abbot Martin Shipperlee 6 February 2019 147/17-148/5
[363] BNT001208_011
[364] Abbot Martin Shipperlee 6 February 2019 146/4-7, 148/21-149/6
[365] BNT001114_003
[366] Abbot Martin Shipperlee 6 February 2019 146/8-19
[367] Abbot Martin Shipperlee 6 February 2019 154/12-20

36. In 2006, the sexual abuse committed by Pearce was established in a civil trial brought by RC-A6 against both Peace and the trust. The judge, Mr Justice Field, said he found Pearce and the account that he gave in court "*extremely unconvincing*" and not having "*the ring of truth*".[368] In contrast, he found RC-A6 "*an entirely convincing, reliable and credible witness*".[369] The allegations RC-A6 made against Pearce were found proven, as was similar abuse of two other boys, X (RC-A418) and Z (RC-A419).[370]

37. During the proceedings, Pearce left the monastery and lived with a family member. After the trial, minutes of the Abbot's Council meeting of July 2006 noted there had been a "*comment from a parishioner which indicated that there might well be disquiet at his returning to the monastery so soon*".[371] Despite this and the judgment, no change was made to the restrictions upon Pearce.[372] Abbot Shipperlee told us that he went back to Mr Turner about the risk following the ruling.[373] When asked about this, Mr Turner said that there was no reconsideration although "*thinking about it now, perhaps we should have reconsidered it*".[374]

38. Following the civil judgment against Pearce, the Diocese child protection team should have advised strongly that Pearce be required to leave Ealing Abbey. Abbot Shipperlee should have insisted that Pearce live elsewhere, rather than remain at Ealing Abbey, where he could and did use his position to abuse another child.[375] While there may have been countervailing considerations as Shipperlee noted,[376] such as difficulties in finding a suitable and safe place for Pearce to live, it should not have been insurmountable because it had previously been possible to make arrangements for him to leave the monastery during the civil trial.

39. After his return, Pearce went on to abuse RC-A621. He was a 16-year-old pupil at St Benedict's who in December 2006 had started working in the monastery at weekends. In January 2008, RC-A621 disclosed that he had been sexually abused by Pearce for over a year, having met him while working in the kitchens. Pearce was arrested, prosecuted and later that year pleaded guilty to sexual offences in respect of RC-A621 and four other boys. Abbot Shipperlee had known that RC-A621 was working in the monastery, and that Pearce had access to the areas where he was stationed. He also became aware that Pearce, despite the restrictions upon him, had come to know RC-A621, as Pearce himself told the abbot around April 2007 that the boy had spoken to him about becoming a monk.[377] Abbot Shipperlee did nothing to advise against or stop that contact. He told us that he simply did not see RC-A621, at the age of 16, as a child.[378] That was wrong.

40. Abbot Shipperlee failed adequately to consider the risk of the abuse of children by Pearce, both generally and specifically in RC-A621's case. Following the civil judgment against Pearce, the Diocese of Westminster child protection team should have advised strongly that Pearce be required to leave Ealing Abbey. As a result of their failures and inadequate action, children were left at risk of abuse by Pearce, who did indeed go on to abuse RC-A621. This could have been prevented.

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[368] BNT001206_018 paras 83, 85
[369] BNT001206_018-019 para 83
[370] 'Z' and 'X', BNT001206_018 para 82
[371] BNT007045_021
[372] Abbot Martin Shipperlee 6 February 2019 156/15
[373] Abbot Martin Shipperlee 6 February 2019 155/21-156/3
[374] Peter Turner 6 February 2019 18/8-21
[375] Abbot Martin Shipperlee 6 February 2019 159/1-21
[376] Abbot Martin Shipperlee 6 February 2019 161/21-25
[377] Abbot Martin Shipperlee 6 February 2019 167/1-24
[378] Abbot Martin Shipperlee 6 February 2019 168/1-2

Response of Abbot Shipperlee to Soper

RC-A420

41. In October 2001, RC-A420 brought a civil claim against Soper for sexual abuse that he alleged had occurred in the 1990s when he was 19 years old and serving a sentence of detention at Feltham Young Offender Institution, where Soper had been a chaplain.[379] RC-A420 subsequently told the Metropolitan Police in 2018 that Soper had sexually assaulted him on many occasions, and that the abuse had escalated to rape. He estimated that he had been raped by Soper on at least 10 occasions.[380]

42. In December 2001, the Diocesan child protection coordinator, James Curry, advised Abbot Shipperlee that RC-A420's claim should be reported to the police. Abbot Shipperlee "*undertook*" to Mr Curry that he would act on this[381] but it seems that he in fact decided not to do so, favouring his own judgment of the facts over an independent review of the evidence.

> *"Q. Did you bring the A420 matter to the police's attention?*
>
> *A. I did not.*
>
> *Q. Why not?*
>
> *A. Because I simply did not believe that this was possible. In fact, I was outraged that such an accusation could be made against someone of whom I – well, it did not occur to me that it was possible that this sort of thing could happen.*
>
> *Q. Do you agree that that decision was wrong?*
>
> *A. Oh, yes, absolutely wrong."*[382]

43. Abbot Shipperlee told us that he was "*convinced in my own mind that this must be a spurious claim*".[383] As a result of his failure to report this allegation to the police, when they and the Crown Prosecution Service came to consider RC-A622's allegations against Soper in 2004, they did so without any knowledge of the similar and serious allegations made by RC-A420. Solicitors instructed by the Abbey's insurers wrote to RC-A420, threatening him with legal costs if he pursued his civil claim. RC-A420 described his response to police as follows:

> *"I received a letter back from a solicitor, either [Soper's] personal one or one from the Abbey basically telling me to drop the claim or they would take me to court for costs which ran in £1000 pound from what they said I could not afford this and I couldn't afford a solicitor so I contacted one solicitor by 'phone' and told them I was dropping the claim. They then sent me paperwork to discontinue this which I completed and sent back. On top of not having enough money I was scared as all I wanted to do was have Laurence SOPER pay for what he had done and on getting a letter from powerful solicitors scared me I guess."*[384]

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[379] Abbot Martin Shipperlee 7 February 2019 3/7-14; BNT007139_021 para 36.3
[380] MPS002983_002
[381] DOW000030_005
[382] Abbot Martin Shipperlee 7 February 2019 3/22-4/6
[383] Abbot Martin Shipperlee 7 February 2019 5/15
[384] MPS002976

44. Shortly after this, in 2002, Soper went to Rome to become the general treasurer to the International Benedictine Confederation at Sant'Anselmo. Abbot Shipperlee did not inform the Abbot Primate, Notker Wolf, of the allegation of RC-A420 against Soper.[385] As a result, the Abbot Primate was unaware of the potential risk Soper represented.

RC-A622

45. In 2004, RC-A622 told the Metropolitan Police that he had been abused and repeatedly raped by Soper in the 1970s when he was a pupil. Abbot Shipperlee heard that RC-A622 had made an allegation (whether from the police or from Mr Turner he was not sure)[386] but he again failed to act and did not seek the details, nor did he commission any risk assessment. He said:

> *"I didn't know particularly the details of the case. I did learn them subsequently, and horrifying details they are too."*
>
> *Q. It is not long after this that you are instructing David Tregaskis in relation to Father Pearce, and you also instructed him in relation to RC-F41.*
>
> *A. Yes.*
>
> *Q. Yet here you had received two allegations in respect of Laurence Soper, and you didn't think it necessary to seek a risk assessment as far as he was concerned?*
>
> *A. Well, I didn't not think it necessary; otherwise, I would have. Both these accusations, as they have come to me, come from slightly odd directions. This is not an excuse, this is an explanation of how I was perceiving it, in that, one, the first one, in 2001, is a civil claim without any other seeming process; and the second – again, something has happened but nothing is happening. Now, in retrospect, you are quite right, it would have been a very good thing to do, but I did not."*[387]

Further allegations

46. In 2008, further complaints of sexual abuse were made against Soper by RC-A11.[388] However, it was not until May 2010, after another allegation from RC-A591,[389] that Abbot Shipperlee finally travelled to Rome to place him under formal restrictions.[390]

Response of Abbot Shipperlee to RC-F41

47. In April 2005, RC-A421 disclosed to Mr Turner that he had been abused by RC-F41 while on a school trip to Italy in 1984. RC-F41 admitted to Mr Turner that he had inserted his finger into the anus of the boy, supposedly to relieve his constipation, although *"he realised immediately what he had done was wrong and sinful, and he has worried about it ever since"*.[391]

48. At Mr Turner's recommendation, RC-F41 was removed from public ministry and assessed by Mr Tregaskis. RC-F41 told Mr Tregaskis that *"the fact I felt guilty means perhaps there was (sexual desire)"*.[392] He also disclosed other abusive behaviour, such as *"kissing now*

[385] Abbot Martin Shipperlee 7 February 2019 10/17
[386] Abbot Martin Shipperlee 7 February 2019 11/6-18
[387] Abbot Martin Shipperlee 7 February 2019 12/14-13/7
[388] INQ001661_013
[389] BNT007139_022 para 36.8
[390] Abbot Martin Shipperlee 7 February 2019 15/21
[391] BNT000825_003
[392] BNT001026_007

and then" and feeling an inappropriate attraction towards some boys (which resulted in his request to give up his position within the school in 1989). He said that his attraction to boys was current, and that sexual images had come into his mind the previous Sunday when he observed an altar boy.[393] Restrictions were imposed upon him.

49. RC-F41 could not be prosecuted in respect of RC-A421's allegation, as the incident had occurred in Italy and so could not at that time (prior to the Sex Offenders Act 1997) be prosecuted in the UK. RC-A421 later made further allegations, for which RC-F41 stood trial in 2007 but was acquitted.

50. Despite RC-F41's admissions in respect of the incident in Italy, Abbot Shipperlee's response to his acquittal in June 2007 was to question the restrictions upon him. He wrote to Mr Turner that:

> "*Parishioners do not understand why he continues to be under restrictions and, to be honest, I'm not sure I do either … At the moment, it is far from obvious that RC-F41 has ever posed a risk to children.*"[394]

Mr Turner replied that the restrictions had to continue.

51. In 2008, Mr Turner received a call from a child protection coordinator in Middlesbrough because RC-F41 had made a request to say mass in a local church. RC-F41 had said that he had been found innocent of all matters and that the diocese "*had been slow in revoking our recommendations*". Mr Turner informed his counterpart of the true position and RC-F41 was not permitted to perform any public ministry in Middlesbrough.[395]

The Wright–Nixson report of 2009

52. As a result of Pearce's conviction in August 2009, Abbot Shipperlee proposed an independent review to the Abbot's Council and said that he would seek the recommendations of CSAS before proceeding.[396] Shortly afterwards he met with an interested member of the public, Jonathan West, who urged him to undertake "*a review of the past to discover as far as possible the scope of the abuse*" and take "*tangible actions to try as far as possible to prevent any repetition of such crimes*".[397]

53. In October 2009, Philip Wright, the Safeguarding Coordinator for the diocese of Arundel and Brighton, and John Nixson, an independent child protection specialist, were instructed to undertake the task. Despite child protection concerns at the Abbey extending beyond Pearce to allegations against both Soper and RC-F41, the review was limited to the offending of Pearce[398] and to two days' work.[399]

54. The authors met Abbot Shipperlee but did not hold any interviews with school staff or others. A copy of the school child protection policy was provided to the authors but they did not check that this complied with Department for Children, Schools and Families guidance as asserted.[400] The main basis of the report was a document produced by Abbot Shipperlee giving the background to allegations against Pearce. However, this omitted a

[393] BNT001026_007
[394] DOW000022_15
[395] DOW000047_016 para 75
[396] BNT007045_033
[397] INQ003001_006
[398] BNT001114
[399] INQ003916_004 para 22
[400] INQ003916_004 para 26; INQ003560_002 para 3

number of allegations, mentioning just RC-A418, RC-A6 and RC-A621.[401] There was no consideration of the underlying documentary material. Mr Nixson, in his written evidence to the Inquiry, stated:

> *"With the benefit of further reflection, it is now evident to me that Abbot Martin presented the existing concerns and findings about individual members of the religious community in a minimal manner. At the time this was one aspect of the situation that led me to feel that the review was, to some extent, a mechanical exercise intended to enable Ealing Abbey to satisfy CSAS that it was procedurally compliant rather than fully embracing safeguarding as an essential element of the abbey's culture for the future."*[402]

Abbot Shipperlee accepted that the scope of the instructions given to Mr Nixson and Mr Wright could have been broader, but did not agree that he had minimised concerns or that material was withheld. He told us that he had told Mr Nixson and Mr Wright that they could look at anything they wanted, but that they had *"decided that they had wanted to concentrate on present matters. That was their decision on what they wanted to do"*.[403]

55. The authors should have made clear their reservations, and the limitations of their review, within the body of their report. As a means of addressing what had gone wrong at Ealing Abbey and St Benedict's, and what improvements were required, their review was inadequate.

56. In August 2010, Ealing Abbey instructed Lord Carlile to conduct another independent review, and Kevin McCoy (a *"child care and social care specialist"*[404]) to undertake a thorough review of files so as to identify matters giving rise to child protection concerns. These reviews were precipitated by the concerns raised in 2010 by external agencies, in particular the Department for Education (DfE) and the Independent Schools Inspectorate (ISI), as well as scrutiny in the media and in Jonathan West's blog.

The response of Christopher Cleugh as headmaster of St Benedict's

57. In 2002, Dr Dachs was replaced as the lay headmaster of St Benedict's senior school by Christopher Cleugh. As headmaster, he set the tone for staff, pupils and parents in terms of how child protection concerns were dealt with. Mr Cleugh also had a principal role in addressing, from the school's perspective, the danger posed by monks identified as risks and placed under restrictions. He was responsible for the school's interaction with external institutions and its child protection policy. Mr Cleugh's leadership in all of these areas was inadequate.

The tone of his leadership

58. Mr Cleugh repeatedly minimised questions of child sexual abuse to teachers and to external institutions and parents, to the point of materially misrepresenting significant facts. For example, in a draft letter he wrote to parents in late August 2010 to respond to the publication of the ISI's follow-up inspection that month,[405] he emphasised that the school had been deemed fully compliant by the ISI in its earlier November 2009 report. This was

[401] INQ003560_023-025
[402] INQ003916_004-005 para 28
[403] Abbot Martin Shipperlee 7 February 2019 30/12-31/25
[404] BNT003761_001
[405] ISI001130_001

despite the fact that the ISI's latest report found it not to be so.[406] He also wrote that the ISI had advised him that the child protection policy was "*an exemplar of excellence*" when it had not.[407]

59. The Inquiry heard evidence that Mr Cleugh did not address safeguarding issues openly and proactively. He was defensive.

59.1. Mr Halsall said that "*When Cleugh became head, I attempted to make him aware of past issues with Pearce and others. He did not welcome this.*"[408]

59.2. Ms Ravenscroft said that after she had raised the allegation of abuse of RC-A418, "*the new headmaster, Mr Cleugh, was obviously unhappy*" and said he treated her like a traitor.[409]

59.3. Ms Mortemore said that when Pearce was being investigated, Mr Cleugh "*called a meeting and told us not to talk to anybody outside the school*".[410] Mr Cleugh admitted this, although suggested that it was "*advice*".[411]

60. The same defensive approach, painting Ealing Abbey and St Benedict's as the victim, was apparent in a prize-giving address Mr Cleugh gave in 2010. He disparaged media coverage and a blog run by the campaigner Jonathan West:

> "*Recent media and blog coverage seem hell-bent on trying to discredit the School and, at the same time, destroy the excellent relationship between School and Monastery. Is this part of an anti-Catholic movement linked to the papal visit? I do not know, but it feels very much as if we are being targeted.*"[412]

Consideration of risks

61. Mr Cleugh also did not give due thought to the risks posed by Pearce and RC-F41, despite knowing of the allegations made in respect of them and that they resided next to the school. He raised no concerns about their proximity internally or externally, including to the Charity Commission.

62. Pearce remained a trustee of the school until 2004. As Mr Cleugh said:

> "*A. All I can say is, I clearly got that wrong, for which I very, very much regret, but at the time, there wasn't a mandatory duty to report, and I regret that I did not do it.*
>
> *Q. Did you think it was appropriate or raise any concerns? Did you just not think about it, that he was a Trustee?*
>
> *A. I clearly did not think about it and clearly I should have reported it, but there wasn't – it wasn't an automatic thing that I thought about at that time, which I most certainly would have done four or five years later.*"[413]

[406] Christopher Cleugh 8 February 2019 3/21-5/8
[407] Christopher Cleugh 8 February 2019 6/6-7/20
[408] MPS002946_003
[409] MPS002950_002
[410] MPS002957_003
[411] Christopher Cleugh 7 February 2019 129/1
[412] INQ002991_005
[413] Christopher Cleugh 7 February 2019 130/10-20

63. Mr Cleugh showed a lack of concern in respect of RC-F41 when allegations were made in 2005 and restrictions were imposed. He said he had never seen the Tregaskis report and was not aware that RC-F41 had accepted that there might be a sexual motivation to his having inserted his finger into RC-A421's anus. He told us:

> *"Q: Do you feel at all that you were kept in the dark about some salient information [about RC-F41] that you should have known?*
>
> *A: Well, I think – I've admitted that I actually knew the information. I hadn't properly thought about it in that particular sense."*[414]

64. In 2006, Mr Cleugh had no concerns about Pearce continuing to reside adjacent to the school:

> *"Q. Did you feel it was satisfactory having someone accused of child sexual abuse against whom, once we got to 2006, there had been a civil judgment, did you think it was satisfactory that he should be living adjacent to the school?*
>
> *A. I think the answer is, in hindsight, I definitely know that that wasn't the case, but I never flagged it up as an issue. And I realise that that's something that I might well – I should have done; not might well have done, should have done."*[415]

65. However, Mr Cleugh knew that RC-A621 was working in the monastery, was interested in training for the priesthood and was *"close friends with some of the monastic community"*.[416] Even after the civil judgment against Pearce in 2006, Mr Cleugh did not consider the possibility that Pearce might pose a further risk:

> *"I have already unreservedly apologised for what was a very bad judgment on my part in that particular case, yes, absolutely."*[417]

The belated acceptance to this Inquiry of some responsibility for the abuse of RC-A621 was in contrast to the presentation of the case to the ISI in 2009, when the school *"accepted no responsibility for the failure of the restrictive conditions imposed on Father David Pearce"*.[418] This seems to be an example of what Mr Halsall described as a culture of cover-up and denial at the school having been *"followed recently by passing the buck"*.[419]

Interaction with external institutions

66. Mr Cleugh failed to represent accurately the situation at St Benedict's to external institutions. For example, he told ISI inspectors at a preliminary visit in July 2009 that one of the monks had been charged with an assault on a pupil doing work experience in the monastery, but omitted that this had occurred while Pearce was under restrictions. He also did not inform them that there had been a civil action in 2006 when substantial damages had been awarded to RC-A6 and abuse found proven in respect of two others, nor about the abuse of four other boys dating back to the 1970s which had resulted in Pearce being convicted.[420] In his evidence, Mr Cleugh referred repeatedly to the information being *"all in the letter"* to parents dated 2 October 2009, which was also provided to the ISI. He

[414] Christopher Cleugh 7 February 2019 143/23-144/2
[415] Christopher Cleugh 7 February 2019 132/2-11
[416] Christopher Cleugh 7 February 2019 134/12-16
[417] Christopher Cleugh 7 February 2019 134/18-20
[418] ISI001095_007
[419] MPS002946_003
[420] ISI001121_001

told us that the letter "*actually cite*[d] *the number of cases that he was accused of going back 25/30 years*".[421] However, that letter, written by Abbot Shipperlee, does not provide the detail suggested; it merely refers to there being more than one victim:

> "*Fr David Pearce, who taught at St Benedict's from 1976–1992, pleaded guilty on 10th August to serious criminal offences against children and has now been sentenced to 8 years imprisonment.*"[422]

67. Mr Cleugh also failed to inform the ISI that the Charity Commission was undertaking two related statutory inquiries into Pearce's abuse:

> "*I didn't think that was particularly relevant at the time … I mean, in retrospect, I should have done it, I accept that. But I obviously didn't mention it at the time.*"[423]

St Benedict's child protection policy

68. There were significant deficiencies in St Benedict's child protection policy, in particular with regard to external reporting, which was largely a matter of discretion. These deficiencies are put in sharp focus in light of the above findings in respect of Mr Cleugh and his leadership in the period from 2002 to 2010, which was resistant to external involvement.

69. We have not seen any of St Benedict's child protection policies prior to 2009. However, there are significant defects in the September 2009 version. Most seriously, paragraph 23 provided that allegations of child sexual abuse would not always be referred to the local authority designated officer (LADO) at Ealing social services, or the police, when they should have been:

> "*A referral to the [Ealing LADO] or police will not normally be made where:*
>
> – *the complaint does not involve a serious criminal offence; and*
>
> – *a referral would be contrary to the wishes of a pupil complainant who is of sufficient maturity and understanding and properly informed, and contrary also to the wishes of the complainant's parents; and*
>
> – *the case is one that can be satisfactorily investigated and dealt with under the School's internal procedures, the parents being kept fully informed, as appropriate.*"[424]

70. This 2009 policy claimed to be compliant with the statutory guidance, *Safeguarding Children and Safer Recruitment in Education*. Mr Cleugh said that he had been satisfied that it was compliant.[425]

> **70.1.** The statutory guidance, however, explicitly stated that the LADO must be informed whenever there is an allegation that a teacher or member of staff has "*behaved in a way that has harmed a child, or may have harmed a child; possibly committed a criminal offence against or related to a child; or behaved towards a child, or children, in a way that indicates she or he is unsuitable to work with children*".[426]

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[421] Christopher Cleugh 7 February 2019 157/1-6
[422] BNT001164
[423] Christopher Cleugh 7 February 2019 161/5-9
[424] BNT000765_008
[425] Christopher Cleugh 7 February 2019 169/8-15
[426] Christopher Cleugh 7 February 2019 170/1 to 172/9; INQ003830_063-067 paras 5.1, 5.14, 5.36

70.2. There was no requirement that the allegation involve "*a serious criminal offence*" (which was itself undefined in St Benedict's policy).[427]

70.3. The discretion afforded to St Benedict's under its own policy not to report an allegation, and to conduct an internal investigation, contradicted the statutory guidance. As a result, the threshold for external reporting was too high and wrongly subject to discretion.

70.4. St Benedict's definition of sexual abuse was also unsatisfactory in the light of statutory guidance.[428]

71. Mr Cleugh conceded that the policy "*had flaws*" and "*was wrong*".[429] While as Mr Cleugh conceded he "*had the overall responsibility*",[430] responsibility for the deficiencies in the policy does not rest with Mr Cleugh alone, or with his deputy who was the designated child protection lead at the time.[431] The policy had been drafted with the assistance of the school's solicitors, Veale Wasborough LLP.[432] The ISI inspectors in 2009 found that the policy was compliant, which the ISI has now accepted was a failing on its part.[433] The Charity Commission as well as Mr Wright and Mr Nixson also asserted that the policy was adequate, without proper consideration.[434] It would have been obvious, simply from reading the statutory guidance, that the school's policy was not compliant.

D.4: 2010 to the present

The Carlile report

72. Concern with the institutional response of Ealing Abbey and St Benedict's to allegations of child sexual abuse came to a head in 2010. Pressure came from five directions.

- In December 2009, the Charity Commission published its report following its two statutory inquiries in 2006 and 2008. It was "extremely critical" of the trustees' failure to implement restrictions upon Pearce, and indicated that the Commission would actively monitor the charity.
- The views of certain members of the public gained momentum, especially through Jonathan West's blog.
- In April 2010 a series of articles appeared in *The Times*[435] and an interview with Abbot Martin Shipperlee was aired on BBC Radio 4.
- Following the withdrawal of the 2009 report, the follow-up ISI inspection of April and May 2010 was critical and made a number of recommendations. These included that St Benedict's should "Ensure that any staff or members of the religious community live away from the school, if they are subject to allegations of misconduct or convicted of wrongdoing".[436]

[427] Christopher Cleugh 7 February 2019 174/6-8
[428] Christopher Cleugh 7 February 2019 175/22-176/10
[429] Christopher Cleugh 7 February 2019 175/7-21
[430] Christopher Cleugh 7 February 2019 169/8-15
[431] Christopher Cleugh 7 February 2019 169/8-15
[432] Christopher Cleugh 7 February 2019 168/18-20, 173/1
[433] INQ004178_006 para 13
[434] CYC000255_004; INQ003916_004 para 26; INQ003560_002 para 3
[435] INQ003040_012-013 para 70
[436] ISI000019_004

- On 16 July 2010, Penny Jones of the DfE wrote to Shipperlee to inform him that the Minister of State for Schools was seeking "assurance that all ISI's recommendations will be implemented promptly".[437]

73. It was against this background that, in July 2010, Anthony Nelson of Haworth & Gallagher solicitors was instructed to advise Abbot Shipperlee in connection with child protection issues and the ISI report. He advised that "*the School and the Abbey, the Abbot being essentially the Head of both, should seek to establish trust with the Regulatory Authorities and to avoid at all costs mistrust*".[438] Subsequently Dr Kevin McCoy was instructed to undertake a documentary review. Mr Nelson also contacted Lord Carlile, with whom he had a previous professional connection,[439] writing:

> "*It is suggested at this stage by the lay person advising the Abbey that an independent report, chaired by yourself in conjunction with Dr McCoy's particular skills, would be advantageous to the Abbey.*"[440]

Lord Carlile agreed, but on the understanding that the report would be published online and printed copies made available upon request. His inquiry was formally announced in August 2010.[441]

74. Abbot Shipperlee subsequently presented written representations to Lord Carlile in January 2011, in which he suggested that the purpose of reform should be to implement five principles:

> "*1. to create a governing body with clear independence and autonomous decision-making power;*
>
> *2. to establish clear accountability between school management, governors and Trustees;*
>
> *3. to create a system of governance that is transparent and understandable to outsiders;*
>
> *4. to develop a governing body capable of addressing any concerns over Safeguarding, and monitoring the effective implementation of policies and procedures in this area;*
>
> *5. to ensure the Benedictine nature of the school is preserved. This remains a particular principle for St Benedict's, Ealing, and part of the choice parents make to send their children to the school.*"[442]

75. Lord Carlile's final report was produced in November 2011. In it, he agreed with Abbot Shipperlee as to the principles, but continued:

> "*It has been suggested to me that these purposes could be met by changes to the existing governance structure under a single trust, with delegation of functions to committees with some guarantees of independence. I do not agree. I have no doubt that circumstances have given rise to an overwhelming imperative for the creation of two charitable trusts …* "[443]

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[437] ISI001117_001
[438] BNT001139_001
[439] INQ003700_002 para 11
[440] INQ002984_004
[441] BNT001113_003
[442] BNT001124_002
[443] BNT001113_012

76. Abbot Shipperlee enacted the formal separation of the school from the monastery swiftly after Lord Carlile's report, notwithstanding his initial reservations about that course. Given external pressures he had little choice. For example, the DfE was provided with an embargoed copy of the report ahead of publication, and concluded that the report's recommendation, if implemented, would bring about the necessary changes to the management and leadership of the school.[444] St Benedict's duly became formally independent of Ealing Abbey on 1 September 2012.

St Benedict's post-Carlile

77. Following the separation, St Benedict's became a registered charity and a company limited by guarantee, independent of the Abbey. The chair of the governing body must be a lay person. The majority of other governors are lay: only the Abbot and two members of the Ealing monastic community are governors, along with 10 to 17 others.

78. After the identification of defects in its child protection policy in 2010, there followed a lengthy process of revision in light of concerns raised by the ISI and Jonathan West. Since at least October 2013, external reporting to the LADO of all complaints or suspicions of abuse has been compulsory.[445]

79. In 2016, Andrew Johnson was appointed headmaster of St Benedict's. He described a number of improvements to safeguarding, including record-keeping and vetting, compulsory reporting to Ealing social services, safeguarding training for staff, information for students and parents, and the operation of the safeguarding sub-committee under the chair of Sue Vale, an education consultant with relevant expertise.[446] Mr Johnson also outlined that he had commissioned an audit report from Philip Threlfall, an independent safeguarding consultant, whose conclusion was that Mr Johnson, Ms Vale and St Benedict's staff were "*absolutely committed*" to safeguarding, and that "*the right things are in place*".[447] It is the responsibility of all those at the school to remain vigilant and ensure that safeguarding remains a priority.

Developments at Ealing Abbey

80. The instruction of Lord Carlile and the implementation of his key recommendation of structural separation were significant developments undertaken by Abbot Shipperlee. They reflected a more proactive approach by him to trying to learn the lessons of the past and make changes for the future. However, there remained deficiencies in his approach and judgement in the period from 2010.

81. In July 2010, the DfE wrote to Abbot Shipperlee asking him to implement all the ISI's recommendations,[448] in particular regarding the residence of monks ("*Ensure that any staff or members of the religious community live away from the school, if they are subject to allegations of misconduct related to safeguarding or convicted of wrongdoing*"[449]). This recommendation plainly encompassed RC-F41, nonetheless Abbot Shipperlee did not immediately relocate RC-F41. However, he did commission a further report from Mr Tregaskis.[450] On 12 October

[444] INQ003857_010 para 43
[445] BNT000757_005; BNT000757_015
[446] BNT007137
[447] BNT007148
[448] BNT000928
[449] ISI000019_004
[450] BNT001015_002

2010, the Minister of State for Schools, Nick Gibb MP, wrote to the Charity Commission expressing concern that the DfE did not have the jurisdiction to enforce RC-F41 living away from the monastery.[451] Shortly after, on 15 October 2010, Mr Nelson informed the DfE that Abbot Shipperlee would ensure that RC-F41 would move from Ealing Abbey by early January 2011. However, when RC-F41 was moved that month,[452] Abbot Shipperlee failed to inform the Diocese of Brentwood (in breach of the CSAS cross-boundary placement policy[453]). The Bishop of Brentwood subsequently asked that RC-F41 be moved because the diocesan safeguarding commission felt that the premises were unsuitable.[454] Thereafter another location for him was found.

82. There was insufficient monitoring of the restrictions upon RC-F46. The restrictions were first imposed following the allegations of RC-A423 in April 2010. These were subsequently found to be "*unsubstantiated, but not unfounded*".[455] Taken together with allegations made against him by RC-A422 at St Augustine's Priory, a local girls' school, the multi-agency strategy meeting determined that the restrictions were to be maintained. Yet members of the monastic community were not informed of the terms of the covenant of care.[456] Further, for a significant period into 2011, RC-F46 not only refused to agree to his covenant[457] but also sought to evade the restrictions, which came to include that he should "*only access Ealing Abbey Church during the monastic office and with other members of the monastic community and at other times only with the explicit permission of the abbot*".[458]

83. RC-F46's restrictions were not reviewed annually, as they should have been.[459]

[451] BNT000848_002
[452] BNT001005_002
[453] Abbot Martin Shipperlee 7 February 2019 25/9; Peter Turner 6 February 2019 35/14-37/9
[454] DOW000047_017 para 80
[455] BNT000984_001
[456] Abbot Martin Shipperlee 7 February 2019 43/10-22
[457] Abbot Martin Shipperlee 7 February 2019 43/23-44/10
[458] Peter Turner 6 February 2019 38/7-25
[459] Abbot Martin Shipperlee 7 February 2019 65/8-10

Part E

Response of Catholic bodies

Response of Catholic bodies

E.1: Introduction

1. There was a response to the abuse perpetrated at Ealing Abbey and St Benedict's School from three tiers of Catholic institutions:

- the Diocese of Westminster child protection team, with which Ealing Abbey was aligned and which gave advice to Abbot Shipperlee;
- the English Benedictine Congregation (EBC), in particular the Abbot President; and
- the Holy See in Rome and its diplomatic representative in the UK, the Apostolic Nuncio.

E.2: Diocese of Westminster

2. In 2001, following the Nolan report, Ealing Abbey referred safeguarding matters to the Diocese of Westminster child protection team. The rationale for this arrangement, as the Nolan working group of the EBC made plain, was so that each monastery could have "*the support of experienced, impartial advice*".[460] This alignment eventually became more formalised in a written agreement in 2013.[461] Then the Abbot of Ealing Abbey became formally obliged to refer questions to the renamed Safeguarding Service, although the Diocese cannot force the abbot to comply with its recommendations.[462] In practice, however, Abbot Shipperlee did refer questions to the Diocese of Westminster child protection team throughout his time as abbot, and did comply with its recommendations.[463]

3. The key official in the Diocese of Westminster child protection team was the Child Protection Officer. From 2002 to 2014, this was Mr Peter Turner, a former police officer of 35 years with experience in child protection matters.[464] He worked under the leadership of the Child Protection Coordinator, Monsignor Harry Turner. Peter Turner was responsible for carrying out the team's tasks.[465] His work included dealing with complainants (if allegations were made direct to the Diocese), liaising with external agencies (in particular social services and the police) and providing advice to priests and religious (ie a person bound by religious vows, such as a monk or a nun, but in this context, generally the Abbot of Ealing Abbey) about safeguarding matters such as restrictions.[466]

4. The relevant child protection policies were initially those of the Catholic Office for the Protection of Children and Vulnerable Adults (COPCA), established after the Nolan report in 2001. From 2008, these policies were replaced by those of the Catholic Safeguarding Advisory Service (CSAS).[467]

[460] BNT002382_009
[461] INQ003925; Peter Turner 5 February 2019 178/13-23
[462] DOW000051 paras 46–49
[463] Peter Turner 6 February 2019 47/2-18
[464] Peter Turner 5 February 2019 161/5-19
[465] Peter Turner 5 February 2019 163/12-24
[466] Witness statement of Peter Turner (DOW000047_003-006 paras 12–25)
[467] Peter Turner 5 February 2019 164/5, 173/3-6

5. These policies included requirements to maintain a child protection case file for every case, and to refer allegations of child abuse to statutory authorities immediately. Contrary to these policies, there were numerous failings in record-keeping.

5.1. For example, Peter Turner failed to record:

- the complaint made by RC-A418 in 2001 that he had been sexually abused by Father David Pearce in 1992;[468]
- his recommendation in 2002 that Pearce should not come into any contact with children (which he had assured the police that he would make);[469] and
- RC-A419's complaint of sexual abuse by Pearce committed in the 1970s.[470]

Mr Turner also failed to obtain and keep full records of the restrictions upon Pearce.

5.2. Some failures in record-keeping predated Mr Turner. For example, in 2004, he told the police that there were no previous allegations in respect of Soper,[471] who was then being investigated in respect of RC-A622's complaints. In fact, the Diocese of Westminster child protection team was aware of RC-A420's claim in 2001 (before Mr Turner's time) but no records of this were kept.[472]

The significance of such failures is obvious: it means that an accurate picture of allegations was not maintained or available in the event of subsequent concerns.

6. The advice given to Abbot Shipperlee in respect of imposing restrictions upon Pearce and others was deficient. First, in identifying the restrictions upon Pearce, Mr Turner and the Diocese of Westminster child protection team overlooked that RC-A419's account was of abuse by Pearce during a visit as a family friend.[473] Pearce was allowed to continue to visit families within the parish; the only condition was "*that he does not wear clerical dress and that the families are bona fide families/friends*".[474] The conditions should also have stipulated that friends and families be made aware of the restrictions upon him, as Mr Turner admitted in his evidence to us.[475] Similarly, Mr Turner did not ask whether any young people worked in the monastery:

> "*I just assumed that they had kitchen staff working at a weekend like they did during the week.*
>
> *Q: Was that a safe assumption to make?*
>
> *A: With hindsight, no.*"[476]

[468] Peter Turner 6 February 2019 3/1-4/3
[469] Peter Turner 6 February 2019 3/1-5/10
[470] Peter Turner 6 February 2019 6/9-21
[471] Peter Turner 6 February 2019 42/14-22
[472] Peter Turner 6 February 2019 41/10-42/3; DOW000030_005
[473] BNT001208_006
[474] BNT000829_003
[475] Peter Turner 6 February 2019 11/25-12/7
[476] Peter Turner 6 February 2019 17/17-21

7. Mr Turner also failed to advise Abbot Shipperlee as to how the restrictions should be implemented and monitored.[477] Mr Turner had more experience of child protection matters than Abbot Shipperlee, including the difficulties there may be in monitoring compliance with restrictions. As he told the Inquiry:

> *"in my experience, especially with sex offenders, they will do anything to get around any restrictions that are placed upon them".*[478]

8. There was also a failure by Mr Turner to review the risk posed by Pearce in light of relevant developments, such as the civil judgment in favour of RC-A6 in 2006.[479]

9. Despite this lack of proper consideration of the risk posed by Pearce or of what action the Diocese of Westminster child protection team should take, Mr Turner informed the Deputy Child Protection Manager at the London Borough of Ealing in July 2006 that:

> *"I am certain that [Pearce has] been removed from all Ministry, and [does] not have any contact with Children or Young Persons, and that no further action is required at this stage."*[480]

This assertion was made solely on the basis of the fact that restrictions had been put upon Pearce, rather than on how they had been implemented and monitored. To suggest 'certainty' was misleading.[481]

10. This same lack of proper consideration is evident in the Diocese of Westminster child protection team's failure to review or reflect on its approach after it was discovered that Pearce had abused RC-A621 while under restrictions.[482]

11. The Diocese of Westminster child protection team was under-resourced for much of this period (2002 to 2014). That may have contributed to its failures in respect of Ealing Abbey and more broadly (an audit in 2011 by Adrian Child of CSAS found standards not met in a number of areas, including casework and recording practice).[483] Mr Turner's role required him to undertake operational child protection work in respect of 200 parishes and 80 religious congregations. At first, he worked alone, whilst later he had a part-time assistant and, later still, a part-time Disclosure and Barring Service administrator. As Mr Turner's successor, Eva Edohen, said:

> *"It became apparent very quickly after I started in May 2014 that it was impossible for one person to carry out the role … or provide the essential services."*[484]

Mr Turner said that he had repeatedly raised the issue of resources during his time between 2002 and 2014.[485] Regardless of the issue of resources, there were occasions when Mr Turner and the Diocese of Westminster child protection team acted appropriately. For example, they refused to agree with Abbot Shipperlee's request in 2007 that the restrictions upon RC-F41 be lifted.[486]

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[477] Peter Turner 6 February 2019 15/22-25
[478] Peter Turner 6 February 2019 14/11-13
[479] Peter Turner 6 February 2019 19/4-12
[480] DOW000045_002
[481] Peter Turner 6 February 2019 21/22-24
[482] Peter Turner 6 February 2019 26/10-27/4
[483] Peter Turner 6 February 2019 44/11-20; INQ003932
[484] INQ003929_006
[485] Peter Turner 6 February 2019 45/20-46/19
[486] BNT000826_002

12. The broader issue of diocesan funding for child protection may be considered in the wider investigation into the Roman Catholic Church. We note the evidence given by Reverend Jeremy Trood, the Episcopal Vicar for Safeguarding for the Diocese from 2013 until October 2018, that since 2014 the Diocese has restructured its Safeguarding Service,[487] increased staff from two to five, and more than doubled funding.[488]

E.3: English Benedictine Congregation

Ealing Abbey

13. A *motu proprio* (ie a personal edict from the Pope to the Roman Catholic Church) was issued by the Pope in April 2001 making the sexual abuse of children a serious delict (or crime in canon law), and requiring superiors to report clerics against whom there was 'probable knowledge' of child sexual abuse to the Congregation for the Doctrine of Faith (CDF).[489]

14. The Abbot President from 1985 to 2001 was Francis Rossiter. As he was also Abbot of Ealing, his powers and duties as Abbot President were exercised in respect of Ealing by the first assistant of the EBC. From 1985 to 1997, the first assistant was Abbot Patrick Barry of Ampleforth and from 1997 to 2001, Abbot Stephen Ortiger of Worth.[490] At some point Abbot Ortiger learned of allegations of child abuse against Pearce, and he passed on this information to Dom Richard Yeo when Yeo became Abbot President in 2001.[491] However, Abbot President Yeo did nothing about Pearce at this point.[492]

15. Abbot President Yeo undertook visitations of Ealing Abbey on five occasions, in 2003, 2007, 2010, 2013 and 2016. He was also initially involved, alongside Bishop John Arnold (auxiliary bishop of Westminster), in an Apostolic Visitation which was ordered by the CDF in 2011, following the Carlile report.[493]

16. During his 2003 visitation, monks raised concerns with Abbot President Yeo about Pearce and his going onto the school territory. He spoke to Abbot Shipperlee about it, and said that Pearce should not be going through the school. However, Abbot President Yeo did not record the details of that advice, nor did he address it in his report to the monks as a whole.[494] It does not appear that he was treating the issue with due seriousness. In his evidence to us, Dom Yeo criticised Abbot Shipperlee, saying "*that it all seemed to be rather casual*",[495] however his own approach was no less so.

17. The 2007 visitation took place after several further serious allegations had been made against Pearce and the civil court had given judgment against him in 2006. Abbot President Yeo did not read that judgment; although he knew of the trial, he told us "*I don't think I knew then about the judge's comments*".[496] He did not inquire into the restrictions upon Pearce and gave no consideration to the details of managing the risk that Pearce posed to children.[497] In

[487] Following the Cumberlege review, the Diocese of Westminster child protection team was renamed the Safeguarding Service.
[488] DOW000051 paras 19–22
[489] Ampleforth and Downside Investigation Report p119
[490] BNT006991_001 para 3
[491] BNT006991_004 para 16
[492] Dom Richard Yeo 7 February 2019 79/9-25
[493] BNT006963_001
[494] Dom Richard Yeo 7 February 2019 80/4-22; 83/12-19
[495] Dom Richard Yeo 7 February 2019 83/11
[496] Dom Richard Yeo 7 February 2019 84/9-22
[497] Dom Richard Yeo 7 February 2019 85/1-20

his report to the monastic community, there was no express recognition of the fact that the judge in the civil proceedings had found that Pearce had abused RC-A6 and others. Rather, in that report he referred to the impact on Pearce himself, and thereby the community:

> *"all of you have been bruised by what has taken place – not only [RC-F41] and Father David but also the rest of you, because you are their brothers and when they are hurt, you are hurt."*[498]

18. In August 2009, Abbot President Yeo wrote a general report for the Holy See, following the EBC's General Chapter. By that time, Pearce had been charged with the abuse of RC-A621, a current pupil at St Benedict's, committed while he was under restrictions. However, Abbot President Yeo's report said only that:

> *"there is a court case pending which could cause serious damage to Ealing Abbey. It needs to be stressed that the problems arise as a result of abuse that is revealed to have taken place many years ago … "*[499]

There were two mistakes here. First, Abbot President Yeo's assumption that the abuse was entirely historic. Second, his representation of it as such without checking the facts. These illustrate a failure to obtain a proper understanding of the problem.

19. In 2010, Abbot President Yeo undertook an Extraordinary Visitation between 30 August and 7 September, in part as a result of Abbot Shipperlee asking for help. As he told us, "*I think we both realised that something needed to be done.*"[500] In his report, Abbot President Yeo stated that he would enact two Acts of Visitation (ie decrees requiring compliance):[501]

> *"I want to state in unequivocal terms, and this will be the subject of an Act of Visitation, that any member of the community who is under such restrictions is bound, in virtue of the vow of obedience, to observe those restrictions in full, and failure to observe them could lead to serious disciplinary action being taken against that person."*[502]

> *"it is very important to be absolutely clear: there is never any excuse for the sexual abuse of children, young people and vulnerable adults. No member of the community may say or imply, either inside the community or when speaking to outsiders, that any victim who pressed charges against Father David has done wrong. This is so important that it will be the subject of an Act of Visitation, which means that it binds in virtue of the vow of obedience."*[503]

20. Dom Yeo conceded to us that, in retrospect:

> *"I should probably have suggested at the 2007 Visitation that it was too serious a risk to allow … Pearce to continue to live in the monastery."*[504]

[498] BNT001001_004
[499] BNT003517_006
[500] Dom Richard Yeo 7 February 2019 87/4-5
[501] For more detail on acts of visitation, see Ampleforth and Downside Investigation Report p9.
[502] BNT002388_016
[503] BNT002388_019
[504] BNT006991_028

The EBC's wider structural response

21. There were some general developments in respect of safeguarding during Dom Yeo's time as Abbot President. As referred to above, in 2001, post-Nolan, the EBC set up a working group *"to propose a common framework of procedures for Child protection in the houses of the Congregation in light of the recommendations of the Nolan report"*.[505] At the EBC's General Chapter of 2013, it was decided that an expert review of safeguarding would be undertaken before any Ordinary Visitation of a monastery took place.[506] The Abbot President was also given a supervisory role, independent of visitations, thereby strengthening his role in overseeing individual monasteries.[507] In July 2017, the General Chapter made further changes, amending the EBC constitutions so that an abbot may now require a monk to live outside his monastery for safeguarding reasons, whether or not the monk has agreed to move.[508]

22. However, the response of the EBC did not proceed quickly enough. Christopher Jamison (who is Abbot of Worth Abbey) was elected Abbot President on 1 August 2017. He told us:

> *"I think individual abbots and the Abbot President have not, in the past, exercised sufficient authority and leadership in these areas … "*[509]

Abbot President Jamison told us that he has instigated a number of changes since he took up his position as Abbot President. These changes are addressed in Part G.

E.4: Holy See

The Apostolic Visitation

23. The primary response of the Holy See in respect of events at Ealing Abbey was the request for an Apostolic Visitation in 2011. This would appear to have been authorised in response to a lengthy letter of 18 June 2011, sent by Jonathan West, a member of the public and campaigner, to the Apostolic Nuncio:

> *"I request that there be an intervention from the highest levels within the Church. It seems to me that an Apostolic Visitation might be an appropriate response to the situation, to ensure the safety of the children of the schools and of the parish."*[510]

24. The Apostolic Visitation was undertaken by Bishop Arnold and, initially, Abbot President Yeo. The recommendations of the final report in 2012 were that:

- Abbot Shipperlee should not be removed from office;
- the CDF should accept the relevant recommendations made in the Carlile report;
- the EBC should make a further canonical visitation of Ealing Abbey; and
- the healing of those who have been abused was of paramount importance.[511]

[505] BNT002382_007
[506] BNT006991_027 para 128
[507] INQ003781_027 para 79
[508] BNT007129_006; INQ003781 para 66; Abbot President Christopher Jamison 8 February 2019 77/21-24
[509] Abbot President Christopher Jamison 8 February 2019 77/15-17
[510] BNT002473_005
[511] BNT002396_005; BNT002396_006

25. A shortened version of the report was subsequently published, in which the CDF endorsed the recommendations that healing was of paramount importance and that there should be a further canonical Visitation in 2013. However, no mention was made of Abbot Shipperlee, or of accepting the recommendations of the Carlile report. Abbot President Yeo emailed Bishop Arnold in August 2012:

> *"As regards the press release, just remember that the one thing you are not allowed to say is that Rome endorsed Carlile!"*[512]

This statement, that Lord Carlile's report was not to be officially endorsed, was based on instructions from the Holy See.[513] In answering questions in our inquiry, Dom Yeo could not explain it.[514] He did offer two suggestions: first, that there was no need for Rome's endorsement, as Abbot Shipperlee had already endorsed Lord Carlile's report, and second, that the CDF did not want to make a statement in respect of schools.[515] The reason for the apparent reluctance of the Holy See to approve publicly Lord Carlile's recommendations therefore remains an open question. In practice, the Holy See did approve the changes recommended by Lord Carlile, including the giving of part of Ealing Abbey's property to St Benedict's School, when it became independent of the Abbey.[516]

Laurence Soper

26. In 2002, Laurence Soper went to Sant'Anselmo, the international Benedictine college in Rome, to take up a post as Treasurer of the Confederation. The Abbot Primate of Sant'Anselmo was Abbot Primate Notker Wolf, and the Prior was Father Elias Lorenzo.

27. Despite the complaints against Soper made by RC-A420 in 2001 and RC-A622 in 2004 (both of which involved allegations of rape, when RC-A420 was an inmate at Feltham Young Offender Institution and when RC-A622 was a pupil at St Benedict's), it seems that neither Abbot Shipperlee nor Abbot President Yeo informed Abbot Primate Wolf or Father Lorenzo of the allegations. It was not until some time after the Metropolitan Police had interviewed Soper for the second time in June 2009 (following further allegations made by RC-A11) that those with oversight of Soper in Rome were told.[517] That was in 2010, and thereafter Soper was put under restrictions at Sant'Anselmo.[518] By that stage he had lived there without any restrictions for nearly eight years.

28. Later that year, Soper was again interviewed by the police in London, and again released on bail pending further police investigation. He was due to return to Heathrow police station to answer that bail and for further interview on 8 March 2011, but he failed to attend.[519] It was subsequently discovered that, although he had left Sant'Anselmo on 4 March on the pretext of returning to the UK for that purpose,[520] he had in fact absconded.

[512] BNT003195_001
[513] Dom Richard Yeo 7 February 2019 95/16-19
[514] Dom Richard Yeo 7 February 2019 95/6-24
[515] Dom Richard Yeo 7 February 2019 95/25-96/9
[516] BNT006991_025 para 119
[517] BNT006991_007 para 31
[518] BNT001105
[519] OHY006751_017
[520] MPS002948_005

29. It was not until 2016 that Soper was traced to Kosovo, then detained and extradited to the UK to face trial. It appears that during his time in hiding he supported himself with substantial private funds that he had received on the death of his parents in 2009.[521] He kept this money in a private bank account at the Vatican Bank (also known as the Institute of Works of Religion (IOR)) and on 8 March 2011, having arrived in Kosovo, he cashed a cheque for 200,000 Euros drawn from that account.[522] He made nine further transfers from his Vatican Bank account between March 2011 and February 2015.[523] Papers taken from him on his arrest show that on at least the last two occasions, 12 May 2014 and 2 February 2015, he transferred the money by faxing a payment order to the Vatican Bank, giving his address in Kosovo.[524] However, later attempts by Soper to transfer money in 2016 failed, causing him on 28 March 2016 to write a letter to the IOR asking for the address on the account to be changed, and transfer to be made.[525]

30. In November 2015, Detective Sergeant (DS) Chris Sloan of the Metropolitan Police was tasked to assist with undertaking financial enquiries in relation to Soper.[526] In November and December 2015, DS Sloan asked for two intelligence requests to be made of the Holy See through the National Crime Agency (NCA), which was the gateway for such international enquiries.[527] According to Commander Neil Jerome, it appears that although DS Sloan did not himself receive any response, the NCA was provided with information originating from the Holy See that led to Soper's eventual arrest in Kosovo in May 2016.[528]

31. We do not know what the Holy See knew, whether any steps were taken after Soper's disappearance to discover whether he had an account at the Vatican Bank, or whether they had any information that might have assisted in locating him earlier.

32. Prior to the hearing we sought a witness statement from the Holy See in relation to these, and other, matters. The Chair's powers to compel evidence are limited to the United Kingdom and as a result the request to the Holy See has been to provide information on a voluntary basis. The request was initially made to the Apostolic Nuncio to the United Kingdom, the Holy See's diplomatic representative in the UK. He is covered by diplomatic immunity and therefore cannot be compelled to give evidence.

33. Our request asked a number of questions in respect of a series of factual issues. The Holy See has confirmed that it does not intend to provide a witness statement. As a result, the Inquiry is unable to fully understand and assess the role that the Holy See may have played. We continue to pursue this matter with the Holy See, with the assistance of the Foreign and Commonwealth Office, and have recently received some documentation which is being reviewed and may be considered further, if necessary, during the hearings we are holding in October and November 2019.

[521] OHY007769_002-006
[522] INQ001661_023
[523] OHY007769_012
[524] OHY007769
[525] OHY007769
[526] OHY007897_004 para 12
[527] OHY007897_004-005 paras 14, 15
[528] OHY007897_008

Part F

Response of external institutions

Response of external institutions

F.1: Introduction

1. Statutory authorities were involved in responding to the allegations of child sexual abuse at Ealing Abbey and St Benedict's School (St Benedict's) in a variety of ways.

- The Metropolitan Police Service and Crown Prosecution Service were responsible for investigating and prosecuting criminal complaints.
- The Charity Commission undertook statutory reviews of Ealing Abbey as part of its duty to regulate it as a charity.
- The Department for Education (DfE) regulated St Benedict's, with the assistance of the Independent Schools Inspectorate (ISI) which inspected the school against statutory standards.
- The London Borough of Ealing was the local authority in which Ealing Abbey and St Benedict's are located.

These institutions should work together to promote safeguarding and take effective action. In fact, as set out below, their responses were at times deficient, both individually and collectively.

F.2: Metropolitan Police Service

2. There were deficiencies in the response of the Metropolitan Police both within individual investigations and more broadly. This was recognised by Commander Neil Jerome, Commander of the Specialist Crime Unit, in his evidence to us.[529] He told us that 66 complaints[530] had been made to the police in respect of Ealing Abbey and St Benedict's between 1992 and 2018. These resulted in 28 charges and convictions of five individuals: David Pearce, Laurence Soper, John Maestri, Stephen Skelton and Peter Allott.

3. Commander Jerome explained[531] that of the 32 allegations made before July 2011:

- the police decided to take no further action in relation to eight;
- the Crown Prosecution Service decided not to prosecute three;
- not guilty verdicts were reached in three; and
- the remaining 18 resulted in convictions.

[529] Neil Jerome 5 February 2019 1-105
[530] One of these was in fact not an allegation but an admission of abuse towards an unnamed boy that was volunteered by Maestri.
[531] OHY006752

Of the 33 allegations made after July 2011:

- 22 resulted in police decisions to take no further action, for various reasons which included the alleged perpetrator being deceased, insufficient evidence or the complainant not wanting to proceed with the allegation;[532]
- the Crown Prosecution Service decided not to prosecute in three;
- the allegations were transferred to other forces in two; and
- there were six convictions.

4. In 2001, RC-A418 told the police that Pearce had forcibly grabbed his trousers and pants and looked down into his pants, and that Pearce had put his hands down the swimming trunks of another boy, RC-A632, "*for a couple of seconds having a feel around*".[533] Abbot Martin Shipperlee also informed the police of the earlier complaints of both RC-A595 in 1992 and RC-A631 in 1998.[534] Formal statements were taken from both RC-A418 and RC-A632. A third former pupil also told police in 2001 that he had witnessed Pearce unnecessarily forcing a child to get undressed in front of him.[535]

5. Despite this, the Metropolitan Police failed to investigate appropriately. In July 2002, Detective Sergeant (DS) Gareth Morgan decided to take RC-A418's allegations no further, and did not even consider it necessary to interview Pearce in respect of them.[536]

> "*I have been unable to find evidence of any criminal offences*".[537]

This was unreasonable because there was evidence of indecent assault, as Commander Jerome agreed.[538] DS Morgan also observed that RC-A418 and RC-A632 were "*reluctant to give evidence in court*".[539] This was despite RC-A632 saying in December 2001 that he would be willing to attend court and there being nothing in the crime report to suggest a change in his mind.[540] While RC-A418 was initially uncertain about making a formal statement, he had subsequently done so on 19 November 2001.[541] Even if RC-A418 and RC-A632 were reluctant to give evidence in court, there is nothing to suggest that consideration was given to measures that could be used to support them.[542] There is no evidence that the 1992 case file relating to RC-A595 was properly considered.[543] There is nothing in the police records to indicate that the allegation of RC-A418 was referred to social services. This was particularly striking as Pearce was still working and living at the Abbey, adjacent to the school.[544] Given the concerted effort of a teacher, Katherine Ravenscroft, and a monk, Father Alban Nunn, to bring concerns about Pearce to the Metropolitan Police's attention, it is regrettable that this investigation into RC-A418's complaint should then have been handled and dismissed in such a manner.

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[532] OHY006752
[533] OHY006649_016
[534] MPS003014_027 (RC-A631); MPS003014_033 (RC-A595)
[535] MPS003014_037
[536] MPS003014_043-045
[537] MPS003014_043-044
[538] Neil Jerome 5 February 2019 53/22-25
[539] MPS003014_044-045
[540] Neil Jerome 5 February 2019 54/10-19
[541] MPS003014_35
[542] Neil Jerome 5 February 2019 54/20-25
[543] MPS003066_001 suggests that it may have been called by Morgan on 14 November 2001, but there are no substantive comments upon it in the case file for RC-A418's complaint.
[544] Neil Jerome 5 February 2019 49/9-19

6. The lack of care is likewise evident when another officer, Detective Constable (DC) Kevin Hudson, picked up the case again in 2004, after RC-A6's complaint. DC Hudson appears to have made no effort to contact Ms Ravenscroft. There is no evidence of his having contacted St Benedict's to enquire of her whereabouts. He recorded on the police record of the investigation that she was an "*ex teacher*" and "*untraceable*", yet Ms Ravenscroft was still teaching at St Benedict's.[545]

7. There were also several weaknesses in the police investigation in the case of RC-A6, who in 2004 made a number of allegations against Pearce, including being abused in the school infirmary.

8. RC-A6 felt unsupported by the police. On 18 May 2004, DC Hudson noted: "*I have not been able to progress this investigation, due to other work commitments. I have update*[d] *the victim* [RC-A6] *to that effect*".[546] RC-A6 told us:

> "*I rang Hudson to enquire about the investigation after a large period of silence and was told he was investigating a girl who had suffered more than me, so therefore my case was less important. I felt awful and ashamed about myself.*"[547]

When asked whether this was an appropriate thing to say, Commander Jerome said "*Absolutely not*".[548]

9. Further, when DC Hudson presented the case of RC-A6 to the Crown Prosecution Service, there is no evidence that previous allegations – including those of RC-A595 in 1992, RC-A418 and RC-A632 in 2001/2 or RC-A631 in 1998 – were specifically mentioned or drawn to the attention of the reviewing lawyer, Azra Khan.[549] The crime report states that "*The CPS reviewed the file containing the evidence obtained during the course of this investigation*";[550] however, the underlying evidence from the earlier investigations in respect of RC-A418 and RC-A632 does not appear to have been included or detailed.[551] This was a serious omission, especially since RC-A418 had been contacted again in 2004 and had confirmed his willingness to assist and attend court.[552] Any failure to provide a full picture would have inevitably impacted on the Crown Prosecution Service's decision, which was that there was too little evidence to prosecute.[553]

10. Despite a High Court having found in RC-A6's favour in a civil judgment in February 2006, it was not until after RC-A621's allegations against Pearce in 2008 that the Metropolitan Police reopened the investigation into his abuse of RC-A6. The police did not learn of the civil judgment. This was a missed opportunity to reconsider RC-A6's case earlier. Had this happened, Pearce's later abuse of RC-A621 might have been prevented.

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[545] INQ003777_002
[546] MPS002970_037
[547] INQ003799_017 para 88
[548] Neil Jerome 5 February 2019 69/12-19
[549] Neil Jerome 5 February 2019 77/17-24
[550] MPS002970_42
[551] Azra Khan's advice refers to having seen "*the advice file*" consisting of witness statements of RC-A6, his mother and another ex-pupil (OHY006649_004) – but not of RC-A418 or RC-A632.
[552] MPS003014_045
[553] OHY006649_004-005

11. After Soper absconded in March 2011, the Metropolitan Police waited over four years before passing the task of reaching him to a specialist team with dedicated resources. Two officers who were then involved, DS Chris Sloan and DS Shaun Richardson, told us that:

> *"In hindsight the 'manhunt' for SOPER should not have been left with the original investigating Child Abuse Investigating Team (CAIT) overseen by a single investigating Officer. This task should have been passed to those with specialisms in this area of work, who have a wide range of resources at their disposal. Once this was done, in and around December 2015 and primacy was passed to an MPS Major Investigation Team (MIT), SOPER was detained in Kosovo within six months (May 2016)."*[554]

12. There were also more systemic failures in the handling of complaints of child sexual abuse received by the Metropolitan Police. When a complaint was received, the usual procedure was that it would be allocated to an individual officer who would oversee the investigation. From 2015, this changed to there being a pool of detectives who worked together.[555] In respect of the early cases, there were failures in communication between officers investigating the allegations of child sexual abuse arising from within the same institution. These officers were part of a very small team. There was no excuse for the lack of communication about allegations of child sexual abuse, and especially about repeated instances within the same institution. For example, in 2004, there were investigations into both Pearce (RC-A6) and Soper (RC-A622), without links being drawn between them. Commander Jerome agreed that there had been a failure to draw the strands together:

> *"when you look at the totality and you look through each of those allegations … and when they are made, being able to draw the links between those, I think we could have done much better … by way of an example, [in] 2004, there is an investigation that takes place … the investigating officer of that allegation goes back to the 1992 and also the 2001 allegations to try and draw those links and see if there is any supporting evidence that can be used. So I can see that that takes place. But when you look at the totality of it, then drawing those links, we could have been better … "*[556]

13. Efforts have been made to improve the capability of the Metropolitan Police, and the police in the UK generally, to see links between cases.

> *"We have now got the police national database which now looks at allegations not just within an individual force but across the country. There is now, through the IT and also through vested practice and training, a much better understanding of what those links could be."*[557]

F.3: Crown Prosecution Service

14. Part of the function of the Crown Prosecution Service, since 2004, has been to make a decision about charge and whether to prosecute. This involves applying the Code for Crown Prosecutors. The test to be applied is whether there is sufficient evidence to provide a realistic prospect of conviction, and whether it is in the public interest for the case to be brought to court.[558]

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[554] MPS003541_004
[555] Neil Jerome 5 February 2019 11/19-25
[556] Neil Jerome 5 February 2019 10/22-11/9
[557] Neil Jerome 5 February 2019 99/8-13
[558] Gregor McGill 5 February 2019 110/13-21

David Pearce

15. Pearce was not convicted until 2009, despite allegations being made to the police as early as 1992.

16. In 1992, the Metropolitan Police presented RC-A595's case file (alleging sexual abuse by Pearce in his office at St Benedict's) to the Crown Prosecution Service and asked for advice on prosecution. In the note accompanying the file, WPC Carol Moore and DI Carol Bristow of the Child Protection Team wrote:

> *"13. At the time of writing [RC-A595] wants Father David prosecuted and will attend Court to give evidence. He should make an excellent witness and appears thoroughly truthful. His mother and father are most anxious that we prosecute Father David.*
>
> *14. It is our view that this matter should be brought before a Court."*[559]

17. The Crown Prosecution Service lawyer who reviewed the case file, Matthew McCabe, who gave both written and oral advice to the police, concluded that there was no realistic prospect of conviction.

17.1. Mr McCabe approached the case on the basis that there was a need for corroborative evidence.[560] This reflected the law at the time. In 1992, the legal position was that there was still a requirement that the trial judge should provide a 'corroboration warning' to the jury, alerting them to the dangers of convicting on the uncorroborated evidence of one person where the charge was a sexual offence.[561] This warning was abolished in 1994.[562] The current guidelines on prosecuting child sexual abuse offences are clear that prosecutors should not use a lack of corroboration as a reason not to proceed with a case.[563]

17.2. Mr McCabe's reasoning as set out in his written advice raises other questions:

- He concluded that there was no corroborative evidence, whereas Gregor McGill, Director of Legal Services at the Crown Prosecution Service, agreed that there was some evidence that corroborated RC-A595's account.[564]
- Mr McCabe noted that there was no medical evidence of a physical injury from the alleged indecent assault. However, it is unlikely that any injury would have resulted from an assault of the nature alleged. As Mr McGill told us:

  > *"A prosecutor today would not expect there to be medical evidence arising from an indecent assault of the nature alleged by the complainant and would be aware that the absence of such evidence is not evidence of no assault having occurred."*[565]

[559] MPS003066_025
[560] MPS003529_001
[561] CPS004664_006
[562] Section 32 of Criminal Justice and Public Order Act 1994.
[563] INQ003989_002
[564] Gregor McGill 5 February 2019 126/23-127/20
[565] INQ003989_002

- Mr McCabe stressed that there had been a delay in RC-A595 telling his sister, and some inconsistencies between the accounts he gave to his sister and mother. As Commander Jerome noted, neither delay nor inconsistency is unexpected in the context of a young boy having gone through a traumatic incident.[566]

Of themselves none of these considerations should have been seen as a bar to prosecution.

18. Mr McGill told us that this would still be a challenging case to prosecute today and that, in his view, the decision made by Mr McCabe was a reasonable one at the time.[567]

19. The reasoning contained in Mr McCabe's 1992 written advice would be different today. At that time he focused on the perceived weaknesses of the child's account. He did not look for and identify those factors which provided support to the allegation – for example, RC-A595's recent complaints to his sister and mother, and the evidence of a change in his behaviour.[568] Likewise, in his written advice Mr McCabe did not suggest further lines of investigation to the police – such as seeking evidence from teachers, pupils or others at the school – which Mr McGill told us he should have.[569] Mr McGill also referred to subsequent changes in approach. For example, a prosecutor today should not be troubled by relatively minor discrepancies in a child complainant's accounts or by any delay in reporting the offence. The Crown Prosecution Service also now encourages prosecutors to take a proactive approach, with an emphasis on building a case rather than merely spotting evidential failings.[570]

20. In 2004, the Crown Prosecution Service decided not to prosecute Pearce in respect of the incidents of his sexual abuse of RC-A6, which included touching the child's genitals after swimming. Azra Khan, the Crown Prosecution Service reviewing lawyer, said RC-A6 "*appears to be credible in his account of what happened and I have no doubt what he says is accurate*". Nonetheless she advised that "*it is with deep regret that I have to conclude that we would not be able to secure a conviction against Mr Pearce*"[571] because there was no corroboration of his account. Despite also commenting that "*of course corroboration is not required in such offences*", in effect Ms Khan did adopt corroboration as an evidential necessity and a rationale for not proceeding with the case. This was wrong, and Mr McGill agreed that Ms Khan "*fell into error there*".[572]

21. Moreover, there *was* other evidence that might have supported (and so corroborated) RC-A6's allegation, namely an account from a different boy who alleged that Pearce had put his hands down a boy's swimming trunks. It appears that this was not considered.[573] Further, it is not clear whether the Metropolitan Police provided Ms Khan with other information they held on Pearce, such as the account of RC-A418. Had they done so, her advice might have been different.[574]

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[566] Neil Jerome 5 February 2019 32/17-33/13
[567] Gregor McGill 5 February 132/3
[568] Neil Jerome 5 February 2019 31/3-10
[569] Gregor McGill 5 February 2019 132/4-19
[570] INQ003989_003
[571] OHY006649_004-005
[572] Gregor McGill 5 February 2019 137/1-3
[573] Gregor McGill 5 February 2019 138/8-20; OHY006649_007
[574] Ms Khan noted "*Should any further information come to light then of course I would always be willing to consider the matter afresh*" (OHY006649_004-005) but nothing further was forthcoming from the Metropolitan Police Service.

Laurence Soper

22. Soper was not convicted until 2017, although in 2004 the Crown Prosecution Service decided not to prosecute him in respect of the allegations made by RC-A622 of abuse and multiple rapes.

23. Although these were grave allegations, Claudette Phillips, the Crown Prosecution Service reviewing lawyer, having advised orally, in writing justified her decision not to charge only very briefly, expressing the view that the allegation "*is essentially the victim's version of events against the suspects* [sic]".[575] She also failed to consider whether other supporting evidence might be available or could be sought, and did not advise the Metropolitan Police on these points.[576] The decision not to charge and the advice given were inadequate. Mr McGill accepts this, although he told us that "*we approach these cases in a completely different way in 2019 than we did in 2004*".[577]

24. RC-A622 has said that the case was reconsidered (at least by the police) in 2007 but again a decision was made not to prosecute.[578] Police told him that this was because "*it was one person's word against another*".[579]

25. Soper was prosecuted and convicted in 2017.

F.4: Charity Commission

26. The Charity Commission is a statutory body which regulates charities in England and Wales. Among other things it has powers to investigate, identify and take action in respect of misconduct or mismanagement in the administration of charities. If a statutory inquiry has been opened, it may suspend or remove trustees or appoint an interim manager.[580]

27. Trustees of a charity have a duty of care to safeguard those who come into contact with the charity and its work, and the Charity Commission will therefore consider any failures of trustees in respect of safeguarding to be a regulatory concern. Such failings may result in the Commission exercising its statutory powers to seek to remedy the situation.[581] In respect of Ealing Abbey, the most significant steps taken by the Charity Commission were to undertake two statutory inquiries. The first opened in July 2006 but, before its report was published, a second was opened in February 2008. A combined report was finally published in December 2009.

28. The first inquiry (from 2006 to 2009) was opened following concerns of child sexual abuse being brought to its attention anonymously in June 2006 in respect of Pearce and RC-F41.[582] Its purpose was to establish whether the trustees had taken appropriate action and what further steps were required, if any.[583] In particular, it considered whether "*the trustees were taking appropriate and sufficient steps to safeguard vulnerable beneficiaries*

[575] OHY006651_024
[576] Gregor McGill 5 February 2019 147/22-25, 149/5-24
[577] Gregor McGill 5 February 2019 150/2-10
[578] MPS002981_002
[579] MPS002981_002
[580] Michelle Russell 8 February 2019 22/8-23/19
[581] CYC000210_008 para 30
[582] Pearce is referred to as 'Individual A' in the report, RC-F41 as 'Individual B' (CYC000255_003).
[583] CYC000255_003 para 10

at the school" (ie the pupils of St Benedict's).[584] It concluded that appropriate steps were being taken and no further action was necessary.[585] In fact, Pearce was abusing a pupil of St Benedict's, RC-A621, at the time of this first inquiry.

29. The Charity Commission's conclusion that appropriate steps were being taken was based on little more than assurances given by Ealing Abbey that there were restrictions on Pearce, precluding access to children. The Commission did not seek to identify in any detail what those restrictions were, nor did it consider how they were being implemented or how compliance was being monitored.[586] Michelle Russell, Head of Compliance at the Charity Commission between 2007 and 2011, told us that this reliance on the assurances of charity trustees "*was the approach that was taken by the Commission generally as a regulator at that time*".[587] The Charity Commission also found that the school's child protection policies and procedures were adequate. This again appears to be in part based on the Trust's assertion in correspondence that they were.[588] Relying on assurances given by a body under investigation can never be a sufficient substitute for independent scrutiny.

30. In 2008, the Charity Commission opened a second inquiry, after it was notified of the arrest of Pearce for sexual abuse of RC-A621. It was only during this second inquiry that the Charity Commission considered the restrictions placed on Pearce. It concluded:

> "*Despite assurances from the trustees, they failed to implement the restrictions placed on [Pearce] whilst on Charity premises and the Commission is extremely critical of the trustees in this regard. One of the terms of [Pearce's] continued role in the Charity was that he was to have no access to children and young people on the Charity's premises – the trustees failed to ensure this was the case … "*[589]

This admonishment was, Ms Russell says, "*quite unusual language for us to say publicly*".[590] Despite this criticism, no further regulatory action was taken.

31. A further point is that, during this second inquiry, Charity Commission correspondence risked suggesting that protecting the charity's name required contesting allegations of abuse as a matter of course. For example, a senior compliance and support manager stated in a letter of May 2008:[591]

> *"A charity's reputation is one of its biggest assets. As such, we would expect the trustees to take measures to protect the reputation of the Charity in the future. As a minimum, we would expect the trustees to monitor carefully the outcome of any criminal investigation or prosecution or civil claim into Father Pearce or any other person involved with the Charity in a similar capacity and to take appropriate steps to protect the Charity's name and reputation as necessary. We would also expect the Charity to take reasonable steps to defend its name and reputation if any charges or proceedings were initiated against the Charity. If such a situation were to arise, I would suggest that you contact the Commission for advice."*

[584] CYC000255_004 para 14
[585] CYC000255_006 paras 27, 28
[586] Michelle Russell 8 February 2019 36/25-37/5
[587] Michelle Russell 8 February 2019 27/2-7
[588] Michelle Russell 8 February 2019 39/17-41/18
[589] CYC000255_009 para 53
[590] Michelle Russell 8 February 2019 53/25
[591] CYC000240_002

This letter, and the penultimate sentence in particular, could give the impression that defending reputation was more important than protecting children from abuse. While she said this was not the Commission's intention, Ms Russell agreed that there was a risk that it might be read that way, and that it was something for the Commission to reflect on.[592]

32. Beyond providing "*regulatory advice and guidance*",[593] the Charity Commission relied in its report upon the fact that Ealing Abbey was undertaking "*an independent review*". It requested a copy of this review, and said it would "*actively monitor the Charity to ensure that this happens*".[594]

33. The independent review referred to was that undertaken by Philip Wright and John Nixson in 2009. As discussed in Part D, that review was wholly inadequate. Its deficiencies were pointed out to the Charity Commission in 2010 by Mr Jonathan West,[595] to whom the Commission responded in December 2010:

> "*The independent review that the trustees confirmed would be carried out is a matter for the Charity. The Commission cannot intervene in the administration of a charity.*"[596]

However no reference was made in this letter to the possibility, in certain circumstances, of the Commission appointing an interim manager.

34. By December 2010, Lord Carlile's review had been commissioned following the concerns raised by the ISI and DfE. It was the response of those institutions, rather than of the Charity Commission, that precipitated real change in structure and approach at Ealing Abbey and St Benedict's.

F.5: Independent Schools Inspectorate

35. Since 2003, one of the ways by which the DfE has regulated independent schools has been through inspections which are undertaken against standards set out in law.[597] These standards include provisions in respect of welfare, health and safety of pupils, including the requirement to have a written policy on safeguarding which is implemented effectively.[598] Since January 2015, these standards also include provisions on the quality of leadership and management of the school.[599]

36. The ISI has statutory approval as an inspectorate from the DfE under section 106 of the Education and Skills Act 2008.[600] The ISI first inspected St Benedict's senior school in January 2004. It found that the school complied with child protection standards and noted that it had a detailed child protection policy.[601]

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[592] Michelle Russell 8 February 2019 48/21-51/6
[593] CYC000255_009 para 56
[594] CYC000255_009 para 58
[595] INQ002970_002-005
[596] CYC000249_005
[597] Initially the Education (Independent School Standards) (England) Regulations 2003.
[598] Paragraph 3 of the Schedule to the Education (Independent School Standards) (England) Regulations 2003. This was subsequently amended in 2004 so as to require compliance with DfES guidance *Safeguarding Children in Education*, and in 2008 so as to require compliance with later DfES guidance *Safeguarding Children and Safer Recruitment in Education*.
[599] Education (Independent School Standards) Regulations 2014, Schedule part 8.
[600] Before this, it was approved under section 163 of the Education Act 2002 (ISI001293_005 para 19 Richards).
[601] ISI000016_25 para 6.16. We do not consider Ofsted in this investigation because it had no involvement in St Benedict's School.

37. The next inspections, of both junior and senior schools, were in November 2009. In reports published in February 2010, the ISI found that the school met the regulatory standards for welfare, health and safety of pupils[602] (which by that point required the child protection policy to comply with the guidance *Safeguarding Children and Safer Recruitment in Education*). The senior school report further commented, in respect of leadership and management:

> "*The trustees and advisors are fully aware of, and diligent in discharging their responsibilities for the welfare, health and safety of pupils, including taking proper steps to review and evaluate the effectiveness of their child protection policies and procedures. A serious incident involving a member of the monastic community caused the trustees to request an independent review of the measures taken to minimise risk. The advice received from the independent experts has been fully implemented.*"[603]

38. On 11 February 2010, shortly after the publication of its reports, Mr Jonathan West contacted the ISI expressing concerns. He did not think that the independent review had yet happened, as the Charity Commission had reported that it had been promised but not received in December 2009.[604] The next day another member of the public, Michael Grant, contacted the ISI because he was "*appalled by the report with regards to the issue of child protection*".[605] He referred to the fact that David Pearce was the former head of the junior school and had lost a civil action as well as being "*jailed for eight years after thirty-five years of systematic abuse*".[606]

39. As a result, and after further investigation, on 1 April 2010 the ISI withdrew the 2009 inspection reports from its website "*whilst enquiries are made to ensure that the report is accurate in relation to independent reviews and subsequent actions*".[607] The DfE then, on 16 April 2010, commissioned the ISI to carry out a further unannounced non-routine follow-up inspection.[608] That inspection was undertaken in April and May 2010 and determined (among other things) that the very same child protection policy as was deemed compliant in the 2009 inspection was not so. The subsequent report, published in August 2010, was critical.

> "*The commitment to trust within the community and to St Benedict's rule of love and forgiveness appears on occasion to have overshadowed responsibility for children's welfare, as in the case of [Pearce].*"[609]

It made a number of recommendations, including further improving the safeguarding policy and ensuring that staff or monks subject to allegations of misconduct live away from the school.[610]

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[602] ISI000021_012-013 paras 3.5, 3.8
[603] ISI000021_015 para 4.4
[604] ISI000082
[605] ISI000078
[606] ISI000078
[607] ISI000095
[608] ISI000102
[609] ISI000019_004
[610] ISI000019_004

40. The 2009 inspections were flawed in a number of ways.

40.1. The inspectors did not obtain a full picture of child protection concerns in respect of St Benedict's, including the extent of the offences for which Pearce was convicted and the fact of the Charity Commission inquiry. Whilst the deficiencies in the level of disclosure given by the school and Abbot Shipperlee as chair of governors was a contributory factor, this does not provide a sufficient excuse. The ISI itself should have undertaken further steps to obtain and check relevant information both prior to and during their inspection, especially when the inspectors discovered that David Pearce had recently been convicted of sexually abusing a pupil.[611] As explained by Kate Richards, Chief Inspector since 2017, the ISI now makes specific inquiries of both the local authority and the school itself about allegations and safeguarding incidents, as well as searching for relevant information in the public domain.[612]

40.2. The ISI found, wrongly, that the school's child protection policy was compliant, despite obvious defects, in particular with regard to external reporting. These were picked up in the 2010 inspection but should have been identified earlier. The failure is the more striking given the fact that the reporting inspector noted in his pre-inspection commentary:

> "*We shall need to be particularly alert and meticulous in checking all policies and procedures concerned with child protection.*"[613]

40.3. The 2009 ISI reports confused the independent review into Pearce's offending (which was undertaken by Mr Nixson and Mr Wright) and what the inspector was told about advice provided by the Diocesan child protection officer and another safeguarding professional in respect of RC-F41's restrictions.[614] The senior school report stated:

> *"A serious incident involving a member of the monastic community caused the trustees to request an independent review of the measures taken to minimise risk."*[615]

This plainly related to the review into Pearce's re-offending,[616] but it went on to state that the advice of that independent review had been implemented, which was an error. The advice of Mr Wright and Mr Nixson arising out of their review had not even been given at the time of the ISI inspection, still less implemented.

41. The ISI in conjunction with the DfE subjected St Benedict's to ongoing scrutiny after 2010. In 2012, a team of 12 inspectors visited for four days, and found the school to meet all the statutory requirements. In November 2014, a non-routine emergency inspection was undertaken following an anonymous letter of complaint about safeguarding and governance, and a further regulatory compliance inspection was undertaken in December 2015.[617]

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[611] As specifically referred to in pre-inspection commentary prepared by the reporting inspector; see ISI000555_025
[612] ISI001293_047-048
[613] ISI000555_26 para 3.1
[614] ISI000088_002
[615] ISI000021_015 para 4.4; ISI000020_014 para 4.5
[616] ISI000555_025: *"a member of the monastic community* [ie Pearce] *was recently found guilty of abusing a pupil … Following the recent case, the Abbot has asked the diocese child protection team to conduct an independent investigation into what has happened and whether the steps taken to minimize the risk are sufficient … we need sight of the investigation's outcome by the time of the inspection".*
[617] ISI001293_034-037

This inspection was followed up in January 2016 to consider issues arising from the arrest of Peter Allott, the deputy headmaster. In 2017, the ISI judged St Benedict's to meet the standards required by regulatory compliance and educational quality inspections.[618]

42. However, had it not been for the intervention of members of the public, the ISI might not have re-appraised the safeguarding arrangements at St Benedict's in 2010 and thereafter. Its approach to the inspection of St Benedict's in 2009 fell far short of what should be expected of an independent inspectorate.

F.6: Department for Education

43. The DfE is the regulator of independent schools. Since the Education Act 2002, it has had the power to approve inspectorates, to require inspections of independent schools against the statutory standards, to serve notice on a school which is failing to meet those standards and ultimately to de-register a failing school. Further powers were given to it under the Education and Skills Act 2008.[619]

44. The DfE's involvement with Ealing Abbey and St Benedict's was limited until significant problems were identified.

44.1. In 2007, the DfE agreed to commission an ISI inspection of St Benedict's in 2009.[620] There is no evidence that the DfE relayed to the ISI before its 2009 inspections the fact that the Charity Commission had contacted the DfE in 2007 regarding allegations made against Pearce and RC-F41.[621]

44.2. In 2009, the ISI asked the DfE whether it should do anything in addition to that scheduled inspection, following an email from Ealing Children's Services. That email arose from an anonymous letter which made reference to "*things being hushed up*".[622] The DfE contacted the local authority designated officer (LADO) at Ealing, and was told by the LADO that the Ealing Child Protection Strategy Group wanted to flag with the DfE the comments in the letter "*that indicated the school ethos was to cover up any problems*", although no other information or explanation was given in the letter.[623] The LADO said that the headmaster, Christopher Cleugh, had appeared to cooperate fully. The LADO did not relate the history of Pearce's offending with RC-A621, nor the fact of his arrest and pending prosecution, or that RC-F41 had also been the subject of historic allegations. Ealing Council (through its LADO) should have been in a position to inform the DfE of such facts.[624]

45. It appears that it was only after concerns were raised with the ISI by Jonathan West and Michael Grant that the independent education and school governance division of the DfE became aware of the Charity Commission report of December 2009, and the scale of the problem at Ealing Abbey and St Benedict's. This was despite exchanges in 2006/7 with the Charity Commission, the exchange in 2009 with the LADO and the DfE having a press cuttings service to alert it to safeguarding issues in independent schools.[625]

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[618] ISI000700; ISI000698
[619] As summarised in the witness statement of Kate Dixon dated 17 November 2017 (DFE000585_004-007), to which Penny Jones referred (INQ003857_003).
[620] INQ003857_004
[621] CYC000388_001; CYC000389
[622] INQ003858_002
[623] INQ003858_005
[624] INQ003857_012 paras 52–54
[625] INQ003857_005 para 20

46. In March 2010, Penny Jones, Deputy Director of the Independent Education and School Governance Division at the DfE, expressed her concern to the Charity Commission as follows:

> *"as regulators we are concerned about a culture that has built up in the Trust … can they really be trusted to properly implement and safeguard … child protection at the school".*[626]

47. The DfE commissioned an emergency ISI inspection and remained closely involved. The DfE attended a meeting on 29 July 2010 with Abbot Shipperlee, and repeatedly required assurance that all the ISI's recommendations would be implemented promptly.[627] Of those recommendations, one lay outside the scope of the DfE's statutory powers as a regulator of schools as they existed in 2010:[628] the requirement that any monks who had been the subject of allegations should not reside at Ealing Abbey. As RC-F41 remained resident at Ealing Abbey at the time, there was discussion between the DfE and the Charity Commission as to whether the Charity Commission might be able to use its powers to enforce compliance.[629] In the event, Abbot Shipperlee agreed that RC-F41 would be relocated.

48. After this point, the DfE remained involved with the ongoing monitoring of the school by the ISI. For example, in April 2015, the DfE served a notice upon St Benedict's requiring that an Action Plan be implemented[630] after the school was found not to have met all requirements in the ISI's 2014 inspection, including with regard to details in the safeguarding policy.[631] St Benedict's provided such a plan;[632] the DfE approved this and instructed the ISI to monitor compliance.[633]

49. We note that the DfE considered in 2010 that it did not have the statutory power to enforce a recommendation made by the ISI that monks who had been the subject of allegations should not reside at Ealing Abbey. Penny Jones explained that this lack of jurisdiction arose in 2010 because the DfE had no means of requiring the school to change its governance and leadership.[634] With effect from January 2015, the DfE now has such power following the inclusion within the independent school standards of provision about the quality of leadership and management of schools.[635] In a statement to the Inquiry, Kate Dixon, the Director of the School Quality and Safeguarding Group, makes clear that if a similar situation now arose, the DfE has power to take enforcement action against the school.[636]

F.7: Ealing Council Children's Services

50. Local authorities have for many years had specific duties to safeguard and promote the welfare of children in their area, including the requirement under section 47 of the Children Act 1989 for a local authority to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm. The local authority also has a vital role in working together with other agencies such as the police to safeguard children.

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[626] INQ003857_005-006
[627] 16 July 2010 INQ003858_071
[628] As they then existed (INQ003857_014 para 62 Jones).
[629] BNT000848_002; Michelle Russell 8 February 2019 59/1-61/24
[630] BNT000897_002
[631] BNT000899_004-006
[632] ISI000224_019-025
[633] BNT000893_002
[634] INQ003857_014 para 62
[635] INQ0004360_002-004
[636] INQ0004360_004

51. Despite the long-standing importance of its role, Ealing Council's case records prior to 2009 were stored on one officer's drive and were deleted when he left.[637] As a result, it was unable to find any record in respect of the complaints of RC-A418 in 2001, RC-A6 and RC-A419 in 2004, the imposition of restrictions upon David Pearce in 2005 or the civil judgment against him in 2006.[638] Carolyn Fair, the Director of Children's Services at Ealing Council, has explained that the council's response to allegations "*became systematic*" in 2009. Records of referrals are now processed and stored on a computerised social care database.[639]

52. The inadequacy of historic record-keeping at Ealing Council is reflected in the insufficiency of the information provided by the LADO to the DfE in June 2009. The DfE contacted the LADO at Ealing, and was told by the LADO that the Ealing Child Protection Strategy Group wanted to alert the DfE to a concern "*that indicated the school ethos was to cover up any problems*", although no other information or explanation was given.[640] Most notably, there was no information given about the allegations against Pearce or his impending trial, nor was anything said about RC-F41 despite the Council having been informed in 2006 of historical allegations made against him.[641] The DfE was entitled to expect more detail from the local authority, as in effect Ms Fair admitted.[642] She stated that it was only around 2009 that the LADO role was created and a more consistent approach to record-keeping adopted at Ealing Council Children's Services:

> "*If this LADO role and experience had been established in May 2009 I would expect the LADO to inform the then DCSF, now DfE, due to the number of specific allegations within one establishment.*"[643]

53. The Inquiry also noted a specific error by a social worker in the handling of RC-A595's complaint in 1992. That social worker told Pearce of the allegation against him before the police had interviewed him.[644] By doing so, she put Pearce on notice of the complaint, which not only gave him time to think about the account he would give in interview but was inappropriate, as Commander Jerome agreed:

> "*That absolutely runs the risk of tainting any evidence that may be obtained from the suspect.*"[645]

[637] INQ003706_005 para 29
[638] INQ003706_007-008 paras 44–47
[639] INQ003706_002 paras 7, 8
[640] INQ003858_005
[641] INQ003975_003 para 18
[642] INQ003975_003-004 paras 18–21
[643] INQ003975_004 para 21
[644] MPS003066_045; MPS003066_088
[645] Neil Jerome 5 February 2019 24/14-19

Part G

Wider developments in the English Benedictine Congregation

Wider developments in the English Benedictine Congregation

G.1: Introduction

1. Christopher Jamison has been the Abbot President of the English Benedictine Congregation (EBC) since August 2017,[646] having replaced Dom Richard Yeo. He told us that, since taking up his post as Abbot President, his primary focus has been on improving safeguarding across EBC monasteries and working to ensure that there is an EBC-wide "*culture of continuous improvement*" with regards to safeguarding.[647] To that end, he is working in partnership with 'superiors' (ie abbots, abbesses or priors) of individual monasteries to create more robust safeguarding processes.[648]

2. Under his leadership, the EBC is seeking to address three key areas: responsiveness, accountability and transparency.[649] Abbot President Jamison's evidence to us is summarised below. As the improvements he is seeking to implement are still in their infancy, it is not possible for us to assess how effective they will be in practice.

G.2: Responsiveness

3. In his evidence to the Inquiry, Abbot President Jamison set out the steps that the EBC is currently taking to provide support and redress to survivors of child sexual abuse.

4. In November 2018, the EBC held a seminar on the question of redress. The seminar was attended by a range of stakeholders, including lawyers for the Irish Government's Residential Institutions Redress Board and for the Lambeth Children's Home Redress Scheme.[650] Following this seminar, the EBC has concluded that it is currently beyond its capacity to organise and administer a comprehensive redress scheme for survivors (ie a scheme designed to provide reparations and support to victims and survivors of child sexual abuse, including in the form of financial compensation and counselling and psychological care). Abbot President Jamison has outlined some of the challenges to the establishment of such a scheme. They include how to determine whether a claim is valid and how to assess what the basis for a payment would be. In his view, "*the levels of expertise and staffing required*

[646] INQ003781_001 para 1. (Abbot President Jamison is also the chair of trustees of the EBC Trust and a member of the Catholic Council for the Independent Inquiry into Child Sexual Abuse. Prior to his appointment, Abbot President Jamison held a number of significant positions, including as abbot of Worth Abbey (2002–2010) and as Director of the National Office for Vocation of the Catholic Bishops' Conference of England and Wales (2010–2017).)
[647] INQ003781_001
[648] INQ003781_001
[649] INQ003781_007 para 20
[650] INQ003781_008 para 25

to address … these matters to a high standard, reassuring rather than distressing survivors, is a challenge for a relatively small religious order such as the EBC"[651] and that care must be exercised "*not to raise expectations falsely by promising what* [we] *would struggle to deliver*".[652]

5. Accordingly, the EBC has decided that a better approach would be to create a general support scheme for the Catholic Church in England and Wales as a whole, which could in turn be part of a government scheme.[653]

6. In the meantime, in the absence of a redress scheme, guidelines are currently being developed on the principles and processes that will be applied when a claim of child sexual abuse is brought against any part of the wider Catholic Church in England and Wales.[654]

7. Abbot President Jamison told us that:

> "*What one is trying to do is to find a way of saying to those who approach us, 'This is how you can expect people to respond to you' and to hold people to account to respond in that way. Because at the moment we don't have guidelines, and, as the inquiry has heard, this can be very distressing, meeting so many different responses. I think that the key to this is to get some agreement in guidelines. For example, that … when it is an offence regarding somebody between the ages of 16 and 18, that one will not use a defence of saying, 'But there was consent'. One could rule that out and in advance and say, 'We will not say that. We will accept your claim.'*"[655]

8. The guidelines are presently being considered and expanded upon by the Catholic Safeguarding Advisory Service (CSAS) and a lawyer from Catholic Insurance Services Limited.[656]

9. Abbot President Jamison also told us that individual EBC monasteries have met with survivors and apologised for sexual abuse, and that the majority of survivors who had sought financial redress had now received compensation.[657] He also said that the EBC is investigating how it can provide more immediate forms of support, including by directing survivors to seek support from suitable services.[658]

G.3: Accountability

10. We were told that the EBC is implementing a number of measures designed to improve accountability for child sexual abuse within their institutions.

11. The safeguarding practices of all EBC monasteries will be audited by Praesidium, a secular, non-profit organisation based in the USA specialising in child protection and safeguarding.[659]

12. Abbot President Jamison told us that Praesidium has developed a safeguarding audit programme which has been used for several years by the majority of Benedictine monasteries in the USA. This programme is based on a number of Accreditation Standards

[651] INQ003781_009 para 26
[652] Abbot President Christopher Jamison 8 February 2019 66/2-3
[653] INQ003781_009 para 26
[654] INQ004177_042 para 12
[655] Abbot President Christopher Jamison 8 February 2019 66/19-25, 67/1-7
[656] INQ003781_009 para 27
[657] INQ003781_007-008 para 22
[658] INQ003781_009-010 para 28
[659] Abbot President Christopher Jamison 8 February 2019 67/17-25, 68/1-10

which relate to the prevention of abuse (for example, the screening and training of new monks), responding to abuse (for example, the handling of disclosures) and the supervision of abusers (for example, the support and accountability systems in place for known abusers). These standards have been adapted, in consultation with the CSAS, to the safeguarding requirements and ecclesiastical standards applicable in England and Wales.[660]

13. We understand that Praesidium has been working with individual monasteries since July 2018 to improve their practices and ensure that its Accreditation Standards are adhered to. In addition, on the basis of its audits, Praesidium will submit safeguarding reports on individual monasteries to the Abbot President during the course of the ordinary four-year visitation process. Abbot President Jamison told us that he expects almost all audits of monasteries to be completed by summer 2019. The first audit for each monastery will cover the period back to 2001; subsequent audits will address the more recent past and current practice.[661]

G.4: Transparency

Record-keeping

14. Abbot President Jamison has said that, since becoming Abbot President, he has obtained copies of all safeguarding plans currently in place at individual EBC monasteries. These are now held at the offices of the EBC Trust and will be reviewed annually by Praesidium. However, we note that there remains no centralised system for record-keeping of allegations against monks accused of child sexual abuse within the EBC. Abbot President Jamison has also told us that, in practice, individual abbots will continue to *inform* the Abbot President of any allegations against a member of the Community but that he "*cannot assume responsibility for investigating allegations*" because that responsibility lies with the trustees of the charity of the individual monastery concerned.[662] However, he can of course enquire whether such investigations have been undertaken and their outcome.

Safeguarding policy

15. As of January 2019, there is a new EBC Trust Safeguarding Policy (*Safeguarding Policy and Procedure for Children, Young People & Adults at Risk*). This policy does not apply to each individual monastery (as due to the horizontal nature of the EBC this is a matter for which each monastery is responsible); rather, it is a policy for the EBC Trust itself and applies to those acting on behalf of the trust, such as the Abbot President.[663]

Selection and development of monks

16. The EBC is currently developing a new common process for the selection of candidates to train as monks, which will include a comprehensive application form asking for a complete

[660] INQ003781_010-012 paras 30–33
[661] INQ003781_010-012 paras 31–33
[662] INQ003781_014-015 paras 40, 41
[663] INQ003781_015 para 42

life history and references as well as a psychological assessment. The process will take approximately a year to complete.[664] Abbot President Jamison told us that:

> *"Whereas I cannot currently be sure that standards are consistent across individual monasteries, I expect that the adoption of the proposed common processes will ensure a more rigorous selection of better candidates for training as monks across the EBC. I believe this careful approach to the selection of candidates will enhance the protection provided to children against sexual abuse."*[665]

17. In 2017, the General Chapter of the EBC created the Continuing Formation Commission with responsibility for, amongst other things, training monks on personal relationships and monastic life. Part of this training has involved issues such as: self-awareness, including sexual awareness; celibate living; and care for physical and mental health. In addition, in 2018, the Commission organised a conference at Buckfast Abbey designed to empower monks and nuns to engage more proactively in shaping the life of their community. A number of workshops were held, including: on the "*culture*" of secrecy that had fostered child sexual abuse; on this Inquiry's hearings into Ampleforth and Downside abbeys; and workshops with survivors of child sexual abuse themselves.[666]

18. Abbot President Jamison told us that the EBC is currently planning a follow-up to this conference and that:

> *"As Abbot President, I aim to facilitate cultural and systemic changes within our communities … That is not something that constitutions, policies and procedures can achieve on their own; real change requires working together to enable what some monks and nuns have called 'refoundation', a new expression of a traditional way of life."*[667]

[664] INQ003781_015-016 para 43
[665] INQ003781_016 para 44
[666] INQ003781_015-017 paras 43–47
[667] INQ003781_017 para 48

Part H

Conclusions

Conclusions

H.1: Conclusions in relation to Ealing Abbey and St Benedict's School

1. Until its formal separation in 2012, St Benedict's School, Ealing was governed by the Abbot and monks of Ealing Abbey. The St Benedict's of the 1960s to 1980s was described to us as a place where *"even in the junior school one grew up acclimatising oneself to the eccentricities of a series of frankly terrifying men"*.[668]

2. The child sexual abuse perpetrated against pupils was extensive. Two monks and two lay teachers have been convicted of multiple offences involving the sexual abuse of over 20 children between at least the 1970s and 2008. Another teacher was also convicted of offences relating to the possession of indecent images of children in 2016. The total scale of the abuse can never be known, but is likely to be much greater. Children also suffered severe corporal punishment, which was often used as a means to initiate sexual abuse and for sexual gratification.

3. This abuse was facilitated for decades because of a culture of cover-up and denial at Ealing Abbey and St Benedict's.

4. David Pearce and Laurence Soper, the most prolific convicted abusers at Ealing, were very senior figures at the school and Abbey. Pearce was a senior member of the monastic community, the head of the junior school and then bursar. Soper was head of the middle school, bursar and then Abbot. Their seniority created particular problems for any who wanted to report abuse or concerns of abuse. Staff members have described the atmosphere as feeling *"like the mafia"*[669] and chose not to risk their jobs.

5. Abbot Martin Shipperlee's efforts to improve matters after he took up the abbacy in 2000 were flawed. There were serious shortcomings in his response to allegations and handling of child protection concerns. He failed to pass on information to the police and those undertaking reviews of safeguarding procedures. The action he did take was frequently inadequate and badly judged. Abbot Shipperlee's control and management of safeguarding issues fell well below what is required of someone trusted with the care of children, as he admitted: *"my administration of safeguarding is of insufficient standard"*.[670] He has now resigned from his position.

6. The deficiencies in the leadership of Abbot Shipperlee were compounded by failures of others around him.

7. Christopher Cleugh, headmaster of the school between January 2002 and August 2016, repeatedly minimised questions of child sexual abuse to the point of materially misrepresenting significant facts. He did not address safeguarding issues openly and proactively, and when questioned by external bodies was defensive.

[668] RC-A24 4 February 2019 158/8-10
[669] MPS002950_001; MPS002946_003
[670] Abbot Martin Shipperlee 7 February 2019 68/25

8. Peter Turner and the Diocese of Westminster child protection team played an important role in giving advice on safeguarding to Abbot Shipperlee. That advice was, however, often flawed. For example, Mr Turner's advice as to the restrictions upon Pearce was seriously deficient because no guidance was given as to how compliance with those restrictions should be enforced and monitored.

9. Between 2001 and 2017, Dom Richard Yeo, who was then the Abbot President of the English Benedictine Congregation (EBC), failed to treat allegations of child sexual abuse made against monks still resident next to the school with the necessary urgency and care. At his 2007 visitation of Ealing Abbey, he did not inquire into the restrictions upon Pearce, nor give due importance to the fact that a judge in the civil proceedings in 2006 had found Pearce to have abused RC-A6 and others.

10. It was not until 2010 that concerns with the institutional response of Ealing Abbey and St Benedict's came to a head, with scrutiny from the Charity Commission, the Independent Schools Inspectorate, the Department for Education, the media and members of the general public, including the campaigner Jonathan West.

11. In response, Abbot Shipperlee instructed Lord Carlile of Berriew QC to undertake a review of safeguarding and child protection arrangements at the school. Lord Carlile's report was published in November 2011. Its core recommendation was that there was an "*overwhelming imperative*"[671] for the formal separation of Ealing Abbey and St Benedict's, to ensure that the school had independence and a governing body capable of addressing concerns over safeguarding. Abbot Shipperlee enacted this recommendation, and St Benedict's was formally separated from Ealing Abbey soon afterwards in 2012.

12. External institutions outside of the EBC have a vital role to play in protecting children. They need to appreciate the particular issues in respect of monastic institutions such as these. They must avoid any false deference to the monks, and appraise carefully and critically any evidence given on safeguarding concerns.

13. The responses of external institutions to the events at Ealing were defective in significant respects, resulting in children being left at risk of abuse or further abuse, a risk realised in the case of Pearce's abuse of RC-A621 in 2006 to 2008.

14. The Metropolitan Police made mistakes in how some of the early allegations against Pearce and Soper were investigated. The police decision not to proceed with the case of RC-A418 in 2002 was unreasonable. There were also failures in respect of the investigation into the allegations of RC-A6 in 2004, including a failure to provide all relevant information to the Crown Prosecution Service when a charging decision was sought.

15. The Crown Prosecution Service bears some responsibility for the fact that neither Pearce nor Soper were prosecuted earlier. In 2004, serious allegations were made by RC-A6 and RC-A622 against them. Despite the law having changed, and corroboration no longer being a requirement, in 2004 Crown Prosecution Service lawyers adopted it as a reason not to prosecute either case, rather than looking at ways in which the complainants' accounts could be supported.

[671] BNT001113_012 para 28

16. The Charity Commission's undertaking of their first statutory inquiry into Ealing Abbey's handling of Pearce between 2006 and 2008 was deficient. Its review was undertaken during the period when Pearce was abusing RC-A621, but the Charity Commission concluded that Pearce was being managed appropriately. This was based on assurances given by Ealing Abbey, which the Commission failed to scrutinise or test.

17. The Independent School Inspectorate's inspection of St Benedict's in 2009 concluded that its child protection policy was compliant with statutory guidance, and that an independent review into Pearce's offending had been conducted and its advice fully implemented. Both conclusions were wrong. It took members of the public to point out the errors before the 2009 report was withdrawn in April 2010.

18. In 2010, the Department for Education did not have the statutory power to enforce a recommendation made by the Independent Schools Inspectorate that monks who had been the subject of allegations should not reside at Ealing Abbey. Since January 2015, changes to the statutory standards by which independent schools are judged have rectified this gap in the Department for Education's powers.

19. Abbot Shipperlee resigned from the abbacy on the final day of the hearing of evidence by the Inquiry. Father Dominic Taylor has since been elected Abbot in July 2019. It remains to be seen whether Ealing Abbey proves itself capable in the future of ensuring proper safeguarding of children at risk.

H.2: Conclusions in relation to the English Benedictine Congregation, the abbeys and the schools

20. Despite some differences, there are common themes in the institutional responses by Ampleforth Abbey, Downside Abbey and Ealing Abbey, and the EBC as a whole to child sexual abuse.

21. The nature of these communities as largely autonomous bodies under the authority of an abbot means the leadership of the particular abbot is especially important. If the abbot is ineffective, that is a significant impediment to effective action. If the abbot is himself a perpetrator of abuse, as Laurence Soper was at Ealing, the impediments are overwhelming and therefore the need for effective external oversight is even more crucial.

22. The difficulties that complainants face in bringing allegations of child sexual abuse have historically been acute in respect of abuse perpetrated by monks. When parents were told, some were afraid to damage their own relationships with the institutions or to damage the reputation of the Church, so did not intervene. Some did but found themselves under pressure from the institution to drop their complaint.

23. Often teachers and other monks would be disinclined to believe that a monk could perpetrate such abuse. They were reluctant to support complaints for fear it would undermine the institutions and the Church. That made it harder for complaints to be made, and easier for the abuse to continue.

24. There are particular aspects to managing risk where the alleged perpetrator of abuse is a monk. For example, the monastery is the monk's home, and he usually has no private income and few personal possessions. When considering how to manage the risk a monk posed, the institutions all prioritised the monk rather than the need to protect children at risk.

25. The culture in these institutions was generally closed, defensive and resistant to external involvement. Typically, allegations of child sexual abuse were not raised externally. This was on occasion due to denial of the problem, on others due to an instinct to cover it up. Perpetrators were often moved on – whether a monk or a lay teacher – without any steps to prevent a risk of abuse recurring elsewhere.

26. The closed culture within these institutions was compounded by a lack of safeguarding expertise. As a result, it would be left to monks with no relevant experience to assess the risk posed by another monk or to consider how restrictions would be implemented and monitored.

27. When abbots and others sought advice outside the institution, often from a diocesan safeguarding representative, the advice they received was not always appropriate.

28. There were some efforts made to strengthen safeguarding procedures after the Nolan report in 2001 and again after the Cumberlege report in 2007, but even then (as we identified in our report on Ampleforth and Downside) not all recommendations were followed.

29. The EBC, the abbeys and the schools associated with them were often slow to take action on safeguarding matters, frequently believing they knew better than those with specialist knowledge about child protection. There were repeated failures in making, and then keeping, appropriate records of safeguarding issues. Deficiencies in record-keeping were symptomatic of the generally casual approach of these institutions to issues of child protection, which in turn reflects an underlying failure to take such issues sufficiently seriously.

30. The EBC has not satisfied the Inquiry that in the past it had the institutional capability to ensure proper safeguarding of children, including those attending its schools. For example, during his tenure, Abbot President Yeo showed too little commitment to addressing safeguarding in the EBC with sufficient urgency. While visitations were undertaken, they had little if any practical effect on safeguarding and the protection of children from sexual abuse. The recent extension of the role of the Abbot President of the EBC to have a supervisory role independent of visitations should provide some counterbalance to the authority of the abbot. Much now will depend on the leadership of the Abbot President.

Part 2

Ampleforth and Downside: update

Recent developments at Ampleforth and Downside

Introduction

1. There have been several changes to the leadership and governance of Ampleforth and Downside since the Inquiry's public hearings in November and December 2017,[672] and the publication of our investigation report in August 2018.[673]

Ampleforth

2. There have been a number of changes in personnel. As was outlined in our previous report, Abbot Cuthbert Madden stepped aside from his position as abbot of Ampleforth in 2016.[674] The current prior administrator is Father Gabriel Everitt.[675] John Ridge has also been appointed Interim Director of Safeguarding Compliance, replacing Mick Walker (the Safeguarding Coordinator for the Diocese of Middlesbrough).[676]

3. The Charity Commission-appointed interim manager Emma Moody continues in overseeing certain safeguarding matters related to Ampleforth College, St Martin's Ampleforth and the two related charities.[677] In September 2018, Father Wulstan Peterburs resigned as headmaster of Ampleforth College. We understand that the process of recruiting a new permanent headteacher is underway.[678]

4. Changes have also been made to governance arrangements.

4.1. A new post of Director of Governance has been created to provide, amongst others, overall strategic leadership[679] for the Ampleforth Abbey Trust (AAT) and the St Laurence Education Trust (SLET).[680]

4.2. Two further safeguarding positions will be created in the near future, Director of Safeguarding and Monastic Safeguarding Coordinator.[681]

4.3. The Safeguarding Commission[682] has been disbanded and a replacement commission will be set up in accordance with the guidance provided by the Catholic Safeguarding Advisory Service to address safeguarding concerns.

[672] https://www.iicsa.org.uk/investigations/investigation-into-failings-by-the-catholic-church?page=1&tab=hearing
[673] Ampleforth and Downside Investigation Report
[674] Ampleforth and Downside Investigation Report
[675] INQ003781_032 para 92
[676] INQ003751_009 para 23(d). In addition, in 2018, Father Luke Beckett (Ampleforth Abbey Trust's safeguarding trustee) and Father Terence Richardson (previously prior of Ampleforth Abbey, and prior administrator since 2016 when Father Cuthbert stepped down), resigned from their positions (INQ003751_002-006).
[677] https://www.gov.uk/government/news/charity-commission-appoints-interim-manager-to-ampleforth-abbey-and-the-st-laurence-education-trust
[678] INQ003751_009
[679] INQ003751_007 para 20
[680] INQ003999_004 para 16
[681] INQ003751_018-019 paras 36(f), 36(h)
[682] Established by Ampleforth in 2006 to advise the AAT on safeguarding at Ampleforth Abbey. Ampleforth and Downside Investigation Report

4.4. A new and separate joint AAT and SLET Safeguarding Committee has been created.[683] Any decision taken by the new Safeguarding Commission which might impact upon the operation of the school will be subject to the approval of the Safeguarding Committee.[684]

5. On the recommendation of Abbot President Christopher Jamison, an Apostolic Visitation took place in October 2018.[685]

6. We are aware that Ampleforth remains the subject of scrutiny by external authorities. It is now a matter for those authorities to conclude their work. In those circumstances, we do not feel it appropriate to make further comment.

Downside

7. Between April and May 2018, Abbot President Jamison conducted a canonical visitation of Downside Abbey.[686] He made several recommendations, including ensuring that "*the protection of children and adults remains a priority for the monastic community*" and that the corporate separation of the school and the abbey be completed.[687]

8. In April 2018, the Downside Abbey Trust appointed Mr Nicholas Eldred, a solicitor and company secretary, to oversee the separation of the school and the abbey and to ensure that the school becomes fully self-governing.[688]

9. In July 2018, a new prior administrator, Father Nicholas Wetz, was appointed to replace Dom Leo Maidlow Davis as prior administrator for a period of two years with effect from September 2018.[689] Father Wetz also replaced Dom Maidlow Davis in his roles as a trustee and school governor following his resignation from those positions on 1 September 2018. Andrew Hobbs, formerly the acting headmaster, was appointed as headmaster of Downside School following a competitive recruitment process. Mr Hobbs took up the role in September 2018.[690]

10. Between December 2018 and January 2019, a new legal entity was created to manage the school.[691] Directors were nominated and a process is currently underway for the new entity to obtain charitable status. A board of trustees has been established, to be made up of eight to 12 trustees, with six already appointed.[692] In addition, there will be two ex-officio members, the prior administrator and a nominee of the Diocesan Bishop. No member of the Downside monastic community will be eligible to become a trustee, nor will the chair of trustees have to be a Catholic.[693] We understand that the separation process has been completed and that Downside School began operating as a legal entity in its own right on 12 September 2019.

[683] INQ003751_018
[684] INQ003751_019 para 36(g); INQ003999_006 para 26
[685] INQ003781_034 para 97
[686] INQ003781_035 para 100; BNT007143_016 para 70
[687] INQ003781_035 para 100
[688] BNT007143_001-002 paras 1, 3
[689] BNT007143_003 para 8; Ampleforth and Downside Investigation Report Part C, paras 343, 356; BNT007143_006 para 27
[690] BNT007143_006 para 28
[691] BNT007144_002-003 para 4(c)
[692] BNT007144_005 para 10
[693] BNT007144_005-006 paras 11, 12

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 from sexual abuse within the English Benedictine Congregation.

The scope of this investigation, in so far as it relates to this case study, is that the Inquiry will investigate:[694]

3.1. the English Benedictine Congregation and, consider, in particular:

3.1.1. the nature and extent of child sexual abuse by individuals associated with the Congregation including, but not limited to, teachers in Benedictine schools;

3.1.2. the nature and extent of any failures of the English Benedictine Congregation, the Catholic Church and/or other institutions or agencies to protect children from such abuse;

3.1.3. the adequacy of the response of the English Benedictine Congregation, the Catholic Church, law enforcement agencies, prosecuting authorities and any other relevant institutions to allegations of child sexual abuse by individuals associated with the Congregation;

3.1.4. the extent to which the English Benedictine Congregation and the Catholic Church sought to investigate, learn lessons, implement changes, and/or provide support and reparation to victims and survivors, in response to:

a) allegations of child sexual abuse by individuals associated with the Congregation;

b) criminal investigations and prosecutions and/or civil litigation relating to child sexual abuse by individuals associated with the Congregation;

c) investigations, reviews or inquiries into child sexual abuse within the Congregation, including but not limited to: Dr Elizabeth Mann's 2003 review of Ampleforth School; the Independent School Inspectorate's 2010 inspection into St Benedict's School; Lord Carlile's 2011 inquiry into St Benedict's School/ Ealing Abbey; the apostolic visitation of 2011; and the Charity Commission's inquiries into Ealing Abbey; and/or

d) other external guidance.

3.1.5. the adequacy of child protection and safeguarding policy and practice across the English Benedictine Congregation during the relevant period, including the adequacy of any response to the recommendations of the Nolan and Cumberlege Commissions.

[694] https://www.iicsa.org.uk/key-documents/584/view/childsexualabuseintheromancatholicchurchamended.pdf

2. Core participants and legal representatives

Counsel to this investigation:

Riel Karmy-Jones QC
Matthew Donmall
Jelia Sane

Complainant core participants:

A43, A44, A45, A46, A47, A48, A49, A50, A51, A53, A54, A64, A65, A66, A69, A70, A72, A75, the West London Benedictine Order Abuse Survivors	
Counsel	Iain O'Donnell, Emma-Louise Fenelon
Solicitor	Richard Scorer, Slater and Gordon
F13	
Counsel	Chris Jacobs
Solicitor	David Enright, Howe and Co
G2	
Solicitor	Imran Khan QC, Imran Khan and Partners
C18 and C19	
Counsel	William Chapman
Solicitor	David Greenwood, Switalskis

Institutional core participants:

Adrian Child and Eileen Shearer	
Counsel	Tania Griffiths QC and Julian King
Solicitor	Lachlan Nisbet, Brabners
Jonathan West	
Counsel	Iain O'Donnell, Emma-Louise Fenelon
Solicitor	Richard Scorer, Slater and Gordon
The Monastic Community of Ealing	
Counsel	Ruth Henke QC
Solicitor	Anthony Nelson, Haworth and Gallagher Solicitors
The Catholic Counsel for IICSA	
Counsel	Kate Gallafent QC
Solicitor	Stephen Parkinson, Kingsley Napley
The English Benedictine Congregation	
Counsel	Kate Gallafent QC
Solicitor	Stephen Parkinson, Kingsley Napley
Ampleforth Abbey and Ampleforth School	
Counsel	Matthias Kelly QC
Solicitor	Giles Ward, Milners Law
The Secretary of State for Education	
Counsel	Cathryn McGahey QC
Solicitor	William Barclay, Government Legal Department
Independent Schools Inspectorate	
Counsel	David Wolfe QC, David Lawson
Solicitor	Sarah McKimm, Independent Schools Inspectorate

3. Evidence received by the Inquiry

Number of witness statements obtained:
33
Organisations and individuals to which requests for documentation or witness statements were sent:
Jeremy Harvey, Complainant
RC-A6, Complainant
RC-A8, Complainant
RC-A24, Complainant
RC-A645, Complainant
Jonathan West, Campaigner
Dom Richard Yeo, English Benedictine Congregation
Philip Wright, Safeguarding Coordinator, co-author of 2009 report on safeguarding at Ealing Abbey
Commander Neil Jerome, Metropolitan Police Service
Michelle Russell, Charity Commission
Michael Sheridan, Ofsted
Lord Carlile of Berriew QC
Peter Turner, Former Child Protection Officer/Safeguarding Advisor at the Diocese of Westminster
Abbot Martin Shipperlee, Ealing Abbey
Andrew Johnson, St Benedict's School
Christopher Cleugh, Former headmaster of St Benedict's School
Jenny Share, Ampleforth School
Carolyn Fair, Ealing Council
Kate Richards, Independent Schools Inspectorate
Father Alban Nunn, Ealing Abbey
Gregor McGill, Crown Prosecution Service
Peter Halsall, Former teacher at St Benedict's School
Katherine Ravenscroft, St Benedict's School
Abbot President Christopher Jamison, English Benedictine Congregation
Reverend Jeremy Trood, Downside Abbey
Bishop John Arnold, undertook Apostolic Visitation of 2011
Penny Jones, Department for Education
Suzanne Smith, Disclosure and Barring Service
John Nixson, independent child protection specialist, co-author of 2009 report on safeguarding at Ealing Abbey
Kevin Gregory, Former Officer with the Metropolitan Police Service
Kate Dixon, Department for Education

4. Disclosure of documents

Total number of pages disclosed: 10,694

5. Public hearings including preliminary hearings

Preliminary hearings	
1	5 June 2018
2	1 November 2018
Public hearings	
Days 1–5	4–8 February 2019

6. List of witnesses

Forename	Surname	Title	Called/Read	Hearing day
RC-A8			Called	1
Jeremy	Harvey	Mr	Read	1
RC-A24			Read	1
Neil Alan	Jerome	Commander	Called	2
Gregor	McGill	Mr	Called	2
Peter William	Turner	Mr	Called	2, 3
Martin	Shipperlee	Abbot	Called	3, 4
Richard	Yeo	Dom	Called	4
Christopher Joseph	Cleugh	Mr	Called	4, 5
Sharon Michelle	Russell	Ms	Called	5
Peter Christopher	Jamison	Abbot President	Called	5
RC-A622			Read	5

7. Restriction orders

On 15 August 2016, the Chair issued a restriction order under section 19(2)(b) of the Inquiries Act 2005, granting general anonymity to all core participants who allege that they are the victim and survivor of sexual offences (referred to as 'complainant core participants'). The order prohibited (i) the disclosure or publication of any information that identifies, names or gives the address of a complainant who is a core participant and (ii) the disclosure or publication of any still or moving image of a complainant core participant. The order meant that any complainant core participant within this investigation was granted anonymity, unless they did not wish to remain anonymous. That restriction was amended on 23 March 2018 but only to vary the circumstances in which a complainant core participant may themselves disclose their own core participant status.

The following further restriction order was made during the course of this case study:

- Restriction order prohibiting the disclosure or publication of the name of any individual whose identity has been redacted or ciphered by the Inquiry in connection with its investigation into the English Benedictine Congregation, dated 8 December 2017.[695]

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.[696] 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 would be 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."

[695] https://www.iicsa.org.uk/key-documents/3494/view/2017-12-08-restriction-order-re-documents-published-inquiry-website-during-ebc-case-study-public-hearing-.pdf
[696] https://www.iicsa.org.uk/key-documents/322/view/2018-07-25-inquiry-protocol-redaction-documents-version-3.pdf

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.

Annex 2

Glossary

Abbot/Abbess	The superior of a religious community responsible for governing their institution's life and work.[697] (See Religious Superior)
Abbot President	The leader of a Benedictine Congregation.[698] In the context of this report, the English Benedictine Congregation.
Apostolic Nunciature	The diplomatic office of the Holy See in Great Britain, established in 1982. The location of the Apostolic Nuncio's offices and residence is Wimbledon, south west London.
Apostolic Nuncio	The diplomatic representative of the Holy See in the UK. His role is equivalent to that of an ambassador. The post is presently held by Archbishop Edward Joseph Adams, who was appointed on 8 April 2017.[699]
Apostolic Visitation	A visitation (see also Visitation) ordered by the Holy See, which appoints one or more Visitors to investigate a situation and to report back to the Holy See on what they find.[700]
Benedictine Confederation	A union of autonomous monastic congregations which all follow the teachings (the Rule) of St Benedict. Each of the congregations (of which the English Benedictine Congregation is one) has its own Abbot President. The Confederation has its headquarters at Sant'Anselmo in Rome, which is the seat of the Abbot Primate. (The current Abbot Primate, as at 2019, is Gregory Polan OSB.)[701]
Charity Commission	A non-ministerial government department that regulates registered charities in England and Wales and maintains the Central Register of Charities.[702]
Code of Canon Law	The system of laws which govern the Catholic Church.[703] Laws are articulated in a code, known as the 'Code of Canon Law'. The current code is the 1983 Code of Canon Law. It superseded the 1917 Code of Canon Law, which was the first comprehensive codification of canon law in the Latin Church.

[697] BNT004910_003
[698] BNT004911; BNT004910_010-011
[699] http://www.cbcew.org.uk/home/the-church/apostolic-nuncio-to-great-britain/
[700] BNT004911
[701] Dom Richard Yeo 28 November 2017 128/15-129/3; https://www.osb.org/the-benedictine-order/the-benedictine-confederation
[702] https://www.gov.uk/government/organisations/charity-commission/about
[703] BNT004911

Constitutions of the EBC	Every religious congregation has constitutions. Benedictine monastic congregations have constitutions as well as the Rule of St Benedict (the Rule). Constitutions of the English Benedictine Congregation (EBC) govern all its monasteries, and individual monasteries do not have individual constitutions. Nuns of the EBC have a different set of constitutions from the monks. The constitutions consist of two parts: (i) The Declarations on the Rule – this is complementary to the Rule of St Benedict. (ii) The Statutes – these set out the structure and government of the congregation as a whole.[704]
Covenant of care	Following the Nolan report, the Catholic Church introduced a new policy which was to ask individuals about whom a concern had been raised to accept a covenant of care (now called a safeguarding plan). This is an agreement drawn up between the Church and the individual in question to minimise risks to others by making clear what conditions and restrictions apply, as well as what support is available.[705]
Decree	A formal order. Canon Law 601 gives a religious superior power to compel a member of their community to act in a particular way. If the member does not do so then sanctions can result. This rule is the basis for covenants of care and disciplinary decrees.[706] An example is an Act of Visitation made after a visitation (see Visitation) where the Abbot President can issue a formal decree (made in writing) requiring steps to be taken by the Abbot and institution subject to the visitation.[707]
Delict	A crime in canon law, an external violation of a law or precept gravely imputable by reason of malice or negligence.[708] This is not the same definition as a delict in civil law jurisdictions.
Dispensation	On application from an abbot, the Abbot President can grant a dispensation from temporary vows for a member of the community. However, to be granted dispensation from perpetual vows the Abbot President's Council must agree with the application (although the Abbot President can take the final decision) before it is forwarded to the Holy See for approval.[709]
Ex-gratia payment	A payment for damages, made voluntarily but without any admission of liability or guilt.
Extraordinary visitations	A visitation (see Visitation) held outside of the regular four-yearly intervals of the Ordinary visitations. Held when needed, usually for serious or grave reasons.[710]
First Assistant	The senior member of the Council of the Abbot President, who takes on the role of the Abbot President for visitations of the monastery of which the Abbot President is a member.[711]

[704] BNT004911; BNT004910_008-009
[705] https://www.csas.uk.net/wp-content/uploads/2018/05/Safeguarding-Plans-management-of-risk-and-support-within-the-Church.pdf
[706] AAT000958_005
[707] Dom Richard Yeo 28 November 2017 111/12-112/18
[708] BNT006439_011; http://www.vatican.va/resources/resources_glossary-terms_en.html
[709] BNT004910_018; Dom Richard Yeo 28 November 2017 98/21-99/21
[710] BNT004911; BNT004910_010-011
[711] BNT004911

General Chapter of the EBC	All Roman Catholic congregations, including the English Benedictine Congregation (EBC), have General Chapters. These exercise supreme authority and write the constitutions of the order (with the approval of the Holy See) and elect the General Superior/Abbot President. Due to the structure of the EBC, the monasteries are more autonomous than other congregations of the Roman Catholic Church and therefore the General Chapter of the EBC has less authority than in other orders where there is a centralised system and a more obvious hierarchy of accountability. The General Chapter of the EBC is made up of the Abbot President, an abbot or abbess from each monastery, a delegate elected by the monastery's own chapter and four officials of the EBC. The Abbot President as the most senior figure prepares and runs the General Chapter with the help of his Council. It is the supreme legislative authority of the congregation, saving the right of the Holy See to approve the constitutions. It elects the Abbot President and his Council, and discusses matters of common interest to the monasteries. The General Chapter has ordinary and extraordinary meetings, known as chapters. Ordinary chapters are held every four years and extraordinary chapters are held in times of need. The last extraordinary chapter was held in 2015.[712]
Holy See	The Holy See is the central administration of the Catholic Church, which includes the Pope and the offices of the Vatican.[713] It is located in Vatican City, Italy.[714]
Independent Safeguarding Authority	A non-departmental national vetting and barring agency that was responsible for checking the backgrounds of people working with children and vulnerable adults and ensuring that they were suitable (eg checking they did not have any criminal convictions that would make them unsuitable to work with children). In December 2012, it merged with the Criminal Records Bureau (CRB) to form the Disclosure and Barring Service.[715]
Laicisation	The loss of the clerical state, either through dismissal for offences or through a request from the individual, for example to enable a monk to marry.[716]
Monastic congregation	A union of several autonomous monasteries, under a superior.[717]
Notification requirements	Sometimes referred to as the sex offenders' register. Created by the Sex Offenders Act 1997 and subsequently amended by the Sexual Offences Act 2003. A tool for the management of convicted sex offenders in the community, which requires the offender to provide the police with a number of personal details, and to keep the police informed of any changes to those details. The length of time that an offender is on the sex offenders' register and subject to notification requirements depends on the sentence or order received upon conviction or caution. A person who does not comply with the notification requirements commits a further offence and may receive a prison sentence on conviction.

[712] BNT004911; BNT004910_009-010
[713] AAT000966_012; BNT004911
[714] http://www.vaticanstate.va/content/vaticanstate/en.html
[715] https://www.gov.uk/government/organisations/independent-safeguarding-authority
[716] BNT004910_017
[717] BNT004911; BNT004910_003

Novice	A monk who is undertaking a probationary period at the monastery, which includes training in monastic ways. Within the English Benedictine Congregation, this includes studying the Rule of St Benedict and the constitutions.[718]
Novice master	An experienced monk who provides guidance and oversees the education and training of novice monks wishing to join the institution.[719]
Police caution	In England and Wales, a police caution is an alternative to prosecution and can be given by the police to anyone aged 10 or over for minor crimes. Before a caution can be given, the individual must admit his or her guilt and agree to be cautioned; if the individual does not agree, they can be arrested and formally charged. A caution is not a criminal conviction but can be used as evidence of bad character and will show on standard and enhanced Disclosure and Barring Service (DBS) checks.[720]
Prior	A senior member of the monastery who supports the Abbot and is involved in the day-to-day administration of the monastery. The Prior deputises for the Abbot when the Abbot is absent from the monastery.[721]
Redress scheme	A scheme designed to provide reparations and support to victims and survivors of child sexual abuse, including in the form of financial compensation and counselling and psychological care.
Rehabilitation order	A court order (formerly called a probation order) which places an offender under the supervision of a probation officer for a period of between six months and three years instead of a sentence of imprisonment. The order contains conditions for the supervision and behaviour of the offender during the period of rehabilitation.
Religious	A person bound by religious vows. A Benedictine monk or a nun is a Religious, and so are men and women belonging to all the religious congregations in the Church.[722]
Religious superior	The person who is the head of a religious congregation or a part of a religious congregation. The term encompasses a local superior, a provincial superior and a general superior. In a monastic congregation, the abbot of a monastery of monks, the abbess of a monastery of nuns and the Abbot President of the congregation are all religious superiors.[723]
Roman Curia	The central government of the Church (including its administrative function) which exists to support and serve the Pope whilst exercising his authority.[724]

[718] https://www.downside.co.uk/benedictine-monastery/a-monastic-vocation/stages-becoming-monk/; BNT006861_049-050; Dom Charles Fitzgerald-Lombard 8 December 2017 108/17-23
[719] https://www.downside.co.uk/benedictine-monastery/a-monastic-vocation/stages-becoming-monk/; BNT006861_049-050; Dom Charles Fitzgerald-Lombard 8 December 2017 108/17-23
[720] https://www.gov.uk/caution-warning-penalty
[721] Father George Corrie 1 December 2017 9/18-25; AAT000966_010
[722] BNT004911; BNT004910_003
[723] BNT004911; BNT004910_003
[724] BNT004911; http://www.vatican.va/roman_curia/index.htm

Rule of St Benedict	The Rule was written by St Benedict of Nursia (c. AD 480–547) and is held in a book containing a prologue and 73 chapters. It sets out the rules by which Benedictine monks living together in a community under the authority of an abbot should live and specifies punishments for monks who show fault through disobedience, pride and other grave faults.[725]
Safeguarding plan	See Covenant of care above.
Sex offenders' register	Established by the Sex Offenders Act 1997 (amended by the Sexual Offences Act 2003).[726] The Violent and Sex Offender Register (often known as the sex offenders' register) holds the details of people who have been convicted, cautioned or released from prison for sexual offences against children or adults. The register is monitored by the police. (See also Notification requirements, above.)
Similar fact evidence	A term used in law for evidence of past misconduct that is so similar to the facts of a present case that it may, in certain circumstances, be relied upon in a trial to establish that the accused is likely to have committed the offence.
Statutory agencies	A government agency created by legislation.
Suspended sentence	A sentence of imprisonment imposed by a judge and then 'suspended' (ie conditionally delayed), allowing the defendant to remain in the community. The judge may impose certain conditions during the suspension period (for example a curfew). If the defendant fails to comply with the conditions, or commits another offence during the suspension period, they risk having to serve the original sentence of imprisonment as well as an additional sentence for the new offence.
Visitations	Inspections of English Benedictine Congregation monasteries conducted by the Abbot President (and his assistants) which take place approximately every four years. Their purpose is to pick up on failures to follow the Rule of St Benedict, the constitutions of the congregation or the law of the Church. Visitations are also an opportunity for the Abbot President to give the monasteries a general inspection to see how they are being governed and are working, including to give support and encouragement.[727]
Vows	Temporary vows: After the period of the novitiate, if the individual wishes to commit to the monastic way of life he must apply to the institution he wishes to join. If accepted, the individual makes a temporary commitment (usually three years). During those years the individual undertakes further study to expand their understanding of the monastic life and the Catholic faith. Solemn vows: After three years of temporary vows, the individual in question can make his solemn vows to become a member of the community as a monk and then gains the right to discuss and vote on issues in the community.[728]

[725] BNT004911; Dom Richard Yeo 28 November 2017 94/7-25; 100/21-101/8; 141/10-25; 143/1-5
[726] Sex Offenders Act 1997; Sexual Offences Act 2003
[727] BNT004911; BNT004910_010-011; Dom Richard Yeo 28 November 2017 91/12-22; 105/4-10; 107/5-109/17
[728] Dom Charles Fitzgerald-Lombard 8 December 2017 79/4-14, 109/7-22; BNT003832_010-012

Annex 3

Acronyms

AAT	Ampleforth Abbey Trust AAT is a parent trust. It owns all the buildings and property of Ampleforth Abbey, and is concerned with the running of the monastery and Abbey.[729]
CBC	Catholic Bishops' Conference of England and Wales CBC is the official, permanent assembly of Catholic Bishops in England and Wales made up of the archbishops, bishops and auxiliary bishops of the 22 Catholic dioceses, together with some others.[730]
CDF	Congregations of the Doctrine of the Faith CDF is one of the congregations of the Roman Curia. Its responsibilities include promoting safeguarding and exercising its judicial function.[731]
CICLSAL	Congregation for the Institutes of Consecrated Life and Societies of Apostolic Life CICLSAL is the office of the Vatican which is responsible for supervising the different religious communities in the Catholic Church.[732]
COPCA	Catholic Office for the Protection of Children and Vulnerable Adults Recommendation 16 of the Nolan report led to the establishment of the COPCA in 2002.[733] This organisation was replaced by the Catholic Safeguarding Advisory Service (see CSAS).
CSAS	Catholic Safeguarding Advisory Service CSAS is the national agency for driving and supporting improvements in safeguarding practice within the Catholic Church in England and Wales.[734] This organisation replaced COPCA from 1 July 2008 on the basis of recommendation 3 of the Cumberlege report,[735] and is responsible for implementation, training and advice.[736]
DBS/CRB/ISA	Disclosure and Barring Service The DBS replaced the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) in 2012. The DBS carries out criminal record checks that result in DBS certificates being issued to an individual. Employers can then ask to see this certificate to ensure that they are recruiting suitable people into their organisation. There are currently three levels of criminal record check: basic, standard and enhanced.[737]

[729] Abbot Cuthbert Madden 5 December 2017 37/23-25
[730] http://www.cbcew.org.uk/
[731] AAT000966_012-013; CHC000396_004
[732] BNT004911; AAT000966_012-013; CHC000396 _014
[733] CSA005625_002
[734] CSA005625_002
[735] CSA005625_004
[736] CEW000014_012-013
[737] https://www.gov.uk/government/organisations/disclosure-and-barring-service/about

DfE	Department for Education The DfE is responsible for children's services and education, including early years, schools, higher and further education policy, apprenticeships and wider skills in England. Its responsibilities include teaching and learning for children in the early years and in primary schools and secondary schools.[738] It replaced the Department of Education and Science (DES) in 1992, then became the Department for Education and Employment (DfEE) in 1995, then the Department for Education and Skills (DfES) in 2001, then the Department for Children Schools and Families (DCSF) in 2007, before becoming the Department for Education again in 2010.
ISI	Independent Schools Inspectorate The ISI undertakes inspections of independent schools against statutory standards, and publishes reports following those inspections.[739]
LADO	Local Authority Designated Officer Their role is to give advice, liaise with other agencies and investigate allegations on behalf of the local authority.
NFA	No further action When the police determines that no further action is necessary or possible to be taken when investigating potentially criminal matters.[740]
Ofsted	Office for Standards in Education, Children's Services and Skills Ofsted is a non-ministerial government department which inspects and regulates services that care for children and young people, and services providing education and skills.[741]
SLET	St Laurence Education Trust[742] Ampleforth School has been run by a separate educational trust, the SLET, since 1997.[743] It is a wholly owned subsidiary trust of the Ampleforth Abbey Trust. The SLET and its trustees are responsible for the governance of both Ampleforth College and St Martin's Ampleforth.[744]
SMA	St Martin's Ampleforth In 2001, Ampleforth College Junior School merged with St Martin's, a small local preparatory school eight miles away in Nawton, becoming St Martin's Ampleforth.[745]

[738] https://www.gov.uk/government/organisations/department-for-education/about
[739] https://www.isi.net/about/what-we-do; ISI000232_001-002
[740] https://www.iicsa.org.uk/interim-report/overview/operation-hydrant
[741] https://www.gov.uk/government/organisations/ofsted/about
[742] AAT000962_004
[743] Oral closing submissions on behalf of Ampleforth to IICSA, 15 December 2017 76/4-7
[744] Abbot Cuthbert Madden 5 December 2017 38/1-4
[745] AAT000962_005 para 17

Annex 4

Summary of allegations leading to convictions

Perpetrator/Complainant	Nature of abuse	Date of conviction
David Pearce		
RC-A596	Touching buttocks and genitals; indecent exposure; forced masturbation	August 2009
RC-A597	Grooming; touching genitals; filming in bath; kissing	August 2009
RC-A594	Beating with cane on bare buttocks	August 2009
RC-A621	Grooming; touching buttocks; attempted kissing	August 2009
RC-A6	Touching genitals, after swimming lessons and in the infirmary	August 2009
Laurence Soper		
RC-A600	Caning; touching buttocks	December 2017
RC-A608	Caning; touching buttocks	December 2017
RC-A601	Caning; touching buttocks	December 2017
RC-A609	Caning; touching buttocks	December 2017
RC-A610	Caning; touching buttocks	December 2017
RC-A611	Touching buttocks	December 2017
RC-A622	Rape; touching genitals	December 2017
RC-A8	Caning; touching buttocks	December 2017
RC-A11	Caning; touching genitals	December 2017
RC-A591	Touching genitals	December 2017
John Maestri		
RC-A623	Kissing; forced masturbation	December 2003
RC-A626	Kissing; lying in bed naked and touching body	December 2003
RC-A625	Fondling genitals	June 2005
RC-A11	Kissing; forced masturbation; attempted anal digital penetration	January 2009
Stephen Skelton		
RC-A604	Inappropriate touching	December 2011
Peter Allott		
N/a	Downloading and distributing indecent images of children	March 2016

The following corrections were made to the report on 24 October 2019:

Page 2, paragraph 3: 2015 was amended to read 2016
Page 15, section A.2, paragraph 6: 2015 was amended to read 2016
Page 100, section H.1, paragraph 2: 2015 was amended to read 2016

The following update was made to the report on 25 October 2019:

Page 106, paragraph 3 was amended to include a clearer description of Charity Commission-appointed interim manager Emma Moody's duties with regard to overseeing certain safeguarding matters at Ampleforth College, St Martin's Ampleforth and the two related charities.

The following updates were made to the report on 29 October 2019:

Page 39, paragraph 88, the last sentence was amended to read 'He described Soper visiting him in the infirmary, when he was 11 or 12 years old...'.
Page 112, Annex 1: the Independent Schools Inspectorate was added to the 'Institutional core participants' table.

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