TWO LAMBETH INDEPENDENT

CHILD PROTECTION INQUIRIES

1999 - 2000

THE FINAL REPORT

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A SUMMARY OF THIS REPORT

This Report to the Council of the London Borough of Lambeth relates to activities of the Children and Families Division of the Council's Social Services Department. It is for the Council and its professional managers to judge the extent to which its contents have relevance to other activities organised by the Council.

The critical tone of my September 1999 Report to the Council is further supported by the work undertaken since. In examining some of the results achieved, over the last decade and more, by the Children and Families Division (and its variously named predecessors), I have often been forced to wonder how such a situation could exist.

The hard evidence of repeated organisational failure has been found in five separate topics which I have examined in detail, with examples continuing until at least December 1999 - the approximate end date of the investigated material. The symptoms of a disintegrated organisation which has not yet been restored are apparent in these failures. This situation is not merely one for the history books. It is a current problem. It is my view that, whilst the symptoms of poor practice need the professional correction now being provided, the integration of the Department's organisation is the main challenge facing the Council now.

This unwelcome judgement has to be expressed firmly and publicly because the failures revealed by the investigations relate to two subjects of public concern. First, the organisation which has failed so badly was provided in Lambeth by the local system of democratic government. Secondly, the intended beneficiaries of public investment were especially vulnerable children.

The generalised criticism, however, needs qualification in three important respects. First, there has been clear evidence of excellent work by individuals, despite the surrounding shambles. Both Inquiries came about because of internal vigilance in the Department. Skilled, committed care by individuals has taken place. I have been impressed by the desire of many people whom I have interviewed to provide a proper public service. Secondly, social work is extremely difficult even when organised well. Thirdly, since 1993 the Council has increasingly recognised the Department's weaknesses and worked, with success, to overcome the inherited organisational decrepitude where the need came to attention.

In particular, there have been some significant improvements in organisation since the major changes of 1995/96, but these reforms have not dealt adequately with the organisational inadequacies which are apparent from the investigations. The incompetence disclosed in last September's Report to the Council about the treatment of an individual child in the Council's care related mainly (but not entirely) to 1996 and earlier. The continuing organisational incompetence revealed by the other investigations is also of current significance.

There will rightly be anger at the situation disclosed by this Report, but I have carefully confined the criticism of individuals to specific failures relating to the Department's 1996 response to that individual child's disclosure of sexual abuse. The establishment of individual responsibility for the general organisational failure would cause delay, and divert attention and scarce resources from the extremely urgent need to rectify the organisational deficiencies. In any event, only a Government authorised Inquiry could, in practice, allocate individual responsibility for such a widely defined situation with such deep roots in the past.

There is no evidence that the organisational failures were deliberately intended by the Council. Indeed, there are repeated instances of improvements in organisational arrangements being formally approved, but to little avail. The challenge to the Council, and to me in writing this Report, is the question 'Why did good intentions achieve such poor results?'. The answer to this question lies in the Council's neglect of sound managerial practice in the 1980s and early 1990s. The resultant organisational disintegration has obstructed attempted reforms and prevented the achievement of acceptable results.

Since September 1999 the Council has openly begun a new phase of intensive monitoring and reform. This will, I am confident, continue to reveal more unwelcome consequences of past inadequacies. Indeed, the Council must be ready for such shocks from a variety of sources for a long time to come. Facing up to the past constructively will enable the Council to monitor the adequacy of its present organisation, and so improve the future.

Questions of professional social work practice are being reviewed by others more competent than me, and many reforms of practice are already established. However, neither the wealth of professional advice currently available, nor the current restructuring, will avail if the evidence of long-standing organisational disintegration is ignored. This Report moves from unavoidable evidence of organisational deficiencies to the encouragement of management development, so that the Council can efficiently link realistic aspirations to effective front-line work.

The response to the challenge must be to establish stable management of good quality, and to support the changes which will have to be made. This will be costly, and require a firm review of priorities for expenditure. It will be politically difficult to manage. Other organisational agendas will have to be modified accordingly.

If the organisational challenge identified in this Report is not tackled successfully, there is unlikely to be success for the many initiatives which the Council is currently taking to improve its children's services. If the underlying organisational deficiencies are not remedied, why should the 1999/2000 reforms fare any better than their predecessors? If they do not fare better, why should the Council continue to be entrusted with such important responsibilities?

The Conclusions and Recommendations of the Report are designed to assist the Council in a task which will require its prolonged attention.

TWO LAMBETH INDEPENDENT CHILD PROTECTION INQUIRIES 1999 - 2000

THE FINAL REPORT

PART 1. INTRODUCTION

1.1. This Report

1.1.1. This Report is the Final Report on two Inquiries separately commissioned by the Council from me, a year apart. It seemed sensible to combine the work of the two Inquiries wherever possible, given the extensive similarity of background. Both Inquiries have related mainly to the work of the Children and Families Division (and its predecessors) of the Council's Social Services Department (to which I will refer as the Department) over similar periods of time. In the most general sense, their subject is Child Protection, but that has become incidental to the more fundamental challenge of organisational inadequacy.

1.1.2. The Council has fully respected my independence throughout the two Inquiries, at a time of great concern and determined activity in relation to the work of the Children and Families Division. I applaud the Council's recognition of their unwelcome and difficult responsibilities, as the need for drastic amendment has become increasingly clear. Over the past year there has been intensive activity to check the quality of practice, and to introduce safeguards for the benefit of clients. In Appendix 4, Part 4 I have briefly listed some of the current and recent monitoring relevant to the work of the Children and Families Division.

1.1.3. The Council's arrangements for its work relating to children are, therefore, already the subject of intense professional scrutiny and advice. In any event, I am not a professional social worker. This Report is therefore not focussed on providing recommendations directly related to professional social work, but is concentrated on matters of underlying organisational significance.

1.2. The interim Report of September 1999

1.2.1. On 30th September 1999 the Council received from me an interim Report (to which I will refer as SPR = September Public Report) on the first of the Inquiries. In SPR I referred to the individual identified as *"XXXXX"* in the Terms of Reference of the first Inquiry as 'Alan'. I will do so throughout this Report also.

1.2.2. This Report does not repeat the detailed facts set out in SPR. SPR is essential reading if this Final Report is to be understood fully. I have included explicit cross-references to SPR throughout this Report. The convention used is, e.g. *"paragraph 3.2.1. SPR",* or *"sub-section 3.4. SPR"*. By contrast, cross-references to other parts of this Report are made as, e.g. *"paragraph 1.2.1. above"* or *"sub-section 1.4. below"*.

1.3. The Structure of this Report

1.3.1. One of my main concerns arising from the investigations which began in December 1998 is the excessive quantity of paper which has clogged decision-making by Councillors during the period investigated. This Report is as brief as is reasonably possible, with the supporting material in the Appendices for those who have particular interest in their content. This Introduction to the Report is therefore immediately followed in Part 2 by Conclusions, and in Part 3 by Recommendations.

1.3.2. The Appendices are:

Appendix 1 …… The Scope of the two Inquiries. This Appendix explains the priorities chosen for the two investigations, summarises the responses to the individual Terms of Reference of both Inquiries, and indicates where more detailed information can be found within the Report.

Appendix 2 …… The Factual Findings of the two Inquiries. Part 1 adds a little to the findings of fact already published in SPR relating to the first Inquiry. Part 2 sets out the findings of fact relating to the second Inquiry.

Appendix 3…… Individual Criticisms. Part 1 deals with the scope of the Criticism process, and the reasons for its narrow limits. Part 2 deals with my specific criticism of two former senior officers, arising from their particular conduct relating to part of the first Inquiry's subject-matter.

Appendix 4 …… Monitoring Processes. Part 1 introduces the subject. Part 2 deals with the Council's failure to arrange for monitoring visits to its own Children's Homes. Part 3 deals principally with the Social Services Inspectorate's Reports on their monitoring of the work of the Children and Families Division. Part 4 lists recent monitoring activities relating to the Children and Families Division.

PART 2. THE CONCLUSIONS FROM BOTH INQUIRIES

2.1. The factual Basis of the Conclusions

2.1.1. I have examined five important factual histories relating to the children's work of the Department, all of which turned out to be histories of repeated organisational failure. The detailed supporting facts are given in SPR and in the Appendices to this Report. The reasons why these particular histories have dominated the Inquiries' investigations are explained in Appendix 1 below. The histories are of:-

1) the Department's general care of Alan from 1984 (already reported in SPR);
2) the Department's response to Alan's disclosure of sexual abuse in 1996 (already reported in SPR);
3) the Department's use, until 1998, of Police records to check the background of foster carers (Appendix 2, Part 2 below);
4) the Council's visiting of its own Children's Homes, from before 1991 to 1999 (Appendix 4, Part 2 below);
5) the responses to monitoring reports from the Social Services Inspectorate (to whom I will refer as 'SSI') from 1991 to 1998 (Appendix 4, Part 3 below).

2.2. The Relevance of the five Histories

2.2.1. All these histories relate directly to the Departmental work carried out by the present Children and Families Division and its predecessors. Some of that work involved co-operation with other parts of the Departmental organisation. I have been conscious of the danger of jumping to general conclusions from these specific histories, but there have been certain frequently found, significant features common to all of them. I have become familiar with only a very small sample of the Department's work - a sample which, for statistical purposes, would be insignificant. However, these five histories include work at several levels of responsibility and I have checked, with several people involved in the direction and management of the Department, that the practice revealed was not untypical.

2.2.2. With the exception of some individual failures, a topic dealt with in Appendix 3, Part 2 below, I now have no doubt that the organisational failures which I have investigated were part of general failure in the Department's organisation over time, and the Department's failure was, in the main, a legacy of historic failure in the Council's organisation.

2.2.3. I have been conscious of limitations on available information, because of the poor state of documentary records and defensive self-interest on the part of several of those who have been involved. Despite these limitations, I am confident I have understood the broad picture correctly, even if some details have been inadequately understood or described.

2.2.4. Many of the problems addressed in this Report were expressed or implied in SPR, and the Council has already responded actively within its continuing programme of organisational reform. Unfortunately, a work culture of poor standards cannot be dealt with by formal reorganisation, or by remote dictation. I am confident that the problems of the past can survive any reforms if they are not subjected to a constant, determined process of sensitive, skilful direction and management by the Council. This Report therefore emphasises lessons about the present, inevitably drawn from the past, to assist the Council in making its reforms effective for the future.

2.3. Three general Conclusions

2.3.1. The evidence from the investigations is sufficiently strong to enable me to draw three general conclusions directly from them, and which provide a basis for tackling the organisational failure. More importantly, these Conclusions warn the Council of the inadequacies of previous methods adopted by the Council to improve the Department's organisation and control its work.

2.3.2. The following three Conclusions should not come as a surprise to the Council, but it should be helpful for the obvious to be stated openly. In this way there can be a common basis within the Council for understanding the scale and direction of the changes which the Conclusions invite.

2.3.3. From the information given to the Inquiries I have unhesitatingly drawn two basic Conclusions:-

Conclusion 1. The Council, through its inadequate arrangements in the Social Services Committee, the Department and the Division, has repeatedly failed to fulfil both its statutory duties and its own policies relating to the care and protection of children;

Conclusion 2. The Council has repeatedly tried during the past decade, but repeatedly failed, to create and control an effective Department and Division.

2.3.4. Taken together, these two initial Conclusions present a daunting challenge to the Council. However, if left in this form, these Conclusions are unhelpfully generalised for taking practical measures. The problem to be faced is concentrated in the arrangements linking the Council's intentions to Departmental achievements, about which it knew very little in any organised way. I have therefore drawn a third Conclusion, which is organisational in character. It can act as a bridge between the first two Conclusions and a more detailed breakdown of the organisational weaknesses which are contained in eleven Sub-Conclusions.

2.3.5. The organisational third Conclusion is that, at least in relation to the Children and Families Division (and probably on a much wider scale):-

Conclusion 3. The Council's executive Chain of Command (assuming it once existed) linking departmental Action to the Council has decayed and disintegrated.

The very phrase 'chain of command' sounds incongruous in Lambeth's traditional organisational culture, but its stark orthodoxy is helpful in giving more practical meaning to the general Conclusions, as they are broken up into more manageable pieces.

2.4. The Sub-Conclusions

2.4.1. Inevitably, because these Sub-Conclusions are attempts to look at the third Conclusion in different ways, there is considerable overlap between them. The first four Sub-Conclusions are important for the Council's direct links to the Department in the executive chain of command:-

Sub-Conclusion 1. The Committee system failed;
Sub-Conclusion 2. There has been a misleading emphasis on superficial verbal appearances rather than on results;
Sub-Conclusion 3. There have been unmanaged disruptive tensions within the Council's own decision-making;
Sub-Conclusion 4. The proper role of monitoring has not been adequately appreciated by the Council.

2.4.2. The next five Sub-Conclusions are mainly about the Departmental links in the overall chain of command:-

Sub-Conclusion 5. The Department's organisation was disintegrated;
Sub-Conclusion 6. The art and discipline of departmental managerial decision-making has been under-developed;
Sub-Conclusion 7. The quality of supervision has been inadequate;
Sub-Conclusion 8. Staff morale has been poor;
Sub-Conclusion 9. There has been a lack of basic administrative discipline in the Department;

2.4.3. The two final Sub-Conclusions are about important contributory ineffectiveness:-

Sub-Conclusion 10. External support to the Department from associated Child Protection agencies has been inadequate;
Sub-Conclusion 11. SSI monitoring reports did not directly specify concerns about managerial quality.

2.4.4. Amplification

I now amplify these Conclusions and Sub-Conclusions. I have indicated wherever possible the relevant date of the information supporting each Conclusion and Sub-Conclusion. It is important not to adopt an attitude of wholesale condemnation - the force of some of the supporting evidence may have been reduced by subsequent reforms.

2.5. Conclusion 1.

The Council, through its inadequate arrangements in the Social Services Committee, the Department and the Division, has repeatedly failed to fulfil both its statutory duties and its own policies relating to the care and protection of children.

2.6. The Evidence in Support

2.6.1. (a) The failures have a local origin

The ad hoc development of central-local government arrangements in the provision of national public services over at least the last half century has resulted in a complex system, the opaqueness of which defeats my powers of description.

2.6.2. Throughout this Report I have referred to the Council's responsibilities for the organisational capacity of its own Social Services Department, but even in this respect the Council's freedom to manage is not unfettered. However, I am satisfied that the confusing division of English central and local government responsibilities, which has been so widely criticised for so long, cannot excuse Lambeth's failures described in this Report. It may be that the scale of the incapacity from which it is now recovering is matched in some other local authorities with Social Services responsibilities, but it is not matched in others. Lambeth's organisational history cannot be explained or excused by reference to the general state of central/local authority relationships, and I have seen no evidence of some peculiar local relationship.

2.6.3. (b) The detailed evidence

The Council's Department repeatedly failed Alan, both generally as his parent and, in particular, in its response to his disclosure of sexual abuse whilst in its care, from 1984 to 1998 (SPR). The Department failed to recognise the proper interests of other young people who might have been victims of similar abuse to that alleged by Alan (1996) (SPR). The Department failed to observe elementary requirements designed to protect children for whom it had a responsibility to secure safe fostering, to 1999 (Appendix 2, Part 2 below). The Social Services Committee and the Department failed to organise monitoring visits to the Council's own Children's Homes, from before 1991 to 1999 (Appendix 4, Part 2 below). The Committee and the Department failed to implement repeated recommendations from the SSI from 1993 to 1997 (SPR, and Appendix 4, Parts 2 and 3 below). These are all serious failures.

2.6.4. (c) External influences

During the period covered by the two Inquiries there has been no lack of reminders from national sources about the ever-present danger of child abuse and the need for organised, effective counter-measures. As the years have gone by, national Inquiries have analysed past mistakes and highlighted the lessons to be learned. From 1989 to 1991 the implementation of the Children Act 1989, and its accompanying Guidance, unavoidably raised the profile of children's services to the Council's attention. This process has continued. Organisational, professional and managerial skills are constantly being developed, and a substantial body of good practice has been established nationally. It is against this background that the areas of contrasting incompetence in Lambeth have to be judged.

2.6.5. Several of these national Reports, and the Act and accompanying Guidance, featured in official Committee minutes. Quite apart from general media publicity, therefore, the Council was repeatedly made aware of its responsibilities. Yet the histories I have investigated (paragraph 2.1.1. above), which relate to Lambeth's practice, all show Lambeth's failure to translate the national recommendations into effective local practice.

2.7. Comment

2.7.1. The Council, acting through the Social Services Committee, has failed to achieve the outcomes that were its clear responsibility to achieve. In the subject-matter of both Inquiries the Council is shown to have acted, over the whole period covered, in breach of the law, of accepted good practice and of its own declared policies. The dysfunctionalism of the Department was so great that inadequate standards became the norm, and the proper development of good practice in line with national developments did not take place as it should have done. The work culture of the Department has been inappropriate for the difficult tasks it exists to carry out.

2.7.2. In moving from this first Conclusion towards a more detailed understanding of how such a situation could arise it is also necessary to state the second initial Conclusion, which adds further emphasis to the complexity of the Council's present responsibility.

2.8. Conclusion 2.

The Council has repeatedly tried, but repeatedly failed, during the past Decade to create and control an effective Department and Division

2.9. The Evidence in Support

2.9.1. It would be unfair not to recognise that the Council has tried repeatedly to bring its children's services up to a proper standard, and that those reforms have been effective in some respects. However, if the first Conclusion is correct, the failure of those reforms to achieve a competent Department is self-evident. The history of the Department shows that at least three major reorganisations prior to the present one took place during the past decade - in 1991/92 (sub-section 4.4. SPR), in 1993/94 (sub-section 5.6. SPR), and in 1995/96 (sub-section 6.1. SPR). The organisational failures condemned in the first Conclusion have continued despite these reorganisations.

2.9.2. Passing high-sounding resolutions of purpose (e.g. paragraphs 2.1.4. and 5. SPR) has proved to be an inadequate means of organisational direction. The formally approved changes of 1991/92 arising from the implementation of the Children Act, 1989 were largely professionally led. Similarly, in 1993/94 and 1997 the officers put forward detailed *"Action Plans"* in response to SSI and national Report recommendations (sub-section 5.6. SPR and Appendix 4, Part 3 below). The formal acceptance of these Action Plans did not prove to be a means of re-creation and control.

2.9.3. From the information given to the Inquiries I have observed a process of attempted recovery of Council control, as Councillors increasingly recognised the need for radical changes in the Department in the early 1990s. By 1995/96 Councillors were able to initiate changes in both the senior managers and the senior management structure of the Department (section 6.1. SPR). Some of the major concerns which the Council then had were successfully dealt with as a result.

2.10. Comment

2.10.1. Unfortunately, the quality of the services provided to clients was not the subject of organised supervision by the Council. Whether Councillors did not know of defective Departmental achievements, or whether they did know but were unable to respond adequately, the Council's processes have been gravely deficient.

2.10.2. The measures taken in relation to the Social Services Department in 1995/96 were to employ carefully selected senior managers as intermediaries between the Council and the front line work. In a normal organisation where improvement was intended, this would almost certainly have been adequate. Some improvements undoubtedly did result, but the necessary overall improvement did not. I suggest three principal reasons for this, based on my own experience in conducting the two Inquiries in Lambeth, as well as from the information received by the Inquiries.

2.10.3. First, the gross organisational inadequacy which had to be dealt with was a feature of the organisational infrastructure by which it had to be tackled. You cannot readily mend a broken tool-kit with the broken tools in the kit (I deliberately use an impersonal analogy). Inadequate practice, inadequate records, inadequate competence, inadequate supervision and management were far too extensive to be tackled only by a few changes at the top. I hope that this is now obvious.

2.10.4. Secondly, dealing rapidly with the inherited overspending in 1995 meant turbulence in staffing whilst having to maintain essential services. Senior managers also had to cope with the frequent consequential crises of inherited organisational incompetence, which diverted time and other resources. Senior managers thus had a much reduced opportunity to drive through detailed assessment of operational standards on which to base retraining and restructuring.

2.10.5. Thirdly, in attempting to provide continuing services despite the circumstances, both internal managers and external monitors talked up such improvements as did occur. Even when poor standards were noted they were, in practice, accepted until they could be dealt with.

2.10.6. As the Council shows, yet again, that it intends to provide good public children's services in the Borough, it will do well to reflect carefully on what is needed to overcome a deeply entrenched work culture, and this time ensure satisfactory practical results.

2.11. Conclusion 3.

The Council's executive Chain of Command (assuming it once existed) linking departmental Action to the Council has decayed and disintegrated.

2.12. The Evidence in Support

2.12.1. The evidence in support of this third Conclusion is, quite simply, the discrepancy between what the Council wanted to achieve (as stated by its legal obligations and by its own minutes) and what it actually achieved (as found by the Inquiries and other recent investigations). The detailed evidence is given in the histories related in this Report and in SPR, and also referred to in relation to each of the Sub-Conclusions below.

2.13. Comment

2.13.1. The condemnation expressed in the first Conclusion cannot be avoided by the Council, as though the Department has been a separate organisation. The prime responsibility for the Department and its relationship to the Council is the Council's. Therefore the prime responsibility for effectively controlling the Department remains with the Council. It will need many changes in the ways Councillors behave if the capacity of local democracy to provide Social Services in Lambeth is to be vindicated. A system of more managerially effective corporate governance is needed than that which has operated in the 1980s and 1990s, if the Council is to achieve proper control of its organisational arrangements. This task is easily stated, but formidably difficult to achieve, given the deeply entrenched nature of bad practice found during the investigations into the work of the relevant Committee and the Department.

2.14. Challenge

2.14.1. The challenge to the Council is to establish and sustain a properly focussed formal and informal organisation, which can deliver on properly determined targets and priorities.

2.15. The Sub-Conclusions

2.15.1. The following Sub-Conclusions are intended to indicate more specifically the past practice which has proved inadequate. It is probable that many readers will be tempted to read criticism of identifiable individuals into these Sub-Conclusions, but this would be misguided. I am not indicating blame in what follows - the reasons why individuals found themselves choosing damaging courses of action are complex. In terms of individual blame, this Report is neutral, except to the extent to which it deals with individual criticism in Appendix 3, Part 2 below. Appendix 3, Part 1 sets out the reasons why I have not pursued individual criticism for general organisational failures. However, although the Conclusions and Sub-Conclusions are impersonally worded, there is an inevitable reflection on individual competence. To the extent that such incompetence is current, it is the task of current management to address it.

2.15.2. The Sub-Conclusions, which overlap, are derived directly from the Inquiries' investigations. They are therefore expressed in the past tense, but represent still current challenges.

2.16. Sub-Conclusion 1. The Committee System failed

2.17. Introduction

2.17.1. All Councillors are inundated with demands for their attention. These include residents' problems and complaints, Party loyalties to the Administration or Opposition Groups, and a constantly changing relationship between Local and Central Government. In addition, in the past, there has been time-consuming decision-making by Committee. If one were to award marks for effort, those who have ground through the reams of written papers (see sub-section A4.35. below), and the hours of meetings, pre-meetings and briefings involved in the Committee work, would deserve high commendation. Whilst such public-spirited effort is admirable, the system in which it was employed just did not do the job it was supposed to do.

2.17.2. The failure of the Council to deliver its statutory duty and declared policies relating to vulnerable children inevitably raises embarrassing questions about the appropriateness of the Council's former standard decision-making system (paragraph 2.2.3. SPR). The Social Services Committee was given extensive delegated powers by the Council. In effect, for most practical purposes it was the Council's chosen method of exercising democratic control over the Department's work.

2.17.3. In reading Committee reports, I have not noticed records of meaningful operational data relating to the Committee's responsibilities and priorities being presented in digestible fashion. It may be that I have missed such data in the mountains of paper which went to the Committee and its Sub-Committees. I have certainly not studied them all. If such data was presented in an effective way, then the failure of the Committee to remedy the poor general care of Alan and the poor quality of fostering provided by the Department is even more directly the Committee's responsibility.

2.17.4. Given the comparison between what the Council sought to achieve and the results actually obtained, the condemnation of the Committee system must extend to the whole of the period investigated until the system ceased. Although the Committee system has recently been abandoned by the Council, a recognition of its major faults may assist the Council to avoid its new system becoming subject to the same faults.

2.18. The Evidence in Support

2.18.1. It is obvious, from reading the minutes, that clear differentiation of decision-making to the most appropriate levels was rarely exercised. I cannot, in a Report, quote from all the minutes I have read to provide the detailed evidence. If you question the accuracy of these comments, ask to see a set of Committee papers chosen at random. Over and over again I have asked myself 'Why was a Committee being asked to decide this?'.

2.18.2. There are indications that, in common with experience in many local authorities, the processes of Council and Committee decision-making were mistrusted, and abused, by those involved. Abuse of the process is indicated by the obviously daft quantity of detail which so frequently clogged the Committee's agendas, preventing the Committee from 'seeing the wood for the trees'. Each of the six Social Services Committees which met in 1997/1998 (a year taken at random) had agendas with an average of 300 pages (sub-section A4.35. below). There was plentiful information and decision-making, but little realistic monitoring. (1993 - 1998). Failure to understand the role of Committee members is clear from practical incidents and the lack of monitoring visits related in Appendix 4, Part 2 below.

2.18.3. Through the Sub-Committee system, some individual cases and the more general circumstances of children in care did come before Councillors. In the course of checking the progress of monitoring visits I read several management reports to Committee or Sub-Committee about Children's Homes which highlighted operational difficulties needing further financial support, but which failed to give a realistic description of operational realities for the children (to 1994).

2.18.4. The history of Regulation 22 Visits (Appendix 4, Part 2 below) illustrates the process of control repeatedly followed by the Committee, and the repeated poverty of the practical results (1991 - 1994). If sufficient Councillors could not, or would not, do the visiting, why did the Committee/Sub-Committee not appoint non-Councillors, as the Regulations permitted? Such a solution to a repeated problem was hardly obscure.

2.18.5. An important source of potential monitoring information for the Committee and the Department was the SSI, an independent, external, expert monitor. SSI Reports were (judging by the official minutes) dealt with at Committee in an unrealistically bland way. The various SSI reports were presented in full to the Committee (see Appendix 4, Parts 2 and 3 below and SPR). The Committee had, from receipt of the 1993 SSI Report on an Inspection of three Lambeth Children's Homes, serious warnings about the need to improve the quality of the Council's residential care and Child Protection. The Committee accepted detailed Departmental *"Action plans"* designed by the Department to meet accepted criticisms, and received detailed progress reports on implementation. Many of the recommended improvements did not materialise. Judged by the results evident from the investigations (e.g. sub-section 5.10. SPR), the Committee's considerable work on the *"Action Plans"* was ineffective in major ways.

2.18.6. In early 1994 the Committee decided to close the Council's Children's Homes as quickly as possible. The 1993 SSI Report, which had resulted from informal representations from some Councillors to the Government, had provided a means of breaking through the entrenched opposition of employees to disturbance. I am not criticising the decision, which is outside my Terms of Reference. It may have been the only way in which to deal with a deplorable situation beyond the Committee's control to deal with in any other way. The relevant point is that the situation had become beyond the Committee's control. A disruptive, draconian solution was a consequence of the previous lack of control.

2.19. Comment

2.19.1. The Committee system did not control the work of the Department. The Committee's decisions and intentions did not impact sufficiently on practice, and knowledge of practice did not sufficiently inform the Committee's decision-making. In the indigestible, undifferentiated mass of detailed information traditionally submitted for approval, and in the elimination of appraisal of results actually achieved, the Committee was rendered incapable of acting as a thinking, directional and supervisory head on behalf of the Council.

2.19.2. The Committee and the Department lost sight of the dominant objective, expressed in both the Council's formal policies and the Council's statutory duty, to safeguard and promote the welfare of children in the Council's care. Such a general duty can only be exercised by relating the resources of finance, legal powers and skills which are available to actual situations. Other agendas were followed instead.

2.20. Challenge

2.20.1. The challenge to the Council is to ensure that its new system of democratic control is effective in practice.

2.21. Sub-Conclusion 2. There has been a misleading Emphasis on superficial verbal Appearances rather than on Results

2.22. Introduction

2.22.1. I have separated this subject from the previous Conclusion because the misleading nature of documentation straddles both the Committee's and the Department's practices. A particular feature of the matters investigated is the misleading state of some of the Council's public paper-work, whether in Committee or in the Department. The gap between the Council's formal rhetoric, at several levels of decision-making, and the relevant practical situation, is striking. I am not, of course, suggesting that the quality of public documentation is unimportant, but drawing attention to the misleading contrast between some formal documentation and the reality of related service delivery. However unwelcome reality may be, it should not be ignored.

2.23. The Evidence in Support

2.23.1. I have not read all the reports to, and minutes of, the Social Services Committee and its Sub-Committees, but I have read a large number. The relevant formal documentation at Council/Committee level, e.g. reports and minutes, gives minimum cause for concern to the reader about the actual practical realities now known to have existed at the time in related service delivery. The Annual Reports of the Area Child Protection Committee (to which I will refer as the ACPC) presented to the Committee, also gave an encouraging account of improvements in Child Protection arrangements. They did not indicate the dysfunctional nature of the ACPC at the time (Sub-Conclusion 10 below). Similarly, the presentation to the Committee of the critical SSI Reports was bland, and the minutes reflected this (Appendix 4, Part 3 below).

2.23.2. All the investigated failures in Alan's general care, and in the response to his disclosure of abuse, occurred despite the broadly acceptable Departmental formal policies or procedures to the contrary. This covers the period from 1984 (when Alan was first taken into care) to 1999, the effective final limit of the two Inquiries' investigations (SPR).

2.23.3. The relevant formal documentation relating to monitoring visits by officers and Councillors (Appendix 4, Part 2 below) repeatedly emphasised the Council's monitoring obligation. It explained clearly the purpose of such visits, and proposed ways of implementation. Only when external pressure forced the subject to renewed attention did the extensive failure in practice become apparent. Then the cycle was repeated, repeatedly (1991 - 94).

2.23.4. The Divisional and Departmental Procedures relating to the assessment of foster carers bear little relationship to actual practice before 1999 (Appendix 2, Part 2 below).

2.24. Comment

2.24.1. See the Comment in the related Sub-Conclusion 6.

2.25. Challenge

2.25.1. The challenge to the Council is to make its documented aspirations more closely related to clearly exposed operational realities.

2..26. Sub-Conclusion 3. There have been unmanaged disruptive Tensions within the Council's own Decision-making

2.27. Introduction

2.27.1. The Inquiries' investigations have sometimes indicated, and sometimes clearly disclosed, disruptive tensions in decision-making and its executive consequences.

2.28. The Evidence in Support

2.28.1. There was a mismatch, at times gross, between Departmental income and expenditure (up to 1996) (Finance Department data). This led to turbulent operational consequences as the imbalance was suddenly put right by the Council (1995 - 1996) (paragraph 6.1.4. SPR).

2.28.2. A (draft but intended as final) Report by the District Auditor in 1994 stated: *"- the agreed staffing establishment cannot be funded from the budget, which has to be balanced by delayed recruitment to some posts"* (Appendix 4, Part 3 below). Either the Budget should have been increased, or the staffing establishment reduced.

2.28.3. The draconian response of the Council in 1993 - 1994 to the concerns of Councillors about the quality of the Council's own Children's Homes was to close them as quickly as possible.

2.29. Comment

2.29.1. Because there was no proper flow of management information appropriate to Council level decision-making, operational inadequacies had to reach crisis proportions before the Council responded. The result was turbulence, further postponing the achievement of sound organisation.

2.30. Challenge

2.30.1. The challenge to the Council is to manage continuity between realistic choices on the fulfilment of its responsibilities and the conflicting sub-agenda of its subordinate organisational arrangements.

2.31. Sub-Conclusion 4. The proper Role of Monitoring has not been adequately appreciated by the Council

2.31.1. There are two separate aspects to this Sub-Conclusion, external monitoring and internal monitoring (Appendix 4 below). I deal with the effect of the external SSI and other monitoring reports to the Council in Sub-Conclusion 11. In addition to the work of specialist internal monitors there should also be the normal process of supervision, and the assessment of results, by managers. Sub-Conclusion 7 is therefore interlinked.

2.32. The Evidence in Support

2.32.1. All the five main histories (paragraph 2.1.1. above) related in this Report and SPR were the subject of direct or indirect external monitoring. The monitoring reports ranged from the SSI's detailed Inspections of professional work to the content of well-publicised national Guidance and Inquiry Reports. Relevant parts of the SSI reports and the Council's responses are set out in SPR and in Appendix 4, Parts 2 and 3 below. Some of the relevant national Guidance and Inquiries' Reports are set out, in relation to the assessment of foster carers in Appendix 2, Part 2 below, and in relation to monitoring visits to Children's Homes, in Appendix 4, Part 2 below.

2.32.2. The purpose of visits by Councillors to the Council's Children's Homes, or by suitably independent people on their behalf, was to contribute to the internal monitoring of the quality of care. This internal monitoring was never organised effectively (Appendix 4, Part 2 below), despite the conscientious efforts of some individual Councillors. (1991 - 1999).

2.32.3. The Department's internal Child Protection specialist monitors were organisationally disabled from exercising influential monitoring of the operational work relating to Alan's disclosure. (Main Conclusions on Section 5. No. 4., Main Conclusions on Section 6. No. 5., and Section 7, SPR) (up to 1996). There is no evidence of any outlet from the internal monitors to the Committee about their concerns.

2.32.4. The failure to respond adequately to Alan's disclosure of abuse was closely monitored internally by his social worker (sub-section 6.17 SPR). The failure to ensure the safety of fostered children was monitored internally by the new Manager of Family Finders (Appendix 2, Part 2 below). In neither case were the warnings they gave adequately heeded. The managerial arrangements could not cope with this criticism from subordinates, even when the criticism was of obvious importance. (1996 and 1998/99).

2.33. Comment

2.33.1. The primary responsibility for managing its services is the Council's. All organisations make mistakes; learning from mistakes is a normal part of good management. That is why the extra checks provided by external monitors, using national criteria, are so valuable. It is also the point of having a specialist Child Protection and Quality Assurance section within the Department.

2.33.2. The SSI were the specialist external monitors of professional practice and delivery, and the Council, through the Committee's consideration of SSI reports, had a potential means of learning about operational realities. So did senior management in the Department. The Council's organisational capacity to learn from the mistakes identified by the SSI appears to have been gravely deficient. (to 1997). Given Lambeth's style of Committee work, and the state of Departmental management organisation, the effectiveness of the SSI's Reports was inevitably blunted, formally and informally.

2.34. Challenge

2.34.1. The challenge to the Council is to ensure that both the Council and the Department have a robust capacity to learn from the results of external and internal monitoring.

2.35. Sub-Conclusion 5. The Department's Organisation was disintegrated

2.36. The Evidence in Support

2.36.1. The May 1999 interim Report to the Chief Executive (sub-section 1.5. SPR) referred to:
"*a lack of synergy between different strands of Social Services Departmental activity, and between the Department and other Child Protection agencies."*

"a culture of work which is individualised to discrete responsibilities, and which ignores both the objectives and the potential synergy of Team work."

"a reluctance, by those whose experience is largely confined to the Lambeth Department, to change the established Lambeth way of working, even in the face of strong challenge."
These comments have not been challenged. On the contrary, I have repeatedly heard, from a wide variety of people involved in Lambeth's past affairs, descriptions like 'You pulled a lever, but nothing happened; it wasn't connected'. Considerable changes were made to the formal organisation of children's services, in ways apparently responsive to expert advice and deeply felt concern, from 1991 to 1996. The beneficial effect was marginal on the quality of practice in the four operational topics investigated - Alan's general care, the response to his disclosure, official monitoring visits, and the assessment of foster carers.

2.36.2. It is clear from the investigations that legal duties were ignored, professionally proper decisions were not implemented, formally declared policies and procedures were not followed, mistakes brought to attention were not corrected, the proper involvement of superiors and colleagues was avoided, and elementary records were not properly kept or used. Some of these errors happened repeatedly, at various levels in the Department's decision-making structure, and were apparent in each of the operational topics investigated. The errors in this description apply with varying, but still disconcerting, intensity, throughout the period investigated. (1985 - 1999) (SPR and this Report). I underline these words because they constitute a briefly stated, but terrible, indictment - a summary of the adverse findings of the Report.

2.37. Comment

2.37.1. These are hallmarks of a disintegrated organisation. The 'critical mass' of the work-force was only tenuously connected to senior decision-making, whether in terms of constructive consultation, or of obedience. In short, the Department has had to rely on individuals to produce good work on an individualised basis, often against the grain of established working practices. Such a situation perverts consultation, where direction is seen as an imposition.

2.37.2. From my own researches, and from what I have been told, three reasons peculiar to Lambeth for this unsatisfactory state of affairs can be proposed. I use the rather guarded word 'proposed' because these reasons have not emerged entirely from the fine mesh of the detailed investigations. They are in part my own insights based on coincidental conversations during the investigations, but I am sufficiently convinced of their relevance to put them forward.

2.37.3. First, proper intermediate managerial freedom was devalued by political decision-makers in the 1980s, including too close a relationship between them and the Trades Unions. This undermined the managerial line.

2.37.4. Secondly, when before 1996 there was insufficient trust in the competence of senior managers they were bypassed, rather than their competency/incompetency managed properly. This misdirected the management line. It is worth pondering whether the same was true of attitudes to the Committee.

2.37.5. Thirdly, the failure of the Committee (Sub-Conclusion 2 above) to provide effective control removed democratic legitimacy from the management line.

2.38. Challenge

2.38.1. The challenge to the Council is to strengthen the arrangements which ensure that the Departmental agenda determined by the law and by the chain of command from the Council dominates all sub-agendas within the Department affecting professional practice.

2.39. Sub-Conclusion 6. The Art and Discipline of departmental managerial Decision-making has been under-developed

2.39.1. Sub-Conclusion 5 referred to a lack of organisational integration. This Conclusion looks at the same situation from a different viewpoint.

2.40. The Evidence in Support

2.40.1. The Council has established these two independent Inquiries to establish facts which managerial oversight, in more normal circumstances, should have been able to detect more economically, and in a more timely way. The SSI Report of 1993 was used similarly. I understand the need for an independent Inquiry where a situation has developed beyond being managed internally, and I am not criticising those who established these two Inquiries. I am pointing out that a timely and full managerial process would have obviated the need for expensive and diversionary external Inquiries. The need for an independent Inquiry is itself an indication of organisational incapacity. (1992 - 1999).

2.40.2. Just as I criticise the amount of detail submitted for decision-making up to the Social Services Committee, so I criticise the similar Departmental practice of inadequate delegation. When operations are subject to the kind of turbulence experienced within the Council's arrangements over the past two decades, otherwise routine matters of managerial or professional discretion have tended to become approved at a higher level than normal. I have noted individual efforts to counter-act this, but not a thorough reform accompanied by proper supervision.

2.40.3. Inadequate attention to the appropriateness of decision-making levels in the chain of command resulted in poor care for Alan (SPR). On several occasions in the history of Alan's care and of the response to his disclosure, decisions had to await approval from senior officers overwhelmed by the routine detail presented to them. The result was inadequate attention at any level. (up to 1996).

2.40.4. Within the Department, the continuing lack of effective communication between those who should have been colleagues in managing the joint enterprise of the Council's general care of Alan led to poor care and indefensible inaction. This lack of effective communication was a particularly striking feature of the absurd response to Alan's disclosure of abuse (Sections 6 and 7 SPR). (1985 - 1999).

2.40.5. Even repeated legal requirements were not directed by management into professional practice in the front-line assessment of foster carers. Appendix 2, Part 2 below reveals an inadequate dynamism of managerial practice. (up to 1998).

2.40.6. The subject matter of sub-section 3.22. below is also relevant.

2.41. Comment

2.41.1. It follows from Sub-Conclusion 2 that the Council and the Department have, in the past, used operational material to engage in discussion and publication for its own sake, rather than as a means to an operational end. This has encouraged a narrow approach to the duties of decision-making at political and operational levels, concentrated on making verbal propositions defensible from attack in set-piece debates.

2.41.2. Discussion of this kind, on the scale indicated by the records will, inevitably, have influenced information flows to and from the operational officers, as awareness of superficial or operationally remote values became a prime motivator. Political and bureaucratic correctness of the decision-making processes, and finely detailed theoretical analyses of practical situations, have been too dominant. This has prevented the assertion of more robust managerial values about practical usefulness in pursuit of the Council's duties and policies.

2.41.3. Although there have been important improvements since 1995, there has been an absence of mutual trust and shared vision between links in the Council's chain of command. In consequence, there have been no common objectives or standards on which to focus and energise management. In such circumstances, integrity of organisation is impossible; synergy is unobtainable; inadequate performance is inevitable. The encouragement of managerial values at all levels is essential if the Council, as the head, is to be connected to the body of its associated organisation.

2.42. Challenge

2.42.1. The challenge to the Council is to encourage a decision-making process in which 'managers' are empowered to manage the implementation of approved directions in a succession from Council to front-line worker.

2.43. Sub-Conclusion 7. The Quality of Supervision has been inadequate

2.44. Introduction

2.44.1. This is a particular example of the last Sub-Conclusion. Supervision is a particular form of monitoring, and this Sub-Conclusion is therefore also linked closely with Sub-Conclusion 4. Performance appraisal processes have been developed in recent years, but in those examples I have come across they have been limited both in quantity and quality. I note that the new Departmental structure formally recognises the importance of Performance Management.

2.45. The Evidence in Support

2.45.1. In the following situations, operational supervision must have been inadequate. Either the frequent and permanent practical lapses were missed, or they were accepted, or they were ignored:

(1) The 'drift' shown in SPR relating to Alan's general care (1984 to 1999).

(2) The repeated loss of momentum in the response to Alan's disclosure, described in SPR (1996 - 1998).

(3) The absence of monitoring visits to Children's Homes until 1991, the patchy visiting thereafter until the Homes were closed in 1994, and the failure to visit 'The Chestnuts' which had still not been put right in 1999 (Appendix 4, Part 2 below).

(4) The scale of continuing poor practice relating to the assessment of foster carers shown in Appendix 2, Part 2 below (up to 1999).

2.45.2. In particular incidents where I tried to investigate the supervision actually given, there was little or nothing by way of properly organised record. In several cases the timing and selection of topics appeared to have been dominated by crisis management.

2.46. Comment

2.46.1. Effective supervision is an obviously necessary process if the integrity of the Department, and the links between policies and delivery, are to be assured. It should be a normal part of the managerial appraisal of practice and achievements. Its absence means that results appropriate to the Council's objectives were the object of hope rather than of managerial direction and planned synergy.

2.47. Challenge

2.47.1. The challenge to the Council is to invest in managerially relevant supervision, as a normal part of the appraisal of all its employees' performance, and of the provision of important management information.

2.48. Sub-Conclusion 8. Staff Morale has been Poor

2.49. The Evidence in Support

2.49.1. I hesitate to draw such a broad Sub-Conclusion from the relatively limited exposure I have had to employees in the Department. However, there are some signs in the histories recorded in SPR and in this Report's Appendices. I have also listened to comments from those who gave information to the Inquiries.

2.50. Comment

2.50.1. The need to improve morale is a subject usually raised in the context of salaries and conditions of service. It is important to get these factors right, but there are more subtle influences which are of at least equal importance. I draw attention to six such influences in particular. They are the product of 'managerial hunches', based on conversations with people whose judgement I have come to trust.

(1) Lambeth Council's work has been subject to widespread and repeated criticism for a long time (sub-section A3.9. and Appendix 4, Part 3 below). Such criticism has become so fashionable that the good work carried out by the Council has become smothered by generalised condemnation. I am conscious that the inevitable emphasis of this Report will add to this condemnation, despite my attempts to emphasise some more positive features. The effect of publicity for general failure is adverse for all those involved, but the more so for those who have tried the hardest to improve standards.

(2) Turbulence in operations (Sub-Conclusion 3) has also reduced staff loyalty, and narrowed the focus of individual commitment. In particular, reductions in expenditure have resulted in extensive job losses. Widespread insecurity, and suspicion about the basis for hiring and firing have been, and are, rife. The relevance of employment reduction to the quality of individual and group performance of priority work has not always been transparent (and see sub-section 3.22. below).

(3) Failure to deal with poor performers managerially, and incomplete staffing, have pressured officers into actions which they knew to be hurried and inadequate, yet there seemed to be little alternative. In several instances where, objectively, I should be critical of action taken, I know that the individuals concerned had little choice.

(4) Good employees (and probably good Councillors, too), frequently encountering poor practice and poor support, have come to accept such a state of affairs as normal. I have constantly been surprised at the difficulties involved in progressing the work of the two Inquiries when reliant on assistance from the Department. On some relatively unimportant occasions, I have given up in impatience. I can understand how the frustrations of working amidst inefficiency of support can weaken standards of practice.

(5) I have been told repeatedly that effecting changes in long-established working practices in Lambeth requires extensive and continuous effort by individuals, which cannot be sustained other than by that individual. In the absence of clear organisational priorities, managerial values and shared objectives, this is not surprising. Keen and committed professionals come, and then go, often defeated by a dogged determination to ignore calls for better, but different, working practices from those regarded as the norm by long-serving employees.

2.50.2. All these influences on morale are the consequences of inadequate direction, and poor management. In particular, they are consequences of an organisational inability to recognise and support good work and good workers, whilst also recognising and managing the consequences of bad work and bad workers. Poor morale is the inevitable result.

2.51. Challenge

2.51.1. The challenge to the Council is to create a Departmental appraisal system which openly provides a basis for the management of individual and group work and the assessment of achieved results in accordance with the Department's legally and politically determined priorities.

2.52. Sub-Conclusion 9. There has been a Lack of basic administrative Discipline in the Department

2.53. Introduction

2.53.1. This subject, which has mainly manifested itself in record-keeping and punctuality, may sound like tedious administrative detail, but the information which has come before the two Inquiries is sufficiently alarming to raise the subject's importance to Council-level attention in this Report.

2.53.2. Just as the Council's decisions are evidenced by its formal minutes and supporting documents, so the work of the Department is evidenced by its records. The absence of adequate records destroys an organisation's integrity. An organisation's ability to recall the past reliably is dependent on adequate, accessible records. In this way the unity of an organisation can be continuously maintained, despite the inevitable changes in individual employees and the separation of work into specialist units.

2.53.3. When the turnover of key staff is as great as has occurred in the Department, the dependency on records is greatly increased. When operational turbulence results in inadequate transfers of knowledge, the dependency is further increased. When an organisation is the quasi-parent of many children, those records assume more than ordinary importance. It is an inevitable consequence of poor record keeping that the Council's parental and other 'memories' (e.g. of past suspicions of child abuse which have again become relevant, or the supervision record of subordinate staff) become deficient as time passes. The absence of sound, accessible records inevitably means that decisions made on limited data will also be flawed.

2.53.4. In contrast to the more public paper-work, the Department's routine operational records, and the usage of those records, were often very poor in important respects.

2.54. The Evidence in Support

2.54.1. I have been told of the destruction of meaninglessly organised documents found and destroyed on the departure of officers (1995 - 96). The inability to find documents has, on more than one occasion been explained to me as due to the departure from the Department of the person who had dealt with the subject-matter of the documents. It is as though official documents were treated as personal possessions, rather than Departmental information.

2.54.2. Repeatedly there were no records of important meetings in the response to Alan's disclosure. There was inadequate minuting of the key decisions made in Planning Meetings. A confidential sub-file relating to Alan's disclosure went missing. A set of important correspondence and an obviously-important memorandum went missing within the top-level administrative support system. Important practice documents were out-of-date or of uncertain formal status from their origin (SPR and Appendix 2, Part 2). (to 1999).

2.54.3. Even when important and relevant practice guidance documents were available they were not used, as in the meetings to do with Alan's disclosure (SPR) (1996), and in the assessment of foster carers (Appendix 2, Part 2 below) (to 1999). In both these cases the updating and collation of these important documents was so unsatisfactory as to make them difficult for the uninitiated to use. Routine work practice seems to have been dependent on what, in my youth, was called 'sitting next to Nellie', rather than on instructions contained in Manuals and Procedures.

2.54.4. Important records of past Departmental activities have proved impossible to find. The Department has been unable to find (i) comparatively recent records relating to the supervision of senior employees which I have requested (1999 - 2000); (ii) organised records of such visits as were made to Children's Homes (Appendix 4, Part 2 below) (1992 - 1994); (iii) the file relating to important correspondence exchanged as recently as 1999 between the SSI and the Department (Appendix 2, Part 2 below).

2.54.5. Records of Police checks have been illegally deficient, and Central records have been inaccessible to those assessing prospective foster carers (Appendix 2, Part 2 below).

2.55. Comment

2.55.1. Because the basic administrative support in the Department is so badly organised, every activity is adversely affected.

2.56. Challenge

2.56.1. The challenge to the Council is to ensure that the quality of administrative support is rapidly improved. An intelligent discipline in the creation, use, storage and recovery of bureaucratic records must be adopted at all levels in the Department.

2.57. Sub-Conclusion 10. External Support to the Department from associated Child Protection Agencies has been inadequate

2.58. Introduction

2.58.1. The Council does not have the power to inquire into the affairs of other public agencies, therefore nor have I. Based on the history of the response to Alan's disclosure, I can only express concern at what, from the Council's viewpoint, appears to have been inadequate support from agencies associated with the Department in Child Protection matters. Again, I am in danger of moving unjustifiably from a particular situation to a general proposition, but the indications are too strong to ignore.

2.58.2. The Department was not the only public agency with relevant responsibilities for Child Protection, although it was the leading agency. The ACPC is a forum established in every 'area', including Lambeth, for the local co-ordination of work on Child Protection matters. Such Committees have been in existence since 1988, when they replaced the former Area Review Committees. *"Working Together"* was the title of the founding set of instructions. *"Working Together (2)",* published in 1991, specifically gave the ACPC a mandate to oversee *"a child protection issue likely to be of major public concern".*

2.59. The Evidence in Support

2.59.1. At the time of Alan's disclosure two of the health professionals involved in the discussion of Alan's case were members of the ACPC. The Police would also be represented. From the information given to the first Inquiry about Alan's disclosure I have no impression of the ACPC playing any part, formally or informally, in shaping a response. There could have been informal networking involving the Assistant Director (who was the Chair of the ACPC), about the disappointing failure of the Police to attend the first Planning Meeting. Similarly, one would have expected informal enquiries by the Police and by the two already involved health professionals when there was no evidence of appropriate Child Protection activity by the Department. One of these professionals, a long-serving member of the ACPC, described it to me as *"dysfunctional".*

2.60. Comment

2.60.1. If there had been appropriate, constructive critical concern within the ACPC network, the Department's failure to respond to Alan's disclosure would probably have been exposed and corrected much sooner than by the chance intervention of the Merseyside Police in 1998.

2.61. Challenge

2.61.1. The challenge to the Council is to ensure that constructive inter-relationships are established by the Department with the other agencies in the ACPC.

2.62. Sub-Conclusion 11. SSI monitoring Reports did not directly specify Concerns about managerial Qality

2.63. Introduction

2.63.1. SSI Reports are the subject of comment in Appendix 4, Part 3 below. As with the other agencies to which I referred in the previous Sub-Conclusion, it is not my function to consider the merits of the SSI. However, the lack of emphasis on managerial capacity in its monitoring of children's services during the 1990s is, from the Council's viewpoint, too obvious to miss, whatever the reasons for that lack.

2.64. The Evidence in Support

2.64.1. In the four histories investigated which relate to the Department's operations, the SSI has been, directly or indirectly, involved in every one. The management-related functions of the SSI were clearly set out in its 1994 and 1997 Reports (Appendix 4, Part 3 below), yet the Council's attention was never drawn to managerial deficiencies.

2.65. Comment

2.65.1. The key factor in considering this Sub-Conclusion is the lack of organisational capacity described in preceding Sub-Conclusions which should have been obvious to anyone looking at the quality of work done. This lack of basic capacity was never publicly tackled by the SSI until very recently.

2.65.2. If the signs of organisational incapacity were not missed by the SSI, its dealings with the Council can only be described as politically pusillanimous, until the SSI Report on Mental Health services was reported to the Social Services Committee in January 1999. There is a telling comparison between the methods which were normally used by the District Auditor to inform the Council and the public, and those used in Lambeth by the SSI prior to 1998/1999.

2.65.3. If a Department has sufficient organisational capacity to respond positively to understated monitoring, quiet monitoring processes may work well. Such an approach may minimise professional defensiveness and morale-sapping, exaggerated public criticism. If, as in Lambeth's case, a Department obviously and repeatedly lacked such capacity, it is disappointing that this was not demonstrated to the Department's superiors by way of SSI report to the Committee. The apparent optimism of the Department's ready acceptance of criticism, and its detailed *"Action Plans"* in its responses to the Committee, would then more likely have been exposed to influences outside a closed professional circuit.

2.66. Challenge

2.66.1. The challenge to the Council is to press the Local Government Association to monitor, with the Department of Health, the SSI's monitoring of professional work, so that it adequately takes into account the constitutional arrangements of a local authority.

PART 3. RECOMMENDATIONS

3.1. Introduction

3.1.1. The fifth Term of Reference of the first Inquiry invited me "*To make recommendations as to any amendments to procedures and practices of the Council that will ensure the proper care and protection of children and young people in the Council's care."* The preamble to the second Inquiry implied a similar invitation (see sub-section A1.10 below).

3.1.2. Both these Inquiries began with concerns which the Council had about the quality of particular strands of Lambeth's past social work carried out by the Children and Families Division of the Council's Social Services Department. According to the two basic Conclusions set out in paragraph 2.3.3. above, the identified weaknesses do not lie in Lambeth's formal structures, policies or documents. Nor do they lie in the intentions of the Council, its managers and workers.

3.1.3. The two Conclusions, which are amply supported by the facts, specify a general organisational incapacity which is rooted in an informal Departmental work culture. This culture causes an insidious corruption of standards of work. Abnormally poor standards rule the working life of the Department, and obstruct the achievement of properly directed outcomes. The implementation gap is a chasm. Similar consequences are therefore very likely to continue, unless a proper organisational integrity is established and sustained. This Report's Recommendations concentrate on that essential quality.

3.1.4. The first Recommendation flows from the major organisational criticism of this Report, which the Council will receive, I understand, as other Reports on its Social Services Department's work are received.

3.1.5. RECOMMENDATION 1: The Council should take the time needed to read and digest the Reports, before responding.

3.1.6. There will be a temptation to spin an immediate response, but the situation requires a thoughtful response, carrying wide support across the Council so far as possible. The credibility of the Council as a provider of an important public service is at stake.

3.2. The general Nature of the Recommendations

3.2.1. The following Recommendations are not detailed prescriptions, and their generalised nature may be disappointing to some readers. The emphasis on organisational incapacity is not such as can be dealt with by a series of ad hoc suggestions. Management is not about following detailed prescriptions; it is about taking risks and making compromises to achieve the results which those investing resources in the service intended.

3.2.2. I am wary of Inquiry recommendations of a detailed operational nature, for three reasons:-

(1) Although the scope of the two Inquiries has proved wider than their origins suggested, detailed recommendations about social work could only properly flow from the investigations in relation to a small part of the Department's activities. The two original concerns came to the Council's attention in an unplanned way, and detailed Inquiry recommendations could easily distort their relative importance.

(2) An Inquiry's method of operation is more concerned with establishing history than working out sensible practical solutions. Inquiries and management consultancy necessarily have different optimal methods. The role of inquisitor is too distant from current intense, continuous activity to support a series of specific recommendations relating to detailed practice.

(3) Detailed Inquiry recommendations encourage a bureaucratic response by senior decision-makers. This is a report to the Council, and operational detail is largely inappropriate for that level of decision-making. To ask the Council to approve a series of operational decisions would contradict the basic recommendations of the Report about developing managerial values. What is needed is a robust directional and managerial response to the broad situation.

3.3. The Council's Reform Programme

3.3.1. The first Conclusion of fact set out above was:-
"1. The Council, through its inadequate arrangements in the Social Services Committee, the Department and the Division, has repeatedly failed to fulfil both its statutory duties and its own policies relating to the care and protection of children;"
The Council has, it is clear, already accepted the challenge of this first conclusion, and determined, comprehensive reform is already taking place.

3.3.2. The Council is now engaged in a programme of extensive and thorough monitoring of its social work, accompanied by structural and process changes at related political, managerial and operational levels. In these matters the Council is receiving detailed advice from authoritative sources. I see no advantage in adding to this detailed advice, the sources of some of which are set out in Appendix 4, Part 4 below. I must leave it to those working on the reforms relating to professional practice to report on what is happening.

3.3.3. In addition to reforms relating to the subject-matter of the two Inquiries, the Council has also reformed its formal decision-making structure. There is now so much activity in reforming the Council's organisation that I have not been able to keep up with all the developments whilst writing this Report. My very general understanding of the Council's new decision-making structure encourages me to think that, properly developed and used, it can provide an effective basis on which to implement much of what follows in this Report.

3.4. The Need for continuing Council Supervision

3.4.1. What follows in this Part of the Report can only be helpful insofar as the Council also accepts the second Conclusion, set out in paragraph 2.3.3. above, as an essential focus for its continuing normal supervision of the Department's work. The second Conclusion of fact was:-

2. The Council has repeatedly tried during the past decade, but repeatedly failed, to re-create and control an effective Department and Division."

3.4.2. Whilst these two Conclusions are fundamentally important, they are not helpful for the task of generating present and future practical measures. The essential task, broadly stated, is to move the 'critical mass' of the Department's ethos into a properly professional mode, involving managers and workers alike. This necessarily involves the Council's methods of direction. Taking a more organisationally practical view of these Conclusions, I translated them into the third Conclusion, and a related Challenge:-

"3. The Council's executive Chain of Command (assuming it once existed) linking departmental Action to the Council has decayed and disintegrated.

The challenge to the Council is to establish and sustain a properly focussed formal and informal organisation, which can deliver on properly determined targets and priorities."

3.4.3. I cannot over-emphasise the importance of this third Conclusion and the related Challenge. It follows that any Recommendations should relate to it. This Challenge concentrates on the linkages between the Council, as the prime source of authority and responsibility, and the activities carried on in its name by the Council's Social Services Department, and by the Children and Families Division in particular.

3.4.4. In Part 2 above I developed the significance of this third Conclusion through eleven over-lapping Sub-Conclusions, each flowing from evidence of the underlying organisational weakness of the Division's work. As with the Conclusions, each of these Sub-Conclusions was a product of facts revealed in the investigations, and each ended with a 'Challenge' to the Council. These Challenges, whilst sounding extremely boring and jargonistic, do focus on specific weaknesses which need attention. They are not an 'Action Plan', of the kind which was traditional in Lambeth. Working out the detailed implications of the Challenges is a task for different levels of management, from the Council to the supervisers of front-line workers.

3.5. Observations

3.5.1. The Terms of Reference were not designed to address the general management of the Department. At the risk of going beyond the Terms of Reference I have added some Observations to each Recommendation which, whilst limited in subject-matter to the scope of the investigations, are based only in part on them. Inevitably, the Observations are more the product of my general experience of local authority decision-making over the past 40 years and more. These observations therefore do not flow inevitably from the Inquiries' investigations in the way that the Conclusions, the Sub-Conclusions and the Recommendations do, but they are sparked by those investigations. They are not comprehensive, but I hope that they will help the Council to understand the potential of the brief, generalised Recommendations. I have therefore concentrated mostly on matters of importance at Council-level decision-making.

3.6. The Challenges

3.6.1. At the risk of being irritatingly repetitious, I now set out the Challenges presented by the Sub-Conclusions in Part 2 above, as a basis for making Recommendations.

3.7. Challenges - The Council's Decision-making

3.7.1. The Challenges from the first four Sub-Conclusions had particular relevance to the Council's own level of decision-making in the executive chain of command. These were:-

1. *"to ensure that its new system of democratic control is effective in practice."*
2. *"to make its documented aspirations more closely related to clearly exposed operational realities."*
3. *"to manage continuity between realistic choices on the fulfilment of its responsibilities and the conflicting sub-agenda of its subordinate organisational arrangements."*
4. *"to ensure that both the Council and the Department have a robust capacity to learn from the results of external and internal monitoring."*

3.8. RECOMMENDATION 2: The Council should regularly review its decision-making arrangements to ensure that it is in control of the activities carried out in its name.

3.9. Observations: (1) Two Themes from the first four Sub-Conclusions

3.9.1. The first four Sub-Conclusions, and their related Challenges, hold two themes which link Council level decision-making and the actual achievement of the intended results: (i) the appropriateness of material for decision-making at a given level; and (ii) the balancing of aspirations with realities. I am advocating the creation of an information feedback loop in which practice and policy interact in the community's interest. What follows may all seem very obvious. Its obviousness, however, has not been influential in the historic material I have read during the investigations. If, as I confidently hope, present practice is now better, the Council must safeguard and extend the improvement.

3.9.2. I am aware that the Council has recently paid considerable attention to its decision-making processes, and I must make it clear that I have not examined the results as part of the Inquiries' work. I understand that the Council has now divided the collective functions of Councillors, whilst operating within the full Council's overall control, between Executive and Scrutiny functions. This is a potentially helpful division in organising support to proper and sensible Council decision-making.

3.9.3. Many of the following observations will probably already have been taken into account. My justification for making them is two-fold:-
(1) they might not have been; and
(2) review of decision-making should be constantly cyclical.
Like all machines, the democratic decision-making machine needs constant servicing, renewal and repair. It is a Council product in its own right.

3.9.4. The processes of decision-making in any organisation are often ill thought out. In a democratic body there are additional tensions, beyond those arising from managerial requirements, which have to be accommodated. This gives all the more reason to think consciously about the value of time spent in decision-making, and the need to ensure that it is effective. If the processes can be imagined as pipe-work, their efficiency and effectiveness are obviously separable subjects from the content passing through them.

3.10. Observations (2) Mutual Trust

3.10.1. Decision-making processes can only be described in mechanical terms. Yet, as with all organisational arrangements, the most potent influence on the quality of decision-making is the extent of the trust which the people directly involved have in each other. The formal arrangements are secondary to the need for a strong, informal network. Such a network should enable appropriate material to be selected for consideration at different levels of decision-making. On the basis of the Council's decisions it should also give clear top-down direction, balanced by genuine consultation and accountable freedom to achieve.

3.10.2. In the subject-matter investigated, the real commitment of many of the people involved, to safeguard and promote the welfare of children, had been submerged by the dominance of other, less important, agendas. In a world of political and financial competition, of individual reputations and competitive careers, of unrealistic public aspirations and scant public appreciation, it may be naïve of me to assert the primacy of such a commitment above all these others. However, it is the reason why the relevant public services exist. In the absence of mutual trust related to a common commitment, information will not flow. If information, when given, is abused, editing will in future take place. If information does not flow to those making and implementing decisions, results will be poor. If results are poor, the public services are deficient.

3.10.3. I hope that all the people involved in the decision-making processes will reflect on this. Given such primacy of commitment, any system can be made to work reasonably. Given such primacy, informality can more efficiently carry much of the load. Without it, even the best systems will be distorted to promote the incidental agendas of the people involved. The new start now so evident in the Council's recent decisions about children's services provides a good opportunity to build mutual trust within the Council and the Department.

3.11. Observations (3) Appropriateness of Business

3.11.1. The elected members of the Council collectively are the means whereby the Council principally exercises its powers and duties. If the full Council is to direct and supervise all the activities carried out in its name effectively, the Council's business and supporting information must be chosen carefully, and all subordinate business rigorously delegated to appropriate subordinate levels. This has always been the case in theory, but rarely in practice, in Lambeth and in many other local authorities.

3.11.2. Delegation to Executive Councillors, under the new Local Government Act, or to officers, is a means of enabling the Council to concentrate on essentials. Sensibly implemented, it strengthens managerial capacity without derogation from the Council's primacy on direction.

3.11.3. Subordinate business, inappropriately dealt with at too high a level, wastes the time of Councillors and of senior managers, and is a distraction which cannot be afforded. There is no time left in which to examine general policy and strategy if managerial and operational detail is subjected to an alien process of discussion at too high a level. Further, the impact on the more appropriate decision-making levels distorts and confuses the chain of command.

3.11.4. All Councillors should be prepared to question the appropriateness of the business they are asked to transact, but a particular responsibility falls on the Party spokespeople who lead on behalf of their respective Groups. An informal protocol is important, to help channel ideas and frustrations in an organised, but constructive, way.

3.11.5. The Council is presently facing up to the past failures of its children's services. A particular challenge for the Council's future decision-making processes will almost certainly be a succession of emergencies and embarrassments, which will haunt decision-making as ghosts from these past failures turn into practical realities. Firefighting will continue to be a major call on management time. Given the catharsis of recent months, there is little need to deal formally with each of these incidents at the highest levels. Many will best be dealt with under formally delegated powers within agreed boundaries, based on realistic management information. For example, compensation for individual victims of the Council's past failures, or exception reporting of current, isolated operational failures, can then be dealt with efficiently and relatively informally, provided trust is given and honoured.

3.12. Observations (4) Avoiding Unreal 'Utopianism'

3.12.1. Democratically elected Councils are much more than machines for providing public services. They rightly seek to reflect local concerns, and to use their service provision powers accordingly. Lambeth is subject to considerable social stresses, and the Council has reflected these in its policies. From what I have been told, an unreal 'Utopianism' in the Council's past policy-making has contributed to the collapse of the Department's capacity.

3.12.2. It is an important part of democratic politics to assert the need for what is perceived to be highly desirable. There is nothing wrong, of itself, with the adventurous pioneering of hitherto untried responses to acute local needs. One of the advantages of local democracy ought to be a more rapid response to locally perceived changing social conditions than the national level can achieve. The development of organised public responses to social needs relied on such pioneering, through local legislation, from the Municipal Reform Act 1834 to the 1950s. Lambeth has, I am told, pioneered several such responses over the years, not least at a professional level in social work.

3.12.3. Unfortunately, even where there is wide political agreement on what is highly desirable, such as the elimination of child abuse, its achievement may be difficult, or even impossible, to achieve in practice. What is quite clear is that passing resolutions, even about achievable objectives, achieves very little unless those resolutions are accompanied by managerially sound ways of practical achievement. Such superficiality is what I mean by Utopianism. I have been told that the Council very strongly asserted Utopian ideals, without sufficient regard for practicalities. Alan's care history is a case in point. The subject matter of sub-section 3.22. below is also relevant.

3.12.4. If Utopianism is too stridently asserted by the Council, the reality of failures to achieve Utopia will continue to be strained out of the information coming before the Council. The embarrassment of operational failure will result in conscious or unconscious censorship at several levels of management. The consequence will inevitably be an organisational failure to learn from failure. To put it in a more up-to-date way, political or managerial spin to minimise failure will have a heavy price tag attached. Council direction must be informed by realistic assessment of practicalities.

3.13. Observations (5) Priorities for Council Level Decision-making

3.13.1. There are five standard priorities to be observed in recognising the realities which surround Council level decision-making:- (1) the trends in social behaviour which relate to the service provided or to be provided in response; (2) the availability of finance to fund the continuing or developing responsive service; (3) the availability of skills to implement decisions; (4) the availability of the relevant legal powers needed by the Council; and (5) the measured results achieved against measurable targets. All need realistic information flows from the relevant organisational links in the chain of command.

3.13.2. To these five headings must be added a sixth - reporting mistakes and failures. Public accountability adds to the importance of this subject for a local authority. At present information flows up and down the management line are poor, and the reasons why mistrust over the admission of failures is a feature of Lambeth's work culture need to be understood. If they are understood, effective safeguards in proper cases can be provided, which will encourage the more timely reporting of failures to appropriate levels of management.

3.13.3. The first (trends), the fifth (targets), and the sixth (reporting failures) of these priorities are most likely to provide difficulty. There is an existing accumulation of professional experience relating to finance, law and - to a lesser extent - human resources, to help deal with the second, third and fourth. However, without attention to such information I do not see how the Council can hope to achieve the quality and relevance of services which it wants to achieve.

3.14. Observations (6) Trends

3.14.1. In determining directions for executive action, assessments will have to be made of future situations. Forecasts are rarely exactly right, but that does not mean they should not be attempted. Organisational adaptation to changing needs will never be smoothly (i.e. economically, efficiently and effectively) achieved unless the Council's directional decision-making gets ahead of present situations. Crashing through the gears to end Council-run Homes, or substantial budget overspends, may have been necessary in the past, but it is not a desirable way to run an organisational machine. A useful discipline is to establish what is known and what can reasonably be discovered, to provide a basis for extrapolation. What cannot reasonably be discovered indicates the scale of risk in the forecast, which can be monitored. Arrangements to deal with future organisational problems can then be made, resulting in a more manageable task.

3.15. Observations (7) Targets

3.15.1. Experience of target setting will usefully accumulate if tolerance during the learning process prevails. Setting, and checking the achievement, of targets can easily turn into an inadequate exercise about numbers. This is especially so at the level of supervision of front-line work, where commitment, empathy and concern should be allied to the varying weight of what, by definition, are complex individual cases. However, at Council level, broad statistical analyses of the reality of achievement should be required.

3.16. Observations (8) Reporting Failures and the new Scrutiny Function

3.16.1. I referred in the last paragraph to the Council's function of setting achievable targets. I refer to the related Departmental function in paragraph 3.21.2. below. The development of a Councillor-level scrutiny function provides a much-needed opportunity for the periodic, detailed, monitoring of performance which has been so disastrously absent in the past.

3.16.2. The independence of the new Scrutiny function, responsibly used, will be an important asset to the Council. The tired old system which had become traditional in local authority Committees, in which Party loyalties dictated knee-jerk responses to knee-jerk criticisms, can be replaced with more powerfully reasoned and constructive comment and debate. The misleading nature of 'spin' by those controlling both the action and the information can be reduced.

3.16.3. Scrutiny can be informed by appropriately collated management information, by individual Councillor insights, by internal and external professional monitoring (Appendix 4 below) and, as a last resort when other systems have failed, by 'whistleblowing'. But monitoring should not merely be criticism, by those who sit on the side-lines, of those who have had to make difficult on-the-spot decisions. It is also a potentially useful part of a learning process, if the organisation is to amend its deficiencies and keep up with changing social patterns.

3.16.4. Empathy is as important as objectivity. The Waterhouse Report *"Lost in Care",* dealing with child abuse in Children's Homes in North Wales during the 70s and 80s, published in February 2000, has made two relevant recommendations. Recommendation 8 is: *"Every local authority should establish and implement conscientiously clear whistleblowing procedures enabling members of staff to make complaints and raise matters of concern affecting the treatment or welfare of looked after children without threats or fear of reprisals in any form."* Lambeth, I understand, already has such procedures, but procedures on their own are of limited effectiveness. The effectiveness of such a recommendation depends as much on a general atmosphere of constructive use of criticism as on formal rules.

3.16.5. Recommendation 9 deserves support. This is: *"Consideration should be given to requiring failure by a member of staff to report actual or suspected physical abuse of a child by another member of staff or other person having contact with the child to be made an explicit disciplinary offence."* It is surely an inescapable part of the normal responsibility of any employee of an organisation having the care of children as its function to make such a report.

3.16.6. There is a danger in over-investing in external sources of scrutiny information. By far the major part of monitoring should be carried out internally by managers in the normal course of their supervision. The Council will have to be careful to reduce the diversionary effects of unnecessary external monitoring as confidence in new systems of internal monitoring grows. Unfortunately, the Council's failures have been so profound that external monitoring is inevitably heavy at present. The Executive function is in danger of being overwhelmed by monitors. Managers are having to spend so much time responding to questioning that they are likely to have inadequate time to manage. Given the further extra demands on management imposed by the state of the chain of command, a sensibly limited programme of monitoring in the near future is advisable. This should be based on carefully-chosen priorities, and a proper balance between internal and external monitoring systems.

3.16.7. It is worth noting that the separate subject-matter of the two Inquiries came to the Council's attention from internal, not external, sources. Given the gap which has existed between precept and practice in Lambeth, the Scrutiny function should pay particular attention to the quality of internal performance measurement, and the part it plays in the Departmental flows of management information.

3.16.8. Some further sources of reliable data for the Social Services scrutiny function are referred to in this Report - (i) SSI and District Audit Reports; (ii) national Guidance and regulation; (iii) the observations of those now associated with the work of the Department set out in Appendix 4, Part 4; (iv) the ACPC; and (v) results from internal monitoring. 'Best Value', the 'Quality Protects' Agenda and the Department of Health's Performance Assessment Framework, I am advised, provide further sources.

3.16.9. Another particularly challenging role for those involved in Scrutiny could be that of identifying new needs in a constantly changing society, and challenging the continuing priorities of well established services. Services fossilise, as they develop powerful pressure groups of supporters, beneficiaries and staff. Their continuation may be obviously, unarguably desirable. The danger is that their uncontested use of limited resources prevents the meeting of greater social needs.

3.17. Executive Management

3.17.1. If these priorities for Council decision-making are properly attended to, most of the intermediate steps between Council decisions and implementation can properly be left to Departmental management, linked to the Council through the new Executive Councillor and Cabinet arrangements.

3.17.2. If they are properly attended to, they will test the ability of those in positions of political and executive leadership. The financial implications of the failures dealt with in this Report, and elsewhere, already pose a considerable challenge. It is unlikely that the financial implications of these past failures can be met without painful adjustments to the Council's Budget. Already these include the cost of providing secure foster homes to replace the ones which have had to be abandoned, the strengthening of management, the training of staff with potential, the replacement of staff without potential, the temporary expansion of external monitoring, and the implementation of the recommendations which will continue to flood in from advisers and monitors.

3.17.3. The personnel implications are particularly severe. Although individual criticism plays only a minor role in this Report, the scale of incompetent work inevitably raises managerial questions of significance. Managing incompetent employees effectively, and with due regard to the proper dominance of the Department's purpose, will inevitably raise issues to the Council's attention. How the Council responds will, in large measure, determine the progress of reform.

3.18. Challenges - Departmental Management

3.18.1. The Challenges relating to the next five Sub-Conclusions are mainly about Departmental links in the overall chain of command:-

5. *"to strengthen the arrangements which ensure that the Departmental agenda determined by the law and by the chain of command from the Council dominates all sub-agendas within the Department affecting professional practice."*

6. *"to encourage a decision-making process in which 'managers' are empowered to manage the implementation of approved directions in a succession from Council to front-line worker."*

7. *"to invest in managerially relevant supervision, as a normal part of the appraisal of all its employees' performance, and of the provision of important management information."*

8. *"to create a Departmental appraisal system which openly provides a basis for the management of individual and group work and the assessment of achieved results in accordance with the Department's legally and politically determined priorities."*

9. *"to ensure that the quality of administrative support is rapidly improved. An intelligent discipline in the creation, use, storage and recovery of bureaucratic records must be adopted at all levels in the Department."*

3.19. RECOMMENDATION 3: The Council should include in its programme for the revival of the Department provision for management counselling.

3.20. Introduction

3.20.1. Matters will not be put right by a prescriptive list of things to do. There are, however, two topics additional to the specific recommendation about management counselling on which comment may be helpful.

3.21. Observations - (1) Management Counselling

3.21.1. These Challenges state the obvious. They relate to the practice of management largely irrespective of the context, whether of local government or of social work. They assume that the Council's own decision-making will enable management to manage. But the Departmental managers, however skilled they may be, will benefit from some discreet, objective advice as they develop new systems, determine organisational priorities and balance organisational needs with ongoing service demands.

3.21.2. Perhaps the most difficult challenge for Departmental managers is one which cannot be described in mechanical organisational terms. This is to balance a zero tolerance of inadequate work with sensitive insistence on improvement, using a range of options, as appropriate. These can range from a mild suggestion to dismissal. A managerial culture cannot be created by decrees from on high. Support for intermediate management is as important as that for senior management.

3.21.3. There is a further point. A local authority should take seriously the relationship between its workforce, including management, and the local population. Growing potential professional leaders should be an inherent objective. Developing a capacity to integrate local people into the workforce properly requires an understanding of management which skilled advisers could promote. Investment of this kind is always valuable. Such advice will cost money, but carefully selected advisers will, I am confident, prove cost-effective.

3.22. Observations - (2) Reflecting the local Community in the Workforce

3.22.1. This is a vitally important subject for the Council, which is inextricably linked with that of the previous paragraph. It is also a sensitive subject, but perhaps as a stranger I can perform a service to all by being blunt. The Council is a very significant local employer, and local politics has an appropriate concern that the workforce profile should reflect the diverse and heterogeneous community profile. If this concern is not to be another Utopian ideal, strong on words but weak in practice, it will need specific, direct and ongoing management.

3.22.2. Although they are now raised in this part of the Report as incidental to the Terms of Reference, and have not been actively pursued in the Inquiries' investigations, institutional racism and prejudice are dimensions of organisational health which have been unavoidable. To make no mention of them would be a dereliction of duty on my part.

3.22.3. Local recruitment, unsupported by adequate training, encouragement and supervision, will have a negative effect on both the professional standards of the workforce, and on the concomitant quality of service to the public. What begins as a proper practice of anti-discrimination becomes, over time, discriminatory. The very workers encouraged to join the organisation to reflect the local community are then deprived of professional development. This, in turn, inhibits their employment prospects by way of promotion internally, or to another organisation. It follows as a necessary consequence of the weakness of management exposed in this Report, that the professional development of the workforce has also suffered.

3.22.4. I, and my advisers, have listened very carefully to those who brought information about the Inquiries' subject-matter to us. The following perceptions were expressed during oral hearings. We have not investigated their truth, but are satisfied as to their existence.

(1) A sense of isolation, or fear of being thought racist, or disloyal, appears to have inhibited some professionals from raising concerns about poor standards of work by members of other communities.

(2) Professional scrutiny has been experienced and/or expressed as racist when not clearly applied to all similar professionals in the same way.

(3) Reductions in numbers employed have been perceived as achieved in racist ways.

(4) Relationships between employees of different race have been perceived as tense and polarised.

3.22.5. Because these perceptions and resultant tensions, both of which are undeniable, have existed and exist, they represent a serious obstruction to professional service management and delivery. That management of this sensitive subject is under-developed is not surprising, given the comments on the weakness of management in the Department referred to throughout this Report, and the general slowness in British institutions to recognise the unprofessional nature of racism.

3.23. Observations - (3) Management Information

3.23.1. There is no point beating about the bush. Appropriately collated management information has rarely been readily available to the Inquiries, because it does not exist. If there is no chain of command, it is hardly surprising if the different needs for information of different levels of decision-making are unmet. Investment in the collation of information is a necessity, if a new management structure is to be able to function effectively.

3.24. Challenges - Contributory Ineffectiveness

3.24.1. The Challenges relating to Sub-Conclusions 11 and 12 are about important contributory ineffectiveness involving other public bodies. They translate without more ado into a Recommendation.

3.25. RECOMMENDATION 4: The Council should:-

(1) ensure that constructive relationships are established by the Department with the other agencies in the ACPC.

(2) press the Local Government Association to monitor, with the Department of Health, the SSI's monitoring of professional work, so that it adequately takes into account the constitutional arrangements of a local authority.

3.26. Observations - The ACPC; the SSI

3.26.1. It is now for the ACPC to establish public confidence that 'Working Together' in Lambeth is not just the title of a series of national Reports. The ACPC reports annually to the Council on its work of Child Protection, and the Social Services Department is still the leading agency in the ACPC. Improvement will depend in part on the confidence which the other agencies can now repose in the Council's organisational capacity. In part it will also depend on the confidence which the Council can now repose in the other agencies. The need to strengthen the status and work of the ACPC is clear.

3.26.2. The idea of an independent Chairperson is, I know, being discussed. The choice of a sufficiently strong, respected, leader will be critical. It would reduce the present heavy burden on the Assistant Director (Children and Families), whilst providing a new focus of leadership for the various agencies. It will be a tough job. Perhaps by raising the possibility I can ease the task of considering it.

3.26.3. Appropriate Councillor links with the monitoring work of the SSI need to be established, nationally and locally. Any intermediate challenge by the Department (a necessary part of the local process) must be carefully controlled to avoid the 'massaging' of criticism before the Council is publicly informed.

APPENDIX 1.

THE SCOPE OF THE TWO INQUIRIES

A1.1. Appointment

A1.1.1. I was formally appointed by the Council on 15th December 1998 to conduct the first Inquiry. This essentially has been about the poor response made by the Department in 1996 to a disclosure of abuse by Alan, and which involved the background of his poor general care. I was formally appointed by the Council on 8th November 1999 to conduct the second Inquiry. This has been about the poor practice of the Department to carry out adequate assessments of foster carers. The precise Terms of Reference of both these Inquiries are set out in this Appendix.

A1.2. My Appreciation

A1.2.1. Ms. Gerrilyn Smith has acted throughout as my specialist Child Protection adviser. Her continued support has enabled me to understand the significance of the evidence, despite its complexity for me. I am grateful to the Council for providing me with a further Adviser for the second Inquiry, Ms. Sybil Roach-Tennant, whose complementary knowledge and direct experience of Departmental Social Work relating to children has also been invaluable. I have been guided by the application of their considerable experience. This has been unstintingly made available to me. Brief details of their backgrounds, and mine, are given on the Report's back page.

A1.2.2. I again express my gratitude to the Council, and to its officers. Mr. Tim Stephens has carried the burden of both Inquiries' administrative support, in addition to his existing workload. My frequent requests to him for interview and meeting arrangements, minutes, records and general information have invariably been met with good natured generosity. Without his commitment, efficiency and persistence, the Inquiries' work would have been delayed, and my task made much more difficult.

A1.2.3. I am grateful for all this support, but must take sole responsibility for this Report's contents. However, my two advisers both wish openly to be associated with the Report's basic message of criticism, and of the need to create a managerial capacity which enables social workers to carry out their very difficult tasks.

A1.3. Contemporaneous Influences on the two Inquiries

A1.3.1. The Inquiries have not taken place in a vacuum. Operation Middleton (paragraph 1.2.2. SPR) is a joint Metropolitan Police and Council investigation, staffed independently of the Council. It was established in November 1998, at the same time as the first Inquiry. It is investigating allegations of the abuse of children who were in the Council's care between 1974 and 1994 (when the Council closed the last of its residential Children's Homes managed through the Children and Families Division's predecessor Divisions). Alan's time in the Council's care, and his disclosure of abuse, also come within Operation Middleton's Terms of Reference. The much greater scale of Operation Middleton should provide a wider basis for detailed recommendations about relevant social work practice than the two Inquiries which are the subject of this Report.

A1.3.2. The main factual findings of the first Inquiry were published in September 1999, when SPR was presented as an interim Report to the Council. Even though the first Inquiry was then incomplete, SPR was substantial and detailed. The Council was thereby enabled to pursue its concerns about the Children and Families Division on a firmer basis. At its meeting on 15th December 1999, the Council approved a series of motions relating to children looked after by the Council. In introducing the debate the Leader's report (page 382) stated: *"We fully recognise the depth of the Council's failure so graphically illustrated* [by SPR] *and have acted upon the report …"*

A1.3.3. A joint review of the Department by the SSI and the Audit Commission commenced in April 2000. Such a review is intended to provide an independent assessment of how well the public is served by the Council's Social Services activities as a whole. The joint process is designed to involve the Chief Executive and Councillors, as well as users and the Social Services Department, in the evaluation. This contrasts with previous practice (Appendix 4, Part 3 below), and I welcome the wider skills base and emphasis of such a review. Again, it will provide a more appropriate basis for detailed social work recommendations than this Report could properly provide.

A1.3.4. It is clear from the Department's Position Statement of March 2000, prepared for the Joint Review, that there is no need for me to continue to press the Council or the Department for recognition of its past social work failure. A major objective of any Inquiry, to promote political and professional concern in response to any inadequacies revealed by that Inquiry, has already been achieved during the course of these two Inquiries.

A1.3.5. In addition to Operation Middleton, the Joint Review and SPR, several other investigations and continuing monitoring processes have resulted from the Council's current concerns about its children's responsibilities. Some of these are listed in Appendix 4, Part 4 below.

A1.3.6. The Council's expressed concern on behalf of the public, the Department's consequent intense programme of reform, the broad sweep of Operation Middleton and the potentially joined up process of intense monitoring by the Joint Review, have all encouraged me to be selective about the emphases of this Report in response to the Terms of Reference set out in below.

A1.4. Local independent Inquiries

A1.4.1. I have been aware, from the beginning, of the need to confine the scope of the Inquiries to what was strictly necessary to fulfil the spirit of their various Terms of Reference. The function of an Inquiry is to examine the past with great care, taking into account the advice of relevant experts. The situation thus robustly disclosed can then be confronted by current management. The method, however, is neither expeditious nor user-friendly! The working method of an Inquiry is not the most efficient way of achieving improvements in organisation or in social work practice, and the associated cost is considerable. Any Inquiry should be rigorously confined.

A1.4.2. My decision to limit the scope of the Inquiries to what was strictly necessary was made directly as a result of my own reviews of the purpose and workload of the two Inquiries. Subsequently, I read the Lambeth Inquiry Report of Miss Elizabeth Appleby, Q.C., dated July 1995. That Inquiry had a much wider scope in relation to the Council's affairs than my own Terms of Reference, but its focus was on the breakdown in organisational arrangements which has also become the focus of this Report. The Appleby Report provides support for the strategy I have followed in limiting the scope of the Inquiries. This is shown by the following extracts:

"19. The difficulty that Lambeth faces if it is to turn over each and every stone to discover whether or not a particular fraud or abuse of the system took place is that such action can be very expensive, time consuming and ineffective. ….

97. … What is so surprising is that many of the defects in Lambeth's administration have been identified time and time again by internal audit, by the District Auditor and by independent Reports. …….. The time spent by officers and resources used for looking into the past is considerable, and means that less time and resource is available to improve the future. ……"

A1.4.3. In his Management Letter to Members of December 1995, the District Auditor agreed with *"Elizabeth Appleby's view that it is now time to draw a line under the problems of the past".* I, too, endorse that advice. The Council must accept that its history is of an incompetent organisation for well over a decade in the 80s and early 90s. A robustly broad and sensible view must be taken about continuing to use limited resources in discovering and recording the details of that breakdown. The present task is to put things right.

A1.5. The first Term of Reference.of the first Inquiry

A1.5.1. This was: *"1. To examine the Council's response to any allegations of abuse made by XXXXX* [i.e. Alan] *about* [Steven] *Forrest during and after his appointment* [as a social worker in Lambeth]".

A1.5.2. This dominant first Term of Reference was concerned only with the Council's response to any allegations of abuse by Alan. Steven Forrest was appointed by Lambeth as a residential social worker in 1981. Alan was received into care in 1984. In the course of the first Inquiry I therefore initially examined the recorded history of Alan's care by Lambeth, from 1984 to 1999.

A1.5.3. Only in this way could I note any recorded allegations of abuse which might have been made by Alan about Steven Forrest, and examine the Council's responses, as required by this Term of Reference. The outcome was stated in paragraph 6.3.2. SPR: *"I am not aware of any reliable information that Alan had previously* [to January 1996] *disclosed the abuse in* [a] *specific way to an adult, and consider it to be extremely unlikely that he had done so."* My response to the first Term of Reference was therefore, in the end, confined to the one disclosure made by Alan in 1996, and the Council's grossly inadequate response to it. The succeeding Terms of Reference should similarly be controlled by that limitation. I accepted this by examining and reporting in SPR on Alan's 1996 disclosure in much greater detail than the history of his general care.

A1.5.4. Some minor amendments relating to the findings of fact in SPR are made in Appendix 2, Part 1 below. Otherwise, this Term of Reference was discharged by the contents of SPR.

A1.6. The second Term of Reference.of the first Inquiry

A1.6.1. This was: *"2. To refer any allegations of abuse made by XXXXX to the police."*

The Police were already aware of Alan's one allegation of abuse when the first Inquiry began. No further action, therefore, has been necessary under this Term of Reference.

A1.7. The third Term of Reference.of the first Inquiry

A1.7.1. This was: *"3. To identify any failure to comply with legal requirements, established good practice and procedures of the Council at the time."*

A1.7.2. SPR described Alan's specific disclosure, and what had happened (or, more particularly, what had failed to happen) as a result. It expressly concluded that the Council had failed specifically in relation to his 1996 disclosure of abuse (e.g. Main Conclusions on Section 6, nos. 2. and 3, Main Conclusions on Section 7, nos. 1. and 3, and Main Conclusions on Section 8, no. 1. SPR).

A1.7.3. The phrase *"any failure … good practice"* is a wide one, and it provided a useful cover for the wide scope of SPR. The first Inquiry began in December 1998. I was soon troubled at what I was discovering, as I explored Alan's care history to see if there were earlier allegations of abuse by Alan than that of 1996. I decided to make the Council aware of the organisational incompetence which had clearly occurred during that time, and the wider and continuing consequences which caused me irrepressible concern.

A1.7.4. It was, in my view, a situation too serious to be ignored, even if it was outside the strictly construed scope of the Terms of Reference, following the defining role of the first Term. In practice an unsupported, informal expression of concern would have been of limited assistance to those with power to effect necessary changes. Insofar as the damning conclusions were to be useful I had to provide, as quickly as possible, irrefutable evidence in support. Those willing to amend the situation could then more clearly understand the problem and cope with any opposition to their amending initiatives.

A1.7.5. This was a managerial, rather than an inquisitorial, reaction, based on many years of local government experience. It was not what I was specifically employed to do, and I am embarrassingly aware of that. On 13th May 1999 (sub-section 1.5. SPR), following informal discussion with her over the previous month and a half, I formally expressed my deep concern to the Chief Executive *"about the continuing fractured and ineffective practice of Child Protection by the Lambeth Social Services Department"*.

A1.7.6. SPR followed in September 1999. SPR referred to a history of unintegrated Child Protection activity (e.g. Main Conclusions on Section 4, no. 4, Main Conclusions on Section 5, nos. 4 and 5, Main Conclusions on Section 6, no. 5 and 6, and Main Conclusions on Section 7, nos. 2. and 3. SPR). It also described the Council's failure to look after Alan in accordance with its statutory duties and its own declared policies (e.g. Main Conclusions on Section 4, 1 - 3, and on Section 5, no. 1. SPR).

A1.7.7. Furthermore, SPR stated that these failures were not isolated from the general work and history of the Department, but indicated an appalling scale of historic organisational incompetence (sub-section 2.2. SPR). The history of the Department's dealings with Alan strongly indicated that wider and deeper reform was needed than just in relation to a particular episode of Child Protection. *"any failures"* etc., as referred to in this Term of Reference, were thus identified in SPR as part of a greater problem.

A1.8. The fourth Term of Reference of the first Inquiry

A1.8.1. This was: *"4. To make explicit any demonstrable failure by current or past employees to act in the best interests of children and young people which may become evident in the course of* [the] *investigation."*

A1.8.2. This fourth Term of Reference is also widely framed. The scope for the investigation of individual criticism is vast. The organisational history of the Department and of the Council generally was a major cause of the Council's repeated failures disclosed in SPR and in this Report. I therefore had to consider whether the individuals who were responsible for this history should be called to account, as well as those involved in the inadequate response to Alan's 1996 disclosure. In Appendix 3, Part 1 below I set out specifically why I have confined the purpose of this Term of Reference - the explicit criticism of individual officers - to senior officers involved in the response to Alan's 1996 disclosure.

A1.9. The fifth Term of Reference of the first Inquiry

A1.9.1. This was: *"5. To make recommendations as to any amendments to procedures and practices of the Council that will ensure the proper care and protection of children and young people in the Council's care."*

A1.9.2. Recommendations are made in Part 3 of this Report (above). As repeatedly explained, they relate to underlying organisational problems, rather than the details of social work practice.

A1.10. The second Inquiry's Preamble

A1.10.1. SPR had been published shortly before the second Inquiry was commissioned. By the time of SPR's publication a series of independent checks was taking place in the Department on the value of current practices relating to Child Care, including an audit of fostering files. This audit confirmed existing internal criticism of the Department's practice, and was the cause of the Council's action in establishing the second Inquiry.

A1.10.2. The second Inquiry's Terms of Reference were preceded by the following statement:

"The council has discovered that follow up police checks of foster parents (and adults who reside with them) have not been carried out in all cases and there have been other serious deficiencies with practice in assessing and managing foster carers and placements. It has also received information that this problem was reported to senior managers several months before action was taken to begin to remedy the situation.

The administration intends to commission a further inquiry (terms of reference below), from which it anticipates further lessons will be learnt which will

- *benefit child care management and practice in future*
- *ensure any concerns about child care practice or work with other vulnerable groups are heard and investigated."*

A1.10.3. It is this reference to *"further lessons"* which I regard as an implicit invitation to make recommendations. On a somewhat pedantic note, I am advised that the more recent preferred usage is 'foster carer', rather than 'foster parent'. I have therefore used the former throughout, except in reproducing quotations.

A1.11. The First Term of Reference of the second Inquiry

A1.11.1. This was: *"The inquiry is asked to identify the following: 1. The nature, extent and cause of the failure to carry out appropriate police checks of foster parents or work within established childcare procedures and practice, identifying how such a situation was allowed to develop."*

A1.11.2. The dominant phrase is *"appropriate police checks of foster parents",* following on from the allegations in the Preamble. I have therefore treated the unspecific phrase *"work within established childcare procedures and practice"* as limited to associated matters.

A1.11.3. The facts given in the Preamble, as amplified in Appendix 2, Part 2 below, reinforce the general criticisms of the Department's past made in SPR. The *"nature and extent"* of the deficiencies involved are of long standing, and are not disputed by those now leading the Department. In short, there were breaches of the law, of good practice and of common sense. I have made enquiries about, and constantly been alert to the possibility of, other causes of this failure, but have found no information pointing to a *"cause"* which requires a new, separate investigation. The organisational incompetence illustrated by SPR and this Report inevitably produced widespread discreditable results, and this is the most likely *"cause of the failure",* and of *"how such a situation was allowed to develop"*. This *"cause"* is analysed in more detail in App. 2, Part 2 below.

A1.12. The second Term of Reference of the second Inquiry

A1.12.1. This was: *"2. The detailed chronology of the way the failure was brought to managers' and members' attention."*

A1.12 2. I have regarded this as the main factual nub of this Inquiry, because of the statement in the Preamble that *"… this problem was reported to senior managers several months before action was taken to begin to remedy the situation."* I have therefore set out the sequence of the reporting to the Department's senior management, including relevant Councillors, in Appendix 2, Part 2, below.

A1.13. The third Term of Reference of the second Inquiry

A1.13.1. This was: *"3. Whether management or others did/did not respond and act appropriately in response to information about service failure."*

A1.13.2. Because the most sensible conclusion about the cause of the particular service failure is that it was another symptom of general organisational failure, the reasoning set out in Appendix 3, Part 1 below for confining criticism again applies. In response to this Term of Reference I have looked only at the response to the information about this service failure which followed the appointment of a new Service Manager in December 1997.

A1.13.3. If circumstances had been normal, and if the disclosure of poor foster carer assessments had been an isolated issue then, in my view, the response was unacceptably slow and the passing of information was unacceptably poor. However, circumstances were not normal, and the quality of assessments was not an isolated issue by late 1998. The particular circumstances of early 1999 then added considerable difficulties to managerial information flow at a more senior level. This was followed in mid-1999 by disruptive changes in senior management, causing delays in the flow of information to Councillors which were not intended, and were probably unavoidable in the circumstances. In short, the collective response was poor, symptomatic of the general organisational malaise affecting the Department, and then exxagerated by unusual circumstances. These matters are described in Appendix 2, Part 2 below.

A1.13.4. I have set out generally the limits of appropriateness of individual criticism, including that relating to the more general responsibilities of *"others"* outside the immediate *"management",* in Appendix 3, Part 1 below. I have not become aware of any information that *"others",* responded inappropriately when they were informed of these failures.

APPENDIX 2.

THE FACTUAL FINDINGS OF BOTH INQUIRIES

PART 1. THE FACTS RELATING TO THE FIRST INQUIRY

AMENDMENTS TO SPR

A2.1. The September 1999 Public Report - SPR

A2.1.1. The facts relating to the first Inquiry are almost wholly contained in SPR, but subject now to the following minor comments, amendments and additions.

A2.2. The Presumption of Innocence

A2.2.2. Because Steven Forrest is now dead he cannot defend the serious allegation of unprofessional and criminal conduct made against him. I accept that the word 'disclosure', used repeatedly in SPR and this Report, implies that the alleged abuse actually happened as described.

A2.2.3. Throughout SPR, and throughout this Report, the word 'disclosure', which is now part of social work jargon, is used to mean no more than an allegation requiring a positive official response. Any disclosure requires investigation unless, at the outset, it is reasonably considered fictitious by the relevant agencies. All the professionals closely involved with Alan's reluctant disclosure did accept its probable truth. The first Inquiry's subject-matter is not whether the 'disclosure' was true, but about the Social Services Department's responses to a 'disclosure' which obviously raised important issues for the Department and others dependent upon the Department.

A2.2.4. I therefore accept the desirability of emphasising that Steven Forrest was not convicted of any criminal offence. This emphasis is not forensic pedantry. Although it is often very difficult for genuine victims of sexual abuse to make a complaint to the relevant public services sufficiently persuasive to lead to the conviction of the perpetrator, false complaints are made from time to time. The need to assert the usual safeguards provided by English law for accused people ought never to be ignored.

A2.2.5. As SPR itself stated, in paragraph 3.1.1.:

"I think it only fair to emphasise that [Steven Forrest] *has been convicted of no crime, he cannot defend himself against the allegations that have been made against him, and the Inquiry is concerned only with the working hypothesis that Alan's disclosure created."*

A2.3. Amendments to SPR

A2.3.1. There have been very few challenges to SPR which have reached me. For the sake of accuracy I mention the following detailed amendments to SPR:

(1) In the first sentence of paragraph 6.12.6. SPR the word *"obtaining"* should not appear. Please delete it in your copy of SPR, as it destroys the point of the sentence. This was about the significance of the advice received, not about how it was obtained.

(2) In paragraph 7.3.15 SPR the reference to MCP&QA**1**, in the second sentence, should be to MCP&QA**2**, as the opening sentence of paragraph 7.3.14. SPR made clear.

(3) In paragraph 8.3.2. SPR, the final sentence reads: *"By coincidence, the other Team Manager was the one who had supported the work of the Consultant Child Psychiatrist at the hospital in April 1996 when Alan's disclosure had been the subject of a consultation with him, but she was not aware of Alan's case in the Team, and of this connection, until November 1998."*

This should be replaced with*: "By coincidence, the other Team Manager was the one who had supported the work of the Consultant Child Psychiatrist at the hospital in April 1996, when Alan's disclosure had been the subject of a consultation with him. Although this Team Manager was aware of Alan's case in the Team's caseload, and allocated it to SW3 in August 1998, she was not aware of the connection with the April 1996 consultation until the end of October 1998."* (and see paragraphs 8.4.1. and 8.7.2. SPR).

(4) In view of the criticism of DSS2 and AD1 contained in Appendix 3, Part 2 below, the tentative explanation given in paragraph 7.3.12. SPR is withdrawn.

(5) In the various references to SSI Reports I wrongly attributed the dates given on their covers to the timing of the Reports. These dates are, in fact, the dates of the Inspections on which the Reports were based. An account of the reporting of these inspections is given in Appendix 4, Part 3 below).

(6) In the opening sentence of paragraph 6.4.6. SPR I understated the extent of the changes introduced in the 1995 Departmental CPPs. However, since it is clear that these procedures were not followed in the Planning Meetings called in response to Alan's disclosure, this understatement is not important of itself.

A2.4. Update on Alan

A2.4.1. Since Alan's history has been so prominently described in SPR, a general statement about his present circumstances is appropriate here. When I enquired some weeks ago, he was in good health, living with his immediate family, and had gained employment with a local company. I am satisfied with the account of the support he has received from the Council since his disclosure was addressed properly. The skilled and experienced social worker until recently allocated to his case believed, he told me, that Alan had settled and should achieve the goals he had set himself. In Alan's own words he wants *"to get on with his life"*, and I hope that the Council and the media will respect this when dealing with this Report.

PART 2. THE FACTS RELATING TO THE SECOND INQUIRY

POLICE CHECKS AND THE ASSESSMENT OF FOSTER CARERS

A2.5. Introduction

A2.5.1. The second Inquiry's Terms of Reference began, in its Preamble, with a statement of fact "*that follow up police checks of foster parents (and adults who reside with them) have not been carried out in all cases and there have been other serious deficiencies with practice in assessing and managing foster carers and placements."*

A2.5.2. The Terms of Reference, based on this statement of fact, asked me to identify: (1) "*The nature, extent and cause of the failure …., identifying how such a situation was allowed to develop."*; (2) *"The detailed chronology of the way the failure was brought to managers' and members' attention." ;* and (3) *"Whether management or others did/did not respond and act appropriately in response to information about service failure."*

A2.5.3. I have confined the investigation to the subject of Police Checks. However, my advisers and I, from incidental observations, are satisfied that this topic does not represent the sole area of deficient practice.

A2.5.4. Although Police checks on the background of foster carers are only of negative value, they are an obviously important source of relevant information for the crucially important task of assessing suitability. Not only should Police and other checks be made on prospective foster carers; checks should also be made on others in the household. Not only should the family be checked before approval to fostering is given; checks should be repeated if later information gives rise to concern. By law, the records of foster carer checks must be kept intact by those making them, for at least 10 years from the date on which approval of the person to whom the record relates is terminated. After preliminary investigation, I divided the overall failure into three subjects:
(1) police checks on prospective foster carers and other members of their households;
(2) reviews of the suitability of foster carers; and
(3) the retention of records.

A2.6. The Legal Requirements

A2.6.1. The Department's failures relating to Police and other checks on foster carers and their associates are not just matters of good practice. There are also relevant legal requirements. What follows is by no means a full account of the relevant law and Guidance. It is merely a series of extracts from public documents which would certainly have been made available to the Department, which I have gleaned from several sources. My purpose in setting them out is to show that the requirement for making and recording the checks is of long standing, as a recognised precaution of good practice. Throughout the following resume I have underlined certain phrases for emphasis.

A2.6.2. The requirement has been widely and repeatedly published, with a persuasive rationale which was increasingly emphasised over time. The factual account of the Department's failure set out below can be compared with this sub-section, in order to judge the seriousness of its nature and extent.

A2.6.3. 1955. The Boarding Out of Children Regulations 1955, made under powers conferred by the Children Act 1948, replaced Regulations of 1946. They laid down requirements for the selection of foster carers to whom children were 'boarded out'. Where a placement exceeded eight weeks, information had first to be obtained *"as to whether any member of the foster parents' household is believed …. to have been convicted of any offence which would render it undesirable that the child should associate with him."* (Regulation 17 (1)(b)(ii)).

A2.6.4. This requirement obviously implied a need to make checks with the Police, though this course of action was not spelt out formally. At this time, therefore, it could be argued that Police checks were not compulsory, though it is difficult to see how else the required information could have been authoritatively obtained.

A2.6.5. 1986. In addition to the requirements of Regulations, local authorities have been given formal directions in Government Circulars - directions which have statutory force by virtue of the Local Authority Social Services Act 1970. Such Circulars appeared in 1986 (HOC(86)44, LAC(86)10), implementing recommendations made in a Home Office led review. This had recommended that checks should be made with local Police before staff, volunteers, or others working officially with children were taken on. From 1986, therefore, the proper method of obtaining information about criminal records relating to those working with children was recognised officially as being a Police check.

A2.6.6. 1988. The Boarding-out of Children (Foster Placement) Regulations 1988 revoked the 1955 Regulations and abandoned the distinction between placements of less than eight weeks and longer placements.

A2.6.7. Regulation 3 required a local authority to be satisfied as to the suitability of foster carers, having regard to references and specified information. The specified information included *"15. Any criminal convictions of the foster parent and other adult members of the household".* Regulation 3 also required a review to take place *"from time to time"* of the continued suitability of the foster parent and the household.

A2.6.8. Regulation 14 required a local authority to compile a record of every applicant foster carer, whether approved or not, the record to include information obtained in the process of approval (and therefore Police checks). Regulation 15 required that such a record *"shall be retained for at least 10 years from the date on which approval of the household of the person to whom the record relates was terminated".* Regulation 15 also required the safe keeping of the record. The record could only be destroyed if *"they have made a recording which reproduces the total contents of such record."*

A2.6.9. In December 1988 another joint circular (LAC(88)19) revised the 1986 circular. It was entitled: *"Protection of Children: Disclosure of Criminal Background of those with Access to Children".* It purpose was to explain *"the procedures for checking with local police forces the possible criminal background of those who apply to work with children. The arrangements apply to .... and others such as ... foster parents caring for children boarded out with them."*

A2.6.10. This last sentence appears to have been an after-thought. At paragraph 20 the Circular contradicted the requirement of Regulation 15. *"The information the police will provide is of a confidential nature. It must be used only to judge the suitability or otherwise of a person for the position in question. …. Once this has been done, the information should be destroyed. An indication on the records that a check with the police has been carried out may be made but should not refer to any specific offences."* Perhaps this is the origin of Lambeth's practice of destroying police checks. If so, at this time the practice was perhaps excusable, since the purpose of such a Circular is to explain what the law requires. However, I understand that Lambeth's practice has not conformed to the practice required by regulation at this, or any other, time. Annex D of the Circular listed *"Posts subject to Police checks under these arrangements",* but did not include foster carers, unless the phrase *"Adoption and Fostering Officers"* is given an unusually wide definition.

A2.6.11. 1989. A further Circular (LAC (89)4) appeared in January 1989, accompanied by a handbook of official Guidance. The Circular stated (at 3. a.):
"The change reflects the move away from an emphasis on boarding-out as a matter of individual placement and towards the concept of a fostering service, with provision for recruitment, assessment, training, support and review of foster parents, within which individual children are placed with the most suitable available foster parents …".

A2.6.12. The Circular also drew attention to the principal changes from the 1955 Regulations, including (at 3h.): *"revised requirements for the keeping of records, including foster parent records. Case records are to be kept for seventy-five years and foster parent records for a minimum of ten years. Certain documents must be kept in the records and these are specified. The Regulations reflect the importance to good social work and child care practice of full and accurate records …".*
There was no explicit reference to the misleading nature of the 1988 Circular. Despite this, if Lambeth's practice about the retention of Police checks was misled by the December 1988 Circular, the practice should have been corrected in January 1989.

A2.6.13. 1989 - 1991. The Children Act 1989, which made major changes in the duties of local authorities, came into force in 1991. The Foster Placement (Children) Regulations 1991 replaced the 1988 Regulations, but with only two material differences for this Report's narrow purpose. Regulation 4 required that *"Where a foster parent has been approved under regulation 3 the approving authority are to review, at intervals of not more than a year, whether the foster parent and his household continue to be suitable …".* The information which could be taken into account was the same as for original approval, but the relevant Guidance (*"Family Placements"* Vol III), at 3.46, allowed comprehensive re-assessment to *"depend on individual circumstances".* I am advised that, in general practice, Police checks were not carried out at annual or other review, unless there was some specific reason to do so.

A2.6.14. A minor change allowed the keeping of the record (still for at least 10 years from approval being terminated) *"by keeping all the information from the record in some other accessible form (such as by means of a computer)."* The relevant Guidance at 4.53 referred clearly to the need *"for foster parents' case records to be kept for at least ten years from the date approval is terminated, …This should be regarded as a minimum…. Retention for a longer period can be desirable in some cases, for example, where there is a possibility that the foster parents may seek to foster children again and there is information which should be known in the event of a further application."*

A2.6.15. 1993. A lengthy circular of 1993 (LAC93(17) concentrated on targeting Police checks *"more closely on those posts where they are most needed, and to give clearer guidance on the criteria for eligibility for checking"* (1), because of *"the increasing pressures placed on the police by the growing number of checks requested …"* (6). Its emphasis was on the need to check those working with vulnerable children where the post would entail a substantial level of access to children which may also be unsupervised, and which would be regular or sustained (paragraph 15). Paragraph 17 included *"prospective long term and short term foster parents … and other adults in their households"* in this category.

A2.6.16. On the subject of *"Storage and destruction of records"* the Circular stated:
"33. The information the police will provide is of a sensitive and personal nature. It must be used only to judge the suitability or otherwise of a person for the position in question. The nominated officer in the authority who received the information must keep it securely while the judgement is being made. Once this has been done, the information should be destroyed (except for adoption and fostering cases). An indication on the records that a check with the police has been carried out may be made but should not refer to any specific offences."
By this specific exception, the omission in the 1988 Circular was again corrected.

A2.6.17. 1997. The 1991 Regulations were amended by the Children (Protection from Offenders) (Miscellaneous Amendments) Regulations 1997. The specified information which had to be taken into account when assessing foster carers was more extensively worded: *"19. Any previous criminal convictions and any cautions given by a constable in respect of criminal offences relating to him or other member of his household over the age of 18."*

A2.6.18. In October 1997 a Circular (LAC(97)17) gave statutory guidance on these new Regulations. It stated: *"2. The purpose of these Regulations is to prohibit the approval by … local authorities … of any person as a foster carer or adoptive parent where either they or any adult member of their household over the age of 18 is known to have been convicted of, or cautioned for, a specified offence. For certain offences …. [t]he absolute prohibition to act as a foster carer or be approved as a prospective adopter will only be triggered if the offender was 20 years of age or over at the time the offence was committed."*

A2.6.19. The Circular also stated:
"5. The Department recognises that introducing an automatic prohibition on the approval to act as a foster carer may, in ***exceptional*** [original emphasis] *cases exclude* [suitable] *people …. It is for this reason that the Regulations allow agencies to retain a discretion when considering whether to approve an applicant as a foster carer …. where the criminal record checks disclose a conviction …. and where the offender was under 20 at the time …. The emphasis remains, however, on the word* ***exceptional*** [original emphasis]. *The intention of these Regulations is to ensure that known abusers and others guilty of, or cautioned for, offences which raise any doubt as to their suitability to care for children should be denied the opportunity to do so. Where local authorities … can, and choose, to exercise their discretion the approval .... process should specifically confirm on file that the relevant conviction or caution has been considered and the reasons why the decision to approve or reject has been made should be explained in the light of this information. Agencies should retain all the relevant papers securely for future reference and should involve their legal adviser in all such cases.*

[2.6.20.] *6. ….Rigorous attention to the requirements for full police and other checks and the importance of disclosure of convictions should be seen as one of a number of important safeguards.*

……

20. Existing Regulations require that, except in the case of an immediate placement with a relative or friend, a child may only be placed with a foster carer who has been approved under Regulation 3 of the Foster Placement (Children) Regulations 1991. In assessing the suitability of a person to be approved as a foster carer the responsible authority must presently consider amongst other matters the relevant criminal record (if any) of that person or any adult member of his household……

……..

22. Having undertaken the necessary police checks .., the new Regulation 3(4A), requires that responsible authorities shall not regard as suitable to act as a foster parent any person if he or any adult member of his household has been convicted of, or cautioned for, a specified offence. …….

A2.6.21. The process of Lambeth's reform began in 1998. 1997 is therefore a pragmatically useful year at which to stop relating the history of repeated emphases on Police checks and records for the limited purposes of this Report. I have not followed subsequent developments in the relevant requirements, though there have been important further developments following the Government's response to the Children's Safeguards Review.

A2.7. The *"Nature"* and *"Extent"* of the Failure: (1) Legal Requirements

A2.7.1. From this review I draw the following conclusions:-

(1) The need to take Police checks of prospective foster carers and their households into account in the assessment of foster carers has been clear for a very long time indeed. This importance has been reinforced repeatedly since 1988. Any failure to carry out and assess Police checks properly was inexcusable.

(2) An annual review need not include a Police check. Whilst there was no need to make routine periodic re-checks, there were requirements to deal comprehensively with information which came available after the approval of foster carers. There was no obstacle to making a Police check in these circumstances. As the Executive Director's statement quoted in sub-section A2.8. below shows, it would have obviously been prudent to have done so in some cases where this was not done.

(3) From 1988, the record of any Police check made has had to be retained until ten years after approval of the fosterer has been terminated. From 1989 this was a minimum requirement. It will be seen, from a comparison with the Executive Director's statement, that these requirements were not followed. For a few weeks in December 1988/January 1989 there was a not very strong basis for misunderstanding the need to retain the record of Police and other checks. Thereafter, the need to retain was made very clear, and Lambeth's contrary standard practice was inexcusable.

A2.7.2. Given the factual statement in the Preamble, there was obviously little need for me laboriously to conduct basic research on whether failure to use Police checks in the process of assessment had taken place. An independent Auditor, and other investigations, had already established such failure, and it is accepted by the Department.

A2.8. The *"Nature"* and *"Extent"* of the Failure: (2) The present Executive Director's Statement

A2.8.1. I therefore asked the Executive Director of Social Services to provide me with a statement, on behalf of the Department, which would concisely set out this factual background. I quote the relevant part of this statement immediately below. The reduction in the number of foster carers, following re-assessments, from 244 in December 1997 to 130 by the date of the statement, 31st March 2000, is one measure of the *"extent"* of the Department's failure. I need only add to the letter's content that files which were criticised by the independent Auditor included longstanding foster carers. The *"extent"* of the failure over time was also lengthy.

A2.8.2. The Executive Director wrote:-

"By the time [the independent Auditor] *had got to foster-carers with names beginning with 'C'* [in an alphabetically organised audit]*, she had made Exception Reports* [i.e. flagged up concern] *on 35% of them.*

These reports include the following examples:

* *Foster-carers who failed to reveal convictions which were later recorded on a file but no action apparently taken about the implications for fostering.*

* *Foster-carers who were not Police checked.*

* *Foster-carers who were Police checked but no record of the checks is available on the file (a consistent story from staff at all levels is that they were told that a Home Office Regulation required the destruction of Police checks records three months after they were received). Fortunately in some cases two Administrative Assistants under their own initiative and presumably because of a sense of unease did keep the checks off file.*

* *Foster-carers' partners, children and significant others who had no Police checks or no record of them being done.*

* *Foster-carers whose check authorisation forms gave slightly different dates of birth than those on file, and which gave a completely different name from that by which the foster-carer was registered with Lambeth Social Services. This combination, … would fail to throw up accurate information of any relevant convictions.*

* *Failure to address the issue of checks in annual reviews.*

* *Failure to take account of foster-carers previous criminal records and prison sentences in their assessments.*

[A2.8.3.] *As the scale of the problem was evidently huge, it was agreed by the Acting Executive Director and the Chief Executive that the Council's anti-fraud team, CAFT, should be commissioned to undertake a full-blown investigation which would include interviewing all Family Finders' foster-carers to establish identity details and status (whether actively caring or not) and the details of all others in their households. …..*

CAFT reported on 18.11.99. In the course of their work, they discovered that the list of task-centred foster-carers did not present the total picture in terms of carers with whom Lambeth was placing children. Social Workers in the Area Teams were also placing children directly with foster-carers ….. without going through Family Finders. As a result, CAFT were asked to continue their work to trace and interview all foster-carers to ascertain the same information as with the task centred foster-carers in order for Police checks to be requested. …..

[A2.8.4.] *Following the work of* [the independent Auditor]*, the Service Manager and CAFT, action has been taken in respect of task-centred foster carers who were perceived to be an acute risk. This has resulted in a reduction in numbers of foster carers from approximately 244 in December 1997 to approximately 130 today. These remaining foster carers are all being reassessed by an independent expert consultant to ensure that they are still suitable carers. We are working with the National Foster Care Association around the future development of our foster carers and are currently doing a large-scale recruitment drive for new carers with the help of Outhouse, an external agency.*

In addition to the work undertaken by CAFT, a Best Value Review has been conducted on the Family Finders Service. This was prioritised by Members because of the concerns felt about the quality, safety and efficiency of the service.

The findings of this Best Value Review were reported in March 2000, and have far-reaching implications for the structure and future of the service. [I have not included these detailed recommendations in this Report.]

[A2.8.5.] *I am satisfied that the actions that will be taken, if necessary, following the detailed work undertaken by CAFT on individual carers, the revision of the policy and procedures manual and the radical restructure of the Service will ensure that our foster care service will be one that is as safe as possible and better able to meet the needs of children placed in our care.*

The establishment of the corporate Children First Audit Team, the Children First Commission and our partnership with the Children's Society to create the Children's Rights Project will help to ensure that our performance in respect of the children placed in our care is kept under rigorous external scrutiny.

What feels to have been a very 'closed' and unregulated service is now being broken apart and is in the process of being reconstituted as a service that has the needs and welfare of children at its heart." This work continues.

A2.8.6. It will be appreciated from the contents of this letter that the *"nature"* and *"extent"* of the failure relate to a complex of bad practices. The above illustrations cover a wide range of administrative and professional errors, and on a large scale.

A2.9. The *"cause of the failure, identifying how such a situation was allowed to develop":* (1) The Role of the Social Services Committee

A2.9.1. I decided not to spend time checking through minutes to see if the Committee, or a Sub-Committee, were involved in practical responses to these developing legal requirements. Given their mandatory nature, it is difficult to think of a role even for the traditional Committee practice. However, the SSI Report of March 1993 included, on a closely related requirement:
"6.1.3 Unit 3 [Angell Road]

Inspectors were concerned at the lack of police checks on staff in this unit even though they were experienced and may have been employed in the department for some time…

6.1.4 Comment

Local Authorities are required via [the Government Circulars of 1986 and 1988] *to carry out Police checks on persons who have substantial access to children. This is an important part of the process of establishing the suitability of a person for a post in child care. Lambeth recognise the importance of these checks and expect that they will routinely take place. However, prior to the inspection, Lambeth submitted figures for the three homes inspected. For the total staff group employed post 1986 and eligible for a police check, 18% had not been subject to a police check and 4% had not been subject to a DoH consultancy check."*

A2.9.2. A more general survey in the SSI Report showed that, in the then nine Lambeth Children's Homes, 45.7% of relevant staff had not been Police checked, compared with 31.7% who had. There were 19.2% of relevant posts empty (Table 21). The Social Services Committee of 30th July 1993 (3/93-94) accepted the Director's recommendation:
"That the Committee concur with the programme already initiated to undertake police checks on all staff identified in [the circulars] *with access to children."*

A2.9.3. The Lambeth response to a seriously disturbing situation was 'don't worry; we recognise the problem and are already tackling it'. Appendix 4, Part 3 below, refers to the frequent use of this response, when bad practice was unavoidably drawn to the Committee's attention. The 1994 SSI Report confirmed that appropriate checks on the relevant staff in the Homes had been carried out by December 1993. On this occasion, the response was effective. The *"cause"* was not lack of Committee concern.

A2.10. The *"cause of the failure, identifying how such a situation was allowed to develop":* (2) Departmental Instructions

A2.10.1. In sub-section A2.15. (and the following sub-sections) below, the history of the discoveries of bad practice made by a new Service Manager of Family Finders who took up his post in December 1997 is outlined. I therefore looked for official Departmental practice guidance immediately prior to December 1997. Part 13 of the Department's Children and Families Manual dated April 1997 related to *"Fostering". "Section A: Introduction"* stated:
"The Directorate's Adoption and Fostering Section is based at the:-
Family Finders Centre", followed by its address and telephone number.

A2.10.2. The Manual continued:-
"2. Staff based at Family Finders are guided in their work by a comprehensive Procedures Manual containing information and advice on the many procedures which are internal to the Adoption and Fostering Section.
3. Where such procedures are relevant to staff based outside of the Adoption and Fostering Section, they have been reproduced and included in this Children and Families Manual, e.g. The Foster Placement (Children) Regulations 1991. The Adoption Procedures [sic].
4. Field based workers who require advice on other Adoption and Fostering issues should, in the first instance, contact their Adoption and Fostering Area Liaison Worker, or the Duty Worker at Family Finders."
Then follow descriptions of the procedures to be followed.

A2.10.3. In response to my request for the *"comprehensive Procedures Manual"* referred to in paragraph 2 of this 1997 Children and Families Manual, I received a comprehensive pack of procedural documents relating to Fostering. This pack was supplied to me by a long serving Family Finders manager, who wrote: *"I can only surmise that this* [i.e. the reference in the Manual's paragraph 2 above] *refers to procedures which were produced and used by the Adoption and Fostering Section alone. A copy of these procedures are enclosed. The procedures are not dated, and have not been in use for many years".*

A2.10.4. The procedures pack consisted of 158 pages, plus 64 pages of Appendices. It is correct that the procedures are not dated, but the pro forma letters in it include the name of the Director of Social Services until 1995, and that of the Service Manager of Family Finders until December 1997. It is clear that, in the most general terms that are of interest to me, the requirements of the Manual and of the Procedures pack provided for the proper implementation of initial Police Checks. They do not refer to the need to keep the results of Police checks. There had been a written basis for the practice of the Department which was, on the fundamental issue of making Police checks, satisfactory. The *"cause"* was not the formal procedures.

A2.11. The *"cause of the failure, identifying how it was allowed to develop":* (3) An attempted Answer

A2.11.1. From the facts available, I can identify eight causes of the failure.

A2.11.2. (i) I should, in fairness, point out that the process of checking will always be vulnerable to incorrect, or inadequate, information supplied by those being checked. There can be little doubt that this will have been a cause in some cases. Social workers deal with people, not widgets, and people do not always tell the truth.

A2.11.3. (ii) One cause must be failure to collate and assess already available information adequately. The Exception Reports by the independent Auditor were based not on live investigation, but on a perusal of information already on file.

A2.11.4. (iii) Another cause was the practice based, according to strongly asserted oral information, on an internal instruction to destroy the results of Police checks after three months. This has contributed to the disarray of the records. Of course, any return should be treated with great confidentiality. I was told that the internal instruction was attributed to an unspecified 'Home Office instruction'. I have referred in paragraph A2.6.10. above to Circular LAC 93 (17) as a possible source of such a misunderstanding. It was, however, an inexcusable misunderstanding on the part of anyone responsible for instructions and supervision, given the clarity of repeated official requirements, then and since.

A2.11.5. (iv) I was disappointed to see, on one return from the Police dated 1st December 1999, which I happened to see on a file, the following pro forma introduction:
"Please find attached details of the convictions/cautions recorded against the person detailed below who may be identical to the subject of your enquiry. This information is forwarded in accordance with Home Office circulars and must be kept secure while judgement is being made and thereafter must be destroyed. Record may be kept that Police checks have been carried out but should not refer to specific offences."
Evidently it was not only Family Finders staff who were confused.

A2.11.6. (v) Other checks which would have yielded relevant information were obviously not insisted upon by management. Of particular significance is the absence of information for use in assessments from the Department's own central records. The 1991 Guidance (at 3.17) had required: *"Authorities should check their own records in respect of the applicants and other members of the household".* It is clear that such information was not readily obtainable or reliable, seven years later. That must be a Departmental managerial failure.

A2.11.7. (vi) As the Service Manager put it in his memo to the Executive Director of 5th February 1999 (sub-section A2.17. below): "*Where Police checks were returned with a negative answer about the foster-carer applicant themselves but a recommendation [*by the Police] *that others* [unspecified] *at the address were Police checked this was not done*." I could accept that in some cases it would be difficult to establish which other people were living at the address. The extent of this failure, however, makes that an insufficient explanation.

A2.11.8. If the Police think it sufficiently important to suggest further investigation, it can only be satisfactory to leave the task unfulfilled in exceptional circumstances approved by the Fostering Panel or senior management. If the unspecific nature of the Police concern was a significant practical problem for the Department, it should have been raised, through Child Protection specialists on the ACPC, or on another professional network.

A2.11.9. (vii) In December 1998 the Service Manager sent an email to managers within Family Finders, expressing the need for all staff to be aware of the need for proper boundaries to be recognised when dealing with people recruited from individual workers' social networks. Such recruitment sources were properly recognised as productive, given the pressures to find prospective foster carers.

A2.11.10. However, according to the email, the Service Manager had had experience of confidential information being used by people he had interviewed, which could only have come through staff social contact. I cannot be certain that this situation also encouraged the poor assessment of prospective foster carers. It is a probability I cannot discount. The practice is neither improper nor undesirable of itself, but requires careful management, sound training, and the strictest supervision if the avoidance of inherent and dangerous bias in assessments is to be guaranteed.

A2.11.11. (viii) The independent Auditor's reports included criticisms of *"Administrative"* as well as of *"Practice"* matters within the files examined.

A2.11.12. I emphasise that this sub-section is about the Department's failure. I have not discovered any single cause of the failure which can be distinguished from the general diagnosis of organisational collapse over many years. As with all organisational failures, it is probable that individuals were often to blame for their contributions to the failure to carry out adequate checks. Poor management, poor training and supervision, which all result from individual conduct, and individual acts of negligence, are all likely to have made their contribution. For the reasons given in Appendix 3, Part 1 below I have not pursued this probability of individual blame.

A2.12. Organisational and Individual Responsibility

A2.12.1. I have, from time to time, tried to prevent indiscriminate, generalised condemnation of everyone associated with the failures criticised in this Report. The effect of such condemnation on morale is very negative (Sub-Conclusion 8). I cannot comment on the quality of individual contributions to the work of the Family Finders Unit, because I have not investigated beyond the narrow scope of the Terms of Reference. However, I emphasise here the reference in the Executive Director's statement (paragraph A2.8.2. above) to the two administrative assistants who had unofficially retained the information about Police Checks, because of their unease about the instructed practice of destroying such information. Not for the first time in this Report, nor the last, I wish to emphasise a distinction between organisational failure and the good quality of some individuals' work contributions, despite the scale of organisational failure.

A2.12.2. Individual and often hard-pressed front-line workers cannot be expected to overcome organisational deficiencies such as the deplorable central records. Similarly, if the established practice accepted by management, whether or not it originated from an express instruction, was to destroy the information obtained in a Police check, front-line workers cannot be expected individually to ignore such an implied instruction.

A2.13. The *"Detailed Chronology"* and the appropriateness of Responses

A2.13.1. The second Term of Reference of the second Inquiry asked me to identify *"the detailed chronology of the way the failure was brought to managers' and members' attention".* The third Term of Reference of the second Inquiry asked me to identify "*Whether management or others did/did not respond and act appropriately in response to information about service failure."* These inter-related subjects are most conveniently dealt with together.

A2.14. A new Service Manager

A2.14.1. A new Service Manager of Family Finders took up his post in December 1997. His appointment was a delayed consequence of the new Departmental management installed by the Council in 1995/1996. A new Executive Director of the Department had effectively taken up her post at the end of April 1996 (SPR 6.8.7.). A new Manager of the Child Protection and Quality Assurance Section had been promoted to that post in March 1996 (paragraph 6.2.3. SPR).

A2.14.2. The Service Manager of 'Family Finders' was temporarily promoted to Acting Assistant Director, Children and Families Division (which included Family Finders) from February 1996 (SPR 6.1.5.). In January 1997 she was appointed to the substantive post, but retained her previous responsibility as Service Manager until December 1997, when her successor took up his post. This double burden on her cannot have helped the proper supervision of the Section, and would have hindered any needed improvements during that time.

A2.14.3. The Assistant Director was suspended on 14th May 1999, and she has been the subject of the process of individual criticism set out in Appendix 3, Part 2 below relating to the first Inquiry's work. I have therefore not asked for her assistance in my understanding of the second Inquiry's subject-matter. Similarly, because the former Executive Director has also has been the subject of the individual criticism process set out in Appendix 3, Part 2 below, I have not asked for her assistance. I have limited the following narrative of the discovery of past failures almost entirely to the firm ground of contemporaneous documents.

A2.15. The first Indications

A2.15.1. At first the new Manager of Family Finders who arrived in December 1997 was given other priorities, but became increasingly concerned about the quality of work, systems and discipline in Family Finders. On 16th July 1998 he sent an email to his sub-managers, and copied it to the Assistant Director:

"*Subject: Checks: police and central records*

To confirm the decision made at MTM [the section's Management Team] *yesterday we are agreed that with immediate effect you will programme all foster carers, present and future to be checked against Central records and that Police checks will extend to 16 yr olds not just 17 yr olds as is present practice in some teams.* ***For the avoidance of doubt this is a must do*** *[original emphasis*]***.***

Please ascertain from your team admin who may need support from Placements admin what is a reasonable time frame to complete the task for present carers. If it seems likely to stretch beyond 25th Sept please let me know.

As part of our quality assurance I will expect to see evidence in future panel reports, annual reviews and the like that this decision is being implemented.

[A2.15.2.] *Other action that is required is re-design of our procedures and forms to include the relevant questions. I have agreed with* [D] *that* [A] *could lead a small mixed group to fulfil the terms of reference below:*
** review the current guidance and procedure manual entries re checks*
** draft amendments to the guidance and forms including the consent form signed by applicants*
** model our checks on those carried out for Child Minders*
** liaise with* [P] *re insertion of revised guidance into C&F* [Children and Families Division's] *manual*
** any suggested additions/amendments to these ToR* [Terms of Reference] *by 24th July"*

A2.15.3. This copy email was the first written intimation of concern to a senior manager about assessment checks that has been drawn to my attention. The emailed instruction showed that action to deal with the concern was being taken by the new Manager. The new broom was sweeping clean. In October 1998, the Manager began to voice his growing concerns to the Executive Director and other senior managers about the quality of Lambeth's foster care practice, according to the note which he prepared for the Acting Director of Social Services in late August 1999.

A2.15.4. In November 1998 the first Inquiry was informally established, following other concerns about the Child Protection practice of the Department which had surfaced in October 1998 (sub-sections 8.5 - 8.9. SPR). My Terms of Reference in that Inquiry did not refer to the concerns about foster carers, and I remained unaware of them until November 1999.

A2.15.5. The Manager's concerns continued to increase as more examples of bad management, bad practice and inadequate systems came to his attention. I have seen emails in December 1998 in which he increased the pressure on his staff, and on the Department. In particular he pressed the need for the Section to be able to check foster carer applicants against the Department's own central records. Technically, the information systems in place made this very difficult.

A2.16. Intervention by the SSI

A2.16.1. An individual case involving the sexual abuse of a fostered child (the details must remain confidential) caused the SSI to write to the Executive Director on 11th January 1999. Two other local authorities were involved in the case, and the SSI had also written a similar letter to their Directors of Social Services. However, a second letter was simultaneously sent by the SSI to the Lambeth Executive Director. The SSI were very concerned that the case appeared to have shown a lack of co-operation between the local authorities and of proper procedures.

A2.16.2. The SSI letter stated:
"You will see from the enclosed letter that I have written to Directors to try and confirm that this case and matters arising have been dealt with.

I am writing a separate letter to you because of the particular circumstances of Lambeth and the Barratt enquiring [sic] *and Operation Middleton."*

A2.16.3. According to the SSI's letter, the case involved *"the acceptance of a schedule 1 offence in a* [foster] *carer, and files have been lost".* The letter went on:
"The case clearly shows staff failing to follow procedures and social work practice below the standard required …….

Taking all these issues into account you may think it wise to take action that produces:- ….

An evaluation of practice with regard to
- assessment of carers
- placement with foster carers and visits, reviews, checks.
- placement for adoption - time taken.
- child protection referral - quality of practice
- foster carers and registrations
- follow up of children placed
- information sharing with other agencies

A list of learning points and action taken to improve practice.

This case is viewed seriously by SSI and in the current situation it seems prudent that you ensure <u>all</u> matters are dealt with scrupulously and practice improved."

A2.16.4. This was clearly a significant letter, addressed to the Director, which authoritatively cast doubt on the Children and Families Division's Child Protection and Fostering practices in very important respects. It called for a comprehensive review of practice.

A2.16.5. I have repeatedly tried to obtain the relevant correspondence from the Department's Headquarters in Mary Seacole House. I had become aware of the SSI letter, and the Service Manager's response given below, from another source. After several weeks of trying to obtain the correspondence I had to ask the SSI for their record of the correspondence with the Department.

A2.16.6. This failure to be able to produce recent correspondence on a very important subject raised by a very important correspondent, and handled at the most senior levels in the Department, has completely destroyed what confidence I had retained in the most basic organisational competence of the Department. It may be that someone reading this will know where the correspondence is. That is not the point. It should have been produced within five minutes of being requested in any half-competent organisation. The absence of the Department's own correspondence means that I have not been able to trace the internal activity following receipt of the SSI's letter.

<u>A2.17. The Departmental Response</u>

A2.17.1. It would be normal practice for the Director to refer the letter to the Assistant Director (Children and Families) to establish a response, and to determine a strategy for action. The Assistant Director had already corresponded with the SSI about the case in 1998. Unfortunately, the Assistant Director was unexpectedly on sick leave from 19th January to 16th March 1999. In the Assistant Director's absence, the Executive Director must have sent the SSI letter to the Service Manager of Family Finders to enable a reply to be drafted.

A2.17.2. On 5th February 1999 the Service Manager sent a memo to the Executive Director, containing a basis for her to reply to the SSI. It contained an express warning of the continuing dangers from past bad practice. I reproduce it below, apart from a final paragraph which does not directly relate to this Inquiry:

A2.17.3. "*Re* [the SSI]*'s letter of 11lh Jan 1999*

In [the Assistant Director's] *absence I have now discussed this matter at considerable length with* [C], *Snr Team Manager. …. My purpose in writing this is to give you information about the issues about which* [the SSI] *has asked for your written response. Also, to clarify roles and responsibilities in this case.*

Roles

Firstly, [C] *has previously related to* [the Assistant Director] *in the detailed management of the action points in this case. We had all agreed that this made sense given that they were familiar with the history. I am therefore not able to account for decisions in the case or to speculate about the thinking which informed decisions and actions.*

I am assuming that I am authorised to progress the action points in this case outlined in the letter.

[A2.17.4.] Progress on action points as outlined in [the SSI's] *letter*

Approval and placement of foster carers where a Schedule 1 Offence is known

I am sorry that I am not yet able to guarantee that there are no Schedule 1 Offenders among our foster-carer households for the reasons below: [my emphasis]

** Family Finders did not carry out Central Record checks and I will forward you evidence of my efforts to remedy this separately*
** Where Police checks were returned with a negative answer about the foster-carer applicant themselves but a recommendation that others at the address were Police checked this was not done*
Review of practice and consideration of disciplinary action
In relation to the specific case these fell into [the Assistant Director's] *remit.*

[A2.17.5.] *In general practice terms I have*
** convened a working group to review procedures and practice includes a review of checking procedures to bring them up to standards required in Utting and Children's Safeguards Review* [two pieces of national guidance]
** will in collaboration with CPQA* [Child Protection and Quality Assurance] *recommend that allegations against carers should be investigated by independent practitioners outside Family Finders*
** have already discussed with the acting Independent Reviews Manager whether his team could chair foster carer reviews - due to resource constraints that team will have to concentrate on CLA* [Children Looked After] *reviews so I am seeking alternative independent oversight and this may come from the Quality Protects bid for Audit services*

[A2.17.6.] *Sharing of information between agencies and carers*

My review of practice suggests that there has been a diversity of practices about sharing of information between agencies. Among some Family Finders staff and managers there has been at best an odd understanding and application of 'confidentiality' which has led to information being withheld or not recorded and therefore not shared.

Follow up on all children who might have been at risk

I am not in a position to account for the apparent past failure to follow up the 65 children. I have instructed [C] *to obtain their names and essential information from Family Finders files and records. However I have the following questions:*
Should the names just be passed to [Operation Middleton]*?*
Should there be a discrete investigation to follow up these children only?
Should the information also be passed to the Barratt enquiry?
My information is limited and I would value some direction about the next steps.

[A2.17.7.] *Leaming points and ensuring practice is changed accordingly*

There is already a chronological summary on file and this can be expanded.
Regarding the other matters which are Lambeth specific it is for [the Assistant Director] *or you to implement the plan to commission an external review of all our Procedures as stated in her letter to* [the SSI] *of 25/11/98.*
My view is that the issues pertaining to Family Finders are so pressing that I should use my underspend to commission a discrete piece of work focused on Family Finders procedures and practice.

I hope the above is sufficient for you to send an interim response to [the SSI]."

A2.17.8. On 6th February 1999 the Manager sent another email to the Executive Director, detailing his current difficulties and some of his concerns about checks of foster carers against the central records of the Department. This memo and the email establish that two significant condemnations of the state of Family Finders procedures and practices were put to the Executive Director in early February 1999. The memo also proposed remedial action for authorisation.

A2.17.9. On 8th February 1999 the Manager sent to the Manager of the Child Protection and Quality Assurance Section a copy of this memorandum and this email. By this date, both these Managers (of Family Finders, and of the Child Protection and Quality Assurance Section) were minded to leave Lambeth's employment.

A2.18. The Absence of a Decisive Response - A Need for Caution

A2.18.1. I have considered whether the SSI's concern should have been the subject of report by the Executive Director to the Chair of the Social Services Committee and others. In normal circumstances, I would certainly have expected this situation to have been the subject of informal discussion between those who linked Departmental management to the Council. Preliminary warning of another probable major deficiency in a children's service, following closely on the setting up of the first Inquiry and Operation Middleton, immediately strikes the observer as highly desirable. The potential political implications were substantial.

A2.18.2. I have to resist basing criticism on a view of how an isolated problem, or even a series of isolated problems, in a normal Department would be dealt with. Unfortunately, there was an engulfing tide of concerns about Lambeth's children's services beginning to flow at this time. In addition, in the Department, management information is not easily collated, and the Assistant Director was temporarily absent. There was an uneasy feeling amongst relevant senior officers that individual signals from diverse sources were beginning to point to a hitherto unsuspected major service failure. Circumstances increasingly became abnormal. In the growing concerns about the work of the Children and Families Division discussed around this time, the specific subject was probably lost.

A2.18.3. The temporarily absent Assistant Director, was not only the senior manager of the Children and Families Division of which Family Finders was a part; she was also the former direct manager of Family Finders. The Executive Director elected to await the Assistant Director's return and her version of the situation, before pursuing the specific details of this particular example of concern with the SSI.

A2.18.4. On 27th January 1999 the Executive Director wrote to the SSI:
"Thank you for your 2 letters in relation to ….. I will discuss the issues you raise with [the Assistant Director] *and reply to you as soon as possible. Unfortunately,* [the Assistant Director] *is currently off sick ….. and there may be some delay before I can respond, but I will raise them with her immediately on her return."*
The Assistant Director returned to work on 16th March 1999, by which time the Executive Director was intending to leave.

AA2.18.5. This sequence of events disclosed by contemporaneous documents does indicate a tardiness of "*response to information about service failure".* It also underlines the dysfunctionality of the Department. I do not think it wise, in these circumstances, to pursue the responsibility of individual Departmental managers further. Additional reasons for being cautious about criticism of individuals are in Appendix 3, Part 1, below.

A2.19. The Chief Executive

A2.19.1. Reference should also be made to sub-section A3.13. below.

A2.19.2. On 1st April 1999 I expressed to the Chief Executive clear concern about the first Inquiry's findings to date. I had previously indicated that my concern was growing more certain, despite the early stage the first Inquiry had then reached. On 13th May 1999 I sent to the Chief Executive the interim Report set out in sub-section 1.5. SPR. On 14th May 1999 the Executive Director suspended the Assistant Director (Children and Families). On the same day the Executive Director retired from Lambeth's employment.

A2.19.3. Sub-section A2.18. above and the previous paragraph deal only with facts directly relevant to the subject-matter under investigation. They ignore all the pressures arising in the normal course of the Department's work, and which had to be dealt with by the temporary team running the Division - the Chief Executive, the Acting Executive Director, and the Manager of the Child Protection and Quality Assurance Section, who had become the Acting Assistant Director of the Children and Families Division. All three of these officials had to take on these responsibilities, in the absence of an Executive Director and an Assistant Director, in addition to normal workloads. In time, of course, additional help was recruited.

A2.19.4. During the early part of 1999, other indications of concern about the work of the Children and Families Division were being picked up by the Chief Executive. For example, I have had only limited contact with the work of Operation Middleton, which was focused on Lambeth's former residential child care, but I know that its progress was also being reported to the Chief Executive at this time. Once more, against this abnormal background it is unwise to make judgements about the appropriateness of responses in relation to one specific subject, as though circumstances were normal. Executive Direction of the Department was now in the hands of the Chief Executive for the most important, politically significant, purposes. It was right that the next step should be to identify the extent of allegedly widespread deficiencies of practice in the Children and Families Division in a coherent, factual way.

A2.19.5. After 14th May 1999, the Chief Executive was regularly and frequently meeting with the Acting Assistant Director (Children and Families). The Chief Executive firmly grasped the difficult situation, and dynamically supported the senior professional staff now responsible for the work of the Department. I base this view on responses to my direct questions to some of the people concerned, and on my own knowledge.

A2.19.6. Amongst several initiatives to monitor the quality of work in the Children and Families Division, the Chief Executive approved a proposal by the Acting Assistant Director in May 1999 relating to this subject. This was that the independent Auditor should be appointed to undertake an audit of foster carer records, as had been first suggested by the Manager of Family Finders in his memo to the then Executive Director of 5th February 1999. The independent Auditor began the Audit on 14th June 1999.

A2.20. Informing the Council: (1) Generally

A2.20.1. By the time the Independent Auditor began her work the scale of past bad practice in the Children and Families Division generally was becoming increasingly evident. As more and more failures and possible failures came to attention the network of people who needed to be informed informally grew.

A2.20.2. I have not closely followed this informal sharing of sensitive information, because so much of the information which was giving rise to concern is outside my Terms of Reference. However, I have no reason to believe that there was any improper secrecy. The suspension of the Assistant Director (Children and Families) was publicised in the South London Press on 21 May 1999, a week after it had taken place. In any event, suspension could not have taken place without causing internal informal discussion afterwards.

A2.20.3. According to the newspaper report, it was stated that the decision to suspend the Assistant Director *"was taken on the advice of John Barratt …."* I have never expressed an opinion on whether or not the suspension of the Assistant Director would be, or was, an appropriate response to the interim Report. It was none of my business, though I recognise that the interim report had obviously been extremely influential in the decision. The report then correctly quoted a Council statement that the Chief Executive *"has been advised of certain concerns in respect of the children and families division …. These concerns were raised by Mr John Barratt …"* It is important to establish that I have determinedly played no part in the disciplinary proceedings relating to the Assistant Director, in order to preserve my independence in considering whether to make criticisms of her as an individual.

A2.21. Informing the Council: (2) The Secretary

A2.21.1. At the end of June 1999 the Secretary for Social Services and Health Improvement was being briefed on the increasing disclosures of widespread incompetence. The Secretary was the leading majority Party Councillor dealing with the work of the Department. In the previous municipal year she had been the Chair of the Social Services Committee, and in the current municipal year she is the Executive Member for Children and Health. Her detailed contemporaneous notes have been helpful in understanding the following sequence of events.

A2.21.2. After a regular monthly briefing on 28th June 1999 she wrote critically to the Chief Executive, asking for more direct and prompt briefings simultaneously with the Leader of the Council. By this time, in addition to normal managerial requirements, the management of the deficiencies being revealed had to be undertaken. In the absence of both the Departmental Director and the relevant Assistant Director, this work had to be directed by the Chief Executive from a position of inevitable professional ignorance, despite the considerable assistance of Departmental officers holding temporary office.

A2.21.3. It was also a time for building a new informal network of senior decision makers, given the departure of both the Executive Director and the relevant Assistant Director. A new network developed ad hoc. If the eventual scale of the problem to be faced could have then been foreseen, a different process would have been appropriate.

A2.21.4. I make this cautious comment, because the need to maintain a flow of information about the work of the Department is a very important part in the linkage of the Council to the work of its Department. By normal standards there was unfortunate delay in informing the Secretary about the particular fostering concerns. If those concerns had stood alone, and if circumstances had been normal, I would be critical. But those concerns did not stand alone, and circumstances were not normal.

A2.21.5. On 9th August 1999, at a meeting with the Acting Assistant Director (Children and Families) the Secretary was told, for the first time, about the failures to carry out Police checks on foster carers. A second interim report from the independent Auditor had been made on 3rd August 1999, following a first interim report on 28th June. There was now no doubt about the widespread nature of the default in assessing foster carers.

A2.21.6. The coincidence of this timing with the Council August recess and related holiday absences then led to delays in informing others.

A2.22. The Service Manager's Report

A2.22.1. On 20th August 1999 the Secretary, at a meeting about several other matters, asked the Acting Executive Director for a progress report on the checking of foster carers. At a similar meeting a week later, 27th August 1999, she was told that the Service Manager of Family Finders had produced a long report which would be 'precis-ed' for her.

A2.22.2. The report prepared by the Manager expressed "*surprise that this appears to have become an issue now when I have informed senior staff …. of the depth and range of issues concerning quality of Lambeth foster carers from October 1998.*

This issue is one which has grown as the full extent of the problem became evident as I became more personally involved in looking at files and in effect reassessing assessments of foster carers following complaints from children.

In June of this year [the independent Auditor] *began work, after I brought up the issue of workload with* [the Acting Assistant Director Children and Families] *she suggested that I commission an independent auditor and to this end I have held social work posts vacant in order to fund her salary. …*

I think it is fair to say that my worst fears were confirmed by the independent audit as indicated by the following measure: working in alphabetical order, by the time she had got to foster carers with surnames beginning with 'C' 35% of them were the subject of Exception Reports by her to me. The Exception Reports included the following examples: ….
[The emailed report then contained the kind of examples of bad practice referred to in paragraphs A2.8.2. - 5. above.]

[A2.22.3.] *ACTION TAKEN*
Due to the time lag between authorising Police checks and receiving them back from New Scotland Yard (minimum 10 weeks) I took the initiative of meeting with the Head of the Police Child Protection Team … who had been appraised of the issue I have been facing by [X] *and* [the Acting Assistant Director Children and Families]. *He has agreed to put in place a fast track check against the Police National Computer of any carers where there are urgent questions about suitability to foster. This is working well and I expect to have all carers and relevant others checked by the end of November.*

Whilst the time frame may not be acceptable to members or indeed yourself I have made clear that much of the burden of this work falls upon me individually as the only person with a direct link with the Police Child Protection Team. I am sure you will be aware of the network issues as indicated by the fact that such a systematic breach of the Children Act Placement Regulations could be allowed to occur over a long period of time and in the face of the Utting report, Childrens Sageguards Review and other preceding documents. It is therefore problematic and risky to trust managers who are implicated in the policies and practices of the past to redress the consequences. This is the primary reason for employing an independent auditor. Within current budgetary constraints I cannot afford to employ any extra staff to progress the checks.

[A2.22.4.] *NEXT STEPS*
There is a cost to this level of attrition and am currently losing or blocking a foster care placement at the rate of one a fortnight with the attendant consequences for availability of resources in-house. Although I have met with Outhouse, a launch is planned in September and expect to have up to 60 carers presented to Panel by February next year. The consequences of my actions are that there is continuous pressure on the agency budget. There is simply no short term fix because I firmly believe that unless the deficits outlined above are addressed vigorously Lambeth Children Looked After will continue to be in placements of unacceptable risk. …."

A2.23. Delayed Reporting

A2.23.1. On 31st August 1999 the Secretary wrote to the Chief Executive, protesting at the fact that she had only been informed about the foster carer problem on 9th August, and ended: *"I would like you to give Cabinet an update on children and families issues as soon as possible. I would also like the opposition spokespeople on social services, …., to be given specific briefings about developments in the children and families division."*

A2.23.2. By 3rd September 1999 the Secretary had still not received the promised precis of the Service Manager's note, so she obtained a copy of the original directly from him. I understand that the delay was occasioned by the absence on leave of the Acting Assistant Director, Children and Families, who was the only senior person with relevant expert knowledge to assess what the Manager had written.

A2.23.3. I do not criticise any individual for this obvious organisational failure to inform the Secretary, given the exceptional organisational pressures referred to in previous paragraphs. I am not aware of any sinister reason for the failure, and I see no purpose in wasting time pursuing such a matter, given the general tenor of this Report. However, the need to address the quality of communication between operations and politics in times of crisis should be noted.

A2.23.4. On 6th September 1999 the Secretary had a meeting with the Chief Executive, who had returned that day from holiday, and they reviewed the situation before the Cabinet meeting later that day. By this date the Chief Executive could have been in no doubt that the Report on the first Inquiry, SPR, to be published later that month, would be very critical of the Division. At the Cabinet meeting a week later, 13th September 1999, the Secretary formally proposed that funding in the current year should be guaranteed for several measures to promote the safety of children and to improve practice.

A2.24. Appropriate Responses?

A2.24.1. Given the abnormality of the Departmental situation, and the scale of the responsibilities falling on inexperienced shoulders, I do not think it right to criticise the appropriateness of individual responses made "*to information about service failure*", whether by *"management or others",* despite the delays I have identified. The combination of the ever-increasing scale of service failure being revealed and the small number of people available to cope with the situation resulted in extraordinary burdens on the individuals involved.

APPENDIX 3.

CRITICISM OF INDIVIDUALS

PART 1. INTRODUCTION

A3.1. The relevant Terms of Reference

A3.1.1. My status in making any criticism of individuals rests on the same basis as for the whole of the work of the two Inquiries, namely the commission given to me by the Council. I am not an official, and the criticisms that I make therefore have no status, other than as the opinions of an independent private individual based on the investigations described in this Report. I have, however, been conscious that the Council is likely to publish my Report in full.

A3.1.2. The fourth Term of Reference of the first Inquiry was: *"To make explicit any demonstrable failure by current or past employees to act in the best interests of children and young people which may become evident in the course of* [the] *investigation."* The third Term of Reference of the second Inquiry was: *"Whether management or others did/did not respond and act appropriately in response to information about service failure."*

A3.1.3. I am, therefore, specifically required to report to the Council on the appropriateness of the conduct of individuals involved in the subject-matter of the first Inquiry and, by implication, of those involved in the subject-matter of the second also. In the Conclusions and Sub-Conclusions set out in the Report I have criticised, in impersonal terms, the Department's work which the Inquiries have examined. The criticism of individuals contained in this Appendix is not an alternative criticism of the Department's work. It is a discrete topic, confined to the quite narrow limits of the response to Alan's 1996 disclosure, for the reasons now given.

A3.2. Reasons for avoiding a Process of Individual Criticism relating to the Department's past general incompetence

A3.2.1. Despite the local publicity given to SPR, the major failures in the Department's general competence which SPR clearly indicated have not been disputed, so far as I have been made aware. This Report includes three further histories which also clearly reveal major failures. The existence of these failures is a very serious matter. I can understand, and share, the anger of those who think that anyone directly responsible for any of these failures - officer or Councillor - should be held publicly accountable for the breach of public trust involved. I have been compelled to avoid such a task for both theoretical and practical reasons.

A3.2.2. In any event, public criticism of individuals should have a justification beyond the need for good management, since good management would normally deal with poor individual performance in other, less public, ways.

A3.3. The theoretical reasons

A3.3.1. The theoretical reason was that the two sets of Inquiry Terms of Reference were dominated by two specific subject-matters - disclosures of abuse by Alan, and Police checks on foster carers, respectively. But the Inquiries' main Conclusions regard the relevant identified failures as symptoms of a basic organisational failure. Any general pursuit of individual failure would inevitably have to relate to all those responsible for this organisational failure. This is a task way beyond the Terms of Reference's intentions.

A3.3.2. The relevant Term of Reference of the first Inquiry refers only to the part played by *"employees"*. Councillors, collectively, determine the 'atmosphere' in which Departments have to work. If this were not so, local democracy would be a charade. To ignore the role of Councillors in a pursuit of individual responsibility for general organisational failure would leave many relevant issues in the air.

A3.4. Practical Reasons

A3.4.1. After careful thought, I decided not to ask the Council to consider new and wider Terms of Reference, for the following practical reasons:

(1) The potential work involved would be very considerable. The *"demonstrable failures"* in Alan's general care which had "*become evident in the course of* [the] *investigation"* occurred over a long period, and involved many people. The basic first Conclusion (paragraph 2.3.3. above) which has arisen from the Inquiry's process is about the failure of the Council as a system of government. Any proper examination of individual responsibility for the major organisational breakdown with which Lambeth is still dealing would have to examine the formal and informal inter-relationships between individual people - Councillors and officers. It would have to range much more widely than the Department's affairs alone. Occasional incompetence or impropriety by an individual Councillor, officer or contractor may disrupt the best of organisations. The depth and scale of Lambeth's past organisational incompetence is unlikely to be explained by the misbehaviour of a few readily identifiable individuals.

(2) I am extremely doubtful if an Inquiry established by a local authority, which cannot have power to compel the presentation of evidence, could satisfactorily widen its task to analyse individual responsibility for such political failure and its operational consequences. Even in the limited investigations which I have undertaken, some people involved in Lambeth's past have failed to respond to requests for help.

(3) Many of the people involved, whether senior or junior officers, and whether in the Social Services Department or in central Departments, have now left Lambeth's employment. Many of the Councillors of former times are no longer Members of the Council. I have found it difficult to trace some former employees and Councillors in dealing with some of the comparatively confined subjects on which I am reporting. The task of ensuring comprehensive information would be immense.

(4) Lambeth's patchy records would provide only limited written information. In addition to extensive gaps in the documentary record, it is also likely that there would be conflicts of both genuine and edited oral recollections. The support needed by an Inquiry to examine the formal and informal organisational history of the Council in sufficient detail to support individual criticism would be considerable.

(5) The Department has a demanding enough role in fulfilling its important normal duties, and is already in danger of being overwhelmed by the inevitable requirements of new staff, and new processes. The Department now has a new Chief Officer, and many other changes in senior and middle management have been, or are being, made. Because new officers are not familiar with the past, the task of assisting an Inquiry to discover the past would fall disproportionately onto others. Further, the challenge of organising much needed radical changes in the Department is having to be met through an inherited inadequate organisation. Even in the relatively restricted scope of these two Inquiries I have constantly had to balance the needs for Departmentally based information with the more urgent demands of current work on the time of willing respondents. Any detailed examination of the past would inevitably cause a major diversion of focus and effort for the Department.

(6) The process of individual criticism rightly has to comply with the rules of natural justice as enforced by the Courts. The greater the range of adverse conclusions against individuals, the greater the complexity of the process needed. An informal Inquiry's lack of formal judicial status would weaken its role considerably in choosing between different sets of recollections. The problem has been illustrated within the limited scope of criticism I have adopted. It would be unwise to embark on such a course without the constant availability of legal advice, and a lengthy and expensive forensic process.

(7) The expense involved in such a major investigation would represent a huge burden to the Council.

(8) The extra time involved would delay reporting the Inquiries' organisational findings.

A3.4.2. I acknowledge the force of public accountability, as a reason for pinning down individual responsibility for the conduct of public affairs. Important executive responsibilities fall on both Councillors and senior officers. If the Council insists that its past history should be investigated comprehensively, in order to establish individual accountabilities for the inherited incompetence of its organisation, it will need a formal Tribunal of Inquiry for the purpose. It can try to persuade the Government that such an Inquiry should be established. The Council would have to be very persuasive about the benefits which it thinks would follow. Such an Inquiry would divert the cost involved to the Government's own funds, but the disruption and diversion of the Council's ongoing work would remain. It is not a course which I recommend. Whilst individual criticism in a public Report is dramatic, it can too easily divert attention from the underlying organisational problems. The Council now needs workhorses, not scapegoats!

A3.5. Two closely related Matters

A3.5.1. Although, for these reasons, I have not investigated individual responsibility for the Council's organisational disintegration in the 1980s I have reported on two closely related matters.

A3.5.2. First, in sub-sections A3.7 - A3.15. below, I deal at some length with the accountability of those responsible for the general management of the Council, and of the Department, at the time of Alan's disclosure in 1996. Secondly, in Appendix 4, Part 2 below I have included an account of my pursuit of the repeated failure of Councillors and senior managers to visit Children's Homes in accordance with the law and the Council's decisions throughout the 1990s. This incidentally provides an illustration of some of the above practical reasons for not pursuing individual criticism more generally than I have in Part 2 of this Appendix.

A3.6. Individual Criticisms relating to the Inquiries' two specific Subject-matters

A3.6.1. The first Inquiry's subject-matter, the response to Alan's disclosure in 1996 of sexual abuse whilst in the Council's care, obviously raises questions about individual responsibility, and I have pursued them. The second Inquiry's subject-matter, Police checks on foster carers, does not raise any new basic issues about individual responsibility. Further, the abnormal background described in Appendix 2, Part 2 above makes further consideration of individual criticism inappropriate.

A3.6.2. I have therefore confined the process of individual criticism to the subject of the Departmental response to Alan's 1996 disclosure, and I have been further confined by the absence of relevant written records relating to some of the circumstances.

A3.7. Those in the related Council Organisation - 'others'

A3.7.1. The fourth Term of Reference of the first Inquiry asks me to report "*any demonstrable failure by current or past employees…".* I should immediately emphasise that I am not aware of anyone in another part of the Council's organisation being told about Alan's disclosure in 1996. Responsibility for the failed response can rest, in a direct sense, only on the Department's employees involved in making a response.

A3.7.2. However, I have thought it prudent to consider whether people in other parts of the Council's organisation should have intervened because they were, or should have been, aware of general organisational failure. Was their individual failure to address this general organisational failure in the Social Services Department a blameworthy cause of the failure to respond properly to Alan's disclosure?

A3.7.3. This is not the same matter as the much wider one of individual responsibility for historic organisational failure discussed in sub-sections A3.2. - A3.4. above. This is a much more focussed question about whether others knew of, and ignored, the symptoms of organisational disintegration which allowed the individual direct defaults involved in the response to Alan's disclosure to go unchecked. Why did those outside the Department's own management, but with supervisory responsibilities for the Department as a whole, not tackle the serious, widespread failures of the Children and Families Division revealed in these Inquiries, until late 1998?

A3.7.4. Although the fourth Term of Reference of the first Inquiry confines my critical examination of individuals to *"employees"*, I think it right to state that I have not on that account excluded consideration of Councillors with relevant responsibilities. In any event, the third Term of Reference of the second Inquiry refers more generally to "*others",* and this more focussed question is also relevant to the similar background of the second Inquiry.

A3.7.5. Sometimes I hear it said that 'the person at the top' should automatically take the blame when something has gone wrong. I reject this unreservedly. Such a notion, like all scapegoating, diverts attention from finding the real cause(s) of a scandal. In any event, in a local authority the elected Council itself is, in law, the 'person at the top'.

A3.7.6. The basic question, however, remains. Should *"others"* - the corporate 'centre' - have intervened in the management of the Social Services Department because they were aware, or should have been aware, of general organisational failure? The answer, in my view, has to be that *"others"* were not aware from 1996 to 1998 of the nature or scale of organisational failure. Nor had they any reason to give priority to exploring if there was failure, given other more demanding priorities.

A3.7.7. The immediately following paragraphs give some indication of the relative scale of the organisational challenges which faced these "*others"* at the time. They also indicate the steps which the *"others"* took to strengthen the senior management of the Department in 1995/1996. The lack of effective warning to these *"others"* of managerial incompetence in the Children and Families Division from the external Social Services Inspectorate is also relevant (Appendix 4, Part 3 below). I can see no good reason for pursuing a process of individual criticism against these *"others"* on this account.

A3.8. The Council's Organisational History

A3.8.1. I, and the reader, have to remember that we have been concentrating, in these two Inquiries, on particular topics relating to the Social Services Department, to the exclusion of other topics relating to the Council generally. In considering this question about awareness of general organisational failure in the Social Services Department I have tried to understand the task which faced those *"others".* From the mid-1990s, there has been a determined corporate effort to create a more effective organisation for the Council.

A3.8.2. It will serve no useful purpose to set out a detailed description of the sad state to which the Council's organisation generally had sunk by the early 1990s. It is, however, useful to give a broad description, because it is against this background that the work of individuals in positions of corporate power in the mid-1990s has to be judged.

A3.8.3. The Department's state of competence was only one facet of the organisational problems which resulted from the Council's conduct in the 1980s. The primary challenge to the *"others",* therefore, was to deal with all these organisational problems, but to do so by reference to compelling priorities. Even Hercules would have had to start the flow of the diverted river into one end of the Augean stables!

A3.8.4. In trying to understand this wider organisational context in which the Social Services Department operated I have examined the findings of other independent investigations. This approach has reduced the two Inquiries' workload, whilst providing sufficiently robust information concisely.

A3.9. The District Auditor's Reports and Letters

A3.9.1. One such valuable source of information has been the annual Management Letters to Councillors from the District Auditor on the general organisation and work of the Council, and other Reports of the District Auditor. The District Auditor is concerned with probity, regularity, economy, efficiency and effectiveness, and is appointed by the Audit Commission. He is independent of the Council. One of the Auditor's Public Interest Reports (May 1993) stated that Lambeth had been the object of 17 other Public Interest Reports (i.e. public reports on significant matters about which the Auditor was seriously concerned) between 1979 and 1993! Normally, one Public Interest Report would be a significant and alarming event. The last Public Interest Report for Lambeth, I am told, was in September 1997; an indicator of progress.

A3.9.2. The following extracts from the District Auditor's Management Letters to the Council give some indication of the organisational challenges. The Management Letter dated December 1990 stated:
"3. For a number of years audit reports and Management Letters have recorded a bleak history of management within the Council. The catalogues of weaknesses have made gloomy reading and successes have been few and far between. I am pleased to be able to acknowledge that real progress is now being made in some key areas and that the Council has substantial plans for continuing improvements. ……

5. Audit opinions on the Council's 1985 - 6 and 1986 - 7 accounts have now been given. They were very heavily qualified, mainly as a result of the Council's inability to provide adequate working papers or evidence to support the accounts.

6. I am currently auditing the Council's 1987 - 8 accounts; it is likely that this will also lead to a substantial audit qualification. …"

A3.9.3. The Management Letter dated March 1992 stated:
"2. In my Management Letter last year [sic] *I referred to the bleak history of management within the Council but was able to acknowledge the progress being made and the Council's many plans for further improvements… But I regret that in a number of key areas these plans have not been achieved on target and the Council continues to be managed without some basic information on which future plans and current decisions should be based. ……*

7. In every year since 1984 the Council has failed to meet its statutory duty to publish a Statement of Accounts within nine months of the end of the financial year. The 1989/90 draft Statement of Accounts is still to be signed by the Director of Finance. In addition the Council has now failed to meet the deadline for the 1990/91 Statement of Accounts."

A3.9.4. The Auditor recorded (at 12): *"The latest report* [from the Director of Finance Services to the appropriate Council Committee], *dated 5 February 1992 projects a revenue deficit of £13.6m at 31 March 1992. This compares with the position originally set out in the 1991/92 budget which projected a surplus of £4m at 31 March 1992. Like many earlier budget strategy reports, the current report contains a number of uncertainties. This means that there is not yet a firm basis on which to prepare the 1992/93 budget."* The 1992/93 budget's Financial Year was due to begin within days.

A3.9.5. The Management Letter dated January 1993 included advice so elementary that it would have been an insult, had it not been justified:
"10. The starting point for financial management remains the statutory personal responsibility … of the Director of Financial Services. It is for Members to develop a clear policy framework within which the Director can discharge his statutory duty, whilst at the same time meeting the Council's own stated objectives of delegating financial management to the points closest to service delivery. Before this can be done the Authority must have in place the rules, standards and infrastructure necessary to ensure that delegation operates within a controlled and professionally managed environment."

A3.9.6. The Management Letter dated December 1994 was written after the Elections of May 1994 had brought in a 'hung' Council. This is a situation which in itself can create disruptive organisational dynamics, if there is not an overriding commitment to the needs of the Borough. The Letter referred (at 12) to:
"the absence of political leadership and direction.

13. It appears that much time at Council and Committee meetings has been taken up by motions and arguments reflecting personal animosity between Members or other matters which have not had any direct connection with the provision of services to the Borough's electors and taxpayers. We remain concerned that Councillors are diverted by such matters from their proper duties. …. …

Members have on occasions criticised the performance of officers and we have emphasised the need to recruit and retain high calibre officers who can deliver continuing improvements and help to ensure that the Council is successful in achieving value for money from its resources."

A3.9.7. The organisational challenge was eventually faced by this 'hung' Council, but the political, managerial, financial and bureaucratic systems by which change could be achieved had themselves become grossly defective. Severe and painful decisions had to be made to bring the Council's expenditure under control and to correct previous unwise financial management. Many situations, particularly (I was told) those involving corruption, cried out for urgent amendment.

A3.9.8. The Management Letter for 1994/95, written just before Alan made his disclosure, was hopeful. *"Although many weaknesses still exist in the overall management arrangements of the Authority, there have been significant improvements and many plans are now in place for further changes. Despite the lack of overall political control by any party, we believe that a genuine commitment to securing beneficial change has become more apparent during the past year."* (at 8).

A3.9.9. The Management Letter for 1996/97 stated: *"3. Overall, our audit has demonstrated that the Council is making good progress in a number of areas. It has improved the quality and timeliness of its annual accounts and performance indicators and has strengthened its overall arrangements for preventing and detecting fraud and corruption. The Multi Phased Programme of targeted improvements in service delivery is now delivering real benefits. In other areas there is still much to do, particularly in addressing the financial position and the weaknesses in financial systems."*

A3.9.10. The Management Letter for 1998/99 stated: *"Our overall conclusion is that the progress made in recent years has continued. …*
That is not to say that there are no key issues left to tackle … but it is clear to us that the moves forward made in recent years are having a positive effect."

A3.10. The Appleby Report, 1995

A3.10.1. Another valuable source of information on the size of the task facing the "*others"* in the mid-1990s has been the Report of Miss Elizabeth Appleby, Q.C. dated July 1995. This was six months before Alan's disclosure. The Report's Terms of Reference were widely drawn but did not specifically refer to the Social Services Department. The following extracts from the Appleby Report, based on an independent Inquiry which had taken place in the previous two years, also indicate the general organisational chaos of the Council's organisation.

"7. Whilst I was instructed to focus on a number of specific areas as time went on it became clear to me that Lambeth's problems were widespread and that it would give a false picture of Lambeth if I limited myself to specific areas. Whilst my report concentrates on particular matters I am satisfied that Lambeth is in an appalling mess and that it is unlikely that any department is properly managed.
……..

12. Lambeth's difficulties can be traced back to the late 1970s and 1980s. It was during this time that the seeds were sown which have led to Lambeth's current problems.
……

97. Lambeth is in an appalling mess. The financial control of Lambeth is such that vast amounts of money are wasted and, in consequence, services are severely prejudiced.
…..

98. The source of Lambeth's problem can be traced to the eighties. Those years seem to have created a "culture" in which Lambeth is trapped. The mismanagement of Lambeth has merely grown and grown and became more widespread over the years. I have not looked into each and every Directorate of Lambeth, but I would be very surprised if any department is free from mis-management. I strongly advise Lambeth members to proceed on the basis that mis-management is to be found in each and every Directorate….."
Anyone doubting the massive nature of the challenge facing those involved in dealing with the Council's organisational collapse by the mid-1990s should read these reports.

A3.10.2. The task of responding to the paragraph from the Appleby Report just quoted, thereby creating a sound basis for management of the Council's organisation, was obviously a primary task for the *"others".* The probability, according to the Appleby Report's strong advice about *"each and every Directorate",* of mis-management in the Social Services Department also faced the Council. The *"others"* therefore renewed the Social Services Department's senior management in 1995/1996 (sub-section 6.1. SPR).

A3.11. 1996 Changes in The Social Services Department's Leadership

A3.11.1. A new, experienced and well-recommended permanent Executive Director of Social Services took charge in May 1996, following an experienced and well-recommended interim Acting Director (6.7.7., 6.8.7. SPR). This and other senior Departmental appointments were carefully made by the Council, backed by external professional recommendation and advice.

A3.11.2. The need for the imposition of financial discipline was a continuing major challenge to the Department's senior management. They also had to deal with other crises unrelated to these two Inquiries. The downsizing of the Department absorbed a lot of senior management time. The scale of the downsizing is shown by the following crude statistics of the Departmental workforce. At the financial year end 1995/96, I have been informed, there were 1598 employees, at financial year end 1996/97 there were 1501; and at financial year end 1997/98 there were 1099. Other organisational and behavioural changes were initiated by the extremely pressured new senior managers.

A3.11.3. Criticism of the Department's failures identified in this Report must not obscure the considerable improvements which were achieved for the Council by the new senior managers. Individual criticism of two of these senior managers of the Department is made, in relation only to the Departmental response to Alan's disclosure of abuse, in Part 2 of this Appendix.

A3.11.4. Some people involved in children's matters continued to have anxieties about the Department's competence. I am not aware of any information, however, which should have caused the *"others"* to interfere in the responsibilities of the new Departmental management appointed in 1996. In the absence of the detailed evidence which has recently come to light, the appointment of new senior managers was a sufficient step to have taken. Against this extraordinary background of overall organisational disintegration, I can understand how the now obvious deficiencies in the Children and Families Division in 1996 were obscured by a very pressing and considerable workload of greater priorities. Study of the independent reports from the Auditor(e.g. sub-sections A4.44.-46. below) and Miss Appleby, to which I have just referred, makes these other priorities clear.

A3.11.5. Warnings about the work of the Department had not featured specifically in either the Management Letters, or in the Appleby Report. Indeed, although the District Auditor's Management Letter of December 1994 had referred to children's services, the promised report to Councillors on *"some areas where improvements are needed"* never materialised, so far as I have been able to discover. It was not until mid-1998 that concerns surfaced about the past record of the Children and Families Division, and this quickly led to the setting up of Operation Middleton.

A3.12. Social Services Inspectorate Reports

A3.12.1 The District Auditor and Miss Appleby were not concerned specifically with the work of the Children and Families Division's predecessor Divisions. The Department's children's services were the subject of inspections by the SSI. The SSI reports of 1993, 1994 and 1997 are referred to in SPR and comment is made on their lack of managerial effect in Sub-Conclusion 11 above, and Appendix 4, Part 3 below.

A3.12.2. The criticisms made by the Inspectorate of the Divisions' work were discussed between the Inspectorate and the Department's professional management as matters of professional interest. There was never any hint in those inspection reports that the Department was organisationally incapable of amending its practice where recommended to do so. SSI Reports were put to the Social Services Committee, with recommendations from the Department consisting of appropriate sounding responses. This subject is dealt with in more detail in Appendix 4, Part 3 below.

A3.12.3. I have not been able to find any evidence that Social Services Inspectors ever directly reported in a formal Report that they questioned the managerial ability of the Department, until the report on the *"Inspection of the SSD Arrangements for Care Programme Approach/Care Management"* relating to Mental Health Services. This was reported to the Social Services Committee in February 1999, and the corporate *"others"* then became involved in this particular aspect of the Department's work (sub-section A4.43. below).

A3.12.4. It is not that warning signs were not given by the SSI. They pointed to matters of serious professional concern. But there was little to draw the attention of laypeople, Councillors or corporate officers, to any underlying organisational incompetence of the children's services.

A3.13. The Chief Executive

A3.13.1. A new Chief Executive was appointed by the Council in early 1995, and for present purposes, it is appropriate to regard her as one of the *"others".* I have dealt with her exposed position specifically for two reasons. First, because the shallow 'person at the top' view of responsibility, to which I referred in paragraph A3.7.5. above, might be repeated in relation to her. Secondly, because something of her positive response, once alerted, should be asserted, rather than just a negative statement of no criticism.

A3.13.2. The preceding paragraphs about the Council's proper priorities necessarily applied to her priorities too. The Chief Executive's main concern with the Social Services Department was its budgetary performance, until she became involved with Operation Middleton in late 1998. The 1995/1996 Social Services Budget, although it was the largest in the Council's history before, or since to 1998/1999 (the limit of my investigation), had developed an overspend by July 1995 (paragraph 5.15.1. SPR). By the end of the financial year the Budget was in balance.

A3.13.3. Prior to Autumn 1998, the Children and Families Division's affairs gave no reason for priority treatment over the parts of the Council's organisation that obviously required urgent and radical attention. By contrast, once alarm signals began to sound in Autumn 1998, the Chief Executive enabled the Council to initiate thorough investigations (including the first of these two Inquiries). I have been struck by the contrast between decision-making relating to Social Services before and after the Chief Executive received my May 1999 Report. When I raised my concerns with her in Spring 1999, she acted immediately and decisively. By this time the Chief Executive had become increasingly involved in some of the work of the Children & Families Division, through her close attention to the setting up and work of Operation Middleton.

A3.13.4. The Executive Director of Social Services who had commenced work in 1996 left Lambeth to take up another appointment on 14th May 1999. By this time the Chief Executive had become even more closely involved with the management of the Division. As a result, several managers and other staff were removed from office. A series of audit checks were authorised, to challenge the acceptability of current practices in the Children and Families Division. It was by this process that the deficiencies in foster carer checks were revealed, which led to the second Inquiry.

A3.13.5. I reported to the Council in SPR in September 1999, thus making the Council's failures relating to Alan public. It was because of the work that had already been led by the Chief Executive that a comprehensive Action Plan was immediately ready for the Policy Committee on 6th October 1999 (64/99-00). The Chief Executive left Lambeth's service, at the end of her contract, on 18th February 2000.

A3.14. The Chair of the Social Services Committee

A3.14.1. Although, in May 1999, the Council adopted a new arrangement for the Council's decision-making, the former orthodox role of the Chairman of the Social Services Committee in the period immediately prior to Alan's disclosure also included de facto involvement in executive responsibilities. Obviously, such a person comes within the scope of *"others".* I have described the long-standing ineffectiveness of the Council's Committee system in Sub-Conclusion 1 above.

A3.14.2. I can see no reason for criticising the Chair or the Committee in this context of the response to Alan's disclosure. The Departmental response was so limited that its wider implications were never properly pursued even within the Department. Consideration of the disclosure never reached a stage from which the Executive Director could have passed on information, even informally and confidentially, to the Chair.

A3.15. An important Generalisation

A3.15.1. I have singled out the Chief Executive for particular praise. In relation to all the *"others"* I wish to place on record that I was impressed by the seriousness with which Councillors, of all Parties, and officers holding corporate responsibilities, have supported and received the work of the two Inquiries.

PART 2. CRITICISM OF INDIVIDUALS INVOLVED IN THE RESPONSE TO ALAN'S DISCLOSURE

A3.16. The Danger of Over-reaction

A3.16.1. The main purpose of an Inquiry Report is to establish what happened when past conduct appears to have given rise to a scandalous situation. The exposure of inadequacy should encourage the ending of any bad practice and provide a basis for renewal. In these two Inquiries so much has been shown to have been wrong with the Department's past organisation that there is an inevitable negative emphasis in this Report, with a danger of causing a blanket over-reaction.

A3.16.2. Some work has been well done. Most poor work has been caused by inherited organisational weaknesses. It would be morally outrageous if individuals were to be condemned merely by current association with the matters investigated. It would also inhibit organisational recovery.

A3.17. Recognition of inadequate Work

A3.17.1. In this Appendix about public criticism of individuals I have concentrated on those who occupied senior public offices. The Council is entitled to know if these individuals, in particular, fell short of what the Council was entitled to expect, at a time when the Council was striving to improve the effectiveness of its services.

A3.17.2. Some criticism can be made of more junior officers, many no longer employed in the Department, in relation to Alan's disclosure. I have had regard to their heavy and difficult workload, and to the concurrent acute shortage of staff and organisational dysfunctionality. I have not thought it right to include individual criticism in this Report of conduct which, in other circumstances, would properly have been discussed in private as part of good managerial supervision.

A3.17.3. This does not mean that I am ignoring these deficiencies. Late though it is, I have written to the Executive Director, pointing out work which could have been done better. It will be more appropriate for her to continue to pursue such matters managerially. Given that, in almost all cases, these people are no longer employed by the Council, my purpose in writing relates to organisational lessons to be learnt.

A3.18. Recognition of good Work

A3.18.1. In making criticisms of some officers I do not want to diminish the excellent work of others. It is as difficult to apportion praise fairly as it is to criticise fairly. In any event, neither SPR nor this Report names any of the officers involved in Alan's care, other than the two officers whom I publicly criticise in Part 2 of this Appendix. I am not, therefore, going to single out officers for praise in this Report. I have written to the Executive Director, asking her to write to some of those involved in Alan's care after 1995, passing on the Inquiry's appreciation of their skill and commitment.

A3.18.2. One general comment is particularly important in emphasising the existence at all times of good work in the Department. The processes of exposing and remedying both the failed response to Alan, and the poor practice relating to fostering, sprang from initiatives and persistence by the Department's own staff. Both of the Inquiries resulted from internal vigilance, skill and determination, not from exposure by an external source.

A3.19. The Management of the Department

A3.19.1. In the previous Part of this Appendix I dismissed the possible culpability of the *"others",* those with corporate responsibilities outside the Department's management, for not having interfered in the management of the Department. It is now incumbent upon me to demonstrate to the Council that I have also carefully considered the accountability of all those holding office in the Department's relevant senior managerial structure. The criticism process has included consideration of the actions of several more Departmental officers than the two openly criticised in this Report. I now set out the reasons why I have decided not to criticise their involvement with Alan's disclosure.

A3.19.2. The overall responsibility for the conduct of the Social Services Department lay with the then Executive Director. I explained in paragraph 6.7.6. SPR why I do not criticise the person who was the temporary Acting Director at the time Alan made his disclosure. Criticism of the Executive Director who succeeded him in office is made in sub-section A3.25. below.

A3 19.3. Within the Social Services Department there were two Divisions whose officers should have been directly involved in the response to Alan's disclosure - the new Children and Families Division and the new Quality and Strategy Division. The Acting Assistant Director in charge of the Children and Families Division was, from the beginning, in apparent personal charge of the Departmental process for organising a response to Alan's disclosure (Section 6 SPR). Criticism of this Assistant Director is made in sub-section A3.26. below.

A3.19.4. Those under the Assistant Director's control can only be subjected to criticism if they disobeyed her, or failed properly to support the process which she directed. In examining the details of what happened within that Division's work, I have noted some work of the Assistant Director's subordinates of which I am critical, but none of sufficient contributory seriousness to warrant criticism in this Report. As explained in sub-section A3.17., I have written to the current Executive Director for her to pursue these criticisms managerially.

A3.19.5. The Assistant Director in charge of the Quality and Strategy Division, and his subordinates, all took repeated action to enable a Child Protection process to be re-instated, from the time they were first aware of Alan's disclosure (paragraph 6.17.2. and Section 7 SPR). This included twice referring their concerns to the Executive Director of the Department. When a new opportunity arose to pursue their concerns in 1998 they immediately took it (Section 8 SPR). When their conduct is viewed in this way, further consideration of their conduct by way of criticism does not arise.

A3.20. Reasons for making individual Criticisms in this Report

A3.20.1. I have decided openly to criticise two senior officers in relation to the Departmental response to Alan's disclosure of abuse in 1996 - the former Executive Director of the Department, Ms. Celia Pyke-Lees, and the former Assistant Director (Children and Families), Ms. Constantia Pennie. I make the criticisms in this public Report for the following reasons:

(1) According to their Job Descriptions, both these officers were appointed by Councillors expressly to advise the Council directly, and to implement the Council's policies. The Council therefore have a properly direct interest in their performance.

(2) In both individual cases the default is sufficiently significant and serious to justify inclusion in a Report to the Council.

A3.21. The Background to the individual Criticisms

A3.21.1. The criticisms which follow are ones I consider to be inevitable in the light of well-established facts, and to relate to what is unacceptable and unreasonable conduct. In considering whether or not to criticise, I have taken into account the heavy workload, the organisational upheaval of 1995/96, and the background organisational deficiencies of the Department. I have constantly remembered that throughout 1996 both these officers were working under considerable financial and other pressures, and that they had to work through a defective organisation.

A3.21.2. In the general response to Alan's disclosure there is evidence of a lack of corporacy, inadequately implemented procedures, inadequate supervision, inadequate practice, inadequate inter-agency communication and co-operation, and inadequate paper work. These circumstances provide considerable explanation for several parts of the Department's inadequate response, and also considerable mitigation for inadequate performance. I am satisfied, however, that these circumstances do not explain or excuse the detailed conduct which I specifically criticise. The conduct which I criticise was freely chosen by the officers in question, and was not determined by this background.

A3.22. The Criticism Procedure

A3.22.1. The procedure I followed before finally deciding to criticise these two individual officers was as follows. First, I looked at the course of events which followed Alan's disclosure of abuse in January 1996, basing tentative criticisms mainly on the information which was referred to in SPR. In addition I used some information which is still confidential client information, and some which, to avoid prejudice in that Report, was confidential at the time SPR was published.

A3.22.2. I then wrote individual letters to the two former officers containing lengthy, detailed statements. These explained why I was minded to be critical, gave the precise nature of the tentative criticisms, and set out the facts on which those tentative criticisms were based. I expressly warned that the tentatively expressed criticisms were likely to be included in the Final Public Report, unless they were persuasively countered.

A3.22.3. In the letters I explained that I would consider their response, which could be made in writing, or at a formal meeting, or both. I also invited the two officers to produce information in support of any counter-arguments. I offered to try to persuade witnesses to attend any meeting for cross-examination. Both former officers responded to these letters, Ms. Pyke-Lees in writing, and Ms. Pennie in a series of three formal meetings. I then considered these responses carefully, before reaching final conclusions. It is not appropriate, in a Report of this kind, to set out the lengthy detail of this process. I have, however, given to the Borough Solicitor a copy of both the letters of criticism and of Ms. Pyke-Lees reply, and the tape recordings of the meetings with Ms. Pennie. There are managerial lessons to be learnt from the detail involved. In any event, the Council is in dispute with Ms. Pennie over her dismissal, and it is right that the Council should be able to consider the further information disclosed by the investigation into the first Inquiry. There may be matters relevant to that separate process which I have decided not to pursue, given the stricter limits I have accepted for the process which I followed.

A3.23. Missing Documents

A3.23.1. The criticisms are based on the history I have reconstructed from the recollections and explanations of those involved, but only insofar as corroborated by contemporaneous documentation. Because important parts of such documentation are now unavailable, the scope for reliable criticism by a 'voluntary' Inquiry such as this is thereby confined. The now missing documents which we have been told once existed include the confidential sub-file relating to Alan's 1996 disclosure (6.7.2. SPR), the supervision notes kept by both the Director and the Assistant Director (Children and Families) for the relevant period in 1996, and computerised records of e-mails sent by the Assistant Director. In addition we have had to consider allegations of lies being told to us by others, and the deliberate removal and falsification of documents.

A3.24. The Form of the Criticisms

A3.24.1. In the following paragraphs I set out the criticisms which have resulted from this process. I have not introduced any criticisms beyond those expressly put in writing to the two officers involved. I wish to make it absolutely clear that the criticisms relate exclusively to the subject-matter to which reference is expressly made. It is important that the reader of this Report should consciously separate responsibility for the wide range of serious failure revealed in SPR and elsewhere in this Report from the specific criticisms which follow.

A3.24.2. To understand the significance of the specific criticisms the reader must turn to Sections 6 and 7 SPR.

A3.25. Criticism of the former Executive Director

A3.25.1. The former Executive Director of Social Services, Ms. Celia Pyke-Lees, had to deal with an enormous challenge in leading the Department. An impressive number of people from many backgrounds have spoken to me about her openness to colleagues, and about the improvements which she led.

A3.25.2. However, I am very critical of Ms. Pyke-Lees in relation to the Departmental response to Alan's 1996 disclosure of abuse, on the following two counts:
(1) for failing to understand the serious implications of the continuing challenge by the Assistant Director responsible for the Child Protection specialists to the Departmental response to Alan's 1996 disclosure; and
(2) for failing, in her conduct of the meeting of 28th October 1996, to grip the situation.
These were very serious failures of leadership.

A3.26. Criticism of the former Assistant Director (Children and Families)

A3.26.1. The former Acting Assistant Director, Children and Families, Ms. Constantia Pennie, had a very heavy workload in that post. She also remained responsible for her previous post as Head of Adoption and Fostering throughout 1996. It is clear that during this period she led several improvements in Departmental practice.

A3.26.2. In the meetings which followed my letter of tentative criticism, Ms. Pennie made clear that she had used the Children and Families 1995 Child Protection Procedures and the 1992 Inter-Agency Procedures, in responding to the Area Manager's memorandum to her of 5th February 1996 (6.3.5. SPR).

A3.26.3. I am very critical of Ms. Pennie in relation to the Departmental response to Alan's disclosure of abuse on the following four counts:-
(1) for failing to involve the Child Protection specialists in the consequences of the second Planning Meeting, which she had chaired;
(2) for failing to ensure that other senior Managers were involved in discussion of the issues of wider significance, after the second Planning Meeting;
(3) for failing to involve the Child Protection specialists in the third Planning Meeting, which she chaired, and in its consequences; and
(4) for failing to respond appropriately to the Departmental significance of Alan's disclosure, when repeatedly challenged after the third Planning Meeting.
These were very serious failures of leadership.

APPENDIX 4

MONITORING PROCESSES

PART 1. INTRODUCTION

A4.1. Introduction

A4.1.1. My advisers and I have constantly been shocked at what we have read and heard about the matters investigated. In such a situation it seemed advisable to investigate the effectiveness of the standard monitoring processes which ought to have been available to the Council.

A4.1.2. To monitor is to warn. A warning from an authoritative source enables an individual or organisation to take stock of a situation and to amend existing practices. Properly understood and used, monitoring information should be an important source of learning, valued by managers at all levels of management, and by practitioners at all levels of practice. This Appendix deals with some of the history of internal and external monitoring of the children's work of the Department, and lists some of the recent expansion of external monitoring.

A4.1.3. The Conclusions, Sub-Conclusions and Recommendations in this Report have all been directed at the lack of connection between Council policy-making and its actual achievement in practice. The constructive, systematic monitoring of actual achievement has been missing from the Council's practice. Even when warnings have been given, the Council's organisation has not always responded adequately. Even when failure has been identified, the organisation has not been able to think and to learn.

A4.2. Internal Monitoring

A4.2.1. Democratic control of professional service delivery is itself a monitoring process. The traditional reliance of Lambeth on a Committee system to authorise executive action has been a form of monitoring, though somewhat tedious, inefficient and random (Sub-Conclusion 1, sub-sections 2.16. - 2.20. above).

A4.2.2. One way in which good practice could have connected the work of the Committee meeting with professional service delivery would have been systematic reporting on systematic visiting of Children's Homes by persons appointed by the Committee. This was a legally required duty of the Council. Part 2 of this Appendix shows how the Committee both squandered this monitoring opportunity, and failed to realise, and act upon, its own repeated and obvious ineffectiveness in organising such visiting.

A4.2.3. Normal management within the Department should include monitoring, and most monitoring should be carried out by, and as part of, normal management. Systematic internal monitoring of good quality, covering all activities, can only come from a sound management system, and it is a basic Conclusion of this Report that such a system has been lacking. External monitoring, however excellent and extensive, can never be a substitute for effective internal monitoring.

A4.3. External Monitoring

A4.3.1. Standard external monitoring of the Department is sponsored by central government, in particular through the SSI and, with a different emphasis, through the District Auditor. Local democratic control of complex, professionally delivered services would be difficult to achieve fully in the absence of such independent, authoritative assessments. This is required to supplement, confirm or deny criticisms being formed within the Council, and to provoke Councillors to inquire for themselves. Even if the internal democratic control were independently successful, it would be difficult for a Council to demonstrate its own degree of success to the public, or to a local authority's main source and control of income, the central Government, in the absence of such independent validation.

A4.3.2. The need for central government monitoring of the quality of local authority provided public services has been recognised for a long time. The reason has been twofold. First, Government has sought to ensure exposure of any lack of probity and regularity in the use of publicly provided finance. Secondly, it has sought to ensure that the creeping centralisation of responsibility and control kept pace with ever-growing central grant aid for the increasingly standard public services provided by local authorities.

A4.3.3. The external Audit of legality and financial probity has taken place for a century and a half. In 1983 the Audit Commission became responsible for this external Audit, which was extended to cover arrangements for securing economy, efficiency and effectiveness in the use of resources by local authorities.

A4.3.4. In 1985 the Social Services Inspectorate was created from the Department of Health's Social Work Service, which had been established in 1971. This Service had, in turn, been formed by an amalgamation of two post-war central government inspection services, both of which had roots in 19th century inspection processes. Part 3 of this Appendix shows how Lambeth responded to external monitoring by the SSI.

A4.4. National Regulation, Guidance and Reports

A4.4.1. Throughout this Report reference has been made to Government sponsored Regulations and compulsory 'Guidance', and to Reports of Inquiries established by the Government. Those quoted are only a small part of the stimulus to good practice, which has often come with publicity in the general, as well as in the specialist, media.

A4.4.2. For any organisation wanting to measure its practice against the latest national criteria such documents provide a plumb-line, quite apart from any compulsory nature they may have. The Scrutiny function recently established by the Council should take advantage of this rich and continuing source of relevant standards.

A4.5. The Area Child Protection Committee

A4.5.1. The ACPC, whose Annual Reports and Business Plans come to the Council, is also a potential external monitor, in relation specifically to Child Protection matters. I have referred to the ACPC's role in Sub-Conclusion 10 (sub-sections 2.57. - 61. above) and in Recommendation 4 (sub-sections 3.25. - 26. above). Although the Department is the obvious focus of professional leadership on Child Protection matters for the Council, the necessity of inter-agency co-operation makes the ACPC the prime focus for achieving good practical results.

A4.5.2. I can see considerable advantage in the appointment of an independent Chairperson, given the workload of the Assistant Director (Children and Families) and the need to build up informal mutual trust amongst the agencies involved. The ACPC, formally through its Annual Report and Business Plan, could then provide another source of reliable information for the Council in monitoring Child Protection performance and progress.

A4.6. Further Monitoring recently organised by Lambeth

A4.6.1. Part 4 of this Appendix lists some of the monitoring activities which have recently been organised in relation to the work of the Children and Families Division.

PART 2 THE COUNCIL'S FAILURE TO VISIT ITS CHILDREN'S HOMES

A4.7. Introduction

A4.7.1. Effective corporate parenting is the subject at the heart of both Inquiries. This Part 2 is a description of the repeated attempts by the Council to respond correctly and apparently vigorously but, in practice, unsuccessfully, to very specific, repeated warnings about the ineffectiveness of a particular and important facet of its corporate parenting. It is a story of obvious Councillor concern to visit Children's Homes becoming an obviously unsuccessful repetitive cycle. Plans were followed by failed implementation, failed implementation was followed by criticism, criticism was followed by concern, and concern was again followed by plans etc. It is an account of repeated failure to observe legal requirements over many years.

A4.7.2. Visiting by official representatives of the Council who were independent of those directly managing a Home was required by law, though such visitors did not need to be Councillors. In addition to the legal requirement for independent visiting, there was formal 'Guidance' that visitors' reports, unedited, should *"usually"* be considered by a Committee of the Council. Systematic visiting of its Children's Homes by Councillors themselves was an obvious way of checking that the Homes were meeting the purposes for which the Council provided them. This was strongly recommended as good practice nationally. Unfortunately, neither a thorough system of visiting, nor the proper method of usual reporting, was achieved, despite the efforts of some individual Councillors.

A4.7.3. I first became interested in this subject, which turned up by coincidence, when looking at the history of Alan's general care, and found myself wondering how the Council could have been such awful parents. When I came to consider the general organisational failures, this subject appeared to be small, clearly definable, and important. It might throw some light on the important questions raised by the other failures. Why had Lambeth failed repeatedly to achieve what was so obviously necessary and desirable - and desired? The subject directly involved Councillors, and their senior support staff, to whom the Council had entrusted responsibility for the quality of children's social services.

A4.7.4. My expectation that it was a small subject, and that records would be readily available proved wrong on both counts. I have not been able to obtain the relevant records of the Department on the subject of official visits to the Council's Children's Homes. However, I have been able to piece together a sufficient outline of the subject to report on the Council's process, and to reveal the quality of the Council's achievement. What follows shows consistency with other topics which have caused concern in these two Inquiries. It implicates the whole of the Council's former decision-making process in ineffectiveness, despite excellent talk and paper decisions.

A4.7.5. I have gained information from Committee records, from some random records which the new Departmental archival activity has helpfully produced for me, and from a Departmental officer who was marginally involved. I have also received recollections and papers from those former members of the Children and Families Sub-Committee who were able to respond to my request for help on the topic.

A4.7.6. I begin the story with Regulations made in 1951. The formal requirement for monthly visiting, and the involvement of Councillors in connecting the Council's Committee directly with each Council-provided Home, have a lengthy tradition.

A4.8. The 1951 Requirement - *"The Administration of Children's Homes Regulations, 1951".*

A4.8.1. These Regulations began with the requirement to visit. In relation to *"Local Authority Homes"* they provided: *"1. The administering authority shall make arrangements for every home provided … to be conducted in such a manner and on such principles as are calculated to secure the well-being of the children in the home. …*

2. (1) The administering authority shall make arrangements for the home to be visited at least once in every month by a person who shall satisfy himself whether the home is conducted in the interests of the well-being of the children and shall report to the administering authority upon his visit …

(2) Where the administering authority is a local authority the arrangements shall secure that the person visiting is a member of the children's committee of the local authority, a member of a sub-committee established by that committee or such officer or one of such officers of the local authority as may be designated by the arrangements."

A4.9. The 1972 Legal Requirement - *"The Community Homes Regulations 1972"*

A4.9.1. These Regulations, after opening formalities, also began with requirements about visiting. *"3. (1) The* [local authority] *…shall arrange for the community home under their charge to be conducted so as to make proper provision for the care, treatment and control of the children who are accommodated therein.*

(2) … in the case of a local authority home the authority shall arrange for the home to be visited at least once a month and a report made to them in writing upon the home by such persons as they consider appropriate."
There was thus a weakening of the former emphasis on the direct involvement of Councillors in the duty of visiting and reporting. There was no change in the Council's underlying responsibility to ensure that visits took place, and reports were made.

A4.10. Background Concern

A4.10.1. Concern about the quality of care provided in Children's Homes was repeatedly expressed in national Reports during the late 1980s and the 1990s. The strengthening of independent local inspection was encouraged, to ensure that practice complied with precept.

A4.10.2. An Independent Inspection Unit was approved by the Social Services Committee in November 1990. Although its specific statutory remit covered Children's Homes provided privately, good practice dictated that local authority homes should be conducted to the same standards, with even-handed independent inspections to achieve this. Unfortunately the resources provided for the Inspection Unit proved inadequate to undertake such a task. The Council's own Children's Homes therefore remained uninspected by the Unit, despite the omission being frequently pointed out by the Unit Manager.

A4.11. The Utting Report 1991

A4.11.1. On 30th May 1991 the Department of Health published the Report of an Inquiry (Utting 1) into "*The Pindown Experience and the Protection of Children".* This important Report was extensively publicised, and resulted in major national reviews of residential child care, and of the staffing of Children's Homes. Concern to amend residential child care should have been high on the political and professional agenda of any Social Services authority. Amongst its many recommendations were several about the importance of visits to Children's Homes under Regulation 3 of the 1972 Regulations, as a means of ensuring good practice.

A4.12. Ministerial Direction 1991

A4.12.1. The Utting Report resulted in a formal instruction by the Secretary of State for Health on 3rd June 1991, which included:
"All Social Services authorities should now urgently examine the care in their residential homes for children to ensure that there are no practices of this kind [i.e. 'pindown'] *and that the care policies and procedures are clearly set out, and monitored carefully and regularly by the authority through its management, and by statutory visits (in accordance with regulation 3 of the Community Homes Regulations 1972)."*

A4.12.2. The relevant Assistant Director wrote to the SSI on 12th June 1991 in response to a checklist. Included in his letter was the following paragraph:
"8. b) The current manual for the Childrens Residential Service does indicate that elected Members should complete a pro forma in respect of Statutory Visits and return it directly to the Director of Social Services, however, statutory visits by elected members has not been systematically organised over the past few years and therefore been carried out on an ad hoc basis with no formal reporting to Social Services Committee. The current Chair of Social Services has instructed that officers should provide a pro forma for elected member visits in order to assist members to carry out their statutory visits. It is his intention that a rota of member visits should be set up and resulting reports - presented to Children and Young Persons Sub Committee. This work is underway. The Childrens Services Managers are required to provide a report to members of the Children and Young Persons Sub Committee on issues relating to the running of all childrens homes."
In other words, Lambeth's procedures were right, but insofar as they provided for statutory visits by Councillors, they were not followed in practice.

A4.13. Regulation 22 of the Children's Homes Regulations 1991

A4.13.1. The Department of Health's pressure continued with new Regulations made on 30th June 1991, which superseded the 1972 Regulations. Regulation 22(4) of the Children's Homes Regulations 1991, under the heading *"Accountability and visiting on behalf of responsible authority",* required that *"The local authority who maintain a maintained community home* [i.e. a Children's Home] *shall cause the home to be visited once a month and to report to them in writing upon the conduct of the home."* Whilst the grammar may have been deficient, the intention was clear enough. Even if it were not, the intention was rammed home by the accompanying official Guidance, which local authorities exercising Social Services functions were required to observe. This remained the relevant requirement throughout the period investigated.

A4.13.2. In the official Guidance it was stated:
"Regulation 22 requires monthly visits to all homes by those responsible, or by their representatives (not being someone employed at the home). … An important purpose of these visits is to ensure that the day to day conduct of the home is seen by someone not involved in its operation and who can provide an independent report to the responsible authority. The visits should be unannounced and reports of visits should be seen by the responsible authority without amendment or deletion. In the case of a local authority home this will usually mean that the report should be presented to an appropriate committee of members of the authority. ….

Before each visit the responsible authority should provide the visitor with copies of reports of visits made in the preceding six months. The responsible authority should also provide the visitor with guidance as to the purpose of visiting and the items to be covered. These should always include a check of the records of sanctions imposed on children, the home's daily log and the physical condition of the premises. But the visitor must always be given opportunity for private conversation with any child, other family member, or staff member who requests it; and should always report on their observations of the children."

A4.13.3. No-one reading this could doubt the importance of observing the instructions involved. Independent visitors (not necessarily Councillors) must visit, and their individual reports must *"usually"* go before a Committee, unedited.

A4.14. The Council's first Attempt to reform - 1991

A4.14.1. In June 1991, arrangements were made for the Chair, Vice-Chair and Senior Managers to visit a range of Social Services establishments. Such visits, according to a schedule dated 17th June 1991, took place from July to December 1991, and included eight visits to unspecified Children's Homes. The memo containing this schedule, from the Director to senior officers, also stated: *"Additionally, the Chair/Vice Chair wish to encourage other Members of Committee to visit establishments and as discussed this a.m., has requested a pro forma highlighting the key service issues for the visit to provide a structured and comparable framework for Members …".*

A4.14.2. On 30th July 1991 the Manager of the Inspection Unit advised the Chair of the Social Services Committee that a pro forma for visitors drafted in June was *"probably too detailed"*. *"I am on the point of receiving the DoH Guidance (issued as part of the Children Act) on Children's residential care. As you know, the Guidance was redrafted following the "Pindown" scandal. I propose to produce a pro forma …., ensuring that key aspects of the guidance are not overlooked."*

A4.14.3. A memo of 6th September 1991 from the Director of Social Services to the two Assistant Directors concerned with children's services stated: *"The Chair has asked whether you would submit a very brief information item, in report form, to your respective sub-committees, advising them of the series of visits being undertaken by Chair and Vice-Chair and Senior Managers to a range of Social Services establishments."*

A4.14.4. A meeting of the Children and Young Persons Sub-Committee took place between the writing of a report to the Social Services Committee about visits and the meeting of that Committee on 18th September. On 11th September 1991 this Sub-Committee considered a tabled item on *"Members' Rota".*
"The Chair was of the opinion that although this report had not been available for at least three clear days before the meeting, nonetheless it should be considered as a matter of urgency because of the special circumstances that the visits needed to be set up urgently.
Noted that Members would be briefed with regard to recommendation (3).
RESOLVED: That the recommendations as set out in the report be adopted."

A4.14.5. Unfortunately, the report to which the Sub-Committee minute referred is not in the Minute Book. However, I am confident that it was the same report as one which went to the Social Services Committee a week later. Recommendation 3 of that report was: *"That the Terms of reference of the CYP* [Children and Young Persons] *Sub-Committee be reviewed to ensure that it accords with The Children Act 1989 Guidance and Regulations."*

A4.14.6. On 18th September 1991 the Social Services Committee received the report (SS36/91-92) referring to the 1991 Regulation and Guidance relating to visiting. The report made clear the deficiencies in existing Lambeth practice. It stated:
"2.20 With respect to statutory visits, each children homes was visited by a Children Services Manager at least once a month and sometimes more frequently as required by the Community Homes Regulations 1972. However a specific report to CYP [Children and Young Persons] *Sub-Committee giving details of the findings of these visits has not been done. Although the report of the Principal Manager, Childrens Homes has highlighted issues of concern and incorporated issues identified by the CSM's."*

A4.14.7. Accepting the facts stated in this paragraph, it is doubtful if the visits required by Regulation 22 were taking place. The Guidance had explained that the purpose of such visits was "*that the day to day conduct of the home is seen by someone not involved in its operation and who can provide an independent report to the responsible authority."* In 1993 the SSI did not regard "*immediate external line managers"* as appropriate visitors. In any event, the required reporting was not taking place. "*This practice conflicts with guidance which makes clear that the conduct of the home is seen by someone not involved in its operation and who can provide an independent report to the responsible authority."* (paragraph A4.22.6. below).

A4.14.8. The report continued:
"2.21 Statutory visits by members have not been organised on a systematic basis, and no reports have been submitted to CYP Sub-Committee. Although the Chair and Vice-Chair have established a programme of visits to all Children homes. Previous Chairs and Vice-Chair along with some individual members of the CYP Sub-Committee have undertaken visits on an ad-hoc basis. A checklist which is to be completed by members is attached to this report.

[A4.14.9.] *2.22 A report to CYP Sub-Committee alerting members to the need to establish a formal rota of visits will be presented to CYP Sub-Committee on the 11.9.91 for consideration. A system for collating the reports… will need to be set up and is identified in the action plan. … Arrangements will have to be made for statutory visit reports to be considered by the Chair and Vice-Chair on a monthly basis given the 6 months interval between meetings of the CYP Sub-Committee. Reports will be presented to Committee if there are any developments which require consideration by members."* The report also set out a pro forma Checklist for members to use on their visits, and an action plan which included: *"That systems are put in place to produce reports to CYP sub-committee of the un-edited reports produced by statutory visitors."* I find the conflict between the paragraph of the report just quoted and this extract from the Action Plan confusing.

[A4.14.10.] *"DSS to take action to ensure that the monitoring of care practices is improved, by both officers and statutory visitors. Also the arrangement for inspection of Lambeth Homes by the Inspectorate."*
The concern of Councillors for the quality of care in the Council's Children's Homes was clearly stated, as was their intention to be involved in the visiting.

A4.15. Practical Difficulties

A4.15.1. On 27th September 1991, the Conservative Group Spokesperson for Social Services exchanged correspondence with the then Chief Executive about the rights of Councillors to visit Children's Homes. She was concerned about having to make advance arrangements, and about her right to have access to log books. She had been prevented from gaining unarranged access to one Home, about which she had concerns. The Senior Officer on duty who refused her admission had said that he was acting on instructions from the Assistant Director responsible for the Children's Homes. The following day the Conservative spokesperson returned, to be greeted by the Officer in Charge and the Assistant Director.

A4.15.2. Whilst examining the Home's Log Book she copied in shorthand a note which read: *"All staff please note that no councillor has a right to unrestricted access to the building. Any visits should be pre arranged either direct to the unit by the councillor or through our line management ….. Cllrs. have no right to read any client files (or any other files) unless they have requested this through our line management and this has been agreed by senior officers. …".* The context of this incident was the intention of the Committee that Councillors should undertake "*statutory visits"*. Such an instruction was not in compliance with the Guidance about such visits being *"unannounced".* Nor was it in line with the legal rights of Councillors more generally, as I recall them.

A4.15.3. In his reply the Chief Executive wrote: *"With regard to the entry made in the log book following your visit to the Home, the Unit Manager was instructed by* [the Assistant Director] *to alter his instruction to staff as the original was incorrect.".* He stated that *"officers in the Directorate of Social Services are fully aware of elected member's legitimate right to know, their right to visit institutions and their right to examine personal files. However, we must ensure that this right is exercised in a formal manner with senior management being informed when such rights are to be exercised. Visiting the Home at 11.20pm, unannounced and without prior notice is not an acceptable way of doing business in my view. Nor, I might add, is any attempt during reasonable hours to prevent members from doing so."*
I cannot comment on the detailed circumstances of this incident, but it is plain that there was a less than cordial atmosphere in which Councillors could undertake visits for the purposes of the Regulations and Guidance. As a generalisation, a Councillor might have a very sound reason for visiting at 11.20 pm.

A4.16. The Council's Failure to observe Regulation 22 and its second Attempt to reform - 1992

A4.16.1. I have seen some records of visits to Children's Homes by the Conservative spokesperson in October, November and December 1991 which were obviously based on a standard pro forma. I have also seen reports by an officer on her visits to Children's Homes in early 1992. These latter reports were each attached to a covering pro forma letter from the Administrative Manager in the Family Finders Centre. This was addressed to the Chair of Social Services, the Assistant Director (Children and Young People), and the Acting Principal Manager (Children's Residential Services) - whose permanent position was as Manager of the Family Finders Centre. The enclosed report was stated in the pro forma letter to be *"unedited and as written by the author in line with the recommendations of the Act.*
The guidance on the Childrens Act states that such reports should be circulated to Senior Management and should also be presented to the appropriate committee of elected members."

A4.16.2. The letter then appears to contradict itself: *"The report will subsequently be used to build a composite report to the next Children and Young Persons Services Sub-Committee."* According to the Guidance, as the letter acknowledged, "*reports of visits should be seen by the responsible authority without amendment or deletion. In the case of a local authority home this will usually mean that the report should be presented to an appropriate committee of members of the authority."* Of course, it is possible that the individual reports were also submitted to the Sub-Committee separately, or as appendages to the composite report, but there is no direct evidence of this in the Committee or Sub-Committee records that I have been able to find.

A4.16.3. On 26th February 1992 the Children and Young Persons Services Sub-Committee received such a *"composite report"* (CYP 14/91-92) which drew *"together the individual reports produced by Officers and Members as a result of their monthly visits to Lambeth Children's Homes Establishments."* The report was *"For Information".* The report made reference to the decision of the previous September *"that members would participate in a rota of visits to Children's Homes and would produce reports as a result of those visits. A composite of the reports by both Members and Officers would be presented to CYP Sub-Committee. …"* But *"composites"* had not been agreed.

[A4.16.4.] *"2.1 This report draws together the reports produced by Members and Officers of their visits to Lambeth Children's Homes in the period 1.11.91 to 31.12.91.*

2.2 During this period 36 reports were scheduled for completion - 18 by Officers and 18 by Members. However, as at 31.1.92, only 11 reports had been submitted - 6 by Officers and 5 by Members - and only 3 Members have produced those 5 reports. No visits have been logged as complete in January, 1992.

[A4.16.5.] *2.3 … It is clear from the number of visits not carried out that Lambeth is not meeting its statutory duties in terms of visits etc. It is also clear from the visits that <u>have</u> been completed that Lambeth is not meeting its statutory obligations in some day to day areas of operation, such as record keeping. …*

3.1 By virtue of the provisions of the Children Act 1989 and the Childrens Homes Regulations 1991, the Local Authority has a statutory duty to satisfy itself as to the welfare of children in voluntary and registered children's homes within the borough, by way of visits carried out by one of its Officers … If the Local Authority is in breach of its statutory obligations in this respect, it may become liable to an action in relation to that breach."

A4.16.6. Minute 21 recorded that *"due to non-attendance by some Members the rota would need amending.*

The Assistant Director (CYP) thanked those Members who had submitted reports which he had found very useful and the Chair thanked [the Conservative spokesperson] *for producing such a thorough report. Noted, however, that the report format might need reviewing in order to encapsulate all relevant areas."*
But what about the failure of the officers to ensure that the Council's arrangements fulfilled its lawful duty? The silence of the minutes on this is not necessarily significant, but it becomes a point to watch as the lack of officer visits, as well as of Councillor visits, continued.

A4.16.7. On 22nd April 1992 an Administrative Manager in the Family Finders Centre wrote to members of the Sub-Committee:
"You will recall that the CYP Sub Committee agreed that members should participate in regular visits to Childrens Homes as part of their responsibilities under the Children Act. Between November 91 and March 92 a rota scheme operated whereby members were allocated specific units to visit each month. There was also an expectation that members would produce a written report of their visit.

However, during the 5 month period only 6 members reports were produced out of a possible 50.

At the Sub Committee meeting in January, 1992, it was agreed that as only a minority of members were participating in the scheme, a revised system would be required. The proposal therefore is that there will continue to be an expectation that members will carry out one visit per month. However, to reduce the possibility of the same members visiting the same units over and over again, members are asked to phone Family Finders when they have a proposed date of visit in order that a visit can be allocated. ….

[A4.16.8.] *…. Members should ask for the Admin. Manager or the Placements Officer, who will be able to advise which units require a visit.*

Where members may forget to contact Family Finders to be allocated a visit, officers will contact members individually.

Members will still be expected to produce a written report but in an effort to simplify this task a revised checklist has been produced which comprises a tick box system. Members are advised to read the Guidance Notes at the beginning of the checklist.

If you have any queries on the use of the checklist (enclosed) or the visits scheme in general - please do not hesitate to contact me."

A4.17. Practical Difficulties

A4.17.1. On 10th May 1992 the Conservative spokesperson wrote to the Director, to express concern about this new system for Councillor visits, which involved Councillors in first telephoning to be allocated to a Home. Again, the Councillor's protest was justified by the official Guidance which had specifically stated: "*The visits should be unannounced …".* She wrote: *"It is clearly not satisfactory for Family Finders to control which homes are visited by what members and when. Members need to know that there is no possibility of visits being manipulated and staff would wish to know they are not in a position where they could be accused of doing so. Whilst we appreciate that the former system was not working and that ideally there should be some way of preventing the same homes being visited frequently and others not at all, we are not satisfied that this system is sufficiently independent."*

A4.17.2. The Director wrote on the letter, before passing it to the Assistant Director, *"I think* [the Councillor] *has a point".* The Assistant Director responded a few days later, expressing agreement with the Councillor. The system of allocation would thenceforward be based on an unalterable rota of Homes, a rota which would be openly available to Councillors. In his reply the Assistant Director stated: *"You will remember that at the CYP Sub Committee on the 26 February, there were major concerns as to the lack of visits being conducted by Members, in addition to concerns, that only some homes had been visited during the period, leaving others unvisited. Clearly there was joint concerns by Members and officers that steps should be taken to ensure that all homes are visited on a regular basis. It was for this reason the current proposals were made."*

A4.18. The Warner Report

A4.18.1. During 1992, the Report of the Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes *"Choosing with Care"* (Warner) was published. It had been established in the wake of the conviction of Frank Beck for numerous sexual offences against young people in local authority care, and focused on selection and recruitment methods for staff working in Children's Homes.

A4.18.2. Once again, the quality of care in local authority Children's Homes was a major issue of national concern. On 7th December 1992 the Leader of the Council wrote to the SSI, following concerns expressed within the Council, inviting them to examine the care arrangements in the Council's Children's Homes. As a result, the SSI carried out an inspection of three Lambeth Children's Homes in March 1993 (sub-section 5.3. SPR and sub-sections A4.22., A4.25. and A4.38., A4.39. below).

A4.19. The Council's Failure to observe Regulation 22 and its third Attempt to reform - early 1993

A4.19.1. At the meeting of the Children and Young Persons Sub-Committee held on 6th January 1993 a report was presented on *"Children's Homes".* The report (CYP 11/ 92-93) made no reference to the subject of monitoring visits, but the minute stated: *"It was noted that reports from Members' visits to Children's Homes would be on the next agenda for this Sub-Committee. DSS to note."* I cannot tell from the record why this subject was introduced in this way, but it was clearly important to someone at the meeting. The next meeting of the Sub-Committee was held on 6th April 1993.

A4.19.2. I have been shown a document, informally dated 2nd February 1993, headed *"Standards and Criteria for the Inspection of Children's Homes."* It was probably an advance warning of the criteria to be used by the SSI in their proposed inspection of three Lambeth Children's Homes. There is certainly agreement between the criteria set out in this document and those in the 1993 SSI Inspection Report of three Lambeth Children's Homes. Whatever its origin, its existence in the recovered archives shows that the importance, purpose and Guidance requirements relating to monthly visits was once more drawn to Lambeth's attention. On *"Monthly Visits by Responsible Authority"* it began with a *"Standard Statement The responsible authority will receive each month directly from the appointed visitor a written report on the conduct of the home."* The document then set out the following *"Criteria"*:

[A4.19.3.] *"MANAGEMENT ACTIONS*
That managers have a clear policy and procedural statement, developed and authorized by the responsible authority, which sets out the arrangements for meeting Regulation 22 of the Children's Homes Regulations 1991 and associated guidance.

That copies of reports for the preceding 6 months are available for inspection.

That reports are handed direct and unchanged from the appointed visitor to the responsible authority.

That the responsible authority has issued guidance to the appointed visitors on the purpose of unannounced visits, the items to be covered, including offering the opportunity for private discussion with children and staff.

[A4.19.4.] *HOME PRACTICES*

That staff in the home confirm that monthly visits on behalf of the responsible authority take place unannounced.

That staff confirm that these are conducted in a manner which respects children and staff.

That staff feel that these visits provide an opportunity to raise any concerns they may have with the responsible authority.

[A4.19.5.] *OUTCOMES FOR CHILDREN*

That children confirm that monthly visits are conducted in a manner which respects them.

That children feel that these visits provide an opportunity to raise any concerns they may [sic] *with the responsible authority.*

That children feel the visitor would listen to them."
The importance attached to monthly visits as part of good practice could not have been clearer, and should have been known and acted upon.

A4.20. Practical Difficulties

A4.20.1. In March 1993 the Conservative spokesperson raised the question of rights of access to the children's records kept in the Children's Homes being visited. On two occasions she had been denied access to the records. Because the original enquiry had been misfiled, the Assistant Director replied in May 1993, confirming the right to such access. He wrote:
"I can assure you that officers are clear that Members of the Social Services Committee do have a right of access to records held in each Unit relating to children accommodated by the Department.

As you are aware the Members visit pro forma does indicate the type of records that Members should check as a matter of routine when conducting their statutory visits. …"

A4.20.2. The Councillor replied: *"…In fact the reason I was asking the question in the first place was because on two occasions I had tried at Lambeth Children's Homes to look at records, I have been prevented from doing so. I am grateful for your clarification and will keep this letter on my person when I am visiting children's homes in future."*
Again, I note an unacceptable separation of requirement and practice, and an unhelpful awkwardness between different role players in the Council's arrangements.

A4.21. Commitment

A4.21.1. From what I have been told, there is no doubt that a few Councillors did visit very conscientiously, probably throughout the period 1991 to 1994. Even from the limited evidence of official Minutes, the concern of some Councillors about the quality of care provided in the Council's Children's Homes, and about visiting in particular, continues to be evident. I have seen a Councillor's reports of visits which he made to Children's Homes in 1993, which happen to have survived, which give proof that some conscientious Councillor visits took place.

A4.22. SSI Criticism

A4.22.1. In March 1993 the SSI inspected three of the Council's Children's Homes - Stockwell Park Road, Lorn Road and Angell Road (sub-section 5.3. SPR). Its undated Report was presented to the Social Services Committee in July 1993 (sub-section A4.25. below). Section 12.3 dealt with *"Monthly visits on behalf of responsible authority".* The Standard measure was: *"The responsible authority will receive each month directly from the appointed visitor a written report on the conduct of the home."*

[A4.22.2.] *"12.3.1 Unit 1* [i.e. Stockwell Park Road CH]
There had been no visits by elected members for over 1 year. Visits by managers and/or elected members were commented on by staff as being extremely infrequent.

12.3.2 Unit 2 [i.e. Lorn Road CH]
It had been some time since responsible authority representatives had made visits to the unit. There was not a record of visits. It had also been some time since managers external to the unit had visited and made comment.

12.3.3 Unit 3 [i.e. Angell Road CH]
Monthly visits on behalf of the responsible authority were not an established, regular event and it was of serious concern that work carried out in this unit is not regularly monitored. A visit by the external manager took place immediately prior to the inspection. The required form was not completed appropriately and was unsigned and undated. Records show that the last visits by elected members were over a year ago.

12.3.4 Comment
….. The practice of the authority does not comply with that set out in Children's Homes regulations 22 or the Guidance …

Recommendations
12.3.5 Elected members and senior managers agree and operate a system of routine visiting to all children's homes that takes account of the issues commented upon in this inspection report and those drawn to the public's attention in the Utting report and the Warner report.

12.3.6 The findings of these visits be drawn up and routinely presented to the Social Services Committee for comment and action."
These recommendations were classified as *"medium term - to begin at once and complete in 6 months".* I note that officer, as well as Councillor visits, were recorded as deficient. The Council was still not complying with its known duties.

A4.22.3. In the recovered archives is an SSI Report: *"Corporate Parents Inspection of Residential Child Care Services in 11 Local Authorities November 1992-March 1993."* The copy is otherwise undated, as was the practice of SSI Reports. It will be seen from this summary of Inspections in eleven different local authorities that none of the 11 local authorities inspected had fully implemented Regulation 22 and the associated Guidance. Lambeth was not alone in its failure. The failures in these eleven local authorities described in this summary are all the more surprising given "*the issues … drawn to the public's attention in the Utting report and the Warner report",* to which the 1993 SSI Report on Lambeth had referred. The Utting Report had been published in 1991 (sub-section A4.11. above), and the Warner Report in 1992 (sub-section A4.18. above).

A4.22.4. Amongst the Report's recommendations were:
"Establish independent oversight of the management of children's homes and the quality of care through Regulation 22 visits and reports that inform management monitoring and support systems.

Consider the role and function of reports produced by local Inspection Units in evaluating and reporting to management on the quality of care in children's homes."

A4.22.5. The Report dealt specifically with the standard requirement that *"The responsible authority will receive each month directly from the appointed visitor a written report on the conduct of the home."*

"12.24 This inspection identified considerable weaknesses in the external management and monitoring of residential child care services.

There was a lack of clear strategic oversight by senior managers and Directors of Social Services were not well informed about practice in children's homes.

12.25 By statute all matters relating to the discharge of social services functions stand referred to Social Services Committees. In order to discharge these functions Committees need to establish clear and effective patterns of delegated powers. Although powers may be delegated the Social Services Committee retains responsibility for ensuring that these functions are discharged properly.

[A4.22.6.] *12.26 Regulation 22 visits were, in most cases, being undertaken by the immediate external line managers on a monthly basis and monthly reports produced. However, in a number of cases, these reports did not go to a Social Services Committee. This practice conflicts with guidance which makes clear that the conduct of the home is seen by someone not involved in its operation and who can provide an independent report to the responsible authority.*

12.27 Elected members need to satisfy themselves that there are systems in place for ensuring children are protected and staff are supported to provide appropriate and effective standards of child care. The appointment of a visitor as required by Regulation 22 is an important way of discharging this responsibility.

[A4.22.7.] *12.28 In addition to the discharge of these responsibilities, it has been the practice in many local authorities for elected members to conduct rota visits to children's homes. They represent a further expression of the corporate responsibilities of the local authority for promoting the welfare of children in public care. They also provide opportunity for staff and children to share concerns and achievements with influential figures within local authorities but out of direct line management.*

12.29 In the homes inspected rota visits were a rare occurrence.

[A4.22.8.] *Recommendations*

12.30 As a matter of urgency local authorities should ensure that Regulation 22 visits are carried out either by elected members or a manager external to the line management of children's homes and that reporting arrangements comply with Regulation 22 of the Children's Homes Regulations 1991.

12.31 Reports should be structured so as to require identification of any action taken on issues raised in the last visitor's report or the reasons if no action has been taken on substantive concerns. Senior managers should closely monitor this process.

12.32 Elected members should consider the desirability of making visits to children's homes in order to fulfil their role as corporate parents."

A4.22.9. This Report made very clear the duty of the Council to ensure that monitoring visits by a Councillor or external manager took place, and that unedited reports should be received. It also recommended visits by Councillors as good practice. I have asked if this SSI Report, which also cast doubts on managerial capacity in its paragraph 12.24, was reported to Committee. No trace can be found in the records.

A4.23. Continued Failure

A4.23.1. On 6th April 1993 the Children and Young Persons Sub-Committee met. At its previous meeting, on 6th January 1993 the minutes had recorded: *"It was noted that reports from Members' visits to Children's Homes would be on the next agenda for this Sub-Committee. DSS to note."* The minutes of the April meeting record: *"Members were reminded of their obligation to visit Children's Homes. Officers indicated that the frequency of visits had been extremely low. It was agreed that a further letter would be sent to Members reminding them of the visits. All to note DSS"* This was the final paragraph of a minute headed *"Children's Residential Services Section Report",* but the report makes no mention of individual reports of visits actually carried out.

A4.24. AMA Handbook

A4.24.1. In April 1993, the Association of Metropolitan Authorities (of which Lambeth was a member) produced a handbook of guidance, *"Children in Our Care"*, which was designed to assist councillors in the exercise of their functions. The Foreword by the Chair of the Association of Metropolitan Authorities' Social Services Committee referred to the Utting Report *"Children in the Public Care"* of 1991, and that Report's call *"on local authority elected members to visit children's homes."*

A4.24.2. The Chair wrote:
"We hope that it will be of practical use to Councillors. It reminds you that you are not double guessing for officers, nor are you acting as professional inspectors. You are visitors in your own right. …

You are there to see how things are working, and report, where necessary, to the appropriate authority. It is not meant to be a time consuming activity but it must be thorough, sensitive and caring, as one expects any parent, corporate or not to be. Whoever else, they are children in our care."

A4.25. The Committee's Reception of the SSI Criticism

A4.25.1. On 30th July 1993 the Social Services Committee considered the SSI Report on the inspection of the three Lambeth Children's Homes which had taken place the previous March. The response to the SSI Report by the Director of Social Services (SS 28 and 28a/93-94) recommended the Committee to receive the Report, agree the management action plan and receive a progress report at the October/November meeting.

A4.25.2. The Director's particular response about monitoring visits was:
"The arrangement for visits to children's homes by Officers and Members were agreed by Committee in September 1991. The Directorate also provided a pro forma for the conduct of these visits to assist both Officers and Members, which included all the areas that need to be monitored as part of the visit. Following the agreement at Committee a rota for Members visits was established by the Section Admin Manager and circulated....

The Directorate acknowledges that these formal visits have not been carried out at the frequency specified by Committee or as detailed in the Regulations….."

A4.25.3. The action recommended was: *"a) DSS/Committee to reinforce current arrangements for visits to children's homes by both Officers and Members. Section Admin manager to continue to monitor this process and report to A.D.C&F (R)/Chair* [i.e. the Assistant Director, Children and Families (Resources)/ the Chair of the Committee] *where necessary visits are not undertaken.*
b) The Principal/Service Manager to review the current pro forma for statutory visits, with reference to the issues raised in the Inspection report, and issue new form and guidance as required.
To be completed by October 1993."
This advice was accepted.

A4.26. AMA Handbook

A4.26.1. On 24th August 1993 the Assistant Director wrote to the Conservative spokesperson:
"RE: AMA HANDBOOK "CHILDREN IN OUR CARE"
I apologise for the delay in responding to your enquiry regarding the above documents dated 14th May 1993. As you may remember this matter was raised at the Social Services Committee on the 1st July and the Director indicated that copies of the summary of the handbook were provided to each member of the Social Services Committee and that the more detailed Guidance document had been placed in the Members Room for reference.

If any further copies are required by Members that requests [sic] *are made to the Committee Section whose responsibility it is for providing copies of this document to them."*

A4.27. The Council's Failure to observe Regulation 22 and its fourth Attempt to reform - 1993 - 1994

A4.27.1. In 1993 the Social Services Committee considered a number of externally generated documents, in addition to the SSI Inspection Report. As a result the Committee decided to make considerable organisational changes to improve the quality of the Department's services. These are briefly described in subsection 5.6. SPR. Amongst these changes was the establishment of a new Children & Families Sub-Committee, by the Social Services Committee on 28th September 1993 (SS43/93-94), whose Terms of Reference included:
"2.(ii) to arrange a rota for regular visits to each residential and day care establishments under its control by one or more of its members, who shall report the result of such visits to the sub-committee."

A4.28. The new Sub-Committee

A4.28.1. The Director's proposed response to the SSI criticism about statutory visits had been to establish a new system by October 1993. On 4th October 1993 the Chair of Social Services wrote to all members of the Social Services Committee about a review of the pro forma report used for such visits. She told them that she had asked for a more comprehensive review, and that *"the guidelines as set out in the AMA Booklet "Children in our Care" should be implemented by the department and that all our visits from now on should accord with that advice."*

A4.28.2. At the new Sub-Committee's first meeting, on 19th October 1993, a report (CF1/93-94) stated that in the period January - June 1993 a total of 44 Councillor and 44 officer visits/written reports had been due for completion. Only five Councillor visits, 24 officer visits and 16 reports had been completed. Whatever the reasons for this failure, the Sub-Committee's Terms of Reference now expressly required its members to rectify the situation. However, these Terms of Reference represented only a superficial difference from the situation in 1991, when the Committee had been told that the new Sub-Committee's predecessor would then do what was necessary.

A4.28.3. At its next meeting, on 24th November 1993, the Sub-Committee (CF7/93-94) established a system of Councillor visits on a trial basis, such visits to be voluntary, and the system to be reviewed at the Sub-Committee's next meeting. These decisions were based on a thorough report, which openly acknowledged inadequate past practice, and noted official Guidance and recommendations. It recommended that each of the Sub-Committee's members should be 'attached' to a particular Home for three months at a time. It gave guidelines on how to make visits useful, and included a pro forma for a report to the Committee on each visit.

A4.28.4. At the following meeting of the Sub-Committee, on 7th February 1994, (CF 16/93-94) *"the Assistant Director agreed to ensure that all Members had been allocated to a children's home for visiting purposes".* By this time there was a strengthening feeling amongst Councillors that the only effective way to deal with the poor quality of Lambeth's Council-provided Children's Homes was to close them.

A4.28.5. On 24th January 1994 the Conservative spokesperson wrote to the Director:
*"In the absence of any formal inspection procedure of council run children's homes over an unacceptable number of months and in view of concerns expressed to me about the home I visited Angell Road Children's Home on the morning of Sunday 23rd January …. It seems that little has changed at Angell Road since the SSI inspection ……
I am copying this letter to the SSI"*

A4.28.6. On 9th February 1994 the relevant Assistant Director replied that *"… the difficulties identified by you are utterly unacceptable and indefensible".* After dealing with matters relating to the state of the Home, he wrote:
"With regard to the arrangements for Members to visit childrens homes - you will recall that Members agreed at the last C&F Sub-Cttee to institute a new arrangement for Members to visit childrens homes. It was agreed that each Member of the Social Services Committee who wished to participate in visits would contact … and would be allocated to a specified home for twelve weeks. I regret that the allocation of Members has not progressed as quickly as it should have, but I have personally taken action to ensure that this is completed without delay."

A4.28.7. In March 1994 the decision was taken to close the Children's Homes, to boost fostering, and to have proper Family Centres which could intervene earlier in individual cases than the existing system permitted.

A4.29. Two SSI Inspections, 1994

A4.29.1. In April 1994 the SSI carried out an Inspection of the Council's Inspection Unit, and in May an *"Inspection of Lambeth Residential Child Care"*, as a follow-up to the critical inspection Report of March 1993. The SSI Reports on both these 1994 Inspections were presented to the Social Services Committee in October 1994.

A4.30. The Closure of Lambeth's Children's Homes

A4.30.1. The Children and Families Sub-Committee met three times in 1994-95. The Children's Residential Services Section Report (CF4f/94-95) to the Sub-Committee of 22nd September 1994 included: *"1.2 The section is currently in the process of closing down the residential service in accordance with the decision of the Committee in relation to the Child Care Strategy report (March 2nd 94). It is envisaged that the current residential service will be closed by Dec./Jan. 94/95 and the new Resource Centre service will be operational from Jan/Feb 95. ……*

1.3 To achieve this target admissions to the units are being stopped on a phased basis to allow for the closures to be achieved with minimal disruption to the young people in residence. Admissions to the longer stay units was stopped in July 1994 and the emergency units will stop admitting young people from approximately Sept./Oct. 94."

A4.31. The Committee and the two 1994 SSI Reports

A4.31.1. The meeting of the Social Services Committee on 19th October 1994 considered the Report by the SSI on the April Inspection of the Lambeth Inspection Unit (report 37/94-95). The SSI Report covered many matters not directly related to the present narrow purpose, but included:

"6.4 The Inspection Unit had not been able to carry out any inspections on the local authority's own community homes or day nurseries. ……
11.9 SSI was told that the Inspection Unit did not routinely receive reports of Councillors visits to services they inspected. …
Recommendations …
"11.15 Copies of Councillors' reports of visits to services should be made available to the Inspection Unit."
It was also minuted that *"Councillor* [E] *requested that details of which members had made visits to residential homes be circulated".*

A4.31.2. At the same meeting, the SSI Report on the May 1994 Inspection of Residential Child Care was received (SS62/94-95). Of the 14 adverse findings, the last stated: *"Elected members had failed to visit units on a monthly basis."* The related Recommendation was: *"12.3.2 Elected members should be encouraged to visit units regularly to monitor the quality of care carried out on behalf of the Borough of Lambeth."*

A4.31.3. The relevant minute stated: *"Members asked that consideration be given to the importance of members visits including the provision of training for members. Members requested easily digestible monitoring information on the implementation of the new system."* I am not clear who was being asked to give consideration to the importance of members' visits. Presumably it was a request to 'the powers that be', the Committee's own relevant powers being illusory.

A4.32. The Children and Families Sub-Committee

A4.32.1. According to information from the Committee secretariat, the Children and Families Sub-Committee met only once in 1995-96 (plus one informal meeting), although two further meetings were scheduled. The closure programme was taking its course, and (according to oral information) visiting was coming to be regarded as pointless. The Council's Children's Homes were reported as closed by January 1995.

A4.32.2. I have spoken with five members of the former Children and Families Sub-Committee, but mainly about other matters. I have written to 13 other people who, as Councillors, were members of the Sub-Committee from its inception in October 1993 to its disappearance in 1995/96, specifically about this subject. In the letter I set out a brief history of some of the Sub-Committee's relevant minutes, and stated: *"As things stand, it looks as though yet more well-intentioned planning disappeared into inaction. Is this so, or did you make visits to Children's Homes, and receive reports on such visits at the Sub-Committee?".*

A4.32.3. Three former Sub-Committee members did not respond at all to my letter and one failed to turn up for the arranged interview and was not able to make another appointment. Of those who did respond, five had no recollection of these matters. One former member is now too infirm to respond. The present addresses of two other such people could not be traced.

A4.32.4. A former Councillor told me he had *"made several such visits between 1992 and 1993 at least. Some of them I visited twice. Such visits were not monthly due to pressures of other committee duties. All visits were announced. Reports from such visits did go to social services committees because I distinctly remember discussing them there."*

A4.32.5. He commented that my observation in my letter that *"as things stand, it looks as though yet more well-intentioned planning disappeared into inaction"* was *"unfair. The well-intentioned planning did not disappear into inaction. It broke down due to both an underestimation of the practical resources needed to put it fully into practice and pressures on Social Services to deal with other equally serious problems bearing down upon the Council at that time (like a £15 million corruption scandal)."* This response is helpful in drawing attention to other contemporaneous pressures, but it does not explain why other ways of fulfilling Regulation 22's requirements were not pursued.

A4.32.6. Of those present and former Councillors interviewed, two did visit Children's Homes and write reports, but did not find the organisational context supportive in practice. The third visited once, and again found the support unhelpful. The fourth, whose particular involvement with Social Services concerned other worrying matters, had no recollection of this subject.

A4.33. 'The Chestnuts'

A4.33.1. By the time of the next SSI inspection Report on Lambeth Child Care, in 1997, the SSI reported *"3.19 Lambeth no longer manages children's homes of its own".* Although the common understanding was that Lambeth hadceased to have residential Children's Homes in 1994, the significance of a residential unit for children with learning difficulties, called 'The Chestnuts', was overlooked. Its precise legal status in the regulatory regime has been debated. Viewed sensibly as a home for children, the safeguards required by law seem to me to have been obviously relevant for a Social Services Department to apply.

A4.33.2. I now understand that the history of this unit has been the subject of another Inquiry on behalf of the Council, but what follows in this Report results from my quite separate concentration on Regulation 22 visits. The Council's Inspection Unit did not carry out an inspection of 'The Chestnuts' until requested by the Adult Services Division of the Department (which was then responsible for the unit) in 1997. An inspection was carried out for the year 1997 - 1998, making twelve requirements and five recommendations. Later that year the management of the unit was transferred to the Children and Families Division.

A4.33.3. The Inspection Unit's inspection report on 'The Chestnuts' for the year April 1998 - 1999 contained the heading *"Monthly visits on behalf of responsible authority".* Against the usual Standard - *"The responsible authority will receive each month directly from the appointed visitor a written report."* it was reported: *"There was no evidence that this had been done."* The Inspection Unit consequently required *"That regulation 22 visits of the home are conducted regularly. Time scale: immediate"*. It was of little encouragement to read, immediately following that requirement, of eight further requirements relating to the Home (not directly relevant to the subject of Regulation 22 visits), which were stated to be outstanding from the previous year's inspection. 'The Chestnuts' is now no longer a Home for which Regulation 22 visits are required. I have been unable to find out when it closed, or if such visits were made following the critical 1998 - 1999 Report of the Inspection Unit.

A4.34. Corporate Parenting in the 21st Century

A4.34.1. On 5th April 2000 the Director of Policy reported to the Policy Committee (231/99-00) on the first full year of the Operation Middleton investigation**.** An Appendix gave an informative account of the Council's response to the February 2000 Waterhouse Report *"Lost in Care",* dealing with child abuse in Children's Homes in North Wales during the 70s and 80s. The intense review currently being undertaken by the Council is producing a wide range of initiatives to improve the quality of the Council's care for its children. The brief extracts quoted below do not do justice to this review, but are confined to one subject - the visiting of Children's Homes.

A4.34.2. Item 40(d) of the Appendix referred to *"Rota visits by elected members"*. The advice given to the Committee was that Lambeth no longer had any homes coming within the requirements of Regulation 22.

A4.34.3. Councillors were recommended (item 60) to pursue the possibility of regular scheduled and unscheduled visits to contracted homes *"as part of quality monitoring and listening to children in relation to Corporate Parenting.".*

A4.34.4. *"Proposals for Action on Corporate Parenting - Stage 1"* approved by the Policy Committee on 12th July 2000 (report 8/00-01) included:
"3.1.1 Elected members will be given increased opportunities and responsibilities to listen directly to what young people have to say about the care that Lambeth provides ….

Currently, children's care homes in Lambeth are managed through a contract with Shaftesbury and Arethusa. The 2 homes are categorised as Voluntary sector homes and are therefore registered and inspected directly by the Department of Health and not by Lambeth Registration and Inspection Unit. This arrangement means that elected members are not required to undertake Regulation 22 visits to ensure themselves that care standards are being met.

[A4.34.5.] *Proposals for action*
3.1.2 The contract with Shaftesbury and Arethusa be revised to include the facility for elected members to visit on a delegated member basis to ensure that care standards are met, that children are being given good support …. And that children have the opportunity to talk directly to members about the care being provided. One elected member be delegated per home to undertake the visits over a 12 month period at a frequency of once monthly or comparable to what a regulation 22 visit schedule would be.
….
3.1.4 Elected members … be supported by training … [etc]

3.1.5 Written reports of the members visits to be made to Cabinet, Scrutiny Committee, Children First Commission and the executive directors of Social Services, Education, Leisure and the Chief Executive of the Health Authority."

A4.34.6. The lesson from the past is, of course, that proper initiatives are a necessary start, but only a start. The real challenge is to ensure that the system of visiting actually works. If it doesn't, because in practice Councillors already carry too heavy a load, the option of appointing other visitors for the task is available.

A4.35. An important Aside - Clutter

A4.35.1. As I studied these, and other agendas and minutes, I could not help noticing the indigestible amounts of information which were put before Committee members. I certainly did not read all the pages of the Committees' and Sub-Committees' agenda, but I noted there were 333 pages on one occasion. I then looked at the numbers of pages of the agenda for some other meetings quoted in this Report. The Children and Families Sub-Committee of 19th October 1993 had 96 pages. The Children and Families Sub-Committee of 7th February 1994 had 195 pages! Out of curiosity I asked for the number of pages in Social Services Committee Agendas in the Municipal Year 1997/98. The answer was 512, 377, 76, 224, 250, and 398, an average of 300! Anecdotal recollections by several people to whom I have spoken have confirmed that these quantities are consistent with general experience in the work of the Council and its Committees over a long period.

A4.35.2. I know from experience in several local authorities that detailed decision-making is a method of control often practised in the name of democracy. It has been authoritatively condemned since at least 1967 (see the Report of the Committee on the Management of Local Government, HMSO, 1967), and, in my view, is a patronising use of Councillors' time. The big, controlling issues are lost in the welter of what should be secondary detail. The Conclusions, and especially Sub-Conclusion 1 (sub-sections 2.16. - 2.20. above), show that it did not work in Lambeth. There has to be a better way of enabling the Council to direct the Council's affairs.

PART 3. THE SOCIAL SERVICES INSPECTORATE'S AND THE DISTRICT AUDITOR'S REPORTS

A4.36. The SSI Reports to the Council

A4.36.1. Some of these Reports were referred to briefly in SPR, mainly with reference to Child Protection work (paragraphs 4.4., 5.3.., 5.6., and 5.10.. SPR). They have also been referred to in the previous Part of this Appendix, in Sub-Conclusion 11 (sub-sections 2.62. - 2.66. above), and in Appendix 3, Part 1 above. The references in this Part 3 are to the SSI reports of 1993, 1994 and 1997 on children's services, and to their general monitoring significance for the Council, rather than to their detailed professional significance.

A4.37. The 1993 SSI Report

A4.37.1. In March 1993 the SSI inspected three of the Council's Children's Homes - Stockwell Park Road, Lorn Road and Angell Road, following concerns expressed within the Council. The report of the inspection was critical of operational matters in eight summary paragraphs (1.5 - 1.12), amplified in detail later in the SSI Report. No reader of the SSI Report could fail to be concerned at the overall quality of care described.

"1.13 The senior managers in Lambeth have been given a verbal briefing and SSI's concerns were made clear. The Director undertook to investigate the situation and put remedial action in process. …

1.15 Lambeth have made some progress in improving the situation, but there is much to be done. The Director has a restructuring of the service planned for the near future and expects to make significant progress in improving the service. It is proposed that SSI carry out an inspection later in the year; this would provide more detail and enable progress made to the service to be evaluated. SSI will keep in close touch with matters.

In order to facilitate action by the local authority in taking forward the findings of this report, the recommendations are set out as follows:
Immediate - to begin at once and complete in 3 months
Medium term - to begin at once and complete in 6 months
Longer term - to begin at once and complete within 1 year."

[A4.37.2.] *"3.1.1 The inspection in the London Borough of Lambeth was carried out in a local and national context of concern about the quality of residential child care available for children in the public care.*

3.1.2 Locally, concerns relating to the quality of care offered in Lambeth were brought to public attention through media coverage of allegations of inappropriate behaviour by staff at some children's homes, concern over matters of control and over the appointment of particular members of staff.

3.1.3 The inspection took place at short notice to the authority … "

A4.37.3. The further inspection referred to in paragraph 1.15 of the Report took place in May 1994 (see sub-sections 4.39. and 40. below).

A4.38. The Department's and the Committee's Responses

A4.38.1. On 30th July 1993 the Social Services Committee considered the SSI Report on the inspection of the previous March. The response to the Report by the Director of Social Services (SS28 and 28a/93-94) recommended the Committee to receive the Report, agree the management Action Plan prepared by the Department and receive a progress report at the October/November meeting.

A4.38.2. The Director's response to the SSI recommendations began with *"A National Overview",* which referred to four recent national Reports on residential care, as a context for the SSI Report. *"All the reports reflect growing disquiet with how children's homes are run, but promote general agreement on what needs to be done to put things right."*

A4.38.3. The Committee's minute reads: *"Members of the Department of Health SSI team then addressed the Committee and answered questions. The Committee were advised that the focus of the inspection had been the quality of care given to children and the management of that care. The Inspectorate team added that the young people and staff at the homes had cooperated fully with the inspection and expressed their thanks to all those involved.*

[A4.38.4.] *The Director of Social Services then addressed the Committee stating that the directorate welcomed the report and accepted the criticisms it contained. He added that management were already aware of many of the problems highlighted and had been endeavouring to resolve them. Officers paramount consideration was the needs of children and provision of the best service possible and a substantial action plan had been drawn up in response to the report. …*

Officers then gave the Committee a detailed outline of recommendations contained in the text of the report and took questions."

A4.38.5. The Action Plan had been made available to the SSI, and progress on implementation was to be monitored by a further SSI inspection. The Committee was assured that progress on implementation would be reported to the next meeting. The minute indicating the presence of the SSI Inspectors at the meeting did not note that they expressed any concern or disapproval of the course proposed by the Director. The Committee decided to make the considerable organisational changes proposed in the Action Plan. This is briefly described in subsection 5.6. SPR.

A4.38.6. No matter how concerned a Councillor might have been about the quality of care provided in Lambeth's Children's Homes prior to this Committee meeting, (s)he would probably have been reassured by such a minute. Deficiencies had been exposed and the action required had been plainly stated by the SSI, the professional monitors. The criticisms had been accepted by the Department, and the substantial remedial action proposed indicated a dynamic response.

A4.39. The 1994 SSI Report

A4.39.1. In May 1994 the SSI carried out an *"Inspection of Lambeth Residential Child Care"*, as the promised follow-up to the Inspection Report of March 1993. However, a decision to close the Lambeth Children's Homes had already been taken by the Council.

A4.39.2. The Report of the Inspection explained the status of the SSI:
1. The Social Services Inspectorate is a professional division of the Department of Health. It is headed by the Chief Inspector, who is responsible to the Secretary of State for professional advice on Government policy and on the quality of Social Services provision. The Inspectorate assists Ministers to carry out their responsibilities for personal social services, and exercises statutory powers on behalf of the Secretary of State. It is independent of the local authority, voluntary and private sector providers of social services, and seeks to include the perspectives of service users, carers and lay people in inspection work.

2. The purposes of the Social Services Inspectorate are:
to inspect personal social services provision and its organisation and management [my emphasis] *in order to promote quality standards, improve effectiveness and efficiency, and ensure the safety and well-being of service users.*
to provide professional and social services advice and expertise to Ministers, the Department and the field on the formulation, implementation and review of social services and health policies, and the effective and efficient delivery of social services [my emphasis]*; and*
to facilitate communications between the Department and the field."

A4.39.3. To a concerned layperson this was a reassuring message. The Council should be able to rely on being alerted to significant problems in "*organisation and management"* and in *"effectiveness and efficiency"* from monitors with such a background.

A4.39.4. The Report continued:
1.1 This was a follow-up to an inspection carried out in March 1993. The earlier inspection was at the request of the Parliamentary Under Secretary of State for Health. The 1993 inspection reported a number of serious concerns with the quality of residential child care in Lambeth.

1.2 Lambeth were required to take action to improve the service and this inspection was carried out to assess the progress made and its impact on practice. During the year between inspections senior managers in Lambeth had reported three times (December 1993, February 1994 and May 1994) to the Social Services Committee on their work to improve the service.

1.3 The year had been a difficult one for Lambeth Social Services. Senior managers had worked within a climate of financial constraint to try and improve the service. At the same time as work was in progress to improve the service, considerable effort was put into a radical re-design of the whole residential child care service.

[A4.39.5.] *1.4 This large and complex piece of work had a major impact on all staff concerned and a consequent disturbance to the service and the children looked after by it. It is anticipated that the new service will come on stream between November 1994 and March 1995.*

1.5 This report should be read with the understanding of the impact of such significant upheaval upon staff and children.

1.6 Despite the activity proposed and described by senior managers in their reports, the impact upon practice fell short of their expectations and of the requirement of the regulations …

1.7 Overall, the improvements were limited and patchy and some important essentials of good practice particularly in relation to care plans and supervision were still not adequate.

[A4.39.6.] *1.8 Lambeth proposes to establish a new, small and high quality service. If such a service is to succeed it is essential that the recommendations of the two inspections are integrated into the foundation of the new service.*

1.9 The new service must have:
Clear and accurate statements of purpose.
Regular, formal, recorded supervision.
Clear, written agreed and operated care plans for ALL children.
Targeted training programmes for residential staff.
Routine and rigorous monitoring of the quality of practice by managers and members.

1.10 SSI will monitor the development of this new service.

1.11 The new service will be inspected one year after its inauguration to evaluate its impact on the quality of care provided for the children being looked after and the extent to which the recommendations arising from this report have been implemented."

A4.39.7. Because the Children's Homes were now being rapidly closed, the original focus of the 1993 SSI Inspection was no longer as important as it had been. However, I have heard from Councillors active in the Committee at this time that there were growing informal concerns about the general effectiveness and efficiency of the Department. Although the Inspection Report's account of failure must have encouraged such concerns, there was no underlying note of apprehension in the Report about the future capacity of the Department to cope.

A4.40. The Department's and the Committee's Responses

A4.40.1. The SSI Report was formally received at the meeting of the Social Services Committee on 19th October 1994. The relevant minute (SS37/94-95) stated:
"It was noted that the service had been completely reorganised and the success of the new service would have to be evaluated by the SSI in due course. …."
A layperson could note that the new service being planned, which was not being criticised in anticipation, would be inspected in March 1996 (i.e. a year after the new service was expected to be operative), according to paragraph 1.11 of the SSI's Report just quoted.

A4.41. The 1997 SSI Report

A4.41.1. The next SSI Inspection was in June 1997 - of *"Planning and Decision Making for Children Looked After - Lambeth".* It therefore took place a year after the failed response to Alan's disclosure in 1996, and a year before the internal discovery of the failures to carry out adequate assessment of foster carers. The Report of this Inspection stated:
"3.1 This inspection in the London Borough of Lambeth was part of a national programme of inspections taking place between April and November 1997.

3.2 The main purpose of the inspection was:-
To evaluate planning and decision making for children looked after by local authorities.
and
To make recommendations to assist the development of an effective service [my emphasis].

3.3 The key objectives were to evaluate:-
Compliance with legislation and regulation.
The policy and strategic framework for services to children.
The processes in the Social Services Department.
The management of the service.
The quality of the practice.
Outcomes for children. [my emphasis]

[A4.41.2.] *3.4 The Children Act Guidance describes the purpose of planning as safeguarding and promoting the child's welfare. It promotes the individual plans required for children, as preventing drift and helping to focus work. …*

3.6 Reviews are described as 'A continuous process of planning and reconsideration of the plan for the child'.

3.9 This report, together with the reports of nine other authorities inspected, will provide the material for a national overview report."
The Inspection therefore purported to be a comprehensive inspection of the Department's newly reorganised work in relation to the planning and reviewing of the Council's care for children. Ostensibly, organisational capacity was covered by paragraphs 3.2 and 3.3 quoted above.

A4.42. The Department's and the Committee's Responses

A4.42.1. The Department's report referring the SSI Report to the Social Services Committee held on 12th February 1998 (SS70/97-98) attached the summary of the Report and its recommendations, and indicated that the full Report was available. I have carefully read the 18 paragraphs of the 1997 SSI Report's Summary, and its recommendations, and can find nothing which should have caused lay people to be alarmed, sufficiently to justify intervention in the management of the Department. If they read, or heard second-hand of, this SSI Report they could, in my view, properly assume that its criticisms had no priority claim on their attention. The matters criticised were important, but required professional, not political or organisational, responses beyond that provided by the normal Committee process.

A4.42.2. The Departmental report rightly emphasised the current difficulties of organisational change and budget reductions, the positive comments on staff and their supervision, the complexity of the individual cases looked at, and the post-1995 changes which were already in hand to improve the quality of service. The Departmental report welcomed all the Inspection's recommendations positively, and put forward an Action Plan for dealing with them.

A4.42.3. The minutes of the Committee recorded (minute 112/97-98): *"Representatives from the Social Services Inspectorate of the Department of Health (SSI) who had been responsible for the inspection attended the meeting to present their findings and to respond in detail to members' queries on the methodology for, and the outcome of, the inspection. The inspectors commended much of the work which they had examined, but also recommended a number of improvements.*

The Committee acknowledged, in particular, the vital importance of the Council's 'corporate parent' function. Close liaison between the Education and Social Services Directorates, for example, would be of paramount importance in ensuring that the educational needs of children in the Council's care were addressed as effectively as possible. …

[A4.42.4] *RESOLVED: 1. That the findings of the Social Services Inspectorate's review of planning and decision making for children looked after in Lambeth be noted.*

2. That the action plan presented to the Social Services Inspectorate by the Executive Director - Social Services (EDSS) in response to the recommendations of the review identified at (1) above be endorsed, and that the EDSS report progress in achievement of the action plan targets to the Cycle 2, 1998/99 meeting of the Committee.

3. [this referred Education-related matters to the Education Committee and the Education Executive Director]*."*

A4.42.5. The Social Services Committee which met on 18th February 1999 received an update from the Director, reporting on the extent to which the Action Plan submitted a year previously had been implemented. By this time, the first of these two Inquiries had been in progress for three months. The Committee was assured: *".. we have been largely successful in achieving the targets set … Resource limitations have impacted on full implementation."* Four matters needing further attention were specified.

A4.43. A Contrast of Style

A4.43.1. It is interesting to contrast the 1997 SSI Report with the 1998 SSI Report on the *"Inspection of the SSD Arrangements for Care Programme Approach/Care Management"*, dealing with Mental Health services provided jointly by the Council and other agencies. This Report ended its initial Summary:
"1.25 Until current arrangements are significantly improved the mental health service in Lambeth poses considerable risk to staff, service users and members of the general public. We came to this conclusion having found evidence of a lack of clarity in operational procedures/practices, poor communication at a number of levels and an overall lack of thorough risk assessments. There was a need for much clearer management guidance - including protocols which defined the scope and boundaries of staff responsibilities."

A4.43.2. The minutes of the Social Services Committee of 18th February 1999 record that, after an introduction and explanation of background from the SSI Inspectors: *"The Committee noted that staff had been commended for their commitment to and enthusiasm about mental health provision but that overall the service was fragmented and with no clear strategic lead; there had been poor joint working between the Council, Health Authority and Mental Health trusts; a lack of staff understanding of their role and remit combined with poor management support and the need for better consultation with users and carers."*

A4.43.3. The Committee resolved that the recommendations of the SSI Report (which included the need for *"a radical review of service provision"*) *"be welcomed and accepted"*; and the Department's Action Plan be approved. Significantly, the Committee set up several task forces *"to progress work on key areas on the agenda for social services".* The composition of these task forces was to be *"cross party member/ officer/ stakeholder".*

A4.43.4. The subject of Mental Health is not within my Terms of Reference. I introduce the topic in this scanty fashion for two reasons only. The first is to demonstrate, from the comparison between the SSI reports, that the Reports dealing with children's services were not worded in a similar way to raise corporate alarm. The second reason is to remind readers that there was no lack of other alarming topics within the Social Services Department which required, and on this occasion (I understand) received, immediate priority treatment from the relevant Departmental officers and the Council.

A4.44. The District Auditor's Reports to the Council - The District Auditor's Tasks

A4.44.1. The monitoring tasks of the District Auditor, as stated in his Management Letter to Councillors dated December 1995, were: *"As your external auditors we give an independent assessment of how the Council is discharging its stewardship of public money. We do this by following the Audit Commission's Code of Audit Practice (approved by Parliament) which requires us to review:*
your financial health
your management arrangements
the value for money provided by specific services
the adequacy of your systems for producing accurate financial information …."
The District Auditor therefore had an explicit monitoring role relating to management arrangements.

A4.45. Children's Services

A4.45.1. The District Auditor's reports dealing with the general management of the Council are referred to in sub-section A3.9. above. The only substantial reference by the District Auditor I have seen relating to children's services in Lambeth is in his Management Letter to Councillors dated December 1994 and a related draft report (sub-section 5.12. SPR). The Letter included 2 1/2 pages on children's services, following implementation of the Children Act 1989 and an Audit Commission Report on such services.

A4.45.2. The Letter stated:
"77. Our work at Lambeth focused on:
* *the management of social services which promote the well-being of children, in the light of the Children Act;*
* *the extent to which organisational structures and processes are in place to enable services to be delivered in accordance with the philosophy of the Children Act; and*
* *the co-ordination of services between agencies, particularly health and social services, but also education. ….*

81. The Authority has reviewed its childrens services to meet the requirements of the Children Act."

A4.45.3. The Letter stated that the Audit had identified six areas of good practice and some good projects. It then referred to *"areas where improvements are needed. In many cases the SSD are already aware of the problems and have taken initial steps to improve the situation. The detailed findings of the review are being discussed with the Director of Social Services and will be reported to Members in the near future. The key issues being discussed are:*
Strategy and Needs Assessment
Management Arrangements
Management and Financial Information
Child Protection
Children Looked After
Provision for the Under 8s."
These were large and important subjects, of considerable interest to a Council and corporate HQ which was working at the reform of the Council's organisation.

A4.45.4. The audit had also examined the client role for Central Support Services, and found *"good practices"* and *"a number of management practices and processes where the Authority still has scope for improvement"*. The latter were mainly about Trading Agreements and Compulsory Competitive Tendering. *"90. A detailed action plan is being discussed with officers…."*

A4.45.5. Despite the Letter's express statement ("*The detailed findings of the review are being discussed with the Director of Social Services and will be reported to Members in the near future")* I have not been able to discover any such report to Councillors. According to the District Auditor, a draft Report on these outstanding topics was *"issued to Social Services' Managers in October 1994. Discussions of our recommendations took place leading to an agreed action plan issued to* [the Director] *in March 1995…".* I have not been able to trace any further distribution of it.

A4.46. The Draft Report

A4.46.1. The District Auditor's Draft Report was entitled *"Promoting the Well Being of Children"*. According to this Report an initial overview had (at 5.) *"identified key areas requiring investigation as a priority".* A meeting had been held with the two relevant Assistant Directors of Social Services and *"It was agreed that further work would be undertaken in three main areas:*
- *Child Protection*
- *Children Looked After*
- *Service for Under 8's."*

A4.46.2. In its *"Main Conclusions"* (at 9.) *"the audit also identified areas where improvements are needed. In many cases the SSD are already aware of the problems and have taken initial steps to improve the situation."* In addition to those quoted in paragraph 5.12.3. SPR the draft/final report identified needed improvements in *"Strategy and Needs Assessment", "Management Arrangements",* and *"Management and Financial Information."*

A4.46.3. The *"Management Arrangements"* paragraph is the only one relevant in the present context. It stated:

"- the agreed staffing establishment cannot be funded from the budget, which has to be balanced by delayed recruitment to some posts;

- although numbers have gone down there are still unallocated high priority cases."

Even if Councillors, or other corporate *"others"* responsible for the Council's service quality, saw this draft/final Report they would not have been unduly alarmed. As ever, "*the SSD are already aware of the problems and have taken initial steps to improve the situation*". There was no indication that the Department was organisationally incapable of addressing the identified problems and recommendations.

PART 4. RECENT AND CURRENT MONITORING INVESTIGATIONS

A4.47.1. I append a list of recent and current monitoring activities, based on information supplied by the Department. The list is not exhaustive. Its purpose is to emphasise that the Council, and the Department of Health, are determined to monitor the Children and Families work of the Lambeth Social Services Department more effectively than has happened in the past.

1. The potential of the new Scrutiny Committee system, with its specific Social Services Scrutiny Committee, is referred to in sub-section 3.16 above.
2. Audit of case files of 'looked after children'. This Audit is now completed.
3. Corporate Anti Fraud Team (CAFT) projects, commissioned in mid-1999, reviewed identity verification and Police checks on individual foster carers. These projects have been completed.
4. Operation Middleton is a continuing joint investigation with the Metropolitan Police into allegations of abuse in Lambeth Children's Homes 1974 - 1995. The social work team in Operation Middleton is following up specific cases arising from the CAFT projects.
5. 'The Chestnuts' Children's Home Inquiry, referred to in sub-section A4.33. above, is an independent investigation into the circumstances of the closure of this residential respite home for children with a disability. Its report is imminent.
6. Social Services Inspectorate. The Joint Review with the Audit Commission, which occurred in May - June 2000, was paralleled by a simultaneous SSI inspection of Lambeth's planning and decision-making for Child Protection and 'looked after children' services. The Report of the SSI inspection is imminent, and that of the Joint Review is due in December 2000.
7. Children First Commission. This is an independent lay body, launched in summer 2000 to report publicly on the effectiveness of the Council's corporate parenting.
8. National Foster Care Association - Lambeth Partnership. This has already begun work to support and strengthen the development of a high quality foster care service to at least national standards.
9. NSPCC - Lambeth Child Protection Partnership. This is due to begin work this Autumn in conjunction with the restructuring of the Children and Families Division.
10. Children First Audit Team. This is a cross-departmental team, accountable to the Borough Solicitor, expected to be in service by Spring 2001.

These two Inquiries were conducted by Mr. John Barratt, LL.M. He began local authority work in 1952, qualifying and then working as a solicitor for five County Borough Councils in succession. He was Chief Executive of Cambridgeshire County Council 1973 - 1986. Since then he has worked as a management consultant, mainly on local government matters, specialising over the past decade on conducting independent Inquiries.

Advisers to the Inquiry work were:

Ms. Sybil F Roach-Tennant, J.P., M.B.A.., B.A., C.Q.S.W.. Ms. Roach-Tennant was Principal Officer, Policy and Race, Sheffield Social Services 1989 - 92, Assistant Service Manager, Children & Families, Sheffield Social Services 1992 - 95, and is currently Project Manager, Familymakers, Catholic Children's Society. She was Chairperson of the Sheffield and District African Caribbean Community, 1989 - 95, and has been a magistrate on the South Yorkshire Bench since 1988.

Ms. Gerrilyn Smith, B.A. (Hons), M.Phil., is a Clinical Psychologist and Systemic Therapist. She has worked in various settings including the National Health Service, Social Services, Probation Service and briefly in the Private Residential Sector. She ran the Department of Health Training Programme on Child Sexual Abuse from 1989 to 1994. She was a member of the Independent Panel of Inquiry into alleged child sexual abuse in Children's Homes in North Wales which produced the 1996 Jillings Report (unpublished). She now works as an independent Consultant, Trainer and Clinician dealing with child abuse issues across the life cycle.

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