THE LAMBETH INDEPENDENT CHILD PROTECTION INQUIRY 1999

THE FACTUAL BACKGROUND

PART 1 - A PUBLIC REPORT

SECTION 1. INTRODUCTION

1.1. Appointment and Terms of Reference.

1.1.1. I was formally appointed by the London Borough of Lambeth on 15th December 1998 to conduct an independent investigation with the following Terms of Reference:-

"1. To examine the Council's response to any allegations of abuse made by XXXXX [a young person in Lambeth Council's care] *about* [Steven] *Forrest during and after his appointment* [as a social worker in Lambeth].
2. To refer any allegations of abuse made by XXXXX to the police.
3. To identify any failure to comply with legal requirements, established good practice and procedures of the Council at the time.
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.*
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."

1.1.2. I am grateful to the Council for the helpful support which has been given to me during the Inquiry, particularly by the Chief Executive and the Borough Solicitor. The Committee Secretariat Manager in the Borough Solicitor's Office, Mr. Tim Stephens, has been Administrative Secretary to the Inquiry, a task which was additional to his existing workload. His constant readiness to assist has made the Inquiry's administrative work flow easily and efficiently, and I am very grateful to him. I am also grateful to those present and former officers of the Council who responded to my invitations to help me. Some gave oral information to me, often supplemented by contemporaneous documents. Others responded to requests for specific information and documents.

1.1.3. I have been greatly assisted throughout the Inquiry by Ms. Gerrilyn Smith, a Clinical Psychologist and independent Child Protection Consultant, who was appointed by the Council as my specialist Child Protection adviser on the recommendation of the Department of Health. I am very conscious of my debt to her for her clear advice, which I have borne in mind when writing this Report. However, I must take sole responsibility for this Report's existence, and for its contents.

1.1.4. The following abbreviated description of Lambeth and its Council is taken from the Council's recent recruitment information:

"Lambeth is one of a ring of thirteen local authorities which constitute Inner London. It measures some seven miles north to south, and about two and a half miles east to west. There are many important sites and cultural attractions within the Borough's boundaries. Lambeth includes the South Bank complex .....
The North of the Borough is bounded by the River Thames, which faces the Houses of Parliament and the famous Big Ben. .....
The central part of the Borough extends from the Oval in the north to Clapham Common and Brockwell Park in the south. This is mainly a residential area, with pockets of commerce and industry. The area contains many of the Council's housing developments. ..... The location in this central area, of many Council office buildings, contributes to the high proportion of employment in administration and public services.
Travelling down from the north of the Borough, through the densely built-up areas ..., the bustle of the city quickly becomes a calm. The south of the Borough is predominately residential but contains smaller areas of deprivation. .....

Lambeth is the second largest inner London Borough with a population of 264,700 (1996 mid year estimate). Between 1981 and 1991 the population fell by 11% - the second highest loss for a London Borough.
Socially and culturally, Lambeth is one of the most diverse communities in Great Britain. 30% of Lambeth's population are from ethnic minorities - the sixth highest figure for a London Borough. 22% [are] *from black groups and 4% from groups from the Indian sub continent. Lambeth has the highest proportion of Black Caribbean residents of any London Borough, and the third highest for Black Africans.*
Lambeth also attracts refugees from many nations/countries.

Lambeth is ranked as the twelfth most deprived Council area in England on the Government's 1998 local Index of Deprivation. .....
In 1995-96 Lambeth had the highest overall reported crime rate in London, double the London average, and consequently the highest rates of young adults sent to prison. A recent audit of youth crime, Reducing Youth Crime In Lambeth, by Crime Concern, reported high rates of truancy and exclusion, low rates of educational achievement and high numbers of unemployed and homeless young people.
The population of Lambeth also has higher than average percentages of children, adolescents and young people. .....

About the Council

The agenda for change in the Council is not focused on any one service area. Rather, it recognises that the whole organisation and culture of Lambeth needs to be transformed, with greater initiative being shown by management and responsibility being taken for making the changes needed. All staff have a role to play in achieving dramatic improvements in services and addressing the poor perceptions held by residents ....

The administration has established ten themes, each of which will demand fundamental changes in the way the Council is run. Underpinning these themes are three principles: Efficiency, Quality and Partnership, which the administration intends should characterise the new Council.

* *Improving financial management and fighting fraud (Corporate Services)*
* *Cleaner streets and a brighter fresher borough (Environment)*
* *Your home, your future (Housing)*
* *Better schools and new hope for youth (Education)*
* *Help when you need it and respect at all times (Social Services)*
* *New jobs and training opportunities (Chief Executive's)*
* *Putting customers first (Chief Executive's)*
* *Action on crime (Chief Executive's)*
* *A greener Lambeth (Chief Executive's)*
* *A strong voice for London, civic pride for Lambeth (Chief Executive's)*

Breaking out of the traditional departmental packaging and taking to heart our new policy ideas will require a rapid change in the minds of staff at all levels. Each of these themes has repercussions in every departmental area. Examining how they can be implemented will take further work. .....

The root and branch reforms required will take time to have their effect and the Council will need to refocus its attention onto the key priorities. .....

Lambeth Council came into being in 1965. It returns 64 councillors. In recent years, it has been a hung authority, but following the local elections in May, 1998, the composition of the Council is:

Labour	*41 seats*
Liberal Democrats	*18 seats*
Conservatives	*5 seats*

The Council has an annual turnover of £750 million and is also the major property owner in the Borough. It is also the largest employer in the Borough, with a workforce of 6,400 people."

1.2. This Inquiry

1.2.1. It is important for the reader to register from the beginning that this Inquiry is concerned only with the Council's treatment of the individual referred to in the Terms of Reference as XXXXX. It is, however, important to think of XXXXX as a person, not as a commodity, to gain a proper appreciation of the history of his care. I would prefer to use his name when referring to him, but a proper need for confidentiality prevents this. I do not intend to follow the precedent in the Terms of Reference. Instead, I will substitute the fictitious name of 'Alan' throughout this Report.

1.2.2. There is another independent Inquiry which is looking more widely at the extent of child abuse in Lambeth's former Children's Homes. This separate Inquiry is working in close liaison with investigations being undertaken by the Metropolitan Police, and has been confused with this Inquiry in some media reports. The existence of this other Inquiry and of these other investigations has enabled me to stick closely to the narrow focus of this Inquiry. However, even a narrowly focussed Inquiry has to take account of the circumstances in which the relevant events took place. I have therefore had to examine the whole of Alan's history in the Council's care, and the contemporaneous practices of, and pressures on, those who were responsible for him. This means that I have examined documents relating to the Council generally, as well as documents relating to the appointment of Steven Forrest in 1981, and to the history of Alan since he was taken into care in 1984.

1.2.3. I have conducted a more detailed examination of events in the time following Alan's allegation of abuse in January 1996, than in the period before 1996. For this later period the documentary information has been supplemented by oral information from those significantly involved. Although the Inquiry has been concerned only with one individual's history, what follows is necessarily a selective narrative from that history. The Inquiry having established that there was inaction in dealing with Alan's disclosure of abuse, and that the Council's care of Alan was deficient in other important respects, the function of understanding and describing how these deficiencies arose inevitably focusses the narrative onto what went wrong. I therefore want to emphasise here at the outset, as I shall do repeatedly, that some of the individuals who were involved with Alan's care worked with skill; and with commendable commitment to his welfare.

1.2.4. The scope of the Inquiry is shown more clearly by the titles of the following Sections, and brief conclusions are set out after each of the Sections 3 - 8:

Section 2 .....THIS REPORT'S FINDINGS

Section 3 ..... THE HISTORY OF STEVEN FORREST'S APPOINTMENTS

Section 4 ..... THE EARLY YEARS OF ALAN'S CARE

Section 5 ..... A NEW HOME FOR ALAN

Section 6 ..... ACTION AND INACTION ON ALAN'S DISCLOSURE OF ABUSE

Section 7 ..... INTERNAL CRITICISM AND THE RESPONSE

Section 8 .....POLICE INTERVENTION AND BELATED ACTION

1.3. Abbreviations

1.3.1. This Report contains abbreviations, particularly when referring to people who frequently became involved in dealing with the allegation of abuse which Alan made at the end of January 1996 (see Sections 6 - 8 below). The key to these abbreviations, in order of first reference, is:

ACPC ..... The Area Child Protection Committee;

SSI ..... The Social Services Inspectorate;

MCP&QA1.....The Manager, Child Protection and Quality Assurance to March 1996;

AD1 ..... The Assistant Director for TM1 and SW1 from February 1996, and Head of Adoption and Fostering in Lambeth from 1988;

Mr. and Mrs. N ...The owners of, and care providers in, Alan's Home 1992 - 1996;

SW1 .....Alan's social worker, February 1993 - June 1996;

TM1 ..... The Team Manager responsible for SW1 and her successor until September 1997;

DSS1 ..... The Acting Director of Social Services from October 1995 until the beginning of May 1996;

AD2 .....The Assistant Director who became responsible for specialist Child Protection work in early 1996;

MCP&QA2 ..... MCP&QA1's successor in March 1996;

CPPs ..... The Lambeth Child Protection Procedures;

DSS2 ..... The Director of Social Services from March 1996 until May 1999;

CP1 ..... A specialist Child Protection Officer;

SW2 .....Alan's social worker from July 1996 until June 1998;

SW3 ..... Alan's social worker from August 1998 until June 1999.

1.4. The Limitations on this Report's Clarity

1.4.1. The task of an Inquiry Report is, primarily, to set out clearly what has happened. Its purpose is to provide an independent, open basis for organisational discussion and decision about improvements. However, it is important to notice four limitations on the clarity of this Second Report. One limitation is immediately apparent - the need to avoid prejudicing the other Inquiry/investigations. Secondly, the need to avoid criticising individuals before they have had a proper opportunity to explain their individual circumstances is a particularly important feature of this Report. The Report has been prepared before the completion of the Inquiry's task, for the reasons given in sub-section 2.2. below.

1.4.2. The third limitation is the very proper right to privacy of Alan. I have respected this, apart from the unavoidable fact which is at the root of this Inquiry - that he disclosed that he had been sexually abused whilst he was at Angell Road Children's Home. Since Alan's history in Lambeth's care is the basis of the detailed historical record and analysis which I have undertaken in the Inquiry so far, and which underlies the open Part 1 of this Report, I have had to exclude some of Alan's personal detail from Part 1. This private detail, and some matters relating to the first two limitations, are set out in Part 2 of this Report, and it is a matter for the Council to decide to whom the contents of Part 2 should be entrusted. I cannot see any useful purpose being served by Part 2's distribution to a wider readership than is necessary to establish that any generalisations in Part 1 of this Report are justified by the full supporting details in Part 2. I have made Part 2 available to those conducting the other investigation.

1.4.3. I am advised by the Council's Solicitor that the Local Government Act 1972, in Part I of Schedule 12A, permits the Council to maintain the confidentiality of information relating to: *"a particular employee, former employee"* (paragraph 1); to *"the adoption, care, fostering or education of any particular child"* (paragraph 6); and to *"Any action taken or to be taken in connection with the prevention, investigation or prosecution of crime"* (paragraph 14). These three categories of exempt information from the Council's duty to conduct its affairs in public, for the reasons given, have strictly defined the limitations on grounds of confidentiality which I have observed in writing Part I of this Report within the Terms of Reference.

1.4.4. The fourth limitation on clarity is the impossibility of understanding fully, and therefore of describing clearly, the many other pressures on the people concerned with Alan's care. Even in a sound organisation there are many competing demands on staff. Because these pressures are often not directly within the scope of this Inquiry they are absent from its record. However, I have tried to indicate the organisational turbulence in which people in Lambeth had to operate, particularly in the critically important period in early 1996 when Alan first made his disclosure of sexual abuse. I have also been conscious of the ethnic tensions in many of Lambeth's affairs, but this dimension is not within our Terms of Reference, and has not been pursued.

1.5. <u>The Interim Report of May 1999</u>

1.5.1. I have described the method adopted by the Inquiry in a brief Interim Report which I made to the Chief Executive on 13th May 1999, for reasons which are made clear in that Report. Normally there would be no Report of an Inquiry until it had run its full course. This first Report, which the Chief Executive has already used on a restricted basis, is given below, in full: *"I have now almost concluded the first part of the Inquiry which you commissioned me to undertake into Lambeth LBC's response to a disclosure of sexual abuse. The disclosure was made by a young person in the care of the Council at the time of the abuse and of the disclosure, the alleged abuser being a man employed by the Council to look after him.*

I regard this first part of the Inquiry as establishing a reliable account of the history of this young person, of his care by the Council, and of the response to his disclosure. It has also been necessary to explore some of the context in which the individual child's care was undertaken.

[1.5.2.]*The period covered by the Inquiry is from 1984, when the child was first received into care, to the beginning of this year, 1999. In this first stage I still have some important details to clarify. However, I consider it to be my duty to communicate to you now, by way of this interim Report, my deep concern about the continuing fractured and ineffective practice of Child Protection by the Lambeth Social Services Department which the Inquiry has revealed.*

Naturally, I have some hesitation in presenting any interim Report. Even this first stage [of the Inquiry] *has not been open to challenge, though I have this morning posted a draft history to* [the other independent] *Inquiry. In the second stage of the Inquiry my task will be to clarify some detailed contradictions or omissions in the accounts people have already given me, and to supplement my detailed knowledge of some events whose significance was not known to me when I conducted earlier interviews.*

[1.5.3.] *Given the deep concern I have expressed above, it is probable that I will also have to consider who should be publicly criticised for the failure of the relevant public service. This third stage will involve putting written tentative criticism before the individuals involved, and giving them a full opportunity to respond, before finalising my Report to the Council.*

It would be rashly optimistic to predict that these further comparatively detailed and necessary processes can be properly accomplished in a short time. I am satisfied that they cannot affect my concern about the general situation. Hence, I am making this interim Report to enable you to take more timely action than would be possible if you had to wait until the conclusion of the Inquiry.

[1.5.4.] *Because it is only an interim Report it is brief and generalised. I am very unwilling to be drawn into detailed discussion, and there is no possibility that I can speculate on the attribution of individual blame. However, I am satisfied that there has been a lack of synergy between different strands of Social Services Departmental activity, and between the Department and other Child Protection agencies. The gulf between specialists and generalists has not been bridged, despite the repeated obviousness of the gulf between them, and despite the constantly obvious importance of the subject-matter. I have read and heard enough to be satisfied that Child Protection practice, in Lambeth, remains worryingly inadequate and incoherent, and therefore ineffective.*

There has been a resultant slowness to keep up with the demands of developing good practice. This situation is symptomatic of a more widely distributed incompetence which I have observed, involving a culture of work which is individualised to discrete responsibilities, and which ignores both the objectives and the potential synergy of Team work. This indicates inadequate general management and a lack of firmly held direction, applicable to the whole period I have examined.

[1.5.5.] *I suggest that there are two main causes for this extremely unsatisfactory situation. The first is an unavoidable legacy of general organisational incompetence. The practice of Child Protection is itself only a small part of the complex activities of the Social Services Department. In turn, the activities of this Department are only a part of the political and operational activities of the Council. It is clear that those who have had senior responsibility for integrating specialist with generalist Child Protection practice have also had to cope with a heavy burden of competing organisational pressures.*

[1.5.6.] *The second cause is 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. Because ineffective practice has become established, only a very rigorous appraisal of present Lambeth practice against best practice criteria will now break the local traditions, despite their obvious failings. The basic organisation of the Department needs to be remoulded, and its people motivated, to improve communication, mutual trust, and clarity of overriding objectives.*

Given the current vacancy in the Executive Director's post, there is at present an opportunity to introduce strong, determined leadership with, I trust, political support to deal with the discomfort that is likely to ensue. Given the likely timescale for the new appointment, I intend that the detailed final Report of the Inquiry, by describing past and present weaknesses, will be of assistance to the new Executive Director in this major task."

SECTION 2. THIS REPORT'S FINDINGS

2.1. A General Conclusion

2.1.1. This Report discloses a long history of inadequate organisational responses to Alan's needs, in marked contrast to the excellent work of some of the individual officers who were responsible for Alan's personal care. One expects to find organisational incompetence in any organisation under intense scrutiny, but the catalogue of organisational incompetence that has characterised the care of Alan from his reception into care in 1984 is shocking.

2.1.2. I am advised that the Council's statutory duty towards such a child for the period up to 14.10.1991 (when the Children Act 1989 took effect), is set out in the Child Care Act 1980. It is to give *"first consideration"* to the welfare of a child in care. For the remaining period the duty is set out in the Children Act 1989: *"It shall be the duty of a local authority looking after any child (a) to safeguard and promote his* [sic] *welfare".* One does not need to be a lawyer to understand the basic meaning of such duties. The Council failed to look after Alan in accordance with these duties both in general and, in particular, in relation to his disclosure of abuse in 1996.

2.1.3. (a) The failure to care for Alan generally:
It is not so much that poor decisions were made about Alan's general care, as that good decisions were not implemented effectively. This deficiency can be clearly illustrated by comparing the Council's formally declared policies with the Council's actual achievements for Alan. The Council's relevant policies in fulfilment of its legal duties to Alan were summarised in a Report, by the Director of Social Services to the Social Services Committee on the Gibelli case, in November 1992, as follows:

2.1.4. *"1.1 Lambeth Child Care Policy 1982*

The Lambeth Social Services Child Care Policy was formalised In 1981-1982 in the committee report "A Planning Policy for Children In Care" SS98181-82 and clearly sets out the council's position and responsibilities regarding children in its care.

A summary of the recommendations contained in that report stated:-

> *a) That wherever possible, no child in the care of Lambeth Council should spend the major part of its childhood in local authority care.*
>
> *b) That no child who comes into care.under the age of 10 remains in care for more than two years.*
>
> c) [irrelevant to this Report]

d) The prime focus in planning for children coming into care should be:-

i) rehabilitation with the child's own family

ii) if that is not possible, the provision of a permanent substitute family either by adoption or fostering appropriate to the needs of the child.

iii) all social work practice to be aimed towards recruitment, training and supervising of staff in line with the pursuit of this Child Care Policy. ....."

2.1.5. The Director's Report continued: *"Lambeth Child Care Policy 1991*
The child care policy was revised following implementation of the Children Act 1989 and approved by the Social Services Committee on 25.7.91. The [revised] *policy states that:*

"Lambeth Council acknowledges its responsibilities as an inner-city borough and the demands placed upon it by a population containing a variety of cultures and family structures and with racial, economic and social needs. In order to respond to these needs the Child Care Policy has been designed to build on previous initiatives to address equal opportunity issues and to promote service delivery which will be sensitive to the Lambeth Community. The objectives of the Policy are therefore:-

To reinforce the Council's belief in the uniqueness of every child and our long-standing commitment to the welfare principle, now enshrined in legislation. .....

The welfare principle
In all matters concerning children and families the welfare of the child Is paramount.

Children have a right to be protected from abuse. ....."

2.1.6. It is unarguable that Alan was received into care in 1984, aged 2½. He returned to his family aged 16, having been moved five times (plus some very short emergency placements) within the Council's residential care system during the 13½ intervening years (see the Appendix at the end of Part 1). The detailed account set out in Part 1, and more fully in Part 2, shows the varying effectiveness of the reactive, unplanned responses to his recognised needs, and the practical irrelevance of the Council's splendid-sounding Child Care Policies of 1982 and 1991, and officers' careful discussions.

2.1.7. (b) The failure to respond to Alan's disclosure of sexual abuse:
The organisational incompetence which characterised the general care of Alan was also demonstrated by the complete absence of focussed action to help him deal with the disclosure, on the basis of received expert advice. Nor was there appropriate action to follow up the potential significance of his disclosure in relation to other children. The Council had formal procedures which were appropriate, and specialist advisers were available in case of difficulty. Yet, after the initial response, the procedures were not followed, and the advisers were ignored. A clear and not unexpected disclosure had been made, those receiving the disclosure properly brought it to attention, but inadequate meetings were held, and then nothing actually happened. Even when it was subsequently pointed out that nothing had happened, still nothing happened.

2.1.8. One has to conclude that the Council's organisation, in its achievements for Alan, failed to achieve a), b), or d) i)/ii) of the Council's 1982 policy. Nor can I see any convincing evidence of the achievement of d) iii), when looking at the detailed history of Alan's childhood in Lambeth's care. The 1991 Policy also failed, and failed not only Alan but also the other former residents at risk in the children's home in which Alan had been abused. The welfare principle was not paramount in practice.

2.2. The Reason for a Further Report at this Time

2.2.1. Since writing the last sentence of the Interim Report quoted in sub-section 1.5. above, I have revised my estimate of the timescale for production of a Final Report. This is because the outstanding work of this Inquiry would be connected with matters which may also be the concern of the other independent Inquiry, and therefore also of the Police. The Final Report of the Inquiry will have to be postponed, at least until it is clear that its outstanding work will not prejudice the work of the other investigations. Although I would have preferred to complete the second stage of the Inquiry - the clarification of some of the detail - before publishing this Report, I have not done so fully. The reason for this Report is to justify, simply by relating the main facts, the deep concern so unequivocally expressed in the Interim Report, and to do so in a timely way. The need for action is too serious and urgent to await the final Report of this Inquiry. I judge the urgent need for a more detailed report than the brief interim Report to outweigh the advantage which the marginally greater clarity could have brought.

2.2.2. The organisational incompetence involved in the extensive failures (viewed from Alan's perspective) exposed in this Report is not a consequence of a few individual mistakes. By organisational incompetence I mean the inability of the Council, as an organisation, to fulfil its responsibilities to a reasonable degree over a protracted period of time, to children in need of care. I have made it clear in both the Interim Report, and again in this Report, that I am appalled at the scale of this organisational incompetence throughout the period covered by this Report. Although 'the Council', in the sense of the elected Councillors who have held office during this period, have played only a small direct part in the care of Alan, they cannot avoid all responsibility on that account. Either Councillors do have a significant influence on the way a Council's organisation works, or they are involved in a pretence. In my general experience over the last forty years, Councillors collectively have always had a significant influence on the organisational capacities of their Councils.

2.2.3. The extensive organisational failures therefore raise a considerable question about the effectiveness of the Council's former Committee system for supervising its Social Services responsibilities. In Lambeth I have noted signals which point back to an organisational gap between Council decision making and the reality of organisational achievements. Like many Committees elsewhere, Lambeth's have concentrated on the control of practice through detailed decision-making, despite the obvious limits of such a method. If this view is correct, there are important political challenges to be faced urgently by the Council about the quality and power of its direction and management, including the monitoring of achieved results. I understand that some national resources are available for this very purpose. Whatever the hard won improvements of the last few years, the systematic linking of prioritised social problems to policy, and policy to identified results must be developed. In this way the quality of practice will become apparent.

2.2.4. By the Interim Report, and by this Report, the Council has been put on notice, in a more timely way than the timescale of the full Inquiry permits, that good Child Protection practice for children in the Council's care is insufficiently well-established. The Council's careful and consistent support to the Councillors, officers and other agencies who are involved in developing the practice of Child Protection, a topic not always well understood by the public whom they represent, is necessary, as part of the programme of renewal which the Council is undertaking. There is considerable national guidance on Child Protection readily available, which Lambeth has been slow to follow in practice. The Council must insist that it is followed, unless good reason can be shown for not doing so. This is not a matter of passing pious resolutions, but of ensuring that the political challenge mentioned in paragraph 2.2.3. above is resolutely followed through, despite the likely resistance of those who resent changes in practice. Only then will there be a connection between political theory and effective practice.

2.2.5. Furthermore, the history in this Report shows that the important organisational deficiency relating to Child Protection practice emanates from organisational characteristics which, almost certainly, affect other activities. It would be unwise of the Council to concentrate solely on Child Protection matters.

2.3. Organisational and Individual Incompetence Compared

2.3.1. Undoubtedly, there are individual people responsible for the failure to care adequately for Alan. It does not necessarily follow, however, that those who were, or are, currently in positions of relevant responsibility are necessarily the ones to blame. Often they were/are struggling to improve the situation they inherited, were/are having to cope with inadequate systems and support in the process, and having to deal with continuing consequences of those inadequacies. Before attaching blame, it is important to establish a clear link between individual responsibility and the organisational actions or inactions being criticised. That is a task of the Inquiry which is still to be undertaken.

2.3.2. I therefore wish to offset my strong opinion about Lambeth's organisational incompetence with the following specific observations:

1. In examining in detail the record of Alan's care, I have been impressed by the conscientiousness, professionalism and genuine care offered to him by several individual officers acting on behalf of the Council. It would, therefore, be unjust to impute guilt to any individual simply by that individual's association with Alan's care.

2. It is clear that some individuals dealing with Alan's case found it difficult or impossible to do what they thought should be done, on several occasions. Where a person has acted in a way which, viewed in isolation, is less than the best, the limitations imposed by the surrounding organisational incompetence have to be borne in mind, before reaching an adverse judgement on that individual's conduct. Furthermore, even in the most effective organisations people have to choose between competing claims on time and other resources.

3. Current organisational inadequacies are most likely to be the responsibility, at least in part, of those who were in office in the past. There have been considerable improvements in organisational competence established in Lambeth over the last few years. I have felt admiration for those who are successfully facing the Herculean task of bringing the organisation to a reasonable level of performance and achievement.

4. Finding individual scapegoats may appear to provide a temptingly simple 'solution' to the problem of embarrassing public criticism, but scapegoating will avoid the wider social, organisational and political challenges that arise from the complex context of the individual scapegoats' actions.

5. In the limited scope of this Inquiry, I have not become aware of any corruption, as distinct from incompetence, as a cause of the failure to care for Alan apart, of course, from the sexual abuse which occurred whilst he was in the Council's care.

6. The practice of adequate Child Protection has long been recognised to involve co-operation by Social Services with other agencies, including Health, Education and the Police. The adequacy of the support given by other agencies has not been examined in detail in this first stage of the Inquiry. However, it is clear that an appropriate multi-agency approach to Alan's care and to his disclosure of abuse was not achieved. The Area Child Protection Committee (to whom I will refer as 'the ACPC') - whose function is to enable the 'Working Together' of independent local agencies - has been persuasively described to me as poorly supported, and as *"dysfunctional"*, descriptions which have not been contradicted by anything I have heard or read.

7. The work of the Lambeth Social Services Department is monitored by the Social Services Inspectorate (to whom I will refer as 'the SSI'). It will become apparent that some of their repeated advice about Child Care has been repeatedly ignored in practice. The advice of the District Auditor has also been ignored. I am not satisfied that these monitoring systems have sufficiently drawn the attention of the Council and the Chief Executive to the organisational defaults.

2.4. The Relationship between this Report and the Terms of Reference

2.4.1. This Second Report should largely fulfil Terms of Reference 1 and 3 (see paragraph 1.1.1. above). Term of Reference 2 has not been relevant, because the Police had already been made aware of allegations relating to the abuse of Alan before the Inquiry began, and Alan has so far made no further allegations.

2.4.2. Term of Reference 4 cannot be fulfilled in its entirety until this Inquiry has been completed. It is essential that the third stage of the Inquiry - giving individuals an adequate opportunity to respond to tentative criticism - is completed before any criticism of those individuals is made by the Inquiry.

2.4.3. I am also conscious of the need to avoid prejudicing the Police work, the need to take into account any relevant insights from the parallel independent, and wider, Inquiry and the need to avoid possible duplication of work with that Inquiry, before undertaking a third stage. However, I have sought to make explicit in this Report the demonstrable organisational failure of the Social Services Department in the way in which it dealt with Alan's situation. Term of Reference 4 is therefore partially fulfilled.

2.4.4. A Report on Term of Reference 5 will also be more valuably considered alongside the conclusions of the other, wider independent Inquiry. Formal organisational changes ought not to be made solely on the basis of a narrowly constructed Inquiry such as this. In any case, several formal arrangements for Child Protection work have been tried within the Social Services Department over the last fifteen years, without conspicuous success, and there have been successive attempts to improve the formal procedures. I detect a Lambeth loyalty to very local custom and practice, which has obstructed the acceptance of the new and better ways of dealing with professional problems expressed in the formal procedures, and a lack of basic organisational discipline.

2.4.5. The challenge is not primarily about formal bureaucratic organisation and process, so much as about the stimulation of co-operative, objectively purposeful attitudes across inevitable bureaucratic divisions when inevitable tensions have to be absorbed. The history of Alan's care shows a lack of the synergy on which Departmental organisation should focus in its fulfilment of the Council's Social Services responsibilities. If the "*procedures*" already in existence had been co-operatively and intelligently used they would have proved adequate for the task of dealing with Alan's case. It is the practice, rather than the procedures, which needs attention.

2.4.6. I have already recommended to the Chief Executive that the Council's most senior Child Protection specialist should work to the Chief Executive on the implementation of any outstanding national guidelines, or of SSI recommendations, relating to Child Protection. I am confident that the Chief Executive will insist that such implementation takes place, unless good reason to the contrary is demonstrated. Again, I express the hope that the Council will support her. There will be entrenched opposition in some quarters, and organised resistance, if past attempts are any guide. In particular, I suggest that the Council defines the proper scope of the Trades Unions in such matters. I detect that in the past negotiation with the relevant Union officials has replaced or distorted proper communication with staff through the normal management hierarchy. Trades Unions have a proper place, but the boundaries need definition.

SECTION 3. THE HISTORY OF STEVEN FORREST'S APPOINTMENTS

A. The Non-Confidential Detail

3.1. Introduction

3.1.1. Rather than make an unnecessary mystery, I have not treated relevant personal information about Steven Forrest as confidential. He is identified in the Terms of Reference, his medical condition has already received publicity, and the remaining information is of little consequence. However, I think it only fair to emphasise that he 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.

3.2. First Appointment

3.2.1. On 10.2.1981 Steven Forrest applied for the post of *"Children's Residential Care Officer"* at Lorn Road Children's Home. He was at that time employed at a Boy's Club in London as an Assistant Warden but, according to a referee from the Club, was currently redundant because of a reduction in accommodation at the Club. Before this he had been employed as a Tele-communications Technician, also working part-time as an Assistant Youth Worker at a Youth Centre, in Lancashire.

3.2.2. On 23.2.1981 Steven Forrest was interviewed, and appointed to the post, subject to satisfactory references etc. His referee from the Boy's Club, where he was currently employed, wrote that he had recommended Steven Forrest to apply for the post, and supported the suitability of his application. He stated *"I know of no reason why he should not be employed in a children's home."* His employer as a Tele-communications Technician wrote that his *"conduct, reliability and performance of duty were satisfactory in all respects. Although the type of work he has applied for differs greatly from that of Technician, we have no reasons to doubt his suitability for the position as Childrens Care Officer."* The District Community Physician certified that Steven Forrest was *"Medically fit for employment by the Borough Council."* The Home Office wrote *"No Observations"* in response to Lambeth's formal enquiry about him. Steven Forrest was appointed.

3.2.3. On 1.4.1981 Steven Forrest commenced work, not at Lorn Road but at 40 Stockwell Park Road, as a Children's Residential Care Officer. He was 29 years old.

3.2.4. On 1.7.1981 a Three Month Probationary Service report was completed by Steven Forrest's supervisor. The reporting officer stated: *"The home is not functioning as required by the department no children within the home full compliment of staff etc and therefore I cannot fulfill the required terms as stated on form, but feel that the candidate will make a worthwhile contribution to the home."* [sic].

3.2.5. On 12.8.1981 the 4½ month probationary report stated: *"Mr S. Forrest has proved to be a useful member of the team, and with support and guidance will be a valuable R.S.W.* [Residential Social Worker]".

3.3. Second Appointment

3.3.1. On 26/29.10.1982 Steven Forrest applied for the post of *"Team Leader at Angell Road Children's Home"* in Lambeth. His two referees were both Senior Residential Child Care Officers with South London addresses.

3.3.2. On 15.12.1982 Steven Forrest was appointed; the references are missing from the file. Perhaps they were not taken up (as could properly be the case with an existing employee), or the referees were contacted informally?

3.3.3. On 17.1.1983 Steven Forrest took up his new post as a Team Leader at Angell Road Children's Home, twenty-one months after commencing work as a Residential Social Worker.

B. Main Conclusion on Section 3

On the face of it, there is nothing necessarily alarming in this filed information about Steven Forrest's appointments. The appointments predated the more stringent guidelines for employing residential workers set out in the Warner Report in 1992. There is a range of possible explanations for Steven Forrest's appointment to Stockwell Park Home after applying for Lorn Road, and for the absence of the references when he was appointed to Angell Road Home. If there are any sinister conclusions to be drawn, they may emerge from the other investigations, when contemporaneous practice and people have been considered, and any cross-references to Steven Forrest's appointments have been noted. I do not feel justified in pursuing these appointments further as part of this Inquiry at this time.

SECTION 4. THE EARLY YEARS OF ALAN'S CARE

A. The Non-Confidential Detail

4.1. Reception into the Council's Care

4.1.1. Alan was born in December 1981. On 26.2.1984 Alan was taken informally into care by the Council. There was a brief period in which he was returned to the care of his mother, but on 19.7.1984, when he was 2½ years old, Alan was formally received into care by Lambeth, with his two older sisters. He was accommodated at a Children's Home in Croydon, *"until further notice"*.

4.1.2. In December 1984, Alan became 3 years old.

4.2. Assumption of Parental Rights

4.2.1. On 8.2.1985 there was a Review by relevant social workers, who decided to apply to the Council's Cases Sub-Committee for approval to the Council assuming Parental Rights. On 7.3.1985 his mother was told that the Social Services Department planned to place Alan for adoption. On 5.7.1985, at a Cases Sub-Committee, the social workers' report included: *"However he has now spent over a third of his life in care and all present at the Reviews this past year, particularly Dr. -, Child Psychiatrist, Brixton Child Guidance, have expressed their increasing concern about the long term effects of Alan remaining 'in limbo' for much longer. ..."*, and recommended that the Committee vest parental rights and duties in the Council. The Sub-Committee, for a proper but confidential reason, deferred consideration to the next meeting.

4.2.2. On 2.9.1985 Alan's social worker reported: *"Alan is showing worrying signs of being 'institutionalised'. ... Of all children* [a comparison with Alan's two sisters] *I am most concerned about Alan. He has been in care 18 months of his 3 3/4 years and it shows."* A Supplementary Report included *"...In the meantime the effect on the children has become marked as uncertainty grows about their future. In particular this is true of Alan who has spent 18 months of his 3¾ years in care...."* A resolution vesting parental rights and responsibilities in the London Borough of Lambeth Council was passed on 2.9.1985 in relation to Alan, with conditions making placement *"doubly difficult"*, according to the social worker. This was presumably a reference to the Sub-Committee's rider *"That the officers investigate the possibility of placing the children together in a long term foster placement with regular access to the children by* [a parent]."

4.2.3. The Council therefore assumed parental rights and responsibilities for the express purpose of securing Alan's long term need for care, through permanency of support within another family, but with ongoing contact with his family of origin. This intention was in line with the Council's 1982 Policy and with the Child Psychiatrist's view of Alan's needs. Unfortunately, the intention was not fulfilled by the Council.

4.2.4. In December 1985, Alan became 4 years old.

4.3. Arranging Fostering

4.3.1. On 19.2.1986 Alan's social worker, who was leaving Lambeth, wrote in his Transfer Summary of 24.3.1986: *"Alan has continued to show more and more signs of being institutionalised. ..... He needs to be moved as soon as possible."* On 6.11.1986 the idea of fostering was actively considered at a Review Meeting.

4.3.2. In December 1986, Alan became 5 years old.

4.3.3. The workers directly involved with Alan's care were increasingly concerned about the length of time Alan had been in care. On 2.9.1987 it was *"Agreed that Mr & Mrs E would be a suitable family – fostering will now arrange a full assessment of the family."* The psychiatrist's, and others', concern about Alan remaining 'in limbo' had been reported to the Cases Sub-Committee on 5.7.1985, over two years previously. Already, the history denotes a gap between the Lambeth Child Care Policy 1982 *"That no child who comes into care under the age of 10 remains in care for more than two years"*, and the reality of Alan's experience. Yet Alan remained in residential care for a further 11 years.

4.3.4. In December 1987, Alan became 6 years old.

4.4. Basic Organisation, 1988-92

4.4.1. On 14.10.1991, the Children Act 1989 came into force, as had the new Lambeth Child Care Policy 1991 the previous July (see paragraph 2.1.5. above). The Government had published guidance on the implementation of the new Act, including advice relating to the need for dynamism in following Child Protection procedures. Also in 1991, the Government published *"Working Together Under the Children Act 1989, A guide to arrangements for inter-agency co-operation for the protection of children from abuse"*. It is under this guidance that the role of the ACPC was established, whereby Social Services Departments must take the lead in co-ordinating a multi-agency approach to Child Protection with other agencies, notably Police, and Health.

4.4.2. In June 1991, the SSI reported on *"Child Protection Services in Lambeth"*. I note that the Manager, Child Protection and Quality Assurance (to whom I will refer as 'MCP&QA1') was one of the three person Inspection Team, the other two being independent SSI Inspectors. The Report stated that the Social Services Department had been restructured in 1988, and there were seven Divisions.

4.4.3. It reported that one Assistant Director had been made responsible to the Director for *"3.3.4 ... a common management line for children's services, such as residential homes, adoption and fostering, day care, adolescent services and group work which were formerly split between three divisions."* This Division was known as the Children and Young Persons Division until 1992, when the Assistant Director took charge of the re-named Children and Families (Resources) Division. The Job Description of this Assistant Director, in *"Main Purpose of Job"*, gave responsibility for (inter alia) *"implementation and the effective control, monitoring and development of services to children at risk in the Borough"*.

4.4.4. The Report continued:
"... *3.3.7 Child Protection Services are managed within the Community Services Division. ... 3.4.1 Casework responsibility for child protection is held by the seven Area and two Hospital Social Work Teams. Case Conferences are chaired by Area and Hospital staff predominantly, with Managers chairing all initial conferences and Team leaders chairing a share of Review Conferences. The Child Protection Coordinator is also available to chair conferences as, occasionally, is the Principal Officer.*[ie MCP&QA1]. *The Department's intention is to move to Independent chairing of conferences where the Child Protection Officers will undertake to chair perhaps 50% of the total (running at approximately 1700 conferences per year). Team leaders will then only chair Review conferences on cases they do not supervise."*
Despite *"the Department's intention"*, and repeated recommendations from the SSI, the implementation of independent Chairing of conferences took many years to gain acceptance within the Department in practice.

4.4.5. The Assistant Director responsible for this Community Services Division took charge of the renamed Children and Families (Care) Division in 1992. The Job Descriptions for these two Assistant Director posts set out an acceptable formal arrangement for the integration of Child Protection across the Department. Under this arrangement, the care institutions were managed under one Assistant Director - Children and Young Persons Division, with an emphasised responsibility to provide *"services to children at risk"*. The operational Area Teams and the specialist Child Protection staff were managed under the other Assistant Director - Community Services Division. In theory, it should have been an encouragement to the integration of developing good Child Protection practice with the general operational work.

4.4.6. A new provision of specialist Child Protection Officers began, I was told, in 1990. The most senior Child Protection specialist was known at this time, confusingly, as the Principal Officer, Children and Families. This was the officer who is referred to in this Report as MCP&QA1, who joined Lambeth in August 1990. He was responsible to the Assistant Director (Community Services), and was responsible for the Child Protection Co-ordinator. The Child Protection Coordinator was, in turn, responsible for *"A Team of Six Child Protection Officers"*, the number of which, according to the 1991 Report, had by then risen to four in theory, but only one in practice.

4.4.7. Although the Child Protection Officers increasingly chaired Child Protection conferences, they were not allowed to place a child's name on or off the At Risk Register. The Director had meetings of a Child Protection Review Group which, in 1990, was a large body of senior managers. In practice, MCP&QA1 worked confidentially to the Director, and the Child Protection Co-ordinator was *"out there"* advising on the operational work. One senior officer told me: *"The Tyra Henry case was well before my time, but it caused the Director to take a much more hands on approach to Child Protection than I had been used to* [in previous appointments]."

4.4.8. The 1991 SSI inspection of Lambeth's Child Protection service was related specifically to the implementation in Lambeth of the Tyra Henry and Doreen Aston Inquiry Reports, and generally. The Inspection Findings were critical of Lambeth's Child Protection practice, and made recommendations for improvement. Of relevance to this Report are the SSI Report's conclusions that the management of information was weak; that there were tensions in the Department about some case conference decisions, that the role of the new ACPC was uncertain; and that conference chairing and minuting, long term work and risk assessment, required attention. In particular: *"4.11.9 Inspectors' attention was drawn to the inadequacies of existing guidance in respect of abuse of children at the hands of "professional " carers - ... - particularly around the responsibility for investigation of the abuse, independent of line management. ..."*.

4.4.9. In my opinion, the handling of Alan's case in 1996 showed that the force of this SSI Report's conclusions had not been accepted into the general practice of the Department during the intervening five years. In particular, there was a less rigorous approach to allegations involving a staff member than when an 'outsider' was involved. There is obviously a heightened need for confidentiality when an allegation of abuse is made against a staff member, and that staff member's line management undoubtedly need to be involved in consideration of the situation. Neither of these considerations overrides the need for the same independence and rigour as would be present in a case involving a non-staff member. Lambeth ignored this advice, in practice.

4.4.10. During 1991 the Report of the Staffordshire Child Care Inquiry 1990, *"The Pindown Experience and the Protection of Children"* was published, raising the need for Councillors and managers to control the provision of residential child care. All local authorities were required to review their residential services in the light of this report.

4.5. A Brief Fostering

4.5.1. On 5.7.1988 a statutory Review took place, at which the delay in dealing with Alan's fostering was discussed. It had been agreed on 2.9.1987 that the Es would be a suitable family, subject to a full assessment. On 21.10.1988, thirteen months later, a Fostering Panel *"agreed on the matching of all three of the children* [i.e. Alan and his two sisters] *to be placed with Mr & Mrs E at* --- [a place in Surrey]. *As a permanent foster placement."* Alan was placed with Mr. and Mrs. E from 9.1.1989. Three and a half years had now passed since concern about Alan's institutionalised life had first been expressed on 5.7.1985, when the Council had assumed parental rights.

4.5.2. In December 1988, Alan became 7 years old.

4.5.3. The fostering placement did not succeed. No school arrangements had been made for Alan and his sisters, so that Mrs. E had had to take time off work to look after them, and Lambeth failed to pay the E's for 7 weeks. On 13.3.1989, only two months into the placement, it was agreed at a Review to remove Alan on a planned basis from the E's as soon as possible. Alan was moved to Angell Road Children's Home on 8.4.1989.

4.5.4. The history recorded in the minutes of a Disruption Conference held on 13.7.1989 contains an explanation for this unacceptable delay in placing Alan and his sisters with the Es: *"The E's responded to an advertisement in the local press in May 1986. Their application was dealt with in October 1987 by the panel. The delay was due to changing circumstances. The social worker in charge of the case had resigned and no one was allocated to cater for the children's case until October 1988. In the meantime the social services were assessing the family potential as a pre-requisite to being a foster parent. The E's were not informed of the outcome and hence they were quite distressed at being kept in the dark. It was explained to them that it was a breakdown in communication and apologies were in order.'* The E's had applied to become foster parents to these children in May 1986. It was not until October 1988, almost 2½ years later, that the placement of the three children with the E's was finally approved, and they were then placed inefficiently, and inappropriately.

4.6. A General Description of Alan's Care at Angell Road Children's Home

4.6.1. Consistently with my responsibility to maintain a proper confidentiality I can only give a very general description of Alan's care at this Lambeth Children's Home. The description is derived almost entirely from my reading of the filed records relating to Alan, who arrived at Angell Road Children's Home on 8.4.1989. These records, therefore, were written by those who were responsible for Alan's care. The Officer then in Charge of the Home was Alan's first key worker there from 6.7.1989. He was convicted in July 1999 of sexually abusing other children who had been in his care. Of course, there are entries in the Angell Road files by, or about, Steven Forrest but, not surprisingly, these do not relate to sexual abuse. During October and November 1989 there was discussion about a long term placement/ adoption for Alan.

4.6.2. In December 1989, Alan became 8 years old.

4.6.3. There is an entry: *"On the 23.1.90 Alan's Statutory Review .... (d) s/w to get funding authority to refer Alan to ....., a Private Child Care Consultancy Resource, who could help Alan to cope with all the hurt & rejection ..... (e) Alan's Adoption Panel is 2.5.90.."* The projected Adoption Panel was inquorate, so no decision about Alan could be made. On 26.6.1990 a reconvened Adoption Panel approved the proposal that Alan should be adopted, *"subject to Cases Sub-Committee"*. On 9.7.1990 the Cases Sub-Committee gave approval for Alan to be placed for adoption.

4.6.4. The Child Care Consultancy provided therapy sessions to Alan for the next three years, but there is little evidence on the files of the efficacy of this work, and no regular reports. I have been unimpressed by the management of psychological support to Alan throughout his care by Lambeth. Despite all the detailed written observations on his behaviour, no one ever organised an appropriate and effective therapeutic response, co-ordinated with his care, though therapy was purchased. It is a symptom of the dysfunctionality of the Department about which I have expressed concern.

4.6.5. On 24.7.1990 Alan's social worker recorded the suspension of the Officer in Charge of Angell Road, Alan's key worker there. The social worker called to see Alan at the Home. Alan *"said he is happy with no problems at Angell Rd, apart from the fact that* [the Officer in Charge] *... is suspended from work (internal discipline). Alan has another K/W Steve."* This new key worker was Steven Forrest. There follow several routine entries in the Children's Home daily log, amongst many others, by Steven Forrest.

4.7. Another Attempted Fostering

4.7.1. In December 1990, Alan became 9 years old.

4.7.2. During the latter part of 1990, and particularly during April/May 1991, there was a series of observations involving Alan, which should have led to decisive consideration of Alan's long term placement needs. A letter from Alan's Head Teacher dated 16.5.1991 asked for "*... urgency* [to] *be given to finding Alan an adoptive family ...*". Almost a year had elapsed since the Cases Sub-Committee, in July 1990, had approved Alan being put forward for adoption. One of the concerns expressed by the Head Teacher was "*the cessation of the adoption-related therapy sessions shortly after Christmas*". Within a week, a further 12 sessions had been authorised.

4.7.3. On 24.5.1991, at Alan's Statutory Review there was recorded: "*.... A consensus view that Alan needs a family a.s.a.p.*". According to a Social Work Assessment Form written by his social worker on 8.12 1992: "*At a review on 24/5/91 it was felt that Alan should be given the chance of a task centred foster placement as a bridging alternative until a suitable family could be found.*" This idea was pursued, but financial constraints caused difficulties. Contact was made in July 1991 with a professional fosterer with therapeutic skills, who was associated with Alan's therapist. In August 1991 a social worker from the Brixton Child Guidance Unit urged that a specialist agency should be employed to place Alan with an adoptive family. "*Alan has waited long enough for a permanent family. His many and complex needs require specialist involvement. I hope that ... Lambeth's Fostering and Adoption Panel ... will agree to an agency ... being approached as a matter of urgency, before Alan's mental and emotional well being deteriorates further.*"

4.7.4. An Adoption Panel in September 1991 considered Alan's situation, and proposed that he should be placed with the professional foster parent, and further therapy sessions were arranged. The Chair of the Adoption Panel, according to a note by Alan's social worker's Team Manager [I have used throughout this Report the term 'Team Manager' in preference to an earlier Lambeth usage of the term 'Team Leader'), "*also recommended that Area 8 A*[rea] *S S M*[anager] *to discuss with* [the Head of Adoption and Fostering] – *feel that enough has not been done to find a family for Alan*". The Head of Adoption and Fostering became Assistant Director, Children and Families in 1996 (and she is referred to, from 1996, as 'AD1' in this Report).

4.7.5. The desirability of adoption for Alan had first been mentioned in a note of 7.3.1985, and psychiatric concern about him "*remaining in limbo for much longer*", on 5.7.1985. There had been the bungled fostering arrangement with the E's, and a new formal authorisation for adoption on 9.7.1990. This latest initiative, an interim foster placement with a particular fosterer, had been mooted at Alan's statutory review on 24.5.1991. Alan, who was a 3¼ year old child when adoption was first considered in 1985, was now nearly 10 years old. The Lambeth Child Care Policy 1982 (see paragraph 2.1.4. above) had stated: "*a) That wherever possible, no child in the care of Lambeth Council should spend the major part of its childhood in local authority care. b) That no child who comes into care.under the age of 10 remains in care for more than two years.*" In the jargon, decisions about Alan's care had been subject to continuous 'drift', resulting in injurious disregard of the Council's Policy for him by the Department.

4.8. Two Changes

4.8.1. About this time Steven Forrest ceased to be available as Alan's key worker at Angell Road Children's Home. I assume that he was now too ill to be at work. On 14.10.1991 Alan's situation became subject to section 31 of the Children Act 1989, the date on which the Children Act 1989, and the Council's amplified Child Care Policy 1991 (see paragraph 2.1.5. above), came into force. According to legal advice I have received: *"By virtue of paragraph 15* [of Schedule 14] *the Council's parental rights resolution was deemed to be a Care Order, and accordingly all the provisions pursuant to the Children Act and the regulations made thereunder with regard to children in care apply from that date. ... Section 22 creates a general duty upon the Authority to safeguard and promote the welfare of any child it is looking after. ...."*

4.8.2. In December 1991, Alan became 10 years old.

4.9. Basic Organisation 1992 - 1996

4.9.1. During 1992 there was another reorganisation of the Social Services Department. The Assistant Director, Children and Young Persons Division became Assistant Director, Children and Families (Resources). In similar wording to the previous situation, the Job description included *"Operational management To be responsible for the operation, development, standards of professional practice and performance of the Children and Families (Resources) Division, with particular reference to the protection of children who are at risk."* It again included responsibility for Adoption and Fostering, and Children's Homes. The Assistant Director, Community Services became Assistant Director, Children and Families (Care). He remained responsible for managing the specialist Child Protection staff. The Principal Officer's (MCP&QA1's) title changed to Manager, Child Protection and Quality Assurance, but the job content was not, he told me, significantly different in practice. The Department's responsibility for providing effective Child Protection continued to be, at least in theory, a shared accountability between the two Divisions, not a single function of one of the separate management lines.

4.10. Warner Report

4.10.1. In 1992 the Report of the Warner Committee into the Selection, Development and Management of Staff in Children's Homes was published, the Committee having been established following the conviction of Frank Beck for numerous sexual offences against young people in local authority care. In 1992 there was also published the Memorandum of Good Practice on Video Recorded Interviews with Child Witnesses for Criminal Proceedings, which underlined joint working between Police and Social Services Departments when investigating child abuse. I am not satisfied that Lambeth developed either the expertise or the rigour which this Memorandum ought to have stimulated. It was, I understand, difficult for the new Child Protection Officers, who were distributed to bases within the Area Offices, to establish their role in the face of the traditional organisational hierarchies.

4.11. The Death of Steven Forrest

4.11.1. On 2.2.1992 Steven Forrest died of *"broncho pneumonia"*. The Certified Copy of the Death Certificate is in his Personnel File, endorsed with a manuscript note *"original seen 4/2/92"*. There is no reference in the File to HIV status, or to AIDS, directly or indirectly. It would have been contrary to the Council's practice, and regarded as discriminatory, to have attached any employment significance to his HIV status. On 3.2.1992, Alan was told of his key worker's death "*due to being very sick in hospital*". Alan was distressed and, according to the file notes, caringly supported at Angell Road through this time. Whether the cause of Alan's distress was properly understood would be difficult to establish now.

4.12. Child Protection Investigation 1992

4.12.1. During 1992 there was an examination of possibilities of Child Abuse having taken place at (inter alia) Angell Road Children's Home by MCP&QA1. This included an examination of some of Alan's past circumstances, but not with reference to Steven Forrest.

4.13. The Remaining Years at Angell Road

4.13.1. In February 1992, a new Officer in Charge began work at Angell Road. She was urged, she told me, by her manager to be alert for any disclosure by Alan that he had been sexually abused whilst at Angell Road. This was not arising out of any concern about Steven Forrest, but in relation to another former residential worker there. According to another informant, Alan was well known within the Area Office as being *"troubled"*. Not long after the new Officer-in-Charge had come to Angell Road, she became convinced that Alan had been sexually abused in the Home, and reported to her manager the experience of Alan's behaviour which led her to that conclusion. Later experiences confirmed her in this conclusion. This coincided with the discreet Child Protection investigations by MCP&QA1 about Angell Road and two other Children's Homes, which ultimately involved the Police, and occupied almost the whole of 1992.

4.14. Two More Failed Fosterings

4.14.1. In March 1992, a monthly report on Alan stated: *"In our view Alan would get a lot of benefit from a planned therapeutic placement. ....."* A specific therapeutic placement suitable for Alan had first been identified at the Adoption Panel in the previous September. Pressure was put upon the Adoption and Fostering Section of the Department to find such a placement for Alan. On 16.3.1992, the specialist fosterer who had been approached the previous July (see paragraph 4.7.3. above) refused to have Alan because *"I have been very confused and concerned by the way this referral has been conducted ...., with whom I work closely, and who is Alan's play therapist, felt that Alan would be ideally placed here, and has been considerably concerned at his despondency due to no appropriate family having been found for him. It was due to her concern for Alan, and the fact that I felt that we were a family experienced in dealing with his problems, that I was prepared to be tolerant of the poor communication between the department and myself. However, I need to make it clear that I would have great reservations concerning the possibility of me being able to work with the inefficiency and lack of respect that, I feel, I have encountered so far.*

[4.14.2.] *We are working with disintegrate children, usually due to poor care having been taken by the adults in their lives. If we are professionally disintegrated then I believe that we will further damage the children. If Alan were to be placed here, I would be concerned that the confusion I have already encountered would probably continue. I feel that for these reasons it would be inappropriate for Alan to be placed here now, and I would hope that any future family placements considered for Alan would be dealt with in a manner that would prevent so much confusion. I sincerely hope that a family can soon be found for Alan, and that a better future lies ahead for him."*

4.14.3. On 18.3.1992 the Team Manager responsible for Alan's social worker wrote to the Area Manager: *"I feel extremely disappointed and angry with A*[doption] *& F*[ostering] *and* [the relevant Assistant Director] *and would like you to take this case up with* [the Head of Adoption & Fostering] *and* [the Assistant Director].
I have written long memos with full details since Septe [sic] *and 6 months later there has still not been any movement.*
We are back to square one with Alan continuing to deteriorate, ... and local services having completely and utterly failed him. Angell Rd cannot cope and are not able to do anything for Alan. Your comments please." After apologies and representations from Alan's social worker, on 26.3.1992 the fosterer again offered to take Alan in May 1992.

4.14.4. In April 1992 there was a handover of Alan's case from the social worker who had been with Alan since April 1988. The new social worker remained with Alan's case until February 1993. In June 1992 she wrote optimistically about Alan in a note to her Team Manager *"partly as a result of new contact with* [a member of his family] *and partly because of continued therapy ..... . Alan is not getting anything else in terms of therapy and counselling and I feel his sessions should continue..."*. This proposal was agreed by the Team Manager and by the Area Manager.

4.14.5. On 17.6.1992, the therapeutic fosterer told Alan's new social worker, according to the file note, *"that she had kept a vacancy for Alan for ten weeks last year and wasn't prepared to do that again. She went over the history of poor communication she had experienced with Lambeth and the fact that she had actually been referred Alan last July and we had hardly progressed. After much discussion* [the fosterer] *said that she would not consider Alan being referred ...."* Amongst the reasons she was reported to have given for refusal were: *"4) It is not fair to keep Alan waiting any longer as he needs a placement now.* [she no longer had a current vacancy]. *5) The bad experience she had received from Lambeth ie poor communication last year and the concern that she might not be well supported."* The fosterer had been formally approved on 11.9.1991, ie 9 months previously. An explanation for the failed placement was given in a report dated 23.10.1992, which stated: "*A therapeutic family was identified as Mrs .... but, because of the delay (6 months) in securing funding for the placement and the educational unit attached to the establishment, Alan's referral was not successful.*". More lack of synergy; more drift.

4.15. Further Plans

4.15.1. On 18.6.1992 Alan's social worker told his key worker at Angell Road Home that she would start her assessment of a member of Alan's family, as now the next plan was to settle Alan with this person. His therapist expressed the view that Alan *"has turned a corner this winter and is making steady progress."* On 10.7.1992 the social worker told the family member that Alan's move from Angell Road would not take place *"... in the next couple of months."*

4.15.2. On 23.7.1992, following a Statutory Review on 15.6.1992, the social worker noted: *"... (3) Angell Rd informed* [i.e. told the social worker] *that they cannot keep Alan longer than 6 months. Long term specialist home (small children's home) to be explored... "*. The new Officer in Charge at Angell Road from the previous February told me that she had become increasingly concerned that, whatever the theoretical plan for Alan to be fostered or adopted, there was no effective action. It was for this reason that she had informed the social worker that she wanted Alan's future to be actioned within the next six months. On 29.7.1992 the social worker noted: *"We talked* [ie with Alan] *about what it would be like to be living in a family again. I reminded Alan that it would be some time before he would be allowed to go..."* On 5.8.1992 the Area Manager instructed the Team Manager: *"Please ensure that rehabilitation plans are drawn up to ensure a speedy* [move] ..." This plan to place Alan with this member of Alan's family never came to fruition.

4.16. Departure from Angell Road

4.16.1. The circumstances which caused Alan's departure from Angell Road Children's Home in September 1992, where he had been resident since 8.4.1989, cannot be described in this public Report. Suffice it to state that children were involved in incidents and behaviour there which caused concern. A Planning Meeting on or just before 29th October 1992, which included a Child Protection Officer and a Policewoman, was held about another child at which it was decided that Alan should be moved. *"It was clear after some discussion that a change in the current residents at Angell Road need to take place. It was agreed that management would need to discuss this matter outside the planning process, but that attention should be centered on the possible move of Alan or* [P] *and* {Q]. *It was noted that a move for both* [P] *and* [Q] *should not be done in a rush..."*

4.16.2. The Area Manager envisaged a planned move for Alan to a small residential Home, for a few weeks. On 30.9.1992 Alan's social worker noted that *"Placements have been asked to find Alan another placement.* [The Under Manager at Angell Road] *is requesting that an urgent management meeting be held as soon as possible."* Lambeth 'Placements' had telephoned a small Children's Home in Kent, to see if there was a vacancy, and there was, the people who owned this Home told me. However, more senior officers had decided that Alan should be removed from Angell Road Children's Home forthwith. There was concern amongst those dealing with the incidents there that Alan might have been the victim of sexual abuse at some time in the past. On 29.9.1992, Alan was suddenly moved to another Children's Home in Lambeth, where he stayed for one night.

B. Main Conclusions on Section 4

1. The delay which occurred between the initial Sub-Committee instruction to pursue fostering in Sept 1985, and an expression of interest in the children by the E's in May 1986, followed by the failed fostering placement with them in early 1989, represented over four years of a young child's life. In any event, the eventual placement should have been better researched and certainly more sensitively and efficiently handled.

2. The "drift" which occurred in placing Alan with the E's was only part of the unacceptable drift in dealing with Alan's needs which continued to occur between good plans and poor delivery. In particular, a later appropriate seeming placement for Alan in 1991/92 was **twice** lost because of further incompetence. The suddenness of his departure from Angell Road was insensitive. The gap between the Council's express policies in fulfilment of their statutory responsibility to Alan and the Council's actual achievements for him points to major and continuing organisational incompetence. The Council did not deliver what it proposed to provide generally, or what was repeatedly noted with concern as being individually necessary in Alan's case. The contrast between decisions and action could not be more striking.

3. It is impossible to find any evidence that there was an effective 'overview' of Alan's case. The detailed evidence reveals a piecemeal, reactive approach, repeated failure to act on agreed plans, and a poor understanding of child development. In particular, Alan's behaviour cried out for therapeutic help, but such help as was given appears to have been organised in a sporadic, unaccountable and unco-ordinated way. Alan, who was now nearly eleven years old, remained in the residential care 'limbo' which had first been identified by the Brixton Child Guidance Psychiatrist on 5.7.1985, when he was 3 1/2. The Council's Policy targets were missed to a deplorable extent.

4. Lambeth was made aware that its Child Protection practice was seriously deficient, despite the increased national awareness of dangers to children.

5. Lambeth was alerted to the probability that Alan had been sexually abused whilst at Angell Road, but there is no record that Alan made disclosure to any professional involved in his care.

SECTION 5. A NEW HOME FOR ALAN

A. The Non-Confidential Detail

5.1. The New Arrangements

5.1.1. I will refer to the owners of Alan's new Home in Kent as 'Mr. and Mrs. N'. The next step, after the telephone call from 'Placements', should have been a call to them from Alan's social worker, to fill in the background and to give them an opportunity to consider whether they wanted to accept the referral of Alan.

5.1.2. On 30.9.1992 Mr. and Mrs. N told me, they had been out, on their day off. When they returned to the house Alan was there, waiting in a minibus in the street, accompanied by a worker from Angell Road whom Alan seemed to know and like. It was a fait accompli; Mr. and Mrs. N did not think it right for Alan to be rejected and sent back, when he was already there. They were told little about Alan's background, and nothing relating to sexual abuse. Mr. and Mrs. N understood the placement to be short term, having regard to the plan for Alan to live with his relative.

5.1.3. In fact, Alan stayed with Mr. and Mrs. N for almost four years, until June 1996, based on the renewal by Lambeth of three-monthly contracts, following his obviously satisfactory progress there. Although, as they thought, he had been 'dumped' on them, they demonstrated a commitment to Alan, as a child in need, and they appear to have done their utmost to meet his needs. However, the failure to supply Mr. and Mrs. N with important background information about Alan must have limited their ability to care properly for him and, in turn, for the other children in their care. I regard this omission as extremely serious, given the implications of the background.

5.1.4. There was discussion, in the Social Services Department and with the Police, about the circumstances in which it had been thought necessary to remove Alan from Angell Road Children's Home. There were concerns expressed, based on indirect evidence, about whether Alan was a victim of sexual abuse. The significance of this possibility in relation to a child who had been in the Council's care for most of his life was noted. A joint Police/ Social Services interview of Alan, with this in mind, was ordered, to take place quickly. The possibility of abuse within a Lambeth Children's Home was not covered up.

5.1.5. On 23.10.1992, a Report was submitted to the Adoption Panel. This requested the reversal of the previous adoption decision in respect of Alan, and the approval of the move to the family member informally planned the previous June. In practice, this did not happen.

5.1.6. In early November 1992 the joint Police/Social Work interview took place. After the interview a Child Protection Officer was told by her colleague, the interviewer, that she was very concerned that Alan was not telling her everything, and she felt that he had been damaged by some kind of abuse.

5.1.7. On 25.11.1992 the Kent Education Department wrote to Alan's social worker: *"... I understand from Alan's foster parents* [sic] *that he has a statement of special educational need, although she* [Mrs. N] *has not received a copy. ... I should be grateful if you would forward a copy of Alan's statement, along with further details of the long-term plans that your department have agreed upon."* I was told that when Alan's Special Educational Needs statement came to Mr. and Mrs. N, it had not been updated.

5.1.8. On 8.12.1992, Alan's social worker wrote a summary of Alan's history in Lambeth's care so far. Her Team Manager added:
"... there has been another planning meeting at [Alan's new home in Kent] *(7th Dec 92) where Alan indicated to ... he would like to stay* [there] *as long as possible. He is being nurtured there, is thriving, receiving individual care and is extremely happy there. Alan has been in care since the age of two and has had several moves and traumas. It appears that his needs appear to be being met at* [his new home] *and I would therefore request that the placement be authorized until end of March for further definite plans to be made."*
This decision was implemented. Alan stayed at this home until the middle of 1996.

5.1.9. In December 1992, Alan became 11 years old.

5.2. A New Social Worker for Alan

5.2.1. On 15.2.1993 a new social worker took over from the one who had been with Alan's case since April the previous year. The new social worker remained in this capacity until June 1996. Because the narrative covering the Department's response to Alan's disclosure of abuse commences during this social worker's involvement with Alan's case, I will refer to her as 'SW1'. The quality of care provided by SW1 appears to have been of a high order. Although the Council's organisation will be seen to have failed to produce satisfactory results, this dismal state of affairs must never obscure the praiseworthy efforts of individuals like SW1 to achieve good care, despite the organisation within which they had to work.

5.3. SSI Inspection of Angell Road 1993

5.3.1. In March 1993 the Social Services Inspectorate reported on *"an Inspection of Three Residential Children's Homes in the London Borough of Lambeth"*, one of which was Angell Road. The Report was critical of management direction and support. There was specific reference to Child Protection, indicating basic deficiencies. In relation specifically to Child Protection Procedures at Angell Road the Report (at 6.2.3) stated: *"Staff were aware of the guidance but reported that they had little time to read and integrate them into the practice. Staff also voiced concern as to the degree of support they received when dealing with sensitive matters of child protection. Staff had not taken part in child protection training. Staff were vigilant and took precautions with regard to child protection and this was a regular discussion item at staff meetings."*

5.3.2. In relation to all three Homes, the Inspectors cast doubt on the independence of the process used in Lambeth whereby all incidents of child protection in residential child care were referred to the Assistant Director. This is a repetition of the point made in paragraph 4.4.8. above, about line management being too heavily involved in Child Protection investigations of staff. Their Report stated: *"It is possible that this requirement is not in keeping with the process outlined in Working Together and it would appear that it may exclude the normal operation of independent child protection investigation."*

5.3.3. The Inspectors recommended (at 6.2.6) that this should be reviewed, *"taking into account the recommendations of Working Together and including a representative of the child protection service. Consideration be given to bringing issues of child protection in residential child care within the framework of child protection as operated under the ACPC guidelines across the borough."* The force of this important recommendation was not apparent in the response to Alan's disclosure in 1996. Lambeth continued to be slow to bring CPP rigour to cases involving children already in its residential care.

5.3.4. The Inspectors noted (at 6.3.1), *"It was required practice that all information of significance to the protection of children in homes should be notified to the Assistant Director of Residential Care. He would convene a planning meeting and determine the best course of action. Whilst this system is known to staff, it is not always operated at speed and with a thoroughness that ensures all those involved are kept informed as to developments and the outcome of the planning meeting and subsequent actions."* They therefore recommended (at 6.3.2): *"That in the light of the review of the current arrangements of notification to the Assistant Director, a clear mechanism is established for the communication of the outcome of any planning meetings held and that a system of follow-up and checking is instituted to ensure that decisions at these planning meetings are operated speedily."* Again, the force of this recommendation was not apparent in the response to Alan's disclosure in 1996.

5.3.5. In relation to Care Reviews the Inspectors reported (at 9.2.4): *"The review and case planning process for young people seemed to be operating in considerable disarray. ... This is a serious cause for concern and evidence from many research documents suggests that the drift and lack of planning for children in residential child care causes serious problems for those young people. ..."*. This comment described Alan's situation exactly. The Inspectors recommended (at 9.2.5): *"A clear case planning and review procedure is established, ... This is placed on the file in the residential unit and routinely and regularly reviewed, commented upon and adjusted so that it can take account of the changing situations."*

5.3.6. The Inspectors (at 12.3.1) noted in relation specifically to Angell Road: *"Monthly visits on behalf of the responsible authority were not an established, regular event... Records show that the last visits by elected members were over a year ago."*

5.4. A New Team Manager for SW1

5.4.1. During August 1993, the Team Manager for Alan's case left Lambeth, and a new Team Manager, to whom I shall refer as 'TM1', took her place. At first TM1 was Acting Team Manager alone, and then she shared the post with another person when it was permanently filled. In practice, however, TM1 was the effective Team Manager for Alan's social workers, SW1 and SW2, and his case, until August 1997.

5.5. More Concern about Sexual Abuse

5.5.1. SW1 noted in October 1993 that Mr. and Mrs. N *"are wondering whether Alan needs some form of counselling to tackle issues from his past. They both feel that this may include dealing with the various abuses that Alan has hinted at...."*. Mr. and Mrs. N were in no doubt, from indirect references volunteered by Alan, that he had been sexually abused. A joint Police/Social Work interview with Alan had taken place only the previous November, without any disclosure of abuse by Alan, but the likelihood that Alan had been sexually abused was strengthened by the house parents' observations. I am advised that it is not unusual for there to be a high level of reasonable suspicion, but no disclosure of sexual abuse, despite formal opportunities to disclose, especially when the perpetrator was a professional carer.

5.5.2. In December 1993 Alan became 12 years old.

5.6. Action Plan

5.6.1. On 1.12.1993, the Social Services Committee's agenda included a report on the Department's Management Action Plan, which set out many proposed changes to the way the Department would operate. In its weight of detail it was impressive, and presumably complied with the Council's normal process for enabling Councillors to take their responsibility for the effectiveness of the Council's organisation through the traditional Committee system. The disabling nature of such a process has been clearly condemned since the 'Maud' Committee's Report on *"the Management of Local Government"* in 1967. The Council now has a new process, which will have to be firmly guarded against repetition of such nonsense in other forms. Detail can be important exceptionally, but it cannot take the place of reliable management information as a basis for overall direction.

5.6.2. On 16.2.1994 and 28.3.1994 the Committee received an update on progress in implementing the Action Plan. One task was related to one of the SSI recommendations (see paragraphs 4.4.8. and 5.3.2. above): *"As part of the current Child Protection procedure review the current arrangement of referring all matters to Assistant Director level for dealing with allegations against Lambeth employees, foster carers child minders and staff employed by Private and Voluntary Children's Homes will be reviewed."* The target for achievement was January 1994.

5.6.3. The Progress Report for 1.12.1993 stated: *"Changes to the Child protection procedures cannot be made until the Directorate restructuring has been achieved and appropriate training provided for Service Managers."* The Progress Report for 16.2.1994 stated: *"The changes to the C&F(R) reorganisation are currently subject to consultation with the relevant Trade Unions. However Senior Managers have been on specific training on Child Protection. Further developments will be provided to the C&F Sub-Committee at the next cycle."* The Progress Report for 28.3.1994 stated: *"Following the decision of the Council regarding the Child Care Strategy the issue of establishing alternative arrangements for the chair of CP planning meetings is being considered and will report to C&F Sub next cycle."* The urgent need to amend the procedure for investigating allegations against staff was therefore officially recorded.

5.6.4. In relation to the SSI recommendation (see paragraph 5.3.4. above) to establish a clear mechanism *"for the communication of the outcome of any planning meeting held and that a system of follow-up and checking is instituted to ensure that decisions at these planning meetings are operated speedily"*, the Progress Report for 1.12.1993 stated: "*The A.D. C&F(R) will establish a monitoring system to ensure that all relevant people receive copies of the agreed actions following Planning meetings. These arrangements will be reinforced via the training programme being developed for Service managers.*" The accountability of the Resources Division for implementation, as distinct from specialist advice, was thus acknowledged.

5.6.5. The Progress Report for 16.2.1994 stated: "*A draft system has been developed to ensure the monitoring of Child Protection cases from the initiation of a referral to the communication of the Planning Meeting decisions. This system is intended to be computer based therefore discussions are planned with the Information Technology Officer. Further developments will be reported to Committee in the next cycle.*" The Progress Report for 28.3.1994 stated: "*A manual system is now in place for the monitoring of the planning meeting process from the point of referral to final decision. This system will be developed and converted to a computer based system in due course.*" The Committee was informed that this task had been *"Achieved"*. The system might have been achieved, but its practice certainly was not, as the history of Alan's case in 1996 will show.

5.6.6. I have not thought it a right use of public resources to follow through the progress of the SSI recommendations further, for three reasons. First, my general conclusion about Child Protection procedures in Lambeth is that it is the practice, rather than policies and procedures, which is of concern. Secondly, the SSI themselves reported on progress in May 1994 (see sub-section 5.10. below). Thirdly, an expert review of theory and practice will be more effective and efficient than the use of my Inquiry process. Accordingly, the Chief Executive has already responded positively to my suggestion that such a review takes place.

5.7. The Care of Alan in Kent during 1994

5.7.1. Alan continued to be cared for at the small Home in Kent, and his social worker continued to be SW1. In February 1994 circumstances occurred which strengthened the suspicion of SW1, and of Mr. and Mrs. N, that Alan had been sexually abused during his care by Lambeth prior to his move to Kent. The Kent Police were involved.

5.7.2. At the initiative of Mr. and Mrs. N, Alan was interviewed in March 1994 by a Consultant Psychiatrist and Psychotherapist, who recommended the re-institution of therapy sessions. The previously authorized sessions, which had intermittently taken place since 1990, had lapsed. In June 1994, arrangements were made with a therapist near to Alan's Home. She was told of Alan's background, including the possibility that he had been sexually abused. Therapy sessions began in November 1994, and continued until July 1996, when the therapist brought them to an end after discovering co-incidentally that Alan had made a disclosure of sexual abuse the previous February. I have found few written references in the file to Alan's therapy, apart from administrative detail. It is, therefore, difficult to assess its effectiveness. My comments in paragraph 4.6.4. above continue to apply. Certainly, evidence of the need for effective therapy continued to be obvious.

5.8. SSI Report on Lambeth's Inspection Unit 1994

5.8.1. In April 1994, the Social Services Inspectorate reported on an *"Inspection of the Inspection Unit"* in Lambeth. The Report made recommendations for improved practice, but also recognised *"examples of the positive impact of inspection on service provision in both the local authority and independent sectors."*

5.9. A New Council

5.9.1. In May 1994 the four yearly elections produced a "hung" Council. In September 1997 the District Auditor issued a report in the public interest on the audits for 1994/95 and 1995/96, in which he stated: *"The political make up of the Council changed following the 1994 local elections. Although no party has overall control, after a period of uncertainty immediately following the elections, Members of the 'hung' Council have worked together to tackle major issues. They have sought to balance the need to reduce Council Tax, make budget cuts and remove inefficiencies, while at the same time improving the quality of services provided."* The consequences of the previous organisational disintegration still continue to challenge those currently holding responsibility in the Council.

5.10. SSI Report on Residential Child Care 1994

5.10.1. In May 1994 the Social Services Inspectorate reported on an *"Inspection of Lambeth Residential Child Care".*

"1.1 This was a follow-up to an inspection carried out in March 1993. [see sub-section 5.3. above]. *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.

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."

[5.10.2.] *"Conclusions*
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."
The SSI Report then referred to five basic needs, which included *"Routine and rigorous monitoring of the quality of practice by managers and members."*

5.10.3. The body of the report was generally critical and unflattering. It reported (at 6.1.1) that the *"Assistant Director was still the focal point for child protection incidents in residential care. This process puts pressure on the Assistant Director, but was seen by staff to operate adequately. In one Unit the time between reporting of an incident to the Assistant Director and the planning meeting was over three weeks and staff and the external manager were not clear as to the outcome.*
6.1.2. Inspectors were told that in some cases where the child protection incident involved a member of staff, the process and outcome of the investigation were not clear, and sometimes appeared unresolved for many months." [my emphasis]
Again, Lambeth was told about flaws in its Child Protection practice when staff were accused of abuse. The history of Alan's case in 1996 shows that the Lambeth practice did not significantly alter.

5.10.4. By this time there were, I was told, a Senior Child Protection Officer, and three Child Protection Officers, who now independently chaired some case conferences, against, I was told, resistance from some middle managers in the Areas. Four Minute Takers had also been appointed, to improve the recording of decisions.

5.10.5. It is clear to me, from information given by several people who worked in the Department at this time, that the development of independent advice to, and scrutiny of, the practice of Child Protection within the Lambeth Social Services Department created internal antagonisms. This considerable tension seems to me to have been endured by senior management, rather than managed. It was certainly a major cause of the otherwise inexplicable failure of the Department to deal appropriately with Alan's disclosure of sexual abuse in 1996. There was also, in practice, an organisational cleavage between the work of MCP&QA1, who reported confidentially to the Director on major investigations involving staff, and the Child Protection Co-ordinator's Team, who dealt with individual cases in the Area Offices. This led to considerable confusion about roles and co-operation after the 1996 changes of organisation and staff.

5.11. Draft Guidelines for Working with HIV in Child Protection

5.11.1. On 10.11.1994 the Child Protection specialists asked the Director to include the following document in the agenda of his Child Protection Group. I understand that this document was never formally approved by the Council, but that its content does reflect the general practice which was followed by the specialists. Its significance for this Report is to provide background to the way in which Alan's disclosure of abuse, allegedly by a person known to have *"died of AIDS"*, was dealt with in 1996.

5.11.2. *"HIV/CHILD PROTECTION SUB-GROUP*
DRAFT GUIDELINES FOR WORKING WITH HIV IN CHILD PROTECTION

This document should be read in conjunction with:-
Lambeth's HIV policy and sub-section on children and families.
Further copies may be obtained from the Health Liaison Unit MSH.

HIV TESTING / MEDICAL INVESTIGATIONS
Dealing with HIV issues in the aftermath of abuse is the responsibility of appropriately qualified medical and specialist workers. The social worker, in promoting the welfare of the child, should facilitate the child/family in receiving the appropriate medical services. HIV testing should not become a routine test following the sexual abuse of a child, in most cases this would be an inappropriate response. However it is important that during a C.P. investigation, if a child is found to have been involved in a high risk activity (ie. unprotected penetrative sexual intercourse, anal or vaginal; blood entering blood stream of other person, or sharing of injecting equipment) the social worker must consider fully the implications for the child. This includes emotional, psychological, physical factors, as well as the risk of STD transmission, eg. Hep B, HIV. The child should be offered the opportunity to meet with the appropriate medical personnel, to examine their health needs following the abuse.

[5.11.3.] *If the child is referred for testing the social worker should make themselves aware of the issues of infection with the appropriate HIV specialist worker at the testing site, prior to any medical taking place. The specialist HIV worker will advise them how to proceed.*
Requests for testing of a child may come from a variety of sources. If testing is being requested by the child, the HIV specialist workers must be consulted at the planning stage to ensure that full pre-test counselling, appropriate to the age and development of the child is arranged. This is to ensure the child's informed consent to the test.
Due to anxiety, testing is often requested by the parents or those holding parental responsibility. Whilst it is recognised that parent/s wanting their children tested can go elsewhere, to ensure the child's welfare and best interests the social worker is responsible for directing the parents to a specialist HIV centre (see appendix) where testing of children, protocol and guidelines exist.

[5.11.4.] *CHILD PROTECTION INVESTIGATIONS*
A person's HIV diagnosis is never relevant to a Child Protection investigation, only the issue that they are suffering from a stressful medical condition. As any member of the public may be HIV positive the social worker's response should be uniform in all cases, taking into account the possibility of HIV and other sexual health matters. If appropriate referral is made to sexual health specialists it is never necessary to record on file details of a person's sexual health.

[5.11.5.] *INTRODUCTION OF CONFIDENTIAL INFORMATION TO CONFERENCE*
It is the responsibility of the chair of the child protection conference to ensure that Lambeth's commitment to equal opportunities is adhered to in the conference. A conference will begin with a statement from the chair of a commitment not to discriminate against or stereotype any person or group of people.

[5.11.6.] *Where a member of any agency has concern about a child's sexual health, and thinks it might relate to a Child Protection matter, they must seek advice from the Team Manager (HIV Specialist Team) or the Child Protection Co-ordinator. Prior to this consultation taking place there should be no record made of the matter.*
If information about a person's HIV status is given to the conference, it is then the responsibility of the chair of the conference to challenge this in the light of his/her opening statement, and to ensure that the information is not included in the record of the conference. The matter will then be referred to the conference member's manager as a matter of serious professional concern. This practice is to be recommended in response to any discriminatory behaviour in the professional arena."

5.11.7. I have also been referred to another, much longer, Lambeth document from about this time, and of similar status. The title of this document is *"Policy on HIV Infection and AIDS"*. In relation to Child Protection, it is to much the same effect as the document just quoted. The clear, and sensible, message from both documents was that the relevance of an alleged abuser's HIV status was dependant upon whether there had been abuse, and <u>any</u> case of abuse <u>might</u> involve an abuser who was HIV positive. Child Abuse investigations, therefore, should treat HIV status as an important but consequential factor. The course adopted in 1996, after Alan had made his disclosure, was consistently contrary to this message. The Department did not work as an integrated unit.

5.11.8. In December 1994, Alan became 13 years old.

<u>5.12. The District Auditor's Management Letter to Councillors</u>

5.12.1. This letter, dated 30.12.1994, included 2½ pages on Children's Services, following the implementation of the Children Act 1989. The audit had identified areas of good practice, and *"some 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: .....* [amongst other issues] *Child Protection .... "*. I have not been able to discover any report to Councillors, despite repeated searching of Committee Minutes by appropriate officers.

5.12.2. In the Spring of 1995 a Draft Report was issued by the District Auditor on *"Promoting the Well Being of Children"*. A meeting had been held with the 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."*
The Main Conclusions stated: *"Lambeth has reviewed its childrens services to meet the requirements of the Children Act. Particular areas of good practice identified by this audit include: ...."* Then followed a description of seven areas of administration appropriate for review by an auditor. It also praised Lambeth's schemes for supporting children leaving care and preventing family breakdown.