7.3.9. On 8.8.1996, CP1 sent an E-mail to AD2, copied to MCP&QA2. It picked up an important administrative point in MCP&QA2's E-mail of 29.7.1999 to which a response had not been received in AD1's reply, and kept the subject of Alan's case *"on the boil"*, I was told.
"Subject: Insurance implications
[MCP&QA2] *has reminded me of a child, Alan ... dob 12/12/81 who is accommodated by Lambeth. In Jan 96 Alan disclosed to his social worker that he had been sexually abused by a residential worker within a Lambeth Children's home who we now know later died of an AIDS related illness. The social worker, who has now left Lambeth was advised not to record any details on the case file.*
[AD1] *chaired three planning meetings and is aware of the detail. I believe that Alan also suggested that another young person may have been abused by the same person. The case is held at South District. I don't know if our insurers have been informed."*
AD2, the following day, sent an E-mail to DSS2 with CP1's E-mail attached:*"Are you aware of this case? It sounds worrying that no further action has been taken?"*

7.3.10. DSS2 had now been in sole command of the Department for three months. She told me that spoke to AD1 about the case, expressing concern that nothing was happening, and referred to the publicity about the 'Trotter Affair' in nearby Hackney, which was gaining momentum at this time. She told me that she was reassured that AD1 was dealing with Alan's case, not ignoring it. AD1 had spoken about what 'we' had been doing, and since AD1 held the Chair of the ACPC, DSS2 assumed that AD1 was dealing with the Child Protection issues, as well as with those relating to the care of Alan. AD1, she thought, clearly had an action plan, so DSS2 was no longer alarmed.

7.3.11. She understood from AD1 that there had been Planning Meetings, and the Health people had been involved, so there was no question of a 'cover-up' (as was alleged in Hackney). Amongst the problems being tackled was that of getting confirmation about Steven Forrest's HIV status. The psychiatric advice had been that it was inappropriate to talk to Alan about what had happened. The health risk to Alan was fairly low. DSS2 told me she offered to AD1 to get in touch with the Health Authority about the confirmation of Steven Forrest's HIV status, if this would be helpful. DSS2 then told AD2 that she had discussed Alan's case with AD1, and was satisfied that the matter <u>was</u> being followed through.

7.3.12. AD1's recollection is that when DSS2 raised the matter with her, AD1 told DSS2 what action she was taking to support Alan, and made it clear that the specialist Child Protection issues were not her responsibility. DSS2's words to me illustrate a possible but hidden ambiguity in what may have been the conversation. She told me: "[AD1] *was aware of the issues; that was why it was reassuring. She gave a coherent account of what was happening, and gave me the impression that* [the Child Protection specialists] *had not caught up. I therefore advised her to speak to* [AD2] *and* [MCP&QA2]." In other words, when AD1 was actually saying that the Child Protection specialists had been slow to follow through Alan's disclosure, DSS2 thought AD1 was saying that the Child Protection specialists, in making complaint, were not up to date with the action which had been, and was, being taken.

7.3.13. However attractive this possible explanation for the misunderstanding between DSS2 and AD1 may be, it must not obscure two important organisational facts. The first is that such an explanation relies on an organisational separation of something called 'Child Protection' from something called 'Child Care'. Secondly and similarly, the way that an overall view of all the issues raised by Alan's disclosure was considered, in the circumstances presented by structures and/or relationships in the Department, was by separate communication with the Director from each of the two Assistant Directors. I also note that, on the basis of DSS2's account, she instructed the obvious communications gap between the Divisions to be closed. And it was not.

7.3.14. Five months had elapsed since MCP&QA1 had left Lambeth, when the two Divisions had last worked co-operatively on this important case. It must have been obvious to senior managers, DSS2, AD1 and AD2, that strong criticism was being made by specialist advisers, about the treatment of Alan's disclosure. So far as I can tell, at no time was there a focussed discussion by these three senior managers about Alan's case, based upon consideration of the available records and operational briefings, that could have resolved the criticism, until the Merseyside Police intervened in 1998.

7.3.15. CP1, to whom SW1 had expressed her concerns when leaving Lambeth, had been repeatedly asking MCP&QA2 about progress in examining the Child Protection implications of Alan's disclosure. MCP&QA1 told her that AD2 had spoken to the Director, who had informed her that everything had been done that could be done. They decided that they could not do any more about Alan's case unless another opportunity came along.

7.4. Another Placement for Alan

7.4.1. On 9.8.1996, the managers of Alan's *"unsuitable"* placement terminated the arrangement abruptly, and Alan stayed for two nights in one Home, and then a third night in another. On 12.8.1996 Alan was moved to a new placement, where he remained until returned to the care of a relative in December 1997. He was now in a permanent placement, but Life Story Work did not take place. A connection between the causes of Alan's unsatisfactory placement moves since his disclosure the previous January, and the failure to support him in the way that had been clearly recommended by the Consultant Child Psychiatrist the previous April, is clear to me from the confidential detail. The continuing confidentiality imposed by the inadequate Child Protection process also prevented background information from being given to any of his new carers.

7.4.2. In a brief period, June to August, Alan had lost a social worker with whom he had developed a good relationship, his therapist, and his supportive Home in Kent. The perception that the Consultant Child Psychiatrist had advised against speaking to Alan about his abuse and related issues persisted. It seems that no one actually referred to the text of the written advice on file. Even in the limited and specifically advised activities needed to support Alan in relation to his disclosure, and despite the evidence of his personal situation, there was still no action.

7.5. The Second Attempt to Reinstate a Child Protection Process

7.5.1. On 14.8.1996, CP1 raised again with MCP&QA2 the subject of SW1's concerns, and gave her the original memo of 14 June 1996, which CP1 had received from SW1. CP1 and MCP&QA2 were relatively newly transferred to AD2's Division and, I was told, they thought that he did not understand their Child Protection concerns. They also felt that the other Division, based on their experience in developing the specialist Child Protection role in other Planning Meetings, would be resistant to any direct initiative by them. So they planned to take their concerns up the management line to the Director, DSS2, but via AD2 because of his senior status. MCP&QA2 and CPO1 immediately composed a detailed memo to AD2, with a view to it being a means whereby he could raise their concerns about Alan's case with DSS2, even though he was not familiar with the factual background, nor experienced in Child Protection matters in practice.

7.5.2. After briefly reciting the history of Alan's disclosure of sexual abuse, the memo stated: *"The decisions appear to have been that work would be undertaken with Alan after a placement move, around having been sexually abused (although not specifically stated)."* This was a plain reminder of the need to work with Alan on his experience. It then referred to the possibility of his HIV status, and the need for him to be given information about this. The memo (with emphasis as in the original) continued:

[7.5.3.] *"Child Protection*
Usually, children who allege abuse are spoken with to elicit the details so that their protective and therapeutic needs can be identified and addressed and the implications for other children/staff etc., can be addressed also.

From the memo this does not appear to have happened. He disclosed to the social worker but the more usual more detailed questioning did not take place.

HIV/AIDS
It is not clear whether the perpetrator was HIV positive at the time of the alleged abuse or indeed whether the allegation is true.
Lambeth does not appear to have a procedure addressing what to do in this type of situation.
[AD1] *appears to have decided that the child should not be told.*
It is difficult to ascertain what the risk are without the more detailed question about the alleged abuse. Decisions about informing him, testing and its implications would then have to be made.
It may be that [AD1's] *apparent position is the one we want to take. It carries with it certain risk, but we may be satisfied to live with that!*

[7.5.4.] *General Comments*
Confirmation of the accuracy of the memo does not appear to be available as no minutes were taken of the meetings.

Appendix 3 (Please read) [This was the 30.7.96 memo from AD1 to MCP&QA2 - see paragraph 7.3.5. above.]
[AD1] *responded that the other children were considered - the one other child?. That implies that a named other child was implicated.*
She adds that the risk of them contracting HIV was minimal hence the decision not to interview them.

[7.5.5.] *Child Protection:*
The primary purpose of interviews with children implicated in disclosures made by other children, is to establish their protective and therapeutic needs and respond to them. This did not happen.

HIV
It may have been appropriate to establish whether they were abused before a decision as to whether the risk is "minimal', and merits no further discussion. Clearly, if they were not abused then there is no risk. If they were, then a decision point is: Do we tell them, consider testing and its implications and deal with the consequences or do we keep quiet.

In summary, it is my view that such matter should first and foremost be addressed via the child protection procedures because it will inform decisions about the HIV/AIDs status and resultant actions.

I know however following the heated debates over planning meetings, that [AD1's] *preferred model, is for the Assistant Director to manage these matters and to take appropriate decisions. There is nothing wrong with that, but it carries its perils. These include acting outside of existing Child Protection Procedures, timeframes and recording requirements. I guess the only real consequence is that in an enquiry this could be questioned but if the department was clear that the AD can override procedures then its not a problem.*

I would find it most useful to know from yourself, [AD2] *and perhaps* [DSS2] *whether* [AD1's] *way of managing such allegations is the one Lambeth subscribes to. If so, then when such things are questioned the questioning must be directed to* [AD1] *and any other role for myself and the* [Child Protection] *team is determined by yourselves."*

[7.5.6.] Appendices were attached, according to the memo's introduction *"which evidences information and actions taken to date"*. AD2 told me that Appendix 1 was the memo from SW1 to CP1 of 14.6.1996; Appendix 2 was MCP&QA2 to AD1 of 29.7.1996; Appendix 3 was AD1's reply of 30.7.1996; Appendix 4 was CP1 to AD2 of 8.8.1996; (see respectively paragraphs 6.17.3., 7.3.1., 7.3.5., and 7.3.9., above).

7.5.7. This memo very clearly raised for AD2's attention not only the Child Protection specialists' concerns about Alan's case, but also the general question about the Department's handling of Child Protection investigations, the role of the specialists, and the responsibilities of the other Division. In this Report I am not assessing the accuracy of the perceptions about AD1 noted by MCP&QA2 in this memo. However, I regard the existence of those perceptions as another indication of a most serious organisational problem which, even if it had not been apparent before, was now being squarely raised for urgent attention by the Department's most senior managers.

7.5.8. The following day, 15.8.1996, CP1 sent a memo to MCP&QA2:
"Thank you for passing to me a copy of your memo to [AD2] *regarding the issues for Alan. You asked me to clarify further anything I am able to from my discussion with* [SW1].

.... On 12/6/96, just prior to her leaving, she contacted me for advice about Alan's situation and in particular how to ensure that his needs could be met given that she had been told not to make any records on file about his situation.

[SW1's] *concern initially was that given the delays in planning meetings for Alan, and the decisions stemming from them, she had been unable to intervene in any of the issues for Alan around this subject.*

As well as her own frustration that she had now lost the opportunity of using the relationship she had built up with Alan to investigate and help him to deal with his alleged abuse, there was also her concern that she had been told not to make records about this subject on file because of its confidentiality, and that therefore she was unable to ensure a proper handover of information to the new social worker. [SW1] *informed me that the Police Child Protection Team had not seen the need to become involved in our planning meetings because the death of the alleged perpetrator had meant that there was no chance of a prosecution, unless presumably any new information came forward. However* [SW1] *did say that she believed that Alan had mentioned that another child may also possibly have been abused as well.*

[7.5.9.] [SW1] *said that initially she was told that no action should be taken until it had been confirmed that the worker concerned (who I believe was called Steve Forrest) had died of an AIDS-related illness.*

Previously it was [SW1] *who had made this connection from information which she was aware of unrelated to work. She had therefore been unable to investigate with Alan the extent of his allegations or any information relating to other children. Once this had been confirmed, a considerable time had passed and things had moved on for Alan who was by now experiencing difficulty in his placement. I understand that this led to the advice from* [the Consultant Child Psychiatrist] *that it was not appropriate to begin "disclosure" work with Alan whilst his situation was so unsettled.*

I advised [SW1] *that she should discuss again with her team manager the need to leave an accurate transfer summary on file about the issues for Alan, whose needs in all this should be seen to be paramount. We also agreed that she would write to me raising these issues formally, as she had done so by phone, so that I could follow them up after she had left, if this was required.*

[7.5.10.] *I was concerned that the issue of HIV and AIDS should not be allowed to distort the response to this allegation. As we generally do not know the HIV status of clients and alleged perpetrators when we come into contact with them, I had understood from my contact with the HIV team at St Thomas' hospital that it is more appropriate that we deal with all investigations as if the perpetrator may be HIV positive. This would involve consideration in each case of possible medical issues involved, and work with the child should include counselling around safe sex issues and whether or not HIV is a concern for them.*

If we worked in this way generally, Alan's records could have contained details of a full and proper investigation without fear of breaching confidentiality, and the HIV status of the alleged perpetrator would have become less important to the planning for this investigation.

I have contacted South area to attempt to follow up what action is currently being taken for Alan, but am informed that [TM1], *who is manager for the case is on annual leave until the end of this week. The case is allocated to* [SW2], *Senior Practitioner, who works parttime and will not be available again this week."*

7.5.11. These two memoranda clearly set out the course preferred by the Child Protection specialists, in both Alan's interest, and generally. It seems to me to represent sound advice, and to reflect the approach set out in previous statements of Lambeth's practice where HIV status was a factor (see sub-section 5.11. above). Although it repeated a misunderstanding about the Consultant Child Psychiatrist's written advice (which the two Child Protection specialists had not seen, and which had not given any encouragement to postponing action) shared by TM1, it gave a way forward. As has been illustrated repeatedly, the Department did not lack for good advice. Given normal intra-Departmental communication, MCP&QA2's E-mail could have kickstarted an adequate Child Protection process, even at this late date - more than six months after Alan's disclosure.

7.5.12. Endorsed in manuscript by AD2 on the memo to him from MCP&QA2 is *"PI c for* [DSS2]" and then by his secretary - *"sent 20/8".* I take this to mean *"Please copy for* [DSS2]" - *"sent 20.8.96."* AD2 told me *"I could see this had to be dealt with at Director level both in general and in particular."* The second attempt by the Child Protection specialists to activate a proper Child Protection process should now have informed the Director fully about their concerns. The Director, however, did not respond.

7.5.13. DSS2 told me in March of this year (1999) that she had seen the memo for the first time the previous evening, when AD2 had left some files with her on his departure from Lambeth. Her diary for 20.8.1996, the day the copy of the memo was sent to her, shows that it was her last day in the office until 2.9.1996, and that she had to leave by 1 pm. I do not know at what time the copy memo was sent for the Director's attention, nor what happened during her absence. There are therefore several possible explanations for this most unfortunate failure of communication.

7.5.14. It is certainly contrary to the direction she repeatedly gave to the Department that DSS2 should have ignored such a stirring call for action. One of the main impacts of her coming to Lambeth, according to several people who should know, has been her reversal of any attempts to cover up mistakes or problems. In view of the several attempts made by AD2 to follow up with DSS2 the significance of this copy memo, any deliberate intention by her to ignore it would have had to be both repetitive and obvious. No one has suggested that this was so.

7.5.15. Several members of the Department have referred to the determination of the Director, DSS2, (as one of them put it) to "*reach out to staff to restore confidence and to change the Department's culture. It was closed and inward looking, and had been managed in practice by an inner circle rather than the formal top management.* [The Director] *wanted staff to feel that they were part of the decision-making structure.*" Another confirmed this: "*She has been refreshing and has integrity. She wanted questions to be asked. Lambeth has always put the lid on. She wanted investigations to take place and has been steadfast about the wider Inquiry* [a reference to the investigations which began in 1998, following the intervention of the Merseyside Police]."

7.5.16. DSS2 told me that failure to deal adequately with Child Sexual Abuse in Lambeth was not a subject which had at that time come to her attention as a major problem generally. It had been raised specifically in MCP&QA2's memo of 14.8.1996 to AD2, which he had sent on to DSS2 on 20.8.1996, but which she, unknown to AD2, had not seen. If she had seen this memo, she would not have waited from her return from leave in early September until a meeting at the end of October to discuss the challenges raised by MCP&QA2's memo. This rings true.

7.5.17. Extraordinary though it may be, I am inclined to accept that DSS2 never saw the memo sent to her on 20.8.1996, until recently, and so her conduct of future discussion of the subject matter was necessarily both misled and misleading. Nor was it copied to AD1. Those who had created and sent the memo did not know DSS2 had not seen it. Once again, they felt thwarted by senior indifference and intransigence.

7.6. <u>The Third Attempt to Reinstate a Child Protection Process</u>

7.6.1. On 12.9.1996 AD2 sent an E-mail to DSS2, copied to AD1:<u>"*Subject: CP Matters*</u>
Can we find some time soon to discuss the outstanding matters re SW with AIDS S.... [another topic] *etc also separately there is an urgent issue re ... that is giving rise for concern.*" AD2 could properly assume that the memo which he had copied to DSS2 would have come to her mind on reading this. Instead, given that DSS2 had not seen it, she would only have the memory of her earlier conversation with AD1 about the "*SW with AIDS*" [see paragraphs 7.3.9 - 11. above].

7.6.2. On 18.9.96 AD2 sent another E-mail to DSS2, copied to AD1:
"*Subject: Social Worker with AIDS*
You will recall we agreed to defer discussing this matter further until [AD1] *had returned from leave – Given all that has happened in Hackney I believe we must check that all necessary actions have been undertaken.*"

7.6.3. On 10.9.1996 the ruling Hackney Labour Group had split, and the Council had authorized an Inquiry into the 'Trotter Affair'. This had occurred amidst considerable speculative and factual criticism in the media, of that Council's response to an allegation of sexual abuse by a residential social worker who had died of an HIV related illness. In particular, there were allegations in Hackney (subsequently shown to be unfounded) that leading Councillors and senior Social Services officers there had 'covered up' the abuse for Party political reasons. Although there had been no suggestion of similar motivation applying to Lambeth's treatment of Alan's case, I can understand the parallelism of the Hackney situation being used as a topical peg on which to hang the need to reconsider Alan's case. Further, I can understand that the possibility of a 'cover up', whatever the motivation, would be a major concern for a Director.

7.6.4. DSS2 responded to AD2 by E-mail the same day: *"Subject: CP Matters*
Sorry for delay in responding – have only just seen E Mail. Please could you arrange a time for a meeting for you, me and [AD1] *on these matters. I have had a brief discussion with* [AD1] *re the social worker you mentioned and need to feed this back to you. I suspect we need at least one hour to cover all these topics. Could* [a secretary] *organise for the near future."* DSS2 told me of her conversation with AD1. *"She knew all about it. I thought that she must not have closed the loop. I needed to feed back that* [AD1] *was doing things, and* [AD2's] *side did not know. Perhaps there was a double loop, and I had better tell him? Perhaps* [AD1] *had talked to* [MCP&QA2], *but not* [AD2]. *The matter was under action so there was no need for urgent intervention."*

7.6.5. AD1 had been away on leave in late August until early September. She told me that shortly after she came back from leave she reminded DSS2 that this case of Alan was the one that she had discussed with her previously. *"We went through again what I understood had been offered to Alan - in a discussion rather than in a meeting. I told her the part I had always understood had been passed to* [MCP&QA1]. [DSS2] *felt we needed a meeting with* [AD2]."

7.6.6. On the basis that DSS2 had not seen MCP&QA2's memo to AD2 of 14.8.1996, the only new written issue for her was the question 'Was Hackney a parallel?', to which AD2 had referred in his E-mail of 18.9.1996. The Hackney allegations of a 'cover-up' were not a parallel, because action had obviously been taken in Lambeth which were obviously inconsistent with a cover-up, such as the involvement of the three doctors. However, I am at a loss as to how the gross inaction in Lambeth, by way of a normal Child Protection investigation, could have been lost in these electronic and oral conversations.

7.6.7. On 24.9.1996, AD1 sent an E-mail to AD2:
"Subject: Re: Social Worker with AIDS
Thanks for the reminder. I have notes of the action taken and the TL [Team Leader, i.e. TM1] *is still in Lambeth. I think we should set up a meeting."* The meeting was arranged for 28.10.1996, in DSS2's office. AD2, on 4.10.1996, asked the secretary who had arranged the meeting if she had checked the availability of MCP&QA2 for the meeting. In a further E-mail he checked with the secretary that the meeting she had called was *"not the 'budget' meeting on C*[hild] *P*[rotection] *matters"*. Plainly, he attached importance to the meeting.

7.6.8. Later that day DSS2 asked AD2, by E mail: *"Subject: Re: CP Matters*
Any progress in arranging a meeting with [AD1] *about HIV/AIDS, and other CP matters? I thought I had better check in case you were expecting me to arrange it!"* DSS2 told me that she was checking because nothing had happened, and she thought it might be up to her to take the initiative. In response, AD2 confirmed that the meeting had just been arranged, and asked if it should involve MCP&QA2. He wrote: *"I think it should given her involvement in these matters". DSS2* replied: *"I think it would be helpful to involve* [MCP&QA2] - *as long as* [AD1] *is happy. But it would be more fruitful"*. Again, there was a real possibility of bringing together, for the first time since mid-March 1996, the two relevant Divisions for a meeting chaired by the Director, which could focus on Alan's case.

7.7. The Overview Meeting of the Department's Top Managers

7.7.1. On 28.10.1996, the meeting took place between DSS2, AD1 and AD2, but the only written record I have been able to trace, other than an entry in DSS2's diary: *"CP matters"*, is a manuscript note made at the meeting by AD1. MCP&QA2 was not at the meeting, and neither DSS2 nor AD1 remember the question being dealt with which had been raised by AD2 about the desirability of MCP&QA2's involvement in the meeting. Several matters relating to Child Protection, other than Alan's case, were discussed. The relevant part of AD1's manuscript note is as follows:

"HIV/AIDS Case

1) Have Area 7/8 got lost on issue of counselling for Alan Go back to [the Consultant Child Psychiatrist] *re counselling for Alan now he more settled.* [TM1].

2) CHs issues/Planning meetings commissioning

- who is leading on investigations to outside world

- investigative work to be done by CP section"

It is impossible now to reconstruct a reliable account of the meeting. What is clear from this note is that the basic concerns about the significance of Alan's disclosure were raised. But nothing happened as a result. The meeting failed to address effectively the main issues of general managerial concern raised by Alan's case - why were Child Protection specialists in AD2's Division not being involved co-operatively with the operational social work of AD1's Division?

7.7.2. That there was such a gap, needing such a meeting to bridge it, was a major organisational issue. Given that the subject of Alan's case was, as all three participants in the meeting agree, explicitly raised for discussion, how could this gaping organisational hole have been side-stepped, irrespective of the existence/non-existence of the memo of concern copied to DSS2 on 20.8.1996? If, as DSS2 thought, AD1 was dealing with the case in all its aspects, she was doing so without the involvement of the Child Protection specialists. If, as AD1 thought, AD1 was dealing only with the support of Alan, what action was being taken by others in the Department?

7.7.3. AD1 recalled that Alan's case was discussed, but she was not asked to take any action as a result. Both AD1 and AD2 recalled discussion about the difficulty in confirming whether Steven Forrest had suffered from an HIV related illness, and that DSS2 had said she would seek confirmation from her Health Service contacts if this would help. They also both recalled that Alan's therapeutic needs were discussed, and that the psychiatric advice had been that Alan should be pursued gently about the abuse. Yet the HIV issue was secondary, according to the express advice of AD2's experts in the missing memo, and the precise advice of the Consultant Child Psychiatrist was not checked against his actual letter of advice.

7.7.4. No further instructions were given to Alan's social worker or to her Team Manager. No instructions for action were given to the Child Protection specialists, despite *"investigative work to be done by CP section"*. It does seem to have been a superficial discussion, if the meeting did not realise that the document which was the prime source of the meeting was missing. Even the action advised by the Consultant Child Psychiatrist in support of Alan appears not to have been examined. The scale of misunderstanding defies belief, but it is clear enough that it occurred, and that no remedial action resulted from this meeting.

7.7.5. The issues raised in MCP&QA2's memo to AD2 of 14.8.1996 (see paragraphs 7.5.2.et seq. above), and notably the wider implications involving other children, were not addressed, and MCP&QA2 told me that she never received any feedback from the meeting about Alan's case. She knew that she had given a detailed account to her Assistant Director about her professional concerns, and assumed that he would now take control. It had been traditional, in her experience of Lambeth, for such matters to be dealt with very confidentially by her seniors. She assumed that they did not trust her, or that her new post was not sufficiently senior for her to be included in a senior management group set up to supervise the extensive investigation which was necessary. As the current MCP&QA she held the most senior specialist Child Protection post. If MCP&QA2 could think in this way it is not surprising that front line social workers and their Team Manager should think similarly about their exclusion from Child Protection matters being dealt with at a senior level.

7.7.6. I have visited the suite of offices in which were situated the individual offices occupied by the three participants in the meeting. Whatever the cause of the failure to co-operate effectively, it was not geographical isolation from each other. There is a central, open plan area where the secretaries work. A room each for both of the Assistant Directors and for the Director opens off this central area. I have rarely seen a layout more physically conducive to co-operative activity. Quite apart from monthly formal supervision meetings by the Director with each Assistant Director individually, there must have been countless opportunities for a two- or three-sided informal discussion about perceived inadequacies in dealing with Alan's case. All that was needed to meet the situation disclosed by MCP&QA2's memo of 14.8.1996, and the preceding weeks of anxiety, could have been met by a simple recognition that there was need to call a properly constituted Child Protection Planning Meeting, in which social workers together fulfilled their employer's responsibility towards children in their care.

7.7.7. This inability to discuss and organise an integrated, effective approach to Child Protection in Lambeth is the focus of the deep concern which I expressed in my Interim Report. The three participants in this meeting were the Director, the Assistant Director in charge of specialist Child Protection, and the Assistant Director who was the Department's representative on, and Chair of, the ACPC. I cannot, at this stage, apportion blame for this astonishing failure.

7.8. The end of the Child Protection Process

7.8.1. The meeting between DSS2, AD1 and AD2 on 28.10.1996 marked the end of any attempt by Lambeth to respond appropriately to Alan's disclosure, until the intervention of the Merseyside Police in 1998. The wider issues raised by that disclosure lay untouched, and there was no activity to follow them up. Nor was there any further surprise or concern expressed at the inactivity. Despite all the indignation and effort, despite all the skill and sound advice which was available, nothing was achieved for Alan, either. The care of Alan continued, with no influential reference being made to his disclosure, or to the expert psychiatric advice. For example a Case Review Note of 30.8.1997 included, as its only reference:
"(g) .... Alan disclosed that he had previously been abused by a staff member whilst at Angel Road Children's Home. ... This disclosure was dealt with under the Local Authority Procedures ..." A formal undertaking to a new carer, dated 16.12.1997, stated *"Alan is in good health"*. Alan's disclosure had been *"dealt with"*, according to the Department's inaccurate formal record.

7.8.2. On 12.12.1996, Alan became 15 years of age.

B. Main Conclusions on Section 7

1. The new arrangements for strengthening the independence of specialist Child Protection involvement in operational social work, introduced in February 1996, proved inadequate in practice. The repeatedly ineffective way in which Alan's disclosure was managed by the Department in 1996 was a consequence of that inadequacy. No Child Protection investigation actually took place, despite repeated opportunities to re-start. Furthermore, Alan's needs for appropriate therapy and placement were not met. Amidst much talk and activity, Alan's disclosure was, in terms of effective practice, ignored.

2. The concerns expressed by Alan's departing social worker in mid-June 1996 caused the specialist Child Protection Unit to make three separate attempts to resume a proper investigative process. They were unsuccessful on each occasion.

3. Those responsible for taking action were looking for leadership. It was not given to them. Senior managers gave the appearance of being in control of the Child Protection and Child Care processes in relation to Alan, but were not sufficiently in touch with actual events, or with each other. As a result, there was no integrated, effective response to Alan's disclosure. I draw no conclusion about individual responsibility for this deplorable state of affairs in this Report.

SECTION 8. POLICE INTERVENTION AND BELATED ACTION

A. The Non-Confidential Detail

8.1. General Matters

8.1.1. Although there is nothing directly relevant to report about the consequences of Alan's disclosure from the holding of the senior management meeting on 28.10.1996 until June 1998, some occurrences during this intervening period are of interest to this Inquiry. On 29.1.1997 AD1 was appointed substantive Assistant Director Children & Families. The post had been re-advertised. The Council was advised on both occasions by external consultants.

8.2. 1997 SSI Report

8.2.1. In June 1997 the Social Services Inspectorate reported on an *"Inspection of Planning and Decision Making for Children Looked After - Lambeth"*. It recognised good practice in the Department, but made criticisms, some of which are also illustrated by Alan's history as set out in this Report. After setting out the principles of a Children's Services Plan published jointly with the Health Authority the Report stated:
"4.8 We found that social workers had not always implemented these policies in a way that was sensitive to the individual needs and wishes of children looked after.
4.9 We saw that social workers were not always confident as to what was Lambeth SSD's policy. There was a particular problem with child protection investigations. Staff were not always confident about details of the guidelines, nor aware that written guidance was available as this was communicated verbally and informally.
4.10 The new written guidelines produced by the Child Protection and Quality Assurance Unit had **not** [original emphasis] *been incorporated into the recently produced manual of policy and procedures."*

8.2.2. The following extract is, by coincidence, a good description of Lambeth's care of Alan throughout his 13 1/2 years in their residential care system:
"8.5 We found instances of considerable drift ranging from 2-10 years where decisions for permanency had been taken but the plans had not been implemented. The most severe was that of a child who was known to the department at age 2, was eventually looked after at the age of 4 and was still in the system at age 14 having had a series of placements. ...

9.6 A lack of suitable placements frustrated the implementation of good child care plans. There was often little choice of placement with 'making do' replacing accurate matching.

...

9.9. The implementation of some care plans failed because of a lack of suitable resources. The close monitoring of time in care would enable the SSD to better manage the prevention of drift of children looked after...."

8.2.3. Indirect reference to tensions within the Department can be found:
"10.8 Reviews were chaired by the team managers responsible for supervising the case responsible social workers, and the reviews were countersigned by the local area managers. There had been resistance from the areas in the past to the introduction of the inter-area chairing of reviews though it was planned that staff from the child protection and quality assurance section should in future chair the fourth review at 15 months.
10.12 The use of independent persons to chair reviews would ensure greater consistency of practice across the three areas as well as subjecting decisions to greater scrutiny and challenge."

8.2.4. Successive Reports by the SSI had drawn attention to major deficiencies in Lambeth's Child Care practice. Some of the observations related to repeated deficiencies. I know only too well the problems facing both the writers and the readers of Reports. At some point something more than another Report is required, if the Council is to be realistically alerted to entrenched bad practice. The repeated failure of Lambeth to follow the repeated advice of the SSI should surely have led to an exceptional method of drawing the Council's attention to its dangerous arrangements.

8.3. Change of Team Manager

8.3.1. On 31.8.1997 TM1 left Lambeth. She told me that she handed the Confidential file on Alan, which had been started on 16.2.96 in accordance with the first Planning Meeting's instructions, and which TM1 had since kept confidentially secure, personally to the Area Manager. Its whereabouts are now unknown. TM1 had expected more to have been done. She told me *"I thought it was going to be big - that the Director would take it on ... I expected that when I had passed the information up it would be acted on. I also thought that work would be done with Alan on the issue of AIDS".*

8.3.2. On 22nd September 1997 TM1 was succeeded by two experienced Team Managers in a Job Share arrangement. Because SW2 was also part time, her work, and therefore Alan's case, came under the direct supervision of one of these Team Managers, whose attendance coincided with that of SW2. The first that this Team Manager knew about the HIV background to Alan's disclosure was when the story broke in the Press in mid-November 1998. By coincidence, the other Team Manager was the one who had supported the work of the Consultant Child Psychiatrist at the hospital in April 1996 when Alan's disclosure had been the subject of a consultation with him, but she was not aware of Alan's case in the Team, and of this connection, until November 1998.

8.3.3. TM1 had conscientiously prepared a note on each of the 60 cases which she was leaving for her successor's attention. The note TM1 prepared relating to Alan made reference to his 1996 disclosure as follows: *"Background History:*
.... Alan's care history has been very negative and has been abusive. He was placed in a Lambeth Childrens Home where he was abused a set of planning meetings was held regarding this in 1996 as it was only in January 1996 that he disclosed the abuse he had suffered. ..."

8.3.4. The reference to Planning Meetings relating to abuse in 1996, which might have alerted a person with adequate time to a need to investigate further was not, of itself, an adequate alarm signal for the new and busy part-time Team Manager who took over Alan's case. The original instruction about confidentiality had prevented TM1 from disclosing more in an open report, and there was nothing further about Child Protection matters for her to report. She had, however, lost sight of the "Life Story" decision at the third Planning Meeting which she had then recorded in the Minutes: "*3. Life Story Work to recommence once in new permanent placement.*" This grossly inadequate handover of the case was not TM's responsibility, but a direct and continuing result of the failed Planning Meetings and their associated processes.

8.3.5. On 8.12.1997, at a Review Meeting, it was agreed that Alan should return to the care of a member of his family on 10.12.1997.

8.3.6. On 12.12.1997, Alan became 16 years of age.

8.4. Change of Social Worker

8.4.1. In February 1998, the Area Office made organisational re-arrangements, and SW2 went to another Team, taking her cases with her. This led to an unequal distribution of work, and Alan's case was immediately transferred back for reallocation. In August the case was given to a social worker (to whom I will refer as 'SW3') with almost two years post-qualification experience, who had started work in Lambeth a few days previously, and with a senior practitioner as her supervisor because of her comparative inexperience. Neither SW3, nor her superviser, nor her effective Team Manager, were aware of the HIV dimension to Alan's disclosure, nor of any action which they were required to take in relation to that disclosure.

8.4.2. SW3's identified main task was to arrange for the transfer of the case to the Young Adults Team, to help Alan towards independence. She told me she had noted that the file clearly stated the Child Protection papers had been removed, and that the Minutes of the first two Planning Meetings were not on the file, despite SW1's request. She had also noted the Psychiatrist's recommendation (as recorded in the Minutes of the third Planning Meeting, which were on the file) that *"Alan would not benefit from therapy but needed to have the opportunity to speak about his feelings and anger in a very basic way"*, and (according to the same Minutes) that this appeared to have been done. Because the complexities of Alan's case had been lost, in the previous departmental failures, it had been transformed into the relatively simple task of arranging its transfer to another part of the organisation, a task appropriate for someone of SW3's experience.

8.5. Resumed Child Protection Activity

8.5.1. In June 1998, as a result of an investigation into another matter begun in Merseyside, the Lambeth Child Protection Officers, in conjunction with the Metropolitan Police, began to investigate the history of children who had been in Angell Road Children's Home. This, of course, included Alan and enabled his disclosure to be brought to attention once more. The intervention of the Merseyside Police brought about a full Departmental response to Alan's disclosure, otherwise it would have been completely overlooked.

8.5.2. DSS2 organised meetings of a senior management group, including both AD1 and AD2, advised by Child Protection specialists, under the heading *"Co-ordination of Current Child Protection Issues"*. The senior organisational gulf was therefore bridged by the Director in these arrangements. SW3, as Alan's social worker, was invited to go to a briefing meeting about the new investigation, but was unable to attend. Her Team manager was not aware of this development at the time. A Child Protection Officer wrote to Alan:*"...I would like to meet with you to give you the opportunity to bring to our attention any concerns you may have about the time you spent at any children's home in Lambeth .."* The Child Protection Officer also arranged for a joint visit to Alan by SW3 and a police constable from the Police Child Protection Unit. *"The interview will be about the allegation Alan made whilst in care some years ago. Alan is to be asked if he is willing to talk about his experience. - this is linked in with a wider investigation being undertaken at present."*

[8.5.3.] SW3 noted: *"2:10:98 Home Visit with ... from the child protection police unit. I was unable to warn the family that I would be bringing* [the policeman] *with me as they are not contactable by phone, however we agreed that we would ask permission for him to be there on reaching the house. We did not discuss the case history in length on the journey there. My information was limited to Alan having made an allegation of abuse by a carer in the Lambeth Children's home, Angell Road. .... In the file it appears that this information was then passed on to the social services, a meeting held, a psychiatrist was involved and he/ she felt that it would be better not to pursue the allegation and after this there was no follow up to it. It is stated that a decision was made to keep the details of the allegation and 'follow up' out of the live files, it is not made clear where this information is.*
My awareness of the case was that they were now wishing to look further into what happened at the home.

[8.5.4.] *I explained to* [the policeman] *that I had not held the case for long and this would be the first contact with the family. I explained that I would need to spend some time talking to Alan and his Mother generally as well as giving time for him to speak to him.*
When we got there Alan was there with his Mother, ..., and his sister[s], ... and ...., as well as their children. I introduced myself and [the policeman] *..... Alan had received* [the Child Protection Officer's] *letter regarding the investigation.*
I then talked to Alan and Mrs [his mother] *about my role, which is to hold a review which is outstanding and transfer the case to the young adults team due to Alans age .....*

[8.5.5.] *.....At this point* [the policeman] *... asked if he could speak to Alan, Mrs ... was in the middle of a conversation to myself. The house was quite chaotic with Alans sisters talking / shouting and trying to have conversations with their Mother and Alan at the same time as myself. I asked* [the policeman].... *if I should accompany him to speak to Alan, he said that there was no need to do this. Alan then went with* [the policeman] *... into the kitchen. I waited until Mrs .... had finished speaking and then went into the kitchen. I asked Alan if he was O.k, he said yes.* [The policeman] *... said that Alan had clearly stated that he did not wish to speak about his experience in the children home, and it was made clear that we respected this. ..."*

8.5.6. I am not favourably impressed by this description of joint Police/Social Services work. Lambeth's CPPs had consistently and emphatically stated the need for careful planning prior to any interview. According to this account, the interview with Alan was patently ill-prepared and was not conducted in accordance with recognised good practice. With no warning, a policeman, unaccompanied, talks to Alan in his bedroom, about Alan being sexually abused by a man in his bedroom at Angell Road! SW3 spoke to the Child Protection Officer who had arranged the meeting and informed her of the outcome, and the Child Protection Officer said she would speak to SW2, who was still working for Lambeth and would have known Alan for longer.

8.5.7. On 12.10.1998, CP1, the Senior Child Protection Officer to whom SW1 had spoken of her concerns about lack of progress on Alan's disclosure in June 1996, briefed SW3 on the background to the case. She also attached a Child Protection Officer to assist SW3. She was concerned that Alan's situation should now be dealt with properly. It was then agreed that Alan should be re-interviewed, this time including the Merseyside Police. SW3 noted: *"I was then informed that it is thought that Steven Forrest had died of an HIV /Aids related illness which has huge implications .... Alan is not thought to be aware of this and was not informed. It appears that the cause of Mr Forrests death have not been proved as of yet. Due to the incubation period for Hiv/Aids it is possible that Alan could have been infected, however we cannnot tell him until the information is proved."*

8.5.8. SW3 and her new colleague, the Child Protection Officer, were unable to make telephone contact with Alan, so they travelled to Alan's home on 14.10.1998, having written a letter about the new interview, and having arranged a room in which it could take place. After sensitive support from the two social workers, Alan was reinterviewed, this time by the Merseyside Police, and he repeated his disclosure of sexual abuse by Steven Forrest whilst at Angell Road Children's Home. The two social workers agreed to consult their superiors, with a view to postponing the transfer of Alan's case to the Young Adults Team, to maintain some continuity of support. They also began to seek formal confirmation of Forrest's medical condition, before approaching Alan about it.

8.6. Departmental Overview Resumed

8.6.1. On 16.10.1998, in the morning, there was a *"Special DMT Meeting Co-ordination of Current CP Issues"*, the senior management group established by DSS2 to supervise the growing investigations, to which AD1 sent her apologies. The Steven Forrest case was, according to one contemporaneous note I have seen, one of those discussed at the meeting. In the afternoon there was a further meeting between DSS2, AD1, AD2 and CP1, at which CP1 had to make clear the specialist Child Protection Officers' concerns about the way Alan's case had not been followed through in the past. This meeting, according to the note, decided to seek confirmation of Steven Forrest's *"cause of death, and when he was infected"*, and to take urgent action to follow up the implications for other children.

8.7. An Independent Inquiry

8.7.1. DSS2 received a letter, dated 21.10.1998, from Merseyside Police:
"I am the Senior Investigating Officer of Operation Care, the Merseyside Police investigation into allegations of historical child abuse within residential establishments. ....
As part of this investigation. on 14th October, 1998, two of my detectives interviewed Alan, in the presence of his social workers. During the course of this interview Alan disclosed ...
In liaison with members of your Child Protection Team, my officers learnt that Lambeth Social Services were aware of this allegation in February 1996. Further to this it is believed that Mr. FORREST died of an H.I.V. related illness. To date Alan is not aware of this fact.
A report outlining Alan's disclosure has been forwarded to the Lambeth Child Protection Unit of the Metropolitan Police."

8.7.2. CP1 and AD2 then discussed the situation, and the desirability of holding an independent Inquiry into the concerns about inactivity which had been voiced by Child Protection specialists since June 1996, and which were also implicit in the letter from Merseyside. AD2 then recommended this course to DSS2. On 29.10.1998 the other joint Team Manager made a note in the file, having realised her previous connection with Alan's disclosure, "*and it is now likely that there will be an independent enquiry into the whole situation."*

8.8. Steven Forrest's HIV Status Confirmed

8.8.1. On 22.10.1998 the Police obtained official confirmation that Steven Forrest had been treated for HIV related symptoms, and informed CP1. Perhaps I am using hindsight unfairly, but it is difficult to understand why, after the second Planning Meeting had failed to establish formally Steven Forrest's HIV status after enquiry by the Consultant Paediatrician in March 1996, the Police had not been approached for assistance then. If, as should have happened, Minutes of the first two Planning Meetings had been appropriately circulated, perhaps the Police would have volunteered their help. CP1 informed the Child Protection Officer now assisting SW3 in Alan's case, and he informed SW3 that the HIV status of Alan's alleged abuser was confirmed. She immediately tried to telephone Alan to make an appointment to see him, but was not successful.

8.8.2. A Recorded Delivery letter asking to see him was sent the following day, 27.10.1998. The Child Protection Officer contacted health professionals in Alan's area, but without identifying him, to arrange a test for Alan, should he wish to take it, and find out about counselling for him. The letter did not arrive in time, and the social workers had to make an appointment, via his mother, to see Alan the following day, 28.10.1998. They did eventually see him on this day and, according to the file notes, sensitively told him about Steven Forrest's death from an HIV related illness.

8.9. This Inquiry

8.9.1. On 6.11.1998, DSS2 wrote to the Merseyside Police: " ... *I am arranging for an independent review of the issue concerning events in 1996".* A further *"Special Departmental Management Team meeting"* was held on 10.11.1998, one of the senior management group series for *"Co-ordination of Current Child Protection Issues".* According to its minutes: *"6. SF* [Steven Forrest]
An independent investigation was being set up into decision making in 94/96."

8.9.2. On 17.11.1998 there was an article in a national newspaper about the failure of Lambeth to respond adequately to the disclosure which Alan had made in January 1996. That day, in a meeting with the Chief Executive and others, I discussed the future conduct of this Inquiry. I have tried to keep abreast of the ongoing work relating to Alan, but I see no useful purpose in describing the subsequent course of events. When SW3 left Lambeth in June 1999 the process of transferring Alan's case to another social worker was not, in my view, satisfactory. However, I am pleased to report that when I met Alan, a short time ago, he appeared to me to have established a good relationship with his new, very experienced, social worker.

8.9.3. On 12.12.1998, Alan became 17 years old.

B. Main Conclusions on Section 8

1. By the middle of 1997, eighteen months after Alan had made his disclosure, the Departmental machine was operating in relation to Alan as though his disclosure had never been made. The failure of senior management to deal co-operatively with the disclosure had resulted in new key staff being unaware of the work to be done with Alan.

2. There is evidence of poor inter-agency co-operation with the local Police.

3. The intervention of the Merseyside Police in mid-1998 led to the imposition of a senior Department-wide overview of sexual abuse in the former Lambeth children's homes, to the establishment of a proper response to Alan's disclosure, and to this Independent Inquiry.

4. Alan did receive committed, professional support when the subject of his disclosure was forced to attention, almost three years after he had first made it. But incompetence still marred some official dealings with him.

APPENDIX

ALAN'S LIFE JOURNEY

1. At Home with Parents	0 - 2 yrs	'81 -'83
2. 'A' Residential Unit, Croydon	2 - 7 yrs	'83 -'89
3. Adoptive Family, Surrey	7yrs	'89 (3 months)
4. Angell Road Res. Unit, Lambeth	7 - 11 yrs	'89 - '92
5. Stockwell Park Res. Unit, Lambeth	11 yrs	'92 (one night)
6. 'B' Res. Unit, Kent	11 - 14yrs	'92 - '96
7. 'C' Res. Unit	14yrs	'96 (1 week)
8. 'D' Res. Unit	14yrs	'96 (2 nights)
9. 'E' Res. Unit	14yrs	'96 (1 night)
10. 'F' Res. Unit	14 - 16yrs	'96 -'98
11. Family of Origin Placements	16yrs	'98 - '99
12. Hostel, Lambeth	17yrs	'99.