The Lambeth Council Investigation

Opening Statement by Counsel to the Inquiry

Introduction

1. Chair, today you and the Panel begin a 4 week hearing in the Lambeth Investigation. The investigation will examine the scale and nature of the sexual abuse experienced by children in the care of Lambeth Council over decades, and the extent of any institutional failures to protect children in care from sexual abuse and exploitation. The investigation will not only examine institutional failures of the past, but it is committed to a careful evidential evaluation of how children in care might be made safer in the future, and how they might be protected from sexual abuse.
2. May I first introduce counsel to the investigation, core participants, and their representatives. I am Rachel Langdale QC, and together with Clair Dobbin, Clare Brown, Amelia Nice and Ruth Kennedy, we represent counsel to the Lambeth Investigation.
3. The investigation team has been assisted in its work by the participation of a number of victim and complainant core participants and their legal representatives. Chair, I will now introduce the core participant teams as follows and ask that each advocate speak into the microphone and make themselves known as they are introduced so that they appear briefly on screen:

Complainant Core Participants

i. Complainant Core Participants represented by Switalskis and Susannah Johnson;

ii. Complainant Core Participants represented by Verisona Law, Remedy Law and Mr Iain O'Donnell;

iii. Complainant Core Participants represented Imran Khan QC, Imran Khan & Partners

iv. Complainant Core Participants represented by Malcolm Johnson, Hudgells

v. Complainant Core Participants represented by Alan Collins, Hugh James

vi. LA-A25 represented by Richard Scorer, Slater & Gordon

vii. LA-A24 represented by Aswini Weereratne QC and Simpson Millar

viii. LA-A131 represented by Stephen Simblet on behalf of and Uppal Taylor

4. 5 other individuals are core participants in this investigation. They are Steven Whaley and Dr Nigel Goldie (*represented by Howe and Co and Chris Jacobs)* and Anna Tapsell (*represented by Simpson Millar and Aswini Weereratne QC)*, former Leader of the Council, Joan Twelves, (*represented by Desmond Doherty and Henry Toner QC)* and Richard Gargini, (*represented by 3D Law and James Berry*).

<u>The Institutional Core Participants are:</u>

ix. Lambeth Council represented by Alex Verdan QC;

x. The Crown Prosecution Service (CPS) represented by Ed Brown QC;

xi. The Commissioner of Police of the Metropolis (MPS) represented by Samantha Leek QC;

xii. The Independent Office for Police Conduct (IOPC) represented by Gerry Boyle QC; and

xiii. The Secretary of State for Education (DfE) represented by Catherine McGahey QC.

5. Today you will be hearing an opening statement from the Inquiry, and you will hear core participant opening statements tomorrow. On Wednesday, you will start hearing oral evidence. The evidence will continue for the rest of this week and all of next week. The week commencing the 13th July is a non-sitting week for the Inquiry. We will resume on Monday 20th July for two weeks, and at the end of those two weeks there will be a non-sitting day on Thursday 30th July, and closing statements for core participants will be made on Friday 31st July.

6. Chair, as you and the Panel are fully aware, children living in care in residential homes and foster families are amongst the most vulnerable in society. Some, with complex needs or communication difficulties, will be even more vulnerable. Allegations of sexual abuse in children's homes - homes intended to be harbours of safety and respite, often from violence, sexual abuse and neglect; homes intended to promote the wellbeing of children - demand a thorough examination. Central to the Lambeth Council Investigation, the Inquiry will consider the experiences of children in care. We will investigate where there were child protection failures by Lambeth Council, the police and other public

authorities. We will examine the extent to which vulnerabilities of children rendered them at risk of sexual abuse, and whether those vulnerabilities shaped how public authorities responded to them.

7. May I summarise today the scope of the Lambeth investigation, and the topics and issues we will be considering over the next month. The investigation and the evidence fall to be examined within the following sections:

i. the experience of children in care, to include residential care, fostering and adoption;

ii. the culture at Lambeth Council over time, including the relationship between officers and councillors, and Lambeth's response to allegations of child sexual abuse;

iii. external inspection of Lambeth's children services, including the role of Ofsted and its current inspections;

iv. the response of the MPS to allegations of child sexual abuse

v. prosecutorial decisions around child sexual abuse; and

vi. obtaining allegations and medical evidence from complainants of child sexual abuse.

Experiences of children in care, including residential care, fostering and adoption

8. The Inquiry will receive evidence in a number of ways to enable greater understanding of the nature of individual experiences of children in care. Firstly, the Inquiry will be assisted by the participation of complainant core participants who are sharing their experience of being in the care of Lambeth as a child with you, Chair and Panel, and the public. Their identities are protected, of course, by the use of a cipher. All of the complainant core participants in this investigation describe being sexually abused as children. Between them they provide a substantial body of written evidence and highlight enduring issues about being in care, including feelings of isolation, fear and vulnerability. You are also due to hear oral evidence from 11 victim survivor / complainant CPs. Additionally, every complainant core participant's voice within this investigation has been incorporated within a thematic gist table, which will be introduced and read into the evidence by Miss Nice of counsel as the hearing progresses.

9. In addition to contributions from victim/survivor complainant core participants, Counsel to the Investigation have considered extensive materials provided by Lambeth Council and other core participants with particular emphasis on case study homes: Shirley Oaks, Angell Road, South Vale Assessment Centre, Ivy House and Monkton Street. This includes statements which were provided over time to the police in other investigations into Lambeth care homes.

10. We emphasise (as we have done before) that these case study homes do not represent the totality of what happened to children in Lambeth's care. Far from it. They have been selected so as to provide a focus for the hearing, to enable thematic issues to be considered which are indicative of the wider picture within Lambeth, or the culture operating within the Council over a period of time. In terms of understanding the experiences of children in care, the case study homes provide a proportionate focus from which to examine those experiences. Documentary review of material emanating from those homes, including care files, has yielded a wealth of information surrounding responses to children in care.

11. We have been struck many times over by the distressing circumstances in which children were taken into residential care in Lambeth in the first instance. Some came into care because of extreme neglect; because of bereavement; because they had been abandoned; because they had endured painful physical violence or because of sexual abuse within the family setting. Others came into care because of housing problems or material conditions in the family home. All of them needed care and protection.

12. In a speech in 2019, Sir James Munby (the former President of the Family Division) reflected on a case which he had determined in 2002 about children in Lambeth's care and which he described as a shocking case of two brothers 'lost in care' (para 43): He reflected on what he had said in that case- namely, '*the State assumes a heavy burden when it takes a child into care. The least that the State can be expected to do is not itself to cause significant harm to the children whom it takes into its care ... Indeed ... if the*

State is to justify removing children from their parents it can only be on the basis that the State is going to provide a better quality of care than that from which the child in care has been rescued'.

13. This investigation raises fundamental questions as to whether life was any better or, indeed, whether it was far worse for some children, after they came into Lambeth's care. We are conscious that sexual abuse cannot be separated from other important themes which will emerge from the evidence, including but not limited to the anguish of separation from siblings, racism, fear, the paucity of leaving care provision and the lost opportunity to fulfil each child's promise.

14. We note just a few examples at the outset. This is the account of a young woman who spoke to Lambeth in the 1990s on a confidential basis about her time in care. She was adamant she did not want to be known; she did not want to complain – she was just telling Lambeth how it was. Like many children she was concerned about how other children had been treated. She gave, as an example of violence to children, a description of a child being held down in a bath of cold water because he swore at a member of staff. He was then made to repeat a nursery rhyme several times, as proof he could complete a series of sentences without swearing. It was customary for the staff member involved to slap children. The young woman stated that the child's screams could be heard throughout the building but she did not believe that any senior member of staff had investigated the screams then or thereafter. She herself had taken refuge in her room.

15. She referred to overt racism she had experienced at the hands of staff. She referred to her own sexual abuse by a residential social worker. She had not realized at the time that she was vulnerable. The person from Lambeth who spoke to her asked how she had managed to survive – she said that her main concern had been to *"keep her head down and grow up and get out of the care system"*.

16. If the height of a child in care's aspiration is simply to grow up so as to escape it, then that is a damning indictment of the care system. The bleakness of life for some children in Lambeth's homes is evident. One former resident was asked by the Children's Homes in Lambeth Enquiry (of which you will hear more later) to describe something good that happened to him when he lived in a Lambeth home. He replied *"one day they let us outside into the field next door and I thought we were leaving, which made me happy for a while."*

17. LA-A25, a core participant, was placed in care aged 3 and stayed at Shirley Oaks until leaving aged 17. She suffered prolonged sexual abuse by Donald Hosegood, alongside threats and vicious punishment. The abuse started when she was aged 11 or 12. By the age of 16, she had a Saturday job. One day, she broke down at work due to the continuing abuse. She confided in a co-worker who took her to the manager, who then called the police. She was taken to a London police station and gave a police statement. Chair and Panel, you may think that from the moment she made her allegations, LA-25 was treated without compassion or support. She went on to repeat the allegations to a social worker and asked him if he would call her 'a liar." The duty social worker's recorded response

was to say that "*if she knew she was telling the truth there was no reason for me to assume she was lying*." The psychiatrist at Shirley Oaks, LA-F127, saw LA-25 several times in 1974. He dismissed her concerns as '*attention seeking'*. We will hear direct evidence from LA-25 about her experience of dealing with the authorities and a criminal trial when a child in care.

18. Some children died in Lambeth's care. In 1975, a baby girl, who had not yet reached her first birthday was found dead. She had been sleeping, harnessed to a top bunk bed and had asphyxiated. Records demonstrate that the baby girl's older sister had spoken to her mother on the telephone previously, and said that staff force fed the baby, tied the baby in the bed and didn't look after her when the baby was crying. There is another record of the sister speaking to a social worker about a cot for the baby.

19. These cases and many others will illustrate why the investigation of Lambeth matters. It would be an injustice to treat this investigation as though it is somehow of historical significance. Aside from the fact that a number of matters that we will look at did not happen that long ago, the cases we will examine continue to affect adults now, and it is the culture which allowed this state of affairs to exist over such a long period of time that must be scrutinised. Laws, policies and regulation can be changed, but it is vital that we understand how people and organisations, whose very job it was to provide care and to keep children safe, , could expose children to such risk in the first place. Understanding the experiences of children in care reinforces the need for society's vigilance when it comes to safeguarding the future lives of children in care.

20. The investigation team has drawn up focused summaries from records compiled at the time of the Children's Homes in Lambeth Enquiry (known as CHILE) in 1998. Lambeth set up CHILE as a counterpart to the Middleton police investigation. This was a joint investigation which lasted some five years. The effectiveness or impact of CHILE is a matter that will be considered in oral evidence. The summaries provide an insight into the work of CHILE and they provide this investigation with a further seam of evidence from which children's experiences can be understood.

21. The CHILE files reflect only a small proportion of the children who were in the care of Lambeth but nonetheless they speak to the wider experience of children in Lambeth homes, in homes in other parts of the country and in foster care. The summaries of the CHILE records prepared by CTI have been wholly anonymised in order to protect the identity of the children involved. Lambeth Council were asked to indicate whether there was anything within the investigation team summaries with which it disagreed, or wished to correct. That process having been undertaken, the Inquiry is able to admit those anonymised summaries into evidence.

22. You can be confident, Chair, that at the conclusion of this hearing you will have an extensive body of evidence from which to assess the experiences of children in Lambeth's care and over time.

23. Let me turn now, by reference to case study homes and the CHILE files, to highlight some of the evidence around experiences of children in Lambeth's care and the thematic issues which emerge.

Shirley Oaks

24. Unlike our other case study homes, Lambeth at no point commissioned any internal report or inquiry into any allegation or incidents of abuse at Shirley Oaks. The primary sources of information for this investigation are, first, the voices of core participants who lived there. Second, written records from Lambeth which have remained in existence from the time, including the individual care records of children. Third, statements made to the police; principally those made between 1998-2002 by former staff and children in care during a police investigation called Operation Middleton, and some made to police in other more recent investigations.

25. We have also been able to compare our evidence and analysis with that of the Shirley Oaks Survivors Association, as set out in their work including "*Looking for a Place Called Home (2016).*"

26. Shirley Oaks was purpose-built as a long-stay residential care home for children aged 2 – 17 years. It dated back to 1904. It was built on 77-acres and was the oldest and largest of the homes operated by Lambeth. The premise was that children should be brought up in a home environment rather than an institution. To that end the home was comprised of some 39 individual cottages.

27. It was intended to be a self-sufficient 'village', with a primary school, infirmary, swimming pool, workshops and other buildings. Many children refer to not leaving the site at all. The site could accommodate up to 350 children at one time.

28. Children lived in small groups in the individual houses with house parents. House parents were employed by Lambeth on a 'live in' basis, often with their partner living with them to help assist with care of the children. One such houseparent was William Hook (who was later convicted of numerous child sexual abuse offences). He was described, as you will hear later, as a Walter Mitty character, allowed to be a houseparent in exchange for food and lodging.

29. Children would also spend time with 'social aunts and uncles' who were members of the public invited by the Council to volunteer to spend time with children in a children's home. They were permitted to do activities with the children, or to take children on day trips or holidays away from Shirley Oaks.

30. Lambeth accept that during the period Shirley Oaks operated there were no requirements for staff to hold qualifications in social work, be police checked, or to undertake specific training prior to working in a children's home. No child protection safeguards were in place in the social aunt and uncle system.

31. It appears that the doors to Shirley Oaks may have been open, in essence, to any adult professing an interest in taking children out; taking them to church; playing sport with them or even just showing an interest in them. That is a matter which will be considered in evidence.

32. Physical access to Shirley Oaks site was largely unregulated. LA-A50, for example, refers to the housemother having house parties and adults bringing alcohol, which they would give the children. LA-50 says: "*Shirley Oaks was such a big site, with different people*

coming and going and different organization(s) inputting with activities, it was easy for a visitor to give the impression of (being) a staff member." LA-50 says that he was sexually abused by a man referred to as 'the rugby player' who was a regular visitor, but not staff. This man was in fact Geoffrey Clarke, implicated in the sexual abuse of many children. He was convicted in 1998 of 8 counts including indecent assault and taking an indecent photograph of a child. He was also charged in Operation Middleton but took his own life on the third day of trial.

33. LA-A20 refers to men having unrestricted access to parts of Shirley Oaks. LA-A67 recalls that two priests visited regularly and took a particular interest in his sisters. One would stay the night. Visitors books should have been used to track who was there, but they never were.

34. A former community service volunteer at Rowan House in 1977, referred to a lot of people coming and going, husbands, boyfriends, visitors – and a high turnover of staff generally. Furthermore, the volunteer described a '*distinct lack of interest by the Upper Management about any concerns raised by children in any of the houses'*.

35. If the aim of Shirley Oaks was to replicate the experience of homeliness, then from the outset, there is evidence to show that aim was not met. In April 1964 (before Lambeth assumed responsibility for Shirley Oaks), the Superintending Inspector for London Region (Central) wrote that: *"Pressure on this large cottage group daunts progress. Despite a good administration, and some material improvements, the housemothers in*

*these crowded cottages rarely achieve a high standard of care". [*See Home Office report to the Inquiry p.10].

36. Lambeth Children's Officer made a report to the October 1967 meeting of the Children's Committee (underlined in the original) questioning the very fitness of Shirley Oaks for the care of children in future: It records:

"*The Committee is at this point invited to consider whether it wishes "Shirley Oaks" to continue in use indefinitely. There has been much criticism in the past of very large children's homes and a considerable number up and down the country have been closed in the past forty years. They are usually condemned for providing too institutional a life, for having insufficient links with the community and with encouraging the children to look inwards to the resources, such as swimming baths and libraries, within the home rather than outwards to community resources at large. For these reasons, the Home Office may possibly ask the Council to consider the closure of this very large home….*"

37. Many cottages were in a state of serious disrepair. A report presented to the Social Services Committee after a visit by Don Thomas in 1972 described the facilities and accommodation as '*totally unacceptable'*. Shirley Oaks nonetheless remained in use until 1983.

38. The investigation is acutely conscious that there are public concerns as to whether children from black, asian, minority ethnic backgrounds were even more disadvantaged by their care in Lambeth or even more vulnerable to sexual abuse. Racism was evident from the earliest days of Shirley Oaks. An extract from a Home Office Inspection of

Shirley Oaks from the 1960s referred to house mothers who would not, in the language of the report, receive "coloured children".

39. Figures in 1980 showed that an average of 55% of children in Lambeth's residential care were black and that an average of 57% of children placed in Shirley Oaks were black. A minority of children in care (approx. 23%) were placed in residential establishments. The numbers of black children in residential care were disproportionate to their representation within the overall child population in Lambeth which was approx. 40% [LAM010408 at 6.1.3]. A headcount carried out in Shirley Oaks in June 1980 found that out of 66 children who had lived there for more than two years, 14 were white, 52 were black. [LAM010408].

40. We will see that within written policy documents it was well understood by Lambeth that all children in care but particularly those in long term care would suffer damage to their self- esteem and their sense of identity, and that this assumed an added dimension for black children whose cultural and racial heritage was not acknowledged and whose experiences of discrimination and disadvantage might be denied. LA-A108, a black child fostered by a white family when she was aged 9 reflected Lambeth's understanding. She says: *'I was with a white family in a predominantly white area and I stood out like a sore thumb. I just wanted to be accepted but because of my colour I was an easy target for racist taunts'*. [MPS003366].

41. The key question for this investigation is whatever knowledge was reflected in policy documents, what did any of Lambeth's childcare policies actually achieve in practice**?**

Were the lives of children any the better for policies intended to improve their sense of self and identity? Were suitable placements for each child found and in accordance with each child's needs and best interests? Or did the practical reality over time illustrate something very different.

42. In 1991 a Social Services manager wrote about a child who had been excluded from a care home:

"The Panel was very concerned that a 13 year old black girl who was also the victim of two sexual assaults while in care …….could be so excluded after one incident in a children's home. As you know the Panel is involved with monitoring the suitability of placements in Private and Voluntary establishments, with a view to a reduction. Consequently we were appalled that a young person deemed unsuitable for a Lambeth CH could be cared for quite adequately in a Private and Voluntary facility.

This manager criticised homes for putting staff before children before concluding:

"Clearly this arbitrary style of decision making will continue to militate against the interests of children and black children in particular as they seem to experience more moves than white children with the resultant impairment of their emotional development".

43. Children in their statements to the police in 1999 refer to race and racism as being a barrier to disclosure and part of the abuse they experienced. LA -A117 refers to not being able to talk to her housemother who '*was white and she didn't want me'*. LA-A50 was subject to sexual abuse by a man who was also physically violent and racially abusive.

44. Former children within Shirley Oaks refer to the stigma attached to being in care. LA-B27 says: *"Staff would often give the child the idea that because they were an orphan or whatever, they would never amount to anything'[...] 'Academically the children were not pushed so the children grew up to manual jobs as I did. It was assumed the children would not amount to much."'* LA -A67 was placed in care in the 1960s. He remembers: *"we were often told we were not normal children, we were scum, we'd never amount to anything and we didn't deserve to be looked after. The home was run on fear… all the children only wanted to be loved and have some affection shown to them'.*

45. A theme which we have noted throughout this investigation is the sadness of those individuals who felt profoundly let down by the lack of care invested in their education. One former resident conveyed her anger to CHILE at being placed in a school for children with special needs when she did not have any. We have reviewed her records which have recorded her, in childhood, as bright.

46. Many children referred in their statements to the police and in their engagement with CHILE as suffering regular violence as punishment, and this is also reflected in SOSA's work.

47. Sometimes such abuse had to be confronted. A record from 1972 records a child being found, cold and distressed, by a milkman in the grounds of Shirley Oaks. The child explained that he had received a beating from a house father and spent the night in an outhouse. He was found by a doctor to have extensive bruising to the buttocks. This was regarded by Lambeth as an infringement of rules on corporal punishment and the child

was returned to the home. The housefather was the spouse of a housemother – the file notes that far from this incident being a cause for concern, he was likely to be recommended to be made a full time housefather as the couple "appeared to be running a happy house".

48. LA-A76 recalls the unprovoked nature of the violence – simple, ordinary childlike things, like singing resulted in a slap around the face. LA-A63 was placed at Shirley Oaks at around 18 months of age. He left when he was 16 years of age. He recalls the violence of the housemother - *She 'hit you all the time for next to nothing.'* The housemother was so difficult to work with that he remembers her assistants came and went quite quickly. We note that a high turnover of staff, of course, reduced the opportunity for children to form any trusting relationship with an adult within the home.

49. LA-A228 describes an incident of sexual abuse in which Hosegood had threatened him: '*I remember that just before it finished I told him I would tell someone. It was in the workshop and he put a pair of garden shears to my throat. He said he could cut me up in little pieces and bury me so that no one would find me.'*

50. We understand children witnessed violence being used against other children. Some intervened at their own risk. Others were too scared but as a result felt guilty. LA-A158 remembers watching a housemother beating a young boy and wedging him against a wall so that the edge of the table pushed against the child's neck. LA-B28 also remembers witnessing this incident. The boy was gasping for breath. LA-A158 thought the boy would be killed but managed to pull the table back by breaking one of the table legs so

the boy could escape. LA-A20 says that the violent beatings at the hands of his house mother, LA-F65, occurred weekly, sometimes 5 times a week . He says: *'At the time I didn't know any different, I just thought all children were treated this way. It wasn't really until I went to secondary school and formed friendships with children outside Shirley Oaks that I began to realize that such treatment wasn't usual and was wrong.'*

51. LA-A20 reports that he took the "*brunt of the housemother's frustration*". He says, *'Looking back, I believe that this was because I was vulnerable because I was not visited by any family and so didn't have anyone to complain to.'*

52. Jane Warwick, an Administrator for Lambeth for 15 years from 1975, describes to the police a ledger she located at Shirley Oaks when the home was closing and which included photographs of many of the children and descriptions of so called "*ailments and defects*". In 2014 she said in a statement to the police: "It was shocking to look at as it was an account of the physical destruction of the children."

53. For victims of sexual abuse, the fear, violence and isolation at Shirley Oaks closed down the possibilities to report to other adults. LA-A158, a victim of long term sexual abuse recalls: *'LA-F64 would say that I had to keep it a secret otherwise my mum would have one of her tempers and be locked away in prison. I was never physically threatened [. . .] however, we were very isolated at Shirley Oakes. You went to school on site until you were 11 years old. Everything was provided for, we never went shopping for clothes or food. We had our own swimming pool so we never had to leave site even for swimming*

lessons. We went on holiday for two weeks in the summer, which was probably the only time we saw proper shops.'

54. Children describe how they were removed from education after making a complaint. LA-A67 states that after his disclosure about sexual abuse by LA-F93, 'for a while' he was kept away from school and from other children at Shirley Oaks as if he had done something wrong. LA-A76 describes being isolated after alleging sexual abuse by LA-F37. A residential social worker told the police in January 2003 that a child who was the victim of sexual abuse by two men was *'out of school, he was excluded for a long time and only got two hours tuition per week from a tutor. He had no routine and was bored for a lot of the time. The system failed him miserably.'*

55. LA-B25 says she witnessed the sexual abuse of her two brothers by different men at different times. On one occasion, the abuser was Patrick Grant. You will hear more about Grant in this opening. She says: "*Grant followed him and beat him with a leather belt. I heard LA-A3 screaming whilst he was being beaten. He was my brother. I don't think I'll ever forget that, it really upset me.'* LA-B25 does not remember having a social worker but says she told other staff about the abuse she witnessed. Nothing was done.

56. LA-A63 recalls an occasion in which he and another boy climbed onto the swimming pool roof. Looking down they witnessed Hook sexually abusing another boy in the swimming changing rooms. *'The pool was well lit as it was a summer's evening and still daylight. I would have been about twenty feet away from them. I watched for about ten or fifteen seconds long enough to be sure of what was happening. We then slid back down*

quietly. We said something to each other at the time. It was not mentioned afterwards. (The other boy) had seen what I had seen.'

57. Some children refer to having been prescribed medication for sleeping or otherwise for managing anxiety. LA-A228 refers to boys being medicated to calm them down. That medication was an option is supported by a 1973 reference in the record book of Holly House, where a doctor notes: '*Nice, no children on sedatives. A OK!'* Children refer to being medicated after having told someone about ongoing sexual abuse. The psychiatrist, LA-F127, prescribed medication for LA-A64 who he described as having an "angry and aggressive streak". This child was being sexually abused by William Hook at the time. LA-A64 says he was given sleeping pills for the nightmares which developed after he confronted Hook about the abuse. He remembers that the pills just made it more difficult to get up in the morning.

58. 1978 saw the phased closure of Shirley Oaks commence. Children were returned home, fostered, placed in other homes or independent accommodation. Lambeth accepts that 'this period was marked by considerable instability and very probably a strongly felt sense of insecurity for children living at Shirley Oaks.'

59. It finally closed in 1983. Gloria Newlands, who started working at Shirley Oaks in 1974, remembers that:

'Eventually Shirley Oaks was closed down. ... the children then had to be fostered out. I remember it was very sad as some of the kids found it difficult to deal with and broke

down. No one seemed to care about or give any thought for the staff or kids when this happened.'

60. Judging by the standards of care planning operated by Lambeth at that time, it is unlikely that the children's subsequent placements were planned with care. Furthermore, the records of the lives of many children were also lost. Gina Noble worked at Shirley Oaks in various houses from approximately 1969 for 15 years. She recalled that: .

'When the home was closed down I remember a lot of the records were destroyed. I remember thinking how strange it was because so many records were made and kept, yet when the home closed down they were just left lying around in the offices. Therefore when the building was pulled down they must have been destroyed with it.'

61. Shirley Oaks may have closed down physically in 1983 but its legacy endures for those who spent time in their childhoods there. We will examine, for example, what happened to children in Rowan House. Philip Temple, a man about whom there were suspicions when he worked for Wandsworth Council, became its housefather. He was subject to very serious allegations of sexual abuse by children at the time. You will hear evidence about how those allegations were treated. Philip Temple left Lambeth and went on to abuse other children. Evidence will be given as to how he was finally apprehended.

62. He was replaced by Patrick Grant. Like Temple, Grant sexually abused children in his care. There is evidence he abused at least one of the same children as Temple. He also left Lambeth and abused more children. He too was finally apprehended after many years. You will hear evidence about that.

63. We will look within this hearing at how individuals like Geoffrey Clarke and Hook were able to weave themselves into the very fabric of life at Shirley Oaks to devastating impact on those whom they abused.

Angell Road

64. Angell Road was one of the Homes that was intended to replace provision at Shirley Oaks. It opened on New Year's day in 1981. The housefather, for this refurbished, new home, was Michael Carroll.

65. Michael Carroll came to Lambeth from Liverpool and took up a position at Highland Road in March 1978. He had followed a colleague from Liverpool who was on the original Lambeth Panel which interviewed him. One year later he was made the Senior Assistant Officer in Charge of Highland Road.

66. At Angell Road, he was joined in 1982 by a new Team Leader at the home, Steven Forrest. In 1984, LA-F4 joined the staff. You will hear more about these men in this opening and in the evidence.

67. Michael Carroll was by all accounts a powerful man in Lambeth Council. He was highly regarded and appears to have been prized in a local authority where it was difficult to recruit and retain people. Carroll involved himself with vulnerable families, on the face of it, going an extra mile to offer support to families in need. He brought children to his home; he gave them money for doing jobs around his house and took them on holidays. In respect of one sibling group, he continued to involve himself in decisions about their care after they had left the children's home. Their parent was observed by CHILE to be dependent on Carroll (who described himself as a 'friend to the family').

68. Another group of siblings, who were pre-school, were cared for at Angell Road on a daycare basis, seemingly informally, Carroll having arranged this with their mother. There is evidence that it was generally the position that Carroll was able to have children admitted to Angell Road for "daycare" without formality or oversight.

69. Carroll was also a convicted child sexual abuser. He concealed that conviction from Lambeth when he applied to work there. Those who provided references for him in 1978 did not mention it either. You will hear that Lambeth came to learn of this conviction from Croydon Council when Carroll and his wife applied to be foster parents. After an initial assessment, Croydon declined to consider the application any further, for a number of reasons including that it would not expose Croydon children to the risk posed by a foster carer with a conviction for child abuse.

70. You will hear that Lambeth officials decided that Carroll should not be dismissed on account of his conviction nor on account of his concealment of it. The decision to retain him, not just as a Lambeth Council employee but as the OIC of Angell Road, was one of the first decisions taken by David Pope, the newly appointed Director of Social Services. Chair, you will be asked to consider the ramifications of this decision for the children who came to live in Angell Road. The issue that arises is not simply whether Lambeth put children at risk of sexual abuse by Carroll (and prioritized his needs over risk to children) but whether they put children, whose vulnerability was above and beyond *even* that of other children in care, in his path.

71. You will hear evidence that Angell Road was regarded as a centre in Lambeth for "direct work" with children. Indeed, it is understood that Lambeth managers approached Angell Road to be the location for this work. The inquiry understands direct work in this context to have meant individualised play or art with children as a therapeutic tool or as a tool to assist children in explaining experiences or things which had happened to them. There was a flat in Angell Road which was equipped for this purpose. One witness to the police described it as a "*goodie area*" with toys that were not available in the rest of the house.

72. Carroll was described by one witness as having a marked interest in this work and being a "real advocate" for it. According to another police witness, when Carroll attended an advanced social work course in 1986/ 1987, he was required to submit photographs of his session work with a child. He submitted a photograph of a small boy – aged 4/5 years in his underwear. This caused the course tutor concern (enough to pass this on to the former social worker from Lambeth who arranged training in direct work at Angell Road).

73. This event not appear to have caused anyone to pause and ask whether the centre of Lambeth's direct work with children should be in the hands of a convicted abuser. To the contrary, in 1988 it was noted that

"...the majority of staff at Angell Road have all done the basic Training Course in "Direct Work with Children" and have all practised with individual children: the purpose of the work is to develop techniques to enable children, through play, to ventilate feelings of grief, loss and anger; lifestory work, personal safety (abuse prevention) work.

The work room is furnished with necessary equipment and materials to facilitate the work" ..."

74. Records show that Michael Carroll and Steven Forrest both undertook direct work with children. LA-F4 is also recorded as having done a course in direct work.

75. On 30 January 1990, the Director of Social Services David Pope put forward a report to the Social Services Committee, which included a proposal that Angell Road would specialise in working with children who had "*suffered abuse*" or were "*emotionally damaged*" requiring "*longer term work.*" Whether there was any formal designation of Angell Road as a specialist home, will be considered in evidence. It appears, regardless of whether this was an official moniker, Angell Road was already doing work of a specialist nature and that children, who were believed to have been sexually abused prior to coming to Angell Road, lived there.

76. As you will hear, Michael Carroll's position in Lambeth unravelled in 1991. He was dismissed because of financial irregularities. There was an earlier warning of what was to come. An anonymous letter in 1984 was taken sufficiently seriously to warrant action. It referred to Carroll as an autocrat who referred to everything as 'his'. The letter spoke of him using the mini bus as though it were his; barring staff from using it for school runs so that children and staff had to use buses. It referred to staff being required to do washing and cook food for a family whose children were no longer in care. The letter referred to Carroll's corruption and to the bills for his food compared to the cheap food children were fed. In 1991 Ms Anna Tapsell came to learn of Carroll's past because of her

involvement in the misconduct process and, as you will hear in evidence, she became seriously alarmed about his history in Lambeth and sought to involve the Social Services Inspectorate.

77. As for other aspects of the quality of life for children in Angell Road, it was the subject of an SSI inspection in 1993. It is Unit 3 in that report. The inspection noted the lack of police checks on staff and that the visitors' book did not always show the people who visited the home. Staff had not taken part in child protection training. It noted children to be drifting around during the day as opposed to taking part in meaningful activity. There were delays in drawing up care plans. The report notes that a field work team leader made it clear to inspectors that it was not a priority to allocate social workers to children in residential childcare. The SSI noted that in common with the other homes inspected, there was a lack of social work trained staff. There was no clear in-house training. Former Councillor Clare Whelan, who will give evidence in this inquiry, visited Angel Road in January 1994 and recorded:

"Much of the furniture throughout the building is in a disgusting state …there are broken windows, many of the windows are filthy. In several rooms the wall paper was peeling wires were loose all over the place. There were few pictures or evidence of belongings."

It seemed to her little had changed since the SSI report.

78. What was life like for children living in Angell Road? Writing in 1991, Michael Carroll's replacement wrote of the treatment of children in Angell Road: *"Children are an irritation in this building, staff do not consider that they are the reason they are*

employed. The practice of care and routine is rarely used…On numerous occasions children have been treated unfairly, this stems from whether they are liked or not." She went on:

> *"Overall the practice in Angell Road is unacceptable, degrading and bordering on the harmful. Practices are twenty years out of date ……All staff are tight lipped and children worry about being alone to face the wrath, if they speak out of turn."*

79. When she was interviewed by CHILE, Carroll's replacement also referred to how punitive staff could be and to one member of staff saying in a training situation that staff did not need to know techniques for dealing with difficult children because they would be pinned against the wall by Carroll and another member of staff.

80. The evidence seen by the investigation demonstrates that Angell Road cared for very young children *and* children in their teenage years. The evidence suggests that it may have been a frightening and confusing place for a number of children who lived there. First, there is clear evidence that Carroll was not the only abuser who worked in Angell Road. You will hear about LA-F4, who I mentioned joined Angell Road in 1984. He had been a social uncle at Shirley Oaks.

81. LA-F4's relationship with two children in Angell Road became an acute cause for concern in 1988 (although it appears that he had always been a cause for concern at Angell Rd).

82. A letter written by a staff member in April 1988 to Michael Carroll set out the concern LA-F4 was causing because of his relationship with two children. I am going to refer to these children as Z and X . The letter said:

"In all the time that [F4] has worked here at Angell Road he has had a very close relationship with one of the residents here child Z [it is such a close relationship that at times the other kids talk about it and also feel left out, because he has time just for her. It has become such a problem that other members of the staff group have approached me concerning the matter and they will either talk to you or write a report for you.

I am concerned at the role [F4] plays as key worker to X too. It isn't just the expensive presents he bought for him. The time he spends with him even when he is off duty, on leave or off sick. He will always be there for [X] day and night. This causes lots of problems with the relation- ship he has got with [child Z] Plus the other children again feel left out. He also made several attempts to see children who are not with us anymore."

"There is no doubt in my mind [F4] is over involved with X and it is coming to a point where [another Angell Road care worker] can't cope with it any longer…."

83. After this letter was sent to Carroll, a third child made a disclosure of a disturbing nature. This child was of preschool age (I shall call her Y). She was one of those children who was in Angell Road on a seemingly informal basis – she had no social worker. Her sibling was also there on the same basis. Y had a disclosure session with a member of Angell

Road staff. It might be thought of concern that Y, who was in this children's home for daycare, informally, would be subject to such a process. But, putting that to one side, she described an incident with one of the children who was mentioned in the letter. She described two men being present – she named one of them as LA-F4. I won't describe the detail of what she said but it clearly gave rise to the concern that two children from Angell Road had been in a situation of sexual abuse with two men, one of whom was identified as LA-F4.

84. You will hear that Carroll took on a prominent role in investigating these matters. There was delay. It appears that Y was never given a proper interview. There was no police investigation into what she said had happened. The possible involvement of another man in the abuse of these children went uninvestigated.

85. As far as the children referred to in the letter above are concerned, we understand one of them to have disclosed abuse by F4 in 1988. F4 faced misconduct proceedings within Lambeth and you will hear more about that in evidence. A number of concerns endure. One is whether Carroll impeded the investigation into F4 so as to ensure that there was as little external scrutiny as possible. The second issue is the evidence that there were three men working in this home, at the same time, each of whom is implicated in the sexual abuse of children.

86. You will also hear evidence from this time about information which raised the possibility that Y and her younger sibling were abused by a very much older child in Angell Road. This is an area that the investigation must confront. I want to make clear that by doing so

we are not seeking to stigmatise or apportion blame to children. We are concerned about the possibility of this happening to younger children and the issues arising; namely, whether there was sufficient supervision of all children; whether the issue was taken sufficiently seriously or investigated so as to understand why it was taking place; and whether sufficient regard was had to the emotional welfare of children and the impact of this upon them.

87. The third individual suspected of sexual abuse in Angell Road was Steven Forrest. The treatment of a disclosure by a boy at Angell Road of sexual abuse by Forrest was so calamitous that it was the subject of an inquiry of its own – the Barratt Inquiry. In short, this child made a disclosure of sexual abuse by Forrest who had died, a few years previously, of an aids related illness.

88. The child at the centre of the Barratt Report came into Lambeth's care aged 2 ½ and spent most of the rest of childhood in its care. Barratt pointed out the huge disjunction between Lambeth's policy (that no child who came into care under the age of ten would remain in care for more than two years) and this child's experience. For him, the reality was that he lived in residential homes for most of his childhood. The Barratt report sets out exhaustively the drift in his care, his increasing institutionalisation and the sheer limbo of his childhood. I mention this because it is another facet of what life was like for children, like him, in Angell Road and other homes.

89. We will ask questions about whether Lambeth really got to the truth of what might have been happening in Angell Road up to the suspension of Carroll and the death of Steven Forrest.

South Vale Assessment Centre

90. South Vale Assessment Centre was a different sort of home from Angell Road and Shirley Oaks. It was built in 1967 and opened in 1968 as a large observation and assessment centre. It is described in some records as providing a home for up to 40 children but it appears more likely that it accommodated up to 30.

91. At its inception, it was intended that children would live there for a short period in order to assess their future needs and where it would be appropriate for them to live. That mission appears to have changed over time, so that children lived there on a much longer-term basis. There is evidence from those who worked there in the 1980s to suggest that children were there for many years. It appears that it evolved into a community children's home. In 1989 as part of the Children's Home Review it was decided that it should become an outreach resource. That did not happen and it finally closed in 1993.

92. The building itself was purpose built to facilitate the observation and assessment of children. It was referred to as having developed as an institution and looking like one, according to one report its "*sheer size strongly militating against guarantees of a high standard of individualized and family group care…*"

93. This sense of Southvale as an institution rather than a home can be seen, in its earliest days, in a letter which a foster family sent to Lambeth about their concerns about a foster child, who I shall call X, who they looked after: They wrote:

> *"Firstly not only was X, our foster child, viciously assaulted by a member of the staff at Southvale, but we have heard from another foster mother that she has reported to the Children's dept (sic) an assault on a child in Southvale and has had several such reports from children in her care who have been to Southvale.*
>
> *When X was admitted to Southvale all her clothes were taken away and she had to wear the institutions' clothes ... this greatly worried us as we have always been taught by our childcare officer that this takes away a child's sense of identity and is contrary to the practice of good childcare..."*

94. The writer went on to say that children could only be visited on Sundays between 2-4pm , and there were no facilities to bring in children. The foster parents thought this was "extraordinary" and queried how families with children could see their children in Lambeth. The couple also described children as "virtually imprisoned" in Southvale. Concerning assaults, they pointed out that none of the children could contact their social worker except through the staff and that this was "*open to abuse*". Some of the themes highlighted within this letter were still evident decades later.

95. In keeping with an institutional way of life, Southvale operated on a points-based system. This was not a reward system- it was referred to as a *"loss of privileges"* system. This was not really accurate either- a 1988 version of this policy explains that if children failed

to attain 84 points in a week from Friday -Thursday, the child or young person lost privileges for the following week starting on Friday morning. Privileges were things like using a tape recorder, going out on their own, music.

96. One former temporary group leader at Southvale gave a statement to police in 2013 about how Southvale operated in the 1980s and how he regarded it as *"dysfunctional"*. He explained that many children stayed in Southvale for years. He noted that there was one child there as young as three years. There were social workers and keys workers "who were completely untrained in social care and childcare", although this was not unusual.

97. Pausing there, and on the point of untrained care workers, you may think it illuminating in terms of referencing or checks of those who worked in Southvale, that one care worker recruited in 1990 was known at the time of his recruitment to have had seven previous convictions, including one for unlawful wounding (for which he had received a sentence of five years imprisonment). He was redeployed from South Vale to Monkton Street and then to its sister unit Chestnuts. Both of these homes cared for children with special needs. He was to face allegations of sexual abuse at Chestnuts. You will also hear evidence about LA-F14, employed at Southvale who faced allegations of sexual abuse at Southvale and another home. He had undeclared convictions and whilst an attempt to prosecute him for sexual abuse was unsuccessful, he was convicted of possession of a firearm.

98. Returning to the evidence given by the temporary team leader, like the foster carers who wrote the letter in 1971, he said that there was little outside scrutiny of the home – complaints were dealt with by the people complained about. Moreover, there was a culture of not believing children – justifying this by their histories and using their past experiences against them. The more the children raised concerns, the less likely they would be believed.

99. Of the points system, he said this:

> *"this involved staff and children meeting towards the end of each day and discussing behaviour which merited points being awarded or removed. There was an opportunity for the system to be manipulated by staff particularly as they were untrained and there was favouritism displayed towards certain children, particularly by Les Paul…often the children came from damaged and dysfunctional backgrounds and were clearly flattered and responded to any attention given to them by staff".*

100. He also explained that it was common practice that children could be taken out by staff without any checks or risk assessments for an afternoon or even a weekend .The former team leader [Dr Lindsay] concluded:

> *"From my experience, the atmosphere of that home and the lack of reporting and accountability would have facilitated an abuser to offend against children. The opportunity existed for vulnerable children to be exploited"*

101. During Operation Bell in 1992, a senior personnel officer was interviewed by police. She described the OIC's policy at Southvale was to run what she described as a "team-fit"

style of management. This meant a "very physical, competitive, sports- based philosophy regards children" She, like many other people who spoke to the police, commented upon the favouritism shown towards some children. Also, **"***the level of collusion between male staff at South Vale was so intense that obtaining the truth of the matter was too difficult. All members of staff were 'afraid' of the OIC***."**

102. This sense of fear was conveyed in the interviews which took place in 1989 with two female members of staff from Southvale. Notes of the interview with one of these women referred to her concern about the punitive environment, the excessive control and the emotional and physical abuse of children at Southvale. She said that the spark had gone from the children moved over from St Saviours – *"as if they had no fight left"*. She referred to favouritism in relation to both staff and children; *"one particular child never had any new clothes bought, never got as many privileges as the others."* When she asked the other staff why this was the case, she was told *"the [Officer in Charge] hates him."* Even the child told her that this was why he had no new clothes. She found this hard to believe then overheard the OIC tell the child he hated him. On the other hand, she mentioned another child, singled out by the OIC for special treats and taken up to the OIC's flat.

103. The other female care worker gave a similar account.She also referred to the "humiliation" of children, to their being bullied and humiliated. She was concerned about the treatment of black children, including skin, hair and dietary needs. She said that black staff provided hair and skin products to children because Southvale *refused* to buy them.

She felt unable to challenge bad practice. No discussion was allowed to take place. When she raised the issue of children being offered food appropriate to their culture, she was told by the OIC that "*they did not like troublemakers- if she carried on life would be made difficult for her"*. She too mentioned the child, singled out to be taken up to the OIC's flat.

104. Both of these care workers were invited to write down their concerns. A manuscript note written by one of these care workers survives. The note explained that children were humiliated in front of staff and children about why they were in care. They were told they behaved like animals and were disturbed. Graphic details of their family history were mentioned in front of other children. The author had never seen the correct restraining techniques used.

105. If one child was disliked by senior staff – he or she would always be picked on. The author said of one child who was not liked and who was in trouble with the police that the OIC told him he had the power over whether he went to a 'lock up' or not. She mentioned one child who had chicken pox, who had been scalded by hot tea, and had to go to hospital - "we were told we could not speak about this". The author said that a certain duty officer was, in her words, *"always going on about the blacks on duty"* and making racist comments towards children. Children were forced to eat food they did not eat for cultural or religious reasons. She said- Southvale is ruled by fear.

106. The disclosures by these members of staff precipitated the Zephyrine Inquiry. I will explain more about that Inquiry in the course of this opening. For present purposes, it is

of note that it referred to Southvale seeming to have functioned as "*a reformatory"* for children *"whose challenging behaviour was beyond the capacity of other establishments."*

107. What we know is that many children who came through the doors of Southvale were sexually abused by those charged with their care. Lambeth Council, whilst accepting that the true extent of sexual abuse linked to Southvale may never be known, is aware of 140 people who have made disclosures of sexual abuse related to their time at Southvale. There have been a number of convictions which you will hear more about in the course of the hearing.

108. Lesley Paul was someone who, on the face of it, might have been thought to fit well with the descriptions of Southvale's regimented approach to childcare. He was a Care Officer at South Vale from 1979. We are not aware of his having any qualifications. He had been a Special Constable, until 1981, attached to the West End Central police station. Records from Operation Bell refer to his having been stopped in July 1979 when he was a constable, in suspicious circumstances in the toilets in Piccadilly Circus. According to the temporary team leader who I mentioned earlier, [Dr Lindsay], Paul made a point of being a Special Constable.

109. On Paul's own account being a Special Constable was *"quite a good thing to do because they felt that was an extra…an extra deterrent control for wayward children."* When asked about whether he himself told children that he was a Special Constable he said that

there were specific children that management wanted him to tell because *"they're the ones that needed…to know that they were being watched."*

110. In an interview with the MPS in 2001 Paul suggested that at South Vale he was *"dealing with difficult children and some of these children were probably the most disturbed, the most difficult you would ever meet in your life."* The police were able to challenge him about this. In a report which she wrote about Southvale, former councillor Clare Whelan referred to the home as having acquired a reputation for being one which was *"able to cope with 'difficult' and disturbed children that other homes were unable to handle"*. A report from the 1980s referred to some children being there charged with serious offences and some children placed there awaiting a trial or criminal proceedings .

111. That Southvale had this sort of reputation may have suited Les Paul (and indeed made children there more vulnerable to abuse) but it is not an accurate picture of all of the children who lived there. The material disclosed to the Inquiry appear to us to show (as indeed must be evident from the fact that very young children were placed there and that its use evolved into a general children's home) that many children who lived there were in care for all of the same reasons as children in other homes and not because they were disturbed or involved in criminality.

112. Lesley Paul was a physically imposing man and may have been imposing in other ways. According to the group leader, Dr Lindsay, Paul made inappropriate racial comments which were very offensive. Paul faced a misconduct hearing in May 1984 in relation to an allegation that he made a racist comment to a child and other inappropriate comments

(although the record does not specify what these were). It is not clear how this allegation was finally resolved. There was a hearing but the matter appears to have been referred to the Director of Social Services and the Chief Executive who determined it should be referred back to a different Panel. By that stage, it was determined that too much time had passed and Paul was given a written warning. On 24 April 1990 a complaint report was made about him (although we do not know what that complaint was about). It appears that a parent complained about Paul, and how he spoke to them in a racist way. A complaint was raised (dated 25 September 1990) *"outlining the above concerns…states Les was racist and should not be working in this kind of environment"*.

113. The "environment" referred to may have been a reflection of that fact that by 1990, most of the children who lived in Southvale were from a black, asian or minority ethnic (BAME) background. In Lesley Paul we see the gulf between Lambeth's long standing policy aspirations for children from a BAME background and the reality of what children faced in Lambeth homes.

114. Lesley Paul has now been convicted three times for the sexual abuse of boys in Lambeth's care. It took some time for a fuller picture of his offending to emerge. DI Morley will give evidence about the incremental way investigations into Paul developed. He was first arrested and charged in 1992 as part of Operation Bell, he was arrested and charged as part of Operation Middleton and was arrested and charged again much more recently in Operation Trinity. He was convicted on each occasion but, as you will hear, it

was only his final conviction and sentence which marked the gravity of his conduct over the years.

115. He was tried in 1992 in respect of the sexual abuse of three boys. One victim was from Southvale, another victim came to know Paul through the child at Southvale. The evidence demonstrates this child from Southvale to have been groomed by Paul, there is evidence that his sole parent also became friendly with Paul and that they spent time with him as family. Like Carroll, this suggests that Les Paul had an ability to work his way into the lives of vulnerable families.

116. This child moved on to a different placement and told police that from this point *"he more or less moved in with Paul."* He also described going on a long holiday with Paul. He alleged he told his social worker that he was living with Paul. Ms Annie Hudson, Lambeth Council's corporate witness, will provide evidence as to what Lambeth knew about this child's relationship with Paul. What prompted this former resident to make a disclosure about his abuse, like others who came forward, was concern about another child.

117. Another careworker who worked at Southvale for 13 years (in the late 1970s and 1980s) gave a statement to the police in 2003. She said that Paul was often criticised for having favourites. She recalled one child who need cream applied to his anus and how Paul would volunteer for this. He would also offer to supervise the boys' showers. Paul asked her to come on a camping trip with him and some boys from Southvale. She slept in one tent, he slept in another with the boys. She said that these matters did not assume

significance until Paul was prosecuted for the first time. She also referred to him taking boys out to Soho which she disagreed with.

118. In Operation Middleton, Paul was convicted of five offences of indecent assault, relating to four victims from Southvale. As I will explain later in this opening, an issue which arises is why some allegations which were made in and around the time of Middleton were not proceeded with. In Operation Trinity, five men who had been children in Southvale came forward. Paul was convicted of a number of offences relating to all of these victims, with the exception of one.

119. It is important to note that one of Paul's victims gave evidence of being abused by Paul and a number of men at an address. He was very young when this happened. He also recalled an incident of being abused by another man at Paul's flat.

120. We also know that during the period he worked for Lambeth, Paul photographed many boys. Upon his arrest, numerous photographs of children were found at a search of his flat. These suggest that he had ready and intimate access to children. A number of his victims describe being photographed by him. He made a film showing the abuse of a child in Lambeth's care. Chair, the issue of whether Lambeth staff were involved in the possible production and dissemination of pornography or imagery of child abuse is one that endures. We know that Paul made such images- I will say more later in this opening about suspicions that he was involved in its distribution.

121. We know then that children from Southvale were abused by Lesley Paul. What was known by those charged with their care at the time? A complainant in one of the criminal

investigations into Paul gave evidence that he had told his social worker that he was being abused. That social worker, who was qualified, provided evidence to the police about this disclosure. This was the only time in his eighteen- year career that a child made a disclosure of sexual abuse to him. The note of this disclosure survived. The social worker said in his statement to the police –

> *"This was completely out of character for X to say this as he was a toughie and one of the boys. It must have taken a lot of courage for him to say this to me. He was very quiet and matter of fact as he spoke. I believed him completely. This was so out of character it had to be true. I was surprised that X was the victim of abuse because I felt like he was a tough little boy".*

122. The social worker explained to the boy that they needed to report it to the police but the child did not want to. The social worker explained to police that he spoke to his Team manager who said they had to respect the child's wishes. The social worker told the child that because he didn't want to take it further, he would have to go back to Southvale until a placement became available. This is what happened. The social worker noted at the end of his statement that he was probably the only person to whom the child could have turned to for help.

123. One member of staff (who had been a team leader and a group leader at Southvale for two periods in the 1980s) gave a statement to police in 2002. He said that he wondered if Paul did have an overt interest in boys. He recalled a boy being upset and sent to his room. Lesley Paul followed him up to his room a short time later. The group leader noted

that Paul had been gone some time, he entered the child's room to find Les Paul lying on a bed with the child. The team leader said that he thought this was "totally unacceptable and inappropriate" but Paul made light of it. When he came back to Southvale in the mid-1980s the team leader said that there was concern about Paul seeing former residents outside of work. He said boys were taken camping and that there was concern about Paul's behaviour (he did not explain what behaviour he meant) and that he thought the OIC dealt with it. He said that one boy confided that he felt uneasy about Paul. Paul was later convicted of the abuse of the same boy. The team leader stated to police "*as the years went by I felt uneasy about Leslie being with the boys*".

124. Another convicted child abuser worked at South Vale. This was Patrick Grant, who worked at Rowan House and who had faced trial for sexual abuse in 1978. Two of the complainants in that trial were from Shirley Oaks. Patrick Grant was acquitted upon the direction of the Judge in 1978. We do not understand his failed prosecution in 1978 to have resulted in any misconduct process – far from it- as we understand the evidence, Grant was promoted to team leader at Southvale.

125. You will hear evidence that in Operation Trinity, two men who gave evidence about Les Paul also made allegations of abuse against Patrick Grant. This led Operation Trinity to investigate Patrick Grant and Bernard Collins who worked with him at Fircroft Home in Surbiton (which was not a Lambeth home). In 2018, Patrick Grant was charged with offences of child sexual abuse against individuals in Rowan House and South Vale

Assessment Centre and other homes. You will hear about the outcome of that trial later in this opening.

126. It suffices to note here that it appears that history may have repeated itself. That Grant came to Rowan House and may have abused children abused by Philip Temple. Grant moved on to Southvale and, again, may have abused children abused by Paul. DI Morley will be able to provide more evidence about this.

127. There were other employees at Southvale whose conduct gave cause for serious concern. LA-F8 (F8) had been a care worker at St Saviours who transferred over to Southvale. One care worker (who in fact was the same woman who I mentioned was interviewed about her concerns about ill treatment of children at Southvale in 1989), made a statement in 2013 confirming that she had found F8 in bed with a child. She explained that she could not tell management within the home but did inform managers within the social services department. It appears that this information was available to the Zephyrine inquiry.

128. The assistant officer in charge of Southvale gave a statement in 1992, in the context of Operation Bell. She recounted that in 1989 she found F8 in a bedroom with a child. The child was entirely unclothed. F8 said that he needed to have cream applied to him. This was a different child to the one I mentioned before in this context. The assistant officer in charge told police that staff never did this, save for babies and very small children. This child was older. I will explain why she said she did not come forward sooner when I deal with Lambeth's response later in this opening.

129. There is much to be said about Southvale, its ethos and whether it facilitated the sexual abuse of children. You will hear much more about this home and the experiences of children within it during the course of the hearing.

Ivy House

130. Amongst an already vulnerable group, children in local authority care with communication difficulties and complex needs are even more vulnerable. The selection of Ivy House and Monkton Street as case studies enable you, Chair and panel, to consider how those especially vulnerable children were dealt with surrounding allegations of child sexual abuse.

131. The law and language used surrounding children with complex needs has developed considerably over time. The 1970s commenced with the *Education (Handicapped Children) Act 1970* which abolished previous statutory powers for classifying "*children suffering from a disability of mind as children unsuitable for education at school*". The Act was followed by a White Paper in June 1971 entitled "*Better Services for the Mentally Handicapped*." This White Paper outlined a desire to move away from caring for people in institutional settings and to increase the provision of local and community care. Where residential care was required, the paper recommended that local authorities should consider more homely settings. This desire for homely settings was to be repeated over ten years later in Lambeth's 1982 paper, "*Meeting the needs of Mentally Handicapped People: A Strategic Review"* which stated: "*in all residential accommodation it is an objective to promote homeliness.*"

132. It was not until September 1974, however, approximately nine years after Lambeth Council was formed and took over responsibility for children's residential care in the

Borough and three years after the 1971 White Paper on "Better Services for the Mentally Handicapped", that the Social Services Committee acknowledged the lack of provision for what they described as "*a potential demand for services from 400 mentally handicapped children and 1000 physically handicapped children.*"

133. A further two years passed, before the opening in 1976 of Ivy House, a residential children home aimed at providing short breaks for children aged between 8 and 18. Three years later, in 1979, Chestnut Road, described as a "Long Stay Community home for mentally handicapped boys and girls" was opened, providing 12 places for children aged between 1 and 18 years, and the following year, in 1980, Monkton Street opened in Kennington as a "long stay home for mentally handicapped children" with 13 places for children aged 0 to 18 years. Ivy House remained open until 1990, with Monkton Street closing six years later in 1996 and Chestnut Road being the last of Lambeth's Residential Children's homes to close in 2000.

134. Prior to the opening of these 3 specialist homes, some children with complex needs were placed in other Lambeth residential homes, sometimes moving from home to home. One of the CHILE files reviewed by the investigation team documents the series of placements of a very young child, described as having learning disabilities due to possible brain damage at birth. From the age of three he was moved from place to place, with placements at Shirley Oaks, Stockwell Park and at least five other homes, including (when a teenager) a period of just over a year at Monkton Street. In the main, however, residential provision for those with complex needs at that time was catered for

predominantly by hospital stays or in private and voluntary homes, sometimes located some distance from Lambeth.

135. One such private home, to which Lambeth children were sent from the late 1960s, was "the Manor House" in Bristol. The Manor was a privately owned home that appears to have been registered as a "*Mental Nursing Home for 20 subnormal/severely subnormal patients under 18 years.*" The file of one child placed there sets out that at 14 months the child was assessed by Lambeth's medical officer as "subnormal" and unsuitable for adoption, although a later examination found her to be of normal intelligence. She was placed at the Manor in the late 1960s aged 2 and remained there for almost ten years. She went for long periods without being seen by a social worker from Lambeth, one such period lasting three years and six months. It was reported that the child had signs of deprivation and institutionalisation, that were likely to remain a severe problem throughout her life. A subsequent placement with a social aunt and uncle broke down and this was followed by a series of placements, including at South Vale. This was not an isolated case. A visit to Manor House in 1975 by Lambeth noted concern about a number of other children placed at the home. There were at that time 19 Children under the care of Lambeth at the Manor House. Fifteen of these children had received no social work contact for over two years, due it appears to the long term ill health of one social worker. The children were found to have few possessions or clothing that could be called their own and it was reported that the owner of Manor House was determined to frustrate attempts to remove any children from the institution.

136. Despite the opening of Ivy House and Monkton Street, the placement of children out of the borough did not cease. In the mid 1990s, an older teenage child in the care of Lambeth, who was described as having moderate learning difficulties, was sent to a home Frontier House in Kent. This child went on to allege severe physical abuse, and the Home, following an exposing television programme of physical abuse of children by staff, was subsequently closed.

137. Returning to Ivy House if I may, when it was first opened in 1976, it was located on the Shirley Oaks site in Croydon. Whilst generally referred to throughout its period of operation as Ivy House, the home in fact moved locations a number of times, being based at three different cottages on the Shirley Oaks site between 1976 and 1987. On 22 September 1987, due to the sale of the Shirley Oaks site, Ivy House moved to a new location in Croydon, on Warham Road, where it remained until its closure in 1990.

138. Ivy House offered "short break" residential care to children, both during term time and school holidays. Many of the children who spent time at Ivy House also attended one of the two specialist schools in the Borough, Shelly School and Windmill School, for children with "Severe Learning Difficulties", and which catered for children aged between two and nineteen years old. Children would attend school during the day, returning to Ivy House overnight.

139. Whilst records of precise numbers of children who stayed at Ivy House are incomplete, it appears to have been a provision that was used by a significant number of families. A report entitled *"Special Educational Needs"* presented to the Social Services Committee

on 22 November 1988 noted that families were entitled to six weeks per year "short break" cover at Ivy House and at that time eighty families were using the service offered by Ivy House. The age range of children cared for at Ivy House fluctuated but the children, both girls and boys, were predominantly aged between five and nineteen. In 1985 it was said that the average occupancy was thirteen children, slightly below the maximum capacity of 15, with the majority of children being aged between 11 and 19 years old and a ratio of one boy to two girls. The needs of the children cared for varied.

140. There does not appear to have been a set staff child to ratio, but a document dated 1978 which considered staffing for Chestnut Road, based on the experience of Ivy House, suggested that a ratio of 1:4 was deemed usual. At the disciplinary hearing of LA-F12, a member of staff at Ivy House, the evidence given was that in 1985 there would generally be four or five staff on duty caring for thirteen children with more staff on duty at weekends when more children were in residence. At night the standard cover would be two or three members of staff on duty, with one senior officer sleeping in.

141. As early as 1968 a report entitled *"Recruitment Advertising: Children's Department*" set out difficulties in recruiting residential staff. This remained true over twelve years later and was certainly true of the specialist children's homes run by Lambeth. A Sub-Committee meeting in November 1981 recorded the "*extreme concern*" about staffing levels in Ivy House, Monkton Street and Chestnut Road which were described as "*inadequate*." Qualifications of staff was also an issue Lambeth. The 1981 Report of the London Borough Training Committee (Social Services): "*Mental Handicap: Progress*

Problems and Priorities" noted that: "*Data shows that a large number of Local Authority Staff, particularly those working in residential care, are unqualified.*"

142. The situation did not improve. In his report to the Children's Homes Sub-Committee on 16 November 1988, twenty years after the *difficulties* of recruiting residential staff had been raised in the 1968 "Recruitment Advertising" report, Robert Morton (Principal Manager Children's Homes) set out the problem with stark clarity: "*there are simply too few staff available to cover all the homes, to provide adequate and safe staffing levels for good child care*." Morton's report was accompanied by a report from the Placement Officer, who spoke of a "*staffing crisis*" noting: "*With Lambeth homes currently running at below 60% of full operational capacity due to staffing shortages there is consequent unavoidable heavy usage of Private and Voluntary homes.*" The very problem that the opening of specialist homes had sought to resolve in part, namely the use of private and voluntary homes, continued.

143. One of the responses of Lambeth to the recruitment difficulties across the service and the issue of reliance on agency staff pending permanent appointments, is set out at paragraph 9.73 of Lambeth's Corporate Witness statement, by Annie Hudson. In July 1989 it was decided to offer appointments to staff pending police checks subject to certain conditions being met, namely satisfactory references and new staff not being placed in sole charge of children until police checks were completed.

144. It is disturbing to note that even after the last of Lambeth's residential children's homes had shut, in August/September 2001 the follow up Social Security Inspectorate *Inspection*

of Child Protection Planning and decision making for Looked after Children referred to the fact that staffing was still problematic and whilst recruitment checks had improved, recommendations were still made for checks on agency staff to be required prior to appointment.

145. Within this oral hearing the Inquiry will hear evidence around a teenage girls allegation that she had been sexually abused at Ivy House. LA-A26 used gestures and words which conveyed to her mother that she had been sexually abused, and she also provided a first name when making the allegation.

146. LA-A26's mother called Ann Worthington, a social worker, requesting that she visit the family home urgently. Ann Worthington was a social worker employed by Lambeth and from whom we will hear evidence. We will also hear evidence from others involved in the subsequent assessment of LA-26's complaint, and the various management investigations and disciplinary proceedings which followed.

Monkton Street

147. Whereas Ivy House was established as a home for short stays, Monkton Street which opened in 1980, four years after Ivy House, was intended as a long stay home. However it is clear, as demonstrated by the case of LA-A49, that over time it was used for both long and short stay residential placements for children with complex needs, prior to its closure in 1996. Whilst the intended age range of children was 0 to 18 years, records suggest that on occasions the upper age limit extended to 21 years.

148. LA-A49 was a 12 year old boy with complex needs and communication difficulties, who was cared for by his mother and attended Shelly School, a specialist school in Lambeth for children with special learning needs. He spent short stay residential periods at Ivy House and Chestnut Road prior to attending Monkton Street for short stays.

149. In July 1986 the mother of LA-A49 reported that her son had made allegations of sexual abuse by LA-F26. This led to LA-49 being subject to questions and undergoing a series of medical examinations . First at a GP surgery, subsequently at St. Thomas's Hospital, and finally by the police, where he was both interviewed by a Police Officer and underwent a third examination at the station.

150. It was the findings by the police doctor, following the examination of LA-A49, that appears to have led to a further nine children who stayed at Monkton House being requested to undergo medical examinations. Some of these examinations took place at the

police station, others at Monkton Street. All of the children examined had complex needs and communication difficulties. None of the children, other than LA-A49, had prior to the examination made any allegation of child sexual abuse nor does it appear that any attempt was made to interview any of these nine children in advance of the examination. Following the examination, one further teenage male child, LA-A291 made an allegation to his mother of sexual assault by a member of staff at Monkton Road, although the child was unable to identify the alleged perpetrator by name.

151. In some cases parents gave consent to the examination and attended the examinations, in others the Local Authority gave permission and in some cases social workers were present at the examination. The reports refer to some of the children displaying fear and physically resisting the examination. In one case the examining doctor records that the assistance of four adults was required in order to facilitate the examination, in another it is said the examination was "*almost impossible due to her resistance and fear.*"

152. As in the case of LA-A26 at Ivy House, an inquiry was set up to investigate the allegation of child sexual abuse. It extended beyond the individual allegation to encompass "*other alleged incidents of child sexual abuse at the home*." Four senior staff were appointed as members of the Investigating panel and advisors, including a consultant paediatrician, a child protection consultant and a special schools team leader. The investigation interviewed all members of staff at Monkton street, the parents of children who were the subject of allegations and a number of social workers at Monkton Street. Further social work and medical files for the children concerned were inspected. The inquiry found that

LA-F26 had no disciplinary case to answer, although it notes that it was considered that in view of the strong feelings of parents it would "be extremely difficult for LA-F26 to resume his duties effectively". It also made a number of recommendations, including that a detailed Social Services policy and procedure be prepared regarding the handling of allegations of sexual abuse of children in care.

153. When in 1988 a further allegation of child sexual abuse was made against a different staff member at Monkton Street, LA-F2, a similar inquiry was set up to investigate. That panel found in relation to LA-F2 there were no grounds for disciplinary action .

ii. <u>The culture at Lambeth Council over time, including the relationship between members and councillors, and Lambeth's response to allegations of child sexual abuse</u>

154. The Inquiry has received evidence surrounding the structure of decision making and responsibility for children's services within Lambeth, and will hear evidence from former officers and councillors upon this issue. We will also hear evidence about the relationship between councillors and officers, and the ability or otherwise of councillors to hold officers to account. There is evidence that the relationship between councilors and officers was fraught at times. For example, Sub Committee meetings were described as having become "platforms for abusing social workers" and it is recorded that there was a meeting at which over half of the Social Services Directorate staff gave a vote of no confidence against the Vice Chair and Chair of the Social Services Committee. Sir Stephen Bubb and Lady Janet Boateng amongst others will give evidence from the perspective of councillors as to the nature of this relationship.

155. In 1965, following the abolition of the London County Council, Lambeth Council was created, and responsibility for children's homes was transferred. Since that time, roles and job titles within the Council have inevitably changed over the course of 5 decades. In essence, however, and in terms of responsibility for children's services, senior officer

roles within the Council have remained, and for elected members significant roles likewise. In terms of officers, in 1971 the statutory role of Director of Social Services was created to replace the previous role of Children's Officer. Since 2004, a Director of Children's Services was introduced, and the current Director of Children's Services role in Lambeth is held by the Strategic Director for Children's Services, who has lead responsibility for delivery of all Lambeth's children services for children and families. Councillors, meanwhile, have held positions over time as Chair of the Children's Committee or Social Services Committee, and since 2004 as Lead Member for Children's Services. Today, both the Director of Children's Services and Lead Member of Children's Services within Lambeth have a shared responsibility with all officers and members of the local authority to act as effective and caring corporate parents for looked after children.

156. You will hear evidence, Chair, upon whether there was effective management and leadership over time within Lambeth, and whether or not there was effective policy oversight from Councillors in relation to children in the care of Lambeth and the quality of their experiences. In terms of the knowledge management and leadership had surrounding services provided to children and risks to their safety, it is important to understand the chronology of Lambeth and the knowledge which was acquired on a cumulative basis. With this in mind, all core participants have had input into a working chronology prepared by the investigation team, and the result is a detailed document

which will doubtless be referred to during the hearing, and which will continue to be added to as the hearing proceeds.

157. Lambeth's knowledge and understanding of child protection and its response to allegations of child sexual abuse can be assessed in a number of ways. Firstly, by analysing information Lambeth obtained or should have obtained from individual complaints from children around child sexual abuse. With emphasis on the case study homes, responses to individual, recorded complaints of sexual abuse by children have been considered by the inquiry.

158. In addition, one of the most conspicuous features of how Lambeth responded to allegations against it, is the sheer number of internal inspections, reviews, reports and public inquiries which it commissioned or generated These are critical not just to understanding Lambeth's institutional knowledge and how it responded to a given incident or allegation, but to the question of whether the commissioning of reports became an end in itself- a convenient signal that something was being done but which changed nothing.

159. Whether the investigations and inquiries in the 1980s, 1990s and into the 2000s altered the experiences of children in care in any way is a matter which you, Chair, and panel, will doubtless have in mind throughout. The reports that were commissioned fall to be examined in terms of (i) what each report did *and did not* identify surrounding child protection and (ii) whether they substantively changed how Lambeth responded to child sexual abuse. In chronological order we highlight some of the reports below, and look at

the background from which Lambeth's institutional response to the sexual abuse of children is to be viewed. As stated earlier, none of the reports were undertaken before the 1980s.

160. By way of general background to Lambeth Council, its political turbulence, financial mismanagement and corruption in the 1980s have been widely commented upon, in the public domain. On the theme of financial control, Ms Hudson states in the Lambeth Corporate Witness Statement, *"the seeds of malaise went back to the decision by Lambeth Councillors in 1985 to refuse to set a rate as part of their political campaign against rate-capping. This led to surcharging in 1986, with 30 Lambeth Councillors being required to repay the amount the Council lost in interest and being disqualified from office. By 1988/89, there was a predicted overspend across the Council of £60 million. By 1990, in order to compensate for this overspending, 1000 jobs were required to be cut across the Council. When council tax replaced the community charge in 1993, Lambeth was required to collect £65.5 million. However, Lambeth only managed to collect 10% of council tax due for the year, the second lowest collection rate in the country. During this period at Lambeth, there is demonstrable evidence of financial mismanagement across the Council which would have had a significant impact on quality of service delivery to children in Lambeth's care and their families."*

161. Lord Mann tells us in a written statement to this investigation that he was elected to Lambeth Council as a Labour Councillor in May 1986 as part of a "*changing of the guard*". By way of explanation for that phrase - "*Shortly before my election, it was*

discovered and made public that the existing team of Councillors, led by the leader of the Council Ted Knight, had been involved in setting an illegal budget, and that this had resulted in the Council spending money it didn't have. When I arrived, the majority of existing Lambeth Councillors were in the process of being removed, and the incoming team comprised of largely first-time Councillors". The Inquiry will examine whether and if so how the introduction of so many new councillors at one point in time may have impacted upon the strategic oversight of children's services.

162. Given the extent of the budgeting irregularities experienced by the Council prior to his election, Lord Mann states that the Construction Services Committee of which he became Chair in 1988 had a particular focus on corruption in construction services. Lord Mann says there were two key aspects to this: (i) corruption in the Council's relationships with contractors – for example, the Council allowed specific contractors to underbid for the purpose of being awarded a contract, but then subsequently to vary the contract to increase the price, and (ii) major organised theft of materials (through, for example, duplicated orders). Lord Mann says "*At the time, Lambeth controlled vast swathes of housing, and this meant that the Committee habitually dealt with a huge number of construction contracts relating to the building and maintenance of the Council".* He formed an investigations team, and at its height the Investigations Team and Construction internal audit were conducting around 23 simultaneous investigations. Lord Mann says "*we found that corruption was endemic in Lambeth Council's activities in the local area.*"

163. There is evidence that area children's care was not immune from this corruption. The investigation understands that the senior children's homes officer was dismissed for fraud for selling food donated by Marks and Spencers to children's homes. A CHILE record refers to one member of staff having food to the value of £1300 in a home freezer. There is documentation from the Social Services Inspectorate recording concerns (shared by Lambeth) that the investigation into Ivy House, carried out by the senior children's homes officer, may have been tainted by corruption as a member of staff in Ivy House was also implicated in the fraud.

164. As noted above, Michael Carroll was implicated in corrupt practices in 1984 and ultimately sacked for fraud in 1991. One employee who worked at Angell Road gave evidence to the police of Michael Carroll also being involved in the collection of food from Marks and Spencers. She said that he took food home that was for the children. These are matters about which former counsellor Ms Tapsell may be able to give evidence.

165. Whether and in so far as financial constraint or mismanagement impacted upon the nature and extent of sexual abuse inflicted upon children in Lambeth's care is a matter which will be touched on by some of the witnesses in this investigation.

166. From the investigation's perspective, it is right to point out that sweeping generalisations around finances cannot begin to explain the scale or context of the sexual abuse which took place within Lambeth. Taking the early 1990s as an example, in 1991, the Social Services Inspectorate noted Lambeth's spending on social work staffing to be the joint

highest in London. (LAM013007). The same report noted that social services spending per head was the third highest in London. Lambeth was the third highest spender in London on children's services per head of child population – the second largest children's budget in London. A 1993 SSI report noted, gross spending on children's services to be the highest in London. Gross spending on residential services was the highest in London (LAM014141 at 60). Furthermore, a review by Faith Boardman in or around 2002 noted that over the preceding five years authorised expenditure available to Social Services rose from £100m a year to £172m a year. The review reported that despite that increase, over the past 40 months Social Services had overspent by nearly £30m. She described it as a major threat to the Council's stability.

167. Returning then to the Lambeth commissioned reports. In 1986, two contrasting management inquiries were set up in response to the allegation of sexual abuse made by LA-A26 against a member of staff at Ivy House and referred to earlier. A first management inquiry was set up immediately after LA-A26's allegation had been reported by the social worker Ann Worthington. A three person panel produced a 5 page report which summarised the evidence of the social worker and the co-workers of LA-F12, including the officer in charge from Ivy House. Neither LA-A26 nor her parents were approached to give evidence to the panel, nor was any specialist advice or report sought from any person with experience of complaints of child sexual abuse or of the particular complex needs of the child. The report concluded that there was "no suggestion" that the case be pursued.

168. In December 1985, Robin Osmond, the Director of Social Services wrote to the parents of LA-A26 saying there was no evidence to substantiate a charge against LA-F12. This was followed by a letter on 3rd January 1986 from Robin Osmond to all Ivy House parents, referring to allegations made by parents of a child at Ivy House and the fact that the police carried out a formal investigation and "could not find evidence to substantiate a charge".

169. The family of LA-A26 were deeply unhappy with the outcome of the First Management investigation and the fact that LA-F12 was back working at Ivy House. They contacted the Children's Legal Centre, who in turn wrote to Janet Boateng requesting a full inquiry and that LA-F12 be suspended pending the inquiry outcome. A second management investigation followed, which you will hear evidence about. With a differently constituted panel, and after receiving expert evidence, it recommended an immediate disciplinary hearing against LA-F12. At the disciplinary hearing against LA-F12, the management team presented the evidence in support of the allegation that LA-26 had been sexually abused by LA-F12.

170. The Disciplinary panel found, in short, that it was convinced that there was a high probability that LA-26 has been abused; that it could have happened at Ivy House but a majority of the panel do not think on balance that has been shown to be a high probability; and given that position the case against LA-F12 was not proven.

171. The Brixton Family Support group wrote an open letter to the then leader of the Council setting out the family's anger that LA-F12 had been cleared of gross misconduct, and

demanding a public explanation as to why LA-F12 was able to continue working with some of the most vulnerable children in society.

172. The seminal report of the death of Tyra Henry was published in 1987. It was called 'Whose Child? - a reflection of how Lambeth lost sight of its responsibility for Tyra. This was not a report about child sexual abuse, but it speaks to wider issue relevant here.

173. Tyra died of what the report described as "extensive and appalling injuries" in 1984, whilst in Lambeth's care (aged one year and ten months) and on the 'At Risk' register. She was murdered by her father. Her brother (in 1982) had suffered what the report described as terrible and permanent injuries (blindness and brain damage) as a result of deliberate harm. The children's father was acquitted of causing these injuries on the basis that it could not be said that it was he (as opposed to anyone else) who had inflicted them (Chapter 2, paras 16- 18). The report detailed failings which left Tyra at risk. She was cared for by her grandmother but, directly related to her death, her mother removed her from the grandmother's home when the electricity was cut off. Lambeth Social Services was aware of severe overcrowding in the family home and that the electricity had been cut off. The report notes *"Nor is there any sign of an active and urgent response to the information that a child in Lambeth's care was in a situation where on top of all the other known problems, there was now no electricity and no near prospect of restoring it unless the council took on the task. There was no apparent appreciation that the possibility of using candles for light in a household which had earlier lost a child in a fire must have been a real source of fear.....It is unsurprising in all these circumstances that Claudette*

moved with Tyra into Andrew's flat and that Beatrice Henry let Tyra go….". [Chapter 4, para. 32].

174. The Report reiterated that it was the local authority corporately which bore responsibility for providing support and maintenance to children in its care; *"The failure of its directorates to work adequately in harness is a failure for which, constitutionally, the elected members are answerable……We point this out in order to stress that if the limbs of a local authority are not working in coordination, this is itself represents an incipient failure on the part of the local authority to carry out its functions"* [Chapter 6 para. 9]. Those who gave evidence to the Inquiry included Robin Osmond, David Pope, Jack Smith, Stephen Bubb and Janet Boateng.

175. In 1988 Robert *Morton*, Principal Manager Children's Homes wrote a report for the Children's Homes Sub-Committee [LAM028710]. Within it he stated: "*Having been in post for less than 3 months, there are areas and issues within the section which are extremely worrying, unacceptable and are requiring urgent attention.* " And later in the report, "*The extent of the problems within the Children's Homes Section cannot be underestimated. The present situation has not occurred overnight, it has evolved for whatever reason for over many years. The results of ineffective management, bad planning and poor practice are now being tackled. This process in itself is causing further problems and in fact uncovering even more issues of concern. In relation to the circumstances of the staffing and resources, we are simply unable to maintain the present level of care never mind improve. Staff sickness is extremely high, every day the section is*

struggling to staff homes. The present situation cannot prevail and will collapse without change".

176. Mr Morton provided a further report for the Children's Homes Sub-Committee for its meeting on the 16th November 1988. In it he stated: " *My last report was frank and detailed, relating to the serious situation within the section…. I would simply state the situation is still extremely serious".* It was accompanied by a report from Mr Byron, the Children's Homes Placement Manager. Mr Byron stated that he was *"frankly appalled"* at the state of affairs that awaited him upon his appointment in September 1988. "*Information and filing systems which are unwieldy at best and at worst unworkable. Inadequate recording procedures, with information in some cases years out of date. There were no established procedures for dealing with referrals and placements. Monitoring control systems simply did not exist. The state of affairs did not result overnight but would appear to be the result of years of neglect and inefficiency."*

177. In January 1990 the 'Report of the Enquiry into South Vale Assessment Centre' [Zephyrine Report] was published. The panel drawn from Lambeth staff was set up to investigate fully the management and running of Southvale with particular regard to the allegations made by staff of racism, sexism and bad childcare and management practices. It had the power to call children to give evidence. We understand that it did not hear from any children. The Zephyrine report did not find misconduct at Southvale but said that it was *far from happy* with certain practices. Whether this was a missed opportunity to

uncover sexual abuse is an issue which we will return to in this opening and in the evidence.

178. A Lambeth review of placements at Private and Voluntary Homes suggests in February 1990 that there were 187 children placed in Private and Voluntary Homes and 'regional establishments.' The review states that this was at variance with central records which showed that between 5 February 1990 and 22nd February 1990, 69 placements were made in Private and Voluntary Homes. The review highlighted the high level use of such placements, and that children were in residential care solely because of housing difficulties. It noted that there were ineffective monitoring systems; statutory reviews were not being carried out in time and there was not a great deal of evidence of preventative work. Robert Morton wrote to Jack Smith (Principal Officer Social Work) in the following terms: " *I am particularly concerned at the apparent lack of the statutory reviews and care plan action relating to children in our care and through your appropriate line managers I wish to be made aware of how these issues are developing.".*

179. On 20th September 1990, a final report from Mr Morton was presented to the Children and Young Person's Committee. He stated: *"my personal fear, concern, and indeed a factor of my decision to move on, relate to the standard of care, lack of planning and lack of adherence to good professional standards and procedures remains'*. Mr Morton made clear his opinion surrounding placement of children and that Lambeth continued to admit young people into care contrary to policy, and when it was totally inappropriate to do so. Young people remained in care due to lack of planning, intervention and appropriate

resources. The number of under 5 year olds admitted into care grew and the timescales for young people in care continued to escalate.

180. On 1st January 1990 Ms Whelan wrote to Virginia Bottomley, and highlighted that she had become "*more and more concerned about Lambeth children's services.*" In particular, Robert Morton's grave concerns and his 1990 report; continuing problems at Southvale Children's Home, and The Melting Pot Foundation, of which she stated: "*a hostel for black adolescents funded in the main by Lambeth. I believe funding should have been immediately withdrawn because of a recent inquiry. It has not."* [CWH000037].

181. In 1991, The Child Protection Services in Lambeth Report ('CPSL') considered the extent to which Lambeth had responded to the recommendations in the reports which followed the deaths of Tyra Henry and Doreen Aston. It detailed, amongst many other outstanding issues, the use by Lambeth of unqualified social workers (paragraph 8.2.7) and the delay in conducting child protection investigations. It also referred to confusion about the number of unallocated cases (paragraph 5.5). On 6th November 1991, Virginia Bottomley MP wrote to Councillor Nicholas about this Inspectorate's Report. The letter refers to Lambeth having a level of unqualified social workers which was 14% higher than in other boroughs.

182. On 7th November 1991 Lambeth produced a report regarding Norbert McCooty.This report was instigated by the Judge at the Old Bailey who sentenced Mr McCooty. The Judge had asked Lambeth to investigate why Mr McCooty had not been in secure accommodation and therefore been at liberty to rape a 53 year-old woman. At para

8.27-8.29, the report sets out that the Council had no legal power to delegate functions to members, and yet this is what had happened in relation to decisions to place children in secure accommodation. In the McCooty case, the report records that the Chair did not agree with the report of a social worker that Mr McCooty be placed in secure accommodation. The issue which arises and which is relevant in this investigation is whether Councillors were making decisions, which affected children, in a way which was appropriate. Where did the line lie between decisions which were a matter of professional judgement for officials and decisions which were for councilors.

183. In April 1992, a Social Services Inspectorate report identified Lambeth as having one of the highest numbers of unallocated cases in London and that this was a cause for concern. The report stated of Lambeth (and other councils with high levels of unallocated cases) "*this represents a serious long term failure to fulfil statutory responsibilities towards children requiring protection."* David Pope replied to the SSI suggesting amongst other reasons that penalties, rate capping and poll tax capping linked to financial management difficulties limited the ability of the Council to provide sufficient resources for child protection.

184. In 1992, The Parliamentary Under-Secretary of State wrote to the Leader of the Council and asked for arrangements to be made for a management review to be undertaken by a person independent of Lambeth Council into the circumstances of the employment of Carroll as Officer -in-charge at Angell Road, and to whom I have already referred. Richard Clough was subsequently appointed to undertake this review.

185. As you will hear in evidence, a number of matters came to a head in 1992. In December 1992, Mr Yeo notified Lambeth Council that he had asked the Social Services Inspectorate to conduct a full inspection of Lambeth's residential services to commence in 1993 .

186. As I have mentioned in relation to Angell Road, in March 1993, the SSI published the 'Report of an Inspection of Three Residential Children's Homes in the London Borough of Lambeth.' This inspection took place in the context of media reports about the behaviour of staff, concerns over control and the appointment of staff in residential child care for children in Lambeth. The homes inspected were Stockwell Park Road, Lorn Road and Angell Road. The inspection noted, amongst other issues: a lack of police checks on staff; inadequate record keeping surrounding visitors; high levels of staff sickness, vacancies and reliance on agency staff; lack of training and support in child protection; lack of planning for children; and poor recording keeping.

187. The Clough Report was provided to Lambeth in May 1993. Unsurprisingly it concluded that the decision to retain Michael Carroll after his conviction came to light was wrong and legitimised Carroll's position as a carer in whatever setting. Henry Gilby was Chief Executive at Lambeth between 1993 and 1994 and in a statement to the Inquiry says that he met Mr Clough as soon as the report had been submitted to the Council and he asked Mr Clough to reconsider making recommendations to the Council (none were made within his report). The Inquiry will hear oral evidence from Mr Clough and will consider his report and decision-making around recommendations.

188. In 1993, a report into the death of Mia Gibelli (LAM014045] was published. Mia Gibelli did not live in a children's home but with her mother. She was killed by her mother in circumstances where Lambeth knew she had previously attempted to kill Mia's sibling. The report made a number of criticisms relevant to Lambeth's social services and its provision of social work. Tim Yeo MP is reported to have said in an interview with LBC radio [LAM009811]: *"Lambeth have been once again guilty of the grossest degree of incompetence, but it is, I am afraid, part and parcel of their record generally in relation to childcare"*.

189. In early 1994, Lambeth received a copy of the 'Investigation into Alleged Breaches of the Council's Equal Opportunities Policies in the Housing Department' (also known as the Harris Report or the Three Women Report). Although this was a report concerning the Housing Department, it also raised issues about the possible abuse of children. According to a statement provided by panel chair Ms Harris, the Director of Housing Service had indicated that allegations had been made which concerned the issue *"that pornographic material had been exchanged amongst officers in housing and elsewhere."* I will say more about the Harris report later. For now, Ms Harris says in a statement to this Inquiry, *"I do not recall any person disclosing allegations of child sexual abuse during the time the Panel was investigating, preparing, or writing the report"*.

190. Yvette Adams was a senior Human Resources professional employed at Lambeth from 1989 to October 2000. She was also asked to sit on the Investigation Panel for the Harris report. Commenting on the culture within the social services department and the Harris

investigation, Ms Adams said in a statement to the Inquiry: *"I would say that the advent of the equal opportunities policies and processes ensured the organisation stopped functioning according to custom and practice - functioning started working towards being more transparent, with explicit policies, procedures, and accountability lines. Under the old set-up pre-1980, this investigation may never have taken place and this is made reference to in the report. On the other hand, the implementation of the Council's EOP only scratched the surface as long standing managerial networks still operated with impunity. The culture was very much about who you know and it was mainly a white organisation which recruited in its own image."*

191. Elizabeth Appleby QC's report was commissioned in April 1993 and she reported in 1995. Of the turbulent period in the 1980s, Elizabeth Appleby QC subsequently found and stated in her 1995 report: *"I am satisfied that in the 1980s Lambeth's ruling party was intent on obstructing the implementation of government policy in a number of areas. The facts clearly indicate that it had little or no regard to reducing public expenditure, that it refused to accept the consequences of the abolition of the Greater London Council, that it embarked on a policy of protecting its workforce at all costs, thereby undermining the compulsory competitive tendering legislation...Further, I am satisfied that Lambeth operated an unwritten policy which served to undermine and severely prejudice the collection of rent arrears, the collection of poll tax, and later the collection of council tax".*

192. The Appleby Report documented widespread dysfunction in the operation of the Council and its Directorates. Ms Appleby QC concluded: "*Lambeth is in an appalling mess. The financial control of Lambeth is such that vast amounts of money are wasted and, in consequence, services are severely prejudiced. What is so surprising is that many defects in Lambeth's administration have been identified time and time again by internal audit, by the District Auditor and by independent reports. It seems that while the conclusions and recommendations flowing from the audits and reports have been readily accepted by chief officers and the political leadership, Lambeth has been totally unable or totally unwilling to translate its plans and ambitions into positive actions. Lambeth seems intent on living in the past and never improving its future."*

193. In April 1994, there was an SSI inspection of the Inspection Unit in Lambeth Social Services Department. The inspection concluded that the Lambeth Unit had not been able to reach its statutory and advisory targets. There was a further SSI inspection in May 1994 This was to assess progress after the 1993 inspection. A number of failings continued to be noted. These included that basic information about children was missing from their files; written care plans were not on file or known to staff; and training on child protection had begun but progress was uneven. The report stated *"overall the improvements were limited and patchy, and some worrying essentials of practice (care plans and supervision) were still not adequate."* In 1994, Anna Tapsell wrote a memo to the Director of Social Services in which she raised concerns about unallocated cases .Ms Tapsell received a letter in response from a Minister in the Department of Health (in her

capacity as Chair of the Social Services Committee) in which he recorded that the situation surrounding unallocated cases had seriously deteriorated, particularly for looked-after children.

194. In May 1999, John Barratt, having been commissioned to write a report surrounding allegations of sexual abuse made against Steven Forrest, issued an interim report. He did so because of his *"...deep concern about the continuing fractured and ineffective practice of child protection by Lambeth Social Services Department"* On 30th September 1999, John Barratt's report 'The Lambeth Independent Child Protection Inquiry 1999' was published. This was the first report into the allegations that a child in Lambeth's care had been sexually abused by Steven Forrest. Mr Barratt stated at the outset of his report that the catalogue of organisational incompetence that characterised the care of LA/A29, from his reception into care in 1984, was *shocking* (paragraph 2.1.1).

195. There was an inspection in May- June 2000 by the order of the Minister of State for Health. Its overall impression was of a children and families division struggling under considerable and relentless pressure. In many areas basic work systems were functioning poorly or had collapsed. This led to inefficient, fragmented and inconsistent work practices. The SSI noted:

"We were particularly concerned about potentially large numbers of children who had not properly been regarded as looked after. They had not been allocated a social worker, were not placed with approved carers, and had none of the protection afforded by visiting

monitoring or statutory reviews. Urgent action was needed to trace these children and secure their safety"

Furthermore, significant numbers of looked after children and those on the child protection register did not have social workers.

196. In August 2000, the Chair of Lambeth's Inspection Advisory Panel resigned, stating in a letter to the Leader of the Council that "*the performance of the Directorate, which is consuming huge resources and not delivering acceptable services, represents a betrayal of some of the most vulnerable members of the community and after careful consideration I feel that my continued involvement in this Authority would be a form of collusion with its mal-administration."*

197. In November 2000 the Secretary of State for Health (the Right Honourable John Hutton MP) wrote to the Chief Executive at Lambeth to say that Lambeth Social Services Directorate was to be placed on the list of monitored authorities. [The Minister wrote: "*I am extremely concerned about what the effect of failures in basic statutory responsibilities means for the safety and welfare of children in Lambeth"*. Directions under Section 7A of the Local Authority Social Services Act 1970 were issued, to "*ensure that Lambeth takes the action required to rectify the situation by 31st August 2001*.

198. Key areas for which statutory directions were issued included: all looked after children placed with foster carers, in children's homes or with parents should be visited at the frequency required by the relevant legislation; all children on the child protection register

should have an allocated social worker; a formal protocol with the police to guide inter-agency working in relation to child protection should be produced; the approvals of all local authority foster parents should be reviewed at the required frequency and all prospective foster carers should be checked against the list maintained by the Secretary for State.

199. On 24th October 2000, John Barratt's final report 'Two Lambeth Independent Child Protection Inquiries 1999-2000' was published. He drew three basic conclusions:

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

(ii) The Council has repeatedly tried during the last decade, but repeatedly failed, to create and control an effective department and division.

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

200. In September 2001, LA/A135 (1986-2001) died and was the subject of a Part 8 Case Review . LA/A135 had been in the care of Lambeth since 1990. The Part 8 review noted that LA/A135 had been placed by Lambeth in a home in 1991, despite being informed of concerns about this home by Surrey Social Services.

Birtley Farm House was for teenagers with therapeutic needs - this child was seven years old when he was sent there. He was supposed to be there on an emergency basis. He was there for five months .

201. LA-A135 said that he had been abused while living there but was not moved for several months. According to the Part 8 Case Review, when he was interviewed in May 1992, LA-A135 was neither then nor at any later date offered assessment, counselling or therapy of any kind . LA/A135 took his own life in Feltham Young Offenders Institution. The review described the care afforded to LA/A135 as an *"object (sic) lesson in the potentially disastrous consequences of failure to plan/implement plans for children in care."*

202. In December 2001, there was a re-inspection of Lambeth required by the Secretary of State for Health. [LAM018930]. This was a re-inspection to assess progress in meeting the statutory directions issued in November 2000. It identified a number of areas of improvement, including reviews of foster carers and appropriate checks being conducted on foster carers. It detailed a number of key issues that still had to be addressed, including that all looked after children in foster homes, children's homes or placed with parents should be visited at the appropriate frequency .

203. In March 2002 Lambeth was subject to an improvement plan (LAM019939). In a letter to the Chief Executive, Jo Cleary (Assistant Chief Inspector, Social Services Inspectorate) wrote that the monthly monitoring data produced by Lambeth *"shows steady progress, which gives confidence of future sustainability"*. Lambeth was thanked for its openness and responsiveness in its relationship with the SSI. In 2007 Ofsted assumed responsibility for the inspection and regulation of children's services. We will consider their input at a later stage.

204. Chair, this is just an overview of key points in the Lambeth chronology. It is not the full picture – as you will hear there were criminal investigations, trials and the Children's Homes in Lambeth Enquiry. In short, many other sources of information to Lambeth about what was happening to children in its care.

205. You will hear from witnesses who were in Lambeth, as officials or as councillors at critical points in this chronology; some had responsibility for responding to these investigations, the responsibility to make change. You will hear from Directors of Social Services and Chief Executives. The issue is whether Lambeth was impervious to real change when it came to children in its care. We will invite witnesses to stand back from this chronology and to explain why, into the 2000s, despite all these investigations, reports and inquiries Lambeth still appeared to be falling fundamentally short in respect of child protection.

206. May I turn now to the case study homes and Lambeth's responses to allegations of abuse. This will not be an exhaustive summary for obvious reason. It will, however, highlight the issues to be explored within each of the case study homes.

Shirley Oaks

207. Purported management of Shirley Oaks changed over time. Between 1965 and 1973, Shirley Oaks operated as one large children's home with individual cottages on site. A Superintendent reported to the Council via a Committee. In April 1973, the centralised management structure of Shirley Oaks was disbanded and each of the cottages operated as a semi-autonomous individual children's home. Officers-in-Charge ran the homes, in consultation with the Group Management Officer based within the Social Services Directorate. Despite the reality of the sexual abuse being perpetrated within Shirley Oaks, the investigation has received no written evidence to suggest that allegations of sexual abuse were formally referred to the Council Committees or were discussed at Group Management Officer level.

208. There was no procedure in place for children to report any personal concerns in a secure and confidential manner. Mr Lewis, a housefather at Shirley Oaks between 1972 and 1982 said that he would tell children to go to "the Lodge" if they wanted to report anything. Lambeth explain that the Lodge was likely to be an administrative building but there has also been reference to a flat at the Lodge that was commonly referred to as 'Lodge House'. [AH/5, para 3.22] Other evidence suggests Lodge House was occupied for many years by a Superintendent, LA-F93, who was himself abusing children.

209. Few contemporaneous documents have been located which record allegations of sexual abuse being made. However, children providing statements as adults say that they told members of staff about abuse and describe the way in which Lambeth responded.

Responses ranged from explicit disbelief and punishment, to limited efforts to remove the alleged perpetrator from their role. Children report nothing being done, and feeling less able to report other concerns. No child describes a sympathetic response or anything which led Lambeth to carefully assess the allegations or investigate the risk to other children.

210. LA-A64, LA-A50, LA-A341 and LA-A108 are some of the children who describe telling staff including house parents about being sexually abused but nothing being done in response. LA-A341 complained to his housemother about a sexual assault by a social uncle which occurred on a trip out of Shirley Oaks; She *'didn't say anything and I left it at that. Nothing ever happened when we told adults about things'*. This same housemother dismissed LA-A50-'s complaint about a social uncle's sexual assault as the man *"only playing."*

211. Hosegood's abuse of LA-A69 started when she was about 6 or 7 years old. Hosegood abused her and another girl she shared a bedroom with. Hosegood told LA-A69 that if she said anything about his behaviour to anyone, he would kill her. She was terrified of him and believed him. When she did find the courage to tell people she was not believed.

212. In 1978, a former resident of Shirley Oaks wrote to The Children's Homes Officer about an 8 year old's allegation of sexual abuse by a much older child at the home. She said to the Children's Homes Officer: "*I'm writing in the hope that you will resolve a very serious problem that has been worrying me for weeks*". The writer knew that the young child had complained about being touched by an older child, but that the child's

housemother (LA-F65) flatly disbelieved the allegation. The housemother told the writer that *"she had discussed it with the group Social Worker who visits the house and also with the psychiatrist and they all came up with the conclusion that it was in LA451's mind."* In response to the letter, the Children's Officer wrote: *"Thank you for your letter setting out your concerns... The allegations you make are indeed taken seriously and I am arranging for an investigation to look into the matters you raise."* No investigation or follow up has been located within the documents , despite the powerful nature of the letter and its ending - *"Please do not treat this letter as just another complaint, it is more of a 'plea' than anything. Please do something."* Disturbingly, the writer had made it clear that she understood that the abuse was continuing, as the young child was frightened to tell the housemother because she wouldn't believe it.

213. There is plenty of evidence that staff and children alike were aware of numerous rumours about various perpetrators. LA-F93 was referred to as someone to avoid. LA-A164 says of LA-F92 he *'would call the pupils to his desk which was at the front of the class room, to look at their work. You would stand beside him looking at your book on the table. He would put his arm around my waist.."* and indecent assault is described. "*I remembered this being odd at first, but he did this to all the girls, it was the way it was.*'

214. Whilst Hook worked at Shirley Oaks, LA-A197 recalls that other boys used to say Hook touched them. Various staff refer to their being widespread rumours. This includes Donald Thomas who was employed by Lambeth between 1966 and 1986 in various management roles, including Senior Children's Homes officer in the 1970s before

becoming Principal Children's Homes Officer. In his statement to police in January 2000 Mr Thomas says *'I am aware that there was possibly some concern or a rumour about an incident. It was of a nature I cannot recall at this time. He did leave Shirley Oaks I had no further contact with him.*'

215. Hook groomed children. LA-A64 refers to the special attention and gifts he would receive from Hook, such as a watch and a bicycle. In her statement to police dated September 2000, LA-A64's sister recalls *'I also remember my mother being very concerned about this man [Hook] when he bought LA-A64 a bicycle, I can remember her confronting LA-F65 on more than one occasion about different issues concerning LA-A64 but I can't remember now exactly what they were about. Nothing ever seemed to change'*

216. LA-A63 refers to Hook giving him extra pocket money and presents after he began sexually abusing him. Despite these rumours and evidence of gifts, Hook, an unpaid member of staff, was not subject to investigation by Lambeth.

217. Many staff also had suspicions about Clarke. A Lambeth social worker between 1970 and 1978 recalls that "*we all had our doubts about Geoff. By this I mean myself and other members of staff.*" *'The reason we had doubts about Geoff was because we couldn't really understand why he was there at Shirley Oaks, spending so much time with the children without getting paid for it. ...generally he was trusted to spend time with the children unsupervised, within and outside the house. .. ...In the evenings he'd take the children up to bed. He'd go upstairs on his own with them. He'd spend some time up*

there. I don't know how long generally, but it was long enough for us to assume he was reading to them. Probably at least half an hour or more, possibly longer.'

218. One housefather between 1978 -1991 describes a child coming back from swimming with Clarke and complaining about having to get changed in the same cubicles. This caused him to make a complaint about Clarke. The housefather says : *'We were told to discuss our concerns with Clarke which we did. He was very defensive about the whole matter and said something like "What are you trying to imply?" I told him that we weren't trying to imply anything but wanted an explanation and he ended up walking off and refusing to discuss the matter further. Despite having reported the matter to our management, nothing further happened'*

219. Even when concerns became individually pronounced in relation to a particular child, Lambeth took no action. The relationship between Clarke and LA-A51, for example, was clearly a source of concern. Clarke was asked to limit the time he was spending with the child**.** Furthermore, LA-A51's father wrote to the Council questioning whether Clarke was fit to work with children. In addition, a letter in 1975 addressed to 'Admin and Legal' from the 'Committee Secretary' states that it encloses copies of a letter from LA-A51's family *'in which a serious complaint is made concerning a member of staff at Shirley Oaks'*. The writer states *'I have acknowledged receipt and said that the matter is being immediately investigated by Social Services Directorate'*. It also says additional copies of the letter were enclosed so that 'if desired' the letter can be passed on to others.

No evidence has been found of any such investigation. During Operation Middleton LA-A51 told police that he had been sexually abused by Clarke whilst at Shirley Oaks.

220. LA-A67 provided a statement to police in February 2000. He gives an account of abuse by three men at Shirley Oaks. These included a man referred to as the 'boiler man' who other children also describe as perpetrating violent sexual abuse against them [LA-A134 and LA-A76]. He was then abused by LA-F93, who used to take LA-A67 out on day trips. LA-A67 was terrified of this man but his housemother told him that he was lucky to have the opportunity for a trip out of the home. After the trips, LA-F93 would take him back to the Lodge and abuse him. On one occasion, LA-F93 had his hands around LA-A67s throat who was crying. LA-A67 thought he was about to die. LA-A67 returned home. He must have cried out during the night because his house mother woke him and he told her about the abuse. The housemother told him not to be 'so stupid.' The next day she said she did not want to discuss it and kept him away from the other children in his own room as though he had done something wrong.

221. Staff witnessed inappropriate and abusive conduct by Hosegood and yet it was not investigated. LA-A25 says a staff member witnessed Donald Hosegood looking at her naked . One recalls witnessing Hosegood going into the toilet with LA-A25. She says: *'Mr Hosegood would on occasions behave inappropriately in my opinion. For example he would come downstairs dressed only in a towel around his middle in full view of the children. One day I saw him walk into a toilet which LA-A25 was already using. It was early in the morning, shortly after I'd come on duty… and was a few months after I'd*

started working there…. He didn't knock he just marched in. I felt that his behaviour was totally inappropriate and challenged him. He told me that his wife was in charge and simply dismissed my concerns. I witnessed him do this on about two or three separate occasions. I hadn't been working at Shirley Oaks for very long at this time and didn't take the matter any further.'

222. Another member of staff told the police ….: '*It was difficult to speak out against other members of staff particularly if you had concerns about them but no proof. It would place you in a vulnerable position in fear of losing your job*.'

223. Even when staff witnessed abuse, children were not subsequently protected. LA-A63 was a victim of Hook's, and recalls that his housemother LA-F65 walked in on an incident of abuse but did nothing. LA-A63 said in his December 1999 statement to police that he was lying on the bed naked and Hook was sitting on the bed next to him. He remembers '*the door opening and LA-F65 was standing there' Hook told her 'it was alright, I was not feeling well and he had put me to bed'*. LA-A63 goes on *'LA-F65 would have seen us'.*

224. A housemother found an alleged perpetrator, LA-F37, in the bedroom of LA-A76's which she shared with her sister and another girl. He had sexually assaulted her, then hid under the bed before assaulting her again – and then behind the door when she went to get help. The housemother caught him behind the door and told him to leave. LA-A76 then heard other men arrive who she thought were senior managers. LA-A76 was too afraid to tell the housemother what had happened and that she had been sexually assaulted. She made up a story instead. She says the housemother *'ended up making me*

feel responsible about the welfare of his [LA-F37's] wife and child. She made it quite clear to me that he had a wife and a child and they would be in trouble, and because of what she said about them, it shut me up.' The housemother made her go to confession.

225. In police statements provided in 2001 and 2002, the incident was remembered by LA-A76 and a housemother who remembered LA-A76 waking her in the night and saying that a man was in her room. She took the girl back to her bedroom and found the man hiding behind the door which connected the house to the neighbouring home. She said 'I knew there was something untoward.' The housemother reported it to the Acting Head at the home, and LA-F37's wife. Police were not involved**.** Two different staff members refer to it all 'being kept very hush hush'. 'When they left, it was all hushed up'. [MPS003703]. LA-A76 reflects *'They were cowards, because they weren't going to help us with it and would say it was for our own good just to forget it. This was unfair as those things stick with you for life [...] They could have helped me then but they didn't want to, they just wanted to shut it up. I told LA-F93 about it, but there was no point in that because he was up to no good himself. I used to watch him when he was touching my brother'.*

226. Donald Hosegood was employed at Shirley Oaks as a housefather at Cedar Cottage and Fir House between May 1968 and October 1975. He was jointly appointed with his wife, who was a full time housemother. Contemporaneous allegations of sexual abuse by Hosegood were made by or on behalf of 6 of the 8 children accommodated in Fir House,

and one other child. Children were interviewed by the police and Hosegood stood trial in 1975.

227. An internal Memorandum written in September 1974 by the Senior Children's Homes officer to the Director of Lambeth Legal Services sets out the fact of the allegations by the children, the police interview and referral of the case to the Director of Public Prosecutions, noting that the police investigation '*has pre-empted any enquiry we might make'* and that the allegations had not been pursed in depth and that they are categorically denied. The Memo states: *'It is the belief in this Directorate that the majority of the accusations against the housefather are pure fantasy. The history of the children is that some are given to sexual fantasy and the previous relationship between the housefather in [sic] these children also suggests an element of victimization against him'*

228. The reply Memorandum from the Director of Admin and Legal Services, sent one week later, states *'my view is that the least said the better on this matter until a decision has been made by the police authorities in respect of the allegations. Once the decision is made then the situation can be reviewed in light of that decision.'*

229. Philip Temple, eventually convicted of 27 charges relating to child abuse in 2016, admitted to having been disturbed by a female member of staff when he assaulted LA-A5, something the victim also refers to. *'I remember one occasion when he was doing this to me when a lady walked in on us, I don't know her name, or who she was, I presume she*

was a female member of staff. I remember that he made out to her that I had a bruise on my leg'.

230. In February 1977 sexual abuse allegations were made against Temple. He was the Officer in Charge. These were reported to the police; investigated but no charges followed. You will hear more about this in evidence.

231. Temple returned to work on 2nd March 1977. The very young Deputy Officer in Charge at Rowan House was not content with his returning to the home, to the children who made the allegations. She conveyed this to management who did not take action. An account of what happened is recorded in the records of one of the social workers involved at the time and who described how the Officer in Charge felt '*very bitter about how the matter was managed*'. In a meeting with Temple , at which two members of staff management were present, including the Principal Officer of children's services, it was this young Officer in Charge who '*had to confront'* Temple and was *'virtually put in the position of justifying her refusal to accept him as Housefather at Rowan.'* In response, Temple '*accused her of envy'*. After this, Temple '*had requested a meeting with all the staff at which they were instructed not to refer to the sexual allegation at all, ie. they had to reject him purely in terms of House Management. The Officer in charge had purposely said nothing at this meeting but all the staff had expressed strong feelings that his attitude to the children had been inappropriate.'*

232. In April 1977 the family of LA-A4 reported that he had also been sexually abused by Temple. These allegations were put to Temple by 'two senior managers' *"whereupon he*

admitted that there was truth in it" and resigned immediately. An officer employed by Lambeth responsible for recruiting and supporting staff recalled Temple admitting the allegations were true. The officer stated he later received a letter from Temple in 1977/1978 apologising for betraying his trust.

233. Patrick Grant took over the role of Officer-in-Charge at Rowan House upon the departure of Temple. On 8 February 1978, Grant was suspended after he was charged with 10 counts of indecent assault of boys under 16 years. The abuse was alleged to have occurred both at Rowan House and during his previous employment at another children's home. Whilst awaiting trial, on 26 June 1978, Grant returned to work and was temporarily transferred to Adult Services to undertake administrative duties until the conclusion of the trial. On 2 October 1978 he was offered a secondment to undertake training to become a qualified social worker. It is understood that the judge at trial directed the jury to acquit Grant. There was no misconduct process. Grant was therefore able to carry on working with children, apparently completely unchecked and unrestricted. Lambeth agree that its treatment and promotion of this perpetrator was 'deeply disturbing' [AH/1 para 6.32.] The consequence was that Grant was able to continue working in the childcare system until 1991, and thereafter for probation services. As I will explain, his conduct was to catch up with him and he was to be convicted, but not until 2019.

Angell Road

234. Consideration of Lambeth's response to Angell Road, starts with consideration of its response to Michael Carroll's conviction. In 1986 Robin Osmond, the then Director of Social Services received a telephone call from Croydon Council to say that an assessment of the Carrolls as foster parents had revealed Carroll to have been convicted of a sexual assault upon a child. This led Lambeth to institute a misconduct process against Carroll. The investigation understands Carroll's account to have been that he was 17 years at the

time of the offence, in care, and that the conduct had been *horseplay* between boys of the same age..

235. The misconduct hearing was chaired by David Pope. Lambeth was provided with the Court register which gave some background to the offence. This made clear that the offence occurred on 7 October 1966 [Carroll's DOB was 13 September 1948] when Carroll was 18 and that the victim was 12 years old [LAM001506]. A letter from Merseyside Police stated that Carroll as a former resident of St Edmunds had entered the bedroom of the 12 year old boy, tickled him, then sexually assaulted him. This information was received by Lambeth [LAM0001509].

236. An issue you may want to consider Chair is whether Lambeth elected to accept Carroll's version of events rather than those conveyed in the records it received. You may also wish to consider whether Lambeth conveyed, as time went on, Carroll's version of this offence – taking up his characterization of it as horseplay-as opposed to sexual abuse. As one Social Services Inspector put it in 1992, "it seems extraordinary that sexual behavior between an 18 year old and 13 (sic) year old boy is accepted as horseplay and not constituting a sexual assault. Where does Lambeth get its ideas from?" CQC000297 / 3

237. It appears that the decision to retain Carroll was to put Lambeth in a bind when, not long after the misconduct process, Carroll applied to foster children in the care of Lambeth. Croydon, you will recall, had said no to the Carrolls' fostering application. Lambeth asked Wandsworth to consider this application on its behalf.

238. The social worker who undertook the assessment of the Carrolls made the following entry in her records for 14 March 1988:

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

239. This record supports, on the face of it, that a Lambeth officer was suggesting that Wandsworth should make a misleading entry in its report about Carroll's criminal record. Counsel to the investigation rely on the contemporaneous reocrds of the time in respect of this issue and the written witness evidence to the effect that Lambeth officials asked Wandsworth officials to represent that police checks were satisfactory for Carroll. Statements from Brenda Jones, Alison Barrowball and Bernadette Khan will be read into the transcript in due course. In short, Ms Khan describes how she refused the direction and went on to record Carroll's conviction. Furthermore, she says that Lambeth Council subsequently accepted that an inappropriate and unprofessional telephone callwas made to the Wandsworth team.

240. At paragraph 205 of the Clough Report it was recorded that Jack Smith admitted asking for this telephone call to be made to Wandsworth. The Clough report also refers (at

paragraph 211) to Jack Smith having provided a note in support of the Carroll application. The Clough report stated that Mr Smith confirmed the existence of this letter in correspondence to the Director of Social Services. Overall, Clough was critical of the decision to retain Carroll. A decision which David Pope had, as we understand it, played a central role in.

241. In a memo dated 23 February 1994 David Pope set out the findings of an internal management investigation which Lambeth undertook after the Clough report. This report came to different conclusions from those reached by Clough. For example [at paragraph 1.11] that Jack Smith did *not* recall having a discussion with Brenda Jones about the police references being marked 'satisfactory'. The issue that arises is why Lambeth undertook its own investigation when there had been an independent one and what basis it had for reaching different conclusions to that reached by the independent fact finder, Clough. Also, why did David Pope seemingly have a role in all of this when he had been criticised by Clough in the first place.

242. As you have also heard the Barratt report considered Lambeth's response (or lack of it) to a disclosure about sexual abuse by Steven Forrest. As I have already indicated the question is whether between Barratt, CHILE and Middleton, Lambeth ever really got a grip on what might have happened to children who lived in Angell Road or whether there remain outstanding concerns about this.

Southvale Assessment Centre

243. Southvale was subject to very little by way of external scrutiny after the setting up of the Social Services Inspectorate. Lambeth's response to the concerns raised in 1989 about physical and emotional abuse, the humiliation of children and racism was to constitute an internal panel of enquiry chaired by Edgar Zephyrine. A number of staff were suspended before the Enquiry commenced.

244. This enquiry was set up in 1989 and reported in early 1990. By this point, staff must have had concerns about Lesley Paul and we know that even the Assistant Officer in Charge had found F8 with a naked child. 50 members of staff were interviewed as part of the Enquiry [p.8].

245. There are a number of points that can be made about the Zephyrine report. Firstly, it does not set out the very serious allegations which gave rise to it. Secondly, it provides no analysis as to what accounts were given about each allegation or how it arrived at its conclusions. It does contain statements like *"allegations of favouritism were refuted by over 50% of interviewees"*. In terms of racism, the report stated that the evidence about this was *"circumstantial"*. The report also refers to witnesses saying that *"Southvale was not like other homes"* and could not be judged by the same standards as other homes. The report appears to proceed on the acceptance that Southvale had a *special function* amongst Lambeth children's homes – we will ask Ms Hudson more about whether this was accurate or not.

246. Where the Zephyrine Enquiry made stronger and clearer findings was on the absence of staff from BAME backgrounds in the management structure. It also noted the lack of understanding of the need for children from BAME backgrounds to develop a positive cultural identity. Staff were unaware of basic expectations in this respect. The report also stated in respect of F8 that there was a strong view that he was favoured by the OIC and received special privileges. Overall, the Panel concluded that allegations of misconduct were not made out but that Southvale was not well managed.

247. What is striking about this report is that the allegations which preceded it, from the two different care workers mentioned earlier today , were very serious. There is no indication in the report as to how these allegations were treated; whether they were rejected or why. As may be apparent from this opening, these allegations correspond with what other individuals said in evidence to the police about how Southvale operated. There is at least some indication that where the inquiry was provided with conflicting evidence, this simply led to the conclusion that an allegation could not be made out.

248. The second point and perhaps most surprising point of all is that there is nothing to suggest that the Zephyrine Panel spoke to any children from the home, despite having the power to do so. Why was this? There is also nothing on the face of the Zephyrine report to suggest that the Panel investigated allegations of sexual abuse despite there being evidence to suggest that the Inquiry was aware of the allegation that **F8** had been found in bed with a child.

249. The first police investigation which touched upon Southvale was Operation Bell in 1992. Officers from Operation Bell spoke to Edgar Zephyrine who Chaired the enquiry. Notes of that meeting survive. Officers asked Mr Zephyrine about the information provided to Operation Bell about F8. It appears that this allegation was made to the Panel but according to Mr Zephyrine – *"The enquiry accepted F8's version of events which was that he was there to counsel the child who was disturbed"*.

250. How is it possible that the enquiry interviewed 50 members of staff and failed to uncover the reality of what was going on at South Vale? Perhaps the Panel was not equipped to interrogate the situation. We will ask Ms Hudson about that. The answer may also be that some staff were not forthcoming. One person who it appears did not provide information in 1989 that might have been expected of her was the Assistant Officer in charge (who I have already mentioned).

251. F8 was subject to a misconduct process in 1993. This investigation was brought in respect of the two allegations made to Operation Bell that F8 had been found in bed with a child and had been found in a room with the same child who was naked. The Assistant OIC said that F8 had been given special responsibility for this child by the OIC. F8 spent large amounts of time with this child and not working within the team. The position of the OIC was that the staff should back off F8. The issues were not talked about more directly because F8 was a favourite of the OIC. The assistant did not report finding F8 with the naked child because the OIC favoured F8's position and was not supportive of her. She

did not feel she would be listened to. I pause to note that the Assistant OIC did not do what more junior staff had done and report her concerns to external managers.

252. The misconduct process noted that both of these incidents occurred prior to the Zephyrine inquiry but that only one was before the Zephyrine inquiry. It stated that there was no record that these matters were formally put to F8. It appears from this record that F8 had been suspended but no reasons were recorded for this and that he was reinstated after the Zephyrine inquiry. It appears then that it was Operation Bell which led to F8's misconduct process – not the earlier allegation of his being found in a bed with a child.

253. Of concern to the inquiry is that these allegations were found proved against F8. He had denied that either incident had taken place. However, he was not dismissed but given a final written warning and it was recommended that he not work with children. It was also recommended that his *"relationship"* with the child be reviewed. I will pick up on this thread when I turn to the police response to Southvale.

Ivy House/Monkton Street

254. A number of themes emerge from Lambeth's response to the allegations of sexual abuse that arose at Ivy House and Monkton Street.

255. One relates to the conduct of management inquiries. The Director of Social Services explicitly acknowledged the first 1985 Ivy House inquiry to have been inadequate. Inquiries that were subsequently set up to investigate allegations of sexual abuse by members of staff at Ivy House and Monkton Street had wider terms of reference, investigative processes that included interviewing the parents of the child, conducting extensive questioning of staff and seeking the assistance of experts with knowledge of the child and in the field of child sexual abuse.

256. However whilst the second Ivy House investigation may be an example of improved practice surrounding the setting up of investigations in particular cases, Lambeth failed to engage subsequently with the wider issue of reviewing the management and supervisory systems for the protection of particularly vulnerable children or to review and develop a policy for investigating this type of allegation. This was despite this being the explicit remit of the Special Review panel set up in the wake of the Ivy House and Monkton Street complaints, whose report was never published and recommendations never considered. Further Lambeth failed to respond to the child centred requests of groups including the Brixton Family Support Group and Black in Care who in 1986 and 1987 demanded that:

"a complaints procedure for children with mental disabilities in Lambeth children's homes be urgently reviewed with guidelines quickly set up": and that

"Lambeth Social Services not only urgently reviews its policy and practise in child abuse cases but also quickly implements effective methods of dealing with child sexual abuse with fuller consultation with groups dealing with sexual abuse."

257. The fact remains that following both the Ivy House investigation and the two Monkton Street investigations, no disciplinary action was taken against any of the three individuals despite the fact that a member of the Special Panel, appointed to look at the wider picture of investigation commented that there was sufficient evidence *"for a responsible employer to regard the individual members of staff to be a risk to children."*

258. These cases raise the ongoing question within child protection and which will be explored in evidence surrounding what to do when a disciplinary panel clears a member of staff, but where concerns remain as to whether that individual poses a safeguarding risk. In the Ivy House case study this manifested itself in the issue of how to approach the giving of a reference. In the case of LA-F26, the subject of allegations whilst working at Monkton Street, it appears he remained at Lambeth but working in an adult setting [CQC000352] As for LA-F2, a further Monkton Street employee, he remained working, which included some limited contact with children, but with an agreement that he should not come into contact with the complainant child due to the distress caused.

259. The last of the Lambeth Children's homes to close was Chestnut Road. In a report by Richard Evans and Elisabeth Ford dated 6th September 2000 regarding the closure of

Chestnut Road, consideration was given to what the report described as "*Employment Practices – dangerous employees and the paramountcy of the welfare of the child.*" The report refers to the example of an employee who was appointed by Lambeth in 1990 subject to references, police checks and medical clearance. A police check received on 18 June 1990 noted seven offences from robbery to unlawful wounding, burglary and theft. Despite this police check, his appointment was authorised and he took up a post at South Vale in 1990. Whilst at South Vale he faced allegations of using physical force but the investigation was inconclusive "*as witness statements were not consistent."* In 1995 when South Vale was closed he was offered a post at Monkton Street, without any disclosure being made of his past convictions. When Monkton Street closed he was relocated to Chestnut Road. Whilst as Chestnut Road allegations were made against him of sexual abuse.

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

Fostering and adoption

261. If children's homes in Lambeth were not replicating the sense of security and safety that a family home might provide, how did children fare in foster care? We have seen evidence of children who had fond memories of foster care and who enjoyed supportive relationships with foster carers. We have also noted some deeply concerning and disturbing accounts about foster care. You will receive written and oral evidence from core participants about their experiences of being fostered whilst in Lambeth's care and its impact upon their lives.

262. We will look at the system for making decisions about fostering and adoption in Lambeth and, in particular, the Social Services Cases Sub-Committee and the role which it appears to have played in fostering and adoption decisions. The question arises as to whether councillors overstepped the boundary between decisions which were really questions of professional judgement for social workers. If they did, was this because there was little confidence in that judgement or because there was little trust between these respective parts of the machinery.

263. The Inquiry understands that in terms of identifying families for fostering and adoption, Lambeth saw good reason to strive to place children with families who shared their ethnicity. Lambeth was concerned about the disadvantages of placing children in families

who might have very little understanding of their needs, their identity and the prejudice and disadvantage they faced.

264. In 1992 the SSI was overtly critical of the policy as putting the ethnicity of a child above all other considerations in deciding where to place them. It noted: *"We agreed, even at first glance that we found this policy document to be defective". The 'major concerns' included: "..that the document appears to elevate the single minded pursuit of "same race placement" above all other important elements in considering the welfare need of a child in placement..*"

265. In 1997, there was an SSI inspection called 'Inspection of Planning and Decision Making for Children Looked After - Lambeth' which noted issues about 'drift.' The report suggested that: "*there was a positive commitment to 'same race placements' and a strong emphasis on the importance of religion, culture and language in placement decisions."* It went on to note: *" The implementation of this policy was sometimes frustrated with 'colour' appearing to be the defining factor in placement decisions, without due account being taken of individual cultural and religious backgrounds as well as their personal experiences and wishes. This contributed to drift.* And later, "*We found considerable instances of 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 (para 8.5)."*

266. Whether this criticism was fair is something which Lambeth witnesses may have a view about. From the Inquiry's perspective and on the current evidence in breach of all of its child care policies, children in Lambeth's care appear to have spent longer periods in institutions and without clear plans for their future than they should have done.

267. Another issue relevant to children in foster care and which Ms Hudson will give evidence about is police checks on foster carers and the extent to which Lambeth knew which children it had placed in foster care and where. Audits were carried out in 1999 in order to ascertain this. A memo in 1999 recorded that there was [LAM015822]:

(i) Limited management information on foster carers and members of the household.

(ii) Limited history of police checks on foster carers

(iii) Virtually no history of police checks on other household members.

(iv) Lack of management controls.

(v) Misuse of senior management position in resolving potential de-registrations or concerns related to carers.

268. The inspection in 2000 identified, as I said earlier, potentially large numbers of children who had not properly been regarded as looked after. A joint review by the SSI and the Audit commission (December 2000) recorded, in respect of children's services:

"*This identified continuing and significant failings in meeting statutory duties. Cases were unallocated, reviews were not carried out and there was evidence that children were placed in substitute care arrangements outwith the statutory looked after system and its intended, inherent safeguards* [LAM013017]."

269. I give one example of such a fostering arrangement which cuts across many of the themes in this investigation. LA-F36, took his own life having provided evidence to CHILE/ Middleton. [LAM000898]. The evidence demonstrated that he had been sent to live in Cornwall with LA-F36, a man Lambeth knew (having been informed by Cornwall Social Services) had been dismissed from his teaching job for reasons related to indecency with boys. Reports were made raising concerns about this child during the placement. Social workers from Lambeth went to Cornwall to see this child – you will hear evidence from one of them about the decisions they took and why this child remained in Cornwall. Eventually, this child and the foster carer were brought to stay in Angell Road (when Michael Carroll was the officer in charge).

iii. External inspections of Lambeth's children services, including the role of Ofsted and its inspections now

270. The Local Authority Social Services Act 1970 as amended continues to be the primary statutory code for the establishment and operation of local authority social services departments. It contains the mechanism whereby central government departments provide guidance, directions and orders to local authorities in the provision by them of social services. With effect from 1st April 1991, the National Health Service and Community Care Act 1990 inserted into section 7 of the 1970 Act new duties upon local authorities including as follows:

(i) to act under the guidance of the Secretary of State in the exercise of their functions

and discretion (section 7(1) as originally enacted);

(ii) to exercise their functions in accordance with Directions given by the Secretary of State (section 7A (1))

(iii) to comply with any Order made by the Secretary of State in relation to the local authority's failure to abide by its statutory duties (other than those contained in the Children Act 1989) to ensure that the duties are complied with.

271. Comprehensive powers to inspect were vested in the Secretary of State by section 58 of the Children and Young Persons Act 1969 and from its commencement section 74 of the Child Care Act 1980, relating to all forms of premises where children in care were

accommodated, where children had been boarded out by a voluntary organisation and where foster children and protected children were being accommodated and maintained.

272. You have heard already Chair that statutory directions by the Minister were issued to Lambeth in 2000, with action required by August 2001. Whether directions or orders might have been issued at an earlier stage is a matter for consideration.

273. You will hear evidence from Jo Cleary (Assistant Chief Inspector, SSI) Lord Laming (Chief Inspector of the SSI in 1991), Denise Platt (SSI Chief Inspector in 1998 and Shadow Chair of the Commission for Social Care Inspection which followed the SSI)) and Virginia Bottomley MP (Minister of State for Health 1989-1992). We will consider the role of the SSI and the implementation of its powers. You will hear evidence about whether the Social Services Inspectorate was effective in identifying risks to children in Lambeth's care, and how effective it was in bringing the risks to children to the attention of Ministers. Did the workings of the SSI improve the quality of service provision to children? Did the inspection reports written about Lambeth and any follow up to those reports change the culture or working practices within Lambeth Council in any way?

274. As referred to earlier, the Right Honourable Tim Yeo MP commissioned an independent report into the recruitment and retention of Michael Carroll after his conviction for child abuse came to light. David Pope (Director of Lambeth Social Services) had been party to the original decision to retain Michael Carroll. Mr Yeo in his written evidence says: "*I understand that the Chair of Lambeth's Social Services Committee had demanded an Inquiry into why Michael Carroll had not been sacked*". Mr Yeo says that following

discussions with the SSI he agreed to ask Lambeth to arrange for an independent person to carry out the review of Michael Carroll's employment and Lambeth appointed Mr Clough. Mr Yeo left the Department in May 1993, and the report was produced soon thereafter.

275. Mr Yeo also says that he had agreed with the SSI that it would carry out a full and early investigation of Lambeth residential care services (LAM013143). His recollection is that "*I hoped that asking the SSRI to carry out a full inspection of Lambeth Council's residential childcare service would identify the failings in the service and the causes of the findings*." The inspection that took place in 1993, however, was limited to 3 homes. In written evidence to this Inquiry Mr Yeo comments that he cannot now recall if he was involved in the decision to limit the scope of the SSI's investigation to 3 homes or the reason for that decision. Furthermore, he says that "*From reading (the inspection) report now it does not appear that any ministerial action was required in consequence of its conclusions and recommendations*."

276. From 2007, Ofsted was responsible for external inspection of Lambeth children services. Lambeth was not operating any children's homes at this point. The majority of children's homes registered in England by Ofsted are operated by companies, partnerships, or individuals. Lambeth is able to commission places in those homes, as well as having access to foster care placements through its own foster care services or independent fostering agencies registered by Ofsted.

277. In May 2009, Lambeth's fostering service was judged to be "*good.*" In 2012, its fostering service was judged to be "outstanding". Carolyn Adcock, Senior Inspector of Education, Children's Services and Skills, is due to give evidence to the Inquiry about contemporary inspections in respect of Lambeth; its openness to regulation and inspection and issues within Lambeth now from the Regulator's perspective surrounding the protection of children in care from child sexual abuse.

iv. <u>The response of the Metropolitan Police Service to allegations of child sexual abuse</u>

278. Chair, as you reported in the Nottinghamshire Council Investigation Inquiry Report, research commissioned by the Inquiry from the Crime and Research Institute at Cardiff University sets out how the national approach to police investigations into allegations of child sexual abuse has developed over time. From 1963, Home Office circulars referred to the need for police forces to work with local authorities in relation to children in need of care, protection and control. By 1988, sexual abuse was included in the definition of child abuse, joint working with social services was expected, and the paramount consideration was the welfare of the child. By the end of the 1990s, all forces had child protection units which '*normally*' took primary responsibility for investigating child abuse cases. As a minimum, they were required to investigate all allegations of child abuse within the family or against a carer. In the 2000s, both the Victoria Climbié/ Laming Report and the Bichard Inquiry (2004) criticised HMIC for not taking a

sufficiently active role in child protection through its inspections of police forces. The Laming Report also recommended that police officers in child protection roles should hold senior rank and have appropriate qualifications.

279. Since 2010, you reported Chair that there has been a significant increase in the volume of allegations of non-recent sexual abuse. A thematic review of child protection in 8 police forces conducted by Her Majesty's Inspectorate of Constabulary (HMIC) in 2014-2015 found that some forces were struggling to manage rising investigative demands with *'systemic weaknesses'* and high workloads [Nottinghamshire Report, B6-28.1-28.4].

280. With that timeframe surrounding force organisation, within the Lambeth investigation we asked the MPS how allegations were dealt with between 1963-1988; 1988-1999; 2000-2010 and from 2010-present day.

281. The Inquiry will hear from Commander Murray, who comments on the structure of the MPS during those periods, particularly addressing whether there were specialist teams investigating child sexual abuse or whether such allegations were investigated by local officers. The Investigation seeks to know whether the MPS had any policies or procedures in place and how effective '*working together*' or inter-agency cooperation between the MPS and Lambeth Council was. Also, how MPS intelligence systems, in particular the provision of information or sharing of information with any statutory bodies in relation to child sexual abusers (either alleged or convicted) developed during each period.

282. The MPS have also been asked to set out its approach to the taking of complaints from children over time, including children with complex needs and communication difficulties.

283. In 2016, national recommendations encouraged police forces to review each other's public protection arrangements. HMIC conducted an investigation of the MPS and criticisms were made of its investigation of child sexual abuse [see paragraph 8.9 onwards, pg 12 of EWM000464]. HMIC identified that there was no-one of Chief Officer rank within the MPS with clear overall responsibility for child protection; but rather *'ownership was split over several portfolios'*. Some cases '*fell between the gaps*' and there were significant weaknesses with information management systems and processes.

284. As far as MPS investigations in Lambeth are concerned, the Inquiry has served a number of detailed specific Rule 9 requests in order to have the fullest possible picture of allegations of child sexual abuse emanating from children in Lambeth's care. Through the evidence of DI Simon Morley, the MPS has provided an overview of the police operations that relate to children within the care of Lambeth. DI Morley will also provide evidence surrounding 2 investigations carried out under the auspices of the IOPC (the Independent Office of Police Complaints) . Detailed by perpetrator or alleged perpetrator, the MPS has also been asked to set out its knowledge in respect of the movement of any perpetrator or alleged perpetrator immediately following any MPS investigation into the sexual abuse of children.

The Harris Report

285. The Inquiry understands that the then-Chief Executive of Lambeth Council, Henry Gilby, went to the MPS in December 1993 with a copy of the Harris Report, a supplementary report to it [HGL000002] and a list of names and addresses. Specifically, it is understood that he met with an Assistant Commissioner of the MPS at Kennington Police Station at around this time. Whilst the Harris Report was concerned, in part, with the allegations made by LAG1 and harassment within the Lambeth Housing Department, it also referred to 3 matters of interest to the Lambeth Investigation, namely: (i) the extent to which Lambeth officers may have been involved in the production of pornography; (ii) whether that included indecent images of children and (iii) the possible exploitation of children by Lambeth staff.

286. In respect of the allegations made by LAG1 (as reflected in the Harris Report), it is understood that these were the subject of a police investigation called Operation Pragada. That investigation was concluded in 1993 following CPS advice that no further action be taken. LAG1 is understood to have made further allegations in 1994. Again, it is understood that these did not change the position and that a closing report by DCI Vincent Harvey concluded that LAG1's allegations lacked credibility.

287. I mention this because there are enduring concerns about the Harris Report, that it raised a number of questions about the sexual abuse of children in Lambeth's care but did not on

the face of the report, provide any clear information as to the sources of information or provide any answers as to what investigation there was about it. This is a matter which will be touched upon in evidence.

The Appleby Report

288. In July 1995, Ms Elizabeth Appleby QC produced a report for Lambeth Council. At paragraph 21 she noted, having received numerous allegations, that causes of Lambeth's problems included the influence of freemasonry, a '*mafia'* exerting pressure on the officers, and a pornographic ring holding officers and members to ransom. She stated she received no evidence to substantiate these allegations**.** The Inquiry has obtained a statement about the organisation and work of the Freemasons, and you will hear from David Staples, Chief Executive Officer and Grand Secretary of the United Lodge of England. Conspiracy theories existed within Lambeth around membership of the Freemasons, and we will look at that issue

Operation Middleton

289. The Inquiry will hear evidence about Operation Middleton, how it came to be set up, what its remit was, and its relationship with its Lambeth counterpart CHILE. A question that has been asked about Middleton and CHILE is how effective were they given the length of time their joint role lasted for, the number of allegations they received and

ultimately the paucity of people prosecuted by the end of Operation Middleton. There is an issue as to why certain individuals like Philip Temple were not prosecuted during Middleton. You will hear evidence from retired former Superintendent Gargini, who led Middleton in its beginning and who will explain its methodology. Detective Inspector Morley will provide extensive evidence about a number of different MPS operations related to children in the care of Lambeth, including Middleton. This will include individuals investigated, individuals referred to the CPS for advice or a charging decision; and the number of individuals brought to trial.

Operation Trawler and Middleton

290. Another enduring issue in Lambeth surrounds Operation Trawler. This was an investigation set up in tandem with Operation Care (the Merseyside investigation into Carroll). As has been widely reported in the press Operation Trawler was led by the now retired former Detective Chief Inspector, Clive Driscoll. There has been speculation in the press that he was removed from Operation Trawler for political reasons or as part of a cover-up to protect sensitivities within Lambeth. Again, it has been reported that these sensitivities were that political figures were implicated in allegations of abuse brought to the attention of Mr Driscoll. This allegation has itself been the subject of an entirely separate investigation by the Independent Office for Police Complaints.

291. You will hear evidence from Mr Driscoll, Dr Nigel Goldie (who worked in Lambeth) and again, Mr Gargini on some of the issues in the public domain – in essence- going to the

question of whether there was a cover up and whether political figures were protected from investigation. You will also hear evidence about the IOPC investigation into these matters and the conclusions that the IOPC has drawn upon that issue.

292. It has also been speculated upon in the press that Lord Paul Boateng visited the Angell Road home and that his wife Lady Janet Boateng, intervened in an application made by John Carroll, to foster children . You will hear evidence from Mr Clive Walsh about a meeting which he alleges took place about such a fostering application at which Lady Boateng was present. You will hear evidence from Lady Janet Boateng in reply to the allegations that she ever pressurized another local authority to allow Carroll to foster.

293. As for Lord Paul Boateng and his having any links to Angell Road, it is not the function of this investigation to ventilate rumours about individuals, but rather to focus on the terms of reference and to follow the evidence in a proportionate way. I make clear, as did Leading Counsel to the Inquiry in a preliminary hearing of 24 March 2016, that no individual has come forward to the inquiry to implicate Lord Paul Boateng in their abuse. As is well known a former Lambeth employee provided information to media outlets that she had seen Lord Boateng at Angell Road. That witness is no longer alive.

294. Lord Boateng made a statement to the police in 2019. He was asked by the Inquiry if he was content to adopt its contents for the purposes of the Inquiry. He indicated that he was. Lord Boetang states that he did not know John Carroll in a personal sense, that he had not met him or as far as he could recall ever visited Angell Road. He stated he had no knowledge of any fostering application by the Carrolls. In his written evidence he sets

out his work as a solicitor and how he appeared regularly in the juvenile courts throughout London on behalf of clients, some of whom would have been in care. He says that he may well have visited for the purose of taking instructions and interviewing witnesses a number of care facilities (secure and ordinary) in which the children in the care of Lambeth had been placed. He says that "*I did so quite independently of my wife who at one time worked in the care system and who later served as Chairman of Lambeth Social Services*."

295. A principal concern of this inquiry is to examine insitutional responses to child sexual abuse. With that remit in mind, witnesses will be asked to address, for example, former DI Driscoll's concern that he was removed from Operation Trawler so as to protect political figures from Lambeth. We will also ask witnesses from both the MPS and the Social Services Inspectorate about that.

Shirley Oaks

296. The MPS response to allegations of abuse made by children at Shirley Oaks broadly falls into three categories; those limited situations where police were involved at the time, investigations stemming from Operation Middleton and investigations since.

297. One of the significant challenges facing the Inquiry is that very limited police paperwork has been located from the time regarding contemporaneous allegations. That applies to LA-F93, William Hook and Philip Temple in respect of whom children (and in some cases, staff) recall the involvement of police. It also applies to Donald Hosegood and Patrick Grant where police investigations led to criminal trials in 1975 and 1978, respectively.

298. The Inquiry has served a number of detailed specific Rule 9 requests in respect of alleged perpetrators at the time. These requests have requested further information about issues including:

i. (i)The extent the MPS were or may have been aware of an alleged perpetrator before any allegations were made regarding child abuse;

ii. (ii) details of contemporaneous reports made to police and the nature of any subsequent investigation;

(iii) support provided to children who made or about whom allegations were made during a police investigation;

iii. (iv) the circumstances of the acquittal of a defendant where relevant ;

iv. (v) the extent an individual may have been identified during Operation Middleton as someone who had abused children whilst he was employed by Lambeth Council;

v. (vi)t he extent to which police Operations since Operation Middleton were able to uncover allegations that had not previously been investigated during earlier operations - and if so, why;

vi. (vii) whether the MPS is aware of the extent to which a perpetrator operated alone or had links to other abusers;

vii. (viii) decisions to charge some but not other allegations;

viii. (ix)decision to take no further action;

ix. (x)missed opportunities to charge or prosecute and the consequences of historic failures in individual cases;

x. (xi) the MPS's knowledge of the full history of offending related to some of the individual perpetrators;

xi. (xii)the identity and the actions of particular officers where relevant to a particular case;

xii. (xiii) police efforts made to locate contemporaneous files.

299. The individuals followed include William Hook, Patrick Grant, Philip Temple, Donald Hosegood, Geoffrey Clarke, LA-F93, LA-F127, LA-F109, LA-F184.

300. The evidence before the Inquiry is that perpetrators considered by the police at the time included Hosegood, Temple and Grant and may have included LA-F93 and Hook. In no case was there a conviction at the time.

301. Geoffrey Clarke was convicted in 1998 of child abuse related offences which took place in Kent . He was investigated during Operation Middleton. Charges were brought and he was due to stand trial in respect of the sexual abuse of a boy who had been in his foster care and for other offences of indecent images. He killed himself during the trial.

302. William Hook was the subject of an investigation by Operation Middleton during 1999 and 2001. In October 2000, he was charged with offences totalling over forty charges, and on 28 February 2001, he pleaded guilty to 26 offences. On 11 April 2001 he was sentenced to ten years imprisonment. He was released on license into approved accommodation on 10 December 2007 (having served six years and six months in prison) and was placed on the Sex Offenders Register.

303. As you have already heard, in February 1977, Phillip Temple was suspended from duty at Shirley Oaks after two children at the home made allegations of sexual abuse against him. Following a police investigation, Temple was released without charge. In 1998 and 1999, Temple was tried in respect of three counts of indecent assault on a male aged 15 years, for conduct with took place outside Lambeth. Temple was acquitted and then acquitted again after a retrial. In 2015, Temple was arrested following a new investigation by the Metropolitan Police, known as Operation Marozi. This was an investigation which fell under the umbrella of Operation Winterkey, which is the

Metropolitan Police's specialist capacity to investigate high profile or complex criminal allegations of non-recent child sexual abuse and its response to the Inquiry.

304. The Operation Marozi investigation identified child abuse allegations against Temple dating back to the 1970s, when Temple was employed as a house parent at various children's homes. Police discovered that Temple had been investigated on numerous occasions over a 40-year period in relation to these allegations.

305. On 6 April 2016, Phillip Temple pleaded guilty to 29 offences which included two counts of perjury relating to the trials in 1998 and 1999. On 10 August 2016 Temple was sentenced to 12 years imprisonment. In September 2016 this was increased to 18 years imprisonment following an Attorney General reference - an appeal by the prosecution on the basis that the sentence imposed was unduly lenient.

306. The original sentencing judge referred to the possible failures to stop offending in the past. In the light of those comments, it was felt appropriate to examine the involvement of police when allegations against Mr Temple were made. The case was therefore referred to the IOPC and became a managed investigation. Operation Andesite was created to address whether there were missed opportunities during investigations conducted by police into Mr Temple's abuse. The investigative tasks were carried out by the an MPS officer but independent oversight of the investigation was maintained through regular reviews by a lead investigator from the IOPC.

307. Returning to Patrick Grant, you will recall that he took over from Philip Temple in August 1977. On 8 February 1978, Patrick Grant was suspended after he was charged

with 10 counts of indecent assault of boys under 16 years. As you have heard, in December 1978,

the Judge directed the jury to acquit Grant.

308. Following an investigation by the Metropolitan Police, Operation Trinity, Patrick Grant was charged on 23 April 2018 with 14 offences which related to four complainants one of whom lived in Rowan House, Shirley Oaks at the time of the abuse. Grant was convicted of the offences in respect of him in January 2019. On 12 April 2019, Patrick Grant was sentenced to eight years imprisonment.

309. Hosegood stood trial at The Old Bailey between 16th and 22nd July 1975 in relation to 11 charges of child sexual abuse against four victims. At some point, the Judge directed an acquittal. Operation Middleton did not investigate Donald Hosegood. Evidence will be given about that by DI Morley- the question is raised of whether some individuals were told that he had died when that was not the case.

310. LA-F93 died in 1982. The MPS received allegations against LA-F93 from five people who lived in Shirley Oaks. All allegations were made after 2000.

311. The Inquiry will consider evidence that various other alleged perpetrators were not investigated for reasons including their death, their age and a failure to adequately identify the perpetrator described by the child.

Angell Road

312. As I have mentioned above, Michael Carroll left Lambeth, not because of allegations of abuse, but because allegations of fraud. According to the notes of a meeting between the SSI and Lambeth officials in 1992, the police declined to investigate this fraud consistent with Lambeth local practice involving theft against an employer (the SSI also referred to the Melting Pot in this regard "where there were suspicions of money being laundered from the sale of crack"). The SSI expressed concern at this police discretion and asked if employees were aware of police practice.

313. The record of the 1992 meeting suggests Lambeth officials were asked about Lambeth's failure to notify Carroll to the Department of Health after he had been dismissed – they asked if there was guidance about this. Another Lambeth officer said he didn't think the need to notify the Department of Health applied to embezzling and fraud. The SSI Inspector observed "Does Mr X think that embezzlers and con people are the sorts of people we want to look after children in the public care?" CQC000297.

314. Michael Carroll was revealed to have abused children in Lambeth's care through the Merseyside Police investigation into him (Operation Care) which began following allegations about Carroll arising from when he worked in Liverpool and before he came to Lambeth. Chair, you will receive evidence from LA-181 as to how he came to provide a statement to the police around 1998. He was telephoned by the police and asked if there was anyone from the children's homes that he thought the police should be

talking to – he told them Carroll. On 5 July 1999 Carroll pleaded guilty to 35 of 68 charges of sexual abuse committed against 13 children between 1966 and 1986. He received a term of ten years' imprisonment.

315. As I indicated above, Carroll was also instrumental in investigating allegations against staff in Angell Road and one of the issues which we will look at is whether he might have frustrated the investigation into F4. You will recall I mentioned that one disclosure about F4 came from a child who was pre-school. It appears to have been suggested at the time that a child protection officer said she was too young to be interviewed – it is not clear to us whether that was true. Certainly, months down the line, there is evidence that a number of professionals decided not to take her allegation any further, in part, because of delay.

316. It is also unclear to what extent the police were or were not involved in responding to the allegations made by another child that F4 had sexually abused her in 1988. We know that F4 was charged as part of Operation Bell, in 1993, of abusing her over a four year period. We understand the prosecution offered no evidence because of issues related to credibility. We do not know but will explore in evidence, the extent to which it was understood that F4 had been the subject of allegations in and around 1988, some of which had been corroborated at the time. In respect of the third child, whose mother came forward in 1994 to say he had been sexually abused by F4, it is unclear as to whether or not that allegation was brought to the attention of the police. DI Morley will provide more evidence about this.

Southvale

317. As I have mentioned the first police investigation into Southvale was Operation Bell in 1992. It investigated allegations against Lesley Paul and the allegations made by staff about F8. There were three complainants in respect of Paul. In January 1994 he was convicted of two counts of indecent assault against a male, one count of indecency with a child and one count of taking indecent photographs of a child. He was sentenced to 18 months' imprisonment.

318. Operation Bell also investigated Paul's links to the distribution of pornography. The Deputy Senior Investigating Officer in Operation Bell was Detective Inspector Randall. A submission from him to a Computer Lab from Operation Bell stated "*It is the informed opinion of the Investigating Officer that material relevant to Paul's commercial interest in pornography is to be found on one or more of these discs. This may take the form of names/ addresses, PO boxes etc*…" It goes on to state (see page 3): "*He is considered to be a paedophile and has been actively engaged in the paedography and video tape recording of young males for pornographic purposes. He has extensive connections with persons of a similar ilk in Europe and is strongly suspected of being concerned in the commercial side of child pornography*." DI Morley will give evidence about this aspect of the Operation Bell investigation.

319. In December 1992, Detective Superintendent Tomkins of Operation Bell wrote to David Pope, the Director of Social Services. The investigation had been completed but there had been no trials as yet. Det Supt Tomkins wrote of the Zephyrine inquiry that it was seen as shallow with little depth to its questioning of witnesses. He observed that the fact that no children were interviewed added weight to the theory that it was only intended as a means to change the regime rather than to establish malpractice. Det Supt Tomkins noted that F8 remained in close contact with the foster family of the child he was accused of abusing. He observed that it was unknown how that link had impacted upon the investigation.

320. In fact, the child F8 was suspected of abusing did not make any disclosures about him during Operation Bell. They were to come later. An attempted prosecution of F8 later failed. A third man was prosecuted in respect of allegations that he had sexually abused a child at Southvale. This trial collapsed amidst concerns about how the child concerned had been cross examined.

321. Lesley Paul also featured in Operation Middleton. He was convicted of five offences of indecent assault, relating to four victims. He was sentenced to a total of 16 months' imprisonment. There is a question over Operation Middleton as why other allegations about Paul appear not to have been proceeded with. DI Morley has provided very detailed written evidence about this and will be asked to explain more about this in evidence. In 2015, Les Paul stood trial for the sexual abuse of five men who as children had lived in Southvale. Paul was convicted of offences relating to four of these men. He was sentenced to 13 years' imprisonment. His successive prosecutions are a demonstration of

how the detection of child sexual abuse and attitudes to it on the part of all criminal justice agencies have developed – we will ask DI Morley about this.

322. Patrick Grant stood trial in 2019 and was found Guilty of eight of the 10 counts on the indictment. The jury was unable to reach a verdict which related to the sexual abuse of a child in Southvale. A retrial was set down but the victim made absolutely clear to police that he really did not want to give evidence again. As you have heard Grant was convicted for the sexual abuse of children at Rowan House and Fircroft (and also Walker House in Wales)

Ivy House/Monkton Street

323. The allegation against LA-F12, the employee at Ivy House and the allegation concerning LA-F26, who was employed at Monkton Street were reported to the police, with the assistance of social workers, shortly after the children first made the allegations to their parents. In both cases the child making the allegation was questioned by the police at the police station, and a medical examination was carried out.

324. In both the Ivy House and the Monkton Street cases, the police interviewed the alleged perpetrator, other members of staff and in the case of LA-F26 forensic tests were also carried out. These investigations were met with denials by the alleged perpetrators. This, combined with what the police perceived as an impossibility of obtaining a comprehensible statement from a child with communication difficulties, meant that the police investigations ceased. The CPS decision in both cases was not to pursue the matters.

v. Prosecutorial decisions around child sexual abuse

325. The Investigation will scrutinise decisions around the prosecution of sexual offenders and alleged offenders. In particular, to see whether offenders might have been prosecuted earlier and prevented from causing further significant harm to other child victims.

326. Prosecutions brought by the CPS are governed by the Code for Crown Prosecutors. A prosecution commences if it satisfies the Full Code Test. The Test has two stages. Firstly, the requirement of evidential sufficiency; and secondly, consideration of the public interest. To satisfy the evidential sufficiency stage, the prosecutor must be satisfied that there is sufficient evidence to support a realistic prospect of conviction. As the CPS written evidence to the Inquiry points out, this means that a lawyer examining the test must be satisfied that an objective, impartial and reasonable jury, properly directed and in accordance with the law, are more likely than not to convict the defendant. It is an objective test based upon the prosecutor's assessment of the evidence (including any information they have about the defence).

327. Within this Investigation, through the evidence of Mr Gregor McGill, Director of Legal Services, we will examine decisions that were made around the prosecution of individual suspects/alleged perpetrators following on from complaints from children in the care of Lambeth. Mr McGill has given evidence four times to the Inquiry within different

investigations, and is of appropriate seniority to speak of policy, guidance and its decision-making.

328. It is important when examining decisions made that the applicable law at the time of any decisions being made is appreciated. How a child's evidence is received by a Court has changed over time. So has the need for corroboration. As the 'Law Commission Report on the Corroboration of Evidence in Criminal Trials' (1991) set out, the law of corroboration referred to a series of technical rules that governed the way judges had to direct juries about certain specific categories of prosecution evidence. Before the implementation of the Criminal Justice Act 1988, section 34, a judge was required to warn a jury that it was dangerous to convict on the uncorroborated evidence of a complainant in a trial for a sexual offence. In addition, the judge was required to go on to tell the jury what other evidence was, as a matter of law, capable of constituting corroboration of the evidence under question. The issue of whether the evidence capable of constituting corroboration did, in fact, have a corroborative effect was left to the jury. And finally, the judge was required to direct the jury that if, after heeding the so called corroboration warning, they concluded that the witness was speaking the truth, they were entitled to convict. The corroboration rules (as described) were formulated with the aim of avoiding wrongful conviction. On the 7th January 1988, the Law Commission was asked to review the law and to make recommendations. The Commission recommended abolishing the rule by which the judge should automatically warn the jury that it would be dangerous to convict the accused on the uncorroborated evidence of a prosecution witness

who is the complainant in a trial for a sexual offence. Given that sexual offenders can manipulate situations to abuse children without others present, this was undoubtedly a step towards improved justice for child complainants (indeed all complainants) of sexual abuse.

329. The investigation will examine decisions not to prosecute alleged perpetrators of sexual abuse before the implementation of the 1988 Act in accordance with the law that was applicable at the time. We will examine, despite the complexity of the law on corroboration, whether prosecution advice was nevertheless unduly hesitant or cautious surrounding commencing prosecutions.

330. We will also consider the way in which child witnesses could be heard in a criminal trial at the relevant time. And whether paternalistic or perceived welfare decisions were being made around whether they should be giving evidence or not. It was not until 1988 that for the first time children were permitted to give evidence by video link in cases involving allegations of sexual misconduct or violence. Since 1992, and pursuant to the Criminal Justice Act 1991, children under the age of 14 have been permitted to give unsworn evidence. Video recordings were authorised of the evidence of child witnesses under the age of 17 in cases of sexual offending. This removed the need for a child to be physically in the court with the judge and jury when giving evidence. This investigation will hear evidence about how damaging it could be for children to give evidence in court.

331. Since 1991, cross-examination of a child by a defendant in person is banned. That it might have ever have been permitted, even in theory, seems little short of astonishing now. In 1999, the Youth Justice and Criminal Evidence Act 1999 allowed for special measures for vulnerable witnesses. The need for participation of vulnerable witnesses within the trial process was finally acknowledged at this point.

332. Cross-examination of child witnesses has developed considerably. Comments on inconsistencies within evidence cannot be made within cross-examination. Practice directions and Advocate's Toolkits provide for processes - including ground rule hearings - which should facilitate participation without intimidation of vulnerable witnesses.

333. Against the background of the relevant law and how children participated in the criminal trial process at any given point in time , we will examine how decisions were made for children in Lambeth. In particular, what level of support was offered around involvement in any criminal proceedings; whether complainants were kept abreast of developments in any case; and whether they were provided with assistance in any way when dealing with their abuse. And finally, crucially, in terms of prosecutorial decision making, whether their allegations were prematurely dismissed or determined by prosecutors advising upon the evidence.

vi. Obtaining cogent allegations of allegations and medical evidence from complainants of child sexual abuse

334. Within this final topic area, we will be looking at how cogent allegations of sexual abuse can be obtained from children - including from the especially vulnerable with complex needs and/or communication difficulties. Obtaining the best account from child victims is critical in terms of strengthening the prospects of successful prosecution. We will also be considering the manner in which medical or forensic examination of child complainants have been conducted in the past and what is best practice surrounding invasive examinations now.

335. A 'Review of Pathway following sexual assault for children and young people in London' prepared by The Haven, Kings College Hospital London, on behalf of NHS England in 2015, found that the services commissioned for children in London were not as complete as the packages provided for adults or, in fact, within children's services in other sexual assault referral centres in the UK. One of the authors of the Report, Emma Harwood, is due to give evidence to the Inquiry. The Investigation will consider the benefits of providing holistic services for children and young people who have been sexually assaulted, both in respect of recent and non-recent allegations of abuse. Holistic services will include but are not limited to access to medical examination, psychological assessment, support in police interviews and independent advocacy.

336. The Inquiry will hear from Dr Alison Steele, Officer for Child Protection for the Royal College of Paediatrics and Child Health (RCPCH) and, with her assistance, will consider the developing practices surrounding paediatric medical examination and by who and where forensic examination should be conducted. To be clear, the Investigation is not considering the remit of diagnostic examination or the physical signs of sexual abuse, but rather the support for complainants and best practice around obtaining forensic evidence which can be important in bringing offenders to justice. You have already heard, Chair, that children in Monkton Street were subjected to forensic examination by a single practitioner who had little or no information about them before conducting forensic examination. Children from Shirley Oaks recount being examined by a doctor who, far from protecting them, caused further harm to them. The information and context of any medical examination is of the utmost importance and the training of those required to undertake such examination is of relevance to this investigation. Dr Steele tells us that the RCPCH is updating its safeguarding special interest training module for senior paediatric trainees or consultants wishing to develop their expertise in safeguarding and/or taking on wider responsibilities in this area. The RCPH update is due to be launched in early 2021.

337. You will hear, Chair, from Dr Phibbs, clinical psychologist, around the challenges faced by children with complex needs and/or communication difficulties surrounding providing allegations of sexual abuse. Dr Phibbs will also give her opinion on children in residential settings, and how placement in residential settings may impact upon communication around child sexual abuse.

338. In December 2014, a Joint Inspection Team for the criminal justice system published a report outlining the findings of their joint handling of CSA cases. They reported: *'In short, the inspection found that the (ABE) guidance is not achieving what it set out to do, which is achieving best evidence. This is due in part to poor compliance by interviewers and the failure to properly record divisions and actions with the rationale underpinning these. Immediate improvement could be achieved through better planning at the outset, supplemented by improved supervision of interviewers and better quality assurance of the recording. In turn, the CPS needs to improve feedback to the police'.*

339. The Joint Inspection Report written as it was, 6 years ago, suggests that those who claim, when looking back at the history of Lambeth, that it would all be different now, are surely mistaken. We will hear from a witness from the Ministry of Justice surrounding when reviews to the existing guidance are being contemplated, and whether they see any need for that to happen.

340. Whilst law and practice as it affects children's participation in proceedings may have improved for the better in recent times, we say at the outset that there is no room for complacency or institutional self-congratulation surrounding where we are now. The treatment of child complainants within the criminal justice system has been wholly lamentable in the past. There is work to be done within various institutions to assist in the prevention of child sexual abuse, and to be consistently effective in bringing sexual offenders to justice. With that in mind, it is incumbent upon all witnesses and institutions participating in this Inquiry to give open and frank evidence; to be reflective in respect of

failings of the past; to consider lessons learned and to assist you, Chair and panel, to help prevent any repeat of the appalling experiences of children in the care of Lambeth, some of whom you have already heard about within this opening, and others who you will hear from and about during the evidence itself.

Procedure/Other issues

Disclosure exercise

341. A huge amount of work has been undertaken by IICSA obtaining and preparing evidence for this investigation. Documents were requested from a range of organisations, institutions and individuals, including Lambeth Council, the Metropolitan Police Service and the Crown Prosecution Service. All documents received by the investigation, many as a result of searches, have been reviewed for relevance by the Inquiry team, which has been a considerable task. 35,445 documents totalling 362,780 pages have been received, approximately 1,861 documents totalling 24,244 pages have been disclosed. Of relevance to all core participants and their legal representatives will be the chronology produced with the collaborative efforts of all core participant teams and which is a work in progress. In addition to the chronology, as far as complainant core participant evidence is concerned, you will receive evidence by the means of a thematic gist table as referred to earlier in this morning.

342. In terms of witnesses to be called, the timetable has been put together with input from all core participants to hear from a range of witnesses who between them are able to address the many and various issues raised today.

Procedure

343. To assist everyone's understanding, the evidence will be presented in one of two ways. Witnesses will either give evidence by remote video link, or evidence will, at appropriate points, be read or summarised by a member of the counsel team and formally adduced into evidence by such means.

344. On the 12th May 2020, you determined, Chair, that the Lambeth public hearing would commence by way of virtual hearing if it was not safe to hold it in person at the Inquiry's hearing centre. It is not currently possible and in accordance with government restrictions to have all legal teams and their representatives in one place at Pocock Street. Software and equipment have been provided to witnesses to enable their effective participation in this virtual hearing. Some witnesses and core participants, where it is safe to do so, have been able to join their legal representatives, in order to give virtual evidence at this hearing. It is recognised that for all witnesses and core participants the current format of this hearing has meant adapting working methods. The investigation team notes that there has been full co-operation from core participants and their legal representatives with remote working thus far, and this has been vital in the progression of the work of the Inquiry.

345. Similar with evidence heard in other investigations at Pocock Street, the witness evidence in this investigation will largely be live-streamed. In terms of protecting the identity of complainant core participants, in order to reduce the risk of a breach of any restriction

order imposed to protect their identity, the evidence of anonymous witnesses will not be live-streamed. Where evidence is not live-streamed, it will be recorded and uploaded to the Inquiry website as soon as possible thereafter, together with the transcript.

346. All witnesses will be reminded of the meaning and effect of any restriction order by their legal representatives and the Inquiry legal team before giving evidence, and of the need to refer to ciphers for those covered by them and who should remain anonymous. If there is an inadvertent breach of a restriction order, we will ask you, Chair, to make an immediate further notice order over the evidence incorrectly given.

347. Chair, that concludes all that I would wish to say at this time, and tomorrow you will hear opening statements on behalf of the Lambeth Council investigation Core Participants.