

<p>1 Monday, 29 June 2020</p> <p>2 (10.30 am)</p> <p>3 Welcome and opening remarks by THE CHAIR</p> <p>4 THE CHAIR: Good morning, everyone. I'm Alexis Jay and I'm</p> <p>5 the chair of the Independent Inquiry into Child Sexual</p> <p>6 Abuse. With me are the other panel members of</p> <p>7 the inquiry: Professor Sir Malcolm Evans, Ivor Frank and</p> <p>8 Drusilla Sharpling.</p> <p>9 On behalf of the inquiry, I welcome you all to the</p> <p>10 substantive hearing into the investigation into the</p> <p>11 extent of any institutional failures to protect children</p> <p>12 in the care of Lambeth Council from sexual abuse and</p> <p>13 exploitation. It is the second public hearing to be</p> <p>14 held remotely by this inquiry. Following on from the</p> <p>15 virtual public hearing on child protection in religious</p> <p>16 organisations and settings, the solicitor to the inquiry</p> <p>17 sought the views of all Lambeth Council investigation</p> <p>18 core participants about the possibility of conducting</p> <p>19 the hearing remotely. Having considered all the</p> <p>20 responses, I ruled on 12 May 2020 that a remote hearing</p> <p>21 was both desirable and practicable.</p> <p>22 I would like to thank the core participants,</p> <p>23 witnesses and representatives for their co-operation in</p> <p>24 preparing for this hearing, and indeed to thank the</p> <p>25 inquiry staff for their hard work in making all the</p> <p style="text-align: center;">Page 1</p>	<p>1 necessary arrangements. It will run for 20 days,</p> <p>2 finishing Friday, 31 July 2020.</p> <p>3 This investigation will examine the nature and</p> <p>4 extent of, and institutional responses to, the sexual</p> <p>5 abuse of children in the care of Lambeth Council,</p> <p>6 including those cared for in children's homes by foster</p> <p>7 carers and by adoptive parents. The investigation will</p> <p>8 also examine the following five specific children's</p> <p>9 homes as case studies during the hearing. These</p> <p>10 are: Shirley Oaks; Angell Road; Southvale Assessment</p> <p>11 Centre; Ivy House; and Monkton Street.</p> <p>12 Before we hear from leading counsel to the inquiry,</p> <p>13 Rachel Langdale QC, some points on timing. Each day, we</p> <p>14 will begin from 10.30 am. We will take a 15-minute</p> <p>15 break every hour and will take an hour break for lunch</p> <p>16 at approximately 12.45 pm, returning at 1.45 pm. We</p> <p>17 intend to sit no later than 4.00 pm each day.</p> <p>18 By way of an agenda, we rely on the hearing</p> <p>19 timetable which sets out the order in which witnesses</p> <p>20 will be called, save for where unforeseen circumstances</p> <p>21 require a change to be made.</p> <p>22 A simultaneous hearing transcript will be produced</p> <p>23 and is available to those taking part in this hearing</p> <p>24 via a web browser. The transcript will be published at</p> <p>25 the end of each day on the inquiry website and any</p> <p style="text-align: center;">Page 2</p>
<p>1 directions arising from the day's hearing will also be</p> <p>2 published on the website.</p> <p>3 Participants are asked, as Mr Hughes has said, to</p> <p>4 mute their microphones and turn off their camera unless</p> <p>5 they are speaking. If microphones pick up noise such as</p> <p>6 typing, they will place the person on screen as if they</p> <p>7 are speaking. Turning off cameras will keep the screen</p> <p>8 from becoming distracting by looking too busy for those</p> <p>9 using the gallery view.</p> <p>10 I have made a restriction order protecting the</p> <p>11 identity of complainant core participants and covering</p> <p>12 the redactions and ciphers applied in this</p> <p>13 investigation. For technical reasons, it will not be</p> <p>14 possible to broadcast this hearing with the usual</p> <p>15 three-minute delay. All witnesses and core participants</p> <p>16 have been reminded of these restriction orders and of</p> <p>17 the need to take great care in giving evidence or</p> <p>18 addressing the inquiry to avoid any inadvertent breaches</p> <p>19 of these orders. If there is an inadvertent breach of</p> <p>20 a restriction order, I will make an immediate further</p> <p>21 order over the evidence incorrectly given.</p> <p>22 Members of the public and the press will be</p> <p>23 prohibited from publishing that evidence. The evidence</p> <p>24 of those anonymous witnesses, ie, complainant core</p> <p>25 participants whose identities are protected by</p> <p style="text-align: center;">Page 3</p>	<p>1 restriction orders, will not be live streamed, but</p> <p>2 a transcript of the evidence will be uploaded to the</p> <p>3 inquiry's website as soon as possible thereafter,</p> <p>4 together with an audio file of the evidence, where</p> <p>5 appropriate.</p> <p>6 Please now go ahead, Ms Langdale.</p> <p>7 Opening statement by MS LANGDALE</p> <p>8 MS LANGDALE: Chair, today you and the panel begin</p> <p>9 a four-week hearing in the Lambeth investigation. The</p> <p>10 investigation will examine the scale and nature of</p> <p>11 the sexual abuse experienced by children in the care of</p> <p>12 Lambeth Council over decades and the extent of any</p> <p>13 institutional failures to protect children in care from</p> <p>14 sexual abuse and exploitation.</p> <p>15 The investigation will not only examine</p> <p>16 institutional failures of the past, but it is committed</p> <p>17 to a careful evidential evaluation of how children in</p> <p>18 care might be made safer in the future and how they</p> <p>19 might be protected from sexual abuse.</p> <p>20 May I first introduce counsel to the investigation,</p> <p>21 core participants and their representatives. I am</p> <p>22 Rachel Langdale QC, and together with Clair Dobbin,</p> <p>23 Clare Brown, Amelia Nice and Ruth Kennedy, we represent</p> <p>24 counsel to the Lambeth investigation.</p> <p>25 The investigation team has been assisted in its work</p> <p style="text-align: center;">Page 4</p>

<p>1 by the participation of a number of victim and                  2 complainant core participants and their legal                  3 representatives. Chair, I will now introduce the core                  4 participant teams as follows and ask that each advocate                  5 speak into the microphone and make themselves known as                  6 they are introduced so that they appear briefly on                  7 screen.                  8 Complainant core participants represented by                  9 Switalskis and Susannah Johnson.                  10 MS JOHNSON: Good morning, chair. Good morning, panel                  11 members.                  12 MS LANGDALE: Complainant core participants represented by                  13 Verisona Law, Remedy Law and Mr Iain O'Donnell.                  14 MR O'DONNELL: Thank you. Good morning, chair, good                  15 morning, panel.                  16 MS LANGDALE: Complainant core participants represented by                  17 Imran Khan QC, Imran Khan &amp; Partners.                  18 MR KHAN: Good morning, chair. Good morning, panel.                  19 THE CHAIR: Good morning, Mr Khan.                  20 MS LANGDALE: Complainant core participants represented by                  21 Malcolm Johnson, Hudgells. Mr Johnson, do you hear us                  22 there? You may be on mute, Mr Johnson. Let me move on.                  23 I will perhaps sweep back later.                  24 Complainant core participants represented by                  25 Alan Collins, Hugh James?</p> <p style="text-align: center;">Page 5</p>	<p>1 MR COLLINS: Good morning, chair. Good morning, panel.                  2 MS LANGDALE: LA-A25, represented by Richard Scorer,                  3 Slater &amp; Gordon.                  4 MR SCORER: Good morning, chair and panel.                  5 THE CHAIR: Good morning, Mr Scorer.                  6 MS LANGDALE: LA-A24 and also Anna Tapsell, represented by                  7 Simpson Millar and Aswini Weeraratne QC.                  8 MS WEERERATNE: Good morning, chair and panel.                  9 MS LANGDALE: LA-131 represented by Uppal Taylor and                  10 Stephen Simblet QC.                  11 MR SIMBLET: Good morning, chair. Good morning, panel.                  12 THE CHAIR: Good morning, Mr Simblet.                  13 MS LANGDALE: Five other individuals are core participants                  14 in this investigation. They are Stephen Whaley and                  15 Dr Nigel Goldie, represented by Howe &amp; Co and                  16 Chris Jacobs.                  17 MR JACOBS: Good morning, chair and panel.                  18 MS LANGDALE: As I have indicated, Anna Tapsell is                  19 represented by Aswini Weeraratne QC. Former leader of                  20 the council, Joan Twelves, is represented by                  21 Desmond Doherty and Henry Toner QC.                  22 MR TONER: Good morning, chair. Good morning, everyone                  23 else.                  24 MS LANGDALE: Richard Gargini, represented by 3D Solicitors                  25 and James Berry.</p> <p style="text-align: center;">Page 6</p>
<p>1 MR BERRY: Thank you. Good morning, chair, good morning,                  2 panel.                  3 MS LANGDALE: Institutional core participants,                  4 Lambeth Council, firstly, represented by Alex Verdan QC.                  5 MR VERDAN: Good morning, chair, good morning, panel.                  6 THE CHAIR: Good morning, Mr Verdan.                  7 MS LANGDALE: Crown Prosecution Service represented by                  8 Ed Brown QC.                  9 MS BROWN: Good morning, chair, good morning, panel.                  10 THE CHAIR: Good morning, Mr Brown.                  11 MS LANGDALE: The Commissioner of Police of the Metropolis,                  12 MPS, represented by Samantha Leek QC.                  13 MS LEEK: Good morning, chair and panel.                  14 THE CHAIR: Good morning, Ms Leek.                  15 MS LANGDALE: The Independent Office for Police Conduct, the                  16 IOPC, represented by Gerry Boyle QC.                  17 MR BOYLE: Good morning, chair, good morning, panel.                  18 THE CHAIR: Good morning, Mr Boyle.                  19 MS LANGDALE: Finally, the Secretary of State for Education,                  20 represented by Cathryn McGahey QC.                  21 MS MCGAHEY: Good morning, chair. Good morning, panel.                  22 THE CHAIR: Good morning, Ms McGahey.                  23 MS LANGDALE: Before I begin, Mr Johnson from Hudgells,                  24 complainant core participants representative, I don't                  25 know if you are able to come on screen and say good</p> <p style="text-align: center;">Page 7</p>	<p>1 morning now? I will move on, chair.                  2 Today you will be hearing an opening statement from                  3 the inquiry and you will hear core participant opening                  4 statements tomorrow. On Wednesday, you will start                  5 hearing oral evidence. The evidence will continue for                  6 the rest of this week and all of next week. The week                  7 commencing 13 July is a non-sitting week for the                  8 inquiry. We will resume on Monday, 20 July for two                  9 weeks and at the end of those two weeks there will be                  10 a non-sitting day on Thursday, 30 July and closing                  11 statements for core participants will be made on Friday,                  12 31 July.                  13 Chair, as you and the panel are fully aware,                  14 children living in care in residential homes and foster                  15 families are amongst the most vulnerable in society.                  16 Some with complex needs or communication difficulties                  17 will be even more vulnerable. Allegations of sexual                  18 abuse in children's homes, homes intended to be harbours                  19 of safety and respite, often from violence, sexual abuse                  20 and neglect, homes intended to promote the well-being of                  21 children, demand a thorough investigation.                  22 Central to the Lambeth Council investigation, the                  23 inquiry will consider the experiences of children in                  24 care. We will investigate where there were child                  25 protection failures by Lambeth Council, the police and</p> <p style="text-align: center;">Page 8</p>

<p>1 other public authorities. We will examine the extent to                  2 which vulnerabilities of children rendered them at risk                  3 of sexual abuse and whether those vulnerabilities shaped                  4 how public authorities responded to them.                  5 May I summarise today the scope of the Lambeth                  6 investigation and the topics and issues we will be                  7 considering over the next month. The investigation and                  8 the evidence fall to be examined within the following                  9 sections. Firstly, the experience of children in care                  10 to include residential care, fostering and adoption.                  11 Second, the culture at Lambeth over time, including the                  12 relationship between officers and councillors and                  13 Lambeth's response to allegations of child sexual abuse.                  14 Third, external inspection of Lambeth's children's                  15 services, including the role of Ofsted and its current                  16 inspections.                  17 Fourth, the response of the MPS to allegations of                  18 child sexual abuse.                  19 Fifthly, prosecutorial decisions around child sexual                  20 abuse.                  21 Finally, obtaining allegations and medical evidence                  22 from complainants of child sexual abuse.                  23 Turning then to the first topic, experiences of                  24 children in care, including residential care, fostering                  25 and adoption.</p> <p style="text-align: center;">Page 9</p>	<p>1 The inquiry will receive evidence in a number of                  2 ways to enable greater understanding of the nature of                  3 individual experiences of children in care. Firstly,                  4 the inquiry will be assisted by the participation of                  5 complainant core participants who are sharing their                  6 experience of being in the care of Lambeth as a child                  7 with you, chair and panel, and the public. Their                  8 identities are protected, of course, by the use of                  9 a cipher. All of the complainant participants in this                  10 investigation describe being sexually abused as                  11 children. Between them, they provide a substantial body                  12 of written evidence and highlight enduring issues about                  13 being in care, including feelings of isolation, fear and                  14 vulnerability.                  15 You are also due to hear oral evidence from                  16 12 victim/survivor complainant CPs. Additionally, every                  17 complainant core participant's voice within this                  18 investigation has been incorporated within a thematic                  19 gist table which will be introduced and read into the                  20 evidence by Ms Nice of counsel as the hearing                  21 progresses.                  22 In addition to contributions from victim/survivor                  23 complainant core participants, counsel to the                  24 investigation have considered extensive materials                  25 provided by Lambeth Council and other core participants,</p> <p style="text-align: center;">Page 10</p>
<p>1 with particular emphasis on case study homes:                  2 Shirley Oaks; Angell Road; Southvale Assessment Centre;                  3 Ivy House; and Monkton Street. This includes statements                  4 which were provided over time to the police in other                  5 investigations into Lambeth care homes.                  6 We emphasise, as we have done before, that these                  7 case study homes do not represent the totality of what                  8 happened to children in Lambeth's care; far from it.                  9 They have been selected so as to provide a focus for the                  10 hearing to enable thematic issues to be considered which                  11 are indicative of the wider picture within Lambeth or                  12 the culture operating within the council over a period                  13 of time. In terms of understanding the experiences of                  14 children in care, the case study homes provide                  15 a proportionate focus from which to examine those                  16 experiences. Documentary review of material emanating                  17 from those homes, including care files, has yielded                  18 a wealth of information surrounding responses to                  19 children in care.                  20 We have been struck many times over by the                  21 distressing circumstances in which children were taken                  22 into residential care in Lambeth in the first instance.                  23 Some came into care because of extreme neglect, because                  24 of bereavement, because they had been abandoned, because                  25 they had endured painful, physical violence or because</p> <p style="text-align: center;">Page 11</p>	<p>1 of sexual abuse within the family setting. Others came                  2 into care because of housing problems or material                  3 conditions in the family home. All of them needed care                  4 and protection.                  5 In a speech in 2019, Sir James Munby, the former                  6 President of the Family Division, reflected on a case                  7 which he had determined in 2002 about children in                  8 Lambeth's care and which he described as a shocking case                  9 of two brothers lost in care. He said:                  10 "The state assumes a heavy burden when it takes                  11 a child into care. The least that the state can be                  12 expected to do is not itself to cause significant harm                  13 to the children whom it takes into its care. Indeed, if                  14 the state is to justify removing children from their                  15 parents, it can only be on the basis that the state is                  16 going to provide a better quality of care than that from                  17 which the child in care has been rescued."                  18 This investigation raises fundamental questions as                  19 to whether life was any better or, indeed, whether it                  20 was far worse for some children after they came into                  21 Lambeth's care.                  22 We are conscious that sexual abuse cannot be                  23 separated from other important themes which will emerge                  24 from the evidence, including, but not limited to, the                  25 anguish of separation from siblings, racism, fear, the</p> <p style="text-align: center;">Page 12</p>

<p>1 paucity of leaving care provision and the lost                  2 opportunity to fulfil each child's promise.                  3 We note just a few examples at the outset. This is                  4 the account of a young woman who spoke to Lambeth in the                  5 1990s on a confidential basis about her time in care.                  6 She was adamant she did not want to be known, she didn't                  7 want to complain, she was just telling Lambeth how it                  8 was. Like many children, she was concerned about how                  9 other children had been treated. She gave, as an                  10 example of violence to children, a description of                  11 a child being held down in a bath of cold water because                  12 he swore at a member of staff. He was then made to                  13 repeat a nursery rhyme several times as proof he could                  14 complete a series of sentences without swearing. It was                  15 customary for the staff member involved to slap                  16 children. The young woman stated that the child's                  17 screams could be heard throughout the building but she                  18 did not believe that any senior member of staff had                  19 investigated the screams then or thereafter. She,                  20 herself, had taken refuge in her room.                  21 She referred to overt racism she'd experienced at                  22 the hands of staff. She referred to her own sexual                  23 abuse by a residential social worker. She had not                  24 realised at the time that she was vulnerable.                  25 A person from Lambeth who spoke to her asked how she</p> <p style="text-align: center;">Page 13</p>	<p>1 had managed to survive. She said her main concern had                  2 been to keep her head down and grow up and get out of                  3 the care system.                  4 If the height of a child in care's aspiration is                  5 simply to grow up so as to escape it, then that is                  6 a damning indictment of the care system. The bleakness                  7 of life for some children in Lambeth's homes is evident.                  8 One former resident was asked by the Children's Homes in                  9 Lambeth Enquiry, of which you will hear more later, to                  10 describe something good that happened to him when he                  11 lived in a Lambeth home. He replied, "One day, they let                  12 us outside into the field next door and I thought we                  13 were leaving, which made me happy for a while".                  14 LA-A25, a core participant, was placed in care                  15 aged 3 and stayed at Shirley Oaks until leaving,                  16 aged 17. She suffered prolonged sexual abuse by                  17 Donald Hosegood alongside threats and vicious                  18 punishment. The abuse started when she was aged 11                  19 or 12. By the age of 16, she had a Saturday job. One                  20 day, she broke down at work due to the continuing abuse.                  21 She confided in a co-worker who took her to the manager                  22 who then called the police. She was taken to a London                  23 police station and gave a police statement.                  24 Chair and panel, you may think that from the moment                  25 she made her allegations, LA-A25 was treated without</p> <p style="text-align: center;">Page 14</p>
<p>1 compassion or support. She went on to repeat the                  2 allegations to a social worker and asked him if he would                  3 call her a liar. The duty social worker's recorded                  4 response was to say that, "If she knew she was telling                  5 the truth, there was no reason for me to assume she was                  6 lying". The psychiatrist at Shirley Oaks, LA-F127, saw                  7 L-A25 several times in 1974. He dismissed her concerns                  8 as attention seeking. We will hear direct evidence from                  9 LA-A25 about her experience of dealing with the                  10 authorities and a criminal trial when a child in care.                  11 Some children died in Lambeth's care. In 1975,                  12 a baby girl, who had not yet reached her first birthday,                  13 was found dead. She had been sleeping harnessed to                  14 a top bunk bed and had asphyxiated. Records demonstrate                  15 that the baby girl's older sister had spoken to her                  16 mother on the telephone previously and said that staff                  17 force-fed the baby, tied the baby in the bed and didn't                  18 look after her when the baby was crying. There is                  19 another record of the sister speaking to a social worker                  20 about a cot for the baby.                  21 These cases and many others will illustrate why the                  22 investigation of Lambeth matters. It would be an                  23 injustice to treat this investigation as though it is                  24 somehow of historical significance. Aside from the fact                  25 that a number of matters that we will look at did not</p> <p style="text-align: center;">Page 15</p>	<p>1 happen that long ago, the cases we will examine continue                  2 to affect adults now and it is the culture which allowed                  3 the state of affairs to exist over such a long period of                  4 time that must be scrutinised. Laws, policies and                  5 regulation can be changed, but it is vital that we                  6 understand how people and organisations whose very job                  7 it was to provide care and to keep children safe could                  8 expose children to such risk in the first place.                  9 Understanding the experiences of children in care                  10 reinforces the need for society's vigilance when it                  11 comes to safeguarding the lives of children in care in                  12 the future.                  13 The investigation team has drawn focused summaries                  14 from records compiled at the time during the Children's                  15 Homes in Lambeth Enquiry, known as CHILE, in 1998.                  16 Lambeth set up CHILE as a counterpart to the Middleton                  17 police investigation. This was a joint investigation                  18 which lasted some five years. The effectiveness or                  19 impact of CHILE is a matter that will be considered in                  20 oral evidence. The summaries provide an insight into                  21 the work of CHILE and they provide this investigation                  22 with a further scheme of evidence from which children's                  23 experiences can be understood.                  24 The CHILE files reflect only a small proportion of                  25 the children who were in the care of the Lambeth, but,</p> <p style="text-align: center;">Page 16</p>

<p>1 nonetheless, they speak to the wider experience of                  2 children in Lambeth homes, in homes in other parts of                  3 the country and in foster care. The summaries of                  4 the CHILE records prepared by counsel to the                  5 investigation have been wholly anonymised in order to                  6 protect the identity of the children involved.                  7 Lambeth Council were asked to indicate whether there was                  8 anything within the investigation team's summaries with                  9 which it disagreed or wished to correct. That process                  10 having been undertaken, the inquiry is able to admit                  11 those anonymised summaries into evidence.                  12 You can be confident, chair, that at the conclusion                  13 of this hearing you will have an extensive body of                  14 evidence from which to assess the experiences of                  15 children in Lambeth's care and over time.                  16 Let me turn now, by reference to case study homes in                  17 the CHILE files, to highlight some of the evidence                  18 around experiences of children in Lambeth's care and the                  19 thematic issues which will emerge.                  20 Shirley Oaks, firstly. Unlike our other case study                  21 homes, Lambeth at no point commissioned any internal                  22 report or enquiry into any allegation or incidence of                  23 abuse at Shirley Oaks. The primary sources of                  24 information to this investigation are, first, the voices                  25 of core participants who lived there. Second, written</p> <p style="text-align: center;">Page 17</p>	<p>1 records from Lambeth which have remained in existence                  2 from the time, including the individual care records of                  3 children. Third, statements made to the police,                  4 principally those made between 1998 to 2002 by former                  5 staff and children in care during the police                  6 investigation called Operation Middleton and some made                  7 to police in other more recent investigations.                  8 We have also been able to compare our evidence and                  9 analysis with that of the Shirley Oaks Survivors                  10 Association as set out in their work, including "Looking                  11 for a Place Called Home", 2016.                  12 Shirley Oaks was purpose built as a long-stay                  13 residential care home for children aged 2 to 17 years.                  14 It dated back to 1904. It was built on 77 acres and was                  15 the oldest and largest of the homes operated by Lambeth.                  16 The premise was that children should be brought up in                  17 a home environment rather than in an institution. To                  18 that end, the home was comprised of some 39 individual                  19 cottages. It was intended to be a self-sufficient                  20 village with a primary school, infirmary, swimming pool,                  21 workshops and other buildings. Many children refer to                  22 not leaving the site at all. The site could accommodate                  23 up to 350 children at one time.                  24 Children lived in small groups in the individual                  25 houses with house parents. House parents were employed</p> <p style="text-align: center;">Page 18</p>
<p>1 by Lambeth on a live-in basis, often with their partner                  2 living with them to help assist with care of                  3 the children. One such house parent was William Hook,                  4 who was later convicted of numerous child sexual abuse                  5 offences. He was described, as you will hear later, as                  6 a Walter Mitty character, allowed to be a house parent                  7 in exchange for food and lodging.                  8 Children would also spend time with social aunts and                  9 uncles who were members of the public invited by the                  10 council to volunteer to spend time with children in                  11 a children's home. They were permitted to do activities                  12 with the children or to take children on day trips or                  13 holidays away from Shirley Oaks. Lambeth accept that                  14 during the period Shirley Oaks operated, there were no                  15 requirements for staff to hold qualifications in social                  16 work, be police checked or to undertake specific                  17 training prior to working in a children's home. No                  18 child protection safeguards were in place in the social                  19 aunts and uncles system. It appears that the doors to                  20 Shirley Oaks may have been opened, in essence, to any                  21 adult professing an interest in taking children out --                  22 taking them to church, playing sport with them or even                  23 just showing an interest in them. That is a matter                  24 which will be considered in evidence.                  25 Physical access to Shirley Oaks site was largely</p> <p style="text-align: center;">Page 19</p>	<p>1 unregulated. LA-A50, for example, refers to the house                  2 mother having house parties and adults bringing alcohol                  3 which they would give the children. LA-A50 says                  4 Shirley Oaks was such a big site with different people                  5 coming and going and different organisations inputting                  6 with activities, it was easy for a visitor to give the                  7 impression of being a staff member. LA-A50 says that he                  8 was sexually abused by a man referred to as "the rugby                  9 player", who was a regular visitor but not staff. This                  10 man was, in fact, Geoffrey Clarke, implicated in the                  11 sexual abuse of many children. He was convicted in 1998                  12 of eight counts, including indecent assault and taking                  13 an indecent photograph of a child. He was also charged                  14 in Operation Middleton but took his own life on the                  15 third day of the trial.                  16 LA-A20 refers to men having unrestricted access to                  17 parts of Shirley Oaks. LA-A67 recalls two priests                  18 visited regularly and took a particular interest in his                  19 sisters. One would stay the night.                  20 Visitors books should have been used to track who                  21 was there, but they never were.                  22 A former community service volunteer at Rowan House                  23 in 1977 referred to a lot of people coming and going --                  24 husbands, boyfriends, visitors and a high turnover of                  25 staff generally. Furthermore, the volunteer described</p> <p style="text-align: center;">Page 20</p>

<p>1 a distinct lack of interest by the upper management                  2 about any concerns raised by children in any of                  3 the houses.                  4 If the aim of Shirley Oaks was to replicate the                  5 experience of homeliness, then from the outset there is                  6 evidence to show that aim was not met. In April 1964,                  7 before Lambeth assumed responsibility for Shirley Oaks,                  8 the superintending inspector for London region central                  9 wrote:                  10 "Pressure on this large cottage group daunts                  11 progress. Despite a good administration and some                  12 material improvements, the house mothers in these                  13 crowded cottages rarely achieve a high standard of                  14 care."                  15 Lambeth's children's officer made a report to                  16 the October 1967 meeting of the Children's Committee                  17 questioning the very fitness of Shirley Oaks for the                  18 care of children in future. It records:                  19 "The committee is at this point invited to consider                  20 whether it wishes Shirley Oaks to continue in use                  21 indefinitely. There has been much criticism in the past                  22 of very large children's homes and a considerable number                  23 up and down the country have been closed in the past                  24 40 years. They are usually condemned for providing too                  25 institutional a life, for having insufficient links with</p> <p style="text-align: center;">Page 21</p>	<p>1 the community and with encouraging the children to look                  2 inwards to the resources, such as swimming baths and                  3 libraries within the home, rather than outwards to                  4 community resources at large. For these reasons, the                  5 Home Office may possibly ask the council to consider the                  6 closure of this very large home."                  7 Many cottages were in a state of serious disrepair.                  8 A report presented to the Social Services Committee                  9 after a visit by Don Thomas in 1972 described the                  10 facilities and accommodation as totally unacceptable.                  11 Shirley Oaks nonetheless remained in use until 1983.                  12 The investigation is acutely conscious that there                  13 are public concerns as to whether children from black,                  14 Asian minority ethnic backgrounds were even more                  15 disadvantaged by their care in Lambeth or even more                  16 vulnerable to sexual abuse. Racism was evident from the                  17 earliest days of Shirley Oaks. An extract from                  18 a Home Office inspection of Shirley Oaks from the 1960s                  19 referred to house mothers who would not, in the language                  20 of the report, "receive coloured children".                  21 Figures in 1980 showed that an average of                  22 55 per cent of children in Lambeth's residential care                  23 were black and that an average of 57 per cent of                  24 children placed in Shirley Oaks were black. A minority                  25 of children in care, approximately 23 per cent, were</p> <p style="text-align: center;">Page 22</p>
<p>1 placed in residential establishment. The numbers of                  2 black children in residential care were disproportionate                  3 to their representation within the overall child                  4 population in Lambeth, which was approximately                  5 40 per cent. A head count carried out in Shirley Oaks                  6 in June 1980 found that out of 66 children who lived                  7 there for more than two years, 14 were white, 52 were                  8 black.                  9 We will see that within written policy documents it                  10 was well understood by Lambeth that all children in                  11 care, but particularly those in long-term care, would                  12 suffer damage to their self-esteem and sense of identity                  13 and that this assumed an added dimension for black                  14 children whose cultural and racial heritage was not                  15 acknowledged and whose experiences of discrimination and                  16 disadvantage might be denied. LA-A108, a black child                  17 fostered by a white family when she was aged 9,                  18 reflected Lambeth's understanding. She says, "I was                  19 with a white family in a predominantly white area and                  20 I stood out like a sore thumb. I just wanted to be                  21 accepted, but, because of my colour, I was an easy                  22 target for racist taunts".                  23 The key question for this investigation is, whatever                  24 knowledge or understanding was reflected in policy                  25 documents, what did any of Lambeth's childcare policies</p> <p style="text-align: center;">Page 23</p>	<p>1 actually achieve in practice? Were the lives of                  2 children any the better for policies intended to improve                  3 a sense of self and identity? Were suitable placements                  4 for each child found and in accordance with each child's                  5 needs and best interests or did the practical reality                  6 over time illustrate something very different?                  7 In 1991, the Social Services manager wrote about                  8 a child who had been excluded from a care home:                  9 "The panel was very concerned that a 13-year-old                  10 black girl, who was also the victim of two sexual                  11 assaults while in care, could be so excluded after one                  12 incident in a children's home. As you know, the panel                  13 is involved with monitoring the suitability of                  14 placements in private and voluntary establishments with                  15 a view to a reduction. Consequently, we were appalled                  16 that a young person deemed unsuitable for Lambeth's                  17 children home could be cared for quite adequately in                  18 a private and voluntary facility."                  19 This manager criticised homes for putting staff                  20 before children, before concluding:                  21 "Clearly, this arbitrary style of decision making                  22 will continue to militate against the interests of                  23 children and black children in particular as they seem                  24 to experience more moves than white children with the                  25 resultant impairment of their emotional development."</p> <p style="text-align: center;">Page 24</p>

<p>1 Children in their statements to the police in 1999                  2 referred to race and racism as being a barrier to                  3 disclosure and part of the abuse they experienced.                  4 LA-A117 refers to not being able to talk to her house                  5 mother, who was white and she didn't want me". LA-A50                  6 was subject to sexual abuse by a man who was also                  7 physically violent and racially abusive.                  8 Former children within Shirley Oaks refer to the                  9 stigma attached to being in care. LA-B27 says:                  10 "Staff would often give the child the idea that,                  11 because they were an orphan or whatever, they would                  12 never amount to anything. Academically, the children                  13 were not pushed so the children grew up to manual jobs,                  14 as I did. It was assumed the children would not amount                  15 to much."                  16 LA-A67 was placed in care in the '60s. He                  17 remembers:                  18 "We were often told we were not normal children, we                  19 were scum, we would never amount to anything and we                  20 didn't deserve to be looked after. The home was run on                  21 fear. All the children only wanted to be loved and have                  22 some affection shown to them."                  23 A theme which we have noted throughout this                  24 investigation is the sadness of those individuals who                  25 felt profoundly let down by the lack of care invested in</p> <p style="text-align: center;">Page 25</p>	<p>1 their education. One former resident conveyed her anger                  2 to CHILE at being placed in a school for children with                  3 special needs when she didn't have any. We have                  4 reviewed her records, which have recorded her in                  5 childhood as bright.                  6 Many children referred in their statements to the                  7 police and in their engagement with CHILE as suffering                  8 regular violence as punishment. This is also reflected                  9 in SOSA's work. Sometimes, such abuse had to be                  10 confronted. A record from 1972 records a child being                  11 found cold and distressed by a milkman in the grounds of                  12 Shirley Oaks. The child explained he'd received                  13 a beating from a house father and spent the night in an                  14 out-house. He was found by a doctor to have extensive                  15 bruising to the buttocks. This was regarded by Lambeth                  16 as an infringement of rules on corporal punishment and                  17 the child was returned to the home. The house father                  18 was the spouse of a house mother. The file notes that,                  19 far from this incident being a cause for concern, he was                  20 likely to be recommended to be made a full-time house                  21 father as the couple appeared to be running a happy                  22 house.                  23 LA-A76 recalls the unprovoked nature of                  24 the violence. Simple, ordinary, childlike things, like                  25 singing, resulted in a slap around the face. LA-A63 was</p> <p style="text-align: center;">Page 26</p>
<p>1 placed at Shirley Oaks at around 18 months of age. He                  2 left when he was 16 years of age. He recalls the                  3 violence of the house mother. She hit you all the time                  4 for next to nothing. The house mother was so difficult                  5 to work with, he remembers her assistants came and went                  6 quickly. We note that a high turnover of staff, of                  7 course, reduced the opportunity for children to form any                  8 trusting relationship with an adult within the home.                  9 LA-A228 describes an incident of sexual abuse in                  10 which Hosegood had threatened him:                  11 "I remember that just before it finished, I told him                  12 I would tell someone. It was in the workshop and he put                  13 a pair of garden shears to my throat. He said he could                  14 cut me up in little pieces and bury me so that no-one                  15 would find me."                  16 We understand children witnessed violence being used                  17 against other children. Some intervened at their own                  18 risk. Others were too scared but, as a result, felt                  19 guilty. LA-A158 remembers watching a house mother                  20 beating a young boy and wedging him against a wall so                  21 that the edge of the table pushed against the child's                  22 neck. LA-B28 also remembers witnessing this incident.                  23 The boy was gasping for breath. LA-A158 thought the boy                  24 would be killed, but managed to pull the table back by                  25 breaking one of the table legs so the boy could escape.</p> <p style="text-align: center;">Page 27</p>	<p>1 LA-A20 says the violent beatings at the hands of his                  2 house mother, LA-F65, occurred weekly, sometimes five                  3 times a week. He says:                  4 "At the time, I didn't know any different. I just                  5 thought all children were treated this way. It wasn't                  6 really until I went to secondary school and formed                  7 friendships with children outside Shirley Oaks that                  8 I began to realise that such treatment wasn't usual and                  9 was wrong."                  10 LA-A20 reports he took the brunt of the house                  11 mother's frustration. He says, looking back, "I believe                  12 this is because I was vulnerable because I was not                  13 visited by any family, and so didn't have anyone to                  14 complain to".                  15 Jane Warwick, an administrator for Lambeth for                  16 15 years from 1975, described to the police a ledger she                  17 located at Shirley Oaks when the home was closing which                  18 included photographs of many of the children and                  19 descriptions of so-called ailments and defects. In                  20 2014, she said in a statement to the police, "It was                  21 shocking to look at as it was an account of the physical                  22 destruction of the children".                  23 For victims of sexual abuse, the fear, violence and                  24 isolation at Shirley Oaks closed down the possibilities                  25 to report to other adults. LA-A158, a victim of</p> <p style="text-align: center;">Page 28</p>

<p>1 long-term sexual abuse, recalls:                  2 "LA-F64 would say that I had to keep it a secret.                  3 Otherwise, my mum would have one of her tempers and be                  4 locked away in prison. I was never physically                  5 threatened. However, we were very isolated at                  6 Shirley Oaks. You went to school on site until you were                  7 11 years old. Everything was provided for. We never                  8 went shopping for clothes or food. We had our own                  9 swimming pool, so we never had to leave site, even for                  10 swimming lessons. We went on holiday for two weeks in                  11 the summer which is probably the only time we saw proper                  12 shops."                  13 Children describe how they were removed from                  14 education after making a complaint. LA-A67 states that                  15 after his disclosure about sexual abuse by LA-F93, for                  16 a while he was kept away from school and from other                  17 children at Shirley Oaks as if he had done something                  18 wrong.                  19 LA-A76 describes being isolated after alleging                  20 sexual abuse by LA-F37.                  21 A residential worker told the police in January 2003                  22 that a child who was the victim of sexual abuse by two                  23 men was out of school. He was excluded for a long time                  24 and only got two hours' tuition per week from a tutor.                  25 He had no routine and was bored for a lot of the time.</p> <p style="text-align: center;">Page 29</p>	<p>1 The system failed him miserably.                  2 LA-B25 says she witnessed the sexual abuse of her                  3 two brothers by different men at different times. On                  4 one occasion, the abuser was Patrick Grant. You will                  5 hear more about Grant in this opening. She says, "Grant                  6 followed him and beat him with a leather belt. I heard                  7 screaming whilst he was being beaten. He was my                  8 brother. I don't think I'll ever forget that. It                  9 really upset me". LA-B25 does not remember having                  10 a social worker, but says she told other staff about the                  11 abuse she witnessed. Nothing was done.                  12 LA-A63 recalls an occasion in which he and another                  13 boy climbed onto the swimming pool roof. Looking down,                  14 they witnessed Hook sexually abusing another boy in the                  15 swimming changing rooms:                  16 "The pool was well lit, as it was a summer's evening                  17 and still daylight. I would have been about 20 feet                  18 away from them. I watched for about 10 or 15 seconds,                  19 long enough to be sure of what was happening. We then                  20 slid back down quietly. We said something to each other                  21 at the time. It wasn't mentioned afterwards. The other                  22 boy had seen what I had seen."                  23 Some children refer to having been prescribed                  24 medication for sleeping or otherwise for managing                  25 anxiety. LA-A228 refers to boys being medicated to calm</p> <p style="text-align: center;">Page 30</p>
<p>1 them down. But medication was an option, supported by                  2 a 1973 reference in the record book of Holly House where                  3 a doctor notes, "Nice. No children on sedatives.                  4 A-OK". Children refer to being medicated after having                  5 told someone about ongoing sexual abuse. The                  6 psychiatrist, LA-F127, prescribed medication for LA-A64                  7 who he described as having an angry and aggressive                  8 streak. This child was being sexually abused by                  9 William Hook at the time.                  10 LA-A64 says he was given sleeping pills for the                  11 nightmares which developed after he confronted Hook                  12 about the abuse. He remembers that the pills just made                  13 it more difficult to get up in the morning.                  14 1978 saw the phased closure of Shirley Oaks                  15 commence. Children were returned home, fostered, placed                  16 in other homes or independent accommodation. Lambeth                  17 accepts that this period was marked by considerable                  18 instability and very probably a strongly felt sense of                  19 insecurity for children living at Shirley Oaks. It                  20 finally closed in 1983. Gloria Newlands, who started                  21 work at Shirley Oaks in 1974, remembers:                  22 "Eventually, Shirley Oaks was closed down. The                  23 children then had to be fostered out. I remember it was                  24 very sad, as some of the kids found it difficult to deal                  25 with and broke down. No-one seemed to care about or</p> <p style="text-align: center;">Page 31</p>	<p>1 give any thought for the staff or kids when this                  2 happened."                  3 Judging by the standards of care planning operated                  4 by Lambeth at that time, it is unlikely that the                  5 children's subsequent placements were planned with care.                  6 Furthermore, the records of the lives of many children                  7 were also lost. Gina Noble worked at Shirley Oaks in                  8 various houses from approximately 1969 for 15 years.                  9 She recalled:                  10 "When the home was closed down, I remember a lot of                  11 the records were destroyed. I remember thinking how                  12 strange it was, because so many records were made and                  13 kept, yet, when the home closed down, they were just                  14 left lying around in the offices. Therefore, when the                  15 building was pulled down, they must have been destroyed                  16 with it."                  17 Shirley Oaks may have closed down physically in                  18 1983, but its legacy endures for those who spent time in                  19 their childhoods there. We will examine, for example,                  20 what happened to children in Rowan House.                  21 Philip Temple, a man about whom there were suspicions                  22 when he worked for Wandsworth Council, became its house                  23 father. He was subject to very serious allegations of                  24 sexual abuse by children at the time. You will hear                  25 evidence about how those allegations were treated.</p> <p style="text-align: center;">Page 32</p>



<p>1 Philip Temple left Lambeth and went on to abuse other 2 children. Evidence will be given as to how he was 3 finally apprehended. 4 He was replaced by Patrick Grant. Like Temple, 5 Grant sexually abused children in his care. There is 6 evidence he abused at least one of the same children as 7 Temple. He also left Lambeth and abused more children. 8 He, too, was finally apprehended after many years. You 9 will hear evidence about that. 10 We will look within this hearing at how individuals 11 like Geoffrey Clarke and Hook were able to weave 12 themselves into the very fabric of life at Shirley Oaks 13 with devastating impact on those whom they abused. 14 Angell Road. Angell Road was one of the homes that 15 was intended to replace provision at Shirley Oaks. It 16 opened on New Year's Day in 1981. The house father for 17 this refurbished new home was Michael Carroll, also 18 known as John Carroll. John Carroll came to Lambeth 19 from Liverpool and took up the position at Highland Road 20 in March 1978. He had followed a colleague from 21 Liverpool who was on the original Lambeth panel which 22 interviewed him. One year later, he was made the senior 23 assistant officer in charge of Highland Road. At 24 Angell Road, he was joined in 1982 by a new team leader 25 at the home, Steven Forrest. In 1984, LA-F4 joined the</p> <p style="text-align: center;">Page 33</p>	<p>1 staff. You will hear more about these men in this 2 opening and in the evidence. 3 John Carroll was, by all accounts, a powerful man in 4 Lambeth Council. He was highly regarded and appears to 5 have been prized in a local authority where it was 6 difficult to recruit and retain people. Carroll 7 involved himself with vulnerable families, on the face 8 of it going an extra mile to offer support to families 9 in need. He brought children to his home. He gave them 10 money for doing jobs around his house and took them on 11 holidays. In respect of one sibling group, he continued 12 to involve himself in decisions about their care after 13 they had left the children's home. Their parent was 14 observed by CHILE to be dependent on Carroll, who 15 described himself as a friend to the family. 16 Another group of siblings who were pre school were 17 cared for at Angell Road on a daycare basis, seemingly 18 informally, Carroll having arranged this with their 19 mother. There is evidence that it was generally the 20 position that Carroll was able to have children visit 21 Angell Road for daycare without formality or oversight. 22 Carroll was also a convicted child sexual abuser. He 23 concealed that conviction from Lambeth when he applied 24 to work there. Those who provided references for him in 25 1978 didn't mention it either. You will hear that</p> <p style="text-align: center;">Page 34</p>
<p>1 Lambeth came to learn of his conviction from Croydon 2 Council when Carroll and his wife applied to be foster 3 parents. After initial assessment, Croydon declined to 4 consider the application any further for a number of 5 reasons, including that it would not expose Croydon 6 children to the risks posed by a foster carer with 7 a conviction for child abuse. 8 You will hear that Lambeth officials decided that 9 Carroll should not be dismissed on account of his 10 conviction, nor on account of his concealment of it. 11 The decision to retain him not just as a Lambeth council 12 employee, but as the officer in charge of Angell Road, 13 was one of the first decisions taken by David Pope, the 14 newly appointed Director of Social Services. 15 Chair, you will be asked to consider the 16 ramifications of this decision for the children who came 17 to live in Angell Road. The issue that arises is not 18 simply whether Lambeth put children at risk of sexual 19 abuse by Carroll and prioritised his needs over risks to 20 children, but whether they put children whose 21 vulnerability was above and beyond even that of other 22 children in care in his path. 23 You will hear evidence that Angell Road was regarded 24 as a centre in Lambeth for direct work with children. 25 Indeed, it is understood that Lambeth managers</p> <p style="text-align: center;">Page 35</p>	<p>1 approached Angell Road to be the location for this work. 2 The inquiry understands direct work in this context to 3 have meant individualised play or arts with children as 4 a therapeutic tool was a tool to assist children in 5 explaining experiences or things which had happened to 6 them. There was a flat in Angell Road which was 7 equipped for this purpose. One witness to the police 8 described it as a goody area, with toys that were not 9 available in the rest of the house. 10 Carroll was described by one witness as having 11 a marked interest in this work and being a real advocate 12 for it. According to another police witness, when 13 Carroll attended an advanced social work course in 14 1986/87, he was required to submit photographs of his 15 session work with a child. He submitted the photograph 16 of a small boy, aged 4 to 5 years, in his underwear. 17 This caused the course tutor concern enough to pass it 18 on to the former social worker from Lambeth who arranged 19 training in direct work at Angell Road. 20 This event does not appear to have caused anyone to 21 pause and ask whether the centre of Lambeth's direct 22 work with children should be in the hands of a convicted 23 abuser. To the contrary, in 1988, it was noted that the 24 majority of staff at Angell Road have all done the basic 25 training course and direct work with children and have</p> <p style="text-align: center;">Page 36</p>

<p>1 all practised with individual children. The purpose of                  2 the work is to develop techniques to enable children,                  3 through play, to ventilate feelings of grief, loss and                  4 anger. Live story work, personal safety, abuse                  5 prevention work. The work room is furnished with                  6 necessary equipment and materials to facilitate the                  7 work.                  8 Records show that John Carroll and Steven Forrest                  9 both undertook direct work with children. LA-F4 is also                  10 recorded as having done a course in direct work.                  11 On 30 January 1990, the Director of Social Services,                  12 David Pope, put forward a report to the Social Services                  13 Committee which included a proposal that Angell Road                  14 would specialise in working with children who had                  15 suffered abuse or were emotionally damaged and requiring                  16 longer-term work. Whether there was any formal                  17 designation of Angell Road as a specialist home will be                  18 considered in evidence. It appears, regardless of                  19 whether this was an official moniker, Angell Road was                  20 already doing work of a specialist nature and where                  21 children who were believed to have been sexually abused                  22 prior to coming to Angell Road lived.                  23 As you will hear, John Carroll's position in Lambeth                  24 unravelled in 1991. He was dismissed because of                  25 financial irregularities. There was an earlier warning</p> <p style="text-align: center;">Page 37</p>	<p>1 of what was to come. An anonymous letter in 1984 was                  2 taken sufficiently seriously to warrant action. It                  3 referred to Carroll as an autocrat who referred to                  4 everything as his. The letter spoke of him using the                  5 minibus as though it was his, barring staff from using                  6 it for school runs, so that the children and staff had                  7 to use buses. It referred to staff being required to do                  8 washing and cook food for a family whose children were                  9 no longer in care. The letter referred to Carroll's                  10 corruptions and to the bills for his food compared to                  11 the cheap food children were fed. In 1991,                  12 Ms Anna Tapsell came to learn of Carroll's past because                  13 of her involvement in a misconduct process and, as you                  14 will hear in evidence, she became seriously alarmed                  15 about his history in Lambeth and sought to involve the                  16 Social Services Inspectorate.                  17 As for other aspects of the quality of life for                  18 children in Angell Road, it was the subject of an SSI                  19 inspection in 1993. It is unit 3 in that report. The                  20 inspection noted the lack of police checks on staff and                  21 that the visitors book did not always show the people                  22 who visited the home. Staff had not taken part in child                  23 protection training. It noted children to be drifting                  24 around during the days as opposed to taking part in                  25 meaningful activity. There were delays in drawing up</p> <p style="text-align: center;">Page 38</p>
<p>1 care plans. The report notes that a fieldwork team                  2 leader made it clear to inspectors that it was not                  3 a priority to allocate social workers to children in                  4 residential childcare.                  5 The SSI noted that, in common with the other homes                  6 inspected, there was a lack of social-work-trained                  7 staff. There was no clear in-house training. Former                  8 Councillor Clare Whelan, who will give evidence in this                  9 inquiry, visited Angell Road in January 1994 and                  10 recorded:                  11 "Much of the furniture throughout the building is in                  12 a disgusting state. There are broken windows. Many of                  13 the windows are filthy. In several rooms the wallpaper                  14 was peeling, wires were loose all over the place. There                  15 were few pictures or evidence of belongings."                  16 It seemed to her little had changed since the SSI                  17 report.                  18 What was life like for children living in                  19 Angell Road? Writing in 1991, John Carroll's                  20 replacement wrote of the treatment of children in                  21 Angell Road:                  22 "Children are an irritation in this building. Staff                  23 do not consider that they are the reason they are                  24 employed. The practice of care and routine is rarely                  25 used. On numerous occasions, children have been treated</p> <p style="text-align: center;">Page 39</p>	<p>1 unfairly. This stems from whether they are liked or                  2 not."                  3 She went on:                  4 "Overall, the practice in Angell Road is                  5 unacceptable, degrading and bordering on the harmful.                  6 Practices are 20 years out of date. All staff are                  7 tight-lipped and children worry about being alone to                  8 face the wrath if they speak out of turn."                  9 When she was interviewed by CHILE, Carroll's                  10 replacement also referred to how punitive staff could be                  11 and to one member of staff saying in a training                  12 situation that staff did not need to know techniques for                  13 dealing with difficult children because they would be                  14 pinned against the wall by Carroll and another member of                  15 staff. The evidence seen by the investigation                  16 demonstrates that Angell Road cared for very young                  17 children and children in their teenage years. The                  18 evidence suggests that it may have been a frightening                  19 and confusing place for a number of children who lived                  20 there. First, there is clear evidence that Carroll was                  21 not the only abuser who worked in Angell Road. You will                  22 hear about LA-F4, who I mentioned joined Angell Road in                  23 1984. He had been a social uncle at Shirley Oaks.                  24 LA-F4's relationship with two children in                  25 Angell Road became an acute cause for concern in 1988,</p> <p style="text-align: center;">Page 40</p>

<p>1        though it appears he had always been a cause for concern  2        at Angell Road. A letter written by a staff member  3        in April 1988 to John Carroll set out the concern LA-F4  4        was causing because of his relationship with two  5        children. I'm going to refer to these children as Z and  6        X. The letter said:  7        " In all the time that F4 has worked here at  8        Angell Road, he has had a very close relationship with  9        one of the residents here, Child Z. It is such a close  10       relationship that at other times the kids talk about it  11       and also feel left out because he has time just for her.  12       It has become such a problem that other members of  13       the staff group have approached me concerning the matter  14       and they will either talk to you or write a report for  15       you. I am concerned at the role F4 plays as key worker  16       to X too. It isn't just the expensive present he bought  17       for him, but the time he spends with him even when he's  18       off duty, on leave or off sick. He will always be there  19       for X day and night. This causes lots of problems with  20       the relationship he's got with Child Z. Plus the other  21       children, again, feel left out. He also made several  22       attempts to see children who are not with us anymore.  23       There is no doubt in my mind F4 is overinvolved with X  24       and it is coming to the point where another Angell Road  25       care worker can't cope with it any longer."</p> <p style="text-align: center;">Page 41</p>	<p>1        After this letter was sent to Carroll, a third child  2        made a disclosure of a disturbing nature. This child  3        was of preschool age. I shall call her Y. She was one  4        of those children who was in Angell Road on a seemingly  5        informal basis. She had no social worker. Her sibling  6        was also there on the same basis. Y had a disclosure  7        session with a member of Angell Road staff. It might be  8        thought of concern that Y, who was in this children's  9        home for daycare informally, would be subject to such  10       a process. Putting that to one side, she described an  11       incident with one of the children who was mentioned in  12       the letter. She described two men being present. She  13       named one of them as LA-F4. I won't describe the detail  14       of what she said, but it clearly gave rise to the  15       concern that two children from Angell Road had been in  16       a situation of sexual abuse with two men, one of whom  17       was identified as LA-F4. You will hear Carroll took on  18       a prominent role in investigating these matters. There  19       was delay. It appears Y was never given a proper  20       interview. There was no police investigation into what  21       she said had happened. The possible involvement of  22       another man in the abuse of these children went  23       uninvestigated. As far as the children referred to in  24       the letter above are concerned, we understand one of  25       them to have disclosed abuse by F4 in 1988. F4 faced</p> <p style="text-align: center;">Page 42</p>
<p>1        misconduct proceedings within Lambeth and you will hear  2        more about that in evidence. A number of concerns  3        endure. One is whether Carroll impeded the  4        investigation into F4 so as to ensure that there was as  5        little external scrutiny as possible. The second issue  6        is the evidence that there were three men working in  7        this home at the same time, each of whom was implicated  8        in the sexual abuse of children.  9        You will also hear evidence from this time about  10       information which raised the possibility that Y and her  11       younger sibling were abused by a very much older child  12       in Angell Road. This is an area that the investigation  13       must confront. I want to make clear that, by doing so,  14       we are not seeking to stigmatise or apportion blame to  15       children. We are concerned about the possibility of  16       this happening to younger children and the issues  17       arising, namely, whether there was sufficient  18       supervision of all children, whether the issue was taken  19       sufficiently seriously or investigated so as to  20       understand why it was taking place, and whether  21       sufficient regard was had to the emotional welfare of  22       children and the impact of this upon them.  23       The third individual suspected of sexual abuse in  24       Angell Road was Steven Forrest. The treatment of  25       a disclosure by a boy at Angell Road of sexual abuse by</p> <p style="text-align: center;">Page 43</p>	<p>1        Forrest was so calamitous that it was the subject of an  2        inquiry of its own, the Barratt Inquiry. In short, this  3        child made a disclosure of sexual abuse by Forrest, who  4        had died a few years previously of an AIDS-related  5        illness. The child at the centre of the Barratt Report  6        came into Lambeth's care aged 2 and a half and spent  7        most of the rest of childhood in its care. Barratt  8        pointed out the huge disjunction between Lambeth's  9        policy that no child who came into care under the age of  10       10 would remain in care for more than two years and this  11       child's experience. For him, the reality was that he  12       lived in residential homes for most of his childhood.  13       The Barratt Report sets out exhaustively the drift in  14       his care, his increasing institutionalisation and the  15       sheer limbo of his childhood. I mention this because it  16       is another facet of what life was like for children like  17       him in Angell Road and other homes. We will ask  18       questions about whether Lambeth really got to the truth  19       of what might have been happening in Angell Road up to  20       the suspension of Carroll and the death of  21       Steven Forrest.  22       Chair, I note the time.  23       THE CHAIR: Yes. Thank you, Ms Langdale. We will now take  24       a break and return at 11.45 am.  25       (11.28 am)</p> <p style="text-align: center;">Page 44</p>

<p>1 (A short break)</p> <p>2 (11.45 am)</p> <p>3 MS LANGDALE: Southvale Assessment Centre. Southvale</p> <p>4 Assessment Centre was a different sort of home from</p> <p>5 Angell Road and Shirley Oaks. It was built in 1967 and</p> <p>6 opened in 1968 as a large observation and assessment</p> <p>7 centre. It is described in some records as providing</p> <p>8 a home for up to 40 children, but it appears more likely</p> <p>9 that it accommodated up to 30. At its inception, it was</p> <p>10 intended that children would live there for a short</p> <p>11 period in order to assess their future needs and where</p> <p>12 it would be appropriate for them to live. That mission</p> <p>13 appears to have changed over time, so that children</p> <p>14 lived there on a much longer-term basis. There is</p> <p>15 evidence from those who worked there in the 1980s to</p> <p>16 suggest that children were there for many years. It</p> <p>17 appears that it evolved into a community children's</p> <p>18 home. In 1989, as part of the Children's Homes Review,</p> <p>19 it was decided that it should become an outreach</p> <p>20 resource. That did not happen and it finally closed in</p> <p>21 1993.</p> <p>22 The building itself was purpose built to facilitate</p> <p>23 the observation and assessment of children. It was</p> <p>24 referred to as having developed as an institution and</p> <p>25 looking like one. According to one report, its "sheer</p> <p style="text-align: center;">Page 45</p>	<p>1 size strongly militating against guarantees of a high</p> <p>2 standard of individualised and family group care ..."</p> <p>3 This sense of Southvale as an institution rather</p> <p>4 than a home can be seen, in its earliest days, in</p> <p>5 a letter which a foster family sent to Lambeth about</p> <p>6 their concerns about a foster child who I shall call X</p> <p>7 who they looked after. They wrote:</p> <p>8 "Firstly, not only was X, our foster child,</p> <p>9 viciously assaulted by a member of the staff at</p> <p>10 Southvale, but we have heard from another foster mother</p> <p>11 that she has reported to the Children's Department an</p> <p>12 assault on a child in Southvale and has had several such</p> <p>13 reports from children in her care who have been to</p> <p>14 Southvale. When X was admitted to Southvale, all her</p> <p>15 clothes were taken away and she had to wear the</p> <p>16 institution's clothes. This greatly worried us as we</p> <p>17 have always been taught by our childcare officer that</p> <p>18 this takes away a child's sense of identity. It is</p> <p>19 contrary to the practice of good childcare."</p> <p>20 The writer went on to say that children could only</p> <p>21 be visited on Sundays between 2.00 pm and 4.00 pm and</p> <p>22 there were no facilities to bring in children. The</p> <p>23 foster parents thought this was extraordinary and</p> <p>24 queried how families with children could see their</p> <p>25 children in Lambeth. The couple also described children</p> <p style="text-align: center;">Page 46</p>
<p>1 as virtually imprisoned in Southvale. Concerning</p> <p>2 assaults, they pointed out that none of the children</p> <p>3 could contact their social worker except through the</p> <p>4 staff and that this was open to abuse. Some of</p> <p>5 the themes highlighted within this letter were still</p> <p>6 evident decades later.</p> <p>7 In keeping with an institutional way of life,</p> <p>8 Southvale operated on a points-based system. This was</p> <p>9 not a reward system. It was referred to as a loss of</p> <p>10 privileges system. This wasn't accurate either, really.</p> <p>11 A 1988 version of this policy explains that if children</p> <p>12 failed to attain 84 points in a week from Friday to</p> <p>13 Thursday, the child or young person lost privileges for</p> <p>14 the following week starting on Friday morning.</p> <p>15 Privileges were things like using a tape recorder, or</p> <p>16 going out on their own.</p> <p>17 One former temporary group leader at Southvale gave</p> <p>18 a statement to police in 2013 about how Southvale</p> <p>19 operated in the 1980s and how he regarded it as</p> <p>20 dysfunctional. He explained that many children stayed</p> <p>21 in Southvale for years. He noted that there was one</p> <p>22 child there as young as 3 years. There were social</p> <p>23 workers and key workers who were completely untrained in</p> <p>24 social care and childcare, although this was not</p> <p>25 unusual. Pausing there, and on the point of untrained</p> <p style="text-align: center;">Page 47</p>	<p>1 care workers, you may think it illuminating, in terms of</p> <p>2 referencing or checks of those who worked in Southvale,</p> <p>3 that one care worker recruited in 1990 was known, at the</p> <p>4 time of his recruitment, to have had seven previous</p> <p>5 convictions including one for unlawful wounding for</p> <p>6 which he'd received a sentence of five years'</p> <p>7 imprisonment. He was redeployed from Southvale to</p> <p>8 Monkton Street and then to its sister unit Chestnuts.</p> <p>9 Both of these homes cared for children with special</p> <p>10 needs. He was to face allegations of sexual abuse at</p> <p>11 Chestnuts. You will also hear evidence about LA-F14,</p> <p>12 employed at Southvale, who faced allegations of sexual</p> <p>13 abuse at Southvale and another home. He had undeclared</p> <p>14 convictions and, whilst an attempt to prosecute him for</p> <p>15 sexual abuse was unsuccessful, he was convicted of</p> <p>16 possession of a firearm.</p> <p>17 Returning to the evidence given by the temporary</p> <p>18 team leader at Southvale, like the foster carers who</p> <p>19 wrote the letter in 1971, he said that there was little</p> <p>20 outside scrutiny of the home. Complaints were dealt</p> <p>21 with by the people complained about. Moreover, there</p> <p>22 was a culture of not believing children, justifying this</p> <p>23 by their histories and using their past experiences</p> <p>24 against them. The more the children raised concerns,</p> <p>25 the less likely they would be believed. On the points</p> <p style="text-align: center;">Page 48</p>

<p>1 system, he said this:</p> <p>2 "This involved staff and children meeting towards</p> <p>3 the end of each day and discussing behaviour which</p> <p>4 merited points being awarded or removed. There was an</p> <p>5 opportunity for the system to be manipulated by staff,</p> <p>6 particularly as they were untrained, and there was</p> <p>7 favouritism displayed towards certain children,</p> <p>8 particularly by Les Paul. Often, the children came from</p> <p>9 damaged and dysfunctional backgrounds and were clearly</p> <p>10 flattered and responded to any attention given to them</p> <p>11 by staff."</p> <p>12 He also explained that it was common practice that</p> <p>13 children could be taken out by staff, without any checks</p> <p>14 or risk assessments, for an afternoon or even a weekend.</p> <p>15 A former team leader concluded:</p> <p>16 "From my experience, the atmosphere of that home and</p> <p>17 the lack of reporting and accountability would have</p> <p>18 facilitated an abuser to offend against children. The</p> <p>19 opportunity existed for vulnerable children to be</p> <p>20 exploited."</p> <p>21 During Operation Bell, in 1992, a senior personnel</p> <p>22 officer was interviewed by police. She described the</p> <p>23 officer-in-charge's policy at Southvale was to run what</p> <p>24 she described as a "team-fit style of management". This</p> <p>25 meant a very physical, competitive, sports-based</p> <p style="text-align: center;">Page 49</p>	<p>1 philosophy regards children. She, like many other</p> <p>2 people who spoke to the police, commented upon the</p> <p>3 favouritism shown towards some children. Also, the</p> <p>4 level of collusion between male staff at Southvale was</p> <p>5 so intense that obtaining the truth of the matter was</p> <p>6 too difficult. All members of the staff were afraid of</p> <p>7 the officer in charge. This sense of fear was conveyed</p> <p>8 in the interviews which took place in 1989 with two</p> <p>9 female members of staff from Southvale. Notes of</p> <p>10 the interview with one of these women referred to her</p> <p>11 concern about the punitive environment, the excessive</p> <p>12 control and the emotional and physical abuse of children</p> <p>13 at Southvale. She said the spark had gone from the</p> <p>14 children moved over from St Saviour's as if they had no</p> <p>15 fight left. She referred to favouritism in relation to</p> <p>16 both staff and children. One particular child never had</p> <p>17 any new clothes bought, never got as many privileges as</p> <p>18 the others. When she asked the other staff why this was</p> <p>19 the case, she was told, "The officer-in-charge hates</p> <p>20 him". Even the child told her that was why he had no</p> <p>21 new clothes. She found this hard to believe, then</p> <p>22 overheard the officer-in-charge tell the child he hated</p> <p>23 him.</p> <p>24 On the other hand, she mentioned another child</p> <p>25 singled out by the officer-in-charge for special treats</p> <p style="text-align: center;">Page 50</p>
<p>1 and taken up to the officer-in-charge's flat. The other</p> <p>2 female care worker gave a similar account. She also</p> <p>3 referred to the humiliation of children, to their being</p> <p>4 bullied and humiliated. She was concerned about the</p> <p>5 treatment of black children, including skin, hair and</p> <p>6 dietary needs. She said that black staff provided hair</p> <p>7 and skin products to children because Southvale refused</p> <p>8 to buy them.</p> <p>9 She felt unable to challenge bad practice. No</p> <p>10 discussion was allowed to take place. When she raised</p> <p>11 the issue of children being offered food appropriate to</p> <p>12 their culture, she was told by the officer-in-charge</p> <p>13 that they did not like troublemakers and, if she carried</p> <p>14 on, life would be made difficult for her. She, too,</p> <p>15 mentioned the child singled out to be taken up to the</p> <p>16 officer-in-charge's flat.</p> <p>17 Both of these care workers were invited to write</p> <p>18 down their concerns. A manuscript note written by one</p> <p>19 of these care workers survives. The note explained that</p> <p>20 children were humiliated in front of staff and children</p> <p>21 about why they were in care. They were told they</p> <p>22 behaved like animals and were disturbed. Graphic</p> <p>23 details of their family history were mentioned in front</p> <p>24 of other children. The author had never seen the</p> <p>25 correct restraining techniques used.</p> <p style="text-align: center;">Page 51</p>	<p>1 If one child was disliked by senior staff, he or she</p> <p>2 would always be picked on. The author said of one</p> <p>3 child, who was not liked and who was in trouble with the</p> <p>4 police, that the officer-in-charge told him he had the</p> <p>5 power over whether he went to a lock-up or not. She</p> <p>6 mentioned one child, who had chickenpox, who had been</p> <p>7 scalded by hot tea and had to go to hospital. "We were</p> <p>8 told we could not speak about this". The author said</p> <p>9 that a certain duty officer was, in her words, always</p> <p>10 going on about the blacks on duty and making racist</p> <p>11 comments towards children. Children were forced to eat</p> <p>12 food they did not eat for cultural or religious reasons.</p> <p>13 She described Southvale as being ruled by fear.</p> <p>14 The disclosures by these members of staff</p> <p>15 precipitated the Zephyrine Inquiry. I will explain more</p> <p>16 about that inquiry in the course of this opening. For</p> <p>17 present purposes, it is of note that it referred to</p> <p>18 Southvale seeming to have functioned as a reformatory</p> <p>19 for children whose challenging behaviour was beyond the</p> <p>20 capacity of other establishments. What we know is that</p> <p>21 many children who came through the doors of Southvale</p> <p>22 were sexually abused by those charged with their care.</p> <p>23 Lambeth Council, whilst accepting that the true extent</p> <p>24 of sexual abuse linked to Southvale may never be known,</p> <p>25 is aware of 140 people who have made disclosures of</p> <p style="text-align: center;">Page 52</p>

<p>1 sexual abuse related to their time at Southvale. There                  2 have been a number of convictions which you will hear                  3 more about in the course of the hearing.                  4 Leslie Paul was someone who, on the face of it,                  5 might have been thought to fit well with the                  6 descriptions of Southvale's regimented approach to                  7 childcare. He was a childcare officer at Southvale from                  8 1979. We are not aware of his having any                  9 qualifications. He had been a special constable until                  10 1981, attached to the West End Central Police Station.                  11 Records from Operation Bell refer to his having been                  12 stopped in July 1979, when he was a constable, in                  13 suspicious circumstances in the toilets in                  14 Piccadilly Circus. According to the temporary team                  15 leader whom I mentioned earlier, Paul made a point of                  16 being a special constable.                  17 In an interview with the MPS in 2001, Paul suggested                  18 that at Southvale he was dealing with difficult children                  19 and some of these children were probably the most                  20 disturbed, the most difficult you would ever meet in                  21 your life. In a report which he wrote about Southvale,                  22 former Councillor Clare Whelan referred to the home as                  23 having acquired a reputation for being one which was                  24 able to cope with difficult and disturbed children that                  25 other homes were unable to handle. A report from the</p> <p style="text-align: center;">Page 53</p>	<p>1 1980s referred to some children being there charged with                  2 serious offences and some children placed there awaiting                  3 a trial of criminal proceedings.                  4 That Southvale had this sort of reputation may have                  5 suited Leslie Paul and, indeed, made children there more                  6 vulnerable to abuse. But it is not an accurate or                  7 complete picture. The material disclosed to the inquiry                  8 appears to us to demonstrate that many children who                  9 lived there were in care for all of the same reasons as                  10 children in other homes and not because they were                  11 disturbed or involved in criminality.                  12 Furthermore, it is evident that very young children                  13 were placed there and that its use evolved into                  14 a general children's home.                  15 Leslie Paul was a physically imposing man and may                  16 have been imposing in other ways. According to a group                  17 leader, Paul made inappropriate racial comments which                  18 were very offensive. He faced a misconduct hearing                  19 in May 1984 in relation to an allegation that he'd made                  20 a racist comment to a child and other inappropriate                  21 comments, although the record doesn't specify what those                  22 were. It is not clear how this allegation was finally                  23 resolved. There was a hearing, but the matter appears                  24 to have been referred to the Director of Social Services                  25 and the Chief Executive who determined it should be</p> <p style="text-align: center;">Page 54</p>
<p>1 referred back to a different panel. By that stage, it                  2 was determined that too much time had passed and Paul                  3 was given a written warning. On 24 April 1990,                  4 a complaint report was made about him, although we do                  5 not know what that complaint was about. It appears that                  6 a parent complained about Paul and how he spoke to them                  7 in a racist way. It is noted:                  8 "A complaint was raised, 25 September 1990,                  9 outlining the above concerns, states Les was racist and                  10 should not be working in this kind of environment."                  11 The environment referred to may have been                  12 a reflection of that fact that, by 1990, most of                  13 the children who lived in Southvale were from black,                  14 Asian or minority ethnic backgrounds. In Leslie Paul, we                  15 see the gulf between Lambeth's long-standing policy                  16 aspirations for children from a BAME background and the                  17 reality of what children faced in Lambeth homes.                  18 Paul has now been convicted three times for the                  19 sexual abuse of boys in Lambeth's care. It took some                  20 time for a fuller picture of his offending to emerge.                  21 DI Morley will give evidence about the incremental way                  22 investigations into Paul developed. He was first                  23 arrested and charged in 1992 as part of Operation Bell.                  24 He was arrested and charged as part of                  25 Operation Middleton and was arrested and charged again</p> <p style="text-align: center;">Page 55</p>	<p>1 much more recently in Operation Trinity. He was                  2 convicted on each occasion but, as you will hear, it was                  3 only his final conviction and sentence which marked the                  4 gravity of his conduct over the years.                  5 He was tried in 1992 in respect of the sexual abuse                  6 of three boys. One victim was from Southvale. Another                  7 victim came to know Paul through the child at Southvale.                  8 The evidence demonstrates this child from Southvale to                  9 have been groomed by Paul. There is evidence that his                  10 sole parent also became friendly with Paul and that they                  11 spent time with him as a family. Like Carroll, this                  12 suggests that Paul had an ability to work his way into                  13 the lives of vulnerable families.                  14 This child moved on to a different placement and                  15 told police that, from this point, he more or less moved                  16 in with Paul. He also described going on a long holiday                  17 with Paul. He alleged he told his social worker that he                  18 was living with Paul. Ms Annie Hudson,                  19 Lambeth Council's corporate witness, will provide                  20 evidence as to what Lambeth knew about this child's                  21 relationship with Paul. What prompted this former                  22 resident to make a disclosure about his abuse, like                  23 others who came forward, was concern about another                  24 child.                  25 Another care worker who worked at Southvale for</p> <p style="text-align: center;">Page 56</p>

<p>1 13 years in the late 1970s and '80s gave a statement to                  2 the police in 2003. She said that Paul was often                  3 criticised for having favourites. She recalled one                  4 child who needed cream applied to his anus and how Paul                  5 would volunteer for this. He would also offer to                  6 supervise the boys' showers. Paul asked her to come on                  7 a camping trip with him and some boys from Southvale.                  8 She slept in one tent, he slept in another with the                  9 boys. She said that these matters did not assume                  10 significance until Paul was prosecuted for the first                  11 time. She also referred to him taking boys out to Soho                  12 which she disagreed with.</p> <p>13 In Operation Middleton, Paul was convicted of five                  14 offences of indecent assault relating to four victims                  15 from Southvale. As I will explain later in this                  16 opening, an issue which arises is why some allegations,                  17 which were made in and around the time of Middleton,                  18 were not proceeded with. In Operation Trinity, five men                  19 who had been children in Southvale came forward. Paul                  20 was convicted of a number of offences relating to all of                  21 these victims, with the exception of one.</p> <p>22 It is important to note that one of Paul's victims                  23 gave evidence of being abused by Paul and a number of                  24 men at an address. He was very young when this                  25 happened. He also recalled an incident of being abused</p> <p style="text-align: center;">Page 57</p>	<p>1 by another man at Paul's flat.</p> <p>2 We also know that during the period he worked for                  3 Lambeth, Paul photographed many boys. Upon his arrest,                  4 numerous photographs of children were found at a search                  5 of his flat. These suggest that he had ready and                  6 intimate access to children. A number of his victims                  7 describe being photographed by him. He made a film                  8 showing the abuse of a child in Lambeth's care.</p> <p>9 Chair, the issue of whether Lambeth staff were                  10 involved in the possible production and dissemination of                  11 pornography or imagery of child abuse is one that                  12 endures. We know that Paul made such images. I will                  13 say more later in this opening about suspicions that he                  14 was involved in its distribution.</p> <p>15 We know, then, that children from Southvale were                  16 abused by Leslie Paul. What was known by those charged                  17 with their care at the time? A complainant in one of                  18 the criminal investigations into Paul gave evidence that                  19 he had told his social worker that he was being abused.                  20 That social worker, who was qualified, provided evidence                  21 to the police about this disclosure. This was the only                  22 time in his 18-year career that a child made                  23 a disclosure of sexual abuse to him. The note of the                  24 disclosure survives. The social worker said in his                  25 statement to the police:</p> <p style="text-align: center;">Page 58</p>
<p>1 "This was completely out of character for X to say                  2 this, as he was a toughy and one of the boys. It must                  3 have taken a lot of courage for him to say this to me.                  4 He was very quiet and matter of fact as he spoke.                  5 I believed him completely. This was so out of character                  6 it had to be true. I was surprised that X was the                  7 victim of abuse because I felt like he was a tough                  8 little boy."</p> <p>9 The social worker says he explained to the boy that                  10 they needed to report it to the police, but the child                  11 did not want to. The social worker says that he spoke                  12 to his team manager, who said they had to respect the                  13 child's wishes. The social worker told the boy that                  14 because he didn't want to take it further, he would have                  15 to go back to Southvale until a placement became                  16 available. This is what happened. The social worker                  17 noted at the end of his statement to the police that he                  18 was probably the only person to whom the child could                  19 have turned for help.</p> <p>20 One member of staff, who had been a team leader and                  21 group leader at Southvale for two periods in the 1980s,                  22 gave a statement to police in 2002. He said that he                  23 wondered if Paul did have an overt interest in boys. He                  24 recalled a boy being upset and sent to his room.                  25 Leslie Paul followed him up to his room a short time</p> <p style="text-align: center;">Page 59</p>	<p>1 later. The group leader noted that Paul had been gone                  2 some time. He entered the child's room to find Les Paul                  3 lying on a bed with the child. The team leader said                  4 that he thought this was totally unacceptable and                  5 inappropriate but Paul made light of it. When he came                  6 back to Southvale in the mid 1980s, the team leader said                  7 there was concern about Paul seeing former residents                  8 outside of work. He said boys were taken camping and                  9 there was concern about Paul's behaviour -- he did not                  10 explain what behaviour he meant -- and that he thought                  11 that the officer-in-charge dealt with it. He said that                  12 one boy confided that he felt uneasy about Paul. Paul                  13 was later convicted of the abuse of the same boy. The                  14 team leader stated to police, "As the years went by,                  15 I felt uneasy about Leslie being with the boys".</p> <p>16 Another convicted child abuser worked at Southvale.                  17 This was Patrick Grant, who worked at Rowan House and                  18 who had faced trial for sexual abuse in 1978. Two of                  19 the complainants in that trial were from Shirley Oaks.                  20 Patrick Grant was acquitted upon the direction of                  21 the judge in 1978. We do not understand his failed                  22 prosecution in 1978 to have resulted in any misconduct                  23 process. Far from it, as we understand the evidence,                  24 Grant was promoted to team leader at Southvale.                  25 You will hear evidence that, in Operation Trinity,</p> <p style="text-align: center;">Page 60</p>

<p>1 two men who gave evidence about Les Paul also made                  2 allegations of abuse against Patrick Grant. This led                  3 Operation Trinity to investigate Patrick Grant and                  4 Bernard Collins, who worked with him at Fircroft Home in                  5 Surbiton, which was not a Lambeth home. In 2018,                  6 Patrick Grant was charged with offences of child sexual                  7 abuse against individuals in Rowan House and Southvale                  8 Assessment Centre and other homes. You will hear about                  9 the outcome of that trial later in this opening.                  10 It suffices to note here that it appears that                  11 history may have repeated itself; that Grant came to                  12 Rowan House and may have abused children abused by                  13 Philip Temple. Grant moved on to Southvale and, again,                  14 may have abused children abused by Paul. DI Morley will                  15 be able to provide more evidence about this.                  16 There were other employees at Southvale whose                  17 conduct gave cause for serious concern. LA-F8 had been                  18 a care worker at St Saviour's who transferred over to                  19 Southvale. One care worker, who, in fact, was the same                  20 woman who I mentioned was interviewed about her concerns                  21 about ill-treatment of children at Southvale in 1989,                  22 made a statement in 2013 confirming that she had found                  23 F8 in bed with a child. She explained that she could                  24 not tell management within the home but did inform                  25 managers within the Social Services Department. It</p> <p style="text-align: center;">Page 61</p>	<p>1 appears that this information was available to the                  2 Zephyrine Inquiry.                  3 The assistant officer-in-charge of Southvale gave                  4 a statement in 1992 in the context of Operation Bell.                  5 She recounted that, in 1989, she found F8 in a bedroom                  6 with a child. The child was entirely unclothed. F8                  7 said that he needed to have cream applied to him. This                  8 was a different child to the one I mentioned before in                  9 this context. The assistant officer-in-charge told                  10 police that staff never did this, save for babies and                  11 very small children. This child was older. I will                  12 explain why she said she did not come forward sooner                  13 when I deal with Lambeth's response later in this                  14 opening.                  15 There is much to be said about Southvale, chair, its                  16 ethos and whether that facilitated the sexual abuse of                  17 children. You will hear much more about this home and                  18 the experiences of children within it during the course                  19 of the hearing.                  20 Moving now, please, to Ivy House. Amongst an                  21 already vulnerable group, children in local authority                  22 care with communication difficulties and complex needs                  23 are even more vulnerable. The selection of Ivy House                  24 and Monkton Street as case studies enable you, chair and                  25 panel, to consider how those especially vulnerable</p> <p style="text-align: center;">Page 62</p>
<p>1 children were dealt with surrounding allegations of                  2 child sexual abuse.                  3 The law and language used surrounding children with                  4 complex needs has developed considerably over time. The                  5 1970s commenced with the Education (Handicapped                  6 Children) Act 1970 which abolished previous statutory                  7 powers for classifying children suffering from                  8 a disability of mind as children unsuitable for                  9 education at school. The Act was followed by                  10 a White Paper in June 1971 entitled "Better Services for                  11 the Mentally Handicapped". This White Paper outlined                  12 a desire to move away from caring for people in                  13 institutional settings and to increase the provision of                  14 local and community care. Where residential care was                  15 required, the paper recommended that local authorities                  16 should consider more homely settings. This desire for                  17 homely settings was to be repeated over ten years later                  18 in Lambeth's 1982 paper "Meeting the Needs of Mentally                  19 Handicapped People: A Strategic Review" which stated:                  20 "In all residential accommodation, it is an                  21 objective to promote homeliness."                  22 It was not until 1974, however, approximately nine                  23 years after Lambeth Council was formed and took over                  24 responsibility for children's residential care in the                  25 borough, and three years after the 1971 White Paper on</p> <p style="text-align: center;">Page 63</p>	<p>1 better services for the mentally handicapped that the                  2 Social Services Committee acknowledged the lack of                  3 provision for what they described as a potential demand                  4 for services from 400 mentally handicapped children and                  5 1,000 physically handicapped children.                  6 A further two years passed before the opening in                  7 1976 of Ivy House, a residential children's home aimed                  8 at providing short breaks for children aged between                  9 8 and 18. Three years later, in 1979, Chestnut Road,                  10 described as a long-stay community home for mentally                  11 handicapped boys and girls, was opened, providing                  12 12 places for children aged between 1 and 18 years, and                  13 the following year, in 1980, Monkton Street opened in                  14 Kennington as a long-stay home for mentally handicapped                  15 children with 13 places for children aged 0 to 18 years.                  16 Ivy House remained open until 1990, with Monkton Street                  17 closing six years later in 1996, and Chestnut Road being                  18 the last of Lambeth's residential children's homes to                  19 close in 2000.                  20 Prior to the opening of these three specialist                  21 homes, some children with complex needs were placed in                  22 other Lambeth residential homes, sometimes moving from                  23 home to home. One of the CHILE files reviewed by the                  24 investigation team documents the series of placements of                  25 a very young child described as having learning</p> <p style="text-align: center;">Page 64</p>



<p>1 disabilities due to possible brain damage at birth.                  2 From the age of 3, he was moved from place to place with                  3 placements at Shirley Oaks, Stockwell Park and at least                  4 five other homes, including, when a teenager, a period                  5 of just over a year at Monkton Street. In the main,                  6 however, residential provision for those with complex                  7 needs at that time was catered for predominantly by                  8 hospital stays or in private and voluntary homes                  9 sometimes located some distance from Lambeth.                  10 One such private home, to which Lambeth children                  11 were sent from the late 1960s, was the Manor House in                  12 Bristol. The manor was a privately owned home that                  13 appears to have been registered as "a mental nursing                  14 home for 20 subnormal/severely subnormal patients under                  15 18 years". The file of one child placed there sets out                  16 that, at 14 months, the child was assessed by Lambeth's                  17 medical officer as subnormal and unsuitable for                  18 adoption, although a later examination found her to be                  19 of normal intelligence. She was placed at the manor in                  20 the late 1960s aged 2 and remained there for almost ten                  21 years. She went for long periods without being seen by                  22 a social worker from Lambeth, one such period lasting                  23 three years and six months. It was reported that the                  24 child had signs of deprivation and institutionalisation                  25 that were likely to remain a severe problem throughout</p> <p style="text-align: center;">Page 65</p>	<p>1 her life. A subsequent placement with a social aunt and                  2 uncle broke down and this was followed by a series of                  3 placements, including at Southvale. This was not an                  4 isolated case. A visit to Manor House in 1975 by                  5 Lambeth noted concern about a number of other children                  6 placed at the home. There were, at that time,                  7 19 children under the care of Lambeth at the                  8 Manor House. Fifteen of these children had received no                  9 social work contact for over two years, due, it appears,                  10 to the long-term ill health of one social worker. The                  11 children were found to have few possessions or clothing                  12 that could be called their own and it was reported that                  13 the owner of Manor House was determined to frustrate                  14 attempts to remove any children from the institution.                  15 Despite the opening of Ivy House and Monkton Street,                  16 the placement of children out of the borough did not                  17 cease. In the mid 1990s, an older teenage child in the                  18 care of Lambeth who was described as having moderate                  19 learning difficulties was sent to a home,                  20 Frontier House, in Kent. This child went on to allege                  21 severe physical abuse, and the home, following an                  22 exposing television programme of physical abuse of                  23 children by staff, was subsequently closed.                  24 Returning to Ivy House, if I may, when it was first                  25 opened in 1976, it was located on the Shirley Oaks site</p> <p style="text-align: center;">Page 66</p>
<p>1 in Croydon. Whilst generally referred to throughout its                  2 period of operation as Ivy House, the home, in fact,                  3 moved locations a number of times, being based at three                  4 different cottages on the Shirley Oaks site between 1976                  5 and 1987. On 22 September 1987, due to the sale of                  6 the Shirley Oaks site, Ivy House moved to a new location                  7 in Croydon on Warham Road, where it remained until its                  8 closure in 1990.                  9 Ivy House offered short-break residential care to                  10 children, both during term time and school holidays.                  11 Many of the children who spent time at Ivy House also                  12 attended one of the two specialist schools in the                  13 borough, Shelly School and Windmill School, for children                  14 with severe learning difficulties and which catered for                  15 children aged between 2 and 19. Children would attend                  16 school during the day, returning to Ivy House overnight.                  17 Whilst records of precise numbers of children who                  18 stayed at Ivy House are incomplete, it appears to have                  19 been a provision that was used by a significant number                  20 of families. A report entitled "Special Educational                  21 Needs" presented to the Social Services Committee on                  22 22 November 1988 noted that families were entitled to                  23 six weeks per year short-break cover at Ivy House and at                  24 that time 80 families were using the service. The age                  25 range of children cared for at Ivy House fluctuated, but</p> <p style="text-align: center;">Page 67</p>	<p>1 the children, both girls and boys, were predominantly                  2 between 5 and 19. In 1985, it was said that the average                  3 occupancy was 13 children, slightly below its capacity                  4 of 15, with the majority of children being aged between                  5 11 and 19 years old and a ratio of one boy to two girls.                  6 The needs of the children cared for varied.                  7 There does not appear to have been a set                  8 staff-to-child ratio, but a document dated 1978, which                  9 considered staffing for Chestnut Road based on the                  10 experience of Ivy House, suggested that a ratio of 1:4                  11 was deemed usual. At the disciplinary hearing of                  12 LA-F12, a member of staff at Ivy House, the evidence                  13 given was that, in 1985, there would generally be four                  14 or five staff on duty caring for 13 children with more                  15 staff on duty at weekends when more children were in                  16 residence. At night, the standard cover would be two or                  17 three members of staff on duty, with one senior officer                  18 sleeping in.                  19 As early as 1968, a report entitled "Recruitment                  20 Advertising: Children's Department" set out difficulties                  21 in recruiting residential staff. This remained true                  22 over 12 years later and was certainly true of                  23 the specialist children's homes run by Lambeth.                  24 A subcommittee meeting in November 1981 recorded the                  25 extreme concern about staffing levels in Ivy House,</p> <p style="text-align: center;">Page 68</p>

<p>1 Monkton Street and Chestnut Road which were described as                  2 inadequate. Qualifications of staff was also an issue.                  3 The 1981 report of the London Borough Training Committee                  4 (Social Services) Mental Handicap: Progress Problems and                  5 Priorities, noted that data shows that a large number of                  6 local authority staff, particularly those working in                  7 residential care, are unqualified.                  8 The situation did not improve. In his report to the                  9 Children's Homes Subcommittee on 16 November 1988,                  10 20 years after the difficulties of recruiting                  11 residential staff had been raised in the 1968                  12 recruitment advertising report, Robert Morton, principal                  13 manager children's homes, set out the problem with stark                  14 clarity:                  15 "There are simply too few staff available to cover                  16 all the homes, to provide adequate and safe staffing                  17 levels for good childcare."                  18 Morton's report was accompanied by a report from the                  19 placement officer, who spoke of a staffing crisis,                  20 noting:                  21 "With Lambeth homes currently running at below                  22 60 per cent of full operational capacity due to staffing                  23 shortages, there is consequent unavoidable heavy usage                  24 of private and voluntary homes."                  25 The very problem that the opening of specialist</p> <p style="text-align: center;">Page 69</p>	<p>1 homes had sought to resolve in part, namely, the use of                  2 private and voluntary homes, continued.                  3 One of the responses of Lambeth to the recruitment                  4 difficulties across the service and the issue of                  5 reliance on agency staff pending permanent appointments                  6 is set out at paragraph 9.73 of Lambeth's corporate                  7 witness statement by Annie Hudson. In July 1989, it was                  8 decided to offer appointments to staff pending police                  9 checks subject to certain conditions being met, namely,                  10 satisfactory references and new staff not being placed                  11 in sole charge of children until police checks were                  12 completed.                  13 It is disturbing to note that even after the last of                  14 Lambeth's residential children's homes had shut,                  15 in August/September 2001, the follow-up Social Security                  16 Inspectorate inspection of child protection planning and                  17 decision making for looked-after children referred to                  18 the fact that staffing was still problematic and, whilst                  19 recruitment checks had improved, recommendations were                  20 still made for checks on agency staff to be required                  21 prior to appointment.                  22 Within this oral hearing, the inquiry will hear                  23 evidence around a teenage girl's allegation that she had                  24 been sexually abused at Ivy House. LA-A26 used gestures                  25 and words which conveyed to her mother that she had been</p> <p style="text-align: center;">Page 70</p>
<p>1 sexually abused and she also provided a first name when                  2 making the allegation.                  3 LA-A26's mother called Anne Worthington, a social                  4 worker, requesting that she visit the family home                  5 urgently. Anne Worthington was a social worker employed                  6 by Lambeth and from whom we will hear evidence. We will                  7 also hear evidence from others involved in the                  8 subsequent assessment of LA-A26's complaint and the                  9 various management investigations and disciplinary                  10 proceedings which followed.                  11 Monkton Street. Whereas Ivy House was established                  12 as a home for short stays, Monkton Street, which opened                  13 in 1980, four years after Ivy House, was intended as                  14 a long-stay home. However, it is clear, as demonstrated                  15 by the case of LA-A49, that over time it was used for                  16 both long- and short-stay residential placements for                  17 children with complex needs prior to its closure in                  18 1996. Whilst the intended age range of children was                  19 0 to 18 years, records suggest that, on occasions, the                  20 upper age limit extended to 21 years.                  21 LA-A49 was a 12-year-old boy with complex needs and                  22 communication difficulties who was cared for by his                  23 mother and attended Shelly School, a specialist school                  24 in Lambeth for children with special learning needs. He                  25 spent short-stay residential periods at Ivy House and</p> <p style="text-align: center;">Page 71</p>	<p>1 Chestnut Road prior to attending Monkton Street for                  2 short stays.                  3 In July 1986, the mother of LA-A49 reported that her                  4 son had made allegations of sexual abuse by LA-F26.                  5 This led to LA-A49 being subject to questions and                  6 undergoing a series of medical examinations. First at                  7 a GP surgery, subsequently at St Thomas's Hospital and                  8 finally by the police where he was both interviewed by                  9 a police officer and underwent a third examination at                  10 the station.                  11 It was the findings by the police doctor following                  12 the examination of LA-A49 that appeared to have led to                  13 a further nine children who stayed at Monkton Street                  14 being requested to undergo medical examinations. Some                  15 of these examinations took place at the police station,                  16 others at Monkton Street. All of the children examined                  17 had complex needs and communication difficulties. None                  18 of the children, other than LA-A49, had, prior to the                  19 examination, made any allegation of child sexual abuse                  20 nor does it appear that any attempt was made to                  21 interview any of these nine children in advance of                  22 the examination. Following the examination, one further                  23 teenage male child, LA-A291, made an allegation to his                  24 mother of sexual assault by a member of staff at                  25 Monkton Street, although the child was unable to</p> <p style="text-align: center;">Page 72</p>

<p>1 identify the alleged perpetrator by name.                  2 In some cases, parents gave consent to the                  3 examination and attended the examinations. In others,                  4 the local authority gave permission and in some cases                  5 social workers were present at the examination. The                  6 reports refer to some of the children displaying fear                  7 and physically resisting the examination. In one case,                  8 the examining doctor records that the assistance of four                  9 adults was required in order to facilitate the                  10 examination, in another it is said the examination was                  11 almost impossible due to her resistance and fear.                  12 As in the case of LA-A26 at Ivy House, an enquiry                  13 was set up to investigate the allegation of child sexual                  14 abuse. It extended beyond the individual allegation to                  15 encompass other alleged incidents of child sexual abuse                  16 at the home. Four senior staff were appointed as                  17 members of the investigating panel and advisers,                  18 including a consultant paediatrician, a child protection                  19 consultant and a special schools team leader. The                  20 investigation interviewed all members of staff at                  21 Monkton Street, the parents of children who were the                  22 subject of allegations and a number of social workers.                  23 Further social work and medical files for the children                  24 were inspected. The inquiry found that LA-F26 had no                  25 disciplinary case to answer, although it notes it was</p> <p style="text-align: center;">Page 73</p>	<p>1 considered that, in view of the strong feelings of                  2 parents, it would be extremely difficult for LA-F26 to                  3 resume his duties effectively. It also made a number of                  4 recommendations including that a detailed                  5 Social Services policy and procedure be prepared                  6 regarding the handling of allegations of sexual abuse in                  7 care.                  8 When, in 1988, a further allegation of child sexual                  9 abuse was made against a different staff member at                  10 Monkton Street, LA-F2, a similar enquiry was set up to                  11 investigate. That panel found in relation to LA-F2                  12 there were no grounds for disciplinary action.                  13 May I turn now, then, chair, to the culture at                  14 Lambeth Council over time, including the relationship                  15 between members and councillors and Lambeth's response                  16 to allegations of child sexual abuse.                  17 The inquiry has received evidence surrounding the                  18 structure of decision making and responsibility for                  19 children's services within Lambeth and will hear                  20 evidence from former officers and councillors upon this                  21 issue. We will also hear evidence about the                  22 relationship between councillors and officers, and the                  23 ability or otherwise of councillors to hold officers to                  24 account. There is evidence that the relationship                  25 between councillors and officers was fraught at times.</p> <p style="text-align: center;">Page 74</p>
<p>1 For example, subcommittee meetings were described as                  2 having become "platforms for abusing social workers" and                  3 it is recorded that there was a meeting at which over                  4 half of the Social Services directorate staff gave                  5 a vote of no confidence against the vice chair and chair                  6 of the Social Services Committee. Sir Stephen Bubb and                  7 Lady Janet Boateng, amongst others, will give evidence                  8 from the perspective of councillors as to the nature of                  9 this relationship.                  10 In 1965, following the abolition of the London                  11 County Council, Lambeth Council was created and                  12 responsibility for children's homes was transferred.                  13 Since that time, roles and job titles within the council                  14 have inevitably changed over the course of five decades.                  15 In essence, however, and in terms of responsibility for                  16 children's services, senior officer roles within the                  17 council have remained and for elected members                  18 significant roles likewise. In terms of officers, in                  19 1971, the statutory role of Director of Social Services                  20 was created to replace the previous role of children's                  21 officer. Since 2004, the Director of Children's                  22 Services was introduced, and the current Director of                  23 Children's Services roles in Lambeth is held by the                  24 Strategic Director for Children's Services, who has lead                  25 responsibility for delivery of all Lambeth's children's</p> <p style="text-align: center;">Page 75</p>	<p>1 services for children and families. Councillors,                  2 meanwhile, have held positions over time as chair of                  3 the Children's Committee or Social Services Committee                  4 and, since 2004, as lead member for children's services.                  5 Today, both the Director of Children's Services and lead                  6 member of children's services within Lambeth have                  7 a shared responsibility, with all officers and members                  8 of the local authority to act as effective and caring                  9 corporate parents for looked-after children.                  10 You will hear evidence, chair, upon whether there                  11 was effective management and leadership over time within                  12 Lambeth and whether or not there was effective policy                  13 oversight from councillors in relation to children in                  14 the care of Lambeth and the quality of their                  15 experiences. In terms of the knowledge, management and                  16 leadership had surrounding services provided to children                  17 and risks to their safety, it is important to understand                  18 the chronology of Lambeth and the knowledge which was                  19 acquired on a cumulative basis. With this in mind, all                  20 core participants have had input into a working                  21 chronology prepared by the investigation team and the                  22 result is a detailed document which will doubtless be                  23 referred to during the hearing and which will continue                  24 to be added to as the hearing proceeds.                  25 Lambeth's knowledge and understanding of child</p> <p style="text-align: center;">Page 76</p>

<p>1 protection and its response to allegations of child 2 sexual abuse can be assessed in a number of ways. 3 Firstly, by analysing information Lambeth obtained, or 4 should have obtained, from individual complaints from 5 children around child sexual abuse. With emphasis on 6 the case study homes, responses to individual, recorded 7 complaints of sexual abuse by children have been 8 considered by the inquiry. 9 In addition, one of the most conspicuous features of 10 how Lambeth responded to allegations is the sheer number 11 of internal inspections, reviews, reports and public 12 inquiries which it commissioned or generated. These are 13 critical not just to understanding Lambeth's 14 institutional knowledge and how it responded to a given 15 incident or allegation, but to the question of whether 16 the commissioning of reports became an end in itself, 17 a convenient signal that something was being done, but 18 which changed nothing. 19 Whether the investigations and enquiries in the 20 1980s, '90s and into the 2000s altered the experiences 21 of children in care in any way is a matter which you, 22 chair and panel, will doubtless have in mind throughout. 23 The reports that were commissioned fall to be examined 24 in terms of, firstly, what each report did and did not 25 identify surrounding child protection, and, secondly,</p> <p style="text-align: center;">Page 77</p>	<p>1 whether they substantively changed how Lambeth responded 2 to child sexual abuse. In chronological order, we 3 highlight some of the reports below and look at the 4 background from which Lambeth's institutional response 5 to the sexual abuse of children is to be viewed. As 6 stated earlier, none of the reports were undertaken 7 before the 1980s. 8 By way of general background to the Lambeth Council, 9 its political turbulence, financial mismanagement and 10 corruption in the 1980s have been widely commented upon 11 in the public domain. On the theme of financial 12 control, Ms Hudson states in the Lambeth corporate 13 witness statement: 14 "The seeds of malaise went back to the decision by 15 Lambeth councillors in 1985 to refuse to set a rate as 16 part of their political campaign against rate capping. 17 This led to surcharging in 1986 with 30 Lambeth 18 councillors being required to repay the amount the 19 council lost in interest and being disqualified from 20 office. By 1988/89 there was a predicted overspend 21 across the council of 60 million. By 1990, in order to 22 compensate for this overspending, 1,000 jobs were 23 required to be cut across the Council. When council tax 24 replaced the community charge in 1993, Lambeth was 25 required to collect 65.5 million. However, Lambeth only</p> <p style="text-align: center;">Page 78</p>
<p>1 managed to collect 10 per cent of council tax due for 2 the year, the second lowest collection rate in the 3 country. During this period at Lambeth, there is 4 demonstrable evidence of financial mismanagement across 5 the council which would have had a significant impact on 6 quality of service delivery to children in Lambeth's 7 care and their families." 8 Lord Mann tells us in a written statement to this 9 investigation that he was elected to Lambeth Council as 10 a Labour councillor in May 1986 as part of a changing of 11 the guard. By way of explanation for that phrase, 12 "shortly before my election, it was discovered and made 13 public that the existing team of councillors led by the 14 leader of the council, Ted Knight, had been involved in 15 setting an illegal budget and that this had resulted in 16 the council spending money it didn't have. When 17 I arrived, the majority of existing Lambeth councillors 18 were in the process of being removed and the incoming 19 team comprised of largely first-time councillors." 20 The inquiry will examine whether and, if so, how the 21 introduction of so many new councillors at one point in 22 time may have impacted upon the strategic oversight of 23 children's services. 24 Given the extent of the budgeting irregularities 25 experienced by the council prior to his election,</p> <p style="text-align: center;">Page 79</p>	<p>1 Lord Mann states that the Construction Services 2 Committee of which he became chair in 1988 had 3 a particular focus on corruption in construction 4 services. Lord Mann says there were two key aspects to 5 this: one, corruption in the council's relationships 6 with contractors -- for example, the council allowed 7 specific contractors to underbid for the purpose of 8 being awarded a contract, but then subsequently to vary 9 the contract to increase the price; and, two, major 10 organised theft of materials through, for example, 11 duplicated orders. Lord Mann says: 12 "At the time, Lambeth controlled vast swathes of 13 housing and this meant that the committee habitually 14 dealt with a huge number of construction contracts 15 relating to the building and maintenance of 16 the council." 17 He formed an investigations team and at its height 18 the investigations team and construction internal audit 19 were conducting around 23 simultaneous investigations. 20 Lord Mann says: 21 "We found that corruption was endemic in 22 Lambeth Council's activities in the local area." 23 There is evidence that area children's care was not 24 immune from this corruption. The investigation 25 understands that the senior children's homes officer was</p> <p style="text-align: center;">Page 80</p>

<p>1 dismissed for fraud for selling food donated by Marks &amp; 2 Spencers to children's homes. A CHILE record refers to 3 one member of staff having food to the value of £1,300 4 in a home freezer. There is documentation from the 5 Social Services Inspectorate recording concerns shared 6 by Lambeth that the investigation into Ivy House carried 7 out by the senior children's homes officer may have been 8 tainted by corruption as a member of staff in Ivy House 9 was also implicated in the fraud.</p> <p>10 As noted before, John Carroll was implicated in 11 corrupt practices in 1984 and ultimately sacked for 12 fraud in 1991. One employee who worked at Angell Road 13 gave evidence to the police of Carroll also being 14 involved in the collection of food from 15 Marks &amp; Spencers. She said he took food home that was 16 for the children. These are matters about which former 17 councillor Ms Tapsell may be able to give evidence.</p> <p>18 Whether and insofar as financial constraint or 19 mismanagement impacted upon the nature and extent of 20 sexual abuse inflicted upon children in Lambeth's care 21 is a matter which will be touched on by some of 22 the witnesses in this investigation.</p> <p>23 From the investigation's perspective, it is right to 24 point out that sweeping generalisations around finances 25 cannot begin to explain the scale or context of</p> <p style="text-align: center;">Page 81</p>	<p>1 the sexual abuse which took place within Lambeth. 2 Taking the early 1990s as an example, in 1991, the 3 Social Services Inspectorate noted Lambeth's spending on 4 social work staffing to be the joint highest in London. 5 The same report noted that Social Services' spending per 6 head was the third highest in London. Lambeth was the 7 third highest spender in London on children's services 8 per head of population, the second largest children's 9 budget in London. The 1993 SSI report noted gross 10 spending on children's services to be the highest in 11 London. Gross spending on residential services was the 12 highest in London. Furthermore, a review by 13 Faith Boardman in or around 2002 noted that over the 14 preceding five years authorised expenditure available to 15 Social Services rose from £100 million a year to 16 £172 million a year. The review reported that, despite 17 that increase, over the past 40 months, Social Services 18 had overspent by nearly 30 million. She described it as 19 a major threat to the council's stability.</p> <p>20 Returning then to the Lambeth commissioned reports. 21 In 1986, two contrasting management inquiries were set 22 up in response to the allegation of sexual abuse made by 23 LA-A26 against a member of staff at Ivy House and 24 referred to earlier. A first management inquiry was set 25 up immediately after LA-A26's allegation had been</p> <p style="text-align: center;">Page 82</p>
<p>1 reported by the social worker Anne Worthington. 2 A three-person panel produced a five-page report which 3 summarised the evidence of the social workers and the 4 coworkers of LA-F12 including the officer-in-charge from 5 Ivy House. Neither LA-A26 nor her parents were 6 approached to give evidence to the panel nor was any 7 specialist advice or report sought from any person with 8 experience of complaints of child sexual abuse or of 9 the particular complex needs of the child. The report 10 concluded that there was no suggestion that the case be 11 pursued.</p> <p>12 In December 1985, Robin Osmond, the Director of 13 Social Services, wrote to the parents of LA-A26 saying 14 there was no evidence to substantiate a charge against 15 LA-F12. This was followed by a letter, on 16 3 January 1986, from Robin Osmond to all Ivy House 17 parents referring to allegations made by parents of 18 a child at Ivy House and the fact that the police 19 carried out a formal investigation and could not find 20 evidence to substantiate a charge.</p> <p>21 The family of LA-A26 were deeply unhappy with the 22 outcome of the first management investigation and the 23 fact that LA-F12 was back working at Ivy House. They 24 contacted the Children's Legal Centre, who in turn wrote 25 to Janet Boateng requesting a full enquiry and that</p> <p style="text-align: center;">Page 83</p>	<p>1 LA-F12 be suspended pending the inquiry outcome. 2 A second management investigation followed, which you 3 will hear about. With a differently constituted panel, 4 and after receiving expert evidence, it recommended an 5 immediate disciplinary hearing against LA-F12. At the 6 disciplinary hearing against LA-F12, the management team 7 presented the evidence in support of the allegation that 8 LA-A26 had been sexually abused by LA-F12.</p> <p>9 The disciplinary panel found, in short, that it was 10 convinced that there was a high probability that LA-A26 11 had been abused; that it could have happened at 12 Ivy House; but a majority of the panel do not think, on 13 balance, that this has been shown to be a high 14 probability and, given that position, the case against 15 LA-F12 was not proven.</p> <p>16 The Brixton Family Support Group wrote an open 17 letter to the then leader of the council setting out the 18 family's anger that LA-F12 had been cleared of gross 19 misconduct and demanding a public explanation as to why 20 LA-F12 was able to continue working with some of 21 the most vulnerable children in society.</p> <p>22 The seminal report of the death of Tyra Henry was 23 published in 1987. It was called "Whose child" -- 24 a reflection of how Lambeth lost sight of its 25 responsibility for Tyra. This was not a report about</p> <p style="text-align: center;">Page 84</p>

<p>1 child sexual abuse, but it speaks to the wider issues                  2 relevant here.                  3 Tyra died of what the report described as extensive                  4 and appalling injuries in 1984 whilst in Lambeth's care                  5 and on the at-risk register. She was murdered by her                  6 father. Her brother, in 1982, had suffered what the                  7 report described as terrible and permanent injuries as                  8 a result of deliberate harm. The children's father was                  9 acquitted of causing these injuries on the basis that it                  10 could not be said that it was he, as opposed to anyone                  11 else, who had inflicted them.                  12 The report detailed failings which left Tyra at                  13 risk. She was cared for by his grandmother, but                  14 directly related to her death, her mother removed her                  15 from the grandmother's home when the electricity was cut                  16 off. Lambeth Social Services was aware of the severe                  17 overcrowding in the family home and that the electricity                  18 had been cut off. The report notes:                  19 "Nor is there any sign of an active and urgent                  20 response to the information that a child in Lambeth's                  21 care was in a situation where, on top of all the other                  22 known problems, there was now no electricity and no near                  23 prospect of restoring it unless the council took on the                  24 task. There was no apparent appreciation that the                  25 possibility of using candles for light in a household</p> <p style="text-align: center;">Page 85</p>	<p>1 which had earlier lost a child in a fire must have been                  2 a real source of fear. It is unsurprising, in all these                  3 circumstances, that Claudette moved with Tyra into                  4 Andrew's flat and that Beatrice Henry let Tyra go."                  5 The report reiterated that it was the local                  6 authority corporately which bore responsibility for                  7 providing support and maintenance to children in its                  8 care. It stated:                  9 "The failure of its directorates to work adequately                  10 in harness is a failure for which constitutionally the                  11 elected members are answerable. We point this out in                  12 order to stress that if the limbs of a local authority                  13 are not working in co-ordination, this itself represents                  14 an incipient failure on the part of the local authority                  15 to carry out its functions."                  16 Those who gave evidence to the inquiry included                  17 Robin Osmond, David Pope, Jack Smith, Stephen Bubb and                  18 Janet Boateng.                  19 In 1988, Robert Morton, principal manager children's                  20 homes, wrote a report for the Children's Homes                  21 Subcommittee. Within it he stated:                  22 "Having been in post for less than three months,                  23 there are areas and issues within the section which are                  24 extremely worrying, unacceptable and requiring urgent                  25 attention."</p> <p style="text-align: center;">Page 86</p>
<p>1 Later in the report:                  2 "The extent of the problems within the children's                  3 homes section cannot be underestimated. The present                  4 situation has not occurred overnight. It has evolved,                  5 for whatever reason, over many years. The results of                  6 ineffective management, bad planning and poor practice                  7 are now being tackled. This process in itself is                  8 causing further problems and in fact uncovering even                  9 more issues of concern. In relation to the                  10 circumstances of the staffing and resources, we are                  11 simply unable to maintain the present level of care                  12 never mind improve. Staff sickness is extremely high,                  13 every day the section is struggling to staff homes. The                  14 present situation cannot prevail and will collapse                  15 without change."                  16 Mr Morton provided a further report for the                  17 Children's Homes Subcommittee for its meeting on                  18 16 November 1988. In it he stated:                  19 "My last report was frank and detailed, relating to                  20 the serious situation within the section. I would                  21 simply state the situation is still extremely serious."                  22 It was accompanied by a report from Mr Byron, the                  23 children's homes placement manager. Mr Byron stated                  24 that he was frankly appalled at the state of affairs                  25 that awaited him upon his appointment in September 1988:</p> <p style="text-align: center;">Page 87</p>	<p>1 "Information and filing systems which are unwieldy                  2 at best and at worst unworkable. Inadequate recording                  3 procedures, with information in some cases years out of                  4 date. There were no established procedures for dealing                  5 with referrals and placements. Monitoring control                  6 systems simply did not exist. State of affairs did not                  7 result overnight but would appear to be the result of                  8 years of neglect and inefficiency."                  9 In January 1990, the report of the enquiry into                  10 Southvale Assessment Centre, the Zephyrine Report, was                  11 published. The panel, drawn from Lambeth staff, was set                  12 up to investigate fully the management and running of                  13 Southvale, with particular regard to the allegations by                  14 staff of racism, sexism and bad childcare and management                  15 practices. It had the power to call children to give                  16 evidence. We understand that it did not hear from any                  17 children. The Zephyrine Report did not find misconduct                  18 at Southvale but said that it was far from happy with                  19 certain practices. Whether this was a missed                  20 opportunity to uncover sexual abuse is an issue which we                  21 will return to in this opening and in the evidence.                  22 A Lambeth review of placements at private and                  23 voluntary homes suggests in February 1990 that there                  24 were 187 children placed in private and voluntary homes                  25 and regional establishments. The review states that</p> <p style="text-align: center;">Page 88</p>

<p>1 this was at variance with central records which showed                  2 that between 5 February 1990 and 22 February 1990,                  3 69 placements were made in private and voluntary homes.                  4 The review highlighted the high level use of such                  5 placements and that children were in residential care                  6 solely because of housing difficulties. It noted that                  7 there were ineffective monitoring systems, statutory                  8 reviews were not being carried out in time and there was                  9 not a great deal of evidence of preventative work.                  10 Robert Morton wrote to Jack Smith, principal officer                  11 social work, in the following terms:                  12 "I am particularly concerned at the apparent lack of                  13 the statutory reviews and care plan action relating to                  14 children in our care and through your appropriate line                  15 managers I wish to be made aware of how these issues are                  16 developing."                  17 On 20 September 1990, a final report from Mr Morton                  18 was presented to the Children and Young Persons                  19 Committee. He stated:                  20 "My personal fear, concern and indeed a factor of my                  21 decision to move on relate to the standard of care, lack                  22 of planning and lack of adherence to good professional                  23 standards and procedures."                  24 Mr Morton made clear his opinion surrounding                  25 placement of children and that Lambeth continued to</p> <p style="text-align: center;">Page 89</p>	<p>1 admit young people into care contrary to policy and when                  2 it was totally inappropriate to do so. Young people                  3 remained in care due to lack of planning, intervention                  4 and appropriate resources. The number of                  5 under-five-year-olds admitted into care grew and the                  6 time scales for young people in care continued to                  7 escalate.                  8 On 1 January 1990, Ms Whelan wrote to                  9 Virginia Bottomley and highlighted that she had become                  10 more and more concerned about Lambeth's children's                  11 services; in particular, Robert Morton's grave concerns                  12 and his 1990 report, Continuing Problems at Southvale                  13 Children's Home and also The Melting Pot Foundation of                  14 which she stated, "A hostel for black adolescents funded                  15 in the main by Lambeth. I believe funding should have                  16 been immediately withdrawn because of a recent inquiry.                  17 It has not."                  18 In 1991, the child protection services in Lambeth                  19 report considered the extent to which Lambeth had                  20 responded to the recommendations in the reports which                  21 followed the deaths of Tyra Henry and Doreen Aston. It                  22 detailed, amongst many other outstanding issues, the use                  23 by Lambeth of unqualified social workers and the delay                  24 in conducting child protection investigations. It also                  25 referred to confusion about the number of unallocated</p> <p style="text-align: center;">Page 90</p>
<p>1 cases. On 6 November 1991, Virginia Bottomley MP wrote                  2 to Councillor Nicholas about this inspectorate's report.                  3 The letter referred to Lambeth having a level of                  4 unqualified social workers which was 14 per cent higher                  5 than in other boroughs. On 7 November 1991, Lambeth                  6 produced a report recording Norbert McCooty. This                  7 report was instigated by the judge at the Old Bailey who                  8 sentenced Mr McCooty. The judge had asked Lambeth to                  9 investigate why Mr McCooty had not been in secure                  10 accommodation and, therefore, been at liberty to rape                  11 a 53-year-old woman. Paragraph 8.27 of the report sets                  12 out that the council had no legal power to delegate                  13 functions to members, and yet this is what had happened                  14 in relation to decisions to place children in secure                  15 accommodation. In the McCooty case, the report records                  16 that the chair did not agree with the report of a social                  17 worker that he should be placed in secure accommodation.                  18 The issue which arises and which is relevant to this                  19 investigation is whether councillors were making                  20 decisions which affected children in a way which was                  21 appropriate. Where did the line lie between decisions                  22 which were a matter of professional judgment for                  23 officials and decisions which were for councillors?                  24 In April 1992, a Social Services Inspectorate report                  25 identified Lambeth as having one of the highest numbers</p> <p style="text-align: center;">Page 91</p>	<p>1 of unallocated cases in London and that this was a cause                  2 for concern. The report stated of Lambeth and other                  3 councils with high levels of unallocated cases, "This                  4 represents a serious long-term failure to fulfil                  5 statutory responsibilities towards children requiring                  6 protection". David Pope replied to the SSI suggesting,                  7 amongst other reasons, that penalties, rate capping and                  8 poll tax capping linked to financial management                  9 difficulties limited the ability of the council to                  10 provide sufficient resources for child protection.                  11 Chair, I note the time.                  12 THE CHAIR: Yes, thank you, Ms Langdale. We will now take                  13 the lunch break and return at 1.45 pm.                  14 (12.45 pm)                  15 (The short adjournment)                  16 (1.45 pm)                  17 MS LANGDALE: Chair, picking up from where we were before                  18 the adjournment, we are drilling into the second topic                  19 for the investigation, the culture of Lambeth Council                  20 over time, including the relationship between members                  21 and councillors and Lambeth's response to allegation of                  22 child sexual abuse and I was highlighting various                  23 Lambeth commissioned reports and inspections through the                  24 period. We have reached 1992.                  25 In 1992, chair, the parliamentary</p> <p style="text-align: center;">Page 92</p>

<p>1 Under-Secretary of State wrote to the leader of                  2 the council and asked for arrangements to be made for                  3 a management review to be undertaken by a person                  4 independent of Lambeth Council into the circumstances of                  5 the employment of Carroll as officer-in-charge at                  6 Angell Road and to whom I have already referred.                  7 Richard Clough was subsequently appointed to undertake                  8 this review.                  9 As you will hear in evidence, a number of matters                  10 came to a head in 1992. In December, Mr Yeo notified                  11 Lambeth Council that he'd asked the Social Services                  12 Inspectorate to conduct a full inspection of Lambeth's                  13 residential services to commence in 1993.                  14 As I have mentioned in relation to Angell Road,                  15 in March 1993 the SSI published a report of                  16 an inspection of three residential children's homes in                  17 the London Borough of Lambeth. This inspection took                  18 place in the context of media reports about the                  19 behaviour of staff, concerns over control and the                  20 appointment of staff in residential care for children in                  21 Lambeth.                  22 The homes inspected were Stockwell Park Road,                  23 Lorn Road and Angell Road. The inspection noted,                  24 amongst other issues, lack of police checks on staff,                  25 inadequate record keeping surrounding visitors, high</p> <p style="text-align: center;">Page 93</p>	<p>1 levels of staff sickness, vacancies and reliance on                  2 agency staff, lack of training and support in child                  3 protection, lack of planning for children and poor                  4 record keeping.                  5 The Clough Report was provided to Lambeth                  6 in May 1993. Unsurprisingly, it concluded that the                  7 decision to retain John Carroll after his conviction                  8 came to light was wrong and legitimised Carroll's                  9 position as a carer in whatever setting. Henry Gilby                  10 was chief executive at Lambeth between 1993 and 1994 and                  11 in a statement to the inquiry says that he met Mr Clough                  12 as soon as the report had been submitted to the council                  13 and he asked Mr Clough to reconsider making                  14 recommendations to the council. None were made within                  15 his report. The inquiry will hear oral evidence from                  16 Mr Clough and will consider his report and decision                  17 making around recommendations.                  18 In 1993, a report into the death of Mia Gibelli was                  19 published. Mia Gibelli did not live in a children's                  20 home but with her mother. She was killed by her mother                  21 in circumstances where Lambeth knew she had previously                  22 attempted to kill a sibling. The report made a number                  23 of criticisms relevant to Lambeth's Social Services and                  24 its provision of social work. Tim Yeo MP is reported to                  25 have said in interview with LBC Radio:</p> <p style="text-align: center;">Page 94</p>
<p>1 "Lambeth have been, once again, guilty of                  2 the grossest degree of incompetence, but it is, I'm                  3 afraid, part and parcel of their record generally in                  4 relation to childcare."                  5 In early 1994, Lambeth received a copy of                  6 the investigation into alleged breaches of the council's                  7 equal opportunities policies in the Housing Department,                  8 also known as the Harris Report or the Three Women                  9 Report. Although this was a report concerning the                  10 Housing Department, it also raised issues about the                  11 possible abuse of children. According to a statement                  12 provided by the panel chair, Ms Harris, the director of                  13 housing service had indicated that allegations had been                  14 made which concerned the issue that pornographic                  15 material had been exchanged amongst officers in housing                  16 and elsewhere. I will say more about the Harris Report                  17 later. For now, Ms Harris says in a statement to this                  18 inquiry:                  19 "I do not recall any person disclosing allegations                  20 of child sexual abuse during the time the panel was                  21 investigating, preparing or writing the report."                  22 Yvette Adams was a senior human resource                  23 professional employed at Lambeth from 1989                  24 to October 2000. She was also asked to sit on the                  25 investigation panel for the Harris Report. Commenting</p> <p style="text-align: center;">Page 95</p>	<p>1 on the culture within the Social Services Department and                  2 the Harris investigation, Ms Adams said in a statement                  3 to the inquiry:                  4 "I would say that the advent of the equal                  5 opportunities policies and processes ensured the                  6 organisation stopped functioning according to custom and                  7 practice -- functioning started working towards being                  8 more transparent with explicit policies, procedures and                  9 accountability lines. Under the old setup pre 1980,                  10 this investigation may never have taken place and this                  11 is made reference to in the report. On the other hand,                  12 the implementation of the council's EOP only scratched                  13 the surface, as longstanding managerial networks still                  14 operated with impunity. The culture was very much about                  15 who you know and it was mainly a white organisation                  16 which recruited in its own image."                  17 Elizabeth Appleby QC's report was commissioned                  18 in April 1993 and she reported in 1995. Of                  19 the turbulent period in the 1980s, Elizabeth Appleby QC                  20 found and stated in her 1995 report:                  21 "I am satisfied that in the 1980s Lambeth's ruling                  22 party was intent on obstructing the implementation of                  23 government policy in a number of areas. The facts                  24 clearly indicate that it had little or no regard to                  25 reducing public expenditure, that it refused to accept</p> <p style="text-align: center;">Page 96</p>



<p>1 the consequences of the abolition of the Greater London 2 Council, that it embarked on a policy of protecting its 3 workforce at all costs, thereby undermining the 4 compulsory competitive tendering legislation. Further, 5 I am satisfied that Lambeth operated an unwritten policy 6 which served to undermine and severely prejudice the 7 collection of rent arrears, the collection of poll tax 8 and later the collection of council tax." 9 The Appleby Report documented widespread dysfunction 10 in the operation of the council and its directorates. 11 Ms Appleby QC concluded: 12 "Lambeth is in an appalling mess. The financial 13 control of Lambeth is such that vast amounts of money 14 are wasted and, in consequence, services are severely 15 prejudiced. What is so surprising is that many defects 16 in Lambeth's administration have been identified time 17 and time again by internal audit by the district auditor 18 and by independent reports. It seems that while the 19 conclusions and recommendations flowing from the audits 20 and reports have been readily accepted by chief officers 21 and the political leadership, Lambeth has been totally 22 unable, or totally unwilling, to translate its plans and 23 ambitions into positive actions. Lambeth seems intent 24 on living in the past and never improving its future." 25 In April 1994, there was an SSI inspection of</p> <p style="text-align: center;">Page 97</p>	<p>1 the Inspection Unit in Lambeth Social Services 2 Department. The inspection concluded that the Lambeth 3 unit had not been able to reach its statutory and 4 advisory targets. There was a further SSI inspection 5 in May 1994. This was to assess progress after the 1993 6 inspection. A number of failings continued to be noted. 7 These included that basic information about children was 8 missing from their files; written care plans were not on 9 file or known to staff; and training on child protection 10 had begun but progress was uneven. The report stated: 11 "Overall, the improvements were limited and patchy, 12 and some worrying essentials of practice, care plans and 13 supervision, were still not adequate." 14 In 1994, Anna Tapsell wrote a memo to the Director 15 of Social Services in which she raised concerns about 16 unallocated cases. Ms Tapsell received a letter in 17 response from a minister in the Department of Health in 18 which it recorded that the situation surrounding 19 unallocated cases had seriously deteriorated 20 particularly for looked-after children. 21 In May 1999, John Barratt, having been commissioned 22 to write a report surrounding allegations of sexual 23 abuse made against Steven Forrest, issued an interim 24 report. He did so because of his deep concern about the 25 continuing fractured and ineffective practice of child</p> <p style="text-align: center;">Page 98</p>
<p>1 protection by Lambeth Social Services Department. On 2 30 September 1999, John Barratt's report, "The Lambeth 3 Independent Child Protection Inquiry 1999" was 4 published. This was the first report into the 5 allegations that a child in Lambeth's care had been 6 sexually abused by Steven Forrest. Mr Barratt stated at 7 the outset of his report that the catalogue of 8 organisational incompetence that characterised the care 9 of LA-A29 from his reception into care in 1984 was 10 shocking. 11 There was an inspection in May to June 2000 by the 12 order of the Minister of State for Health. Its overall 13 impression was of a Children and Families Division 14 struggling under considerable and relentless pressure. 15 In many areas, basic work systems were functioning 16 poorly or had collapsed. This led to inefficient, 17 fragmented and inconsistent work practices. The SSI 18 noted: 19 "We were particularly concerned about potentially 20 large numbers of children who had not properly been 21 regarded as looked after. They had not been allocated 22 a social worker, were not placed with approved carers 23 and had none of the protection afforded by visiting, 24 monitoring or statutory reviews. Urgent action was 25 needed to trace these children and secure their safety."</p> <p style="text-align: center;">Page 99</p>	<p>1 Furthermore, significant numbers of looked-after 2 children and those on the Child Protection Register did 3 not have social workers. 4 In August 2000, the chair of Lambeth's Inspection 5 Advisory Panel resigned, stating in a letter to the 6 leader of the council: 7 "The performance of the directorate, which is 8 consuming huge resources and not delivering acceptable 9 services, represents a betrayal of some of the most 10 vulnerable members of the community and, after careful 11 consideration, I feel that my continued involvement in 12 this authority would be a form of collusion with its 13 maladministration." 14 In November 2000, the Secretary of State for Health, 15 the Right Honourable John Hutton MP, wrote to the chief 16 executive at Lambeth to say that Lambeth Social Services 17 Directorate was to be placed on a list of monitored 18 authorities. The minister wrote: 19 "I am extremely concerned about what the effect of 20 failures in basic statutory responsibilities means for 21 the safety and welfare of children in Lambeth." 22 Directions under section 7A of the Local Authority 23 Social Services Act 1970 were issued, to ensure that 24 Lambeth takes the action required to rectify the 25 situation by 31 August 2001.</p> <p style="text-align: center;">Page 100</p>

<p>1 Key areas for which statutory directions were issued                  2 included: all looked-after children placed with foster                  3 carers, in children's homes or with parents should be                  4 visited at the frequency required by the relevant                  5 legislation, all children on the Child Protection                  6 Register should have an allocated social worker;                  7 a formal protocol with the police to guide interagency                  8 working in relation to child protection should be                  9 produced; the approvals of all local authority foster                  10 parents should be reviewed at the required frequency and                  11 all prospective foster carers should be checked against                  12 the list maintained by the Secretary of State.                  13 On 24 October 2000, John Barratt's final report "Two                  14 Lambeth Independent Child Protection Inquiries                  15 1999-2000" was published. He drew three basic                  16 conclusions.                  17 First, the council, through its inadequate                  18 arrangements in the Social Services Committee, the                  19 department and division, has repeatedly failed to fulfil                  20 both its statutory duties and its own policies relating                  21 to the care and protection of children.                  22 Second, the council has repeatedly tried during the                  23 last decade, but repeatedly failed, to create and                  24 control an effective department and division.                  25 Third, the council's executive chain of command,</p> <p style="text-align: center;">Page 101</p>	<p>1 assuming it once existed, linking departmental action to                  2 the council, has decayed and disintegrated.                  3 In September 2001, LA-A135 died and was the subject                  4 of a part 8 case review. LA-A135 had been in the care                  5 of Lambeth since 1990. The part 8 review noted that                  6 LA-A135 had been placed by Lambeth in a home in 1991,                  7 despite being informed of concerns about this home by                  8 Surrey Social Services.                  9 Birtley Farmhouse was for teenagers with therapeutic                  10 needs. This child was 7 years old when he was sent                  11 there. He was supposed to be there on an emergency                  12 basis. He was there for five months.                  13 LA-A135 said he had been abused while living there                  14 but was not moved for several months. According to the                  15 part 8 case review, when he was interviewed in 1992,                  16 LA-A135 was neither then, nor at a later date, offered                  17 assessment, counselling or therapy of any kind. LA-A135                  18 took his own life in Feltham Young Offenders                  19 Institution.                  20 The review described the care afforded to LA-A135 as                  21 an abject lesson in the potentially disastrous                  22 consequences of failure to plan/implement plans for                  23 children in care.                  24 In December 2001, there was a reinspection of                  25 Lambeth required by the Secretary of State for Health.</p> <p style="text-align: center;">Page 102</p>
<p>1 This was a reinspection to assess progress in meeting                  2 the statutory directions issued in November 2000. It                  3 identified a number of areas of improvement, including                  4 reviews of foster carers and appropriate checks being                  5 conducted on foster carers. It detailed a number of key                  6 issues that still had to be addressed, including that                  7 all looked-after children in foster homes, children's                  8 homes or placed with parents should be visited at the                  9 appropriate frequency.                  10 In March 2002, Lambeth was subject to an improvement                  11 plan. In a letter to the chief executive, Jo Cleary,                  12 assistant chief inspector Social Services Inspectorate,                  13 wrote that the monthly monitoring data produced by                  14 Lambeth shows steady progress, which gives confidence of                  15 future sustainability. Lambeth was thanked for its                  16 openness and responsiveness in its relationship with the                  17 SSI. In 2007, Ofsted assumed responsibility for the                  18 inspection and regulation of children's services. We                  19 will consider their input at a later stage.                  20 Chair, this is just an overview of key points in the                  21 Lambeth chronology. It is not the full picture. As you                  22 will hear, there were criminal investigations, trials,                  23 and the Children's Homes in Lambeth Enquiry. In short,                  24 many other sources of information to Lambeth about what                  25 was happening to children in its care.</p> <p style="text-align: center;">Page 103</p>	<p>1 You will hear from witnesses who were in Lambeth as                  2 officials or as councillors at critical points in this                  3 chronology. Some had responsibility for responding to                  4 these investigations, the responsibility to make change.                  5 You will hear from directors of social services and                  6 chief executives. The issue is whether Lambeth was                  7 impervious to real change when it came to children in                  8 its care. We will invite witnesses to stand back from                  9 this chronology and to explain why, into the 2000s,                  10 despite all these investigations, reports and inquiries,                  11 Lambeth still appeared to be falling fundamentally short                  12 in respect of child protection.                  13 May I turn now to the case study homes and Lambeth's                  14 response to allegations of abuse. This will not be an                  15 exhaustive summary for obvious reasons. It will,                  16 however, highlight the issues to be explored within each                  17 of the case study homes.                  18 Shirley Oaks. Purported management of Shirley Oaks                  19 changed over time. Between 1965 and 1973, Shirley Oaks                  20 operated as one large children's home with individual                  21 cottages on site. A superintendent reported to the                  22 council via a committee. In April 1973, the centralised                  23 management structure of Shirley Oaks was disbanded and                  24 each of the cottages operated as a semi-autonomous                  25 individual children's home. Officers in charge ran the</p> <p style="text-align: center;">Page 104</p>

<p>1 homes, in consultation with the group management officer                  2 based within the Social Services directorate. Despite                  3 the reality of the sexual abuse being perpetrated within                  4 Shirley Oaks, the investigation has received no written                  5 evidence to suggest that allegations of sexual abuse                  6 were formally referred to the council committees or were                  7 discussed at group management officer level.                  8 There was no procedure in place for children to                  9 report any personal concerns in a secure and                  10 confidential manner. Mr Lewis, a house father at                  11 Shirley Oaks between 1972 and 1982, said that he would                  12 tell children to go to the lodge if they wanted to                  13 report anything. Lambeth explain that the lodge was                  14 likely to be an administrative building but there's also                  15 been reference to a flat at the lodge that was commonly                  16 referred to as Lodge House. Other evidence suggests                  17 Lodge House was occupied for many years by                  18 a superintendent, LA-F93, who was himself abusing                  19 children.                  20 Few contemporaneous documents have been located                  21 which record allegations of sexual abuse being made.                  22 However, children providing statements as adults say                  23 that they told members of staff about abuse and describe                  24 the way in which Lambeth responded.                  25 Responses range from explicit disbelief and</p> <p style="text-align: center;">Page 105</p>	<p>1 punishment to limited efforts to remove the alleged                  2 perpetrator from their role. Children report nothing                  3 being done and feeling less able to report other                  4 concerns. No child describes a sympathetic response or                  5 anything which led Lambeth to carefully assess the                  6 allegations or investigate the risk to other children.                  7 LA-A64, LA-A50, LA-A341 and LA-A108 are some of                  8 the children who describe telling staff, including house                  9 parents, about being sexually abused but nothing being                  10 done in response. LA-A341 complained to his house                  11 mother about a sexual assault by a social uncle which                  12 occurred on a trip out of Shirley Oaks. "She didn't say                  13 anything. I left it at that. Nothing ever happened                  14 when we told adults about things".                  15 This same house mother dismissed LA-A50's complaint                  16 about a social uncle's sexual assault, saying "The man's                  17 only playing".                  18 Hosegood's abuse of LA-A69 started when she was                  19 about 6 or 7 years old. Hosegood abused her and another                  20 girl she shared a bedroom with. Hosegood told LA-A69                  21 that if she said anything about his behaviour to anyone,                  22 he would kill her. She was terrified of him and                  23 believed him. When she did find the courage to tell                  24 people, she was not believed.                  25 In 1978, a former resident of Shirley Oaks wrote to</p> <p style="text-align: center;">Page 106</p>
<p>1 the children's homes officer about an allegation of                  2 sexual abuse made by an 8-year-old girl, LA-A451,                  3 against a much older child at the home. The former                  4 resident said to the children's homes officer, "I'm                  5 writing in the hope that you will resolve a very serious                  6 problem that has been worrying me for weeks". The                  7 writer knew that the young girl had complained about                  8 being touched by an older child, but that the child's                  9 house mother LA-F65 flatly disbelieved the allegation.                  10 The house mother told the writer that she had discussed                  11 it with the group's social worker, who visits the house,                  12 and also with the psychiatrist, and they all came up                  13 with the conclusion that it was in LA-A451's mind.                  14 In response to the letter from the former resident,                  15 the children's officer wrote:                  16 "Thank you for your letter setting out your                  17 concerns. The allegations you make are indeed taken                  18 seriously and I'm arranging for an investigation to look                  19 into the matters you raise."                  20 No investigation or follow-up has been located                  21 within the documents despite the powerful nature of                  22 the letter and its ending:                  23 "Please do not treat this letter as just another                  24 complaint. It is more of a plea than anything. Please                  25 do something."</p> <p style="text-align: center;">Page 107</p>	<p>1 Disturbingly, the writer had made it clear that she                  2 understood that the abuse was continuing as the young                  3 child was frightened to tell the house mother because                  4 she wouldn't believe her.                  5 There is plenty of evidence that staff and children                  6 alike were aware of numerous rumours about various                  7 perpetrators. LA-F93 was referred to as someone to                  8 avoid. LA-A164 says of LA-F92 he would call the pupils                  9 to his desk, which was at the front of the classroom, to                  10 look at their work:                  11 "You would stand beside him looking at your book on                  12 the table. He would put his arm around my waist ..."                  13 Then LA-A164 goes on to give a description of                  14 indecent assault:                  15 "I remembered this being odd at first. But he did                  16 this to all the girls. It's the way it was."                  17 Whilst Hook worked at Shirley Oaks, LA-A197 recalls                  18 that other boys used to say Hook touched them. Various                  19 staff refer to there being widespread rumours. This                  20 includes Donald Thomas, who was employed by Lambeth                  21 between 1966 and 1986 in various management roles,                  22 including senior children's homes officer in the '70s,                  23 before becoming principal children's homes officer. In                  24 his statement to police in January 2000, Mr Thomas said:                  25 "I am aware that there was possibly some concern or</p> <p style="text-align: center;">Page 108</p>

<p>1 a rumour about an incident. It was of a nature I cannot                  2 recall at this time. He did leave Shirley Oaks. I had                  3 no further contact with him."                  4 Hook groomed children. LA-A64 refers to the special                  5 attention and gifts he would receive from Hook, such as                  6 a watch and a bicycle. In her statement to police                  7 dated September 2000, LA-A64's sister recalls:                  8 "I also remember my mother being very concerned                  9 about this man, Hook, when he bought LA-A64 a bicycle.                  10 I can remember her confronting LA-F65 on more than one                  11 occasion about different issues concerning LA-A64. But                  12 I can't remember now exactly what they were about.                  13 Nothing ever seemed to change."                  14 LA-A63 refers to Hook giving him extra pocket money                  15 and presents after he began sexually abusing him.                  16 Despite these rumours and evidence of gifts, Hook, an                  17 unpaid member of staff, was not subject to investigation                  18 by Lambeth.                  19 Many staff also had suspicions about Clarke.                  20 A Lambeth social worker between 1970 and 1978 recalls                  21 that, "We all had our doubts about Geoff. By this                  22 I mean myself and other members of staff. The reason we                  23 had doubts about Geoff was because we couldn't really                  24 understand why he was there at Shirley Oaks spending so                  25 much time with the children without getting paid for it</p> <p style="text-align: center;">Page 109</p>	<p>1 ... generally, he was trusted to spend time with the                  2 children unsupervised within and outside the house ...                  3 In the evenings, he'd take the children up to bed. He'd                  4 go upstairs on his own with them and spend some time up                  5 there. I don't know how long generally, but it was long                  6 enough for us to assume he was reading to them.                  7 Probably at least half an hour or more, possibly                  8 longer."                  9 One house father between 1978 to 1991 describes                  10 a child coming back from swimming with Clarke and                  11 complaining about having to get changed in the same                  12 cubicles. This caused him to make a complaint about                  13 Clarke. The house father says:                  14 "We were told to discuss our concerns with Clarke,                  15 which we did. He was very defensive about the whole                  16 matter and said something like, what are you trying to                  17 imply? I told him that we weren't trying to imply                  18 anything, but wanted an explanation and he ended up                  19 walking off and refusing to discuss the matter further.                  20 Despite having reported the matter to our management,                  21 nothing further happened."                  22 Even when concerns became individually pronounced in                  23 relation to a particular child, Lambeth took no action.                  24 The relationship between Clarke and LA-A51, for example,                  25 was clearly a source of concern. Clarke was asked to</p> <p style="text-align: center;">Page 110</p>
<p>1 limit the time he was spending with the child.                  2 Furthermore, LA-A51's father wrote to the council                  3 questioning whether Clarke was fit to work with                  4 children. In addition, a letter in 1975 addressed to                  5 admin and legal from the committee secretary states that                  6 it encloses copies of a letter from LA-A51's family in                  7 which a serious complaint is made concerning a member of                  8 staff at Shirley Oaks. The writer states:                  9 "I have acknowledged receipt and said that the                  10 matter is being immediately investigated by                  11 Social Services directorate. It also says additional                  12 copies of the letter were enclosed so that, if desired,                  13 the letter can be passed on to others. No evidence has                  14 been found of any such investigation. During                  15 Operation Middleton, LA-A51 told police he'd been                  16 sexually abused by Clarke whilst at Shirley Oaks.                  17 LA-A67 provided a statement to police                  18 in February 2000. He gives an account of abuse by three                  19 men at Shirley Oaks. These included a man referred to                  20 as "the boilerman", who other children also describe as                  21 perpetrating violent sexual abuse against them. He was                  22 then abused by LA-F93 who used to take LA-A67 out on day                  23 trips. LA-A67 was terrified of this man, but his house                  24 mother told him that he was lucky to have the                  25 opportunity for a trip out of the home. After the</p> <p style="text-align: center;">Page 111</p>	<p>1 trips, LA-F93 would take him back to the lodge and abuse                  2 him. On one occasion, LA-F93 had his hands around                  3 LA-A67's throat who was crying. LA-A67 thought he was                  4 about to die. LA-A67 returned home. He must have cried                  5 out during the night because his house mother woke him                  6 and he said he told her about the abuse. The house                  7 mother told him not to be so stupid. The next day she                  8 said she didn't want to discuss it and kept him away                  9 from the other children in his own room as though he had                  10 done something wrong.                  11 Staff witnessed inappropriate and abusive conduct by                  12 Hosegood and yet it was not investigated. LA-A25 says                  13 a staff member witnessed Donald Hosegood looking at her                  14 naked. One recalls witnessing Hosegood going into the                  15 toilet with LA-A25. She says:                  16 "Mr Hosegood would on occasions behave                  17 inappropriately, in my opinion. For example, he would                  18 come downstairs dressed only in a towel around his                  19 middle in full view of the children. One day I saw him                  20 walk into a toilet which LA-A25 was already using. It                  21 was early in the morning, shortly after I'd come on                  22 duty, and was a few months after I'd started working                  23 there. He didn't knock. He just marched in. I felt                  24 that his behaviour was totally inappropriate and                  25 challenged him. He told me that his wife was in charge</p> <p style="text-align: center;">Page 112</p>

<p>1 and simply dismissed my concerns. I witnessed him do                  2 this on about two or three separate occasions. I hadn't                  3 been working at Shirley Oaks for very long at this time                  4 and didn't take the matter any further."                  5 Another member of staff told the police:                  6 "It was difficult to speak out against other members                  7 of staff, particularly if you had concerns about them                  8 but no proof. It would place you in a vulnerable                  9 position in fear of losing your job."                  10 Even when staff witnessed abuse, children were not                  11 subsequently protected. LA-A63 was a victim of Hook's                  12 and recalls that his house mother, LA-F65, walked in on                  13 an incident of abuse but did nothing. LA-A63 said in                  14 his December 1999 statement to police that he was lying                  15 on the bed naked and Hook was sitting on the bed next to                  16 him. He remembers 'the door opening and LA-F65 was                  17 standing there'. Hook told her 'It was all right, I was                  18 not feeling well and he had put me to bed.' LA-A63 goes                  19 on, "LA-F65 would have seen us".                  20 A house mother found an alleged perpetrator, LA-F37,                  21 in the bedroom of LA-A76's which she shared with her                  22 sister and another girl. He had sexually assaulted her,                  23 then hid under the bed before assaulting her again and                  24 then behind the door when she went to get help. The                  25 house mother caught him behind the door and told him to</p> <p style="text-align: center;">Page 113</p>	<p>1 leave. LA-A76 then heard other men arrive who she                  2 thought were senior managers. LA-A76 was too afraid to                  3 tell the house mother what had happened and that she had                  4 been sexually assaulted. She said the house mother                  5 "ended up making me feel responsible about the welfare                  6 of LA-F37's wife and child. She made it clear to me he                  7 had a wife and child and they would be in trouble and                  8 because of what she said about them, it shut me up".                  9 The house mother made her go to confession.                  10 In police statements provided in 2001 and 2002, the                  11 incident was remembered by LA-A76 and the house mother                  12 who remembered LA-A76 waking her in the night and saying                  13 a man was in her room. She took the girl back to her                  14 bedroom and found the man hiding behind the door which                  15 connected the house to the neighbouring home. She said                  16 I knew there was something untoward. The house mother                  17 reported it to the acting head of the home and LA-F37's                  18 wife. The police were not involved. Two different                  19 staff members refer to it all "being kept very                  20 hush-hush". When they left, it was all hushed up.                  21 LA-F76 reflects:                  22 "They were cowards because they weren't going to                  23 help us with it and would say it was for our own good                  24 just to forget it. This was unfair, as those things                  25 stick with you for life. They could have helped me then</p> <p style="text-align: center;">Page 114</p>
<p>1 but they didn't want to. They just wanted to shut it                  2 up. I told LA-F93 about it but there was no point in                  3 that because he was up to no good himself. I used to                  4 watch him when his was touching my brother.                  5 Donald Hosegood was employed at Shirley Oaks as                  6 a house father at Cedar Cottage and Fir House                  7 between May 1968 and October 1975. He was jointly                  8 appointed with his wife, who was a full time house                  9 mother. Contemporaneous allegations of sexual abuse by                  10 Hosegood were made by, or on behalf of, six of the eight                  11 children accommodated in Fir House and one other child.                  12 Children were interviewed by the police and Hosegood                  13 stood trial in 1975. An internal memorandum written                  14 in September 1974 by the senior children's homes officer                  15 to the director of Lambeth legal services sets out the                  16 facts of the allegations by the children, the police                  17 interview and referral of the case to the Director of                  18 Public Prosecutions, noting that the police                  19 investigation "has pre-empted any enquiry we might make"                  20 and that the allegations had not been pursued in depth                  21 and they are categorically denied. The memo states:                  22 "It is the belief in this directorate that the                  23 majority of the accusations against the house father are                  24 pure fantasy. The history of the children is that some                  25 are given to sexual fantasy and the previous</p> <p style="text-align: center;">Page 115</p>	<p>1 relationship between the house father and these children                  2 also suggests an element of victimisation against him."                  3 The reply memorandum from the director of admin and                  4 legal services, sent one week later, states:                  5 "My view is that the least said the better on this                  6 matter until a decision has been made by the police                  7 authorities in respect of the allegations. Once the                  8 decision is made, then the situation can be reviewed in                  9 the light of that decision."                  10 Philip Temple, eventually convicted of 27 charges                  11 relating to child abuse in 2016, admitted to having been                  12 disturbed by a female member of staff when he assaulted                  13 LA-A5, something the victim also refers to:                  14 "I remember one occasion when he was doing this to                  15 me when a lady walked in on us. I don't know her name                  16 or who she was. I presume she was a female member of                  17 staff. I remember that he made out to her that I had                  18 a bruise on my leg."                  19 In February 1977, sexual abuse allegations were made                  20 against Temple. He was the officer-in-charge. These                  21 were reported to the police, investigated, but no                  22 charges followed. You will hear more about this in                  23 evidence.                  24 Temple returned to work on 2 March 1977. The very                  25 young deputy officer-in-charge at Rowan House was not</p> <p style="text-align: center;">Page 116</p>

<p>1 content with his returning to the home, to the children                  2 who made the allegations. She conveyed this to                  3 management who did not take action. An account of what                  4 happened is recorded in the records of one of the social                  5 workers involved at the time and who described how the                  6 officer-in-charge felt very bitter about how the matter                  7 was managed. In a meeting with Temple, at which two                  8 members of staff management were present, including the                  9 principal officer of children's services, it was this                  10 young officer-in-charge who had to confront Temple and                  11 was virtually put in the position of justifying her                  12 refusal to accept him as house father at Rowan. In                  13 response, Temple accused her of envy. After this,                  14 Temple had requested a meeting with all the staff at                  15 which they were instructed not to refer to the sexual                  16 allegation at all, ie, they had to reject him purely in                  17 terms of house management. The officer-in-charge had                  18 purposely said nothing at this meeting but all the staff                  19 had expressed strong feelings that his attitude to the                  20 children had been inappropriate.</p> <p>21 In April 1977, the family of LA-A4 reported that he                  22 had also been sexually abused by Temple. These                  23 allegations were put to Temple by two senior managers,                  24 whereupon he admitted that there was truth in it and                  25 resigned immediately. An officer employed by Lambeth,</p> <p style="text-align: center;">Page 117</p>	<p>1 responsible for recruiting and supporting staff,                  2 recalled Temple admitting the allegations were true.                  3 The officer said he later received a letter from Temple                  4 in 1977/78 apologising for betraying his trust.</p> <p>5 Patrick Grant took over the role of                  6 officer-in-charge at Rowan House upon the departure of                  7 Temple. On 8 February 1978, Grant was suspended after                  8 he was charged with ten counts of indecent assault of                  9 boys under 16 years. The abuse was alleged to have                  10 occurred both at Rowan House and during his previous                  11 employment at another children's home. Whilst awaiting                  12 trial on 26 June 1978, Grant returned to work and was                  13 temporarily transferred to adult services to undertake                  14 administrative duties until the conclusion of the trial.                  15 On 2 October 1978, he was offered a secondment to                  16 undertake training to become a qualified social worker.                  17 It is understood that the judge at trial directed the                  18 jury to acquit Grant. There was no misconduct process.                  19 Grant was therefore able to carry on working with                  20 children, apparently completely unchecked and                  21 unrestricted. Lambeth agree that its treatment and                  22 promotion of this perpetrator was deeply disturbing.                  23 The consequence was that Grant was able to continue                  24 working in the childcare system until 1991, and                  25 thereafter for probation services. As I will explain,</p> <p style="text-align: center;">Page 118</p>
<p>1 his conduct was to catch up with him and he was to be                  2 convicted, but not until 2019.</p> <p>3 Angell Road. Consideration of Lambeth's response to                  4 Angell Road starts with its consideration of its                  5 response to John Carroll's conviction. In 1986,                  6 Robin Osmond, the then Director of Social Services,                  7 received a telephone call from Croydon Council to say                  8 that an assessment of the Carrolls as foster parents had                  9 revealed Carroll to have been convicted of a sexual                  10 assault upon a child. This led Lambeth to institute                  11 a misconduct process against Carroll. The investigation                  12 understands Carroll's account to have been that he was                  13 17 years at the time of the offence, in care and the                  14 conduct had been horseplay between boys of the same age.</p> <p>15 The misconduct hearing was chaired by David Pope.                  16 Lambeth was provided with the court register, which gave                  17 some background to the offence. This made clear that                  18 the offence occurred on 7 October 1966, when Carroll was                  19 18 and the victim was 12. A letter from Merseyside                  20 police stated that Carroll, as a former resident of                  21 St Edmund's, had entered the bedroom of the 12-year-old                  22 boy, tickled him, then sexually assaulted him. This                  23 information was received by Lambeth.</p> <p>24 An issue you may want to consider, chair, is whether                  25 Lambeth elected to accept Carroll's version of events</p> <p style="text-align: center;">Page 119</p>	<p>1 rather than those conveyed in the records it received.                  2 You may also wish to consider whether Lambeth conveyed,                  3 as time went on, Carroll's version of this offence,                  4 taking up his characterisation of it as horseplay as                  5 opposed to sexual abuse. As one Social Services                  6 inspector put it in 1992, "It seems extraordinary that                  7 sexual behaviour between an 18-year-old and 13-year-old                  8 boy" -- the age she gave -- "is accepted as horseplay                  9 and not constituting a sexual assault. Where does                  10 Lambeth get its ideas from?"</p> <p>11 It appears the decision to retain Carroll was to put                  12 Lambeth in a bind when, not long after the misconduct                  13 process, Carroll applied to foster children in the care                  14 of Lambeth. Croydon, you will recall, had said no to                  15 the Carrolls' fostering application. Lambeth asked                  16 Wandsworth to consider this application on its behalf.</p> <p>17 The social worker who undertook the assessment of                  18 the Carrolls made the following entry in her records of                  19 14 March 1998:</p> <p>20 "Brief discussion with Alison Barraball, principal                  21 officer, who had already had discussions with                  22 Brenda Jones, principal officer, Lambeth Adoption and                  23 Fostering Unit, as to the complications of the case and                  24 which panel the report should be submitted to. It has                  25 been suggested and agreed in joint discussion between</p> <p style="text-align: center;">Page 120</p>

<p>1 Brenda Jones and Jack Smith, chair of Lambeth Adoption 2 and Fostering Panel, that my report state against police 3 reference 'satisfactory' and Jack Smith will take 4 personal responsibility for dealing with this matter at 5 his panel." 6 This record supports, on the face of it, that 7 a Lambeth officer was suggesting that Wandsworth should 8 make a misleading entry in its report about Carroll's 9 criminal record. Counsel to the investigation rely on 10 the contemporaneous records of the time in respect of 11 this issue and the written witness evidence to the 12 inquiry to the effect that Lambeth officials asked 13 Wandsworth officials to represent that police checks 14 were satisfactory for Carroll. Written evidence from 15 Brenda Jones, Alison Barraball and Bernadette Khan will 16 be read into the transcript in due course. In short, 17 Ms Khan describes how she refused the direction and went 18 on to record Carroll's conviction. Furthermore, she 19 says Lambeth Council subsequently accepted that an 20 inappropriate and unprofessional telephone call was made 21 to the Wandsworth team. 22 At paragraph 205 of the Clough Report, it was 23 recorded that Jack Smith admitted asking for this 24 telephone call to be made to Wandsworth. The 25 Clough Report also refers at paragraph 211 to Jack Smith</p> <p style="text-align: center;">Page 121</p>	<p>1 having provided a note in support of the Carroll 2 application. The Clough Report stated that Mr Smith 3 confirmed the existence of this letter in correspondence 4 to the Director of Social Services. Overall, Clough was 5 critical of the decision to retain Carroll. A decision 6 which David Pope had, as we understand, played a central 7 role in. 8 In a memo dated 23 February 1994, David Pope set out 9 the findings of an internal management investigation 10 which Lambeth undertook after the Clough Report. This 11 report came to different conclusions from those reached 12 by Clough. For example, that Jack Smith did not recall 13 having a discussion with Brenda Jones about the police 14 references being marked "satisfactory". The issue that 15 arises is why Lambeth undertook its own investigation 16 when there had been an independent one and what basis it 17 had for reaching different conclusions to that reached 18 by the independent fact finder Clough. Also, why did 19 David Pope seemingly have a role in all of this when he 20 had been criticised by Clough in the first place? 21 As you have also heard, the Barratt Report 22 considered Lambeth's response, or lack of it, to 23 a disclosure about sexual abuse by Steven Forrest. As 24 I have already indicated, the question is whether, 25 between Barratt, CHILE and Middleton, Lambeth ever</p> <p style="text-align: center;">Page 122</p>
<p>1 really got a grip on what might have happened to 2 children who lived in Angell Road or whether there 3 remain outstanding concerns about this. 4 Southvale Assessment Centre. Southvale was subject 5 to very little by way of external scrutiny after the 6 setting up of the Social Services Inspectorate. 7 Lambeth's response to the concerns raised in 1989 about 8 the physical and emotional abuse, the humiliation of 9 children and racism was to constitute an internal panel 10 of enquiry chaired by Edgar Zephyrine. A number of 11 staff were suspended before the inquiry commenced. 12 This inquiry was set up in 1989 and reported in 13 early 1990. By this point, staff must have had concerns 14 about Leslie Paul and we know that even the assistant 15 officer in charge had found F8 with a naked child. 16 50 members of staff were interviewed as part of 17 the Zephyrine Inquiry. 18 There are a number of points that can be made about 19 the Zephyrine Report. Firstly, it does not set out the 20 very serious allegations which gave rise to it. 21 Secondly, it provides no analysis as to what accounts 22 were given about each allegation or how it arrived at 23 its conclusions. It does contain statements like 24 "allegations of favouritism were reputed by over 25 50 per cent of interviewees". In terms of racism, the</p> <p style="text-align: center;">Page 123</p>	<p>1 report stated that the evidence about this was 2 circumstantial. The report also refers to witnesses 3 saying that Southvale was not like other homes and could 4 not be judged by the same standards as other homes. The 5 report appeared to proceed on the acceptance that 6 Southvale had a special function amongst Lambeth 7 Children's Homes. We will ask Ms Hudson more about 8 whether this was accurate or not. 9 Where the Zephyrine Inquiry made stronger and 10 clearer findings was on the absence of staff from BAME 11 backgrounds in the management structure. It also noted 12 the lack of understanding of the need for children from 13 BAME backgrounds to develop a positive cultural 14 identity. Staff were unaware of basic expectations in 15 this respect. The report also stated in respect of F8 16 that there was a strong view that he was favoured by the 17 officer-in-charge and received special privileges. 18 Overall, the panel concluded that allegations of 19 misconduct were not made out but that Southvale was not 20 well managed. 21 What is striking about this report is that the 22 allegations which preceded it from the two different 23 care workers mentioned earlier today were very serious. 24 There is no indication in the report as to how these 25 allegations were treated, whether they were rejected or</p> <p style="text-align: center;">Page 124</p>

<p>1 why. As may be apparent from this opening, these                  2 allegations correspond with what other individuals said                  3 in evidence to the police about how Southvale operated.                  4 There is at least some indication that where the inquiry                  5 was provided with conflicting evidence, this simply led                  6 to the conclusion that an allegation could not be made                  7 out.                  8 The second point, and perhaps most surprising point                  9 of all, is that there is nothing to suggest that the                  10 Zephyrine panel spoke to any children from the home,                  11 despite having the power to do so. Why was this? There                  12 is also nothing on the face of the report to suggest                  13 that the panel investigated allegations of sexual abuse                  14 despite there being evidence to suggest that the inquiry                  15 was aware of the allegation that F8 had been found in                  16 bed with a child.                  17 The first police investigation which touched upon                  18 Southvale was Operation Bell in 1992. Officers from                  19 Operation Bell spoke to Edgar Zephyrine who chaired the                  20 enquiry. Notes of that meeting survive. Officers asked                  21 Mr Zephyrine about the information provided to                  22 Operation Bell about F8. It appears that this                  23 allegation was made to the panel, but, according to                  24 Mr Zephyrine, the inquiry accepted F8's version of                  25 events, which was that he was there to counsel the</p> <p style="text-align: center;">Page 125</p>	<p>1 child, who was disturbed.                  2 How is it possible that the inquiry interviewed                  3 50 members of staff and failed to uncover the reality of                  4 what was going on at Southvale? Perhaps the panel was                  5 not equipped to interrogate the situation. We will ask                  6 Ms Hudson about that. The answer may also be that some                  7 staff were not forthcoming. One person who, it appears,                  8 did not provide information in 1989 that might have been                  9 expected of her was the assistant officer-in-charge                  10 I have already mentioned.                  11 F8 was subject to a misconduct process in 1993.                  12 This investigation was brought in respect of the two                  13 allegations made to Operation Bell that F8 had been                  14 found in bed with a child and had been found in a room                  15 with the same child who was naked. The assistant                  16 officer-in-charge said that F8 had been given special                  17 responsibility for this child by the OIC. F8 spent                  18 large amounts of time with this child and not working                  19 with the team. The position of the officer-in-charge                  20 was that the staff should back off F8. The issues were                  21 not talked about more directly because F8 was                  22 a favourite of the officer-in-charge. The assistant did                  23 not report finding F8 with the naked child because the                  24 officer-in-charge favoured F8's position and was not                  25 supportive of her. She did not feel she would be</p> <p style="text-align: center;">Page 126</p>
<p>1 listened to. I pause to note that the assistant                  2 officer-in-charge did not do what more junior staff had                  3 done and report her concerns to external managers.                  4 The misconduct process noted that both of these                  5 incidents occurred prior to the Zephyrine Inquiry but                  6 that only one was before the Zephyrine Inquiry. It                  7 stated that there was no record that these matters were                  8 formally put to F8. It appears from this record that F8                  9 had been suspended but no reasons were recorded for this                  10 and that he was reinstated after the Zephyrine Inquiry.                  11 It appears then that it was Operation Bell which led to                  12 F8's misconduct process, not the earlier allegation of                  13 him being found in bed with a child.                  14 Of concern to the inquiry is that these allegations                  15 were found proved against F8. He had denied that either                  16 incident had been place. However, he was not dismissed                  17 but given a final written warning and it was recommended                  18 that he not work with children. It was also recommended                  19 that his relationship with the child be reviewed.                  20 I will pick up on this thread when I return to the                  21 police response to Southvale.                  22 Ivy House/Monkton Street. A number of themes emerge                  23 from Lambeth's response to the allegations of sexual                  24 abuse that arose at Ivy House and Monkton Street.                  25 One relates to the conduct of management inquiries.</p> <p style="text-align: center;">Page 127</p>	<p>1 The Director of Social Services explicitly acknowledged                  2 the first 1985 Ivy House inquiry to have been                  3 inadequate. Inquiries that were subsequently set up to                  4 investigate allegations of sexual abuse by members of                  5 staff at Ivy House and Monkton Street had wider terms of                  6 reference, investigative processes that included                  7 interviewing the parents of the child, conducting                  8 extensive questioning of staff and seeking the                  9 assistance of experts with knowledge of the child and in                  10 the field of child sexual abuse.                  11 However, whilst the second Ivy House investigation                  12 may be an example of improved practice surrounding the                  13 setting up of investigations in particular cases,                  14 Lambeth failed to engage subsequently with the wider                  15 issue of reviewing the management and supervisory                  16 systems for the protection of particularly vulnerable                  17 children or to review and develop a policy for                  18 investigating this type of allegation. This was despite                  19 this being the explicit remit of the special review                  20 panel set up in the wake of the Ivy House and                  21 Monkton Street complaints whose report was never                  22 published and recommendations never considered.                  23 Further, Lambeth failed to respond to the child-centred                  24 requests of groups, including the Brixton Family Support                  25 Group and Black in Care, who, in 1986 and 1987,</p> <p style="text-align: center;">Page 128</p>



<p>1 demanded:</p> <p>2 "A complaints procedure for children with mental</p> <p>3 disabilities in Lambeth Children's Homes be urgently</p> <p>4 reviewed with guidelines quickly set up."</p> <p>5 And:</p> <p>6 "Lambeth Social Services not only urgently reviews</p> <p>7 its policy and practice in child abuse cases, but also</p> <p>8 quickly implements effective methods of dealing with</p> <p>9 child sexual abuse with fuller consultation with groups</p> <p>10 dealing with sexual abuse."</p> <p>11 The fact remains that following both the Ivy House</p> <p>12 investigation and the two Monkton Street investigations,</p> <p>13 no disciplinary action was taken against any of</p> <p>14 the three individuals, despite the fact that a member of</p> <p>15 the special panel appointed to look at the wider picture</p> <p>16 of investigation commented that there was sufficient</p> <p>17 evidence "for a responsible employer to regard the</p> <p>18 individual members of staff to be a risk to children".</p> <p>19 These cases raise the ongoing question within child</p> <p>20 protection, which will be explored in evidence,</p> <p>21 surrounding what to do when a disciplinary panel makes</p> <p>22 no findings against a member of staff but where concerns</p> <p>23 remain as to whether that individual poses</p> <p>24 a safeguarding risk. In the Ivy House case study this</p> <p>25 manifested itself in the issue of how to approach the</p> <p style="text-align: center;">Page 129</p>	<p>1 giving of a reference. In the case of LA-F26, the</p> <p>2 subject of allegations whilst working at Monkton Street,</p> <p>3 it appears he remained at Lambeth but working in an</p> <p>4 adult setting. As for LA-F2, a further Monkton Street</p> <p>5 employee, he remained working which included some</p> <p>6 limited contact with children but with an agreement that</p> <p>7 he should not come into contact with the complainant</p> <p>8 child due to the distress caused.</p> <p>9 The last of the Lambeth Children's Homes to close</p> <p>10 was Chestnut Road. In a report by Richard Evans and</p> <p>11 Elisabeth Ford dated 6 September 2000 regarding the</p> <p>12 closure of Chestnut Road, consideration was given to</p> <p>13 what the report described as "Employment practices -</p> <p>14 dangerous employees and the paramountcy of the welfare</p> <p>15 of the child". The report refers to the example of an</p> <p>16 employee who was appointed by Lambeth in 1990 subject to</p> <p>17 references, police checks and medical clearance.</p> <p>18 A police check received in 1990 noted seven offences</p> <p>19 from robbery to unlawful wounding, burglary and theft.</p> <p>20 Despite this police check, his appointment was</p> <p>21 authorised and he took up a post at Southvale. Whilst</p> <p>22 at Southvale, he faced allegations of using physical</p> <p>23 force but the investigation was inclusive "as witness</p> <p>24 statements were not consistent". In 1995, when</p> <p>25 Southvale was closed, he was offered a post at</p> <p style="text-align: center;">Page 130</p>
<p>1 Monkton Street, without any disclosure being made of his</p> <p>2 past convictions. When Monkton Street closed, he was</p> <p>3 relocated to Chestnut Road. Whilst at Chestnut Road,</p> <p>4 allegations were made against him of sexual abuse.</p> <p>5 The report into the closure of Chestnut Road notes</p> <p>6 that he was suspended following complaints from parents</p> <p>7 that something had happened to their children whilst</p> <p>8 receiving respite care at Chestnut Road. The first</p> <p>9 child made a complaint to his mother and the second</p> <p>10 parent came forward after a letter to parents regarding</p> <p>11 the suspension. Both cases were investigated, although</p> <p>12 complicated by the children's difficulty in</p> <p>13 communicating what had happened to them. The result was</p> <p>14 again inconclusive and the child protection report found</p> <p>15 no firm evidence to form the basis of either criminal</p> <p>16 prosecution or a disciplinary hearing. The report</p> <p>17 notes:</p> <p>18 "It was agreed that references would be minimal."</p> <p>19 Fostering and adoption. If children's homes in</p> <p>20 Lambeth were not replicating the sense of security and</p> <p>21 safety that a family home might provide, how did</p> <p>22 children fare in foster care? We have seen evidence of</p> <p>23 children who had fond memories of foster care and who</p> <p>24 enjoyed supportive relationships with foster carers. We</p> <p>25 have also noted some deeply concerning and disturbing</p> <p style="text-align: center;">Page 131</p>	<p>1 accounts about foster care. You will receive written</p> <p>2 and oral evidence from core participants, chair, about</p> <p>3 their experiences of being fostered whilst in Lambeth's</p> <p>4 care and its impact upon their lives.</p> <p>5 We will look at the system for making decisions</p> <p>6 about fostering and adoption in Lambeth and, in</p> <p>7 particular, the Social Services Cases Subcommittee and</p> <p>8 the role which it appears to have played in fostering</p> <p>9 and adoption decisions. The question arises as to</p> <p>10 whether councillors overstepped the boundary between</p> <p>11 decisions which were really questions of professional</p> <p>12 judgment for social workers. If they did, was this</p> <p>13 because there was little confidence in that judgment or</p> <p>14 because there was little trust between these respective</p> <p>15 parts of the machinery.</p> <p>16 The inquiry understands that in terms of identifying</p> <p>17 families for fostering and adoption, Lambeth saw good</p> <p>18 reason to strive to place children with families who</p> <p>19 shared their ethnicity. Lambeth was concerned about the</p> <p>20 disadvantages of placing children in families who might</p> <p>21 have very little understanding of their needs, their</p> <p>22 identity and the prejudice and disadvantage they faced.</p> <p>23 In 1992, the SSI was overtly critical of the policy</p> <p>24 as putting the ethnicity of a child above all other</p> <p>25 considerations in deciding where to place them. It</p> <p style="text-align: center;">Page 132</p>

<p>1 noted:</p> <p>2 "We agreed, even at first glance, that we found this</p> <p>3 policy document to be defective". The "major concerns"</p> <p>4 included, "that the document appears to elevate the</p> <p>5 single-minded pursuit of 'same race placement' above all</p> <p>6 other important elements in considering the welfare need</p> <p>7 of a child in placement ..."</p> <p>8 In 1997, there was an SSI inspection called</p> <p>9 "Inspection of Planning and Decision Making for Children</p> <p>10 Looked After - Lambeth" which noted issues about</p> <p>11 "drift". The report suggested:</p> <p>12 "There was a positive commitment to 'same race</p> <p>13 placements' and a strong emphasis on the importance of</p> <p>14 religion, culture and language in placement decisions."</p> <p>15 It went on to note:</p> <p>16 "The implementation of this policy was sometimes</p> <p>17 frustrated with 'colour' appearing to be the defining</p> <p>18 factor in placement decisions without due account being</p> <p>19 taken of individual cultural and religious backgrounds</p> <p>20 as well as their personal experiences and wishes. This</p> <p>21 contributed to drift."</p> <p>22 Later, the report stated:</p> <p>23 "We found considerable instances of drift ranging</p> <p>24 from 2-10 years where decisions for permanency had been</p> <p>25 taken but the plans had not been implemented. The most</p> <p style="text-align: center;">Page 133</p>	<p>1 severe was of that a child who was known to the</p> <p>2 department at age 2, was eventually looked after at the</p> <p>3 age of 4 and was still in the system at age 14, having</p> <p>4 had a series of placements."</p> <p>5 Whether this criticism was fair is something which</p> <p>6 Lambeth witnesses may have a view about. From the</p> <p>7 inquiry's perspective and on the current evidence, in</p> <p>8 breach of all of its childcare policies, we have seen</p> <p>9 children in Lambeth's care appear to have spent long</p> <p>10 periods in institutions and without clear plans for</p> <p>11 their future when they shouldn't have done.</p> <p>12 Another issue relevant to children in foster care</p> <p>13 and which Ms Hudson will give evidence about is police</p> <p>14 checks on foster carers and the extent to which Lambeth</p> <p>15 knew which children it placed in foster care and where.</p> <p>16 Audits were carried out in 1999 in order to ascertain</p> <p>17 this. A memo in 1999 recorded that there was:</p> <p>18 "(i) Limited management information on foster carers</p> <p>19 and members of the household.</p> <p>20 "(ii) Limited history of police checks on foster</p> <p>21 carers.</p> <p>22 "(iii) Virtually no history of police checks on</p> <p>23 other household members.</p> <p>24 "(iv) Lack of management controls.</p> <p>25 "(v) Misuse of senior management position in</p> <p style="text-align: center;">Page 134</p>
<p>1 resolving potential deregistrations or concerns related</p> <p>2 to carers.</p> <p>3 The inspection in 2000 identified, as I said</p> <p>4 earlier, potentially large numbers of children who had</p> <p>5 not properly been regarded as looked after. A joint</p> <p>6 review by the SSI and the Audit Commission</p> <p>7 in December 2000 recorded in respect of children's</p> <p>8 services:</p> <p>9 "This identified continuing and significant failings</p> <p>10 in meeting statutory duties. Cases were unallocated,</p> <p>11 reviews were not carried out and there was evidence that</p> <p>12 children were placed in substitute care arrangements</p> <p>13 outwith the statutory looked after system and its</p> <p>14 intended, inherent safeguards."</p> <p>15 I give one example of such a fostering arrangement</p> <p>16 which cuts across many of the themes in this</p> <p>17 investigation. LA-F36 took his own life having provided</p> <p>18 evidence to CHILE. The evidence demonstrated that he</p> <p>19 had been sent to live in Cornwall with LA-F36, a man</p> <p>20 Lambeth knew, having been informed by Cornwall</p> <p>21 Social Services, had been dismissed from his teaching</p> <p>22 job for reasons related to indecency with boys. Reports</p> <p>23 were made raising concerns about this child during the</p> <p>24 placement. Social workers from Lambeth went to Cornwall</p> <p>25 to see this child -- and you will hear evidence from one</p> <p style="text-align: center;">Page 135</p>	<p>1 of them -- about the decisions they took and why this</p> <p>2 child remained in Cornwall. This child and the foster</p> <p>3 carer were brought to stay in Angell Road when</p> <p>4 Michael Carroll was the officer-in-charge.</p> <p>5 The third topic, chair, external inspections of</p> <p>6 Lambeth children's services, including the role of</p> <p>7 Ofsted and its inspections now. The Local Authority</p> <p>8 Social Services Act 1970 as amended continues to be the</p> <p>9 primary statutory code for the establishment and</p> <p>10 operation of local authority Social Services</p> <p>11 Departments. It contains the mechanisms whereby central</p> <p>12 government departments provide guidance, directions and</p> <p>13 orders to local authorities in the provision by them of</p> <p>14 Social Services. With effect from 1 April 1991, the</p> <p>15 National Health Service and Community Care Act 1990</p> <p>16 inserted into section 7 of the 1970 Act new duties upon</p> <p>17 local authorities including as follows:</p> <p>18 (i) to act under the guidance of</p> <p>19 the Secretary of State in the exercise of their function</p> <p>20 and discretion;</p> <p>21 (ii) to exercise their functions in accordance with</p> <p>22 directions given by the Secretary of State;</p> <p>23 (iii) to comply with any order made by the</p> <p>24 Secretary of State in relation to the local authority's</p> <p>25 failure to abide by its statutory duties.</p> <p style="text-align: center;">Page 136</p>

<p>1 Comprehensive powers to inspect were vested in the                  2 Secretary of State by section 58 of the Children and                  3 Young Persons Act 1969 and from its commencement                  4 section 74 of the Childcare Act 1980 relating to all                  5 forms of premises where children in care were                  6 accommodated, where children had been boarded out by                  7 a voluntary organisation and where foster children and                  8 protected children were being accommodated and                  9 maintained.                  10 You have already heard, chair, that statutory                  11 directions by the minister were issued to Lambeth in                  12 2000 with action required by August 2001. Whether                  13 directions or orders might have been issued at an                  14 earlier stage is a matter for consideration.                  15 You will hear evidence from Jo Cleary, assistant                  16 chief inspector SSI, Lord Laming, chief Inspector of                  17 the SSI 1991, Denise Platt SSI chief inspector in 1998                  18 and shadow chair of the Commission for Social Care                  19 Inspection which followed the SSI, and                  20 Virginia Bottomley MP, Minister of State for Health 1989                  21 to 1992. We will consider the role of the SSI and the                  22 implementation of its powers. You will hear evidence                  23 about whether the Social Services Inspectorate was                  24 effective in identifying risks to children in Lambeth's                  25 care and how effective it was in bringing the risks to</p> <p style="text-align: center;">Page 137</p>	<p>1 children to the attention of ministers. Did the                  2 workings of the SSI improve the quality of service                  3 provision to children? Did the inspection reports                  4 written about Lambeth and any follow-up to those reports                  5 change the culture or working practices within                  6 Lambeth Council in any way?                  7 As referred to earlier, The Right Honourable                  8 Tim Yeo MP commissioned an independent report into the                  9 recruitment and retention of John Carroll after his                  10 conviction for child abuse came to light. David Pope,                  11 director of Lambeth Social Services, had been party to                  12 the original decision to retain John Carroll. Mr Yeo in                  13 his written evidence says:                  14 "I understand that the chair of Lambeth                  15 Social Services Committee had demanded an inquiry into                  16 why Michael Carroll had not been sacked."                  17 Mr Yeo says that following discussions with the SSI,                  18 he agreed to ask Lambeth for an independent person to                  19 carry out the review of John Carroll's employment and                  20 Lambeth appointed Mr Clough. Mr Yeo left the department                  21 in May 1993 and the report was produced soon thereafter.                  22 Mr Yeo also says that he had agreed with the SSI that it                  23 would carry out a full and early investigation of                  24 Lambeth residential care services. His recollection is                  25 that, "I hoped that asking the SSRI to carry out a full</p> <p style="text-align: center;">Page 138</p>
<p>1 inspection of Lambeth Council's residential childcare                  2 service would identify the failings in the service and                  3 the causes of the findings". The inspection that took                  4 place in 1993 was limited to three homes. In written                  5 evidence to this inquiry, Mr Yeo comments he cannot now                  6 recall if he was involved in the decision to limit the                  7 scope of the SSI's investigation to three homes or the                  8 reason for that decision. Furthermore, he opines:                  9 "From reading the inspection report now, it does not                  10 appear that any ministerial action was required in                  11 consequence of its conclusions and recommendations."                  12 From 2007, Ofsted was responsible for external                  13 inspection of Lambeth children services. Lambeth was                  14 not operating any children's homes at this point. The                  15 majority of children's homes registered in England by                  16 Ofsted are operated by companies, partnerships or                  17 individuals. Lambeth is able to commission places in                  18 those homes as well as having access to foster care                  19 placements through its own foster care services or                  20 independent fostering agencies registered by Ofsted.                  21 In May 2009, Lambeth's fostering service was judged                  22 to be "good". In 2012, its fostering service was judged                  23 to be "outstanding". Carolyn Adcock, senior inspector                  24 of education, children's services and skills, is due to                  25 give evidence to the inquiry about contemporary</p> <p style="text-align: center;">Page 139</p>	<p>1 inspections in respect of Lambeth, its openness to                  2 regulation and inspection and any issues within Lambeth                  3 now, from the regulator's perspective, surrounding the                  4 protection of children in care from child sexual abuse.                  5 Chair, I note the time.                  6 THE CHAIR: Yes, thank you, Ms Langdale. We will return at                  7 3.00 pm.                  8 (2.43 pm)                  9 (The short adjournment)                  10 (3.00 pm)                  11 MS LANGDALE: Before we turn to the response of                  12 the Metropolitan Police Service to allegations of child                  13 sexual abuse, may I make it clear that the child who was                  14 sent to live in Cornwall with LA-F36 was LA-A23.                  15 So response of the Metropolitan Police Service to                  16 allegations of child sexual abuse.                  17 Chair, as you reported in the Nottinghamshire                  18 Council Investigation Inquiry Report, research                  19 commissioned by the inquiry from the Crime and Research                  20 Institute at Cardiff University sets out how the                  21 national approach to police investigations into                  22 allegations of child sexual abuse has developed over                  23 time.                  24 From 1963, Home Office circulars referred to the                  25 need for police forces to work with local authorities in</p> <p style="text-align: center;">Page 140</p>

<p>1 relation to children in need of care, protection and 2 control. 3 By 1988, sexual abuse was included in the definition 4 of child abuse, joint working with Social Services was 5 expected, and the paramount consideration was the 6 welfare of the child. 7 By the end of the 1990s, all forces had child 8 protection units, which normally took primary 9 responsibility for investigating child abuse cases. As 10 a minimum, they were required to investigate all 11 allegations of child abuse within the family or against 12 a carer. 13 In the 2000s, both the Victoria Climbié/Laming 14 Report and the Bichard Inquiry criticised HMIC for not 15 taking a sufficiently active role in child protection 16 through its inspections of police forces. The Laming 17 report also recommended that police officers in child 18 protection roles should hold senior rank and have 19 appropriate qualifications. 20 Since 2010, you reported, chair, that there has been 21 a significant increase in the volume of allegations of 22 non-recent sexual abuse. A thematic review of child 23 protection in eight police forces conducted by 24 Her Majesty's Inspectorate of Constabulary in 2014-15 25 found that some forces were struggling to manage rising</p> <p style="text-align: center;">Page 141</p>	<p>1 investigative demands with systemic weaknesses and high 2 workloads. 3 With that timeframe surrounding force organisations, 4 within the Lambeth investigation we asked the MPS how 5 allegations were dealt with between 1963 and 1988, 1988 6 and 1999, 2000 and 2010 and from 2001 to the present 7 day. 8 The inquiry will hear from Commander Murray, who 9 comments on the structure of the MPS during those 10 periods, particularly addressing whether there were 11 specialist teams investigating child abuse or whether 12 such allegations were investigated by local officers. 13 The investigation seeks to know whether the MPS had any 14 policies or procedures in place and how effective 15 working together or interagency co-operation between the 16 MPS and Lambeth Council was. Also, how MPS intelligence 17 systems, in particular the provision of information or 18 sharing of information with any statutory bodies in 19 relation to child sexual abusers, either alleged or 20 convicted, developed during each period. 21 The MPS has also been asked to set out its approach 22 to the taking of complaints from children over time, 23 including children with complex needs and communication 24 difficulties. 25 In 2016, national recommendations encouraged police</p> <p style="text-align: center;">Page 142</p>
<p>1 forces to review each other's public protection 2 arrangements. HMIC conducted an investigation of 3 the MPS and criticisms were made of its investigation of 4 child sexual abuse. HMIC identified that there was 5 no-one of chief officer rank within the MPS with clear, 6 overall responsibility for child protection, but, 7 rather, ownership was split over several portfolios. 8 Some cases fell between the gaps, and there were 9 significant weaknesses with information management 10 systems and processes. 11 As far as MPS investigations in Lambeth are 12 concerned, the inquiry has served a number of detailed 13 specific rule 9 requests in order to have the fullest 14 possible picture of allegations of child sexual abuse 15 emanating from children in Lambeth's care. Through the 16 evidence of DI Simon Morley, the MPS has provided an 17 overview of the police operations that relate to 18 children within the care of Lambeth. DI Morley will 19 also provide evidence surrounding two investigations 20 carried out under the auspices of the IOPC (the 21 Independent Office of Police Complaints). Detailed by 22 perpetrator or alleged perpetrator, the MPS has also 23 been asked to set out its knowledge in respect of 24 the movement of any perpetrator or alleged perpetrator 25 immediately following any MPS investigation into the</p> <p style="text-align: center;">Page 143</p>	<p>1 sexual abuse of children. 2 The Harris Report. The inquiry understands that the 3 then chief executive of Lambeth Council, Henry Gilby, 4 went to the MPS in December 1993 with a copy of 5 the Harris Report, a supplementary report to it and 6 a list of names and addresses. Specifically, it is 7 understood that he met with an assistant commissioner of 8 the MPS at Kennington police station at around this 9 time. 10 Whilst the Harris Report was concerned in part with 11 the allegations made by LAG1 and harassment within the 12 Lambeth Housing Department, it also referred to three 13 matters of interest to the Lambeth investigation: 14 namely, one, the extent to which Lambeth officers may 15 have been involved in the production of pornography; 16 two, whether that included indecent images of children; 17 and, three, the possible exploitation of children by 18 Lambeth staff. 19 In respect of the allegations made by LAG1, as 20 reflected in the Harris Report, it is understood that 21 these were the subject of a police investigation called 22 Operation Pragada. That investigation was concluded in 23 1993, following CPS advice that no further action be 24 taken. LAG1 is understood to have made further 25 allegations in 1994. Again, it is understood that these</p> <p style="text-align: center;">Page 144</p>

<p>1 did not change the position and that a closing report by                  2 DCI Vincent Harvey concluded that LAGI's allegations                  3 lacked credibility.                  4 I mention this because there are enduring concerns                  5 about the Harris Report, that it raised a number of                  6 questions about the sexual abuse of children in                  7 Lambeth's care, but did not, on the face of the report,                  8 provide any clear information as to the sources of                  9 information or provide any answers as to what                  10 investigation there was about it. This is a matter                  11 which will be touched upon in evidence.                  12 The Appleby report. In July 1995,                  13 Ms Elizabeth Appleby QC produced a report for                  14 Lambeth Council. At paragraph 21 she noted, having                  15 received numerous allegations, that causes of Lambeth's                  16 problems included the influence of Freemasonry, a mafia                  17 exerting pressure on the officers, and a pornographic                  18 ring holding officers and members to ransom. She stated                  19 she received no evidence to substantiate these                  20 allegations. The inquiry has obtained a statement about                  21 the organisation and the work of the Freemasons, and you                  22 will hear from David Staples, chief executive officer                  23 and grand secretary of the United Lodge of England.                  24 Conspiracy theories existed within Lambeth around                  25 membership of the Freemasons, and we will look at that</p> <p style="text-align: center;">Page 145</p>	<p>1 issue.                  2 Operation Middleton. The inquiry will hear evidence                  3 about Operation Middleton -- how it came to be set up,                  4 what its remit was and its relationship with its Lambeth                  5 counterpart, CHILE. A question that has been asked                  6 about Middleton and CHILE is: how effective were they,                  7 given the length of time their joint role lasted for,                  8 the number of allegations they received and ultimately                  9 the number of people prosecuted by the end of Operation                  10 Middleton? There is an issue as to why certain                  11 individuals, like Philip Temple, were not prosecuted                  12 during Middleton.                  13 You will hear evidence from retired former                  14 Superintendent Gargini who led Middleton in its                  15 beginning and who will explain its methodology.                  16 Detective Inspector Morley will provide extensive                  17 evidence about a number of different MPS operations                  18 related to children in the care of the Lambeth,                  19 including Middleton. This will include individuals                  20 investigated, individuals referred to the CPS for advice                  21 or a charging decision, and the number of individuals                  22 brought to trial.                  23 Operations Trawler and Middleton. Another enduring                  24 issue in Lambeth surrounds Operation Trawler. This was                  25 an investigation set up in tandem with Operation Care,</p> <p style="text-align: center;">Page 146</p>
<p>1 the Merseyside investigation into Carroll.                  2 As has been widely reported in the press, Operation                  3 Trawler was led by the now retired former Detective                  4 Chief Inspector Clive Driscoll. There has been                  5 speculation in the press that he was removed from                  6 Operation Trawler for political reasons or as part of                  7 a coverup to protect sensitivities within Lambeth.                  8 Again, it has been reported that these sensitivities                  9 were that political figures were implicated in                  10 allegations of abuse brought to the attention of                  11 Mr Driscoll. This allegation has itself been the                  12 subject of entirely separate investigation by the                  13 Independent Office of Police Complaints.                  14 You will hear evidence from Mr Driscoll,                  15 Dr Nigel Goldie, who worked in Lambeth, and, again,                  16 Mr Gargini on some of the issues in the public domain,                  17 in essence, going to the question of whether there was                  18 a coverup and whether political figures were protected                  19 from investigation. You will also hear evidence about                  20 the IOPC investigation into these matters and the                  21 conclusions that the IOPC has drawn upon that issue.                  22 It has also been speculated upon in the press that                  23 Lord Paul Boateng visited the Angell Road home and that                  24 his wife, Lady Janet Boateng, intervened in an                  25 application made by John Carroll to foster children.</p> <p style="text-align: center;">Page 147</p>	<p>1 You will hear evidence from Mr Clive Walsh about                  2 a meeting which he alleges took place about such                  3 a fostering application at which Lady Boateng was                  4 present. You will hear evidence from Lady Janet Boateng                  5 in reply to the allegations that she ever pressurised                  6 another local authority to allow Carroll to foster.                  7 As for Lord Paul Boateng and his having any links to                  8 Angell Road, as is well known, a former Lambeth employee                  9 provided information to media outlets that she had seen                  10 Lord Boateng at Angell Road. That witness is no longer                  11 alive.                  12 Lord Boateng made a statement to the police in 2019.                  13 He was asked by the inquiry if he was content to adopt                  14 its contents for the purposes of the inquiry. He                  15 indicated that he was. He told the police that he did                  16 not know Mr Carroll personally, that he had no                  17 recollection of ever meeting him and that he had never,                  18 as far as he could recall, visited Angell Road. He said                  19 he had no knowledge of any fostering application by the                  20 Carrolls.                  21 The principal concern of this inquiry is to examine                  22 institutional responses to child sexual abuse. With                  23 that remit in mind, witnesses from the MPS and the SSI                  24 will be asked to address former DI Driscoll's concerns                  25 around why he was removed from Operation Trawler.</p> <p style="text-align: center;">Page 148</p>

<p>1 Shirley Oaks. The MPS response to allegations of                  2 abuse made by children at Shirley Oaks broadly falls                  3 into three categories: those limited situations where                  4 police were involved at the time; investigations                  5 stemming from Operation Middleton; and investigations                  6 since.                  7 One of the significant challenges facing the inquiry                  8 is that very limited police paperwork has been located                  9 from the time regarding contemporaneous allegations.                  10 That applies to LA-F93, William Hook and Philip Temple,                  11 in respect of whom children, and in some cases staff,                  12 recall the involvement of police. It also applies to                  13 Donald Hosegood and Patrick Grant, where police                  14 investigations led to criminal trials in 1957 and 1978                  15 respectively.                  16 The inquiry has served a number of detailed specific                  17 rule 9 requests in respect of alleged perpetrators at                  18 the time. These requests have sought further                  19 information about issues, including: the extent that the                  20 MPS were or may have been aware of an alleged                  21 perpetrator before any allegations were made regarding                  22 child sexual abuse; details of contemporaneous reports                  23 made to the police and the nature of any subsequent                  24 investigation; support provided to children who made, or                  25 about whom allegations were made, during the police</p> <p style="text-align: center;">Page 149</p>	<p>1 investigation; the circumstances of the acquittal of                  2 a defendant where relevant; the extent an individual may                  3 have been identified during Operation Middleton as                  4 someone who had abused children whilst employed by                  5 Lambeth Council; the extent to which police operations                  6 since Operation Middleton were able to uncover                  7 allegations that had not previously been investigated                  8 during earlier operations, and if so why; whether the                  9 MPS is aware of the extent to which a perpetrator                  10 operated alone or had links to other abusers; decisions                  11 to charge some but not other allegations; decisions to                  12 take no further action; missed opportunities to charge                  13 or prosecute and the consequences of historic failures                  14 in individual cases; the MPS's knowledge of the full                  15 history of offending related to some of the individual                  16 perpetrators; police efforts made to locate                  17 contemporaneous files.                  18 The individuals followed include William Hook,                  19 Patrick Grant, Philip Temple, Donald Hosegood,                  20 Geoffrey Clarke, LA-F93, LA-F127, LA-F109, LA-F184.                  21 The evidence before the inquiry is that perpetrators                  22 considered by the police at the time included Hosegood,                  23 Temple and Grant, and may have included LA-F93 and Hook.                  24 In no case was there a conviction at the time.                  25 Geoffrey Clarke was convicted in 1998 of child abuse</p> <p style="text-align: center;">Page 150</p>
<p>1 related offences which took place in Kent. He was                  2 investigated during Operation Middleton. Charges were                  3 brought and he was due to stand trial in respect of                  4 the sexual abuse of a boy who had been in his foster                  5 care and for other offences of indent images. As stated                  6 earlier, he killed himself during the trial.                  7 William Hook was the subject of an investigation by                  8 Operation Middleton during 1999 and 2001.                  9 In October 2000, he was charged with offences totalling                  10 over 40 charges, and on 28 February 2001, he pleaded                  11 guilty to 26 offences. On 11 April 2001, he was                  12 sentenced to ten years' imprisonment. He was released                  13 on licence into approved accommodation on                  14 10 December 2007, having served six years and six months                  15 in prison, and was placed on the sex offenders register.                  16 As you have already heard, in February 1977,                  17 Philip Temple was suspended from duty at Shirley Oaks                  18 after two children at the home made allegations of                  19 sexual abuse against him. Following a police                  20 investigation, Temple was released without charge.                  21 In 1998 and 1999, Temple was tried in respect of                  22 three counts of indecent assault on a male aged 15 years                  23 for conduct which took place outside Lambeth. Temple                  24 was acquitted and then acquitted again after a retrial.                  25 In 2015, Temple was arrested following a new</p> <p style="text-align: center;">Page 151</p>	<p>1 investigation by the Metropolitan Police Service, known                  2 as Operation Marozi. This was an investigation which                  3 fell under the umbrella of Operation Winterkey, which is                  4 the Metropolitan Police's specialist capacity to                  5 investigate high profile or complex criminal allegations                  6 of non-recent child sexual abuse and its response to                  7 this inquiry.                  8 The Operation Marozi investigation identified                  9 child abuse allegations against Temple dating back to                  10 the 1970s when Temple was employed as a house parent at                  11 various children's homes. Police discovered that Temple                  12 had been investigated on numerous occasions over                  13 a 40-year period in relation to these allegations.                  14 On 6 April 2016, Philip Temple pleaded guilty to                  15 29 offences, which included two counts of perjury                  16 relating to the trials in 1998 and 1999. On                  17 10 August 2016, he was sentenced to 12 years'                  18 imprisonment. In September 2016, this was increased to                  19 18 years' imprisonment following an Attorney General                  20 reference -- an appeal by the prosecution on the basis                  21 that the sentence imposed was unduly lenient.                  22 The original sentencing judge referred to the                  23 possible failures to stop offending in the past. In the                  24 light of those comments, it was felt appropriate to                  25 examine the involvement of police when allegations</p> <p style="text-align: center;">Page 152</p>

<p>1 against Mr Temple were made. The case was therefore                  2 referred to the IOPC and became a managed investigation.                  3 Operation Andesite was created to address whether                  4 there were missed opportunities during the                  5 investigations conducted by the police into Mr Temple's                  6 abuse. The investigative tasks were carried out by an                  7 MPS officer, but independent oversight of                  8 the investigation was maintained through regular reviews                  9 by a lead Investigator from the IOPC.                  10 Returning to Patrick Grant, you will recall that he                  11 took over from Philip Temple in August 1977. On                  12 8 February 1978, Patrick Grant was suspended after he                  13 was charged with ten counts of indecent assault against                  14 boys under the age of 16 years. As you have heard,                  15 in December 1978, the judge directed the jury to acquit                  16 Grant.                  17 Following an investigation by the Metropolitan                  18 Police, Operation Trinity, Patrick Grant was charged on                  19 23 April 2018 with 14 offences which related to four                  20 complainants, one of whom lived in Rowan House,                  21 Shirley Oaks at the time of the abuse. Grant was                  22 convicted of the offences in respect of him                  23 in January 2019. On 12 April 2019, Patrick Grant was                  24 sentenced to eight years' imprisonment.                  25 Hosegood stood trial at the Old Bailey between</p> <p style="text-align: center;">Page 153</p>	<p>1 16 and 22 July 1975 in relation to 11 charges of child                  2 sexual abuse against four victims. At some point, the                  3 judge directed an acquittal. Operation Middleton did                  4 not investigate Donald Hosegood. Evidence will be given                  5 about that by DI Morley. The question is raised of                  6 whether some individuals were told that he had died when                  7 that was not the case.                  8 LA-F93 died in 1982. The MPS received allegations                  9 against LA-F93 from five people who lived in                  10 Shirley Oaks. All allegations were made after 2000.                  11 The inquiry will consider evidence that various                  12 other alleged perpetrators were not investigated, for                  13 reasons including their death, their age and a failure                  14 to adequately identify the perpetrator described by the                  15 child.                  16 Angell Road. As I have mentioned above,                  17 John Carroll left Lambeth not because of allegations of                  18 abuse but because of allegations of fraud. According to                  19 the notes of a meeting between the SSI and Lambeth                  20 officials in 1992, the police declined to investigate                  21 this fraud, consistent with Lambeth local practice                  22 involving theft against an employer. The SSI expressed                  23 concern at this police discretion and asked if employees                  24 were aware of police practice. We note at this point                  25 that police were not present at this meeting.</p> <p style="text-align: center;">Page 154</p>
<p>1 The record of the 1992 meeting suggests Lambeth                  2 officials were asked about Lambeth's failure to notify                  3 Carroll to the Department of Health after he had been                  4 dismissed. They asked if there was guidance about this.                  5 Another Lambeth officer said he didn't think the need to                  6 notify the Department of Health applied to embezzling                  7 and fraud. The SSI inspector observed, "Does Mr X think                  8 that embezzlers and con people are the sorts of people                  9 we want to look after children in the public care?"                  10 John Carroll was revealed to have abused children in                  11 Lambeth's care through the Merseyside Police                  12 investigation into him, Operation Care, which began                  13 following allegations about Carroll from when he worked                  14 in Liverpool and before he came to Lambeth.                  15 Chair, you will receive evidence from LA181 as to                  16 how he came to provide a statement to the police around                  17 1998. He was telephoned by the police and asked if                  18 there was anyone from children's homes that he thought                  19 the police should be talking to. He told them Carroll.                  20 On 5 July 1999, Carroll pleaded guilty to 35 of                  21 68 charges of sexual abuse committed against 13 children                  22 between 1966 and 1986. He received a term of ten years'                  23 imprisonment.                  24 As I indicated above, Carroll was also instrumental                  25 in investigating allegations against staff in</p> <p style="text-align: center;">Page 155</p>	<p>1 Angell Road, and one of the issues we will look at is                  2 whether he might have frustrated the investigation into                  3 F4. You will recall I mentioned that one disclosure                  4 about F4 came from a child who was pre-school. It                  5 appears to have been suggested at the time that a child                  6 protection officer said she was too young to be                  7 interviewed. It is not clear to us whether that was                  8 true. Certainly, months down the line there is evidence                  9 that a number of professionals decided not to take her                  10 allegation any further, in part because of delay.                  11 It is also unclear to what extent the police were or                  12 were not involved in responding to the allegations made                  13 by another child that F4 had sexually abused her in                  14 1988. We know that F4 was charged, as part of                  15 Operation Bell, in 1993 of abusing her over a four-year                  16 period. We understand the prosecution offered no                  17 evidence because of issues related to credibility. We                  18 do not know, but will explore in evidence, the extent to                  19 which it was understood that F4 had been the subject of                  20 allegations in and around 1988, some of which had been                  21 corroborated at the time.                  22 In respect of the third child, whose mother came                  23 forward in 1994 to say he had been sexually abused by                  24 F4, it is unclear as to whether or not that allegation                  25 was brought to the attention of the police. DI Morley</p> <p style="text-align: center;">Page 156</p>

<p>1 will provide more evidence about this.</p> <p>2 Southvale. As I have mentioned, the first police</p> <p>3 investigation into Southvale was Operation Bell in 1992.</p> <p>4 It investigated allegations against Leslie Paul and the</p> <p>5 allegations made by staff about F8. There were three</p> <p>6 complainants in respect of Paul.</p> <p>7 In January 1994, he was convicted of two counts of</p> <p>8 indecent assault against a male, one count of indecency</p> <p>9 with a child and one count of taking indecent</p> <p>10 photographs of a child. He was sentenced to 18 months'</p> <p>11 imprisonment.</p> <p>12 Operation Bell also investigated Paul's links to the</p> <p>13 distribution of pornography. The deputy senior</p> <p>14 investigating officer in Operation Bell was Detective</p> <p>15 Inspector Randall. A submission from him to a computer</p> <p>16 lab in Operation Bell stated:</p> <p>17 "It is the informed opinion of the investigating</p> <p>18 officer that material relevant to Paul's commercial</p> <p>19 interest in pornography is to be found on one or more of</p> <p>20 these discs. This may take the form of names/addresses,</p> <p>21 PO Boxes, et cetera."</p> <p>22 It goes on to state:</p> <p>23 "He is considered to be a paedophile and has been</p> <p>24 actively engaged in the paedography and videotape</p> <p>25 recording of young males for pornographic purposes. He</p> <p style="text-align: center;">Page 157</p>	<p>1 has extensive connections with persons of a similar ilk</p> <p>2 in Europe and is strongly suspected of being concerned</p> <p>3 in the commercial side of child pornography."</p> <p>4 DI Morley will give evidence about this aspect of</p> <p>5 the Operation Bell investigation.</p> <p>6 In December 1992, Detective Superintendent Tomkins</p> <p>7 of Operation Bell wrote to David Pope, the Director of</p> <p>8 Social Services. The investigation had been completed</p> <p>9 but there had been no trials as yet. Detective</p> <p>10 Superintendent Tomkins wrote of the Zephyrine Inquiry</p> <p>11 that it was seen as shallow, with little depth to its</p> <p>12 questioning of witnesses. He observed that the fact</p> <p>13 that no children were interviewed added weight to the</p> <p>14 theory that it was only intended as a means to change</p> <p>15 the regime rather than to establish malpractice.</p> <p>16 Detective Superintendent Tomkins also noted that F8</p> <p>17 remained in close contact with the foster family of</p> <p>18 the child he was accused of abusing. He observed that</p> <p>19 it was unknown how that link had impacted upon the</p> <p>20 investigation.</p> <p>21 In fact, the child F8 was suspected of abusing did</p> <p>22 not make any disclosures about him during</p> <p>23 Operation Bell. They were to come later. An attempted</p> <p>24 prosecution of F8 later failed. A third man was</p> <p>25 prosecuted in respect of allegations that he had</p> <p style="text-align: center;">Page 158</p>
<p>1 sexually abused a child at Southvale. This trial</p> <p>2 collapsed amidst concerns about how the child concerned</p> <p>3 had been cross-examined.</p> <p>4 Leslie Paul also featured in Operation Middleton.</p> <p>5 He was convicted of five offences of indecent assault</p> <p>6 relating to four victims. He was sentenced to a total</p> <p>7 of 16 months' imprisonment. There is a question over</p> <p>8 Operation Middleton as to why other allegations about</p> <p>9 Paul appear not to have been proceeded with. DI Morley</p> <p>10 has provided very detailed written evidence about this</p> <p>11 and will be asked to explain more about this in</p> <p>12 evidence.</p> <p>13 In 2015, Les Paul stood trial for the sexual abuse</p> <p>14 of five men who as children had lived in Southvale.</p> <p>15 Paul was convicted of offences relating to four of these</p> <p>16 men. He was sentenced to 13 years' imprisonment. His</p> <p>17 successive prosecutions are a demonstration of how the</p> <p>18 detection of child sexual abuse and attitudes to it on</p> <p>19 the part of all criminal justice agencies have</p> <p>20 developed. We will ask DI Morley about this.</p> <p>21 Patrick Grant stood trial in 2019 and was found</p> <p>22 guilty of eight of the ten counts on the indictment.</p> <p>23 The jury was unable to reach a verdict which related to</p> <p>24 the sexual abuse of a child in Southvale. A retrial was</p> <p>25 set down, but the victim made absolutely clear to police</p> <p style="text-align: center;">Page 159</p>	<p>1 that he really did not want to give evidence again. As</p> <p>2 you have heard, Grant was convicted for the sexual abuse</p> <p>3 of children at Rowan House and Fircroft and also</p> <p>4 Walker House in Wales.</p> <p>5 Ivy House and Monkton Street. The allegation</p> <p>6 against LA-F12, the employee at Ivy House, and the</p> <p>7 allegation concerning LA-F26, who was employed at</p> <p>8 Monkton Street, were reported to the police with the</p> <p>9 assistance of social workers, shortly after the children</p> <p>10 first made the allegations to their parents. In both</p> <p>11 cases, the child making the allegation was questioned by</p> <p>12 the police at the police station and a medical</p> <p>13 examination was carried out.</p> <p>14 In both the Ivy House and the Monkton Street cases,</p> <p>15 the police interviewed the alleged perpetrator, other</p> <p>16 members of staff and, in the case of LA-F26, forensic</p> <p>17 tests were also carried out. These investigations were</p> <p>18 met with denials by the alleged perpetrators. This,</p> <p>19 combined with what the police perceived as an</p> <p>20 impossibility of obtaining a comprehensible statement</p> <p>21 from a child with communication difficulties, meant that</p> <p>22 the police investigations ceased. The CPS decision in</p> <p>23 both cases was to not pursue the matters.</p> <p>24 Our fifth topic, prosecutorial decisions around</p> <p>25 child sexual abuse. The investigation will scrutinise</p> <p style="text-align: center;">Page 160</p>



<p>1 decisions around the prosecution of sexual offenders and                  2 alleged offenders; in particular, to see whether                  3 offenders might have been prosecuted earlier and                  4 prevented from causing further significant harm to other                  5 child victims.                  6 Prosecutions brought by the Crown Prosecution                  7 Service are governed by the Code for Crown Prosecutors.                  8 A prosecution commences if it satisfies the full code                  9 test. The test has two stages: firstly, the requirement                  10 of evidential sufficiency; and, secondly, consideration                  11 of the public interest.                  12 To satisfy the evidential sufficiency stage, the                  13 prosecutor must be satisfied that there is sufficient                  14 evidence to support a realistic prospect of conviction.                  15 As the CPS written evidence to the inquiry points out,                  16 this means that a lawyer examining the test must be                  17 satisfied that an objective, impartial and reasonable                  18 jury, properly directed and in accordance with the law,                  19 is more likely than not to convict the defendant. It is                  20 an objective test based upon the prosecutor's assessment                  21 of the evidence, including any information they have                  22 about the defence.                  23 Within this investigation, through the evidence of                  24 Mr Gregor McGill, director of legal services, we will                  25 examine decisions that were made around the prosecution</p> <p style="text-align: center;">Page 161</p>	<p>1 of individual suspects/alleged perpetrators following on                  2 from complaints from children in the care of Lambeth.                  3 Mr McGill has given evidence four times to the inquiry                  4 within different investigations and is of appropriate                  5 seniority to speak of policy, guidance and its decision                  6 making.                  7 It is important when examining decisions made that                  8 the applicable law at the time of any decisions being                  9 made is appreciated. How a child's evidence is received                  10 by a court has changed over time; so has the need for                  11 corroboration. As the Law Commission Report On the                  12 Corroboration of Evidence in Criminal Trials 1991 set                  13 out, the law of corroboration referred to a series of                  14 technical rules that governed the way judges had to                  15 direct juries about certain specific categories of                  16 prosecution evidence.                  17 Before the implementation of the Criminal                  18 Justice Act 1988, section 4, a judge was required to                  19 warn a jury that it was dangerous to convict on the                  20 uncorroborated evidence of a complainant in a trial for                  21 a sexual offence. In addition, the judge was required                  22 to go on to tell the jury what other evidence was, as                  23 a matter of law, capable of constituting corroboration                  24 of the evidence under question. The issue of whether                  25 the evidence capable of constituting corroboration did,</p> <p style="text-align: center;">Page 162</p>
<p>1 in fact, have a corroborative effect was left to the                  2 jury.                  3 And finally, the judge was required to direct the                  4 jury that if, after heeding the so-called corroboration                  5 warning, they concluded that the witness was speaking                  6 the truth, they were entitled to convict.                  7 The corroboration rules, as described, were                  8 formulated with the aim of avoiding wrongful conviction.                  9 On 7 January 1988, the law commission was asked to                  10 review the law and to make recommendations. The                  11 commission recommended abolishing the rule by which the                  12 judge should automatically warn the jury that it would                  13 be dangerous to convict the accused on the                  14 uncorroborated evidence of a prosecution witness who is                  15 the complainant in a trial for a sexual offence. Given                  16 that sexual offenders can manipulate situations to abuse                  17 children without others present, this was undoubtedly                  18 a step towards improved justice for child complainants                  19 of sexual abuse.                  20 The investigation will examine decisions not to                  21 prosecute alleged perpetrators of sexual abuse before                  22 the implementation of the 1988 Act in accordance with                  23 the law that was applicable at the time. We will                  24 examine, despite the complexity of the law on                  25 corroboration, where the prosecution advice was</p> <p style="text-align: center;">Page 163</p>	<p>1 nevertheless unduly hesitant or cautious surrounding                  2 commencing prosecutions.                  3 We will also consider the way in which child                  4 witnesses could be heard in a criminal trial at the                  5 relevant time and whether paternalistic or perceived                  6 welfare decisions were being made around whether they                  7 should be giving evidence or not.                  8 It was not until 1988 that, for the first time,                  9 children were permitted to give evidence by videolink in                  10 cases involving allegations of sexual misconduct or                  11 violence. Since 1992, and pursuant to the Criminal                  12 Justice Act 1991, children under the age of 14 have been                  13 permitted to give unsworn evidence. Video recordings                  14 were authorised of the evidence of child witnesses under                  15 the age of 17 in cases of sexual offending. This                  16 removed the need for a child to be physically in the                  17 court with the judge and jury when giving evidence.                  18 This investigation will hear evidence about how damaging                  19 it could be for children to give evidence in court.                  20 Since 1991, cross-examination of a child by                  21 a defendant in person is banned; that it might ever have                  22 been permitted, even in theory, seems little short of                  23 astonishing now. In 1999, the Youth Justice and                  24 Criminal Evidence Act 1999 allowed for special measures                  25 for vulnerable witnesses. The need for participation of</p> <p style="text-align: center;">Page 164</p>

<p>1 vulnerable witnesses within the trial process was 2 finally acknowledged at this point. 3 Cross-examination of child witnesses has developed 4 considerably. Comments on inconsistencies within 5 evidence cannot be made within cross-examination. 6 Practice directions and advocate's toolkits provide for 7 processes, including ground rule hearings, which should 8 facilitate participation without intimidation of 9 vulnerable witnesses. 10 Against the background of the relevant law and how 11 children participated in the criminal trial process at 12 any given point in time, we will examine how decisions 13 were made for children in Lambeth: in particular, what 14 level of support was offered around involvement in any 15 criminal proceedings; whether complainants were kept 16 abreast of developments in any case; and whether they 17 were provided with assistance in any way when dealing 18 with their abuse; and finally, crucially, in terms of 19 prosecutorial decision making, whether their allegations 20 were prematurely dismissed or determined by prosecutors 21 when advising upon the evidence. 22 Our final topic, chair: obtaining cogent allegations 23 of abuse and medical evidence from complainants. 24 Within this final topic area, we will be looking at 25 how cogent allegations of sexual abuse can be obtained</p> <p style="text-align: center;">Page 165</p>	<p>1 from children, including from the especially vulnerable 2 with complex needs and/or communication difficulties. 3 Obtaining the best account from child victims is 4 critical in terms of strengthening the prospects of 5 successful prosecution. We will also be considering the 6 manner in which medical or forensic examination of child 7 complainants have been conducted in the past and what is 8 best practice surrounding invasive examinations now. 9 A Review of Pathway Following Sexual Assault for 10 Children and Young People in London, prepared by 11 The Haven, King's College Hospital London, on behalf of 12 NHS England in 2015, found that the services 13 commissioned for children in London were not as complete 14 as the packages provided for adults or, in fact, within 15 children's services in other sexual assault referral 16 centres in the UK. 17 One of the authors of the report, Emma Harwood, is 18 due to give evidence to the inquiry. The investigation 19 will consider the benefits of providing holistic 20 services for children and young people who have been 21 sexually assaulted, both in respect of recent and 22 non-recent allegations of abuse. Holistic services 23 include, but are not limited to, access to medical 24 examination, psychological assessment, support in police 25 interviews and independent advocacy.</p> <p style="text-align: center;">Page 166</p>
<p>1 The inquiry will hear from Dr Alison Steele, officer 2 for child protection for the Royal College of 3 Paediatrics and Child Health, and, with her assistance, 4 will consider the developing practices surrounding 5 paediatric medical examination and by whom and where 6 forensic examination should be conducted. 7 To be clear, the investigation is not considering 8 the remit of diagnostic examination or the physical 9 signs of sexual abuse, but, rather, the support for 10 complainants and best practice around obtaining forensic 11 evidence which can be important in bringing offenders to 12 justice. 13 You have already heard, chair, that children in 14 Monkton Street were subjected to forensic examination by 15 a single practitioner who had little or no information 16 about them before conducting forensic examinations. 17 Children from Shirley Oaks recount being examined by 18 a doctor who, far from protecting them, caused them 19 further harm. 20 The information and context of any medical 21 examination is of the utmost importance and the training 22 of those required to undertake such examination is of 23 relevance to this investigation. 24 Dr Steele tells us that the RCPCH is updating its 25 safeguarding special interest training module for senior</p> <p style="text-align: center;">Page 167</p>	<p>1 paediatric trainees or consultants wishing to develop 2 their expertise in safeguarding and/or taking on wider 3 responsibilities in this area. The RCPCH update is due 4 to be launched in early 2021. 5 You will hear, chair, from Dr Phibbs, clinical 6 psychologist, around the challenges faced by children 7 with complex needs and/or communication difficulties 8 surrounding providing allegations of sexual abuse. 9 Dr Phibbs will also give her opinion on children in 10 residential settings and how placement in residential 11 settings may impact upon communication around child 12 sexual abuse. 13 In December 2014, a joint inspection team for the 14 criminal justice system published a report outlining the 15 findings of their joint handling of CSA cases. They 16 reported: 17 "In short, the inspection found that the (ABE) 18 guidance is not achieving what it set out to do, which 19 is achieving best evidence. This is due in part to poor 20 compliance by interviewers and the failure to properly 21 record divisions and actions with the rationale 22 underpinning these. Immediate improvement could be 23 achieved through better planning at the outset, 24 supplemented by improved supervision of interviewers and 25 better quality assurance of the recording. In turn, the</p> <p style="text-align: center;">Page 168</p>

<p>1 CPS needs to improve feedback to the police."                  2 The joint inspection report, written, as it was,                  3 six years ago, suggests that those who claim, when                  4 looking back at the history of Lambeth, that it would                  5 all be different now are surely mistaken. We will hear                  6 from a witness from the Ministry of Justice surrounding                  7 when reviews to the existing guidance are contemplated                  8 and whether they see any need for that to happen.                  9 Whilst law and practice as it affects children's                  10 participation in proceedings may have improved for the                  11 better in recent times, we say at the outset that there                  12 is no room for complacency or institutional                  13 self-congratulation surrounding where we are now.                  14 The treatment of child complainants within the                  15 criminal justice system has been wholly lamentable in                  16 the past. There is work to be done within various                  17 institutions to assist in the prevention of child sexual                  18 abuse and to be consistently effective in bringing                  19 sexual offenders to justice.                  20 With that in mind, it is incumbent upon all                  21 witnesses and institutions participating in this inquiry                  22 to give open and frank evidence; to be reflective in                  23 respect of failings of the past; to consider lessons                  24 learned; and to assist you, chair and panel, to help                  25 prevent any repeat of the appalling experiences of</p> <p style="text-align: center;">Page 169</p>	<p>1 children in the care of Lambeth, some of whom you have                  2 already heard about within this opening, and others who                  3 you will hear from and about during the evidence itself.                  4 Now I turn to a few procedural and other issues,                  5 chair. Firstly, disclosure. A huge amount of work has                  6 been undertaken by IICSA obtaining and preparing                  7 evidence for this investigation. Documents were                  8 requested from a range of organisations, institutions                  9 and individuals, including Lambeth Council, the                  10 Metropolitan Police Service, and the Crown Prosecution                  11 Service. All documents received by the investigation,                  12 many as a result of searches, have been reviewed for                  13 relevance by the inquiry team, which has been                  14 a considerable task. 35,445 documents totalling                  15 362,780 pages, have been received. Approximately                  16 1,861 documents, totalling 24,244 pages, have been                  17 disclosed.                  18 Of relevance to all core participants and their                  19 legal representatives will be the chronology produced                  20 with the collaborative efforts of all core participant                  21 teams and which is a work in progress. In addition to                  22 the chronology, as far as complainant core participant                  23 evidence is concerned, as mentioned this morning, you                  24 will receive evidence by the means of a thematic gist                  25 table in terms of core participant voices.</p> <p style="text-align: center;">Page 170</p>
<p>1 In terms of witnesses to be called, the timetable                  2 has been put together with input from all core                  3 participants to hear from a range of witnesses who,                  4 between them, are able to address the many and various                  5 issues raised today.                  6 Procedure. To assist everyone's understanding, the                  7 evidence will be presented in one of two ways: witnesses                  8 will either give evidence by remote videolink; or                  9 evidence will, at appropriate points, be read or                  10 summarised by a member of the counsel team and formally                  11 introduced into evidence by such means.                  12 On 12 May 2020, you determined, chair, that the                  13 Lambeth public hearing would commence by way of virtual                  14 hearing if it was not safe to hold it in person at the                  15 inquiry's hearing centre. It is not currently possible                  16 and in accordance with government restrictions to have                  17 all legal teams and their representatives in one place                  18 at Pockock Street. Software and equipment have been                  19 provided to witnesses to enable their effective                  20 participation in this virtual hearing.                  21 Some witnesses and core participants, where it is                  22 safe to do so, have been able to join their legal                  23 representatives in order to give virtual evidence at                  24 this hearing.                  25 It is recognised that, for all witnesses and core</p> <p style="text-align: center;">Page 171</p>	<p>1 participants, the format of this hearing has meant                  2 adapting working methods. The investigation team notes                  3 that there has been full co-operation from core                  4 participants and their legal representatives with remote                  5 working thus far and that this has been vital in the                  6 progression of the work of the inquiry.                  7 Similar with evidence heard in other investigations                  8 at Pockock Street, the witness evidence in this                  9 investigation will largely be live-streamed. In terms                  10 of protecting the identity of complainant core                  11 participants, in order to reduce the risk of a breach of                  12 any restriction order imposed to protect their identity,                  13 the evidence of anonymous witnesses will not be                  14 live-streamed. Where evidence is not live-streamed, it                  15 will be recorded and uploaded to the inquiry website as                  16 soon as possible thereafter, together with the                  17 transcript.                  18 All witnesses will be reminded of the meaning and                  19 effect of any restriction order by their legal                  20 representatives and the inquiry legal team before giving                  21 evidence and of the need to refer to ciphers for those                  22 covered by them and who should remain anonymous. If                  23 there is an inadvertent breach of a restriction order,                  24 we will ask you, chair, to make an immediate further                  25 notice order over the evidence incorrectly given.</p> <p style="text-align: center;">Page 172</p>

<p>1 Chair, that concludes all that I would wish to say 2 at this time. Throughout the opening, I have made 3 reference to a number of reports, extracts and witness 4 statements and other material received as part of this 5 investigation. Due to the number of documents referred 6 to, and given the time that we are now at, I do not 7 propose to read each document reference into the record 8 of today's proceedings. Instead, chair, I ask that you 9 direct that a list of documents referred to in the 10 opening be placed on the inquiry's website and that 11 those documents are adduced in evidence and published on 12 the inquiry website in tranches over the next few days. 13 THE CHAIR: Thank you very much, Ms Langdale. I will make 14 that direction, as you propose. Indeed, we will resume 15 tomorrow to hear core participant opening statements. 16 That concludes our business today. Thank you. 17 (3.40 pm) 18 (The hearing was adjourned to 19 Tuesday, 30 June 2020 at 10.30 am) 20 21 I N D E X 22 23 Welcome and opening remarks by THE .....1 24 CHAIR 25 Opening statement by MS LANGDALE .....4</p> <p>Page 173</p>	

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