Friday, 31 July 2020
(10.00 am)
THE CHAIR: Good morning, everyone, and welcome to Day 19, the final day of this public hearing. Ms Langdale?
MS LANGDALE: Good morning, chair. May I recall, please, Mr David Pope. Mr Pope gave evidence on Day 8 and affirmed on that date, so, Mr Pope, I don't think you need to be sworn or affirmed again.

MR DAVID POPE (continued)

Examination by MS LANGDALE (continued)

MS LANGDALE: Mr Pope, you have provided us with a further statement, dated July 29, 2020. Can you confirm for us that the contents of that statement are true and accurate, as far as you're concerned?
A. I can.
Q. Mr Pope, I am going to ask you to look at some excerpts from the 1993 SSI inspectorate report which relate to unit 2. To be clear, unit 2 is not Angell Road, but it is one of the three homes that the inspectorate assessed at that time.
Mr Hyde, please could we have on the screen LAM028733_053 and _054 next to it. If you look under _053, unit 2, paragraph 10.1.2, the exterior of the building is described first:
"The exterior to the front house is rubbish containers and was smelly and not clean. The rear garden contained a boarded-up Wendy house and a large pile of broken, disused furniture and junk. It contained items of discarded, dirty clothing, waste paper, broken toys and a slide that had been waiting for erection for over two years."
If we look at the other page on the screen, please, in relation to unit 2, if we look underneath "The standard of decoration", we see:
"The standard of decoration, furnishings and equipment for the young people resident at the unit was seriously inadequate. The building was characterised by dirty, broken and inappropriate furniture and equipment and clothing scattered throughout the building and its grounds."
Could we have LAM028733_040. We see the same unit at the bottom:
"Fridges, work surfaces, sinks and microwaves were dirty, and in one home, breakfast cereal four months past the stamped sell-by date was put out for children's breakfast."
Thank you, that can go down. What do those descriptions represent for children in that home, as far as you're concerned, Mr Pope?
A. Not a very good example of care and concern at all. Some of it is just basic housekeeping, and it's just totally unacceptable.
Q. There is a complete lack of care and disregard for children living in a home like that, isn't there?
A. Yes, I think I would agree with that. It was totally unacceptable.
Q. Did you, upon receipt of that report, visit that home?
A. I'm not aware of visiting that or, as I said in my witness statement, any of the homes prior to, or subsequent to, that inspection. I may have done, but I can't recall it, so I couldn't put in my witness statement that I did. But I'm absolutely convinced that -- and that's the problem of not having the full report on our response. I'm absolutely convinced that Ainsley Forbes and his management team did address those issues, because they were obviously -- needed to be addressed very quickly. I'm confident that's what happened.
Q. You know, and we are not going to go to the action plan, there was talk about removing junk, et cetera, between three and six months. There was that kind of response. But I'm asking you a broader question: as a director, when you get that report, what decisions do you make about visiting children's homes for yourself and seeing what they're like?
A. Yes, I agree. I mean, I always, as a manager, recognised the importance of walking the job. I always attempted to try and visit establishments. As you know, there were about 80 in total, of which children's homes were included. But I accept that, over the years, pressure of work, other matters, simply squeezed that to the margin, and I do regret the fact that I didn't visit the establishments or workplaces as often as I would have wished.
Q. I'm focusing on children's homes. If you visited, and when you visited, children's homes, how long would you spend there?
A. Again, I struggle, after all these years, to remember. I know -- I mean, I normally went with either Ainsley Forbes or David Hind, who was the principal manager, but I cannot honestly -- I cannot say how long I stayed there. I just simply can't recall it.
Q. Mr Osmond, in a further statement to the enquiry, Mr Robin Osmond, tells us that, in the post Shirley Oaks era, "we wished to highlight the importance of the children's residential services in Lambeth in order to better understand what life in a children's home was like, and whether there were things that could be done to improve the service. The children's home management group arranged for me to go and stay in a children's

1 home for a weekend. Angell Road was selected by the
2 children's home management group, as it was considered
3 to be a good example of a new family group home."
4 Were you aware of that initiative, that the director
5 should go and spend a weekend at Angell Road?
6 **A. No.**
7 Q. Was that discussed with you?
8 **A. No --**
9 Q. It was (overspeaking).
10 **A. Discussed with me ... sorry, I missed that last bit.**
11 Q. Discussed with you that that had happened, a weekend at
12 Angell Road in that way?
13 **A. Sorry, was that discussed with me by ...?**
14 Q. By Mr Osmond. Was the learning -- the suggestion is
15 that there was a weekend to better understand life in
16 a children's home and whether things could be done to
17 improve the service. Did Mr Osmond ever discuss that
18 with you? You were his assistant director, weren't you,
19 between 1983 and 1988?
20 **A. Yeah, but not in -- on the personal services side, not**
21 **on the children's home side. So I don't recall that**
22 **discussion, no.**
23 Q. Did anyone ever suggest you should do anything like that
24 in terms of visiting Angell Road or any other home,
25 children's home, and staying for a weekend?

1 **A. Not that I recall, no.**
2 Q. Is it the kind of thing you would recall? Staying for
3 a weekend is unusual, often. Would you remember that?
4 **A. I probably would. I didn't want to say nobody did, but**
5 **I don't recall it. It would have been something**
6 **different, so maybe I would have recalled it, yes, but**
7 **I can't say for certain.**
8 Q. But you don't recall it?
9 **A. No, I don't recall it, no.**
10 Q. You can't say for certain? You wouldn't have a memory
11 of staying in a home or in a room in a home?
12 **A. I certainly didn't do it -- sorry, I certainly didn't do**
13 **that, but I don't recall it being raised as something to**
14 **do, no.**
15 Q. Do you know if Jack Smith visited Angell Road or was
16 friendly with Mr Carroll?
17 **A. Well, in relation to the evidence last time and the**
18 **debate about whether he had submitted a letter of**
19 **support for John Carroll, my assumption is that, yes,**
20 **they had some sort of relationship. I don't know at**
21 **what level. I mean, I never discussed it with either of**
22 **them, obviously, but my assumption was that they had**
23 **some -- if he was going to write a reference in support**
24 **of that application, then, yes, I assumed they had some**
25 **form of relationship.**

1 Q. What do you mean "relationship"? What kind of
2 relationship?
3 **A. Well, I mean, some sort of working relationship, or**
4 **maybe, I don't know, maybe a social -- I have absolutely**
5 **no idea. But obviously, if you're going to write**
6 **a recommendation in support of somebody, then presumably**
7 **you know them well enough to do that.**
8 Q. Well, he was actually suggesting that references should
9 be marked to "satisfactory", wasn't he, "satisfactory".
10 It is not just a letter of support, it is saying
11 satisfactory irrespective of the schedule 1 conviction?
12 **A. As you know, there were all sorts of debate about that.**
13 **Yes, I mean, the implication from everything that you**
14 **read is that they were -- they had -- they knew each**
15 **other, to say the very least, yes.**
16 Q. You say there was debate about that. Why was that
17 internal investigation taking place at all after
18 Mr Clough's report on what had happened with the
19 Wandsworth application? It seems surprising that there
20 would even be a question around whether Mr Smith had
21 interfered with that application?
22 **A. Well, I think we went through that in my last oral**
23 **evidence. The SSI asked us to suspend the investigation**
24 **we started, because obviously Dick Clough was doing it,**
25 **carrying out his investigation. When -- after the**

1 **Dick Clough investigation, the committee asked for**
2 **that -- for the suspended internal investigation to**
3 **continue, which is what happened.**
4 Q. In terms of appointing -- it was Verley Chambers, was
5 it, the assistant director, who did that? In terms of
6 appointing him to conduct that internal investigation,
7 he was also a colleague, wasn't he, a close colleague,
8 of Mr Smith's. So how were you going to get an
9 independent view and analysis in that investigation,
10 asking Verley Chambers to conduct it?
11 **A. I can't remember, but, I mean -- I haven't thought about**
12 **it, but I assume that he'd started the investigation**
13 **and, therefore, he and the senior personnel manager**
14 **completed it. It was just to complete that piece of**
15 **work.**
16 Q. Do you agree that Verley Chambers was a close colleague
17 of Jack Smith or not, or would you not know that?
18 **A. He was a colleague, yes, indeed, absolutely, yes.**
19 Q. In terms of your appointment by Mr Osmond to do
20 Michael Carroll's disciplinary hearing, again, can you
21 think why you were asked to do that, because you weren't
22 independent from Social Services, were you? It was
23 a really important issue. It was one where your
24 judgment was going to be assessed down the years, and it
25 continues to be assessed, as a professional. So why

1 would you say yes to that and why would he ask you? Why
2 would you take that on?
3 **A. I don't know why he asked me. I mean, I can't remember**
4 **the actual -- obviously after -- it's 34 years. I can't**
5 **remember the conversation. I just think he asked me to**
6 **do the disciplinary and I think I knew what -- yeah, I'm**
7 **sure when he said it's a disciplinary of an**
8 **officer-in-charge or something, I can't remember the**
9 **detail, it was so long ago, but he just asked me and as**
10 **my boss I presume I just said, "Well, okay". I can't**
11 **remember any kind of discussion about it. I just -- my**
12 **memory was that he asked me to do a disciplinary and**
13 **I agreed. Because obviously disciplinaries had to be**
14 **done by managers and everybody had to take their share.**
15 **I don't remember the actual wording of the thing, but**
16 **all I remember was he asked me and I said, "Yeah, okay**
17 **then, that's ...", you know.**
18 Q. When you say disciplinaries had to be done, we see often
19 members of staff are represented, quite properly, and we
20 see sometimes lawyers are representing them. We don't
21 always see that from the other perspective, whether it
22 is the management team who have done the investigation,
23 for example, in relation to Ivy House, lawyers
24 representing that perspective or giving advice. Was
25 that your experience when you dealt with disciplinaries

1 generally, that you didn't get independent legal advice,
2 either to you chairing it or to those who wanted to
3 advance a particular case, as in the case of Ivy House,
4 the management team?
5 **A. Yes. I mean, I hadn't -- I can't think how many**
6 **chair -- how many disciplines I chaired. I don't**
7 **think -- I can't think. I mean, I know about one,**
8 **obviously, but I can't think how many others I did.**
9 **I presented a number of disciplinary cases when I was in**
10 **adult services, and independent legal advice, no, that**
11 **wasn't something, from memory, that was ever -- well, it**
12 **was certainly not used, no. It wasn't available, from**
13 **what I remember.**
14 Q. But it's something you could have contemplated or said,
15 "This needs input, advice, independence", for either of
16 these enquiries that we are talking about, about such
17 a serious issue?
18 **A. Either enquiries or --**
19 Q. The disciplinary. The disciplinary investigation and
20 then the internal investigation. Conducting those,
21 whether it's into Jack Smith's interference or, in your
22 case, in relation to Mr Carroll, you could have sought
23 independent legal advice or requested it?
24 **A. I suppose it's possible. I have to say, it wasn't**
25 **normal practice, and I don't think I gave that -- or any**

1 **other member of the panel gave that any consideration,**
2 **no.**
3 Q. Throughout your time as Director of Social Services, did
4 any counsellor suggest to you at any point that you
5 should resign or consider resigning?
6 **A. No. No.**
7 Q. Did any of them question to you, directly or indirectly,
8 your fitness to be a Director of Social Services in
9 Lambeth?
10 **A. No.**
11 Q. You say in your statement that it was in mid 1995 you
12 were advised by Heather Rabbatts that the
13 Social Services Committee had considered a projected
14 overspend on the adult social care budget, and wanted
15 a change in leadership. Was that issue the issue around
16 or given for your departure? Was that the issue?
17 **A. Yes. We -- it was 1993/'94 -- let me get this right --**
18 **that's right, was the first tranche of money up from the**
19 **community care budget. What had happened was that the**
20 **financial information systems had used, in the adult**
21 **services home care vote, the agency budget had been --**
22 **for the following year had been based on what had**
23 **actually been spent rather than commitments, and so,**
24 **when we did our first monitoring in the beginning of**
25 **'95, it was obvious that we were headed for an overspend**

1 **on the budget because there was an underestimation the**
2 **year before.**
3 **While I was on leave -- that was reported to the**
4 **Social Services Committee before I went away on holiday,**
5 **and we said we'd need to look at it because there was**
6 **obviously going to be an issue. While I was away,**
7 **further work was done. The committee met to consider**
8 **that work and, when I came back from leave,**
9 **Heather Rabbatts, the first morning I was back, called**
10 **me in and said, "We have had a committee report.**
11 **They're very upset about the overspend -- projected**
12 **overspend, projected overspend, and they want a change**
13 **of leadership".**
14 **Obviously that was very unexpected. Although**
15 **I would say that all the directors were in a redundancy**
16 **situation because the council was undertaking a review**
17 **of the structure, introducing excessive directors, so we**
18 **were all placed under potential redundancy.**
19 **So I said, "Well, what does that mean?", and she**
20 **said, "Well, you know, we need to talk about you taking**
21 **voluntary severance", so that's what happened.**
22 Q. Mr Pope, were, or are you, a Freemason?
23 **A. I have -- I am not a Freemason. I have never been**
24 **a Freemason.**
25 Q. I want to ask you some of the issues that arise about

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1 knowledge of the various reports over a period of time
2 that went into Lambeth. So I want to ask you
3 now: Robert Morton's reports, did you read them?
4 **A. Yes.**
5 Q. We have seen his reports. The inquiry has examined
6 them. 1988, 1989, 1990. He is highlighting the
7 dangerousness, isn't he, and bad practice around
8 children being admitted into residential care?
9 **A. Yes.**
10 Q. So you saw those reports. Did you ever have
11 conversations or follow-up meetings with him about them?
12 **A. Again, it's 30-odd years ago. I'm sure, as a --**
13 **obviously I was a brand new director. I'm sure I had**
14 **meetings with him and the assistant director at the**
15 **time. They were due to enquire before that. I remember**
16 **conversations and concerns being raised by Robert and**
17 **herself and then with Robert and Ainsley Forbes, up to**
18 **the time that then Robert left, yes. So, yes, I -- so,**
19 **yes, I'm confident I had meetings with them, obviously,**
20 **because they were submitting reports to the Children's**
21 **Homes Subcommittee about it.**
22 Q. In 1991, the inspection following up on the
23 recommendations from the Tyra Henry Report raised
24 a number of concerns, including Lambeth's reliance on
25 unqualified social workers and absent a basic training

1 course for them. Were you aware of that, this absence
2 of a basic training course and unqualified social
3 workers?
4 **A. Yes. I did answer that in a report in which**
5 **I identified the fact that, whilst we didn't have**
6 **a basic unqualified social worker course for them to**
7 **attend, we were obviously recruiting people from a wide**
8 **background, from nursing, people who had been social**
9 **workers elsewhere, from other caring professions, and**
10 **they all brought a varied range of skills. What**
11 **happened with each and every one of them was that they**
12 **would meet with their team leader and the training**
13 **manager and identify gaps in their learning which could**
14 **be met by a various range of courses, rather than**
15 **everybody going on the same course.**
16 **Obviously people were coming in at different times,**
17 **and we felt at the time that that was a better way of**
18 **managing it than having a block course, which could only**
19 **happen and people had to wait before they could go on**
20 **it. That's what I remember answering at the time.**
21 Q. In 1992, the level of unqualified social workers was
22 14 per cent higher than other boroughs, and you also had
23 one of the highest number of unallocated cases in
24 London. We see, of course, in the 1993 inspection
25 report, as well as the issues highlighted now, which

1 aren't just about physical conditions, are they -- there
2 are issues about a disregard for children in care --
3 there was an issue raised of lack of police checks at
4 Angell Road and staff had not taken part in child
5 protection training. So that was raised back in 1993,
6 again, wasn't it?
7 **A. I'm sure it was. I can't recall. Obviously I can't**
8 **recall that. Yes.**
9 Q. In 1994, we have got the Harris Report which raised
10 child protection issues for references to evidence that
11 a Lambeth employee may have been involved in the making
12 of images of child abuse. Did you remember looking at
13 the Harris Report and saying, "Do we need to investigate
14 anything from a children's services perspective here?"
15 **A. I'm not sure how widely the Harris Report was**
16 **circulated. I don't recall at the time that report at**
17 **all. I've obviously seen it in the bundle that I was**
18 **sent, but I'm not sure that was -- I'm not sure that was**
19 **circulated or discussed at the time outside of wherever**
20 **it came from. I'm not sure about that. So I don't**
21 **think that's the case.**
22 Q. As far as deep-seated problems concerning the checking
23 of foster and adoptive parents, they endured, didn't
24 they, after 1995, and they go on to the Barratt Report.
25 That was a long-term issue, wasn't it, and in your time

1 as well, of checking foster and adoptive parents?
2 **A. Well, obviously we weren't aware of it at the time, and**
3 **I think, from reading the reports that came out after**
4 **I'd left, I think it was picked up in 1998, something**
5 **like that. I certainly was not aware at the time that**
6 **there was a problem in checking foster parents. In**
7 **fact, as we closed the children's homes, we were**
8 **providing some of that resources into the fostering and**
9 **adoption section, in order to obviously increase the**
10 **number of children accommodated who could move into**
11 **a family placement. So we felt that we -- that we were**
12 **promoting and improving the service there. I was**
13 **certainly not aware, and I don't believe anybody else**
14 **was aware, that there was a problem with police checks**
15 **at that time.**
16 Q. Do you think you should have been aware?
17 **A. Well, I think -- you're always wise with the benefit of**
18 **hindsight. I mean, when you're not aware, the**
19 **understanding is that the principal manager and the**
20 **service staff dealing with that are doing things that**
21 **are in the procedures for them to do. It's only when,**
22 **obviously, you identify that isn't happening, then you**
23 **realise that it wasn't being done. I mean, you rely on**
24 **your management line -- all your managers down the line**
25 **to make sure that procedures are followed.**

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Q. Mr Pope, the inquiry has received evidence from complainant core participants and has considered evidence about other children who were sexually assaulted whilst in the care of Lambeth. Some reported incidents to staff time and again, and they say nothing happened. In some cases, they report senior staff victimising them for making complaints and making them retract complaints.

When you consider all of this, how was it that you didn't know what was happening, that these complaints weren't coming through to you and what was happening?

A. Well, what can I say: if complaints had been stopped in the management line and not come up the line, there's no way I could know. You rely on your senior managers, your middle managers, your junior managers, your social workers, to do the things that they should do and to deal with them and, where necessary, that information is passed up the line. If people don't -- if people block it, then obviously there's no way you can know at the top of your organisation. You rely on your management lines to do the job they're supposed to do and to report things to you that they need to bring to your attention. You don't know what you don't know.

Q. You did know, in 1986 and also in 1987, of the child sexual abuse complaints emanating from Ivy House and

Monkton Street. Now, I'm not going to ask you about the details of those complaints, the inquiry has heard about that evidence, but you, as a director, knew that allegations of child sexual abuse could emerge from homes in Lambeth and was a really live issue by the end of the '80s?

A. Yes. You're right. I was not the director in 1986 and 1987 when Ivy House was going on. But, obviously, all directors, as child sexual abuse became more of an issue, were aware that it was an issue that needed to be seriously addressed, yes.

Q. And proactive about obtaining complaints from children?

A. Yes. Indeed, we had a complaints procedure which we operated with the Children's Society, independent Children's Society, where complaints could be handled -- could be processed. But obviously, in the end, you rely on the integrity and the professionalism and the care of your staff, from social worker right up to the assistant director, to bring -- to deal with the information and to deal with that appropriately and to raise matters that they felt needed to be raised, not to block them off.

Q. It appears, as far as Mr Carroll was concerned, he was relied upon, wasn't he, or trusted by the department, because there is even a development of having direct

work with children who have been sexually abused while he is in charge and a schedule 1 offender?

A. My understanding -- I mean, as I said in my latest witness statement, in relation to some comments made by Mr Whaley, I didn't -- I had no contact, as far as I can recall, with Mr Carroll personally, from the time of the disciplinary until he left. But he -- my understanding was, from colleagues, particularly when we were doing the Clough Report, yes, he was held in some regard. He was seen as somebody who was quite skilled, and I think, generally, yes, you're right, he was held with some regard by a number of staff.

Q. You referred to Mr Whaley's evidence. What, in fact, he said was, whether you were beholden to Michael Carroll and whether there was an unhealthy relationship there. Do you want to expand on that: "Beholden to Michael Carroll". Would you have been beholden to Michael Carroll?

A. I have to say this, and I made the point in my witness statement, I am absolutely at a loss as to why Stephen Whaley made those comments. There is absolutely no truth at all, in any way, that I was directly beholden to Mr Carroll or that there was an unhealthy relationship between myself and Mr Carroll. I had no relationship with Mr Carroll whatsoever, and I -- as far

as I can recall, the only times I ever met him were at the two disciplinaries: one when he was directing manager and one when he was the one being disciplined. I think I can say with confidence that I never met him after the disciplinary or spoke to him in the four years that he remained in service, until he was sacked. For two of those years, obviously, I was the Assistant Director Personal Services, so our paths wouldn't necessarily have crossed, but when I was director for those two years, I have no memory at all of ever meeting him again. So for Mr Whaley to make those comments, I find -- I am just absolutely -- I'm at a loss as to why he would make those comments, when there is absolutely no truth to them whatsoever. I had no relationship with Mr Carroll whatsoever.

MS LANGDALE: I have no further questions, Mr Pope. The chair and panel may.

Questions from THE PANEL

THE CHAIR: Thank you. A couple of questions from me. Just touching on that last point, Mr Pope, how would you describe your relationship with Councillor Whaley when you obviously had to work with him as a senior officer of Lambeth? Was it fraught with difficulties? Was it an easy relationship?

A. I thought it was a generally positive relationship, yes.

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1 **That's perhaps why I'm so shocked that he made these**
2 **comments, and angry that he made these comments.**
3 THE CHAIR: So there is nothing in your past relationship
4 with him that would suggest any friction at all?
5 **A. Well, all directors at times have contentious issues**
6 **that they have to address with members, but with**
7 **regard -- I mean, I found Mr Whaley one of the more**
8 **reasonable councillors to deal with. I can't recall any**
9 **particular points of friction between us, no.**
10 THE CHAIR: Did you ever have cause to discuss children's
11 homes with him or foster care or any related matters?
12 **A. I'm sure we did. I mean, I can't quite remember how**
13 **long he was the chair, but I'm sure, when we were**
14 **preparing for committees and talking about things, yes,**
15 **I'm sure we probably had discussions like that, yes.**
16 THE CHAIR: But you don't recall the subject of child sexual
17 abuse arising particularly?
18 **A. No, I can't. No. No, I can't recall that, no.**
19 THE CHAIR: The second question I want to ask is, did anyone
20 ever suggest to you that there might be a network of
21 child sexual abusers operating in Lambeth or possibly
22 beyond, including Lambeth?
23 **A. No, in my time in Lambeth, no, I -- nobody ever**
24 **suggested that, and I don't recall any discussion about**
25 **it.**

1 THE CHAIR: In view of the various issues that arose around
2 child sexual abuse, you, yourself, never had cause to
3 think that there might be any kind of network?
4 **A. No. No. I mean, obviously, you're -- as time went on,**
5 **you became sensitised to the development of networks,**
6 **but I don't remember recalling concern that it was**
7 **happening in Lambeth, no.**
8 THE CHAIR: Okay. Thank you very much. Ms Sharpling?
9 MS SHARPLING: Thank you, chair. Mr Pope, would you agree
10 that if a manager and leader relied only upon members of
11 his staff to tell him or her what was going on in his or
12 her department, then actually the need for managers and
13 leaders would be much reduced, wouldn't it?
14 **A. Well --**
15 MS SHARPLING: Let me carry on. What I'm concerned about,
16 Mr Pope, is that you were relying on your middle
17 managers and other people within your departments to
18 give you the information that you required or to carry
19 out practices and procedures in accordance with the
20 book, if I can just put it like that.
21 **A. Yes.**
22 MS SHARPLING: I'm just wondering what sort of information
23 stream you might have had to inform you about what was
24 going on in your department, other than those people?
25 Did you do anything separately to understand the

1 performance of your department which did not rely on the
2 managers in place? For instance, commissioning reports
3 and matters such as that?
4 **A. Well, obviously we had -- I'm sure you've seen all the**
5 **evidence. We seemed to be being inspected continually.**
6 **So obviously there was a wealth of information coming**
7 **from external investigators about how the department,**
8 **particularly in children's homes, was performing, and**
9 **obviously members themselves would often write saying,**
10 **you know, "We were worried about this". I'm desperately**
11 **trying to think whether I commissioned any other**
12 **reports. But, basically, I was very reliant -- yes,**
13 **you're right, very reliant on the managers providing**
14 **information, and also the external inspections that were**
15 **ongoing, and we had a considerable number of those.**
16 MS SHARPLING: You mentioned that you were always being
17 inspected, Mr Pope. Did that not raise some alarms as
18 to whether there were some wider performance issues or
19 difficulties in your department?
20 **A. I was aware that we had difficulties and performance**
21 **issues, of course I was. That was what we struggled**
22 **with day after day, week after week, month after month,**
23 **in a -- as I'm sure you've heard, an incredibly**
24 **complicated, complex, crisis-ridden organisation. Yes,**
25 **I was very aware that we had performance issues, and**

1 **I worked extremely hard, as well as did many other**
2 **people, to try and improve matters, so there was no lack**
3 **of awareness of the fact that we had problems, and that**
4 **we were working in an incredibly difficult environment.**
5 **I was absolutely aware of that, yes.**
6 MS SHARPLING: One final question: in the context of that
7 environment, you worked, you say, very hard to bring
8 about improvements, but they were difficult to achieve,
9 were they not, Mr Pope?
10 **A. Oh, absolutely, yes. I mean, we had -- not only did we**
11 **have the normal difficulties of change organisations,**
12 **but we had, as I'm sure you have been advised,**
13 **incredibly strong trade union input, which meant that**
14 **every single action had to be negotiated and ground**
15 **through. It took incredible amounts of time. We had**
16 **difficulties with uncertainties about funding. It was**
17 **almost impossible to plan too far ahead because you were**
18 **never sure how much money you were going to have**
19 **available. And we had the usual problems that a lot of**
20 **London boroughs had with turnover of staff, difficulties**
21 **increasing staff. So, yeah, it was an incredibly**
22 **demanding, complex, crisis-ridden, difficult**
23 **organisation in which to work, yes.**
24 MS SHARPLING: Because of that complexity, were people's
25 eyes off the ball when it came to the welfare of

1 children, do you think?
2 A. **Well, having worked somewhere else as a director,**
3 **there's no doubt, if you take those things away, you had**
4 **much more time and you can spend much more effort in**
5 **dealing with, as you say, the key things rather than**
6 **your energy and effort being taken dealing with the**
7 **noise in order to deal with the important things, yes.**
8 MS SHARPLING: I see. Thank you.
9 THE CHAIR: Mr Frank?
10 MR FRANK: Yes, please. We have also heard from Mr Whaley
11 that there was, at times, what he called "a culture of
12 lack of transparency". Do you recognise that as what
13 was going on whilst you were a director?
14 A. **In the council or in the department, did he --**
15 MR FRANK: I (overspeaking).
16 A. **I can only speak for my own department. I think we were**
17 **in -- everything that we were doing was subject to**
18 **scrutiny, either external or internal. I don't believe**
19 **that there was any lack of transparency. I mean, in**
20 **fact, if you look at the many inspections that took**
21 **place and the action plans we had and the acceptance**
22 **that we had problems, what we were trying to do to**
23 **improve them, no, I don't think there was any lack of**
24 **transparency in my department, no.**
25 MR FRANK: As far as the failure of your managers, middle

1 managers, to report up to you the many defects that we
2 have heard about, was there anything in your own
3 behaviour/conduct that you can imagine now would have
4 given rise to their unwillingness to come and report
5 serious issues to you?
6 A. **No. I considered myself a very open manager, somebody**
7 **who was always willing to listen. I've never had**
8 **anybody say, you know, that I'm difficult to talk to.**
9 **I thought I was an easy person to approach and to raise**
10 **things with. I was always very receptive. So I'm**
11 **not -- my door was always open. In fact, I think that's**
12 **what most people say, that they could always come and**
13 **talk to me. So I don't accept that, no.**
14 MR FRANK: Can you help us as to why you think, then, that
15 your middle managers didn't come and report serious
16 matters to you?
17 A. **Well, I don't know. I mean, that's obviously -- as**
18 **I said earlier, you don't know what you don't know.**
19 **I mean, presumably, if they felt that it needed to go up**
20 **the line, then it would go up the line. Presumably,**
21 **they felt that whatever they did, they were dealing**
22 **with. I can't answer that. I mean -- but all I can say**
23 **is that I believed myself to be an open, receptive**
24 **manager who worked very hard and had the interests of**
25 **staff and users at the centre of everything I did, so**

1 **I don't believe, and I think if you talk to people who**
2 **I worked with closely, I don't believe they would find**
3 **me at all offputting or blocking of them raising things**
4 **with me. No, I don't accept that.**
5 MR FRANK: Nothing further, thank you.
6 THE CHAIR: Sir Malcolm?
7 PROF SIR MALCOLM EVANS: Thank you, yes. Just, I suppose,
8 one quite general question, really. You have been asked
9 very many specific questions, Mr Pope. You were present
10 in Lambeth in what was clearly a very, very critical
11 and -- as you have said, critical time and also a very
12 difficult time. Is there anything else that you think
13 we need to know to help understand why what happened
14 happened?
15 A. **That's very difficult. I've read, obviously, the**
16 **Appleby Report, and obviously after I -- as part of**
17 **this, after I'd left, many years after I'd left, and**
18 **what I thought was a very forensic report by Mr Barratt,**
19 **which picked up, I think, some of the themes.**
20 **I think -- it's not -- it wasn't -- it was just a -- it**
21 **just was full-on. It never stopped. The issues, the**
22 **political issues, the financial issues, the industrial**
23 **relations issues, they just were constant, they were**
24 **just constant. I think Appleby made the point that you**
25 **just somehow got -- you've got to stop looking back and**

1 **you've got to make a radical stop of the organisation,**
2 **because it was a victim of all the things that I've just**
3 **mentioned. It was just an incredibly complex place in**
4 **which to try and achieve things. I can't think of**
5 **anything other than kind of repeating that we said -- it**
6 **was just -- there was political uncertainty. There was**
7 **not even a strong political push, because each group had**
8 **various factions and, as you saw, we had members who**
9 **were disqualified, we had members who were kicked out of**
10 **the party, we had -- it was always adversarial. A lot**
11 **of the debates were "Political" debates, with a large P,**
12 **as well. We had massive industrial relations issues, as**
13 **I have talked about, and we just had a financial system**
14 **which I think Appleby, herself, said was broken. You**
15 **just never knew, from one year to the next, any**
16 **certainty about what the funding was like.**
17 **Looking back, as I did over the years since I left,**
18 **it just seemed all the time we were involved in budget**
19 **reduction exercises or we were building a budget -- it**
20 **took months to build a budget, hundreds of meetings, and**
21 **then, when the budget was done, it was a budget**
22 **reduction, we were involved in budget reduction**
23 **exercises. A budget reduction exercise sounds fairly**
24 **straightforward, but once you get involved in making --**
25 **closing any and making people redundant, effectively**

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1 **redundant, although we had no compulsory redundancy**
2 **programmes, that in itself took massive amounts of time**
3 **in order to achieve that, and you couldn't move forward**
4 **until everybody had been sorted. I think it's that kind**
5 **of -- I don't think there's anything new I can add,**
6 **I think they captured it well. Everything just took so**
7 **long, and so difficult to achieve what should have been**
8 **reasonably straightforward activities.**
9 PROF SIR MALCOLM EVANS: Thank you.
10 THE CHAIR: Thank you, Mr Pope. We have no further
11 questions.
12 **A. Thank you very much.**
13 **(The witness withdrew)**
14 MS LANGDALE: Chair, that concludes Mr Pope's evidence. May
15 I hand over now to Ms Nice of counsel.
16 MS NICE: Thank you, chair. Chair, I will now resume and
17 complete reading in from the gist table, and, as before,
18 chair, I am reading in accounts of children who were
19 placed in care in the 1980s.
20 Summary of evidence of LA-A184 (read)
21 MS NICE: LA-A184 was placed at Shirley Oaks, Angell Road
22 and in other care homes. She says:
23 "I had a terrible time at Shirley Oaks. The staff
24 were cruel and unkind and it was a scary place. The
25 house father used humiliating punishment."

1 She says she developed bedwetting which affected her
2 for many years:
3 "I eventually kept running away as I did not want to
4 be there. I withdrew into myself and I am still like
5 this today. I find it very hard to trust people."
6 At Angell Road, she says it was also a horrible
7 place. John Carroll, who ran the home, scared the
8 children. She says, when he was around, the children
9 became uncomfortable and jumpy. She remembers one boy
10 who had seizures when Carroll would turn up. She says:
11 "Carroll would pick on a child and get them to go up
12 to his office to talk about pocket money."
13 LA-A184 was assaulted by Carroll on one occasion.
14 She had been tied to the bed by a female member of
15 staff. Carroll moved himself onto her, he put socks
16 into her mouth and he inserted a deodorant stick into
17 her vagina. A female member of staff held her down
18 while he did this. Carroll threatened LA-A184 and said
19 something like, "Next time, it will be much worse".
20 LA-A184 did not want to stay there and started running
21 away.
22 On the evening of the incident, she says she sat in
23 the kitchen crying. A staff member asked her what the
24 problem was, but she couldn't tell her because she said
25 she was too scared as a result of threats that Carroll

1 had made:
2 "This was one of the reasons that I wanted to run
3 away, as I thought he was going to get me again or do
4 something even worse".
5 In 1998, she spoke with the police and she mentioned
6 John Carroll. She says:
7 "They informed me that it was John Carroll they were
8 investigating. When I disclosed my abuse to the police,
9 it felt like a dark cloud was lifted from me. I had to
10 go to court for John Carroll's trial and, when I saw
11 him, I screamed in the courtroom, and I was escorted out
12 by the usher."
13 As to her education, she says she received no
14 qualifications from school. She suffers from serious
15 depression and is quite isolated in her life. This has
16 affected her life opportunities and she says it's caused
17 by the abuse and the circumstances of her childhood, for
18 which Lambeth is responsible.
19 Her fear of Carroll drove her to keep running away
20 from Angell Road and, in the end, she was released onto
21 the street with no aftercare or support.
22 As to recommendations, she says that proper checks
23 should be made by local authorities employing
24 individuals working with children. Children should be
25 encouraged to report their abuse and feel that they are

1 in a safe environment to do so.
2 Summary of evidence of LA-A330 (read)
3 MS NICE: LA-A330 was placed in a Lambeth care home. She
4 remembers that she was not told what was happening when
5 she was initially taken into care:
6 "As I walked up the steps of that big, imposing
7 building, I couldn't stop thinking, what the hell was
8 going on? Nobody was talking to me, telling me
9 anything. I just walked up the steps into what turned
10 out to be my hell on earth."
11 She then recalls that she was required to bath in
12 front of others, which was embarrassing, made to change
13 into regulation clothes and given a talk about the care
14 home rules. She describes on one occasion being
15 punished for wanting to leave a classroom because she
16 wanted to go to the toilet and she was placed in a cell.
17 Her room master was on duty. He brought her food and
18 told her that, if she did what she was told, he would
19 release her from the cell. He then violently raped her,
20 he anally raped her and he forced oral sex on her. She
21 was physically sick after the rape. She says he laughed
22 and said she'd have to clear it up after he had finished
23 and he then proceeded to continue to abuse her. He was
24 very violent and she remembers screaming. She says,
25 after it ended, she was let out of the cell:

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"He sent me to bed. Nobody asked where I had been. As I got into bed, the door locked."

The day after that incident, she had a phone call with her dad and she was trying to find a way of telling him. She knew if she tried to tell him clearly what had happened, the call would be stopped. When she had the call, the head of the home was in the room listening. When LA-A330 managed to say that she had had sex, the call was cut off. She then says:

"Then nothing for days. Then I was called into the office. A policeman was there and told me what my dad had told them. So in front of the boss, I told them what happened. That was the last time it was mentioned. Not long after that, I went to live with my cousin and his family."

When she reported it to the police, she was told to put it behind her, and the police would deal with it, but nothing happened. She felt very let down, but felt forced to just try to move on. She has not provided any other reports of the abuse. More recently, she had sought her files from Lambeth, but says she had tremendous difficulty obtaining them, which was unhelpful and stressful in itself.

As to her education, she refers to being dyslexic, but not knowing that when she was at school.

Thereafter, her life has been profoundly affected by depression and she is conscious that she has passed on her own grief to her children, who had to see their mum unable to get out of bed on some days. She also feels she lost all self-confidence. However, she also says that she has had a long marriage and she is now able to consider herself a survivor.

In terms of aftercare, she was removed to live with her cousin after she made allegations of abuse. She says:

"I was taken to my family member's house and I was forgotten about."

In terms of recommendations, she says:

"I would like to think that this sort of abuse isn't happening now, but deep down I know it is. I want everything to be put in place so that children aren't afraid to talk. The council should undertake thorough background checks on anyone who wants to be a carer. They must be 110 per cent creditable. The social worker should be fully qualified and should be able to recognise unusual behaviour of a child who is being abused. I spent years thinking that this had just happened to me. Obviously, now, I realise it happens all over the world. Children need to be able to trust people in authority, the people that are meant to be

looking after them. The reason we are doing this is to stop it happening in the future."

Summary of evidence of LA-A304 (read)

MS NICE: LA-A304 was in a care home and in foster care. Memories of the home included often being cold, hungry, having inadequate clothing and having to be quiet all the time. She wet herself and was humiliated, she recalls racist abuse and being physically hit with implements such as a broom, a spoon, a belt and a shoe:

"As time went on, I became more and more upset and scared about being there."

She describes never having her cultural needs met and the house mother being unable to manage her hair, so much so that she cut it off so she didn't have to comb it. Subsequently, she was in two foster care placements. One was positive. But she was then placed with black foster carers, despite being happy at her previous placement:

"I was told that I had to have black foster parents."

This couple were religiously strict and they were violent and controlling, and she ran away after five years.

LA-A304 was abused along with her brother and another boy at the home by a man, F179. This man would

force her into sexual activity with her brother and with another boy. This would take place in a cupboard. The man also assaulted this child and her brother. The abuse involved forced oral sex and digital penetration. He forced the children to observe abuse of one another. He was also racially abusive when he abused her. On one occasion, he also stubbed a cigarette out on her chest when she wouldn't move out of the way as he was trying to get to her brother.

She also went on to experience abuse after she left care. She recalls staff witnessing the abuse:

"On one occasion, the lady I mentioned walked into the kitchen and saw us in a cupboard with the man and walked straight back out again. She didn't do anything to stop what was going on or ask what was going on."

She did tell the house mother about the cigarette scar, but she says:

"She said I shouldn't tell tales and called me a little runt. She told me if I complained no-one would believe me."

LA-A304 also told her social workers:

"I felt as if they did not really listen to me and ignored me and did not mention anything about it to me. After that, I felt that I should not rock the boat, and maybe I was brainwashed into thinking that. The

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1 response when I was a child was appalling. I wasn't
2 listened to."
3 LA-A304 feels that her mental health has been
4 seriously affected by reliving memories more recently.
5 She feels listened to, but at the same time has an
6 overwhelming sense of paranoia:
7 "I feel like I'm being judged by everyone."
8 As to her education, she says she enjoyed learning
9 and reading, but doesn't really recall a proper
10 education. She's worked in various roles, including
11 social work, the police and fostering and adoption. But
12 describes how she has not been able to keep a job for
13 very long. She says:
14 "I'm always crossing the line, wanting to try and
15 save everyone. I have a general lack of communication
16 skills. I do not know how to deal with a situation
17 unless I'm confrontational."
18 She feels the physical and sexual abuse has affected
19 the rest of her life. She had a breakdown in the past
20 few years, which was assessed as partly having been
21 triggered by what happened while she was in care.
22 In terms of aftercare, she says Social Services
23 agreed she could stay with a friend. When this
24 arrangement ended, she was placed in a flat by
25 Social Services and "left to my own devices". There was

1 no aftercare.
2 In terms of recommendations, she says:
3 "Professionals should not be too quick to write off
4 a looked-after child."
5 She notes that she has witnessed first hand and
6 recently through work for the Fostering Adoption Service
7 that looked-after children were not believed. Too many
8 allegations coming direct from children are explained
9 away as the child being emotionally damaged. Often,
10 this isn't the case, and not being listened to can cause
11 significant damage on top of the abuse that they have
12 already suffered or are still suffering.
13 Summary of evidence of LA-A139 (read)
14 MS NICE: LA-A139 was placed at Southvale, Angell Road and
15 various other care homes and with foster carers. She
16 was repeatedly removed from her father, then returned
17 and taken in and out of care approximately 27 times.
18 Her childhood was so unstable that, as a result, she was
19 unable to form friendships. She was also separated from
20 siblings:
21 "This is a point in my life when I have memories of
22 terrible sadness and pain due to the separation from my
23 sister."
24 This had a devastating effect on her sister also.
25 Her first foster placement was positive. She

1 otherwise has very limited early memory of placements,
2 save individual incidents of sexual abuse. She felt
3 scared all the time at Southvale and Angell Road:
4 "I remember that all the staff were aggressive at
5 Southvale. There were many times we would be left
6 locked in cupboards or our rooms and left without food."
7 At Angell Road she says the people were cruel and
8 unloving:
9 "There was no care being provided. It was an
10 emotionally damaging place for any child to be."
11 The final foster placement was positive, until the
12 foster carers ended the placement, and she was then
13 moved by the council into studio apartments.
14 In terms of sexual abuse, she recalls an incident of
15 sexual touching by John Carroll. She says he always had
16 his hands on the children but that she wasn't used to
17 getting affection so did not fully understand what was
18 happening. At Southvale, her father warned her to stay
19 away from Les Paul. Paul later indecently assaulted her
20 during a camping trip. She remembers being very scared
21 on this trip. At a subsequent placement, she was raped
22 by another child, also while on a camping trip. This
23 boy was encouraged by a senior member of staff, who told
24 the boy to make a man of himself.
25 She was later raped multiple times by a group of

1 boys also with the knowledge of staff. Staff locked the
2 children into the TV room and she says they knew what
3 was going on:
4 "It was on this occasion that I was raped six or
5 seven times on one day after being locked in the room.
6 The TV room looked onto the garden. The staff did look
7 in, walked past the window during this time, so they
8 would have seen what was happening but did not stop it.
9 It felt like it went on for hours. Eventually, we were
10 then all told to get out. I tried telling the staff
11 about what happened, but I was just told to go and play.
12 The same people then dragged me to the bushes in the
13 garden surrounding the home."
14 The boys raped this girl again. She was a very
15 young girl at the time.
16 In terms of contemporaneous disclosure, she says
17 that staff would have known what was going on but did
18 nothing. She spoke to staff about the rapes. Nothing
19 was done. It was only when she moved to foster parents
20 that a complaint was raised with the police. Two of
21 the three boys were on trial and she believes one, the
22 ringleader, was convicted. Thereafter, she received
23 some money from the Criminal Injuries Compensation
24 Board.
25 As to her education, she says she was given

1 inadequate money to travel between sixth form and
2 post-care accommodation, so she couldn't attend school
3 daily. She temporarily moved in with a friend from
4 school but returned to the council apartment to be with
5 her siblings at weekends. She says her education
6 suffered a lot due partly to the location of this
7 council property:
8 "Lambeth were diabolical in their treatment of us.
9 We were just a number to them that needed fitting in
10 somewhere. I appreciate this must have been necessary
11 on occasion, due to the danger we were in, but not for
12 11 years. There was no care plan and it seemed just to
13 be done on an ad hoc basis, day by day, with no real
14 care for our welfare or our needs."
15 With siblings, she was moved into the block of
16 studio apartments:
17 "The accommodation was for young people but we were
18 just left there to fend for ourselves with no guidance
19 on how to cook or clean or carry out any other household
20 duties. There were drug dealers in the premises and
21 police were frequently called."
22 It was a frightening place and she did not leave her
23 room for the first week when she was there.
24 As to recommendations, she said policies and
25 processes should be amended to include an action plan

1 for staff members to act upon in order to investigate
2 child allegations of abuse.
3 Summary of evidence of LA-A136 (read)
4 MS NICE: LA-A136 was placed at Southvale, Angell Road and
5 other care homes. She describes numerous memories of
6 being alone, afraid of certain individuals, in some sort
7 of danger, being physically assaulted and bullied by
8 other children and the severe physical and mental abuse
9 in one of the foster placements.
10 At Southvale, she says:
11 "I was petrified in this place and I remember crying
12 to my mother and asking for her to take me home."
13 She ran away from the care homes a lot and started
14 drinking and smoking cannabis from about age 9 or 10 to
15 forget what was going on. She describes indecent
16 assault by John Carroll in Angell Road, being touched at
17 bath time by various staff and watching them do the same
18 to other children, and various incidents of forced oral
19 sex, during which her assaulter threatened her not to
20 tell anyone or she would not go home to her mum. Some
21 of these incidents were watched by another member of
22 staff.
23 She also describes sexual activity between children,
24 which she says some staff must have been aware of. She
25 told her social worker that she had been touched and

1 beaten up. This was at the time she moved from
2 Angell Road to foster carers:
3 "I can't remember what she said."
4 She also told her grandmother about being abused
5 when she was a teenager. She knows her grandmother
6 tried to contact Social Services. She says:
7 "I believe that I was vulnerable to sexual abuse
8 because of the inconsistency of my mother and her drug
9 addiction. My brother and I were told by the care
10 workers that if we said anything, we wouldn't be allowed
11 home and, in any event, no-one would believe our
12 parents."
13 In terms of recent disclosure, she says she was
14 contacted by Operation Middleton and CHILE, but she did
15 not trust them so she did not provide a statement.
16 However, she does note:
17 "The only thing I would say about the police is that
18 I think it was a good idea to try and contact me. On
19 one occasion, they came around to my flat and left
20 a handwritten note. The note made it clear that they
21 weren't trying to arrest me."
22 In terms of her education, she started secondary
23 school whilst at Angell Road, but was kicked out due to
24 behavioural issues. She was then sent to various
25 centres. At 14, she was sent to college but also asked

1 to leave. She says:
2 "I didn't have an education following this."
3 She was convicted of offending, which then meant
4 a criminal record and prevented her becoming a social
5 worker. After having children, however, she did
6 a degree and a Masters.
7 In terms of aftercare, she was given back to her
8 mother without a correct plan in place. She was
9 involved in gangs, criminality and subject to numerous
10 sexual assaults, including being raped in this period.
11 At 16, she was put in social housing, had to flee and
12 was then in temporary accommodation before having two
13 children whilst in her teens.
14 She was still having aftercare at this stage. The
15 children's fathers were both violent. She says:
16 "The abuse has left me with a series of long-term
17 psychiatric problems. I believe that if I had been
18 given a chance by Lambeth Social Services, as my elder
19 and younger siblings were, that I would not have had
20 this awful life of social exclusion, poverty, crime and
21 abuse. I should have been adopted rather than left with
22 my parents. I have been failed by the system and now,
23 nearly 40 years later, I have still not got over this.
24 I believe I will never get over this and I will go to my
25 grave damaged, angry and failed. I will never, ever be

truly happy because I have been robbed of my life."
In terms of recommendations, she says:
"I realise that things were very different in the 1980s and 1990s, but there should have been some serious vetting of social workers. I don't believe that this all happened by accident. I do recall that John Carroll seemed supremely confident as he actually sent me to a psychiatrist at one point. It seems to me now that some of these professionals -- the psychiatrist, social worker and the police -- knew what was going on. Social workers should see abused children and babies as human beings, not just part of the job or a way to pay the mortgage."
Chair, I note the time. May I continue for a couple more minutes, please?
THE CHAIR: Yes, go ahead.

Summary of evidence of LA-A143 (read)

MS NICE: LA-A143 was placed at Angell Road, foster carers, Southvale and at other care homes. He recalls painful separation from siblings who could not be cared for together. He blocked out many memories of Angell Road. He recalls contact with John Carroll and Steve Forrest and remembers allegations of abuse made about them:
"The last care home was a positive experience, but after here, everything fell apart. When I lost control

of myself completely was when Social Services had a meeting with my key workers about my behaviour and moving forward. What happened in the meeting to me is what really ended up snapping me. I was sat there and I was being asked why I was behaving like I was, and I told them it was because they had taken me away from my mum. Someone then said, 'We didn't take you away from your mum. She gave you up to move on with her life'. I felt this wasn't something that should have been said and it really affected me and I can then remember running out of the meeting and then running away."
He has blocked out many memories of abuse and is unsure if he was abused in some situations.
He also describes abuse by the foster carers' teenage daughter, indecent assaults and that he was in tears at the time, saying he didn't want to do what they were doing.
In terms of disclosure, he says:
"I can recall that on around three or four occasions whilst I was at the care home, I'd spoken to staff members and reported the abuse I had sustained. However, nothing was done to address these issues. I do not know why this was not investigated. I believe now that the reason I did not report the matter to the

police is because, as a 10-year-old child, I had confided in staff members and told them what was happening and, as adults, they had done nothing about it. I felt that nobody was listening to me and that no-one would believe me."
He recalls being interviewed by police about another child, but not regarding his own experiences.
In terms of his education, he says he completed primary school but was expelled or had to leave secondary schools for unruly behaviour or because he found it difficult. He ran away from care, aged 13, and refused to go back. He lived on the streets from age 14. He first went to prison aged 16:
"At 16, I was officially signed out of care."
No aftercare is described. But he goes on to say that, after a long journey and time in prison, he has had some success in music and in mentoring young people.
In terms of recommendations, he says children's homes should have CCTV in order to monitor and evidence abuse that takes place in these homes. Staff should be trained more thoroughly to enable them to identify the signs of an abused child."
Chair, that completes the reading in of the gist table. May I suggest that we adjourn now and resume at 11.25 am?

THE CHAIR: Yes, we will do that, but just before the break, I would like to thank all of the complainants for the complete statements they have submitted. We know that a great deal of work has gone into putting together the gisting table and we are grateful to all of you, all of the complainants, for everything you have done, so thank you very much.
We will now break and return at 11.30 am. Thank you.
(11.07 am)
(A short break)
(11.30 am)
MS BROWN: Chair, with your permission, I will now deal with a number of outstanding issues, including the adducing of further material for publication on the inquiry's website, and seek your agreement at the end that this material may be published.

Further material adduced

MS BROWN: The first outstanding matter relates to the evidence of Lord Boateng. Lord Boateng was called to give oral evidence on Day 14 of the inquiry. For the purposes of transparency, and to provide additional context to the questions Lord Boateng was asked during his oral evidence, may I take this opportunity to set out the position.

1 On 17 July 2020, the inquiry received five witness
2 statements. Four of these witness statements from
3 former child residents at Angell Road referred to
4 Lord Boateng visiting Angell Road. The statements
5 included references to him having a close relationship
6 with Michael Carroll, visiting Michael Carroll's flat
7 with children, spending time alone with children, taking
8 children on outings and attending parties at
9 Angell Road. One statement makes reference to a female
10 staff member who was said to be a friend of
11 Lord Boateng's wife. These statements were all made
12 in July 2020. They describe events said to have taken
13 place between 1980 and 1985.
14 A fifth witness statement, from a former youth
15 worker on ACYC holiday camps run by Michael Carroll,
16 referred to Lord Boateng being a volunteer on these
17 camps and working with Michael Carroll. This statement
18 was made on 17 July 2020. It describes events said to
19 have taken place between 1986 and 1989.
20 As is already in the public domain, Theresa Johnson,
21 deceased, had previously made police statements. The
22 first statement she made in 1998 to Merseyside Police
23 made no reference to Lord Boateng. A later statement,
24 in 2013, referred to visits by Lord Boateng to
25 Angell Road, and a further statement, in 2015, referred

1 to Lord Boateng visiting Angell Road, a child sitting on
2 his knee and him going upstairs with the child.
3 The inquiry has provided all of these statements to
4 core participants. Lord Boateng responded to the
5 inquiry with a statement dated 21 July 2020, stating
6 that he had no recollection of visiting Angell Road, did
7 not know Michael Carroll personally and did not visit
8 his flat. He also stated that he never attended any
9 parties at the home or interacted personally in any way
10 with its staff or residents, and that no known friend of
11 his wife worked as a staff member at Angell Road.
12 Chair, you will recall Lord Boateng's evidence in
13 respect of Angell Road, Michael Carroll and on these
14 points.
15 Turning then to other issues, during the course of
16 the evidence, a number of witnesses have been asked to
17 clarify matters or produce additional evidence.
18 Annie Hudson, the strategic director of Lambeth
19 from May 2016, was called to give evidence to the
20 inquiry on behalf of Lambeth on two occasions. During
21 the course of giving evidence, on the first occasion,
22 she was asked about procedures relating to disciplinary
23 hearings. She has subsequently provided to the inquiry
24 a letter setting out further detail regarding
25 disciplinary processes and references and also setting

1 out the position regarding the referral of safeguarding
2 concerns to Social Work England or the Disclosure and
3 Barring Service. I would ask that this letter from
4 Lambeth, dated 20 July 2020, LAM030334, be adduced and
5 published on the website.
6 A number of additional matters were also put to
7 Annie Hudson following the conclusion of her oral
8 evidence by way of rule 9 request. Lambeth has informed
9 the inquiry that they will be responding to these
10 questions, along with additional questions arising out
11 of the oral evidence of Councillor Davie. We will
12 review the responses disclosed to core participants and,
13 if relevant, publish in due course.
14 Additional rule 9 requests were also made to
15 Detective Inspector Morley and Mr McGill of the CPS
16 following their oral evidence to the inquiry. Detective
17 Inspector Morley has provided an additional statement to
18 the inquiry. We will review the response disclosed to
19 core participants and, if relevant, publish in due
20 course.
21 A response from Mr McGill addressing the issues
22 around achieving best evidence interviews,
23 intermediaries, support to victims and case paper
24 retention is awaited. Once again, we will review the
25 response, disclose to core participants and, if

1 relevant, publish in due course.
2 Chair, as you are aware, during the course of
3 the hearing, in addition to those witnesses giving oral
4 evidence, a number of statements have been read in. As
5 we are now approaching the conclusion of the oral
6 hearings, we would ask that the following statements or
7 sections of statements be uploaded.
8 Dealing first with the evidence of Lambeth, the main
9 corporate statement of Annie Hudson on behalf of Lambeth
10 has already been uploaded -- the reference LAM029331.
11 Ms Hudson also made further statements, dealing with
12 specific case study homes and the issue of fostering,
13 matters which were the subject of questioning during her
14 oral evidence. Thus, in addition to her oral evidence,
15 we would ask that sections of the following be uploaded:
16 the second statement, relating to Ivy House, LAM030078;
17 the third statement, relating to Monkton Street,
18 LAM030068; the fourth statement, relating to Southvale,
19 LAM030157; the fifth statement, relating to
20 Shirley Oaks, LAM030213; the sixth statement, relating
21 to Angell Road, LAM030227; the seventh statement, which
22 deals with fostering, that is LAM030269, and her eighth
23 statement, which deals with the issue of independent
24 visitors, LAM030335, have sections uploaded.
25 The sections we seek to upload are the sections of

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1 those statements that deal predominantly with generic
2 issues in relation to the case study homes and
3 fostering.
4 Turning to evidence from the police, I would ask
5 that sections of the statements received from retired
6 Detective Chief Inspector Ranson -- MPS004524 -- and
7 sections of the statement of retired Deputy Assistant
8 Commissioner Carole Howlett -- MPS004518 -- be uploaded.
9 Richard Gargini gave oral evidence on Day 10 of
10 the inquiry, and we would ask that paragraph 71 of his
11 statement be uploaded. The reference, INQ005746.
12 Chair, you have heard from a number of experts this
13 week, and we would ask that, in addition to their oral
14 evidence, the statement of Simon Cordon of The Haven's
15 Sexual Assault Referral Centres provided by King's
16 College Hospital NHS Foundation Trust be uploaded and
17 the reference for that statement is INQ005999.
18 Chair, you will be aware that during the course of
19 the inquiry, witnesses have been referred to a number of
20 documents that have been shown on screen and uploaded on
21 a daily basis. In addition to these documents, counsel
22 to the inquiry made reference to, and relied upon,
23 a large number of statements in the course of opening.
24 These documents referred to in Ms Langdale's opening are
25 currently being checked in accordance with the redaction

1 protocol and they will then be uploaded.
2 In addition, we would ask that the following
3 documents relating to the oral evidence heard over the
4 course of the inquiry be uploaded, and I will proceed
5 now to list those.
6 First, a number of additional documents relating to
7 Southvale: OHY009010. This is a police interview dated
8 5 October 1992 with a senior personnel officer about
9 Southvale, which is relevant to how the home was being
10 run.
11 LAM013312. This is a contemporaneous handwritten
12 note by a staff member at Southvale, setting out the
13 conditions at the home that they observed.
14 LAM013310, which is a typed document that records
15 a meeting of 9 June 1989, where a staff member expressed
16 to Theresa Johnson concerns about the conditions at
17 Southvale.
18 OHY009725, which is a police interview with
19 Mr Zephyrine dated 9 October 1992 regarding matters
20 raised in the inquiry he conducted into Southvale
21 Children's Home.
22 LAM001030_001, which is a staff record relating to
23 Les Paul, summarising the disciplinary proceedings
24 leading to his dismissal on 6 November 1992.
25 LAM030156_001-003, _011 and _027 of that document.

1 These are all documents that relate to the disciplinary
2 proceedings against LA-F8.
3 The final document in relation to Southvale,
4 OHY008929, which is a letter dated December 1992 from
5 Detective Superintendent Brian Tomkins to David Pope
6 about the investigations at Southvale.
7 There are also some documents relating to
8 Angell Road that we would seek to upload. These are
9 LAM030248_001-009. This is a collection of documents
10 circulated to the Children's Homes Subcommittee on
11 9 October 1984 that relate principally to direct work
12 with children at Angell Road, which we heard evidence
13 about.
14 LAM030236. That's a document setting out the
15 concerns of Ann Valsler about Angell Road and her period
16 there as officer-in-charge, which followed the departure
17 of Michael Carroll.
18 There are then a number of additional documents
19 relating to Mr and Mrs Carroll's fostering applications.
20 The reference WAN000001_111 and _113. That's a letter
21 to Mr and Mrs Carroll from Croydon from 5 February 1986
22 refusing their fostering application and the other page
23 that I referred to is an extract from the Adoption and
24 Fostering Panel minutes dated 21 January 1986.
25 Then the same document reference, WAN000001_022,

1 which is an extract from a reference for Mr and
2 Mrs Carroll for their fostering application in 1988,
3 completed by Bernadette Khan.
4 WAN000001_071, which is a Wandsworth memorandum
5 dated 15 February 1994 about the internal investigation
6 regarding Mr and Mrs Carroll's fostering application and
7 in relation to the fostering issue, INQ002206, which is
8 a report of David Pope to the chair of Social Services
9 dated 23 February 1994 regarding the
10 management/investigation into the fostering application
11 of Mr and Mrs Carroll.
12 There are also a number of documents relate to
13 particular witnesses who have given oral evidence. In
14 relation to the evidence of Anna Tapsell, we would ask
15 that the following be uploaded: CQC000298, which is 1992
16 correspondence between Anna Tapsell and the Social
17 Security Inspectorate regarding concerns about
18 residential care and, relating to the same witness,
19 INQ002089, which are handwritten notes relating to
20 Anna Tapsell's approach to child protection in Lambeth
21 in the light of the Carroll arrest.
22 There are a number of documents relevant to LA-A23
23 that were put to former social worker Chris Hussell, and
24 we would seek, in addition to those documents that were
25 uploaded on screen and subsequently uploaded, the

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1 following documents: LAM030003_003-006 and _009. These
2 are all extracts from the Social Services file of
3 LA-A23. In relation to the same child, LAM030005. That
4 is a letter from Chris Hussell to Robin Osmond dated
5 23 April 1982 regarding LA-A23.
6 The final document we would seek to be uploaded is
7 one that is relevant to Simon Morley's evidence about
8 Les Paul. The reference OHY009010, and that is
9 a document setting out Les Paul's police service record.
10 So, chair, before I turn to one final matter I wish
11 to address, may I seek your agreement to those
12 documents, sections of statements and statements being
13 uploaded?
14 THE CHAIR: Yes, indeed. These can all be published.
15 MS BROWN: Thank you, chair. Finally, chair, the inquiry
16 were grateful to receive during the course of this oral
17 hearing a statement from LA-H3, the mother of LA-A26,
18 the teenaged girl at Ivy House about whom you have
19 heard. I would like to conclude the evidence in the
20 Lambeth oral hearing by reading that statement to you.
21 Statement of LA-H3 (read)
22 MS BROWN: "I, LA-H3, will say as follows:
23 "I am the mother of LA-A26. LA-A26 has learning
24 difficulties and autism, which was diagnosed when she
25 was a young child. LA-A26 is my eldest child, and

1 before the events I describe in the statement, she was
2 always an affectionate child, although, because of her
3 additional needs, she was more demanding to care for,
4 particularly when I had younger children, who also
5 needed my care and attention.
6 "From about November 1984, LA-A26 went to Ivy House
7 in Croydon for regular, short-stay, respite placements,
8 to give me and her family a break from care. The last
9 of these respite placements was from 26 November to
10 2 December 1985. LA-A26 was then in her mid-teens.
11 "I make this statement to describe the complaint of
12 abuse at Ivy House that LA-A26 communicated to me
13 in December 1985, the responses to that complaint that
14 were made after I reported LA-A26's complaint to the
15 authorities and the impact that this has had on LA-A26
16 and our family.
17 "We are, and have always been, a very close family,
18 and LA-A26 is a much-loved daughter, niece, sister and
19 aunt. The things that happened to her at Ivy House and
20 the failure of the authorities to investigate and deal
21 with them properly were really devastating and painful
22 for us. I find it distressing to recall this even now.
23 It has taken me a while to face having to go through it
24 all again for this reason. I have tried to bury it for
25 years.

1 "When LA-A26 returned home from her short breaks at
2 Ivy, I remember that she was often not her usual self.
3 This was not just on the last occasion, but in the
4 months leading up to it. She used to come home angry
5 and distressed. I was initially not too concerned about
6 this. LA-A26 has significant communication difficulties
7 associated with her disabilities, and it can be
8 difficult for her to express herself. She gets a lot of
9 frustration. She can also be highly resistant to
10 change. I thought that she was maybe upset with one of
11 the other children she had met at respite or maybe she
12 didn't like a particular staff member. I never dreamed
13 abuse could be the reason for the change in her
14 behaviour.
15 "I remember attending a coffee morning at Ivy House
16 with other members from my then Contact a Family group.
17 I recall a member of staff showed me the bedroom LA-A26
18 used when at Ivy House. Afterwards, I told LA-A26 that
19 I had been to Ivy and seen her room. It was this that
20 prompted LA-A26 to disclose that she had been abused at
21 Ivy House. She became very distressed, waving her hands
22 with clear indication of fear, saying, 'No Ivy House, no
23 Ivy House' to me several times. She was very distraught
24 at that particular time. I could see the fear in her
25 eyes and of course I was very concerned and shocked by

1 her reaction when I mentioned my visit to Ivy House.
2 "I managed to calm LA-A26 down with much difficulty
3 saying over and over to reassure her, 'No more
4 Ivy House'. After being reassured that she would never
5 go back there, LA-A26 then managed to communicate what
6 was wrong. She told me, using the words which we and
7 our family use for private parts, that she had been
8 sexually abused at Ivy House. She indicated that the
9 perpetrator was a particular male member of staff at
10 Ivy House. She could tell us the person's name clearly.
11 She told us exactly what happened and where. Touching
12 her vagina, then her mouth, she indicated that a sexual
13 act had been performed on her. She also told me that
14 the man had put his penis in her mouth. LA-A26 said,
15 "Suck it, suck it, in the mouth, in the mouth",
16 indicating what he had required her to do.
17 "She indicated that this had happened in the
18 bathroom at Ivy House.
19 "I should add that, although this was very upsetting
20 for me to contemplate, it was quite clear to me that
21 LA-A26 had been sexually abused. There was no doubt in
22 my mind. She was repeating what had been done to her.
23 "LA-A26 has very limited imagination associated with
24 her disability and does not know how to lie. She would
25 not have the capacity to make up something of this

1 nature. Her distress at what she was telling me was
2 very evident and real. She was very distraught and
3 anxious, physically showing her agitation, waving her
4 arms and hands around, hands going everywhere. I had
5 never seen her in such a state as this.
6 "I thought, 'Oh, my God, we need to contact
7 Social Services'. I telephoned the social worker who
8 had been involved in arranging respite for LA-A26,
9 Anne Worthington. A social worker came to our house.
10 I think this might also have been Anne Worthington but
11 cannot remember for definite now who it was. In any
12 event, I told them what LA-A26 had said and said that
13 I suspected that LA-A26 had been abused at Ivy House.
14 "I remember the social worker then asking lots of
15 questions about male family members and friends LA-A26
16 had contact with and about LA-A26's relationship with my
17 husband, her stepfather. I remember this quite clearly.
18 She questioned us in such a way that it felt like we
19 were under interrogation.
20 "I said the only male in our family of the same name
21 as the person LA-A26 had identified was my
22 brother-in-law, my sister's husband. He did not live
23 near us, they did not come to the house. LA-A26 had
24 never been left on her own with him. As I have
25 indicated, LA-A26 can be quite difficult to care for as

1 she has significant additional needs. The wider family
2 are very fond of LA-A26, but I wouldn't ask them to look
3 after her. As for my husband, he had a completely
4 different name which could not be confused with the name
5 LA-A26 had mentioned and, anyway, LA-A26 did not call
6 him by his Christian name, she called him 'Daddy'. It
7 was not possible that LA-A26 could have been abused by
8 a family member and, in any event, that was not what
9 LA-A26 was saying. She was saying it had happened at
10 Ivy House.
11 "I said to the social worker, 'Why are you asking me
12 all these questions?' I did not feel that the social
13 worker was taking seriously LA-A26's complaint that she
14 had been abused by a member of staff at respite. I felt
15 they were trying to shift the blame.
16 "I also reported LA-A26's disclosure to the police.
17 LA-A26 was taken to be examined by the police. The
18 examination was very difficult, and ultimately
19 inconclusive, as LA-A26 was not alleging that there had
20 been any penetration involved. I also recall that
21 LA-A26 was interviewed with the assistance of some
22 anatomical dolls. I was present during that interview,
23 and I believe the interview was recorded. I believe
24 that this was with a lady called Anne Bannister. LA-A26
25 clearly took the male doll's penis and kept putting it

1 in the female doll's mouth, repeating the word several
2 times, "Suck it". She repeatedly did this for a while
3 and I remember she bent her head and said "Sick on the
4 floor". After a while doing this with the male doll,
5 LA-A26 then picked up the undressed female doll and put
6 the doll's vagina in the male doll's mouth. She
7 repeated the family word we used for vagina and 'in the
8 mouth'. She kept repeating this. I do not remember, at
9 this distance of time, much about the enquiries that
10 were carried out by Lambeth Council. I do remember that
11 the outcome of the first investigation, the management
12 investigation that I see from documentation concluded on
13 10 December 1985, was negative. I remember being
14 informed of the conclusion of the first investigation by
15 a social worker.
16 "I was very concerned at the outcome and felt
17 strongly that the matter had not been investigated
18 properly. I felt that we, as a family, were not taken
19 seriously and Lambeth would rather save the reputation
20 of the man involved and cover up what happened to my
21 daughter than conduct a full investigation into such
22 a serious matter. I felt at the time, and still do,
23 that due to LA-A26's mental disability, the matter was
24 brushed under the carpet.
25 "I have seen recorded in a report by the Director of

1 Lambeth Social Services to the Social Services Committee
2 that I was dissatisfied with these findings. That was
3 a total understatement. I was mad at the outcome.
4 I was very, very upset.
5 "As I have said, I felt that LA-A26's case had been
6 swept under the carpet and not taken seriously at all.
7 I thought about that with my husband. We wondered if
8 this was due to LA-A26's circumstances. Maybe, if
9 LA-A26 was not a black child, it would have been taken
10 more seriously, or maybe because we were a working-class
11 family that they felt they could ignore us. We wondered
12 if LA-A26's allegation had been dismissed because of her
13 disability.
14 "Whatever the reason, it was not right at all.
15 I was put in touch with a solicitor, Kay, from the
16 Children's Legal Centre. I was desperate for LA-A26's
17 case to be investigated properly. I had relied on the
18 council and the police to do this and it wasn't done and
19 I was really desperate.
20 "I wanted justice. Not just for LA-A26, but for the
21 other children at Ivy House, some of whom were
22 non-verbal and would not have been able to complain that
23 someone had abused them. It was greatly of concern to
24 me that the man identified by LA-A26 had been allowed to
25 return to work.

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1 "I recall that LA-A26's solicitor approached
2 Councillor Janet Boateng, who was then the chair of
3 the Social Services Committee. I note that the
4 correspondence from Kay at the children's legal Centre
5 dated 27 February 1986 indicates that Kay at least had
6 a meeting with Ms Boateng on 24 January 1986. Kay told
7 me that she had had a meeting with Janet Boateng. Kay
8 was concerned about how the first investigation was
9 handled and will have told Mrs Boateng this.
10 "I wanted my voice to be heard and to be believed
11 that my daughter had been sexually abused. I approached
12 the South London Press, The Voice, and another local
13 newspaper. I wanted the general public to be aware how
14 Lambeth Social Services had covered up what had
15 happened.
16 "After we had pressed for action, it was agreed that
17 a further investigation should be carried out by
18 Lambeth. I remember Lambeth taking a long time to set
19 up the second inquiry and my husband and I were very
20 upset at the delay. Anne Bannister's report also
21 highlighted that LA-A26's school had issues with her
22 behaviour for some months before the disclosure of
23 the abuse, and this was reported in LA-A26's school
24 reports at the end of September 1985, although at the
25 time they did not understand why this was.

1 "This panel eventually found that there were
2 sufficient grounds to justify a charge of gross
3 misconduct being brought against the officer who had
4 been named. I am not sure whether or not I received
5 a letter about this. I can't remember much about this
6 now. The outcome has been subsumed into my recollection
7 of the ultimate negative outcome. We did not get to see
8 either the report of the second management investigation
9 or the report of the disciplinary panel. We were left
10 feeling that we did not have a proper hearing or
11 response from the authorities, in particular
12 Lambeth Council to LA-A26's very serious allegation, and
13 the organisations who were supposed to protect her had
14 let LA-A26 down.
15 "I have no recollection of any special panel being
16 set up by Lambeth following LA-A26's case to review the
17 arrangements in Lambeth Social Services Directorate for
18 investigating allegations of child sexual abuse. I was
19 not invited to take part in any such special panel.
20 "The abuse impacted on the opportunities she had.
21 After what happened at Ivy House, she never went to
22 respite care again for many, many years. She used to
23 say, 'No Ivy House, no Ivy House'. I would say, 'It's
24 all right, LA-A26. You don't have to go'."
25 "We have all had to live with the consequences of

1 what happened. LA-A26 became very distant and is not
2 the loving, trusting young person she had been before.
3 I believe that she suffered lasting trauma and that
4 there are still times that this affects her, even now.
5 "I believe the contents of this statement to be
6 true."
7 Chair, may I suggest that we now move on to the core
8 participant closing submissions. While each team have
9 a limit of ten minutes per core participant, they also
10 have the opportunity to make further written submissions
11 to the inquiry, and we have asked that any further
12 written submissions are provided by 21 October 2020.
13 Thank you.
14 THE CHAIR: Thank you, Ms Brown. Yes, we will now hear the
15 closing statements from core participants, beginning
16 with Ms Johnson.
17 Closing statement by MS JOHNSON
18 MS JOHNSON: Thank you, chair and panel members, and good
19 afternoon, everybody. There can be no doubt that there
20 was widespread abuse of children in the care of Lambeth
21 over decades by multiple perpetrators -- male, sometimes
22 female and sometimes other children. At times, it was
23 co-ordinated and well organised. Their abusive
24 treatment started as soon as they entered care, and the
25 abuse continued. And their abusers became virtually

1 untouchable.
2 The damage done to core participants, all of them,
3 but of course I address the ones that we represent, has
4 been long-lasting and extensive because it has affected
5 them and also their families and their relationships.
6 We say, too, that there was a clear case to answer
7 for criminal neglect, that is, the manslaughter that led
8 to LA-B2's death, and we say that there should be an
9 investigation now into what happened to her.
10 Why did all of these things happen? Time doesn't
11 allow me to comment on each individual, so my remarks
12 are necessarily general, but made very much with all of
13 the core participants we represent in mind.
14 We appreciate that the failures in corporate
15 parenting may be societal -- that is a reflection of
16 the status of the "have-nots" in our society. Plainly,
17 they were out of sight and out of mind. There were
18 complexities, as far as the political structures were
19 concerned, as far as financial difficulties, the role of
20 unions too. But there was also a lack of clarity about
21 responsibilities and about the chain of command, and
22 there was, certainly in the '70s and '80s and to some
23 extent the '90s, with some exceptions, a lack of any
24 real interest by those in power and oversight over
25 children's services into their welfare, and there has

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also been, you have heard, some very poor social work, again with some exceptions.

Whilst there has been an apparent willingness to admit to failures and to take credit for proposed remedial action and for policies which were supposed to protect children, these were not implemented. Too often, after an inspection or an inquiry, senior people moved on and little or nothing was done and there have been many, many missed opportunities.

The attitude to the children in Lambeth was characterised by a failure of imagination and empathy. You do not need to know about paedophilia and grooming as concepts to consider that children are, or may be, at risk.

The Sexual Offences Act of 1956 contained a variety of offences against children and had been in operation for a deal of time. If anyone had cared to listen properly to these children at the time, for example, LA-A7, among many others, who complained to staff and the police about people like Leslie Paul, whose prolific abuse included photographing and filming children, he could have been stopped from abusing many more. At the time he started work at Southvale Children's Home at the beginning of September 1979, section 1 of the Protection of Children Act 1978 which prohibited the taking of

indecent photographs of children, had been in force for over a year and should have been fresh in the minds of those whose duty it was to look after children and protect them, in this case, the local authority and the Metropolitan Police.

We appreciate that there were many difficulties in Lambeth as a working environment, but those who have attended this inquiry at social work or in senior level and have said, by way of explanation, or excuse, that they were not aware of such risks, insult those who suffered forms of abuse that were recognised by the law and punishable by sentences of imprisonment.

Michael Carroll. It is clear that he was able to perpetrate abuse for several reasons. Lambeth had no proper system in place for verifying declarations about the lack of any relevant previous convictions, and so, of course, it didn't uncover his deception. This was left to another local authority. And even after this was discovered, in April 1986, it failed to take appropriate action at his disciplinary hearing, and, shockingly, certain people at Lambeth continued to support his application to foster.

It is plain, we say, that those at senior level were either unable or unwilling to appreciate the significance of his offending. They did not take even

rudimentary steps to safeguard and check the children with whom he was in contact. Instead, it appears that a "clubby" approach to the investigation and disciplinary process was taken, a "We are all in this together"; no independent advice was sought, as you have heard this morning, and no scrutiny took place, and so the result was a foregone conclusion.

As well as demonstrating a lack of imagination, poor judgment and a somewhat arrogant attitude, this was no less than a shocking dereliction of duty. We know now that the result was that Carroll was not dismissed for another five years, until the end of August 1991.

We say that, while there have been some welcome changes in institutional approaches, more change is needed, and we need to look to the future about what that should be. We represent 28 core participants, and they will need some time to reflect further on the evidence they have heard over the last month, but some preliminary points: we say that the evidence before this inquiry has shown that children who have suffered sexual abuse and who have been in care are disadvantaged at all stages. When they are on the cusp of going into care, so, for example, when informal arrangements have been made with private people, not local authority foster carers and no care order, so that there has been a lack

of monitoring and social work visits; in care, and the inquiry has raised the provision of section 9(1) of the Children Act; we will also say there has been, on occasion, a lack of rigour by independent reviewing officers whose duty it is to oversee and scrutinise the care plans of children in care, and to ensure that everyone involved in a child's life fulfils his or her responsibilities.

They are also disadvantaged on leaving care. The inquiry has heard that there have been, on many occasions, insufficient arrangements to support children, and many have been left to fend for themselves, to cope -- badly, often -- and turning to substance misuse, and some are, of course, mentally ill.

Given the difficulties that many have had with disclosing their abuse, some, particularly those with complex difficulties, who may well fall outside the Lambeth Redress Scheme, because, for example, they have a high-value loss of earnings claim or because the loss of an education is difficult to quantify under the category of lost opportunity, their only hope of justice may be via the civil justice system or the criminal justice system.

The criminal justice system is very different to what it once was, and there have been many improvements.

Much has been done to change the environment in which children give evidence, and the multi-disciplinary and child-centred approach pioneered by The Lighthouse is very welcome. But we must not forget that for adult survivors there continue to be very real difficulties. The system suffers from underfunding, and the CPS statistics published just yesterday on rape prosecutions do not give cause for optimism that the criminal justice system alone is a sufficient safety net.

In civil claims, claimants face the hurdle of the Limitation Act 1990 and the hurdle in any negligence claim of proving that the duty of care exists. Often, we say, this causes very real difficulties.

Those we represent want local authorities to be held to account and, in due course, written submissions will be prepared which will consider the possibility of changes in the law and the current regulatory provisions.

As far as regulation is concerned, there is no overarching local authority regulator that can impose financial sanctions on local authorities. We have the local government and social care ombudsman that can make recommendations but cannot impose remedies.

Social Work England regulates individual social workers, and they are independent, but people working in

children's homes who are not social workers remain unregulated.

Councillor Edward Davie told you that elected councillors have available to them, but are not required, to undertake training on children's safeguarding and corporate parenting. They should be.

So there is plainly inconsistency in this country regarding protection and regulation, and there is also inconsistency regarding the duty to report child abuse, which we say needs to be revisited. There is a difference between England and Wales as to the duty to report.

In contrast to this, in both England and Wales there is an obligation to report on female genital mutilation, on regulated health and social care professionals. Does this really make sense? So there remain gaps in the system and we say children continue to be at risk.

These survivors have had enough of hearing about lessons being learned, and, beyond the redress scheme, they need to see real changes being brought about, which will offer other children the protection and the redress that they never had. Thank you, chair.

THE CHAIR: Thank you, Ms Johnson. Mr O'Donnell?

Closing statement by MR O'DONNELL

MR O'DONNELL: Chair, thank you very much. Chair and

members of the panel, as you know, I act in this investigation for the seven Verisona law and Remedy Law survivors. Now, given the volume of evidence you have heard over the last month, there are many issues my CP survivors wish me to address in closing, but these can't be examined properly in these ten minutes so will be dealt with in written closing.

Picking up from where Ms Nice left off with the gist table, I'm instructed to briefly remind the panel of my survivors' stories.

LA-A115 was taken into Lambeth's care in 1966 when he was 2 years old. He was sexually abused in Lambeth's nursery school. His genitals were fondled whenever he was lifted up into a high chair and he was awoken with a hand over his mouth when he was sexually abused in his bed at the nursery. Employees fondled him during bath time. Later in his childhood, one of his Lambeth house mothers tied a bow around his penis and made him walk around naked and staff members laughed at him. He suffered sexual abuse from other child residents. He started having fits and soon began displaying sexualised behaviour. He was anxious and terrified for most of his childhood and he took drugs, as an adult, to block the intrusive memories of the abuse.

LA-A103 was taken into Lambeth's care in the late

1970s and was placed in Shirley Oaks when she was 5 years old. She was separated from her siblings without explanation on arrival. LA-A103 and her brother were introduced to their foster father, LA-F109, at Shirley Oaks. Her little brother kicked F109 in the shin when they met him. F109 responded by hitting him so hard he knocked him to the ground. A Lambeth social worker who had made the introduction did nothing.

F109 then abused A103 and her siblings from the moment they were transferred into his foster care. He beat them daily, held them by the ankles over his dog for it to bite them. And on one occasion, he called A103 a "dirty whore" and pushed his fingers into her vagina.

After years of abuse, A103's sister took a visiting social worker into a separate room and told her what F109 was doing to them all on a daily basis. Incredibly, that social worker came straight back into the front room and told F109 what she'd said and told him not to worry because kids like this make this sort of stuff up. After she'd left, F109 beat A103's sister so hard that she thought he'd killed her and, despite this disclosure, and indeed repeated school complaints about F109, Lambeth permitted him to adopt A103 and her siblings in the late 1980s. Their lives were destroyed

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1 as a result of the abuse they suffered.
2 LA-A154, 155 and 156 are siblings. They and their
3 sister were all placed in Shirley Oaks in 1977. A154,
4 the oldest, remembers, with some horror, turning to her
5 siblings when they arrived and saying, "I think we are
6 going to like it here".
7 Then they were all separated without explanation and
8 deliberately kept apart thereafter. Indeed, when A155
9 ran away from his cottage to see his older sister at
10 hers, her house mother was so incensed that she grabbed
11 him and threw him across the room and then started to
12 hit him before dragging him away, when he was 8 years
13 old. He started bedwetting and having panic attacks
14 after that and lived in a state of constant terror
15 during his time at Shirley Oaks.
16 His younger sister, A156, was also constantly
17 terrified throughout her time at Shirley Oaks. She was
18 left outside in the cold for hours on end without
19 sufficient clothing, like many other children there. On
20 one such occasion, a man approached her in the fields at
21 Shirley Oaks. Without saying anything to her, he simply
22 took his penis out and then started to push his fingers
23 inside her. She had absolutely no idea who he was or
24 where he had come from.
25 Their other sister, whom they don't want to be

1 forgotten, died at a young age as a result of the abuse
2 she suffered in Lambeth's care. Again, the lives of
3 the siblings who survived were destroyed as a result of
4 the abuse they suffered in childhood.
5 LA-A456 was taken into care in 1977. Lambeth placed
6 her initially in Southvale Assessment Centre and again
7 she lived in complete terror from the moment she
8 arrived. Everyone called her a "stinking Paki". She
9 was sent to Shirley Oaks with two of her younger
10 brothers but, again, was kept separate from them. She
11 was put in a room with another girl, LA-B46, who took
12 her under her wing and gave her a real sense of security
13 at the start of her time there. Within days of her
14 arrival, A456 awoke in the dead of the night to hear
15 truly awful sounds coming from her roommate's bed. B46
16 was being raped by their house father LA-F322.
17 A456 was so terrified that she urinated herself.
18 The next morning, she took her wet bedsheets to be
19 cleaned and saw F322 sitting outside her room waiting
20 for her. She dropped the sheets and ran. F322 came
21 after her, shouting. She was so terrified that she wet
22 herself again and this time she also soiled herself. As
23 well as repeatedly raping her roommate, their house
24 father sexually assaulted A456 too. He made her strip
25 naked in the bathroom, grabbed her breasts and started

1 again to put his fingers inside her. He made appalling
2 racist comments as he abused her, saying her breasts
3 were not bad for a Paki. Then repeatedly force-fed her
4 bacon, knowing that her religion and background
5 prohibited it.
6 A456's life has been destroyed as a result.
7 Chair, you will appreciate the common themes appear
8 across our survivors' evidence as I have just described
9 it to you. Those with siblings all being separated on
10 arrival at Shirley Oaks, and all our survivors
11 describing living in a state of constant terror when in
12 Lambeth's care.
13 But one common theme on which I wish to address you
14 now is even more sinister. Four of our CPs recall being
15 given a biscuit with hot chocolate or warm milk before
16 bed at Shirley Oaks. A154 recalls looking forward to
17 this evening treat, as she thought of it, every day, but
18 she also remembers the difficulties she had waking up
19 each day and describes feeling, as she put it, wet and
20 loose in her vagina in the mornings, but never knowing
21 why. As an adult, she recognised this as the feeling
22 she had after sexual activity or an internal vaginal
23 examination. She believes, quite understandably, that
24 she was drugged and sexually abused night after night
25 whilst at Shirley Oaks, as a result.

1 A155 and 156 give similar accounts, as does A456.
2 A155 remembers feeling constantly groggy and struggling
3 to get out of bed each morning during his time there.
4 Despite the fact that he'd always been a habitual light
5 sleeper and early riser. A456 woke up each morning
6 after the warm milk and biscuit evenings feeling sick.
7 Sometimes she woke up sitting on the lavatory, sometimes
8 in her bed, sometimes she woke up with a pillow over her
9 face. Sometimes she woke with what she describes as
10 a brutal pain in her vagina. She believes she was
11 drugged and then raped repeatedly while she was at
12 Shirley Oaks as well.
13 Chair, my CPs have strong views about what must be
14 done to stop the abuse of children in care in the
15 future. A115, as is stated in the gist table, says that
16 children should regularly be taken out of homes and
17 given the opportunity to speak in a different
18 environment. A103 and A154 feel strongly that foster
19 carers need to be vetted more carefully and if abuse is
20 ever to be disclosed, social workers must establish
21 relationships with abused children that are stronger
22 than their relationships with the foster parents they're
23 supervising.
24 They also recommend that totally trustworthy people
25 have to ask children the correct questions because, as

1 A103 puts it, sometimes abused children simply can't say
2 the words. They simply can't speak of being sexually
3 assaulted, but they may be able to nod or shake their
4 head when in a completely safe environment.
5 A155 recommends more spot checks on foster carers
6 and again reiterates the need to talk with children away
7 from their carers. A456 is more direct. She says
8 bluntly you should recommend a mandatory reporting law
9 be enacted across the board. Her view is that if there
10 had been a legal obligation to report suspected abuse,
11 with the threat of prosecution for those who don't
12 report, as I have addressed you on before, chair, she
13 and runs hundreds of other children in Lambeth's care
14 may not have been sexually abused as they were.
15 Chair, I've already addressed you in opening on
16 LA-A61's evidence, my last core participant, and the
17 panel heard from her in evidence on Wednesday, so all
18 I'll say about her case now is that the coverups and
19 repeated refusals to investigate her foster placement
20 took place in the modern era. So it is no good for
21 Lambeth to tell you today that it is terribly sorry for
22 the mistakes of the past and its practices have changed.
23 A61's case demonstrates corruption in Lambeth in the
24 late 1990s and suggests that unless you do all you can
25 to stamp it out, it may well continue.

1 To conclude, as Lord Laming put it in his evidence
2 on 27 July:
3 "Answer: ... an inquiry has got to be about
4 recognising something has gone wrong and how it can be
5 put right. It's not a walk in the park."
6 He is right. This isn't a walk in the park for
7 anyone involved. Quite the opposite. I have been
8 instructed to remind the panel that giving evidence to
9 the inquiry in statement form or in live testimony takes
10 a real toll on survivors. And those who are brave
11 enough to have done so want it to make a real difference
12 as a result. Chair, those are my submissions, thank
13 you.
14 THE CHAIR: Thank you, Mr O'Donnell. Mr Khan?
15 Closing statement by MR KHAN
16 MR KHAN: Good afternoon, chair, good afternoon, panel. My
17 comments are going to be necessarily brief, but I start
18 with reminding chair and panel of a UK Government guide
19 on the conduct of children's homes, authored 1952. It
20 set out what a home should be like, so that it provides
21 the best start in the life of a child. It talks of
22 a children's home as one that must supply affection and
23 interest in the child, it must provide care for his or
24 her future and, notably, it must create a homely
25 environment.

1 For example, each child should feel at bedtime that
2 he or she is especially wanted and cared for. Success
3 in the home is measured by whether staff are able to
4 take the place of parents and that a children's home
5 should attract and keep men and women of the highest
6 quality needed for this crucial work.
7 That, chair, is what our clients needed and wanted
8 at a minimum and what they were entitled to. It is
9 a touchstone by which Lambeth Council should be judged.
10 But before that assessment, we pay tribute to the
11 survivors that have given evidence and who have been
12 involved in this investigation, including our own
13 clients. The public did not see them, but we, of
14 course, did. They have been brave and dignified,
15 they've spoken without vengeance or ill will, as would
16 be entirely justified because of what happened to them.
17 They have spoken with clarity and generosity of spirit.
18 That is of enormous credit to them.
19 We also pay tribute to the Shirley Oaks Survivors
20 Association, Raymond Stevenson and Lucia Hinton for
21 supporting them and revealing all that we have heard in
22 the last few weeks. Without them, we wouldn't be here.
23 But what have we learned over the past four weeks of
24 oral evidence? Well, the image conjured of a life of
25 a child in the care of Lambeth Council has been nothing

1 less than a vision of hell, with experiences that they
2 could never have imagined. We have heard chilling
3 evidence that children were subject to insidious evil
4 acts to which no child should ever be subject.
5 We have heard evidence of disgraceful child
6 protection practice, that the police and council treated
7 allegations of abuse as pure fantasy; of sexual abuse
8 that continued to rage unchecked year after year for
9 decades, at epidemic levels. The problems were so
10 widespread and the torture of the abuse so heinous that
11 everyone will agree that it's been difficult at times to
12 comprehend.
13 From the perspective of all of the institutions,
14 black children were rendered secondary in the care
15 system, racism was rife, systemic, it was the
16 institution life and those who experienced it says it
17 was the norm. However, chair, the inquiry must be
18 candid. These matters are already well documented and
19 much of it is already in the public domain. Our concern
20 is that there is much, much more that is there and not
21 revealed.
22 The inquiry itself has not disclosed everything
23 relevant to its terms of reference and to the issues
24 that require ventilation, so the experience and
25 allegations of our clients in particular are

acknowledged, acknowledged in public. Chair, members of the panel, this is a public inquiry, and, as such, the public need to know everything that is relevant, however difficult or embarrassing it may be to any particular party or any particular individual.

We have also heard, chair, the litany of excuses time and time again from the institutions which at times have been astounding. They have tried to defend the indefensible. This attempt at exculpation cannot be better summed up than at paragraph 58 of the first statement of the former head of Lambeth Social Services, Robin Osmond, who, in the face of overwhelming evidence to the contrary, states this:

"Even with the benefit of hindsight, I think that the documents support the fact that we made every effort to act appropriately and immediately take steps to address any concerns that we may have made a mistake. I think that we did our best to strike a fair balance between investigating allegations raised by, or on behalf of, vulnerable children and ensuring a fair process to our employees that were accused of abuse."

Lambeth past and present have blamed the political machinations of the time or the lack of resources or of them being busy or argue that it was supposedly a different age. Each merits direct condemnation by the

inquiry in its report and we invite you to do that.

Not only did they fail, but they were quite outrageously rewarded for that failure. I remind you, chair, of the letter dated 22 February 1996. A reference was provided to David Pope who gave evidence this morning from the chief executive which reports him as a "highly respected Director of Social Services with a strong professional background" and who the chief executive had no hesitation in recommending. It goes on to say that the Social Services under his tenure stands out as a positive example.

Chair, members of the panel, this exposes those who worked there, or speak for Lambeth, as being in two camps: those who knew and turned a blind eye; or those who were actively complicit in child sexual abuse. The self-image of the council and police portrayed by its leaders in evidence as a beacon of diversity and protector of children, lighting the way for the rest of the world, is a demonstrable and egregious lie, it always has been, which this inquiry has sought to publicly expose.

Chair, it is not simply a matter of exposing wrongdoing. Other inquiries have done that. And those that were abused know so. So we ask, what makes this particular inquiry distinct from the panoply of

investigations that have come before it? How will it be remembered? As we have said, that which we have previously set out are realities that are recognised and thus may be straightforwardly determined. In our submission, this inquiry has to go further if it is to add value to the public's knowledge and understanding. It must interrogate and answer difficult and uncomfortable questions.

It must also do so to meet the level of expectation of children who were in the care of Lambeth Council. That is daunting, but it must be realised. If the inquiry fail to meet their expectations, it will have caused even more damage to those who have suffered already.

Annie Hudson, in her evidence, described the events that happened as an "enigma". This view is deeply problematic for our clients. To grasp the truth may be imperfect, but to shrug off the possibility of finding out what happened, to give up on at least seeking the full truth, is deeply nihilistic and it consequences are dire. If there is no truth, then there is no accountability. So the central question with which this inquiry must grapple is why this systemic level of sexual abuse happened, and the forces that caused it and why it wasn't stopped.

The answers are, of course, complex, interwoven and deep seated. Responsibility lies in more than one place, but that should not mean that findings are not made. You have heard evidence from witnesses about how the council and the police failed to tie matters together. They failed, in the vernacular, to join the dots. Individual cases were investigated as isolated examples. We urge the inquiry not to fall into the same trap and not to miss this opportunity.

So, chair, what is true? Lambeth Council told the inquiry that across the five case study homes there have been 213 alleged abusers and only eight convictions with the number of allegations of abuse standing at 634 separate children. The figures are, of course, higher and do not include those many homes not included as case studies.

Our principal submission from our clients is this, and we invite the inquiry to find this, that there was organised paedophile activity facilitated by the council and a paedophile ring that gained access so as to sexually abuse children. They used the council to access children whilst they, the abusers, remained untouchable. Those in authority knew of its activities. Nothing was done to protect the children. Legions of sexual abusers inveigled their way into the council.

This was not, in any sense, a case of a few rotten apples. It occurred in plain sight and abusers acted with impunity. It was made easy, by the council's process, to carry out rape, child molestation and sexual abuse. It should never have started. It was not stopped.

Lambeth Council say that there is no specific evidence to support this finding. We respectfully disagree. We say that there is evidence and that it shows that it is the only analysis that can reasonably be made. We ask rhetorically: is there any other rational explanation? Was it just a matter of accident or coincidence? Hardly. I paraphrase Ms Kenward in her evidence when she stated this, that Lambeth Council was "ripe for anyone to move in and manipulate it". It was ripe, not because of incompetence or political infighting or lack of resources, but because it had been made a welcome haven for those who wanted to abuse children, and they did, in vast numbers.

Our clients welcome Lambeth Council's examination of their conscience and acceptance of their negligence to all -- I emphasise all -- those whom they were required to protect and care for. What's disturbing, though, is this is not manifested in its conduct, even today. Despite their obsequious statements and profuse

apologies, Lambeth Council still don't accept true responsibility. If it did, applicants would not be fighting to get appropriate compensation in the redress scheme, let alone trying to get into it. If Lambeth Council is truly sorry for what happened and ask our clients to accept that their apologies are genuine, we ask that they -- that is, Lambeth Council -- through their advocate today, who is due to give a closing submission, commit to ensuring that all the children that they failed be appropriately compensated. If that means changing the terms of the present redress scheme, then so be it, or if it means accepting liability outside of it, then so be it.

Children such as those in The Melting Pot need redress. Our client LA-A449 who was sexually abused outside the four walls of a children's home needs redress. Lambeth Council has a responsibility and the means to give that redress.

Lambeth also needs to reconsider its approach to not appropriately compensating those who experienced racism whilst in their care. We look forward anxiously to hearing from Lambeth's advocate today. Because, unfortunately, despite the apologies, there remains a significant gap in trust between our clients and the council.

Put simply, chair, our clients do not trust a word of what Lambeth is saying. They cite by way of example correspondence between SOSA and the chief executive of Lambeth Council Mr Andrew Travers on 25 June of this year, just a few weeks ago. In it, Mr Travers stated that the claim that Lambeth Council asked police for any criminal records of some of the survivors was completely untrue. Outrageously, in that letter they even reserved the right to take action for defamation against SOSA.

In actual fact, chair, in actual fact, it was not a lie, because the police told SOSA:

"Enquiries by our most experienced disclosure officer have found one request in 2017 where Lambeth had asked for checks to be made on five victims. These checks were conducted and an answer was supplied. Thankfully, no details of any convictions were found."

Regrettably, chair, Lambeth Council was not the only institution which failed abused children. Police officers, entrusted to serve and protect, failed miserably to do so. They refused to believe children. They refused to investigate their complaints. When they did, they did not listen. The sheer disparity between the number of allegations and abusers as against the rate of conviction is staggering and the level of its scale. Many children who attempted to escape were

returned to unsafe institutions by the people who were meant to protect them, the police. In a word, the police turned their back on children. This is a grave miscarriage of justice. Our clients now trust in the same vein that the Metropolitan Police will, through their advocate today, commit to urgently providing the restitution to those children that they so badly let down.

Chair, members of the panel, true atonement -- true atonement -- involves a serious consideration of historical responsibility, rather than, as we have seen throughout these proceedings, or are likely to see from the advocates of the institutions today, a simply mere admission of guilt. That is not enough. Both Lambeth Council and the police need to truly atone. Thus far, chair, members of the panel, they have not done so. Thank you.

THE CHAIR: Thank you, Mr Khan. Mr Johnson?

Closing statement by MR JOHNSON

MR JOHNSON: Thank you, chair. I would like to summarise in a few words the conclusions that I believe should emerge from this inquiry. The failure to protect children in the care of Lambeth was the responsibility of a number of statutory agencies, primarily social workers. Individual cases, such as John Carroll and LA-A23,

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1 illustrate the extent of Lambeth's failure, but these
2 are just two examples of appalling practice across
3 a number of decades.
4 At times, the evidence from both management and
5 social workers on the ground indicated that they still
6 do not accept the extent of their failure. In
7 particular, the refrain, "I have no clear memory of that
8 matter" is not convincing.
9 Helen Kenward stated in her evidence that when she
10 began Operation CHILE in 1998, she encountered a culture
11 where social workers were prepared to hide or withhold
12 files from her investigation. This was nearly seven
13 years after the introduction of the Children Act 1989
14 and four years after the closure of Lambeth Children's
15 Homes. This was a culture that was deeply engrained.
16 Witnesses from the police have now admitted that
17 Operation Bell and Operation Middleton were inadequate
18 for the task at hand, which meant that abusers escaped
19 conviction. The political turmoil in Lambeth, which can
20 only be described as a self-serving exercise in vanity,
21 meant that Lambeth's councillors collectively failed
22 their children. Again, whilst some councillors have
23 made fulsome apologies, the overwhelming impression is
24 that they were powerless to do anything about the abuse.
25 Others, who were in office at the time of the abuse,

1 have still not come to terms with the consequences of
2 their failure.
3 There is clear evidence that both councillors and
4 Social Services repeatedly ignored their own recourse.
5 We now know that the commissioning of reports was
6 nothing more than a cynical exercise in window dressing.
7 Madam chair, I would now like to make a number of
8 submissions on the need for changes in the law that
9 emerge from this inquiry. First of all, the government
10 should introduce the concept of mandatory reporting. My
11 colleague, Richard Scorer of Slater & Gordon, will be
12 addressing the panel on the issue of mandatory
13 reporting. I endorse his submissions.
14 Secondly, the panel has specifically asked for
15 submissions on the issue of section 9 of
16 the Children Act 1989. I will be addressing this issue
17 in more detail in my written submissions, but I would
18 like to summarise how section 9 impacts on the voice of
19 the child in care. Section 9 says no court shall make
20 any section 8 order other than a child arrangement order
21 to which subsection 6(b) applies with respect to a child
22 who is in the care of a local authority. A section
23 order is a child arrangements order, which means
24 ordering where and when the child lives or with whom
25 they have contact. A prohibitive steps order, to the

1 effect that no step which could be taken by a parent in
2 meeting his parental responsibility for a child shall be
3 taken by any person without the consent of the court.
4 A specific issue order, which means an order giving
5 directions for the purpose of determining a specific
6 question.
7 So a child can apply for a child arrangements order
8 under section 8, even though it is in local authority
9 care. However, that child is still prohibited from
10 applying for a prohibitive steps order or a specific
11 issue order. In those circumstances, the child is not
12 completely without remedies. It can apply to discharge
13 its care order or appeal against it, apply for judicial
14 review of a prohibitive steps or specific issue order,
15 apply to its independent reviewing officer or an
16 advocate using the Children Act 1989 complaints
17 procedure.
18 The inquiry is concerned with restrictions on the
19 rights of children in local authority care, and what
20 I would submit is that the remedies above are not
21 practical or effective. Discharging a care order is
22 a nuclear option. Judicial review is a far more
23 difficult remedy than an application under the
24 Children Act 1989 and it can be nearly impossible to
25 obtain Legal Aid for such an action. The approach to an

1 independent reviewing officer might fail if the
2 independent reviewing officer is not sufficiently
3 energetic and the local authority can simply refuse any
4 request.
5 Finally, the complaints procedure under the
6 Children Act 1989 is very slow and ultimately legally
7 unenforceable even by the ombudsman.
8 The following are examples of the problems that
9 children in local authority care commonly face where
10 section 9 is an added impediment to their voice.
11 Children wanting contact with siblings. We heard in the
12 inquiry how children were separated from sisters and
13 brothers, often not seeing them for years. Children
14 wishing to go on holiday. Children wishing to change
15 names because of intrafamilial abuse. An application to
16 change one's name does not qualify for Legal Aid under
17 the present Legal Aid rules. It might, however, qualify
18 if an application could be brought under the
19 Children Act 1989.
20 Most seriously, children in care homes where there
21 is an element of detention. At any given time, almost
22 1,500 children are "locked up" in secure children's
23 homes, secure training centres, young offenders'
24 institutions, mental health wards and other residential
25 placements, either for their own safety or the safety of

1 others. For some of these children, there are clear
2 rules setting out the legal basis for their deprivation
3 of liberty. For instance, the Secure Accommodation
4 Regulations. However, in other residential settings, it
5 is unclear what the legal basis is for the deprivation
6 of a child's liberty.
7 If a child in local authority care wishes to
8 challenge that kind of detention, they cannot do so
9 under the Children Act 1989. This is a particular
10 problem where a court making a care order states that
11 a child is to be placed in a residential setting, but
12 does not specify the nature of that setting.
13 Chair, that completes my submissions.
14 THE CHAIR: Thank you very much, Mr Johnson. We will now
15 take the lunch break and return at 1.40 pm. Thank you.
16 (12.40 pm)
17 (The short adjournment)
18 (1.40 pm)
19 THE CHAIR: Good afternoon, everyone. We will continue with
20 closing statements with Mr Collins.
21 Closing statement by MR COLLINS
22 MR COLLINS: Good afternoon, chair. Good afternoon, panel.
23 Listening to the evidence fills one with a sense of
24 horror and feelings of disgust. How is it, in one of,
25 if not the most, advanced capital cities in the world we

1 should have, at the close of the 20th century and in the
2 first decades of the 21st, such disadvantaged and
3 vulnerable children? How is it that the state failed
4 them by leaving them in the care of those whose
5 professionalism was found so tragically wanting.
6 These are two very troubling questions and we can
7 perhaps all be forgiven, when trying to understand the
8 evidence, for having a sense sometimes that we underwent
9 a surreal experience.
10 The evidence from those at the sharp end, the
11 victims, gave their evidence in an often stoic, if I may
12 say so, if not a very sort of matter-of-fact manner,
13 which made it so powerful. Whereas, in contrast, that
14 of those who enjoyed positions of considerable authority
15 appear to have inhabited an entirely different Lambeth.
16 The evidence would suggest, superficially, that
17 there were two Lambeths -- the one experienced by
18 vulnerable children and young people, supposedly in the
19 care of the council, where they were treated very much
20 as second-class citizens and fell prey to the perversion
21 of sex offenders who enjoyed the freedom of a Kafkaesque
22 world that was Lambeth. The second, where politics was
23 the be all and end all, where child abuse was simply an
24 unfortunate happenstance.
25 But, of course, there was only one Lambeth, and the

1 inescapable conclusion is that those charged with the
2 good running of its services and the care and protection
3 of the most vulnerable in society failed lamentably in
4 the performance of their duties.
5 The fault lies with them, and them alone. Following
6 the evidence leads to the realisation that the needs of
7 children in care were eclipsed by a culture that
8 regarded them as secondary to other priorities and
9 aspirations. We see this time and time again when
10 allegations emerge or risks to children are identified,
11 being met with an ineffectual response, if there was
12 one, by Lambeth.
13 This self-induced incapacity to act effectively is
14 attributable to a lack of training of staff, poor
15 recruitment and a lack of intellectual curiosity and
16 rigour on the part of senior officers, and, critically,
17 an absence of objective leadership.
18 At no stage was it ever said, "Enough is enough".
19 Instead, we have a series of reports generated in
20 a culture where accountability was an abstract concept,
21 and where those with positions of responsibility were
22 able, unlike the children in Lambeth's care, to move on;
23 somewhat like a cat crossing a muddy street with its
24 paws unsullied.
25 All of this matters, and it is not simply to

1 acknowledge what occurred, but to ensure history does
2 not repeat itself. The Lambeth story is a parable for
3 our times because accountability remains a very live
4 issue. This inquiry, we believe, will ask the profound
5 question: what are the rights of children in care? We
6 go further and say, "What are the rights of all
7 vulnerable children that look to the state for care or
8 protection?" In the absence of enforceable rights,
9 there can be no accountability, and if there is no
10 accountability, the risk is that history, tragically, is
11 capable of repeating itself. We welcome the opportunity
12 to be able to expand on this in the written submissions.
13 So thank you, chair, thank you, panel.
14 THE CHAIR: Thank you, Mr Collins. Mr Scorer?
15 Closing statement by MR SCORER
16 MR SCORER: Good afternoon. Chair, as you know, we
17 represent LA-A25, who was seriously sexually abused by
18 Donald Hosegood in the early 1970s. You heard her very
19 moving evidence, and you will recall that when she tried
20 to tell a court in 1975 about her abuse by Mr Hosegood,
21 she remembers being laughed at and, indeed, throughout
22 the whole process and afterwards, she was completely
23 unsupported.
24 The scars of that experience have remained with her
25 for many decades, so she approached this inquiry with

1 trepidation, but the opportunity to tell her story has
2 been a real vindication for her.
3 However, it is also true that the evidence of many
4 of the witnesses who have been called at this inquiry
5 has caused her real concern. We endorse the comments
6 that have been made by others today about the appalling
7 litany of failure and coverup over many decades at
8 Lambeth.
9 Our client hoped to see real evidence in this
10 inquiry of lessons being learned by police, prosecuting
11 authorities and by Lambeth Council, and clearly some
12 positive change has occurred, but serious issues remain.
13 Regarding the police, after four weeks of evidence
14 and several police witnesses, and after the disclosure
15 of many thousands of pages of documents, we are still
16 basically in the dark as to why exactly the further
17 investigation and prosecution of Donald Hosegood by
18 Operation Middleton was simply abandoned. There has
19 been a suggestion that Lambeth Council incorrectly told
20 the police that Donald Hosegood was dead, but
21 Commander Gargini apparently has no recollection of
22 this, and seemingly nobody has been able to discover the
23 truth of the matter.
24 Clearly, however, if somebody did tell the police
25 that Hosegood was dead, then that information could have

1 been checked, and should have been checked. Similarly,
2 the indictment from the 1970s could, and should, have
3 been obtained and any decision about whether to
4 prosecute Hosegood for further offences should only have
5 been made after all of these very basic avenues of
6 enquiry had been properly followed through. That's what
7 you would have expected from a reasonably competent
8 police service.
9 However, after hearing the evidence, we still have
10 no proper explanation as to why that didn't happen, and,
11 chair, it is unacceptable that a police service in the
12 21st century can embark on an investigation into
13 a serial sex abuser and simply be unable to account for
14 what happened to that investigation and why it was
15 discontinued.
16 Chair, it seems to us that this is one of many
17 reasons why your report needs to address the issue of
18 record keeping. We recall that this issue was raised in
19 the Nottingham investigation as well, and we urge you,
20 particularly in your final report next year, to address
21 comprehensively the issue of record keeping by agencies
22 such as police, CPS and Social Services.
23 It is completely unacceptable to have a situation
24 where the record keeping or the record retention is so
25 poor that the Metropolitan Police Service, for example,

1 cannot really explain why they took particular decisions
2 in relation to particular investigations of sex
3 offenders.
4 Chair, as you are aware, the issue of record keeping
5 was also raised with Mr McGill from the CPS. He was
6 asked whether he was concerned about the fact that many
7 records relating to investigations into sexual offences
8 are only retained for three to five years, depending on
9 the severity of the offence. He seemed reluctant to
10 express a view on this, although we understand that he's
11 going to come back to the inquiry on it.
12 Chair, many of us in this hearing work on cases
13 involving non-recent sexual offences. We know from
14 experience over many cases that one victim's allegations
15 are often not initially corroborated by other victims,
16 and only later on does other supporting evidence come to
17 light. It is self-evident that in non-recent abuse
18 cases the failure to retain records may have
19 a detrimental effect on future investigations. If
20 documentary evidence relating to police investigations
21 or prosecution decisions five or ten or 20 years
22 previously is destroyed, it will invariably have
23 a detrimental effect on the ability of the court to know
24 what was said previously and, as a result, a detrimental
25 effect on the ability of the court to do justice. This

1 needs to be addressed, particularly given the risk of
2 abuse of process applications by criminal defendants if
3 relevant documents are destroyed.
4 We have other concerns about Mr McGill's evidence.
5 At the beginning of this hearing, Ms Langdale rightly
6 emphasised that, although considerable improvement has
7 occurred in the prosecution of sexual offences over the
8 past 30 years, there is no room for complacency.
9 However, I'm afraid that complacency was what we got
10 from Mr McGill, in our view.
11 He was very keen to highlight that Her Majesty's
12 Crown Prosecution Service Inspectorate had concluded
13 that, over the past four years, the CPS has improved in
14 terms of its compliance with the Code Test. However, he
15 knows very well that the wider picture is that rape
16 prosecutions and convictions have been falling
17 significantly year on year, despite increasing numbers
18 of complaints and, indeed, the CPS admitted this much
19 publicly yesterday.
20 Chair, as you may be aware, Harriet Wistrich from
21 the Centre for Women's Justice has written to you
22 specifically about Mr McGill's evidence in this hearing,
23 and her concern that his evidence simply doesn't reflect
24 the current reality of prosecution of sexual offences.
25 We will refer at greater length to her comments in our

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1 closing written submissions. But, as she points out,
2 the truth is that the numbers of successful rape
3 prosecutions have fallen dramatically over the past
4 three years, and, indeed, the particular target
5 framework used by the CPS is likely to be part of the
6 reason why that is happening.
7 So we urge you to consider carefully the detailed
8 analysis of the failures put forward by the Centre for
9 Women's Justice and we urge you to ask Mr McGill why his
10 evidence was at variance not only with the data, but
11 with the CPS's own admission yesterday that the CPS has
12 been failing victims of rape for the past three years
13 and, indeed, the statement from the police yesterday
14 that they refer fewer cases to the CPS now because they
15 anticipate a higher rate of rejection.
16 Chair, the role of the CPS in tackling sexual abuse
17 is critical. Ten years ago, the CPS made a determined
18 effort to put right past failings in the prosecution of
19 sexual offences and, as you will know very well, people
20 like Nazir Afzal and others re-opened grooming cases
21 which had been seen as hopeless and secured convictions
22 and this was very determined and impressive work.
23 Having heard Mr McGill, we are very concerned that
24 those gains have been eroded or lost, and an attitude of
25 complacency has returned.

1 Chair, as you will recall from her evidence, our
2 client, LA-A25, is also very keen to ensure that the
3 voice of children in care is properly heard. As you
4 will remember, Annie Hudson was questioned as to the
5 mechanisms for this to happen for children in the care
6 of Lambeth Council. In her oral evidence, she corrected
7 her written statement and explained, firstly, that there
8 is an independent visitor system and, secondly, that it
9 is not necessary for children to go through the
10 complaints process in order to access an independent
11 advocate.
12 We are grateful for the assurances she gave around
13 that and the correction of her evidence. However, we do
14 raise this concern: the fact that the systems were
15 seemingly misdescribed in her written statement does beg
16 the question of how important those systems are to
17 Lambeth Council. This is, after all, a local authority
18 which has a long track record of failing children in its
19 care. In these circumstances, having effective
20 mechanisms for children in care to talk openly about
21 concerns that they may have should be top priority for
22 this authority.
23 We appreciate that, in compiling her witness
24 evidence, Ms Hudson had a huge amount of material to
25 deal with. Nonetheless, we are very concerned that the

1 voices of children in care are not at the forefront of
2 Lambeth's thinking and, indeed, other issues, like the
3 failure to have mandatory training on corporate
4 parenting for newly elected members, and indeed
5 mandatory training on safeguarding for newly elected
6 members, again suggests that Lambeth has a long way to
7 travel to become a good corporate parent.
8 What these last four weeks of evidence have
9 demonstrated, as we also saw in Nottingham and Rochdale,
10 is the acute vulnerability of children in care. This
11 vulnerability is sadly only increasing with the impact
12 of austerity and cutbacks to services. As we have seen,
13 this vulnerability has so many dimensions. As
14 Ms Langdale pointed out in her questioning of Mr McGill,
15 the way records are kept about children in care means
16 that ordinary behaviour of children in care might be
17 misconstrued to their detriment in a criminal
18 prosecution. This was just one example. So we have to
19 keep coming back to that vulnerability and how we can
20 address it.
21 In relation to that, and in relation to the issues
22 raised by Mr Frank about section 9 of the Children Act,
23 we will expand at greater length in our written
24 submissions. However, we endorse the analysis put
25 forward by Mr Johnson a few moments ago. We had the

1 benefit of discussing that with him beforehand.
2 Finally, chair, and at the risk of repetition, the
3 vulnerability of children in care reinforces the other
4 point we have made throughout this inquiry. Ultimately,
5 we can't impose upon children the responsibility to come
6 forward and disclose abuse. We all have
7 a responsibility, as adults, to report abuse and
8 suspicions of abuse. Making sure that this actually
9 happens in the future is the central challenge of this
10 inquiry. As with other key social changes, like health
11 and safety or the prevention of discrimination, ensuring
12 that abuse is reported needs legal underpinning in the
13 form of mandatory reporting. So we hope, chair, that
14 this will play a central role in your final report.
15 Those are our closing submissions, thank you.
16 THE CHAIR: Thank you, Mr Scorer. Mr Jacobs?
17 Closing statement by MR S JACOBS
18 MR S JACOBS: Good afternoon, chair and panel. These are
19 the closing submissions of LA-A24.
20 LA-A24 was sexually abused at Shirley Oaks by house
21 parents Don Hosegood and LA-F285. He was also
22 physically abused, ill treated and racially abused.
23 Chair, LA-A24 is one of the many individuals whose
24 account has only been brought to light relatively
25 recently by the work of the Shirley Oaks Survivors

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1 Association. One witness from whom this inquiry has
2 heard is Dr Clive Driscoll, a retired officer of
3 the Metropolitan Police. Towards the end of his
4 evidence, Clive Driscoll posed a rhetorical question in
5 these words. He said:
6 "Answer: I keep coming back to the same thing: how
7 is it that two incredibly noble people, Mr Stevenson and
8 Ms Hinton of the Shirley Oaks Survivors Association,
9 with even a fraction of the resources that
10 Social Services and the police have, have managed to put
11 together 600-plus cases actually that are tested by
12 Lambeth Council's lawyers and also a copper that's an
13 ex-Fraud Squad and get a 44 million payout? How has
14 that happened when we were the agency that should
15 investigate and we were the agency that should have been
16 focusing on what the victims need?"
17 Chair, what an important question for this inquiry
18 to answer. We say that, in large part, the answer is
19 relatively simple: speak to and believe those who have
20 been cared for by persons known or suspected to be
21 serial abusers of children.
22 LA-A24 was cared for by Hosegood but was not spoken
23 to by the Metropolitan Police or by Lambeth in the
24 1970s. He was not spoken to by CHILE, and he was not
25 spoken to by Operation Middleton. He was, however,

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1 spoken to by Shirley Oaks Survivors Association, and so
2 it was that the abuse of him at Shirley Oaks came to
3 light. Therein lies a significant criticism and an
4 important lesson.
5 LA-A24 has not been able to follow the proceedings
6 through the live stream, and has been receiving daily
7 written summaries of the evidence prepared by his
8 solicitor. He has raised three points in response.
9 First, the difficulties of reporting abuse and that
10 he was not listened to when he did so. His own evidence
11 is that his complaints were dismissed or ignored. He
12 reported physical abuse to LA-F93, the deputy head, but
13 it transpires in evidence before this inquiry that, in
14 fact, LA-F93 was himself an abuser.
15 He also reported physical and sexual abuse to his
16 social worker in the early 1970s, but no action was
17 taken, and there is no evidence of the information being
18 passed to the police.
19 Second, he has also reflected on what other
20 survivors have said to the inquiry. He felt no love as
21 a child in care. The carers were more interested, was
22 his impression, in their wage packet than caring for the
23 children well and giving them the nurturing environment
24 they needed. They would give their love to their own
25 children, ignoring those placed in their care. It is

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1 LA-A24's view that people placed in a caring role at
2 a children's home should not have their own children on
3 site, so that they can focus on those who have been
4 placed in their care.
5 Third, he notes the theme amongst other survivor
6 accounts, which applies equally to him, of atrocious or
7 simply non-existent support for children leaving care.
8 Key themes in LA-A24's case and arising in
9 particular from the failed prosecution of Hosegood are:
10 the failure to speak to all the children at Shirley Oaks
11 at the time Hosegood was prosecuted in 1975, or simply,
12 in fact, to give credence to the children's accounts,
13 preferring to brand them as fantasists; the failure of
14 Lambeth and the Metropolitan Police to speak to
15 potential victims and to prosecute Hosegood before his
16 death in 2011; the description of some of the victims as
17 being remedial and finding it difficult to describe what
18 had happened to them; the process of taking evidence
19 from the children and of them giving evidence at court
20 has been described by complainants as "difficult".
21 Children had to give evidence in a courtroom in
22 a witness box in the presence of Hosegood and court
23 officials in robes, the judge and 12 adult jurors, and
24 to face cross-examination in that same environment.
25 They were unsupported through the trial process.

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1 DI John O'Connor, who was involved in the original
2 investigation in the 1970s, remembered that he had no
3 doubt, based on the evidence gathered, that Hosegood was
4 abusing boys and girls in his care. Hosegood was
5 described by him as a bully, who attempted to influence
6 the investigation by the production of the Masonic book.
7 It should be noted that, although DI O'Connor refers
8 to witness statements being taken from staff in 1975,
9 Gloria Newlands, a house mother, provided a witness
10 statement in 2001 to Operation Middleton, MPS003769. In
11 that statement, she says she was never spoken to by
12 police investigating Hosegood in 1975. She recalls
13 Hosegood behaving inappropriately with the children and,
14 in particular, LA-A369. She challenged him and reported
15 the matter to Joan Maddocks, group management officer.
16 Clearly, this appears to be important corroborative
17 evidence available to Operation Middleton and could have
18 been available in 1975.
19 As for Operation Middleton, the evidence remains as
20 set out in DI Morley's extensive first witness
21 statement. He identifies problems with
22 Operation Middleton, that meant that individuals like
23 Hosegood, who should have given significant cause for
24 concern, were overlooked. As indicated, neither the
25 police nor Lambeth made any attempt to contact LA-A24.

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1 Hosegood, too, was never interviewed by
2 Operation Middleton. DI Morley says that
3 Operation Middleton mistakenly believed that all of
4 the allegations made against Hosegood were dealt with in
5 1975. That is an inexcusable error.
6 A number of further possible victims who were
7 mentioned in available statements and other information
8 were not followed up.
9 The Operation Middleton and CHILE failures with
10 regard to Hosegood appear to go against the methods as
11 espoused by Richard Gargini and Helen Kenward that it
12 was intelligence led and relied on existing material.
13 Here was a previously failed prosecution with witnesses
14 available to be interviewed and further lines to be
15 followed up to secure a prosecution. Those lines of
16 enquiry were simply not pursued.
17 DI Morley also reveals that there is no evidence
18 that Operation Middleton officers investigated
19 Hosegood's relationship with other abusers, such as
20 William Hook, also referred to as "Mark", or that they
21 developed an intelligence-led strategy to investigate
22 whether Hosegood was involved with any other sexual
23 abusers within the Shirley Oaks estate or elsewhere.
24 This resonates with Operation Middleton's approach
25 to wider networks of abusers more generally, and its

1 failure to investigate the same. For example, in
2 relation to John Carroll's networks either at Lambeth or
3 North Wales or within other organisations, such as the
4 ACYC.
5 Accordingly, Operation Middleton missed an
6 opportunity to investigate Hosegood further, together
7 with his possible connections with other abusers. It
8 missed this opportunity in relation to other abusers
9 within Lambeth's other children's homes as well.
10 We agree entirely with submissions made by other
11 core participants earlier today that there were networks
12 of paedophiles operating in Lambeth. But there is no
13 explanation as yet in relation to why and how wider
14 networks operated. We submit a proper understanding of
15 this is important in the prevention of similar networks
16 in the future, and we invite the inquiry to consider the
17 need for these networks to be investigated further.
18 Chair and panel, thank you.
19 THE CHAIR: Thank you very much, Mr Jacobs. Mr Simblet?
20 Closing statement by MR SIMBLET
21 MR SIMBLET: Thank you, madam. As you know, I represent,
22 with Mr Ratcliffe from Uppal Taylor, A131. The evidence
23 that we have heard, both live and read, is a catalogue
24 of stolen childhood and lies, including that of A131.
25 He has been following this inquiry closely. Since he

1 was sexually abused at Southvale, he has focused his
2 interest and the interest that we have assisted the
3 inquiry with by submitting questions on what went on at
4 Southvale, but also issues of supervision and support
5 for survivors.
6 I identified LA-A131's particular concerns in
7 opening, referring to his detailed letter from early
8 2017. That made painful disclosures to the council and
9 poignantly asked them for help. He remains, however, in
10 a desperate situation over three years later. I will
11 mention a few things about that because Lambeth Council
12 referred to its redress scheme in its opening.
13 Mr Verdan QC said:
14 "Lambeth has established a redress scheme, the first
15 of its kind in the UK, in operation since January 2018,
16 which has received over 1,600 applications and to date
17 has paid over 46 million to survivors in compensation.
18 This is but one of the ways that Lambeth seeks to
19 provide assistance ..."
20 Then he carried on.
21 While, no doubt, Mr Verdan's headline figures are
22 correct, the implicit suggestion that survivors received
23 sufficient compensation and assistance does not reflect
24 A131's experience of the scheme. He doesn't want it to
25 pass unchallenged. His experiences compare with those

1 that you have heard about in your Accountability and
2 Reparations module, and, indeed, he applied to be a core
3 participant in the second phase of that, but was
4 refused. Accordingly, there's been no airtime in this
5 phase for his concerns and his requests to investigate
6 those issues with Lambeth witnesses were refused by the
7 inquiry itself. We submitted some rule 10 questions on
8 the point, which were refused, and made specific,
9 detailed, written representations to the chair, but this
10 was refused.
11 For those reasons, and since you have asked
12 survivors who gave evidence to make suggestions for
13 reform, and since some others have had their evidence on
14 these issues adduced -- for instance, it is in the gist
15 table read from LA-A7, also from Southvale -- I will
16 mention two of LA-A131's concerns now.
17 One, the assistance that Lambeth provides in housing
18 does not extend to those living outside its catchment
19 area. So that's an obvious problem when you consider
20 that survivors of abuse from institutions are more
21 likely to move away, since they have fewer family or
22 social ties and often need to escape their childhood
23 memories.
24 Secondly, A131 found the compensation process under
25 the redress scheme to be lengthy, painful and difficult.

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1 What he went through -- the disputation, the time
2 taken -- to deal with it is similar to the problems with
3 civil proceedings that you heard about in your
4 Accountability and Reparations module. His own dire
5 circumstances forced him into a position where he had no
6 choice but to accept an offer which was much less than
7 a fair amount. He does not feel helped.
8 For these reasons, LA-A131 asks that his anonymised
9 witness statement and the exhibits, which you have on
10 your system, be put into the public domain on the
11 inquiry website, in the same way as other materials have
12 been adduced.
13 A131 is hoping that the inquiry will be able to hold
14 institutions to account. There have been some
15 opportunities missed, however. Disclosure in the
16 inquiry has been inadequate and late. This reduced the
17 assistance that core participants could give to the
18 inquiry in their important task of holding institutions
19 to account. We made submissions a year ago emphasising
20 the importance of prompt disclosure. It didn't happen.
21 There was no disclosure of any material to core
22 participants until just before Christmas of last year.
23 Tranche 1 was 13 December 2019. Some of the most
24 important material was provided very late.
25 Sometimes, this was because institutions were late

1 in providing materials to the inquiry. For instance,
2 the main police corporate statement came from Mr Morley,
3 and that was late. It was dated 4 May 2020, and
4 couldn't be disclosed until 3 June, less than a month
5 before these hearings started. The lateness of
6 disclosure means important materials being provided even
7 during the hearing, often after witnesses have gone.
8 Even since the inquiry started this final hearing, there
9 have been 26 tranches of disclosure, which is 1,004
10 documents, 8,949 pages, so essentially the equivalent of
11 20 lever arch files worth being disclosed after the oral
12 hearings began.
13 This late disclosure has resulted in some issues
14 seeming more important than they might be and diverted
15 the inquiry away from its key focus on failures of
16 institutional response. Perhaps more airtime went to
17 some issues than actual evidence and actual documentary
18 support would have justified.
19 It also means that core participants are not always
20 able to appreciate the importance of some material until
21 questions have been submitted and, in some cases,
22 important disclosure, as I have said, after the
23 witnesses have already given their evidence. It may
24 have hampered the work in getting to the truth about the
25 extent of networks and coverups.

1 A131 is also hopeful the inquiry can produce
2 a meaningful apology. He acknowledges apologies have
3 been made by institutional core participants in their
4 opening submissions and from some of the witnesses who
5 have appeared on their behalf. They do not go far
6 enough. So, having seen the tone and nature of
7 Robin Osmond's statement, we submitted rule 10 questions
8 for him, seeking an apology. The inquiry refused this,
9 even after additional written representations were
10 submitted to the chair. So the inquiry has, to that
11 extent, prevented A131 seeking an apology from the
12 individual who, as Director of Social Services, had
13 statutory responsibility for him at the time that he was
14 being sexually abused in Southvale.
15 This is disappointing when the inquiry itself is
16 alert to the importance of apologies, and we appreciate
17 Ms Sharpling, in her questions, has specifically
18 elicited apologies from Councillor Dunipace and
19 Sir Stephen Bubb, and the chair, in her questions to
20 Helen Kenward, specifically invited her comment on the
21 failures of directors of Social Services to identify and
22 spot this "horrendous abuse".
23 Now, of course, many questions, including some of
24 our questions, some personally suggested by A131, have
25 been asked and A131 is grateful for the robustness and

1 rigour with which the inquiry's counsel and supporting
2 solicitors have questioned the institutional witnesses.
3 It is also right, since we expressed reservations about
4 how well this would work, to observe that holding the
5 hearing remotely does not appear to have affected the
6 effectiveness of the questioning of witnesses.
7 So now some points on what is to come. We remind
8 the inquiry that, although we have got limited time for
9 oral closing submissions, there will be detailed written
10 submissions and remind the inquiry to be astute to the
11 danger that institutional witnesses may row back in
12 their written submissions from their co-operative
13 approach in oral submissions, and also chime with others
14 that, while witnesses may acknowledge institutional
15 failures, institutions comprise people, and very few
16 individuals acknowledge their own shortcomings.
17 This is difficult when there is such a sustained
18 nature of failures here. Although I have complained
19 about late disclosure, there was also some early
20 disclosure which in some ways set the tone from the
21 first and detailed corporate statement from
22 Ms Annie Hudson. It is an incredibly detailed piece of
23 work, and set out what it said were problems in the
24 1980s and 1990s, culminating in the Appleby Report and
25 then the actions of Heather Rabbatts in taking various

steps to implement it. That analysis, provided early as it was, would appear to affect the inquiry's approach to eliciting material from witnesses, who were sent written questions and themes from the inquiry's lawyers at the stage that witness statements have been sought, and they appear to have been questioned in those statements on the basis this was an accepted narrative.

You need to be careful about this and it would be right not to treat this -- to accept this uncritically.

First, there are a number of Lambeth witnesses who do not accept that: Lady Boateng, Stephen Bubb, Joan Twelves, Sir Herman Ouseley and others. It is important, when looking at what happened in the time of Heather Rabbatts, Nigel Goldie and Stephen Whaley, and so on, not to just assume that, because things were different, they were necessarily better. Things like outsourcing of various services and so on, particularly in relation to children's services, caused problems of their own as you saw in the Nottinghamshire Councils Investigation

Also it was in 2000, after several years of this, that the council's Social Services department was put into special measures, and counsel to the inquiry obtained some important evidence about the failings around this time.

Ms Rabbatts seems to have seen the Appleby Report as a definitive answer or road map. Her answers in her oral evidence made this very clear. But it is plain there are fundamental problems in the Social Services Department at that stage that they could not even be relied upon to marshal documents, hence the Helen Kenward and CHILE inquiry about which I will say more in a moment.

It is also right to say that, essentially, the position, as described, is that the council was in disarray and the chief executive, Ms Rabbatts, claims to have sorted everything out except the Social Services department because, as she said in her evidence, it gave her no cause for concern. That could be seen as a claim to have sorted out all the problems except those under scrutiny in this inquiry, and that's unlikely to be a correct analysis.

It fed into, also, the approach in relation to the investigation of child abuse allegations where Lambeth had so little faith in its social workers that it outsourced this to CHILE and Ms Kenward, the independent consultant.

That leads on to the failures to hold people to account, including by the police and including especially Operation Middleton. The Operation Middleton

fourth and final report from Lambeth Council, 30 October 2003, has as the first words in the executive summary:

"The operation has run successfully since November 1998 and, following a full risk assessment, a joint decision was taken to begin to end the operation."

This rosy view of the operation still seems to persist and it is striking that, even now, the key players from Operation Middleton do not see it as the failure that it was. They only got three convictions and in relation to Leslie Paul, who had already been convicted, the particular offences of which he was convicted massively underplayed the seriousness of his criminality, reflected in the very low sentences imposed. There was no challenge to the evidence of Gregor McGill about this, and indeed what I'm submitting is reflected in contemporaneous police documents.

In those circumstances, we might have expected the key personnel to acknowledge their shortcomings. However, we got the opposite. Mr Gargini and Ms Kenward emphasised what they thought were the innovative features about the obtaining of information and securing evidence and how that had changed practice. It does not appear to have led, however, to very much usable or

probative material, and the evidence-led approach that they describe does not appear to have led anywhere other than to a series of missed opportunities. So there are, even now, 30 to 40 years after those serious acts of abuse, still ongoing police enquiries, and the failure of several police operations to provide justice to those victims and survivors not only delays justice for them but materially affects your work and the cogency of the information available to you. This is because the consequences of police shortcomings then affect your approach, because you, for understandable reasons, focus on the areas where there are convicted perpetrators and where unconvicted perpetrators or unconvicted allegations result in people being anonymised.

So if you have a shortage of convictions, this restricts the scope of what you, as the inquiry, can investigate. The recent materials and submissions of some of the other core participants about ciphering and so on are a manifestation of the problems that the police and council's failures have left you with.

What is also clear is the extent to which the abuse that occurred in children's homes is not just the unforeseeable, unforeseen acts of rogue members of staff but, as others have said, appears to have been part of a network about which nobody was taking any action.

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1 I'm not going to say any more about the
2 Michael Carroll situation other than to highlight
3 Ms Hudson's evidence on 21 July where she said:
4 "Answer: ... what was going on was known by more
5 people than -- this was not about sole individuals
6 operating on their own. There [seemed to be] a culture
7 ... that enabled people to abuse children in an
8 unfettered way. In that sense, there must have been
9 connections between individuals and events."
10 That, chair and panel, is a very, very severe state
11 of affairs.
12 It is also a similar situation arising with
13 Patrick Grant. Since he was in Southvale at the time
14 that A131 was there, I will say something brief about
15 that. Ms Hudson dealt with his case on 21 July. The
16 position is, you may recall, that within three months of
17 his starting at Shirley Oaks, he was the
18 officer-in-charge at Rowan House, and then subsequently
19 was charged -- again, within a very short period of
20 time -- with several counts of sexual abuse.
21 While he was awaiting trial, he was offered
22 a secondment to undertake training as a social worker.
23 Following his acquittal, he took that up without any
24 further investigation. Ms Hudson was correct to say, as
25 she said, that this was a "staggering, staggering

1 decision".
2 We would say so, too, but for the fact that it seems
3 so typical of what was going on in Lambeth at that time
4 and, sadly, persisting for so many years afterwards.
5 Nobody cared.
6 You will note that, even today, there are still gaps
7 in service. Even with the scrutiny that Lambeth is
8 under in this inquiry, the witness on 28 July,
9 Councillor Davie, identified one matter in relation to
10 care leavers that he said he was going to resolve that
11 day. The complex position that local authorities are in
12 with political accountability to their electorate while
13 having, rightly, onerous statutory responsibilities
14 properly to parent those in their care, as Lord Laming
15 and Councillor Davie appreciated, saw, unfortunately,
16 Lambeth fail generations of children.
17 A131 hopes that Lambeth's words will now be backed
18 up by action, and that your recommendations will ensure
19 that they do much better in the future. Thank you very
20 much, chair.
21 THE CHAIR: Thank you, Mr Simblet. I should say that the
22 sound quality from your computer was not great, so the
23 investigation team will request your speaking note to
24 assist the transcribers. Thank you.
25 We now go on to Mr Enright and then Mr Jacobs, on

1 behalf of two core participants.
2 Closing statement by MR ENRIGHT
3 MR ENRIGHT: Chair, Ms Sharpling, Mr Frank, Sir Malcolm,
4 I appear with Mr Whaley, who is with me.
5 Mr Whaley has asked me to thank the inquiry's
6 solicitor team, Ms Merity and Ms Howes, counsel team,
7 witness and IT support teams for their very hard work in
8 staging this important investigation.
9 You will recall Mr Whaley was a Lambeth Councilor,
10 chair of the Management Services Committee, chair of
11 the Social Services Committee and leader of the council
12 from 1991 to 1994.
13 You heard from Mr Whaley on Day 15. He was a candid
14 and impressive witness. He has done all he can to
15 assist this investigation.
16 Mr Whaley has expressed his deep regret that
17 Lambeth Council did not succeed in improving the
18 position of children in care.
19 In his evidence, he explained a need to rely on the
20 advice of qualified practitioners and council officials
21 with expertise in childcare and protection. He stated
22 it was incumbent on officers to provide members with
23 advice that was fair, open and honest. Unfortunately,
24 as we have seen, members were not able to hold officers
25 to account in matters relating to child protection.

1 Mr Whaley has concluded that he did not think it was
2 appropriate for councillors, effectively lay people, to
3 reach complex decisions on such matters.
4 You have heard evidence demonstrating there were
5 a number of chronic problems in Lambeth in the '80s and
6 '90s. First, the council was tainted by corruption,
7 a matter my client became increasingly aware of, as
8 leader, and took action on.
9 Secondly, there was political turmoil in which more
10 energy was spent on confronting the government than
11 delivering services to the people of Lambeth.
12 13 councillors were suspended. You will recall the
13 effect of Mr Whaley having to build a coalition for each
14 decision taken, council meetings lasting all night and
15 decisions only being reached when members left to go to
16 work in the morning. Not conducive to making good
17 decisions.
18 There was administrative incompetence. The inquiry
19 will recall that Mr Whaley, as chair of the Management
20 Services Committee, commissioned a panel to investigate
21 concerns of child sexual abuse at Ivy House. The
22 resulting report was not properly disclosed, and neither
23 was it implemented.
24 Fourthly, there was a toxic culture in the
25 directorates, including Social Services. During these

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1 years, the needs of children were tragically overlooked.
2 Perhaps the starkest example of officials acting
3 inappropriately and without accountability is the
4 debacle concerning John Carroll's continued employment
5 after disclosure of a schedule 1 offence. Mr Whaley
6 could not understand why David Pope adopted the position
7 that he did over John Carroll. Who can?
8 Mr Whaley asked you to consider whether Carroll not
9 only groomed children, but groomed staff and his line
10 managers. Mr Whaley stated in his evidence that he came
11 to the conclusion that Lambeth was incapable of running
12 children's homes safely, and he and others, like
13 Anna Tapsell, decided that all children's homes should
14 be closed.
15 Sadly, Lambeth was by no means alone in having
16 a failing Social Services Department. Lord Laming told
17 you that the Social Services at Lambeth were not an
18 outlier. Lady Bottomley agreed. Lord Laming also said,
19 "Boy, I looked at 150 Social Services departments and
20 I was aware of the shortcomings of every one, including
21 the one I left". But you know that, chair, from your
22 other investigations.
23 In his opening submissions, Mr Whaley urged you to
24 consider two themes. First, the relationship between
25 and the ability of part-time, nonexpert councillors to

1 oversee the work of full-time, professional officers and
2 how children in care can be protected in a time of
3 crisis. On the first theme, you will recall that in the
4 Appleby Report, which was commissioned by Mr Whaley,
5 Dame Elizabeth stated:
6 "I found that a large number of the management are
7 either incompetent or incapable of dealing with the
8 current problems, which are now so widespread that no
9 directorate can be free from criticism. Further, it
10 seems to me that some members are not clear as to their
11 role, namely, setting policy objectives and making
12 decisions in that policy framework. I think
13 consideration should be given to members receiving
14 initial training so that they fully understand their
15 role and what is expected from them."
16 Mr Whaley agrees. He submits that part of
17 the solution to the problems highlighted by Lambeth's
18 past may lie in focused and mandatory training for all
19 councillors.
20 Secondly, Mr Whaley asks you to consider how
21 children can be protected in a time of crisis.
22 Chair, you will find that Lambeth was in crisis. My
23 client asks the inquiry to recommend that all local
24 authorities develop emergency action plans to ensure
25 that children in care are properly protected in a time

1 of crisis. Protecting children in a time of crisis is
2 as relevant today as it was in the past. We live in
3 anticipation of a further national public health crisis.
4 In this event, or if any other crisis materialises,
5 children in care must not be overlooked. Chair, those
6 are my submissions.
7 THE CHAIR: Thank you, Mr Enright. Mr Jacobs?
8 Closing statement by MR C JACOBS
9 MR C JACOBS: Chair, Dr Goldie gave evidence before you on
10 9 July. As you will recall, he had a number of senior
11 managerial roles and became responsible for the child
12 protection team in April 1996. Dr Goldie referred in
13 his evidence to the concerns expressed in the
14 Barratt Report that senior child protection expert staff
15 had been excluded from the investigation into
16 a complaint made by a child concerning Steven Forrest.
17 Dr Goldie sought to raise this matter before the
18 Director and Assistant Director of Social Services, yet
19 no action was taken. Dr Goldie and his child protection
20 officers' attempts to reinstate a child protection
21 process are referenced in the Barratt Report, yet their
22 attempts to escalate this issue to the executive
23 director also fell on stoney ground. These events,
24 chair, typify the situation at Lambeth. As you have
25 noted, successive Directors of Social Services failed to

1 prioritise the protection of vulnerable children in
2 residential care, and we say there are a number of
3 explanations for these failures.
4 Undoubtedly, the political and financial chaos that
5 characterised Lambeth in the 1980s and 1990s played
6 a major part. However, there were also cultural
7 problems. Annie Hudson spoke about accumulative
8 defensiveness in the authority around best childcare
9 practice. Furthermore, many of the investigations and
10 enquiries that were conducted did not result in any
11 positive action. The Clough Report, for example, failed
12 to engage with the stark fact that a schedule 1 offender
13 was working with children. The report made no
14 recommendations to the council on this fundamental
15 point. Yet, even where recommendations were made from
16 investigations, Lambeth failed to implement them in
17 a way so as to improve the lives of children in the care
18 of Lambeth Council.
19 Finally, chair, the Social Services Inspectorate,
20 they failed to grapple with the council's lack of
21 leadership and mismanagement by key officials.
22 So what recommendations can this inquiry make to
23 prevent future generations of children in care suffering
24 the catastrophes that befell children in care in
25 Lambeth? Dr Goldie suggests that clear and inviolable

1 lines of accountability must be implemented in all cases
2 in which local authorities act as the corporate parent
3 of vulnerable children. He asks that your
4 recommendations reinforce the importance of independent
5 scrutiny and oversight and delivery of child protection
6 responsibilities within the organisational structure of
7 all local authorities.
8 Dr Goldie also points to the ongoing relevance of
9 the findings of the Barratt Reports. Dr Goldie has also
10 given important evidence on the issue of where there was
11 inappropriate interference in law enforcement
12 investigations into the sexual abuse of children in the
13 care of the council. In his evidence, he told the
14 investigation that events moved very quickly after he
15 spoke to the chief executive on 17 November 1998, the
16 day after DI Driscoll had named prominent individuals.
17 Assistant Commissioner O'Connor was contacted and
18 Superintendent Gargini was directed to contact Dr Goldie
19 on the following day. Now, chair, it may seem odd that
20 Superintendent Gargini wanted to meet Dr Goldie outside
21 his workplace. Dr Goldie's evidence is that he was told
22 by Gargini to forget about the matter. He found this
23 exchange, in his words, "quite alarming", and this is
24 consistent with Anna Tapsell's evidence as to her
25 treatment.

1 Dr Goldie acknowledges that Lord Boateng gave
2 evidence to the effect that he didn't know Carroll and
3 doesn't recall attending Angell Road. Yet many
4 questions remain. It is clear that no statement was
5 taken from Theresa Johnson concerning her claim citing
6 that LA-F41 at the -- at that home until 2013 and 2015,
7 notwithstanding that she discussed these very matters
8 with DI Driscoll and subsequently with Superintendent
9 Gargini and Helen Kenward a decade earlier. It is not
10 clear why Ms Johnson's evidence was not taken seriously,
11 especially when the police knew that Carroll had
12 a tendency to court contacts within the police force.
13 That was confirmed by the statement of PC Opray and
14 within Lambeth Council, where he was, in the CTI's
15 words, a powerful man. Were allegations of Carroll's
16 attempts to court political contacts as well really so
17 improbable as not to be worthy of an effective
18 investigation?
19 Operation Middleton raises further questions: why
20 was LA-F41 never interviewed by Operation Middleton and
21 not interviewed by police until 2019? Why wasn't he
22 entered onto the HOLMES system? Why was he only
23 referred to in a Middleton decision log by initial and
24 not by name? Furthermore, why was the focus of
25 Operation Middleton moved away from DI Driscoll's lines

1 of enquiry? Chair, these are all more than just missed
2 opportunities and we invite the inquiry to find on the
3 evidence it cannot be discounted that there was
4 inappropriate interference in DI Driscoll's
5 investigations into matters that were politically
6 sensitive. There remain too many unanswered questions
7 to conclude in a different way or otherwise.
8 Finally, chair, Dr Goldie has asked me to raise
9 a further issue in relation to the evidence of
10 DI Morley, who accepted in his evidence on 22 July that
11 Operation Middleton failed a number of people and did
12 not get to the heart or scale of the problems. We ask
13 that the inquiry recommends that police revisit cases of
14 child sexual abuse in Lambeth that were not adequately
15 investigated.
16 Chair, thank you, those are my submissions on behalf
17 of Dr Goldie.
18 THE CHAIR: Thank you, Mr Jacobs. Ms Weereratne?
19 Closing statement by MS WEERERATNE
20 MS WEERERATNE: Thank you, chair and panel. Since the
21 1980s, as a trade union activist, Mrs Tapsell has
22 invested time and energy into investigating the role of
23 wide-scale corruption and fear at Lambeth.
24 She says, chair, that, without this canvas, the
25 whole picture of child abuse at Lambeth -- why it

1 happened and how it could be prevented in the future --
2 is not complete. Mrs Tapsell provided details of these
3 matters to the inquiry in her evidence, several
4 statements and reams of contemporaneous documents. She
5 is concerned that the inquiry has but scratched the
6 surface of what lies at the heart of why there was
7 extensive neglect, physical and sexual abuse of children
8 in Lambeth's care over a prolonged period of time and in
9 spite of so many enquiries and inspections.
10 Her specific concerns as a councillor in relation to
11 children are well documented. In 1992, she wrote
12 presciently of her gut conviction that the children in
13 our care may have come to harm possibly through the
14 activities of more than one person. Although we now
15 know the scale of that harm, there are troubling
16 features, we say, of the available evidence that should
17 have been explored more robustly and some that remain
18 insufficiently explored and suggest that the true scale
19 of what occurred is yet to be uncovered.
20 Dealing with what the inquiry has heard, for now we
21 would like to highlight five points. First, the
22 striking feature of the institutional responses to child
23 sexual abuse in Lambeth is a failure to speak to the
24 children. This was then compounded by the methods
25 adopted by Operation Middleton and CHILE. One example

is Clough, who was tasked with an internal enquiry into Carroll's employment. We aim our criticisms at the Social Services Inspectorate and Lambeth, who set the terms of reference, and who then also decided to withhold no allegations of sexual abuse against Carroll and others at Angell Road from Clough.

A management review was no doubt important, but, in practice, it obfuscated the real issues, which were the implications for the children of being cared for by a schedule 1 offender. Discovery of the horrific consequences was put off until Merseyside's Operation Care in 1998 and, by 1998, the Met Police and Lambeth knew that the convicted Carroll was a serial child abuser and that there were likely to be many children who had been abused by him, Steven Forrest and LA-F4 over a decade or more, which justified a proactive approach. Yet the response was not to speak to the children exposed to those perpetrators, but an intelligence-led operation relying on the review of historic files held by Lambeth and previous allegations or investigations. The fundamental flaw with that plan was that the records were in a chaotic mess and the obvious problem that sexual abuse is rarely recorded.

DS Gargini told Mrs Tapsell that rumour, inference and speculation would not be investigated unless there

was evidence to support the allegation, which included information from victims, witnesses to abuse and documentation. To talk of witnesses to abuse is, of course, wholly unrealistic in this process. This approach left victims to come forward by themselves, so CHILE and Operation Middleton handicapped themselves from the outset.

Attention has already been drawn, on behalf of LA-A24, to the important rhetorical question posed by DI Driscoll, asking how the Shirley Oaks Survivors Association, with a fraction of the resources available to the police and Social Services, managed to put together 600-plus cases tested by Lambeth's lawyers. The answer, we say, is relatively simple: SOSA focused on the survivors, showing understanding and building confidence.

A process of careful interview with children and adult survivors and potential victims is, we say, entirely possible and necessary. Second, Carroll used corruption, fear and the influence of his high-profile networks to get what he wanted. Variously described as "dominant", "bullying", "seductive" or "charming", he was, in fact, thoroughly dishonest, perpetrating widescale fraud, deliberately failing to disclose his conviction and then lying about its seriousness. But he

got away with it. He used corrupt practices like the M&S fraud to secure silence and compliance from staff.

Don Thomas was dismissed for being part of that fraud a year after he presented a lame disciplinary case against Carroll. Perhaps we now know why. The decisions around Carroll have no redeeming feature. There was something wrong, even at that time.

So did Carroll exert undue influence over Mr Pope? Even the refusal of the fostering application was subverted by senior management into a local management arrangement against the strong opinion of the children's social worker, Jo Hughes, and her manager, Pat Horton. Mr Pope wrote to the Social Services Inspectorate that Carroll had "strong networks seen as positive in the borough". Despite further evidence this morning, the basis of this enigmatic statement remains unclear.

Carroll was known to boast about or threaten the use of his connections with influential people. The inquiry has evidence that links Carroll with Lord Boateng, including from Carroll's manager at Angell Road, Theresa Johnson. Any such links, of course, have been denied by Lord Boateng.

The Southwark fostering issue is also relevant to Carroll's links with influential people. Mr Walsh provides the only evidence that Southwark was involved.

The Boatengs deny any knowledge of that fostering application.

There is no identifiable motivation, we say, for Mr Walsh to fabricate the fact that he assessed the Carrolls' application for Lambeth. Mrs Tapsell is clear that there is good reason to prefer his evidence and she invites the inquiry to do so.

Third, there are concerns that Lambeth children were sexually exploited for both private and commercial gain. Les Paul, F46 and Tony Newcombe are all implicated. And there is evidence through LAG1 and the supplementary Harris Report, which we have now seen, that obscene videos involving sadism and animals were made using Lambeth children at Southvale and a hostel linked to Newcombe. It is stomach churning to think of children being used in this way. We say there has been no satisfactory investigation of these issues, nor of the institutional responses to them.

The profit element may explain the powerful interest in keeping it secret and is likely to mean that methods of production and distribution are complex. But when you hear that Carroll ran an unregistered daycare centre at Angell Road, that children went missing from children's homes, that records were in a dreadful state, that some children did not know their date of birth,

1 about the exchange of contractual favours, blackmail and
2 corruption, when you hear that children were shipped to
3 far-flung parts of the country, such as North Wales,
4 without follow-up and the significant use of private
5 homes, when you open your mind to the existence of wider
6 networks in the creation and consumption of such
7 material, you begin to see that there is a big hole in
8 the investigation of institutional responses so far.
9 The North Wales link is particularly troubling.
10 Ms Kenward's opinion is that Carroll was involved in
11 a national network shielding Carroll with Frank Beck,
12 a notorious convicted paedophile from Leicestershire.
13 Was there a link also with John Allen in North Wales?
14 Helen Kenward alerted Heather Rabbatts that children
15 sent to North Wales from Lambeth were not accounted for,
16 literally lost in care, reflecting the title of
17 the Waterhouse Report.
18 Fourth, we submit that Operation Trawler was set up
19 by a dynamic officer intent on taking an entirely
20 appropriate proactive approach and willing to follow up
21 information such as that about the VIP LA-F41. This was
22 not just rumour. In the wake of Waterhouse, knowing how
23 paedophiles operate, and information from
24 Theresa Johnson, former DI Driscoll was looking for the
25 evidence and there is no evidence that he was doing

1 anything more than that. What is striking, we say, is
2 that Driscoll was removed from Trawler summarily,
3 without any conversation or discussion with him to seek
4 an explanation of his plans.
5 We find that extraordinary. The inquiry, chair, is
6 invited to reflect on that point. There is no doubt
7 that he was removed by senior police officers from
8 mentioning LA-F41 at confidential strategy meetings.
9 Thereafter, anything to do with LA-F41 was separated out
10 and suppressed. DS Gargini's evidence is quite clear on
11 that. Was it on instruction? If so, whose instruction?
12 Or was it out of deference to an important person?
13 Operation Alka, we say, is a white elephant of
14 the most obvious kind. Four years to produce
15 perfunctory and flawed self-serving conclusions. We
16 invite the inquiry to ignore it.
17 Fifth, has this inquiry's response to child abuse in
18 Lambeth been adequate? We do not underestimate the
19 scale of the task the inquiry was faced with. This was
20 a particularly complex strand of investigation.
21 However, core participants have been beset by late and
22 ongoing disclosure of documents. As graphically
23 described by Mr Simblet a moment ago: 20 lever arch
24 files worth since the start of hearings and sometimes
25 after the relevant witness had given evidence.

1 Mrs Tapsell provided her documentation in 2017 and some
2 of this was only disclosed yesterday.
3 This has left Mrs Tapsell, and no doubt other CPs,
4 responding on the hoof, inhibited from making timely
5 submissions on further lines of investigation or
6 witnesses to be called.
7 It impacts on the unwieldy rule 10 process by which
8 CPs must submit written questions for witnesses in
9 advance. We have raised concerns of the apparent
10 timidity with which Carroll's links with influential
11 people has been pursued. We have sought clarity over
12 how read evidence has been adduced on this and other
13 issues, such as the corruption in the 1980s, to provide
14 the whole picture. Our concern is that, in a public
15 inquiry, the public must be able to understand and
16 follow what's going on. A public inquiry must be
17 unafraid to delve into the difficult detail. We regret
18 to say that we do not know why the disturbing
19 allegations of the sexual exploitation of children in
20 Lambeth and the making of obscene videos have not been
21 investigated and the responses to it not interrogated
22 more robustly. We have not seen the underlying
23 documentation from Operation Pragada. Similarly, the
24 issue of the wider networks of Lambeth abusers, whether
25 in North Wales or elsewhere, and in particular Carroll's

1 networks, remain unexplored.
2 The question why and how it is to be prevented in
3 the future remain unanswered.
4 So, chair, we repeat what we said in our opening: we
5 invite the inquiry to hold a further investigation
6 focusing on Carroll's wider networks, including LA-F41
7 and North Wales, and the allegations of child sexual
8 exploitation and the supplementary Harris Report.
9 Chair, we will be providing more detailed
10 submissions on these points in writing, so thank you
11 very much.
12 THE CHAIR: Thank you, Ms Weereratne. Mr Berry?
13 Closing statement by MR BERRY
14 MR BERRY: Thank you. Chair and panel, over the past four
15 weeks, the inquiry has heard harrowing evidence from
16 victims of child sex abuse while they were under the
17 care of Lambeth Council, often by the very people
18 charged with their care. Nothing I say is intended to
19 minimise the impact of that abuse or the outrage that it
20 went unchecked for so long.
21 On Mr Gargini's behalf, I will address you on three
22 themes: DI Driscoll; Angell Road and Highland Road; and
23 Operation Middleton.
24 DI Driscoll. It has been alleged that DI Driscoll
25 was improperly removed from Operation Trawler to prevent

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him from investigating LA-F41. Dr Goldie's evidence was that DI Driscoll had mentioned that he wanted to investigate F41's involvement with child sex abuse during a case conference. DI Driscoll had repeated this at another meeting attended by social workers outside the Operation Trawler team.

Dr Goldie thought this was inappropriate and endangering Operation Trawler. He immediately raised it with his line manager and then with Heather Rabbatts, who herself immediately, before Dr Goldie had even left the room, called Assistant Commissioner O'Connor.

That chain of events and the contemporaneous documentation demonstrates that there was a clear concern about DI Driscoll within the council.

Mr Gargini was told to contact Dr Goldie and obtain his account. He did so and sent a report of that meeting to Commander Orde. It was decided that the matters raised by Lambeth would be referred to the complaints department for investigation. The evidence suggests that DI Driscoll was removed from Trawler and, indeed, from the Lambeth CPT by Superintendent Randall because of the issues raised by Lambeth Council. It was a management decision taken by DI Driscoll's line manager, not by Mr Gargini.

The basis for Dr Goldie's concerns about

DI Driscoll's removal appear to be that he thought the response was a bit drastic. That may have been so for a council employee, but not for a police officer. There was, at the time, a disciplinary rule against disclosure of police investigation without proper authority. Sir Hugh Orde's evidence gives a flavour of how improper disclosure was viewed in the MPS. He says:

"I find it extraordinary that a detective inspector thinks it is appropriate to name high-profile politicians amidst a group of people who don't need to know such allegations, regardless of the fact that they are terminal to people's careers."

We say that there are at least two further reasons supporting the fact that there was no improper motive for DI Driscoll's removal from Operation Trawler. First, if the aim was to prevent F41 being investigated, Mr Gargini recommending, and his superiors authorising, a major investigation into child sex abuse in Lambeth over a 20-year period would be the most absurd way of going about it, because any victim or witness of abuse by F41 could have come forward to the MPS or CHILE at any time.

Second, the evidence shows that Operation Middleton did not simply ignore F41 after DI Driscoll's removal. Mr Gargini has set out the steps that were taken, which

included, even towards the end of his time as SIO, deciding that John Carroll was to be interviewed in prison about his alleged association with F41.

The fact remains that neither Trawler nor Middleton ever received a report from a victim or witness of child sex abuse by F41. Had there been such a report, it would have been investigated without fear or favour, regardless of F41's position.

Angell Road and Highland Road. It has been alleged that Operation Middleton's focus shifted away from Angell and Highland Road for improper reasons. This gives rise to three questions: was there a shift away; if so, why; and was the reason improper?

Was there a shift away? In one sense, yes, because, while Mr Gargini listed Angell and Highland Road as his top two priorities, they were not investigated in detail at the outset of Middleton, and I say "in detail" because CHILE did continue to identify and profile former residents and staff of those homes.

Why was there a shift away? That was because Carroll was being investigated by Operation Care, and Steven Forrest, who was dead, was being looked at by the Barratt Inquiry. Carroll's second trial ended in September 2000. By that time, the Middleton team was heavily engaged in work on abuse in other homes, but the

intention was to return to Angell and Highland Road in due course.

Mr Gargini cannot answer for decisions taken after he left Operation Middleton in January 2001.

Was it improper? No, both for the reasons that I have just given, but also because the alleged improper motives do not stand up to the most basic scrutiny. The first alleged improper motive was to avoid embarrassment to the police because Carroll had worked with the Met on Operation Bell. That has been comprehensively debunked because Carroll had left Lambeth one year before Operation Bell even began.

The second alleged improper motive was to avoid embarrassment to the council. Surely the greater embarrassment to the council would be from a police investigation into all of its former care homes, rather than a focus on homes that were already under intense and public scrutiny. But, in any event, the council was simply in no position to dictate or divert the course of Operation Middleton. Middleton was an independent police investigation working in partnership with the independent CHILE team.

Operation Middleton. On Mr Gargini's behalf, I do not seek to gainsay the criticisms of Middleton made in DI Morley's detailed statements. I repeat Mr Gargini's

1 sincere apology for the fact that some victims of child
2 sex abuse had access to justice delayed because of
3 decisions taken in Middleton.
4 I make four headline points for the inquiry's
5 consideration. First, Operation Middleton was a first.
6 It was the first time that the MPS had conducted a major
7 Working Together investigation with an independent
8 social work team, and it was the first time that the Met
9 had put an investigation into any crime other than
10 murder onto the HOLMES system. These may seem like
11 trifling matters now, but investigations fall to be
12 judged against the standards of the time, and 20 years
13 ago, Middleton was seen as ground breaking and it did
14 have successes.
15 Second, Operation Middleton was resourced as
16 a stand-alone major incident involving around
17 13 officers and staff and assisted by a similar number
18 of CHILE staff. The evidence suggests that this level
19 of resources became insufficient when the volume of work
20 increased. The further resources requested by
21 Mr Gargini, and indeed DCI Ranson, were simply not
22 available due to competing demands. But, whatever the
23 shortfall in resources, the numbers were significantly
24 more than those of Trawler, a DI supported by two
25 officers.

1 Third, the intelligence-led model of Middleton was
2 a respectable one chosen for proper reasons. Mr Gargini
3 settled on it after consulting with his superior
4 officers and with the ACPO national policing lead and
5 with the concurrence of the highly experienced
6 Ms Kenward. Paul Clark correctly explained that in the
7 1990s there was a debate in policing about the approach
8 to take in historic abuse investigations, one being to
9 write to all former residents, and the other being an
10 intelligence-led approach looking at records to identify
11 potential victims.
12 It is crucial to note that the intelligence-led
13 approach was proactive. That is because, after being
14 identified, potential victims were approached following
15 a suitable risk assessment. And the intelligence-led
16 work looking at records operated alongside other ways of
17 identifying victims. There was a public appeal. There
18 was a hotline run by CHILE for victims and witnesses to
19 come forward. Witnesses identified other victims who
20 were then followed up, and other forces could refer
21 victims to the MPS, as Merseyside did.
22 Fourth, the terms of reference. Questions have been
23 asked about the use of the word "credibility" in the
24 terms of reference. I want to be clear that this word
25 was not included as a tool to dismiss complaints from

1 victims where there may have been issues about their
2 credibility. Any police investigation has to obtain all
3 relevant evidence, including evidence that might
4 undermine the prosecution or assist the defence to
5 enable the CPS to reach an independent charging
6 decision. If the CPS decides to NFA a case because
7 their independent assessment is that there are issues
8 with the victim's credibility, that is an issue for the
9 CPS. It does not mean that Middleton took an
10 inappropriate approach to victims' credibility.
11 To conclude, the evidence supports findings of both
12 good and poor work by Middleton, but what the evidence
13 most certainly does not support is a finding of
14 a coverup by senior officers in the setup or the conduct
15 of Middleton. That serious allegation has been
16 ventilated in this public hearing. My strong submission
17 is that the evidence supports a positive finding in the
18 public report that the allegation is entirely without
19 foundation. Thank you, chair and panel.
20 THE CHAIR: Thank you, Mr Berry. We will now take our
21 afternoon break and return at 3.05 pm.
22 (2.50 pm)
23 (A short break)
24 (3.05 pm)
25 THE CHAIR: We will now hear from Mr Toner.

1 Closing statement by MR TONER
2 MR TONER: Thank you, chair, good afternoon. Good
3 afternoon, members of the panel. I represent Ms Twelves
4 with my junior counsel, Ms Herdman. As you know,
5 Ms Twelves was elected to the council as part of a large
6 intake of new councillors in 1986, and she was initially
7 Chief Whip until December 1987 and then elected leader
8 in May 1989, which was a post she held until 1991.
9 Ms Twelves, as she emphasised to you in her oral
10 evidence, was one of those people who came to the
11 council to change many things for the better. One of
12 the first steps that she took was to ask the then
13 chief executive to leave, and to replace him with
14 Mr Herman Ouseley, Lord Ouseley as he now is, as the new
15 chief executive, and he was tasked with implementing
16 major changes in many areas of the council's
17 organisation, activities and methods of service
18 delivery.
19 Over the two years that Ms Twelves was leader, as
20 well as shaking up and strengthening corporate
21 management, she was closely involved in budgetary
22 scrutiny across the council and overseeing the
23 implementation of radical restructure. She wasn't
24 involved in the day-to-day work of service delivery, and
25 she would stress that she had very little involvement in

1 the work of the Social Services Committee, its
2 subcommittees or its directorate.
3 Now, in preparing for her witness statement, and
4 reviewing the documents provided by the inquiry,
5 Ms Twelves reviewed some of the major organisational
6 reports from her time as leader and she found it
7 noticeable that the Social Services Directorate was
8 rarely mentioned. She has noted, however, that the
9 council took steps, for both budgetary and operational
10 reasons, to close and restructure several children's
11 homes at the beginning of 1991.
12 In her role as leader, Ms Twelves concentrated on
13 the financial costs and relevant matters, and she relied
14 upon her deputy leaders, chairs and directors to deal
15 with the details of particularly service delivery.
16 In her oral evidence, Ms Twelves touched upon
17 a matter which is this: when Ms Bellos and Ms Twelves
18 were first elected in 1986 as leader and Chief Whip
19 respectively, they were extremely conscious of
20 the sexist and, in respect of Ms Bellos, the racist
21 nature of the way that they were treated. The previous
22 leadership had been all male, as were all the directors.
23 They were the first women to lead the council.
24 Patronising an unhelpful attitude that they
25 encountered, combined with the political and managerial

1 vacuum left by the departure of the previous
2 administration made it so much harder for them to do
3 their jobs, let alone to effect change. Now that these
4 attitudes continue in society to this day shows just how
5 difficult is the task of making change happen.
6 In 1986, the incoming, inexperienced Labour
7 councillors were faced with the impossible task of
8 providing decisive political leadership to deal with
9 weak to non-existent corporate management, to face up to
10 continually reducing budgets and to try and cope with
11 the barrage of legislative changes, which included the
12 introduction of compulsory competitive tendering, the
13 abolition of the GLC and then the Inner London Education
14 Authority and, of course, with the changes brought about
15 by the poll tax.
16 The contradictions arising from pressure on the
17 councillors to stick to, keep to, a manifesto which
18 didn't even acknowledge the defeat of the rate capping
19 campaign, and their awareness of the pressing need to
20 improve services and effect real change, led to a series
21 of unstable political administrations.
22 Now, each administration attempted to come to grips
23 with the council's problems with varying degrees of
24 success, but the circumstances as perceived and as
25 described by Ms Twelves actually enabled corrupt

1 practices and organised paedophiles to take advantage of
2 council's dark corners.
3 Ms Twelves does not pretend that everything she has
4 done in life, including as a Lambeth councillor, has
5 been done perfectly, and none of us can. We all make
6 mistakes, and Ms Twelves will make no excuses for any
7 mistakes she's assessed as having made.
8 You will have noted, chair, that Ms Twelves has
9 fully associated herself with the lengthy corporate
10 apology, if I may call it that, made by the council.
11 She accepts that there are many things that the council
12 could have improved upon in the way in which the public
13 in general and children in particular were served.
14 Nevertheless, she's also proud of much that was achieved
15 during her time. It was her aim that the changes she
16 was introducing would, notwithstanding much reduced
17 budgets, achieve lasting improvement to the provision of
18 services and thereby to the lives of Lambeth residents,
19 whether that be children in care, schools or housing.
20 It is of great regret to her that she was unable to
21 effect those lasting improvements which she sought to
22 create.
23 Lastly, chair, the task of overcoming institutional
24 inertia -- that's inertia to change -- is a long and
25 arduous task. It's striking that so many internal

1 reviews, external reviews, enquiries, inspection reports
2 and the like produced so little change in Lambeth.
3 Now, we all know from experience that this inertia
4 exists today throughout public bodies and not just in
5 England. Ms Twelves endorses fully the inquiry's goal
6 of finding a better way to make change happen and to
7 happen for the best interests of children. Thank you,
8 chair.
9 THE CHAIR: Thank you, Mr Toner. Mr Verdan?
10 Closing statement by MR VERDAN
11 MR VERDAN: Chair, panel, I, together with Ms Perry and
12 Mr Powell, represent Lambeth Council. Over the four
13 weeks of this hearing, members and officers in
14 Lambeth Council have listened carefully to the evidence
15 of all the witnesses, and especially to the incredibly
16 moving and powerful testimony of survivors and victims.
17 The council has learnt much from preparing for this
18 inquiry, and the hearings have also provided Lambeth
19 with a valuable further opportunity to reflect, to
20 learn, to be held accountable and to make and implement
21 change. Lambeth wishes to acknowledge the brave and
22 moving written and oral evidence of the survivors
23 produced in this hearing. This has shed a clear light
24 on a dark period in Lambeth Council's history, one that
25 Lambeth will strive never to repeat.

1 The descriptions of the abuse and cruelty endured by
2 survivors are chilling. Equally, Lambeth acknowledges
3 the neglect and poor treatment that survivors were
4 subjected to whilst Lambeth was supposed to be acting as
5 their parent. Rather than creating anything like loving
6 home conditions, the picture that emerges is one of
7 neglect and horrific abuse in a harsh and cruel
8 environment.
9 At this juncture, Lambeth wishes, once again, to
10 take the opportunity to apologise to the victims and
11 survivors, including those who have courageously come
12 forward to share their stories and experiences. We
13 reaffirm the full apology of Ms Hudson given at the
14 beginning of her evidence and later adopted by other
15 witnesses.
16 Throughout the hearing, the evidence of survivors
17 has reinforced the imperative to ensure that children
18 are listened to and have a real voice in decisions that
19 affect them. Lambeth will continue to ensure that
20 children in its care are able to access people
21 independent of the council who will champion and
22 advocate for their rights and needs.
23 Lambeth holds itself accountable for the failures of
24 the past. Lambeth intends to learn and change as
25 a result of this process, having missed so many previous

1 opportunities to do so at so great a human cost.
2 Whilst the current administration has already taken
3 steps to set up a compensation scheme and has provided
4 counselling and other support to victims and survivors,
5 it recognises that there is much more to be done. It
6 will follow fully through the recommendations from this
7 inquiry.
8 We hope that the evidence given to this inquiry by
9 Ms Hudson and Councillor Davie has demonstrated the
10 council's commitment to continue to improve and its
11 desire to ensure that learning from the inquiry
12 translates into positive action which improves the
13 quality of corporate parenting provided to children in
14 its care.
15 As you have heard in evidence from Councillor Davie,
16 on behalf of the current administration, the leadership
17 of the council is determined to ensure that looked-after
18 children in Lambeth are well cared for in risk-free
19 environments. The council will remain vigilant as there
20 is no place for complacency when protecting children and
21 ensuring all children in care have the very best
22 outcomes. Lastly, I confirm that Lambeth will be
23 providing written submissions and in those will respond
24 as necessary to the specific points raised today by
25 others in their oral submissions. Thank you, chair.

1 THE CHAIR: Thank you, Mr Verdan. Ms Leek?
2 Closing statement by MS LEEK
3 MS LEEK: Over the last month, Commander Alex Murray,
4 DI Simon Morley and others from the Operation Winterkey
5 team have watched these hearings and listened carefully
6 to the evidence. They have been struck in particular by
7 the evidence of victims and survivors of sexual abuse at
8 the hands of those in whose care they were placed and
9 whom they should have been able to trust. These
10 officers want the panel and complainants to know that,
11 as I said in opening, they are not complacent about
12 having learned all of the lessons that need to be
13 learned. They have taken on board the evidence of both
14 good and poor practice, as well as survivors'
15 recommendations for how to protect children better in
16 the future.
17 Chair, as Commander Murray said in evidence, the MPS
18 has come a long way in its approach to safeguarding but
19 there remain considerable challenges.
20 Thanks to the evidence gathered by the inquiry, some
21 survivors have provided accounts of abuse during this
22 investigation that they have not previously reported to
23 the police or that were previously reported to police
24 but without a satisfactory outcome. The officers in
25 Operation Winterkey want to make clear to all

1 complainants that they are available to speak with
2 anyone who wishes to do so. They can look at any
3 unreported allegations and any reported allegation where
4 a complainant feels the police response was not
5 satisfactory.
6 To this end, contact details for Operation Winterkey
7 can be provided to any complainant upon request.
8 Chair, the inquiry has heard extensive evidence
9 about the historic and more recent police investigations
10 into child sexual abuse involving children in the care
11 of the council. As I said in opening, the MPS has no
12 wish to be defensive, and, as acknowledged by DI Morley
13 in his evidence, it is clear that there are aspects of
14 those investigations which were not carried out
15 properly.
16 Opportunities to apprehend suspects earlier, or at
17 all, were missed. Opportunities to investigate possible
18 links between certain known or suspected abusers were
19 missed. The Commissioner apologises for this and for
20 any pain suffered by any complainant as a result of
21 police omissions.
22 However, as Mr Gargini's counsel pointed out,
23 Operation Middleton and CHILE was the first large-scale
24 joint police/local authority investigation into
25 allegations of child sexual abuse. It was ground

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1 breaking, and it was successful in many respects. As
2 Mr Gargini explained, upon being appointed to review
3 Operation Trawler, he recognised that there needed to be
4 an enquiry into the allegations of abuse being made in
5 Lambeth and he recommended that a special team of
6 detectives and child protection experts be put in place
7 to conduct this inquiry. Senior management accepted his
8 recommendations and put in place a dedicated team to
9 investigate these allegations in the form of
10 Operation Middleton.
11 The investigation used the HOLMES computer system.
12 As you have heard already this afternoon, this was the
13 first time that this particular software had been used
14 for a non-murder investigation and was something that
15 senior management had to fight hard for. The team
16 worked closely with social workers who were independent
17 of Lambeth to ensure the welfare of the complainants.
18 The success or outcome of an operation cannot be
19 judged solely by the number of convictions. Numerous
20 suspects were identified, 16 cases were referred to the
21 CPS for charging decisions, five were charged and two
22 ultimately convicted of sexual offences towards
23 children.
24 Victims were supported through the process. Chair,
25 as Ms Kenward said in evidence, the fact that there were

1 few convictions may in part reflect the difficulty of
2 prosecuting historic offences where the victims were
3 young or unable to communicate properly.
4 Operation Middleton and CHILE strengthened the way
5 that Lambeth and the Metropolitan Police Service worked
6 together, and while it is clear that both suffered from
7 under-resourcing as a result of competing priorities,
8 there is no doubt of the good intentions underpinning
9 the investigation and that those involved were committed
10 to trying to uncover the abuse of children in Lambeth.
11 Each investigation must be judged according to the
12 standards of its time. Chair, this may be obvious, but
13 it does bear repetition.
14 There are a number of reasons to explain why more
15 recent investigations have managed to secure the
16 conviction of offenders where Operation Middleton did
17 not. Chair, that does not take away from the criticisms
18 that DI Morley accepted in his evidence.
19 Chair, these reasons include the fact that the last
20 20 years have seen great changes in the way in which
21 current and historic child sexual abuse is investigated
22 and prosecuted in both the Metropolitan Police Service
23 and the criminal justice system more broadly, from the
24 change in ABE interviewing to the use of intermediaries
25 and the special measures available in the court system.

1 It is also clear that many victims were not in
2 a position, in the late 1990s and early 2000s, to report
3 their abuse to police, and it took time for them to feel
4 able to come forward.
5 It should also be noted that the use of HOLMES in
6 child sexual abuse investigations, pioneered by
7 Operation Middleton, has had a lasting effect. Today,
8 Operation Winterkey uses HOLMES in a similar fashion, to
9 ensure that links between allegations are identified.
10 May I turn to allegations of coverup? Chair, as
11 I said in opening, the MPS acknowledges that many of
12 the complaints about police action or inaction are
13 justified. Others, however, are not. The inquiry has
14 heard evidence from a very small number of witnesses who
15 have made allegations of coverup or suppression of
16 investigations into abuse at Lambeth Children's Homes.
17 Chair, it is easy to make such allegations on the basis
18 of rumour or speculation.
19 First of all, Anna Tapsell, through her counsel and
20 in her statement, has alleged that DI Clive Driscoll was
21 removed from Operation Trawler and that
22 Operation Middleton was limited in its terms of
23 reference and closed prematurely in order to suppress
24 investigations that might cause embarrassment to
25 prominent persons. She also alleged that

1 Richard Gargini and Helen Kenward attempted to close her
2 down from investigating any further issues of concern to
3 her.
4 Dr Goldie has said that, following DI Driscoll's
5 removal from Operation Trawler, and following a meeting
6 with Richard Gargini, he had a, and I quote, "feeling"
7 that investigations into prominent persons were being
8 covered up. Clive Driscoll stated in his evidence that,
9 during Operation Trawler, Lambeth officials attempted to
10 steer his investigations away from Highland Road and
11 Angell Road Children's Homes. He suggested that
12 Operation Middleton may have been unduly compromised by
13 pressure from Lambeth.
14 You will recall, however, that when he was pressed
15 as to precisely who attempted to steer him away from
16 these homes, he was unable to give an answer.
17 Chair, not only are there inconsistencies in the
18 evidence provided by these three witnesses, it is also
19 clear that none of them has been able to provide to the
20 inquiry any actual evidence to support their
21 allegations. It is based on feeling and speculation.
22 The allegations have been investigated by the IOPC
23 under Operation Alka. Following extensive enquiries,
24 Operation Alka concluded that DI Driscoll was removed
25 from Operation Trawler through management action

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connected with the complaint made by Lambeth Council and not through suppression.

Chair, we invite the panel to consider the following points. First of all, in his evidence to the inquiry, Mr Gargini set out the steps he took to ensure that historic child sexual abuse in Lambeth's children's homes was properly investigated by the Metropolitan Police Service. This included recommending that a team of full-time detectives and child protection experts be established to investigate the abuse and that formal terms of reference be put in place for the investigation.

He outlined the oversight in place for the investigation by the Gold Group, which was attended not only by senior police officers and senior Lambeth officials, but by representatives from CHILE, Lambeth Social Services and representatives of the Social Services Inspectorate.

Mr Gargini, Heather Rabbatts and Helen Kenward all explained the significance of the CHILE team, which was an independent team of social workers and which was brought in specifically to ensure that all survivors of abuse felt safe coming forward.

Mr Gargini outlined the actions he took arising out of information provided to him by DI Driscoll, namely,

visiting both Anna Tapsell and Theresa Johnson to see what further information they could provide. The contemporaneous handwritten note of the meeting with Ms Tapsell contradicts, in many parts, the allegations that she made about the meeting and makes clear that Ms Tapsell was given an opportunity to share her contents with the Middleton and CHILE teams.

Ms Kenward recalls Mr Gargini advising Anna Tapsell about containing gossip rather than letting it spread like wildfire and that Ms Tapsell did not always understand the difference between intelligence and evidence.

As to the visit to Theresa Johnson, Mr Gargini ultimately considered Ms Johnson's information about the prominent politician to be unspecific and he noted that it did not actually involve any allegations of criminal activity. It was a sighting where it was unconfirmed, and Ms Johnson could not assist in providing Mr Gargini with any credible lines of enquiry.

You will recall, chair, that Ms Kenward recalled that the CHILE team found no information to support Ms Johnson's allegations, and she said in her 2014 statement that Theresa Johnson had provided no evidence that F41 had done anything untoward.

As the Operation Alka report found, in addition to

DI Driscoll mentioning the names of prominent persons in an inappropriate setting, the working relationship between DI Driscoll and Lambeth Council had broken down. This is reflected in the memo sent by DI Driscoll outlining these difficulties and was made very clear in evidence by both Dr Goldie and Dr Driscoll.

Chair, to date, and despite wide media coverage and extensive investigation into the possible involvement of prominent persons in the abuse of Lambeth children, no-one has ever come forward directly to report any allegations of sexual or other abuse against LA-F41 or any person of public prominence connected to Lambeth Council.

Chair, this inquiry will be well aware of the obvious dangers of publicly naming or arresting any individual, still less a high-profile or public figure, unnecessarily or without credible evidence.

Finally, chair, we invite the panel to consider the fact that Operation Middleton's terms of reference required it to look at, and I quote, "alleged instances of child abuse committed by persons over the age of 18 years against children in the care of Lambeth between 1974 and 1994 where credible evidence or intelligence existed". The investigation lasted nearly five years. On any objective assessment, the scope of

Operation Middleton cannot be described as narrow.

Operation Middleton may not have been a perfect investigation, as acknowledged by DI Morley. However, there is simply no evidence to support the view or to support a conclusion that it attempted to suppress allegations made against any particular individuals or that it deliberately set out to avoid investigating certain children's homes in Lambeth.

Chair, moving forward, the Metropolitan Police Service has sought to provide all possible assistance to this inquiry. It has disclosed to you and your team many thousands of pages of material and prepared lengthy statements outlining the history of MPS investigations into abuse at Lambeth.

With regard to the gisted accounts of victims read into evidence by counsel to the inquiry, Operation Winterkey is in the process of looking into the details relating to the reporting of allegations to the police in order to investigate the circumstances. The Metropolitan Police Service will then send out a response so that the chair and panel have a full and accurate picture and so that each complainant may understand what happened with regard to the allegations that were made.

Chair, we hope that the process of examining this

material in this forensic environment will contribute to the public understanding of what has happened in the past in Lambeth and to the survivors' understanding of what happened to them individually.

As an organisation, the Metropolitan Police Service is committed to learning whatever lessons for the future can be drawn from that history.

The Metropolitan Police Service has listened carefully to the submissions of Mr Khan QC with regard to the proposed redress schemes and will respond in detail in writing.

Finally, chair, Operation Winterkey continues actively to investigate allegations of sexual abuse involving children in the care of Lambeth Council. The MPS is committed to bringing more perpetrators of child sexual abuse to justice and taking all possible steps to ensure that the horrors described by the victims and by the survivors and complainants in the course of this hearing cannot ever be repeated. Thank you.

THE CHAIR: Thank you, Ms Leek. Mr Brown?

Closing statement by MR BROWN

MR BROWN: Chair and members of the panel, on behalf of the Crown Prosecution Service today, I will address four fundamental points. We will make good these and others in detailed evidence-based written submissions. I hope

they will be constructive.

The first: CPS independence. In this investigation, there has been an inadvertent tendency to conflate the role of the CPS and that of the police, who are the specialist trained investigators; the CPS are not, and cannot be. They are the prosecutors trained in law, applying it to the evidence that the lawyers are provided with, using only that which is legally admissible. The CPS are not the law makers; parliament is. The CPS must apply it and must advise from the perspective of a criminal prosecution. Police duties are wider and different.

Sir Keir Starmer, when DPP, set down that prosecutorial discretion, in deciding whether to initiate or continue a prosecution, shall be exercised independently and impartially and in accordance with the law. Prosecutors have a duty to the court to act with independence, in the interests of justice, and must remain impartial and objective.

By necessity, the CPS, therefore, is one step away from the consistent, close, personal contact that others have with a victim; accountable, as it nevertheless is. However independence is achieved, acting with its different backdrop, it must be preserved, we submit.

Secondly, nobody -- nobody -- could have had

anything but the most profound sympathy for LA-A25 when she described her experiences in court as a witness in 1975; LA-A80, LA-A69 and others, of course, also. We, today, are perhaps shocked at what the law imposed on a vulnerable witness then in 1975.

In this short time, I must clear up an impression that could have been misconstrued from the opening by counsel to the inquiry, not least so those listening to the Lambeth investigation can hear.

You and the panel have the benefit of, and have reported on, previous investigations, but it was the panel member Mr Frank who first put any detail on this topic in the public domain. What is the topic? It is the preparation for and the giving of evidence here today.

In opening, in respect of court ABE interviews, it was said:

"The joint 2014 inspection report, written, as it was, six years ago, suggests that those who claim, when looking back at the history of Lambeth, that it would be all different now are surely mistaken."

With respect, please note, this is in the face of the all-too-brief evidence now of Dr Phibbs and of Mr McGill(?) and documents before you.

For a victim who is considering whether now, today,

to report all their trusted carers who have the best interests of their loved ones at heart, to hear that, it may well have been misleading for them.

Any witness, any recent witness or practitioner today, had they been called, would have put the inquiry right, and you can call for evidence, if you wish.

Complacency has no place in any institution, as Mr Scorer so rightly said, but in this very personal and all-important area of witness interviews and court experience, there has, indeed, been a sea change.

Lord Judge, perhaps the most victim-centric Lord Chief Justice of modern times, described the measures embedded since that report in 2014 as, I quote, "revolutionary", and by the then DPP Keir Starmer, who, of anybody, knows the rights of individuals, as, I quote, "ground breaking".

Please let there be no mistake, today, for vulnerable witnesses, by law, intermediaries are an engrained part now in a child's participation in the criminal justice system: intermediaries used 550 times per month, 4,500 times with children, in interviews, with the court system, with them throughout their evidence and in cross-examination and with the CPS encouragement.

Victims will not need to be in a courtroom, or even

1 in a court building or in a police station, nor will
2 they see a defendant, nor the jury or wigs and gowns.
3 They will have their evidence-in-chief video recorded
4 very early, and soon will have their cross-examination
5 pre-recorded, before any trial, and will not need to
6 attend court at all, unless they wish to do so.
7 Long before any trial, they will have met privately
8 the judge and counsel, each of whom are not allowed to
9 conduct such cases unless they are specially trained and
10 authorised.
11 Questions in cross-examination will be scrutinised
12 by the judge and restrictions made. Those with very
13 complex and profound needs will, today, be able to
14 provide evidence, including non-verbal victims, and with
15 a specific toolkit to assist an autistic victim. With
16 the help of the intermediary, possibly psychologists and
17 their carer, who can interpret, victims give evidence
18 using props that are needed, with comfort and calming
19 victims.
20 This progress is embedded in every appropriate case
21 today up and down the country, and has been since 2015,
22 and the public, in a public inquiry, should know this,
23 and the CPS encourages the police and the courts to use
24 all the measures now available.
25 It will be little consolation to LA-A25 and others,

1 but I hope that she would not recognise the experience.
2 One clear further result of these changes in the law
3 is that cases of LA-A26 in 1985, LA-A49 and others from
4 Monkton Street in 1986 would now be assisted by those
5 measures so that it is at least possible that such
6 a suspect could potentially face a trial before a jury.
7 It is no coincidence that Dr Phibbs' paper "Opening
8 doors" that you saw was co-authored by the late
9 remarkable Ruth Marchant, because Ruth Marchant also
10 co-authored the majority of those ground rules and
11 toolkits used in court today.
12 The Lighthouse Centre, I hope, is described as
13 a centre of excellence, supported as it is by the CPS,
14 and if the panel, in due course, wishes to make
15 recommendations on the back of the evidence of
16 Emma Harwood, the CPS would likely readily support that.
17 Indeed, Emma Harwood said that the CPS is a briefing
18 partner, has seen the value of it, and has an appetite
19 to get it right.
20 RASSO, the rape and serious sexual offences teams,
21 are now the specialists in place since 2014/15,
22 described in the independent report of last year as
23 "unfailingly having a commitment and determination to do
24 the best they can for both complainant and other parties
25 to the criminal justice system". But the evidence is

1 from that independent report they were not risk averse,
2 maintaining a professional focus, I quote, delivering
3 high-quality case work, code complaint in 98 per cent of
4 cases.
5 Of course it was not all praise, by any means and
6 that might lead to a complacency, and we will identify
7 in our written submissions the criticisms, the
8 improvements needed and what is being done and where we
9 invite recommendations from you, chair, but it is right
10 that you should know where there is praise as well.
11 But the fact is, and the evidence is, that, as the
12 law changed, the CPS has not stood still. Since 2014,
13 not all mentioned before you, amongst the improvements
14 are: the CPS advocates' panel scheme. From 2016, only
15 specially and consistently trained and ticketed
16 barristers are allowed to prosecute, and barristers are
17 obliged to provide lessons learnt in the event of an
18 acquittal, which would include, of course, low-quality
19 ABE interviews.
20 The CPS guidelines on prosecuting cases of child
21 sexual abuse, November 2018 revision, with an emphasis
22 on early consultation, intermediaries described as
23 crucial, supporting victims, myths and case building
24 issues.
25 March last year, CPS Rape and Sexual Offences legal

1 guidance, and, importantly, also last year, the CPS
2 Safeguarding Children as Victims and Witnesses, in which
3 institutional and non-recent cases and ABE interviews
4 are highlighted. I invite you, and indeed others, to
5 read it in due course.
6 Yesterday, a major document, RASSO 2025, was
7 published. I encourage its reading, and we will
8 summarise the detail in our submissions. The challenge,
9 of course, is to implement those guidelines; hence the
10 RASSO 2025 document. This is part of the picture, just
11 as Mr Scorer dealt with part today.
12 Thirdly, the past. In Operation Middleton in 2003,
13 the CPS lawyer was as if a later RASSO lawyer embedded
14 into the operation. On the evidence, he and others were
15 not unsympathetic, and allegations were not prematurely
16 dismissed or determined by prosecutors. We will make
17 this point good later in evidence about detail, but
18 I quote from the 2003 documents. The lawyer spoke of
19 the credibility of the witness in favourable terms and
20 said:
21 "One is forced to conclude, albeit reluctantly ...",
22 et cetera. So you will wish to look at the entire
23 evidence, and not soundbites.
24 I take the case of the suspect F8. We will address
25 each case study in writing, of course. You have heard,

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1 more so in other strands, the impact of the abuse of
2 process. This stopped prosecutions. The late 1990s and
3 the early 2000s were its heyday, as you know.
4 F8's case was described during the hearing as
5 a complete failure in the criminal justice process, not
6 by a witness, but by counsel. I regret to say that the
7 detailed evidence before you does not support that
8 assertion, and, not least, it presupposes we know why
9 the jury acquitted. The myth of late reporting was
10 recognised and was disregarded by the prosecutor. The
11 2003 documents tell us just that.
12 The strength of the abuse of process argument was
13 recognised in 2003, just as it was by the CPS lawyer in
14 2014/15, and by then the missing files had been
15 recovered by the police and were available for
16 disclosure, and that tells us where the true reason,
17 I submit, for not prosecuting in 2003 lay.
18 I will not, of course, say there were not other
19 decisions that could reasonably have been made, but were
20 they wrong at the time? We believe not. Nor will we
21 say there are no mistakes, but you will decide what were
22 important or not.
23 Finally, and fourthly, you were told we will also
24 consider whether paternalistic or perceived welfare
25 decisions were being made around whether they, the

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1 victims, should give evidence or not. The evidence
2 shows that the concern was not, we submit,
3 paternalistic, but it was in the light of the fact that
4 the then sometimes brutal experience in court was ever
5 present.
6 Pausing there for a moment, please, it's as if there
7 are criticisms if the welfare of the child is not
8 considered and there are criticisms if it is. That
9 experience had, of course, a knock-on effect to the
10 objectively tested prospects of a conviction, as did the
11 law of corroboration, both now quite outdated. If the
12 reasons for inconsistencies and delays were misconceived
13 then, this also, then, had a knock-on effect on the
14 prospect of a conviction, inevitably. These all bore on
15 the decisions honestly made by the prosecutors.
16 The CPS was, and is, of course, only one part of
17 the criminal justice system, acting within the law as it
18 then was, but there is, in truth, little evidence of any
19 of the myths or stereotypes being applied in this
20 investigation, and less so, you may think, when the
21 whole passages are examined, as we will do, and put into
22 their proper context, perhaps inadvertently omitted
23 here; elsewhere, in other investigations, maybe, but, we
24 submit, not here.
25 So, chair, any recommendations you make will be

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1 followed up. We recognise that there is much to be
2 done, and collectively. For example, if there is a way
3 that the CPS can properly and further promote the use of
4 the advanced ABE interviews described, already supported
5 by the CPS, then the CPS should; improving and
6 monitoring feedback on ABE interviews, as Mr McGill
7 said. Although it is right to say that both the 2019
8 guidances emphasise the feedback, particularly the
9 safeguarding guidance.
10 The CPS file retention policy may need revision,
11 subject, of course, to our duties under the Public
12 Records Act and the Data Protection Act of 2018 and the
13 GDPR regulations. These are some areas that may attract
14 recommendations; we accept that, of course.
15 The CPS will, however, learn from the evidence of
16 this investigation and from any recommendations you and
17 the panel make, and incorporate them into their plans
18 going forward, and we will continue to seek to assist
19 the inquiry in any way we can. Thank you very much for
20 your attention.
21 THE CHAIR: Thank you, Mr Brown. Finally, Ms Langdale, do
22 you wish to address the hearing?
23 Closing remarks by MS LANGDALE
24 MS LANGDALE: Very briefly, chair. Firstly, to say,
25 clearly, that concludes core participant closing

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1 statements. In terms of the Crown Prosecution Service,
2 we look forward to the response to the further rule 9,
3 which invites comments since 2014 of the detail referred
4 to now, and no doubt we will have that in due course.
5 As you are aware, chair, this inquiry has disclosed
6 a huge amount of material which has shone a light on
7 what it was like to be a child in Lambeth's care over
8 decades. Bringing to public attention the extent to
9 which children were put at risk and what life was like
10 for them has been the inquiry's principal focus, along
11 with the institutional response from a number of
12 institutions.
13 An inquiry of this scale and ambition will
14 inevitably have to disclose documents later than it
15 would wish. We are grateful to core participants who
16 have worked with us and have assisted us, despite the
17 tight timelines described.
18 You have heard oral evidence from 52 witnesses
19 across a range of subjects and a number of other witness
20 statements have been read to you. Counsel to the
21 investigation has not been reticent to bring to public
22 scrutiny difficult issues.
23 Ultimately, chair, it will be for you and the panel
24 to review the evidence and to come to your conclusions.
25

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1 Closing remarks by THE CHAIR
2 THE CHAIR: Thank you, Ms Langdale. As you have said, that
3 today concludes the public hearing into the extent of
4 any institutional failures to protect children in the
5 care of Lambeth Council from sexual abuse and sexual
6 exploitation.
7 MS LANGDALE: Chair, I'm so sorry, I have to correct one
8 matter. I thought you were going to finish there. The
9 written submissions, closing submissions, are
10 due August 2020, not October 2020. I think my colleague
11 today said October 2020, and core participant legal
12 teams may have been relieved or surprised to see that,
13 but it is August 2020 for closing written submissions
14 from core participant teams.
15 THE CHAIR: Thank you. We are grateful to all of the
16 witnesses who have come to give evidence before the
17 inquiry over the course of this week and previous weeks.
18 We would like to thank all of the representatives and
19 all of the inquiry staff for ensuring the smooth
20 progress of the hearings. We will now review the
21 material already provided to us and the remaining items
22 of evidence and further submissions which we are
23 expecting. We will then provide a report on this
24 investigation in the summer of 2021.
25 With that, I will draw these hearings to a close.

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1 Thank you very much to everybody.
2 (3.39 pm)
3 (The hearing concluded)
4
5
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