THE LAMBETH

INDEPENDENT CHILD PROTECTION INQUIRY

1999

THE FACTUAL BACKGROUND

PART 1

A PUBLIC REPORT

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SECTION 1. INTRODUCTION

1.1. Appointment and Terms of Reference.

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

"1. To examine the Council's response to any allegations of abuse made by XXXXX [a young person in Lambeth Council's care] *about* [Steven] *Forrest during and after his appointment* [as a social worker in Lambeth].
2. To refer any allegations of abuse made by XXXXX to the police.
3. To identify any failure to comply with legal requirements, established good practice and procedures of the Council at the time.
4. To make explicit any demonstrable failure by current or past employees to act in the best interests of children and young people which may become evident in the course of [the] *investigation.*
5. To make recommendations as to any amendments to procedures and practices of the Council that will ensure the proper care and protection of children and young people in the Council's care."

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

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

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

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

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

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

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

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

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

Breaking out of the traditional departmental packaging and taking to heart our new policy ideas will require a rapid change in the minds of staff at all levels. Each of these themes has repercussions in every departmental area. Examining how they can be implemented will take further work. …….
The root and branch reforms required will take time to have their effect and the Council will need to refocus its attention onto the key priorities. …….

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

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

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

1.2. This Inquiry

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

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

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

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

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

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

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

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

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

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

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

1.3. Abbreviations

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

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

SSI ..... The Social Services Inspectorate;

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

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

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

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

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

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

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

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

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

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

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

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

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

1.4. The Limitations on this Report's Clarity

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

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

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

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

1.5. The Interim Report of May 1999

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

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

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

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

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

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

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

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

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

[1.5.6.] *The second cause is a reluctance, by those whose experience is largely confined to the Lambeth Department, to change the established Lambeth way of working, even in the face of strong challenge. Because ineffective practice has become established, only a very rigorous appraisal of present Lambeth practice against best practice criteria will now break the local traditions, despite their obvious failings. The basic organisation of the Department needs to be remoulded, and its people motivated, to improve communication, mutual trust, and clarity of overriding objectives.*

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

SECTION 2. THIS REPORT'S FINDINGS

2.1. A General Conclusion

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

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

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

2.1.4. *"1.1 Lambeth Child Care Policy 1982*

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

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

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

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

i) rehabilitation with the child's own family

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

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

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

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

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

The welfare principle

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

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

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

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

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

2.2. The Reason for a Further Report at this Time

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

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

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

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

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

2.3. Organisational and Individual Incompetence Compared

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3. THE HISTORY OF STEVEN FORREST'S APPOINTMENTS

A. The Non-Confidential Detail

3.1. Introduction

3.1.1. Rather than make an unnecessary mystery, I have not treated relevant personal information about Steven Forrest as confidential. He is identified in the Terms of Reference, his medical condition has already received publicity, and the remaining information is of little consequence. However, I think it only fair to emphasise that he has been convicted of no crime, he cannot defend himself against the allegations that have been made against him, and the Inquiry is concerned only with the working hypothesis that Alan's disclosure created.

3.2. First Appointment

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

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

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

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

3.2.5. On 12.8.1981 the 4 1/2 month probationary report stated: *"Mr S. Forrest has proved to be a useful member of the team, and with support and guidance will be a valuable R.S.W.* [Residential Social Worker]".

3.3. Second Appointment

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

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

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

B. Main Conclusion on Section 3

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

SECTION 4. THE EARLY YEARS OF ALAN'S CARE

A. The Non-Confidential Detail

4.1. Reception into the Council's Care

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

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

4.2. Assumption of Parental Rights

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

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

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

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

4.3. Arranging Fostering

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

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

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

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

4.4. Basic Organisation, 1988-92

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

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

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

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

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

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

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

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

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

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

4.5. A Brief Fostering

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

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

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

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

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

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

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

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

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

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

4.7. Another Attempted Fostering

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

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

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

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

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

4.8. Two Changes

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

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

4.9. Basic Organisation 1992 - 1996

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

4.10. Warner Report

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

4.11. The Death of Steven Forrest

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

4.12. Child Protection Investigation 1992

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

4.13. The Remaining Years at Angell Road

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

4.14. Two More Failed Fosterings

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

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

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

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

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

4.15. Further Plans

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

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

4.16. Departure from Angell Road

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

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

B. Main Conclusions on Section 4

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

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

3. It is impossible to find any evidence that there was an effective 'overview' of Alan's case. The detailed evidence reveals a piecemeal, reactive approach, repeated failure to act on agreed plans, and a poor understanding of child development. In particular, Alan's behaviour cried out for therapeutic help, but such help as was given appears to have been organised in a sporadic, unaccountable and unco-ordinated way. Alan, who was now nearly eleven years old, remained in the residential care 'limbo' which had first been identified by the Brixton Child Guidance Psychiatrist on 5.7.1985, when he was 3½. The Council's Policy targets were missed to a deplorable extent.

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

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

SECTION 5. A NEW HOME FOR ALAN

A. The Non-Confidential Detail

5.1. The New Arrangements

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

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

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

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

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

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

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

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

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

5.2. A New Social Worker for Alan

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

5.3. SSI Inspection of Angell Road 1993

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

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

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

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

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

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

5.4. A New Team Manager for SW1

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

5.5. More Concern about Sexual Abuse

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

5.5.2. In December 1993 Alan became 12 years old.

5.6. Action Plan

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

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

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

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

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

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

5.7. The Care of Alan in Kent during 1994

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

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

5.8. SSI Report on Lambeth's Inspection Unit 1994

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

5.9. A New Council

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

5.10. SSI Report on Residential Child Care 1994

5.10.1. In May 1994 the Social Services Inspectorate reported on an *"Inspection of Lambeth Residential Child Care".*
"1.1 This was a follow-up to an inspection carried out in March 1993. [see sub-section 5.3. above]. *The earlier inspection was at the request of the Parliamentary Under Secretary of State for Health. The 1993 inspection reported a number of serious concerns with the quality of residential child care in Lambeth.*

1.2 Lambeth were required to take action to improve the service and this inspection was carried out to assess the progress made and its impact on practice. During the year between inspections senior managers in Lambeth had reported three times (December 1993, February 1994 and May 1994) to the Social Services Committee on their work to improve the service.

1.3 The year had been a difficult one for Lambeth Social Services. Senior managers had worked within a climate of financial constraint to try and improve the service. At the same time as work was in progress to improve the service, considerable effort was put into a radical re-design of the whole residential child care service.

1.4 This large and complex piece of work had a major impact on all staff concerned and a consequent disturbance to the service and the children looked after by it. It is anticipated that the new service will come on stream between November 1994 and March 1995."

[5.10.2.] *"Conclusions*
1.7 Overall, the improvements were limited and patchy and some important essentials of good practice particularly in relation to care plans and supervision were still not adequate."
The SSI Report then referred to five basic needs, which included *"Routine and rigorous monitoring of the quality of practice by managers and members."*

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

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

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

5.11. Draft Guidelines for Working with HIV in Child Protection

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

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

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

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

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

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

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

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

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

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

5.12. The District Auditor's Management Letter to Councillors

5.12.1. This letter, dated 30.12.1994, included 2½ pages on Children's Services, following the implementation of the Children Act 1989. The audit had identified areas of good practice, and *"some areas where improvements are needed. In many cases the SSD are already aware of the problems and have taken initial steps to improve the situation. The detailed findings of the review are being discussed with the Director of Social Services and will be reported to Members in the near future. The key issues being discussed are: ….* [amongst other issues] *Child Protection …. ".* I have not been able to discover any report to Councillors, despite repeated searching of Committee Minutes by appropriate officers.

5.12.2. In the Spring of 1995 a Draft Report was issued by the District Auditor on *"Promoting the Well Being of Children"*. A meeting had been held with the Assistant Directors of Social Services and *"It was agreed that further work would be undertaken in three main areas:*
. *Child Protection*
. *Children Looked After*
. *Service for Under 8's."*
The Main Conclusions stated: *"Lambeth has reviewed its childrens services to meet the requirements of the Children Act. Particular areas of good practice identified by this audit include: …."* Then followed a description of seven areas of administration appropriate for review by an auditor. It also praised Lambeth's schemes for supporting children leaving care and preventing family breakdown.

5.12.3. The Report, however, identified improvements which were needed, including:
"Child Protection
- there was a serious backlog of unwritten and untyped conference minutes especially in one area, which affected decision making at later conferences;
- the Area Child Protection Committee needs more focused and timetable work plans.

Children Looked After
- there are a high number of emergency placements which results in placements without immediate Care Plans, and too few foster placements
- there are too many children under eleven in residential rather than foster placements."

5.12.4. The accompanying Action Plan included the need to *"Stop using Area Managers to chair cases in their own areas. Consider an independent chair scheme or a cross area rota."* This was actioned for completion by October 1995. The Plan also included: *"Ensure that minutes are taken at all conferences and placed on files within a set period. All drafts should reach the chair within seven days and a copy be placed on file."* These were neither novel, nor unreasonable recommendations. It is a disturbing mystery that advice of this kind should need to be repeated so often. It is even more disturbing that the underlying reasons for such good practice appear not to have influenced the conduct of Alan's case in 1996.

5.12.5. This intervention by the external auditor is one of the matters which I would have preferred to research more fully before publishing a Report. At this stage, I do not know why it was not followed through to a formal report stage to the Council.

5.13. The Care of Alan in Kent during 1995

5.13.1. I have nothing of significance for Alan's care to report for 1995, other than some confidential coincidental information which raised once again the likelihood that Alan had been sexually abused at Angell Road Children's Home, though the identity of the abuser remained unknown. Alan remained at the supportive home in Kent, continued to attend therapy sessions nearby, and had regular contact with SW1.

5.14. Messages from Research 1995

5.14.1. In June 1995 the Department of Health published *"Messages from Research"*, which suggested that too many children were made subject to Child Protection procedures (in particular joint Police/Social Services investigations). This practice could be at the expense of providing more appropriate Family Support in some cases. The potential complexity of each individual case coming to the attention of the Social Services Department cannot be over emphasised. I also recognize the immensely difficult task facing those who have to implement decisions. Staff shortages, according to an Area Manager, made it difficult to prioritise cases and find appropriate staff. However, this potential complexity and difficulty should provoke the utmost co-operation between those making the Care decisions and their specialist Child Protection advisers, if the Council's duty to safeguard and protect the child's welfare is to be fulfilled. This seems to me to be so obvious that I have found it difficult to comprehend the clear evidence that co-operation did not occur, and was not routine, in Alan's case in 1996.

5.15. Financial Difficulties

5.15.1. In July 1995 I understand that an overspend on the Community Care Budget was forecast by the Finance Department, leading to a 'cuts package' for the current Social Services budget. Then a considerable gap appeared in the Council's finances, causing a great push to reduce staffing levels before the new financial year began. In October 1995 the Director of Social Services left Lambeth, and was succeeded by an Acting Director on 23.10.1995. The Acting Director, to whom I will refer as 'DSS1', remained until early May 1996.

5.15.2. In December 1995, Alan became 14 years old.

B. Main Conclusions on Section 5

1. Those who took over the direct care of Alan during the period covered by Section 5 worked hard to settle Alan in supportive residential care. The new placement worked well for Alan, even though it was incompetently implemented initially. However, he was still in a temporary and institutional, but supportive, Home. The Lambeth Child Care Policy remained that wherever possible, no child in the care of Lambeth Council should spend the major part of its childhood in local authority care, and that no child who came into care under the age of 10 should remain in care for more than two years. At the end of this period Alan was 13 years old, and had been in residential care for over 10 years.

2. Suspicion grew stronger that Alan had been sexually abused, whilst in care prior to this placement in Kent. Attempts to help him deal with his unsettled past were made through psychodynamic psychotherapy, and by the care offered within the Home in Kent. There is no indication that the psychotherapy was co-ordinated with Alan's care.

3. From several documents, incidents and opinions, I have frequently been made aware of tensions between the work of specialist Child Protection Officers and management of the generalist operational work during this period. The continuation of these tensions contributed significantly to the defective response to Alan's disclosure of abuse in 1996.

4. A more subtle tension in the way Child Protection practice occurred in Lambeth was that between normal case work and major investigations involving staff. I recognize that, in the latter, confidentiality may be an important factor. Large investigations of this kind were carried out by the most senior specialist, and only a small number of the most senior managers were privy to them. In the years prior to Alan's disclosure I have detected a zeal in maintaining confidentiality beyond what was operationally appropriate. It therefore comes as no surprise to me that more junior staff, and other agencies, did not think it their responsibility to question the inactivity which overtook the initial Child Protection process following Alan's disclosure in early 1996.

5. External expert advice on the need to improve Child Protection practices continued to be given. Although the advice was formally accepted, its effect in actual practice was not apparent in 1996. I therefore question if these external monitors were as effective in registering their concerns as the subject-matter required. Of particular significance for this Inquiry is the repeated advice to end the domination by line management of Child Protection cases involving staff, and the need to improve the administrative organisation of Child Protection cases.

7. The system for involving Councillors in assessing the quality of service provided in children's residential homes appears wooden, ill-observed and ineffective.

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

A. The Non-Confidential Detail

6.1. Another Major Reorganisation

6.1.1. The new, Acting, Director of Social Services, DSS1, faced a considerable challenge, in 'downsizing' the Department to meet financial requirements. A draft Report by the District Auditor in August 1996, covering progress on Value for Money reviews, stated in relation to the Department: *"The Directorate is the highest spender per head of population of any local authority in England and Wales. It is, however, reducing its budget by some £17 million or 18% between the 1995/96 and 1996/97 financial years.".* In January 1996, the third major reorganisation of the Department was taking place, with a forced exodus of senior and middle managers. The two Assistant Directors responsible respectively for the Children & Families Care and Resources Divisions retired. Both these Assistant Directors had left by 4.2.1996. As a survivor told me: *"Everything was changing in the structure of the Department. All posts were Acting, and you did not know what the current role was of the people you were dealing with."*

6.1.2. Against this background, the number of Assistant Directors was reduced, so that almost the whole of the responsibilities of both the former Care and the former Resources Divisions were placed under a single Assistant Director, Children and Families, post. A permanent appointment to this post was not made until the end of January 1997. The other Assistant Director post in the new structure relevant to this Report, to whom I will refer as 'AD2', was filled immediately by the appointment of a survivor from the former senior management structure of the Department. He had been Head of Strategic Planning and Development in the pre-1996 arrangements, and now became Assistant Director, Quality and Strategy. The Child Protection Unit had written a paper, I was told, emphasising the need to strengthen their independent role in any new arrangements. In particular, they had recommended that they should be placed under the separate management of the AD2 post, rather than continue in the amalgamated Children and Families Division under the AD1 post, and DSS1 had accepted their case.

6.1.3. The pressures caused by the changes affected middle management too. The Manager of the Area responsible for Alan's case told me: *"Senior managers were leaving, the two Children & Families Divisions were merging, Areas were merging, and middle managers were leaving. In March 1996 there was an enormous merging of services and the merged Areas 7 and 8 took in parts of Areas 2 and 3 to form South Area. Three out of the five Team Managers in this Area took early retirement. During February/March the Assistant Area Manager left. The job was keeping tabs on the overall position and keeping the business going."*

6.1.4. Inevitably when major changes were rapidly required, there were major organisational disruptions. For example, I was told that *"a decision to close Children's Homes had been taken, but the Children's Homes Manager was leaving. Day Care was supposed to go to Education, but there was no programme to make it happen. Family Centres were still there, but with no management. They were going to become Children's Resource Centres in 1994/95 but this plan had changed by 1996. Children's Services Plans were being prepared, but there was no relevant machine to deliver…. There were still two Children's Divisions, and no plan for their amalgamation, though amalgamation had been decided in principle…. All three Areas were totally different from each other."* Rapid departures meant hurried or no transfers of both oral and written information to successors. Lambeth's tradition of relying heavily on oral rather than written information therefore caused considerable problems for the ongoing work. In relation to matters within the scope of this Inquiry, the defective handover of information made the transfer of work problem even more acute.

6.1.5. On 5.2.1996 AD1 formally became Acting Assistant Director Children & Families but, she told me, she was still directly managing the Adoption & Fostering Section, her former job. The Council had not felt able to make an appointment from the candidates who had responded to the advertisement of the Assistant Director job, of whom she was one. Her appointment as Assistant Director remained "Acting" until a second competitive appointments process resulted in AD1 being appointed to the permanent post on 29.1.1997.

6.1.6. The Job Description for this post (taken from the re-advertisement of March/April 1996) stated: *"Responsible for: Service and Area Managers, Services to Adolescents, Adoption & Fostering. Main Purpose of Job: … two key responsibilities. The first is as principal adviser to the Executive Director, the Social Services Committee and the Council, for the strategic development of Children's services in Lambeth to ensure the Borough leads the way in the quality and excellence of management competence and professional practice. The second key task is the operational management of the Children and Families Division so that it delivers services in accordance with any plan approved by the Social Services Committee.*

[6.1.7.] *Corporate Management*
1 To take a leading role in the overall management of the Social Services Directorate.
…
3 To ensure that the Division is managed effectively so that strategies and targets are set and delivered to the required standards. …

Policy Development
3 To be well informed about best practice, legislative change and service innovation, ensuring the Division's policy and practice are reviewed to maintain and develop excellence for the benefit of residents of Lambeth.

[6.1.8.] *Operational Management*
1 To be responsible for the operation, development and quality of practice in the Division.
2 To co-ordinate and direct the work of the Children and Families Division, ensure the review and development of specialist services required to provide the best care and rehabilitation for children and young people who are the responsibility of the Social Services Committee. …

4 To set explicit standards of the highest quality for all functions of the Division. ...
Candidates should demonstrate knowledge of:
Legislative Framework of Children's Services.
Professional Child Care practice.
Management practice."
Thus, there were both Department-wide and Divisional accountabilities.

6.1.9. AD2 became Assistant Director Quality and Strategy on 1.2.1996. He did not formally become responsible for the Child Protection specialists until 1.4.1996, but it was an obvious consequence of the deletion of this responsibility from the terms of the new Children and Families post. The Child Protection Co-ordinator left Lambeth at this time.

6.2. Child Protection - Divided We Stand?

6.2.1. The Departmental integration of Child Protection was formally reinforced by the appointment of AD1, not AD2, as Chair of the ACPC, effective probably from early March, and certainly by May 1996. The *"Working Together"* Guide (see paragraph 4.4.1. above) at 2.9 had stated: "...*Where the Chair is an officer of the Social Services Department, the individual should be of at least Assistant Director status and should possess knowledge and experience of child protection work in addition to chairing skills."* AD2's professional background had been in policy development, and not as a Social Worker. He, therefore, did not fit the *"Working Together"* specification.

6.2.2. The significance of the intended transfer of the management of the Manager, Child Protection & Quality Assurance and the specialist Child Protection staff to AD2 should not be exaggerated. It was not the provision of 'Child Protection' whose management was being transferred, only the management off the specialist advisory Team. The point of the transfer of these Child Protection specialists was to underline the independence of their advice to the operational decision-makers, who dealt with Child Protection issues as part of their work in the other Division.

6.2.3. Any formal bureaucratic arrangement of responsibilities inevitably produces artificial boundaries which are irrelevant to some of the problems to be tackled. The key requirement, in the interests of clients, is effective co-operation, not separation, and the formal arrangements assumed this. It was made abundantly clear in the Job Descriptions of MCP&QA1, and his successor in March 1996 (to whom I will refer as 'MCP&QA2'). Both Job Descriptions began with an objective *"To manage and co-ordinate* [and *"initiate"* in the case of MCP&QA1] *provision of a specialist Child Protection Service across the Directorate* [my emphasis] *to raise the standard of practice and delivery of service at all levels."*

6.2.4. The Job Descriptions also included: *"7. To chair planning meetings and child protection conferences that have across divisional and directorate significance.* [My emphasis]. *To provide professional advice and make appropriate decisions on complex child protection issues and to ensure that the Assistant Director C&F Care Division is informed of any specific difficulties."* The reference to the *"Care"* Division, I was assured by the post-holder, was an anachronism carried forward from MCP&QA1's job in the former structure to MCP&QA2's job in the new structure. The speed of formal change inevitably resulted in tensions throughout the changed structure. MCP&QA1 attended the other Division's Management Team meetings, and Area Managers protested at *"lack of consultation in rewriting of CPO job descriptions".*

6.2.5. On 27.3.1996 AD1 sent an E-mail to MCP&QA2 about *"Case Conference Chairing". "Thanks for your response. I will endeavour to set up a meeting asap between us as there is much to discuss and clarify in terms of responsibility re: CP work between your section and the Area offices. ...".* Unfortunately, the previous tensions between the Areas and the Child Protection specialists remained, despite the intention of the new formal structure. AD1 told me of the model she wanted: *"Supervision of Case work must be in the Areas. This is where it should be driven. A Planning Meeting should say who should do what and it is for the Area to pursue what needs to be done re a specific child. Child Protection* [specialists] *should pursue broader issues."* I accept this statement, but with two provisos. The first is that *"broader issues"* will often require Case work, and Case work may give rise to *"broader issues".* The second is that the very purpose of independent involvement is to criticise, and if criticism is to be effective the driving will have to be shared. Tension is inevitable in such circumstances, and effective means of resolving this tension must be established up to, and by, the highest level of management.

6.2.6. On 1.4.1996 AD2 became formally responsible for the Child Protection specialists, AD2's new Job Description referring to the management of the Division *"to ensure the provision of ... specialist child protection advice ... To be responsible for the management of the child protection and quality assurance function, including the management of the child protection register, and the development of quality audits within children and families services."*

6.2.7. These turbulent organisational changes, which I have attempted to describe, co-incided with the Department's receipt of Alan's disclosure of sexual abuse.

6.3. Alan's Disclosure of Sexual Abuse, and its Initial Reception

6.3.1. Towards the end of January 1996, Alan made a specific allegation to a member of his family that he had been sexually abused whilst at Angell Road Children's Home. Later, Alan also told Mr. N. Mr. N, on 31.1.1996, immediately telephoned SW1 in Lambeth. SW1 discussed the news with her Team Manager, TM1, who advised that the Area Manager should be told. On Friday, 2.2.1996, SW1 told the Area Manager and, at the Area Manager's request, confirmed the information in writing on Monday, 5.2.1996.

6.3.2. I am not aware of any reliable information that Alan had previously disclosed the abuse in this specific way to an adult, and consider it to be extremely unlikely that he had done so. In the confidential Part 2 of this Report, I have drawn together the information which had continued to accumulate over the previous four years, and which could have led to earlier, wider, investigations. These might have thrown light on Alan's situation. It is for the other independent Inquiry to consider what should have been attempted in the light of this, given any other relevant information which was available during those four years.

6.3.3. Neither SW1, nor TM1, nor Mr. and Mrs. N, were surprised at the disclosure of abuse. They had suspected that Alan had been sexually abused, given their knowledge of his behaviour. Now, they had an open disclosure of abuse and, for the first time, the identity of an alleged abuser. It was clear to all these people that an urgent Child Protection response was necessary. For SW1, the allegation was complicated by her informal knowledge that the alleged abuser identified by Alan had *"died of AIDS".*

6.3.4. SW1 wrote to the Area Manager on 5.2.1996 with the information clearly set out, and ended: "*I will be visiting Alan on 6.2.96 to reassure him and offer support to him & his carers following his disclosure. I would be able to attend a Planning Meeting when convenient and would appreciate your further advice in this situation.*" This information about Alan's disclosure, which required a Departmental reaction, arrived in the Lambeth Social Services Department at exactly the same time as the two new Assistant Directors, one of them in a temporary Acting capacity, the other not yet formally confirmed in post, were taking up their responsibilities under an Acting, and temporary, Director. Given the scale of the organisational upheaval taking place, it is difficult to think of a more unhelpful coincidence. It would have been understandable if the initial Departmental response had been deficient. But it was not.

6.3.5. On the same day as she had received SW1's memo, 5.2.1996, the Area Manager wrote to her superior, the new Acting Assistant Director of the Children and Families Division, AD1, who had formally assumed her new Acting duties on that very day. The Area Manager wrote:

"*DISCLOSURE CONCERNING A MEMBER OF STAFF*

I attach a hand written statement by [SW1]*, relating to the alleged past sexual abuse of a child in a Care Order by a member of staff at Angel Road Children's Home. The statement is presented in a hand written form to prevent undue delay. Although the alleged perpetrator is dead, there are a number of issues to be considered centrally as a department and would require an appropriate Planning meeting. Issues to be included are:*

1. *Were other children subjected to the same treatment.*
2. *The welfare of all those children, given that the named perpetrator apparently died of AIDS.*
3. *The value or otherwise of disclosure interview with Alan at this stage.*
4. *Compensation for the children involved."*

6.3.6. I have no doubt, from what I have been told, that the written record is only part of the communication which took place within the Department, from SW1 through TM1 and Area Manager to AD1. I have no doubt that Alan's disclosure created enormous concern that the right course should be taken. This was not only in relation to Alan, but also in relation to the possibility that other children might have been abused. It was an opportunity to help Alan for which SW1 and TM1 had been waiting. From the outset they also saw the wider implications for *"other children"*, and the Area Manager sharply incorporated these wider issues in her very clear note to AD1.

6.3.7. This succinct and clear note ought to have been sufficient to promote a full Departmental response to Alan's disclosure, under the continuing supervision of senior managers. It clearly raised issues which could not properly be determined at Area level. The note did prompt a proper beginning by the Department but, despite the genuine concerns of those directly involved with Alan, the Department failed as lamentably in relation to wider issues of possible/probable extensive child abuse as it continued to do in relation to Alan's individual care. As a working assumption, it was an inescapable Departmental responsibility to investigate whether a residential social worker, alleged to be an abuser by one child, had abused other children to whom he had had access. These wider issues could only be dealt with at the most senior level, and plainly raised a need for the Department to follow Child Protection Procedures.

6.4. The Lambeth Child Protection Procedures

6.4.1. I have been told that the Child Protection Procedures (to which I will refer as 'the CPPs') which should have applied when the Department received the information about Alan's disclosure were the Inter Agency Child Protection Procedures (the Yellow Book), published in 1988 (revised 1992), and the Departmental Child Protection Procedures dated, and circulated in, April 1995. It is often difficult, looking back over time, to establish clearly what documents had been published and when they were circulated, and I have found it difficult to establish what was extant at the material time, given administrative delays in the updating process. However, for my broad purpose of understanding the reasonableness, or otherwise, of what happened when the Department first received the information about Alan's disclosure, the basic process required by successive CPPs is very clear.

6.4.2. The Yellow Book has provided a basic structure for Child Protection investigations from 1988, and throughout the relevant period, even though supplemental Departmental Procedures and revisions have occurred. The Departmental officers involved in Alan's case had been in the Department for several years, and presumably were familiar with these basic and long established requirements. Even if the action to be taken was not clear to them, the advice of the Child Protection specialists was always available for them.

6.4.3. According to the 1988 Yellow Book, a Child Protection matter should be referred to a Child Protection Conference, but in the case of Child Sexual Abuse (as in Alan's case) a Planning Meeting must be held as a preliminary. The aim of such a Planning Meeting was to establish the level of risk, whether immediate legal protective action was needed, the substance of the allegation, and the planning of the investigation. The Planning Meeting should involve Social Services, the Police, a Community Medical Officer or Paediatrician, and the referrer if a professional (as in the case of Mr. N). In relation to an allegation against a staff member, the Assistant Director also had to be notified.

6.4.4. The Departmental Child Protection Manual of 1989 stated that it was complementary to, *"but distinct from the Yellow Book. All staff will read it fully and act on its contents*". It required all child protection cases to be the subject of regular auditing and discussion by the supervising manager, and the Director or an Assistant Director to organise the Planning Meeting.

6.4.5. The revised InterAgency (Yellow Book) Procedures of 1992 laid out a clear timeframe to be followed. The Departmental Children and Families Manual of December 1992, to be used in conjunction with the Inter Agency Procedures, also laid down a clear timescale. If there was insufficient information available to the initial Planning Meeting, another Planning Meeting should be held within a maximum of four weeks. An initial Case Conference should take place within fifteen working days of referral of child sexual abuse, unless a second Planning Meeting was needed. There was no provision for more than two Planning Meetings.

6.4.6. The 1995 Departmental CPPs did not vary this basic, required, structure. However, the management of the complexities of a Child Protection investigation is not a mere mechanical affair, the equivalent of 'painting by numbers'. The language of the CPPs is often one of compulsion, but reasonable professional discretion can still be exercised. However, where a professional deviates from such written procedures, one would expect a clear professional reason for doing so to be recorded. Hence, the emphasis on careful joint planning. I was surprised to find that the operative 1995 procedures were confusing to the extent that they expressly referred to ACPC procedures which had been superceded two months before the time the Departmental CPPs had been published. I mention this minor point to underline the importance of expert advice in underpinning a complex process, and a lack of organisational vigour.

6.4.7. A Planning Meeting is a procedural preliminary to a Child Protection Case Conference. The originating document, the Yellow Book, made clear the responsibility of the person occupying the 'chair' of a Conference to activate administrative arrangements. These include the list of invitees, the availability of information, the assignment of key tasks, the completion of the decision sheets, and the circulation of minutes. There is no comparable specific assignment of this responsibility, that I have been able to find, in relation to a Planning Meeting, but several staff to whom I spoke made the working assumption that this administrative responsibility was the same, and belonged to the 'chair' of the meeting.

6.5. The Calling of the First Planning Meeting

6.5.1. AD1, she told me, discussed the memo from the Area Manager with MCP&QA1. MCP&QA1 told me that he had already been alerted by one of the Area Office people. AD1 had consulted the CPPs, with which, she told me, she was unfamiliar in practice, and she had found them unclear. AD1 and MCP&QA1 agreed that there should be a Planning Meeting, with AD1 in the Chair, and MCP&QA1 there to assist her. At this stage a proper unity of Departmental action was achieved.

6.5.2. On 6.2.1996, SW1 visited Alan at his Home in Kent. *"Alan's first words to me were that he did not want to 'talk about this' but knew that he had to. I reassured Alan that I did not want him to go into any details ... and that I had come ... to see that he was all right, ..."* After discussion beforehand with Mr. and Mrs. N she listed their concerns. These were: the possibility of therapeutic /psychological help to Alan; the Health risk for Alan because of the abuse; the health risks to others; the likely concerns and anger of Alan's family; and Criminal Injuries Compensation for Alan. The possibility that another boy associated with Alan had also been sexually abused by Steven Forrest in Angell Road was discussed. These important matters listed by SW1 were in part the same as, and in part additional to, those so concisely put by the Area Manager in her memo to AD1. They were all taken up in initial discussion within the Social Services Department in subsequent weeks, but only the first became the subject of action, and even that was not pursued effectively.

6.5.3. On 7.2.1996 SW1 wrote to Alan's parents, inviting them to meet her about "*a matter regarding Alan that I need to discuss with you.*". The Department did not stifle the news of Alan's disclosure.

6.5.4. Arrangements were made for a Planning Meeting to take place on 16.2.1996. On 14.2.1996 the Police Child Protection Team informed Social Services that they would not be at the Planning Meeting "*given that Alan's alleged perpetrator has subsequently died and this means that ultimately no Police action could be taken*", according to SW1's note. However, they "*would become involved, if necessary, once the Planning Meeting has agreed further action and if the work necessitated checking the involvement of other members of staff/young people.*" The police officer who made the telephone call *"requested the D.O.B. of Alan's perpetrator if this information becomes available at the Planning Meeting, in order to carry out a Police check to establish whether SF is known to the Police."*

6.5.5. The fact that the alleged abuser was dead had removed any question of a criminal investigation in relation to Alan's specific disclosure. As the police officer's response itself indicated, the possibility that more than one child had been abused was substantial, and the possibility that a paedophile working in a children's home might have had associates could not be dismissed, especially given the history of suspicion about Angell Road Children's Home known to MCP&QA1. The working assumption that an abuser would have abused more than one child was given added weight by unconfirmed information from Mr. N that Alan had been in touch with another former resident in Angell Road who was said to have been sexually abused by the same abuser.

6.5.6. I am aware, from the confidential detail, of an accumulation of information which, if it had been collated and shared, could have properly initiated a joint investigation into the extent of sexual abuse within Angell Road Children's Home. Most of the information had been available to the Department for some time, but the recent changes in senior personnel had removed much personal knowledge of it within the senior management of the Department.

6.5.7. The principles of *"Working Together"* ought to have enabled a joint overview of the information's significance to have been taken. The Police had not closed the door on their involvement, but their absence from the initial Planning process removed a source of correction as that process later went awry. It is for the Police to consider, with the benefit of hindsight, the value their presence at the first Planning Meeting might have contributed. In my view, they would have been able to assess the significance of available information at first hand, to have provided encouragement to a more focussed and continuous process than that which occurred, and to have reconsidered the information which they had obtained in previous investigations.

6.6. The First Planning Meeting

6.6.1. The first Planning Meeting took place on 16.2.1996, and involved AD1 (in the Chair), MCP&QA1, TM1, SW1, and a Community Medical Officer from the Community Health Trust. According to the relevant CPPs, the Police should also have been present, and should have received a copy of the Minutes. Mr and Mrs N would also have been appropriate participants. The official Minutes, recorded by one participant as taken by MCP&QA1, are missing, and no-one recalls their distribution. On this occasion their disappearance and non-circulation may have been the result of MCP&QA1's retirement shortly afterwards. But what had happened to the new systems of monitoring progress (see paragraphs 5.6.4. and 5.6.5. above) that had been advised by the SSI and accepted by the Department?

6.6.2. I have had the benefit of seeing notes made at the meeting by MCP&QA1 and by SW1, and of hearing the recollections of all those who took part. My reconstruction of the proceedings from the informal notes by MCP&QA1 and SW1 is as follows: There was first a general outline of Alan's disclosure, and of his background history (including two significant incidents in 1992 and 1994), leading to a discussion of his state of mind, and the desirability of non-abusive intervention. In relation to the news that Steven Forrest had *"died of AIDS"*, the advice of the Community Medical Officer, based on the information given at the Meeting, was recorded as *"Chances of infection are v. low statistically".* She also advised that the case should be referred to a Community Consultant Paediatrician, who did attend the next Planning Meeting.

6.6.3. There was also discussion about the significance of Alan's disclosure for other children, and the need to go through files and interview other children's social workers. It was therefore agreed that it was necessary to establish which other children had been in the Home at the relevant time. It was decided that MCP&QA1 should establish some important facts - the dates when Steven Forrest had worked at Angell Road Home, and official confirmation of his death from an HIV related illness. Official confirmation about this was considered to be important, not because SW1 was not believed, but because her source was informal and confidential. It was also decided that, in the meantime, SW1 would ensure support for Alan, but take no investigative initiative until these facts had been established. Because Alan was already having therapy, it was decided that it would be better to postpone a decision on the best therapeutic approach until the influential matter of HIV status had been settled. If it was confirmed, expert help might be necessary to follow through its significance with Alan.

6.6.4. I have no criticism to make of this first Planning Meeting's decisions. That Alan had been abused was in no way denied; the need to work with, and support, him sympathetically was accepted; the establishment officially of the HIV threat was a rational preliminary to work with Alan or other children; establishing the scale of the task in tracing other children was also a sensible preliminary. There was no continuing threat from the alleged abuser, assuming that Alan had correctly identified him, and Alan was currently well cared for. Even if I am wrong in justifying the Meeting's decisions, I am confident I am right in not criticising them. The Police had had the opportunity to participate. Medical advice was taken and followed. There was nothing about the decisions which was corrupt, or unprofessional, even if experts, with or without hindsight, could now improve on them. They were not unreasonable decisions. However, the apparent absence of Minutes and decision sheets is not a minor administrative default. They should have been taken, and circulated to participants and to the Police.

6.6.5. SW1, according to the memo which she wrote on 14.6.1996, was *"told by* [AD1] *and* [MCP&QA1] *at the initial Planning Meeting on 16.2.96 not to ask Alan about specific details relating to his abuse until a procedure/course of action had been decided upon."* According to MCP&QA1's notes, it was agreed that all would maintain *"extreme confidentiality until facts are known – with regard to Alan and SF."* Confidentiality was always important in the first stage of an abuse investigation. Although the Police had already made clear the obvious fact that Steven Forrest could not be prosecuted, I can understand extreme caution in protecting what Alan might say about other abusers. Even though the alleged abuser was dead, he might have had associates, and it might be necessary to secure files.

6.6.6. The concern about confidentiality *"until the facts are known"* is also understandable from another angle. The HIV possibility introduced a further pressure for confidentiality, arising from the non-discriminatory policies of the Council. AD1 did not want a formal record about HIV until it had been officially established. *"That was a major issue at this first meeting"*, she told me.

6.6.7. These initial decisions by the Planning Meeting, whilst justifiable at that stage, ought to have underlined that there was also some urgency, because SW1 would have to support Alan in the meantime and he might well create an opportunity to discuss the situation. In that event, how was she to support him? It is disappointing to record that, despite this acceptable start, the fact of Steven Forrest's HIV status was never formally established until after the intervention of the Merseyside Police in October 1998. As a result, Alan was never properly approached about his situation, nor were the wider concerns about other children ever pursued, until 1998.

6.6.8. The Community Medical Officer, whose only involvement was at this Meeting, told me that the decision to confirm the HIV status information was pro-active. It was intended as a basis for dealing with Alan's disclosure, and also for dealing with the needs of other children who might have been abused in Angell Road. However, this extra dimension to Alan's disclosure caused by the informal news about Steven Forrest's HIV status became central to the operational Division's concern to deal with Alan. Because this first Planning Meeting had laid it down as a priority to obtain confirmation of SW1's unofficial information, official confirmation foolishly became a sine qua non. I do not disagree with the initial importance which was attached by the Meeting to confirmation. However, that importance was dependant upon whether there had been abuse. That was the primary issue in relation to other children, and it should have been vigorously pursued from the outset.

6.6.9. Those who dealt closely with Alan were never in doubt about his abuse, despite the forensically limited nature of the evidence, especially in relation to the identity of the abuser. And for all practical purposes, Steven Forrest's HIV status was clearly established by the end of March 1996. I am puzzled that there is no record of the specialist officers in the Social Services Department who dealt with HIV and AIDS related problems being consulted. Judging by the draft documents which they had produced, but which had never been formally approved by the Council, they would have asserted the primacy of dealing with the alleged abuse (see sub-section 5.11. above). This was the attitude expressly put forward by MCP&QA2 in her memo to AD2 of 14.8.1996, and by CP1 to MCP&QA2 of 15.8.1996 (see paragraphs 7.5.3. and 7.5.8. below), and would have informed the discussion at the two following Planning Meetings had Child Protection specialist advice been sought, as it should have been.

6.6.10. It is clear to me that there was a thorough discussion of the significance of Alan's disclosure, and there was certainly no question of a 'cover up' at this initial Planning Meeting. Appropriate people and agencies had been involved. Given that the alleged abuser was dead, there was no urgent need to ensure the safety of children from him, and some basic facts did need to be established. The tasks authorised by this Meeting were allocated to MCP&QA1, and his need for authority to gain access to Steven Forrest's Personnel File would necessarily involve the Acting Director, DSS1, being told the circumstances.

6.7. Action following the First Planning Meeting

6.7.1. According to my understanding of the CPP requirements, this first Planning Meeting should have led to a Case Conference within 15 working days, or a deferred Planning Meeting within 4 weeks - ie by 15th March. In fact, a further Planning Meeting was called on 29th March 1996, this date being determined mainly by the time it took the Community Health Trust to provide information about Steven Forrest's HIV status. Senior management should, in my view, have considered whether a Senior Management Group was needed, as it was potentially a complex investigation. Such a Group was organised in 1998, after the Merseyside Police intervention forcefully brought the situation to Lambeth's attention, but not at this time. I recognize that the turbulent organisational background at this time would obscure the obviousness of such a step for some weeks.

6.7.2. Immediately after this Planning Meeting the notes of the disclosure which had led to the Meeting were removed from the ordinary file, and put in a confidential file which was then held by TM1 until she left Lambeth in August 1997. This was consistent with the decision of the Meeting about confidentiality. Unfortunately, this confidential file has not been found, but there are sufficient alternative sources from contemporaneous documents to provide a reliable alternative account of the Departmental response to Alan's disclosure, in my view.

6.7.3. MCP&QA1 told me he had thought at the first Planning Meeting that he probably still had a list of the children who had been in Angell Road Home during the relevant period, which he had compiled for the investigation in 1992. I have seen such a list in one of the files. His departure a short time later should have provided no major hindrance to obtaining the list. MCP&QA1 had been involved in Child Protection investigations in Lambeth since 1990, and he told me that he expected that the Police would become involved in the wider issues raised by Alan's disclosure, once the relevant information had been collated, despite their refusal to attend the first Planning Meeting on Alan's individual disclosure. MCP&QA put in his diary for 19.2.1996 - the next working day after the Meeting - a reminder to see DSS1 for authorisation to have access to Steven Forrest's personal file, in order to pursue the HIV issue. SW1 informed Mr. and Mrs. N of the decision to await confirmation of certain information before action to help Alan could be taken.

6.7.4. On 20.2.1996, a formal memo was sent by, or in the name of, DSS1 to the Departmental Personnel Section, with a copy to AD1, the Chair of the Planning Meeting which had authorised this action.
"Please could you let me have as a matter of urgency the Personnel File on Steven Forrest. I understand he was formerly a residential social worker in Angell Rd. Children's Home."

6.7.5. On 21.2.1996 DSS1, or someone in his name, wrote to the Consultant Paediatrician nominated at the Planning Meeting, with copies to AD1 and MCP&QA1.
"I am writing to you to formally request your assistance in establishing whether Steven Forrest died as a result of AIDS.
I understand that you have discussed the matter informally with [MCP&QA1] *and that your colleague Dr …. was at the child protection planning meeting last week where the need to seek this information was agreed. You will appreciate, therefore, that our need to clarify this issue arises from the possible need to consider tracing contacts and from the need to provide counselling. I enclose a copy of the death certificate to assist you in your enquiries.*
At this stage no decisions have been taken on how to proceed, beyond trying to clarify the AIDS issue. Once we have a response to that a further planning meeting will be convened."

6.7.6. DSS1, who remained as Acting Director until early May 1996, recollected for me that MCP&QA1 had discussed this case with him. He recalled that it was obviously a potential challenge to the Council's past work and that it raised big issues which would have to be dealt with. The matter was at a very early stage when MCP&QA1 discussed it with him, and they were awaiting developments. MCP&QA1 was looking ahead *"schematically". "We were exploring. We had not reached a point of making big decisions."* This description fits exactly with the content of the letter to the Consultant Paediatrician "… *the possible need to consider tracing contacts and from the need to provide counselling.*", and " *At this stage no decisions have been taken on how to proceed, beyond trying to clarify the AIDS issue. Once we have a response to that a further planning meeting will be convened."* [my emphasis]. I have no hesitation in accepting that, at this stage, the positive approach of the first Planning Meeting, and its decision to look again at the situation after receiving official information about Steven Forrest's HIV status and details of the likely scale of an investigation, entitled an extremely busy Acting Director to leave close consideration of the case until the next Planning Meeting had re-considered it, and reported formally to him on the outcome. However, no such report was made, so far as I am aware.

6.7.7. On 28.2.96, the new Director (to whom I will refer as DSS2) began work at Lambeth. DSS1 remained the operational Acting Director until early May 1996.

6.7.8. According to the file notes, SW1, on 7.3.1996, twice tried to telephone AD1 to find out what was happening. Nearly three weeks had elapsed since the first Planning Meeting, and the CPPs required a deferred Meeting to take place within four weeks. The following day she was told by AD1's secretary that her messages had not been passed to AD1 because of pressure of work. I have no doubt that the pressure of work was harsh, given the background of substantial reorganisation. SW1 repeated her need to know what was happening, and what action she should take in relation to supporting Alan.

6.7.9. On 8.3.1996, the officer from the Police Child Protection Unit, who had declined to attend the first Planning Meeting, spoke to SW1. He had been away on annual leave and wanted to know progress. SW1 told him, according to her note, that she was *"waiting for instructions/ a decision from the Acting ADSS and until then the situation was not moving. …. Agreed to inform* [the officer] *of any further info as soon as it is known to me."* There is no record in the relevant files of any further Police/Social Services contact about Alan's disclosure either way, until the middle of 1998.

6.7.10. According to AD1, she enquired informally of MCP&QA1 whether AIDS had been confirmed, and he told her that it had, and that a letter was coming. On 10.3.1996 MCP&QA1 left Lambeth's service and was succeeded by MCP&QA2. MCP&QA2 told me that she had very little notice of her promotion and, although she does not remember the informal details, I doubt if she was approached about her new job before MCP&QA1 had been given formal Notice on 7.3.1996. I am satisfied that she had not been made aware of the disclosure by Alan, nor about the first Planning Meeting.

6.8. MCP&QA1's Departure

6.8.1. During February 1996 more changes in senior personnel had been discussed. MCP&QA1 was the senior Child Protection specialist, answerable to one of the Assistant Directors whom AD1 had replaced. However, as a deliberate consequence of Departmental reorganisation, AD1 did not have line management responsibility for MCP&QA1 and the specialist Child Protection work. This specialist work was in the course of transfer to the management of the other new Assistant Director, AD2. The intention to transfer it was not in doubt, but there was no formal transfer until 1.4.1996. I am satisfied that it would have been impossible to refer to an organisation chart which would clearly have shown an Assistant Director who had formal line management responsibility for MCP&QA1, and the specialist Child Protection officers, at this time when Alan's disclosure was first considered. I am equally satisfied that the informal shape of the new structure was, in this respect, beyond doubt. In any event, lack of formal clarity ought not to obstruct sensible co-operation within a Department. Indeed, when the lack of formal clarity is obvious, as it was here, the need for informal understanding and co-operation becomes all the greater.

6.8.2. MCP&QA1, in particular, was considering his future, but he did not receive a formal Notice of Redundancy until 7.3.1996. He left on 10.3.1996. He had had a month's informal notice of departure. So he, at least, was aware at the time of the first Planning Meeting that he would be leaving shortly afterwards. Although he was aware, having informally negotiated a package with DSS1, none of the others involved in the first Planning Meeting were then so aware, I was told and accept. He told me that his first unofficially agreed leaving date was to have been the end of the month. In that month he was trying to finish off three major investigations, and it had become unclear who was his line manager because of the new arrangements, and his successor was not named until just before he left.

6.8.3. I cannot find any evidence that the role which MCP&QA1 had performed in the first Planning Meeting was specifically handed over to anyone. In the pressure and chaos in which he was working this is not so surprising as would otherwise be the case. As he told me: *"I was never charged with conducting any kind of investigation into the matter of Alan and Steven Forrest or the possible wider implications. Any such investigations should have been set up at subsequent strategy meetings. I was charged with two specific tasks:*

1. *To seek clarification about the cause of Steven Forrest's death.*
2. *To obtain the Admissions & Discharges Book for Angell Rd. for the relevant period...."*

6.8.4. I agree that the sudden departure of an individual officer, however significant, ought not to disable a Child Protection Planning process, and that any gap in progress ought to be only temporary. MCP&QA1 certainly set in motion the first specific task just mentioned. If he made progress on the second, it seems not to have been communicated to his colleagues. His view that he had not undertaken to conduct any investigations is consistent with his situation, as well as with the informal notes of the Meeting. At the time of the Meeting he was due to leave the Council's service in two working weeks. It is also consistent with DSS1's letter of 28.2.1996 to the Paediatrician *"At this stage no decisions have been taken on how to proceed, beyond trying to clarify the AIDS issue. Once we have a response to that a further planning meeting will be convened."*

6.8.5. AD1 was aware that MCP&QA1 was in discussion with the Director, and that no initiative was needed in the Area's social work as a consequence of the first Planning Meeting. She awaited the confirmation about Steven Forrest's illness, as decided by the Meeting, and MCP&QA1's role to be taken up within the other Division.

6.8.6. The departure of MCP&QA1 had followed the departure of the former Director and two Assistant Directors who, between them, had been responsible for the work relating to all aspects of Child Protection, and in particular to allegations of abuse against staff. This meant that the Department had lost its ability to assess on sight, at a senior level, the interrelationship of old and new general Child Protection information which had accumulated during the years that MCP&QA1, the two Assistant Directors and the former Director, had been in post. Even with a well indexed and well organised filing system this would have caused difficulties for their successors. Such a system did not exist. According to my informants, large quantities of meaninglessly organised documents were disposed of during this organisational upheaval. The discontinuity with the past was emphatic.

6.8.7. DSS1 only knew of the first Planning Meeting's decision to confirm the HIV information, and was due to leave Lambeth's service in another few weeks. When he had been told of the first Planning Meeting's decision he knew that MCP&QA1 was dealing with the case, and expected that any developments would be drawn to his attention. DSS2 was not yet involved in operational matters. In any event she was away from Lambeth from 26.3. to 29.4.1996, partly on business and partly on annual leave. It was because this leave had been anticipated at her appointment that DSS1 had been asked to stay on as Acting Director after DSS2 had formally started work at Lambeth.

6.8.8. AD1 told me that she was not surprised that she was not being involved in whatever was being done by the Child Protection specialists after MCP&QA1's departure. It was usual, in Lambeth, for these matters to be dealt with very confidentially, and she did not expect to be involved. AD1 had a huge task to cope with the consequences of reorganisation, and did not have line management responsibility for the specialist Child Protection work which was clearly involved. She understood that DSS1 and AD2 would take up the 'wider issues'. Nor did AD2 know about the case. His background was not in Child Protection work, and he was not the senior Child Protection specialist at an operational level.

6.8.9. The result was that no senior manager took responsibility for supervising the wider implications of Alan's disclosure. Neither did MCP&QA2, who was the senior Child Protection specialist, know about Alan's disclosure, nor did her subordinates. So far as I can discover, once MCP&QA1 had left, no one with specialist Child Protection responsibilities knew of Alan's disclosure, nor of the work that the first Planning Meeting had authorised, until mid-June 1996. Whilst such a situation is obviously deplorable, its cause or causes flowed from the history of the Department rather than from any wilful default of those who assumed responsibility in the new structure, in my view.

6.9. The Planning Meeting Re-convened

6.9.1. SW1 was informed by AD1's secretary, on 14.3.1996, that a Planning Meeting was to be re-convened, the precise date to be announced soon. Strictly speaking, it should have been called within four weeks of the first Meeting, i.e. by 15.3.1996, followed by an initial Conference within fifteen days of the second Planning Meeting. SW1 had become increasingly concerned at the delay in responding actively to Alan's disclosure, and that she had been told nothing. She decided to express her concern in writing to TM1, who shared SW1's concern.

6.9.2. On 20.3.1996 SW1 did write a memo to TM1. She did not send it, but placed it on the file when she heard, that same day, that a date had been set for the second Planning Meeting, a day on which she could not attend. The delay in calling the second Planning Meeting was due to the time which it had taken the Community Health doctor(s) to obtain information about Steven Forrest's HIV status. On this day, 20.3.1996, the Consultant Paediatrician recommended by the Community Physician at the first Planning Meeting telephoned AD1. According to the manuscript note headed with Alan's name made by AD1, the Consultant Paediatrician told her that Steven Forrest had *"died of AIDS"*. AD1 also wrote in her note:
"- Do we disclose? Very complicated.
- We need to make decision very individual in terms of his [i.e. Alan's] *needs."*

6.9.3. The reason the state of Steven Forrest's health made future action *"very complicated"* was explained by the Consultant Paediatrician who, according to her recollection, informed AD1 *"of the difficulty in obtaining confirmation of this information. This was because the Consultant in Genito-urinary Medicine at .... had been advised by the Hospital solicitors not to release any information. However I understood that implicit in his action of telephoning me on 15 March 1996 was confirmation of AIDS related death."* Health organisations are under a strict obligation to maintain confidentiality about patients with sexually transmitted diseases.

6.9.4. Insofar as the continuing lack of formal certainty about Steven Forrest's HIV status caused a problem, help from Child Protection specialists should have been sought immediately, in my view. In any event, the information from the Consultant Paediatrician was equally relevant to the wider Child Protection issue of other possible victims, assuming that Steven Forrest was the abuser. I have not understood why Departmental arrangements did not enable this information to come to the attention of the specialist Child Protection officers. If it had come to their attention, the unfortunate gap caused by the disruptive pressures of major re-organisation would have been closed without disastrous delay.

6.10 The Second Planning Meeting

6.10.1. On 29.3.1996 the second Planning Meeting took place, six weeks after the first Planning Meeting. The three people present were AD1, TM1, and the Consultant Paediatrician who had telephoned AD1. When the Consultant Paediatrician had telephoned, AD1 had immediately instructed that the Meeting should be called. The purpose of this second Planning Meeting was to resume consideration of the issues arising from Alan's disclosure now that more authoritative information about his alleged abuser's HIV status was available. In my view, the Police should again have been invited. It is inconceivable that a specialist Child Protection Officer should not be present at such a Meeting, but I have already explained how an organisational hiatus had occurred. It was, as the Meeting itself recognised, an omission capable of being put right at a further, properly convened, Meeting.

6.10.2. Again, there are no minutes available to me, nor were any afterwards made available to those involved. So far as I can discover, none were taken. The absence of proper records is likely to cause mistakes, and Lambeth had been warned of the danger by the SSI in 1993 (see paragraph 5.3.4. above), and a new system was claimed as achieved in 1994 (see paragraphs 5.6.4-5. above). The point had been repeated in the 1994 SSI Report (see paragraph 5.10.3. above), and also by the District Auditor in 1994 (see paragraphs 5.12.3-4. above). I have considered the notes made in the Meeting by two of the three participants, TM1 and the Consultant Paediatrician, for their own individual purposes, and the recollections of all three. My reconstruction is as follows.

6.10.3. The Consultant Paediatrician confirmed that Steven Forrest's cause of death was very likely to have been an HIV related illness. I assume, since there was no criminal investigation or prevention of current abuse involved in relation to Steven Forrest, that the normal rule of medical confidentiality had been applied. If the Police had been involved, it would not, as events in 1998 showed. The mystique of the confidentiality already surrounding Steven Forrest's HIV status was thus strengthened.

6.10.4. The Consultant Paediatrician had sought advice from a Consultant in Genito-urinary medicine about the risk of infection following the alleged abuse of Alan, and whether Alan should therefore be offered HIV testing as a matter of urgency. The advice she had been given was that it was by no means automatic that a victim would have contracted HIV infection. The discussion in the Planning Meeting, following this advice was not about <u>if</u> Alan should be told that Steven Forrest had been HIV infected, but about <u>how</u> and <u>when</u> this disclosure to Alan should take place. I am advised that, irrespective of an alleged abuser's HIV status, there are other health related concerns for an abused child. These, too, seem to have been submerged by the dominance which the HIV issue was allowed to assume over other considerations.

6.10.5. Because of concern for Alan's known emotional and behavioural situation, it was felt that further work would best take place in an appropriate therapeutic setting. This would enable other issues such as sexuality, fears and concerns about risk of infection, as well as the trauma of the abuse, to be explored. As this was quite specialist and sensitive work, the Consultant Paediatrician suggested that a Consultant Child Psychiatrist used on other occasions by Lambeth should be consulted about how Alan might best be told and supported. The meeting also considered the situation of a Lambeth boy who was another possible victim.

6.10.6. According to the concise note made by the Consultant Paediatrician, four Actions were determined:
"1. Consultation with [the Consultant Child Psychiatrist]
2. Area staff to prepare a brief report for senior managers through [AD1];
3. Reconvene the planning meeting with [Child Protection & Quality Assurance];
4. [The Consultant Paediatrician] *to write to* [DSS1] *in response to his letter".*

6.10.7. So far, so good. Judging by this note, the Meeting recognised the need for wider Departmental involvement, both through senior management and through the specialist Child Protection Unit. It seems unlikely that the other, and still outstanding, task of determining the scale of an investigation into the circumstances of other children who had been at Angell Road with Steven Forrest, which the first Planning Meeting had given to MCP&QA1, would have been overlooked. I can find in this note a recognition that this second Planning Meeting, though already late, was not properly constituted, and that an investigation would be of a magnitude to require senior management consideration. The wider issues had not yet been lost; indeed, their obvious importance had been re-asserted. In this event a proper Child Protection Conference should have been called as soon as possible, and consideration given to setting up a supervisory senior management group. This did not happen, and it is impossible to understand why, given the clear recognition of the issues in the Meeting, as recorded by the Consultant Paediatrician's note.

6.10.8. The Planning process thereafter continued without the involvement of Child Protection experts. It is, therefore pointless to continue noting the resulting deficiencies which then followed, when compared to a proper Child Protection process. The wider significance of Alan's disclosure was no longer pursued. In my view, it is impossible for a Social Services Department worthy of the name to continue to overlook such an omission, as happened in Alan's case. Laying the blame for this omission is not an appropriate task for this Report.

6.11. Action following the Second Planning Meeting

6.11.1. Of the four Actions noted by the Consultant Paediatrician, there is clear evidence that the first and the last were implemented. The second Action may have been implemented - there is a Supervision Note of 11.4.1996 by TM1 which includes *"Report sent to* [AD1]". However, neither AD1 nor any other senior manager that I have spoken to remembers receiving such a report. I have not found such a report in the available files (but I think it safe to assume that TM1's copy would have been put in the now missing Confidential file which she kept). Other relevant senior managers have no recollection of a discussion about Alan's disclosure at this stage.

6.11.2. The third Action - to *"reconvene the planning meeting with CP + QA*" according to the Consultant Paediatrician's note, which could have led to a full and proper Child Protection investigation, was certainly not implemented. The Consultant Paediatrician's recollection of the purpose of such a reconvened Meeting (from her professional perspective) was that it would "*follow up on these issues arising from therapy, including getting back to Health to arrange HIV testing if the victims so wished. The Community Trust have no record of invitation to nor attendance at any further planning meetings."* Even within the narrow professional field of the Consultant Paediatrician the wider Child Protection issues - *"victims"* - were included.

6.11.3. The wider concerns, most of which had been succinctly stated in the Area Manager's memo to AD1 on 5.2.1996, were not pursued again until MCP&QA2 became aware of them in June 1996. However slow the response to Alan's disclosure had been thus far, and however deficient the calling of the second Planning Meeting had been, the second Planning Meeting had put the case back on track. It now only needed a word in the corridor to question why the Child Protection specialists had not been represented, and to arrange another meeting. I have not yet traced who was responsible for determining, or overlooking, the startling omissions not to report to *"senior managers through* [AD1]", nor to reconvene a Planning Meeting *"with CP + QA".*

6.11.4. Immediately after the meeting the Consultant Paediatrician wrote to DSS1 [Action 4], as follows:
"I am able to respond to your letter of 21 February. Following my enquiries at the ..... hospital, I can confirm that it is extremely likely that Mr Forrest died of an AIDS related illness. This information has already been communicated to [AD1] *by telephone."* This letter, addressed to DSS1 at Mary Seacole House, the Department's HQ, does not appear in any Council file, and no one now recalls having seen it. Presumably it found its way into the missing confidential folder, though I have not established who saw it en route. Since its content merely confirmed what had been said to AD1 on the telephone, and then to AD1 and TM1 at the second Planning Meeting, its loss was no handicap to appropriate action.

6.11.5. On 2.4.1996, pursuant to the first Action determined by the second Planning Meeting, TM1 wrote to the Consultant Child Psychiatrist *"to request a consultation meeting regarding Alan. Alan is the subject of a Full Care Order to the L B of Lambeth. He is placed in a Childrens Home and recently disclosed that he had been sexually abused in a previous placement.*
A Planning Meeting was held involving [AD1] *and a decision was made that we should request consultation from you regarding the way forward. ..."*
The second Planning Meeting had taken place on a Friday; TM1 had failed to reach the Psychiatrist by telephone, and wrote this letter on the following Tuesday, after consulting SW1 about her availability for the consultation. There was no unreasonable delay, only anxiety to be better informed about supporting Alan as soon as possible.

6.11.6. On 11.4.1996 Alan's case was reviewed by TM1 and SW1. After stating that a letter had been sent to the Child Psychiatrist [Action 1], the note of the Supervision included: *"... Report sent to* [AD1]. ..." [This, I assume, related to Action 2 noted by the Consultant Paediatrician.]
"Action:
1 Liaise with [AD1] *weekly* - [TM1]*;*
2 Chase up referral to [the Child Psychiatrist] *in writing* - [TM1]*,"*
3 extra staffing to give respite to Alan's carers;
"4 Continue to visit 6 weekly
5 Planning Meeting to be reconvened following consultation.". [This, I assume, related to Action 3.]

6.11.7. On 15.4.1996, the social work Team Manager at the hospital, who supported the work of the Consultant Child Psychiatrist, had a discussion with TM1. From this the hospital Team manager understood that AD1 was very concerned to make progress very quickly. On the same day AD1, in telephone conversation with the Consultant Child Psychiatrist, emphasised the urgency of the case. In fact the Child Psychiatrist agreed to a consultation taking place much more quickly than was normal. On 18.4.1996 the hospital Team Manager wrote to TM1 confirming a telephone message that the consultation would be on 25th April 1996. The urgency of responding appropriately to Alan's needs was properly recognised.

6.12. The Consultation with the Child Psychiatrist

6.12.1. The consultation took place as arranged, and involved the Consultant Child Psychiatrist, the hospital based Team Manager, TM1 and SW1. No papers had been sent in advance, so the information on which the consultation was based came orally from SW1 and TM1. It is clear from contemporaneous notes, and the recollections of those involved, that the consultation's purpose was to concentrate solely on the best way of supporting Alan. The anxiety of TM1 and SW1 to help Alan was clear. SW1 noted short term aims for Alan, and "*Medium term aim is for some work to be done on health, HIV & AIDS ...*". She also noted: *"Consider compensation under Criminal Injuries Compensation Board."*. The Consultant Child Psychiatrist's advice was incorporated into a letter on 28.4.1996. (see paragraph 6.12.4. below).

6.12.2. However, in the introductory discussion, some of the wider issues were touched on, as background. It was clear to the Consultant Child Psychiatrist, from this initial conversation, that both TM1 and SW1 expected a thorough and onerous Child Protection process to be organised by senior managers about the needs of other children who had been in Lambeth's care. They also emphasised that the subject matter was extremely confidential. Because the single issue presented by TM1 and SW1 was that of meeting Alan's needs, the Child Psychiatrist - who was a long-standing member of the Area Child Protection Committee - did not consider the wider implications. It was his understanding, from what he had been told, that the wider implications were under active initial consideration by the Social Services Department.

6.12.3. By the time of the consultation the continued appropriateness of Alan's placement with them was being questioned by Mr. and Mrs. N, SW1 had been appointed to a post in another local authority, and her imminent departure was known. She had been Alan's social worker for three years, and was conscious that her departure would interrupt the support which the Department could offer Alan, and that a move from Mr. and Mrs. N's care would be another disruption for Alan. Her impatience at the Department's inaction is reflected in her note of the consultation: "*Acknowledgement that Alan's .....* [confidential] *relates to the fact that he may feel that no action has been taken regarding his disclosure. ....*".

6.12.4. On 28.4.1996 the Consultant Child Psychiatrist wrote to TM1: *"...Treatment should, simply, be aimed at helping him gain an understanding of ..... Also to facilitate him gaining a simple and factual understanding of issues connected with ..... Work should not be insight-based but more orientated to problem-solving in the here and now. Thus, work should be done with him on .... Work must concentrate on the here and now/future, not on resolving past upset ...*

6.12.5. *The ideal person to do such work is, of course, [SW1] - who has been Alan's social worker for three years. I understand that she will probably be leaving Lambeth fairly soon. However, we discussed that she will be able to see him on two further occasions. You and SW1 agreed that she could very significantly start some of the above work as discussed. It would obviously be important for any future social worker to carry on with such involvement. I would be more than happy to consult further about this if you found that helpful. ..."*

6.12.6. It is clear to me that obtaining the expert advice commissioned by the Second Planning Meeting involved SW1, and then her successor as Alan's social worker, discussing with Alan a range of topics relating to his personal needs. The strategy recommended by the Consultant also needed to be understood by anyone else having responsibility for the care of Alan, such as Mr. and Mrs. N. I can find no suggestion in the available evidence that the consultation was in any way concerned to restrict Alan's potential role in any Child Protection investigation into the wider issues, although it recommended a psycho-educational approach to enable him to understand his situation, unconstrained by restrictions on tainting his evidence which a criminal investigation into his abuse could impose. The advice certainly did not support inaction, as was the impression which gained later currency. In my judgement, this impression was not an accurate reflection of the advice, either of the consultation as recorded by SW1 and the Child Psychiatrist, or of the letter which the Child Psychiatrist wrote to TM1.

6.13. Increasing Ineffectiveness

6.13.1. Following receipt of the Child Psychiatrist's written advice at the end of April, I would have expected a Planning Meeting to have been called immediately (given the decision of the second Planning Meeting), followed closely by a Case Conference. A Case Conference could have included those who, in addition to Alan's current social worker, needed to be informed in order to care for him appropriately in the light of the advice received, such as Mr. and Mrs. N, his therapist, his teacher, and his parents.

6.13.2. TM1 and SW1 were waiting for the Planning Meeting to be reconvened, but this did not happen until 13.6.1996. As a result, even the first Action determined by the second Planning Meeting, to support Alan in accordance with expert advice from the Consultant Child Psychiatrist, ran into the sand. The delay meant that SW1 was not able to use her sound, well-established relationship with Alan to begin the therapeutic approach to Alan's disclosure, as expressly recommended by the Child Psychiatrist in his letter, though she did continue to support him in other ways. In her Transfer Summary of 11.6.1996, repeated in a note of 14.6.1996 to a Child Protection Officer, SW1 wrote of the period between early February and mid-June 1996: *"...Alan was seen by me as usual during this time and although I acknowledged to him that I knew about his disclosure, I had been told by* [AD1] *and* [MCP&QA1] *at the initial Planning Meeting on 16.2.96 not to ask Alan about specific details relating to his abuse until a procedure/course of action had been decided upon."*
The inadequacy of the Child Protection process which had taken place inevitably distorted the programme of action which was followed.

6.13.3. On 23.5.1996, there is a note in a Case Review by TM1 and SW1: " * *Discussed concerns that there had been no action in regard to Alan's disclosure in January '96.*" The same day TM1 sent an E-mail to AD1: *"I have met with* [the Consultant Child Psychiatrist] *and would like to meet again with you for guidance in how to proceed. I did leave a message for you but have received no response. Please can you let me know if a further meeting will be convened."* On 28.5.1996 AD1 replied to TM1: *"Sorry I don't recall getting the message but I would like another meeting. Could you liaise with* [a secretary] *to fix a date as I will be away for a few days."* The meeting was then fixed for 12.6.1996.

6.13.4. The lack of movement affecting Alan's case was also illustrated by a letter of protest dated 24.5.1996 from the therapist who had been working with Alan since November 1994 in Kent. She had recently heard from Mr. and Mrs. N about Alan's January disclosure of abuse. The therapist had not been told of his disclosure by Lambeth, I was told, because of the controlling first Planning Meeting decision about confidentiality - the participants should maintain *"extreme confidentiality until facts are known ….."*. The facts about HIV status were not officially confirmed, and it needed the continuing formal process to decide what actions could be taken by those caring for Alan.

6.13.5. SW1 was leaving Lambeth's Social Sevices Department on 14.6.1996. She was very concerned at the failure to decide what should be done to help Alan, quite apart from the seriousness of the wider issues which were outstanding, and on which no Child Protection activity was apparent to her. In her final few days at Lambeth she tried to ensure that the drift should not continue, by leaving written information for her successor, and then by alerting a Child Protection Officer with whom she had worked closely on previous cases. In her Transfer Summary for her successor she wrote: *"…The considerable delays between the* [Planning] *meetings seemed to influence the suggested action and handling of this case so that Alan had still not been spoken to about his disclosure at the time of my leaving."*

6.13.6. Among the issues SW1 explicitly raised for her successor to read were: *"Consideration should be given to whether Alan's present placement is meeting his needs in the light of his current behaviour.* [Mr. and Mrs. N] *are very concerned that their care for Alan is less than they would wish to provide for him and that he possibly needs a different environment in order to ….*

Alan's therapy needs to be reviewed and a decision made as to whether this should be maintained or ended according to what Alan needs. This decision should be taken in conjunction with the outstanding work related to the disclosure that Alan made in January 1996…".
These were three very important aspects of the support which Alan needed from the Department - attention to his placement and to his therapy, and work related to his disclosure. They were raised by SW1, just before she left Lambeth, at the third Planning Meeting on 12.6.1996, but thereafter they were dealt with only by default.

6.14. Inter-Divisional Tension

6.14.1. The continuing tension about who should do what between the Child Protection specialists and those managing the operational social work gave rise to concern expressed by the newly responsible AD2 in relation to another case than Alan's. He sent an E-mail on 11.6.1996 to AD1 and to another senior officer, copied to DSS2: *"CP investigation concerning ....Foster Carers*
I have had concerns expressed to me by MCP&QA2 that adverse comments have been made about the way her section has handled the above matter. If you have concerns please let me know so that I can take them up. I am also assured that all relevant staff have been involved throughout the process." I quote this E-mail as one of several showing evidence of the tension, and not to take the part of the sender or the recipient in the matter.

6.15. The Third Planning Meeting

6.15.1. The absence of minutes from the two previous Planning Meetings was of concern to SW1 and TM1, given SW1's imminent departure, and therefore the need for a new social worker to be properly informed about Alan's case. Five weeks after the receipt of the Child Psychiatrist's letter a third Planning Meeting was held on 12.6.1996, involving AD1, TM1 (who took the minutes), and SW1. Despite the Action noted by the Consultant Paediatrician at the previous Planning Meeting to *"reconvene the planning meeting with CP + QA"*, no specialist Child Protection Officer was present. Nor was the Consultant Paediatrician. According to SW1's note of the Meeting "*CMO* [Community Medical Officer] *invited but unable to attend*". Since AD1 told me she had never seen the Child Psychiatrist's letter, I assume that his advice was conveyed to the meeting by oral recollection. If this is so, even the narrowed focus of the Meeting lacked a firm base. In my view, this third Planning Meeting was late, inadequate, and ill prepared.

6.15.2. According to SW1's note of this third Planning Meeting, which she placed in the Confidential section of the open file which would pass to her successor: *"I raised concerns that no action had been taken in respect of Alan's disclosure and that as I was leaving I would be unable to work with Alan, therefore there would be one less trusted adult for him.*
[AD1's] *view was that a formal disclosure interview would be another form of abuse for Alan, but that he should be allowed to tell his story at some time.*
General discussion on how the presenting situation had raised a lot of anxiety. I spoke of my concerns about the lack of a wider enquiry/investigation.
Again spoke of my disappointment at leaving when I would have been able to do a specific piece of work with Alan regarding his abuse if this had been sanctioned earlier. I felt that there had been unnecessary delay/inaction and that Alan had not received a good response to his disclosure and was unhappy with this. Agreement that with hindsight, I could have done the related work with Alan."

6.15.3. AD1's manuscript note of the Meeting, which was obviously taken in the Meeting, states: "[The Consultant Child Psychiatrist] *felt that Alan too damaged & does not have necessary inner strengths to do regressive therapeutic work.*
Best to work [with] *here & now to help him [understand] his present behaviour as a result of post traumatic experiences. ..."*

6.15.4. AD1 then noted that Alan's therapist seemed determined to withdraw, and that this should be confirmed, and that a change of Placement *"might be a good thing".*
" - Do we need to go back to other kids in old C.H. [Children's Home].
- What about other child in [Alan's Home who might have been at risk]*?*
Given the very low risk to Alan can see no real gain to other y.p. to push on the issue. Offer input to [Mr. and Mrs. N] *re: how disclosure has impacted on them."*

6.15.5. The need to take specialist Child Protection advice had been observed in the first Planning Meeting and acknowledged in the second Planning Meeting. These two notes make it clear to me that concerns about the wider issues, noted specifically by SW1, were again considered, but not pursued into action, by the Meeting. It is difficult to understand this omission as accidental. I assume that AD1's note "*Given the very low risk to Alan can see no real gain to other y.p. to push on the issue.*" was confined to the possible infection of one *"other y.p."* who had been specifically identified, rather than the other young people whose situation was of concern. Either way, the subject would plainly have benefited from joint consideration with the Child Protection specialists. The Child Protection process, of which a Planning Meeting is a part, appears to have been turned into an individual child's Care Review, without the benefit of any specialist Child Protection advice on the Child Protection subject-matter.

6.15.6. In relation to: *" - Do we need to go back to other kids in old C.H."* the primary question surely was 'Had other children been abused there?'. This question could not, in my opinion, be properly and reasonably isolated into or from another separate process being secretly carried out by others. The answer to the question was properly the subject of specialist Child Protection advice and action. If the issue was pursued, the social workers of the young people, in Lambeth and perhaps elsewhere, would become involved. Alan, and Alan's care, was necessarily involved in these wider issues, as well as those being dealt with by this Meeting. The lack of Departmental collegiality on such a profoundly important Department-wide matter is deeply worrying.

6.15.7. The brief minutes of this Third Planning Meeting, taken by TM1, begin:
"PURPOSE OF MEETING:
To update on previous meetings and ensure that decision[s] are being followed up and carried out." This purpose, manifestly, was not achieved, by the very composition of the Meeting. However, I am relying on the note made by the Consultant Paediatrician at the second Planning Meeting in making that comment, and neither the note, nor its author were present at this third Meeting. In the absence of formal Minutes of the previous two Meetings, the limited nature of this third Planning Meeting might not have been obvious to participants who, rightly or wrongly, were used to the Lambeth tradition of separate, secretive Child Protection investigations into allegations against staff members.

6.15.8. The description of the Child Psychiatrist's advice and SW1's subsequent contact with Alan are summarised in the Minutes as follows: "*At the meeting* [with the Consultant Child Psychiatrist, he] *felt that Alan would not benefit from therapy but needed to have the opportunity to speak about his feelings and anger in a very basic way.*
Following the meeting [SW1] *has seen Alan and he has been given the opportunity to discuss these issues with* [SW1]. ... *This needs to be ongoing."* [my emphasis]

6.15.9. The Minutes also referred to two other matters relating to Alan, followed by an indication of suitable action.
"His placement is becoming increasingly close to breakdown and .....
Alan's therapist in Dover is very unhappy that we spoke to [the Consultant Child Psychiatrist] *without consulting her first and has written and told the carers of her intention to cease any work with Alan.*
One of the best ways of addressing the issues with Alan may be to begin another Life Story with him, this would enable a worker to address his past difficulties in a simple and natural way." [my emphasis]

6.15.10. The Meeting's minuted Action decisions in relation to Alan were:
"1. An alternative placement is to be sought that will meet Alan's numerous needs. This should be done in a planned way.
2. Fostering Placement to be sought through the Private Sector if necessary, for example, TACT or Families for Children.
3. Life Story Work to recommence once in new permanent placement." [my emphasis]. A further decision was concerned with support for Mr and Mrs N. SW1 also noted a decision, that "*Criminal Injuries Compensation should be considered at some future date."* I have underlined, in the above Action decisions, clear evidence that the decision of this Planning Meeting was that work should be undertaken with Alan, in accordance with what the Meeting took to be the Consultant Child Psychiatrist's advice, once he was in a new placement.

6.15.11. None of the three decisions just set out relating to Alan was implemented. In relation to the first two decisions, Alan was moved to a new, emergency placement, and not in a planned way, and *"Life Story Work"* was never done. The failure to call a Planning Meeting of the kind determined at the second Planning Meeting involving Child Protection specialist advice had lost the opportunity to deal with the other, wider issues properly. The decision noted by SW1 relating to Criminal Injuries Compensation remained unimplemented until October 1998. Mr. and Mrs. N had raised the subject with SW1, and it was one of the issues which had then been raised in writing by the Area Manager, in early February 1996. SW1 had noted the subject during the consultation with the Consultant Child Psychiatrist in April 1996, and she had also included it in her note for her successor.

6.15.12. Criminal Injuries Compensation was not actively pursued for two years nine months after Alan's disclosure, despite the express advice in Part 9 of the Children and Families Manual issued in April 1995 (following similar advice in the October 1991 version) that *"3.1.1 The possibility of a claim being made should be discussed at the time an investigation is being undertaken as a result of a child in the care of the authority being injured as a result of criminal activity by an employee of Lambeth." "3.2.2 The discussion of a claim should be held as soon as possible in order to ensure that any medical or psychological reports will be available when the decision is made to pursue the claim."* I do not think that there was a deliberate attempt to prevent Alan pursuing his rights. Like other failures of service delivery, this one flowed inevitably from the absence of an integrated Departmental approach to Child Protection. In relation to Alan's disclosure of sexual abuse the previous January the Social Services Department had, by mid-June, utterly failed to respond effectively. Individual responsibility for this failure is a topic to be pursued in a subsequent stage of this Inquiry.

6.16. Contributory Pressures

6.16.1. As a post-script to the three Planning Meetings I want to explain my understanding of why the obviously inadequate process paralysed appropriate action by concerned staff. In 1992 critical Reports on the handling of a Child Protection case in the same Area as that responsible for Alan (the Gibelli Case), had made a strong impact on staff who were around then, and were now responsible for Alan's case. Two such members of staff separately, and spontaneously, told me of this. I think it was a fair inference to draw from the 1992 Gibelli Reports that poor implementation of Planning Meeting decisions had contributed to failure to prevent a child's death. A second pressure was the assumption referred to in para 6.4.7., that the person taking the chair at a Case Conference was responsible for organising the related administrative processes which lead to implementation, therefore others should not interfere.

6.17. SW1's Concerns

6.17.1. On 13.6.1996 Mr. N telephoned SW1 to raise again his concern at the unsuitability of the placement for Alan. SW1 said she would refer the information to TM1 in writing, which she did the following day, her last day of work in Lambeth.

6.17.2. On 13.6.1996, in the evening, SW1 telephoned a specialist Child Protection Officer (to whom I will refer as 'CP1') *"to express my concerns about the lack of action for Alan in regard to his disclosure."* SW1 and CP1 had been in the same Area office in the past, and CP1 was aware of the earlier suspicion that Alan had been abused whilst in Lambeth's care. One of the functions of the specialist Child Protection Officers was to be available to give advice, and SW1 took that course to share her concerns, given the limited scope and outcome of the Planning Meetings. The following day CP1 telephoned SW1, and asked her to put her concerns in writing, which she did immediately.

6.17.3. SW1's memo to CP1 of 14.6.1996 referred to her *"…. outstanding concerns. …. This matter was discussed with* [AD1] *at the outset because of the wider implications of involvement of other staff and young people, and because of the particular concerns for Alan.*
There were 3 meetings with [AD1] *between early February and mid-June 1996 to confirm original information and discuss this matter.*
Alan was seen by me as usual during this time and although I acknowledged to him that I knew about his disclosure, I had been told by [AD1] *and* [MCP&QA1] *at the initial Planning Meeting on 16.2.96 not to ask Alan about specific details relating to his abuse until a procedure/course of action had been decided upon.*
The second meeting on 29.3.96, at which I was not present …, suggested a consultation with [the Child Psychiatrist] *…. This took place on 25.4.96.*
The decisions from the last meeting on 12.6.96. were that consideration should be given to finding Alan an alternative placement, ….. , Alan should be offered the opportunity to do life story work and "tell his story" within a new placement and finally that Criminal Injuries Compensation should be considered at some future date. …….
The considerable delays between the meetings have seemed to influence the suggested action and handling of this case so that Alan has not been spoken to about his disclosure at the time of my leaving, neither has any action been taken regarding the wider implications.
Full information on this matter is known to [TM1] *and* [AD1] *as they felt it was unwise to place "sensitive" information on the working file …."*

6.17.4. On the same day, 14.6.1996, SW1 also wrote a memo to AD1, copied to TM1. After pointing out that she was leaving that day, she stated: "*I note that I have not received any copies of minutes taken at the meetings relating to the disclosure that Alan made in January of this year.*
I have placed my own notes on the file but would like to request that minutes be provided for the initial meeting on 16.2.96, the meeting on 29.3.96 which I did not attend because of being on annual leave, and the last meeting on 12.6.96 ...". Although this memo related to little more than administration, it could have prompted a search for the missing Minutes of the first Planning Meeting supposedly held in the other Division, and so bridged the missing connection with the other Division. I do not understand why this obviously important administrative omission was not corrected in relation to the first two Planning Meetings as soon as it was pointed out.

6.17.5. Also on 14.6.1996, SW1 wrote a memo to TM1: "*I would have liked to have been able to discuss this matter with you rather than just leave copies of my memos, so my apologies for having to do it this way.*
I was unhappy with the eventual outcome of the meetings relating to Alan's disclosure and the length of time that has elapsed since he made his abuse known so sought advice from [CP1].
The memo to her is to put my concerns in writing - these copies are for your information."
It does seem extraordinary to me that the concerns such as had been expressed by SW1 should not have prompted immediate action to review what was happening, but they did not. SW1's memo to CP1 was the only information about Alan's disclosure given to the other Division since MCP&QA1 had been active, back in March 1996, so far as I can discover.

B. Main Conclusions on Section 6

1. Alan made a clear disclosure that he had been sexually abused whilst at Angell Road, and identified an abuser. In addition to Alan's individual situation, it was recognised that there were other significant issues to be pursued, affecting other children. The disclosure of abuse came as no surprise to Mr. and Mrs. N, nor to his social worker, nor to her Team Manager. There was a proper initial response by them, and by the Area Manager, which should have enabled the Department to mount a co-ordinated, inter-agency approach to a Child Protection investigation.

2. The issues affecting other children were discussed at the first two, and probably the third, of three Planning Meetings, but no action was taken to maintain the momentum of the wider Child Protection investigation, once the specialist Child Protection Manager initially involved had left the Department, in March 1996, after the first Planning Meeting. Instead, the Child Protection process narrowed to deal only with Alan's individual care, despite the obvious Child Protection implications, and the obvious need for co-operation between the relevant Divisions and with other agencies. The formally required Child Protection process was not followed after the first Planning Meeting.

3. Alan's disclosure had obviously raised Child Protection issues. The basic CP process was long-established, but complex. The Second Planning Meeting recognised the need for a proper process to take place, but this did not happen.

4. Even in the task of dealing with, and supporting, Alan personally, there was delay followed by inaction, as the process drifted.

5. Alan's disclosure occurred at a time of very considerable organisational disruption in the Social Services Department. As a result, in respect of managerial responsibility for the specialist Child Protection Officers, there was initially a lack of formal organisational clarity. Neither this, nor the other organisational consequence of disruption to normal supervision, was the cause of the continuing lack of integration across the two Divisions concerned. These formal organisational problems could easily have been overcome, given a rational and driving sense of common purpose.

6. The overall performance of the Department was seriously deficient. Nor were related agencies vigorous in ensuring an appropriate response to Alan's disclosure.

7. Alan's social worker throughout this period supported him with professional commitment. On her departure she left clear signals that there had been an inadequate response to his disclosure.

SECTION 7 INTERNAL CRITICISM AND THE RESPONSE

A. The Non-Confidential Detail

7.1. Tension Between Divisions

7.1.1. CPO1 immediately informed her immediate manager, MCP&QA2, about SW1's telephone call and memorandum. From mid-June 1996, therefore, the specialist Child Protection unit was again aware of Alan's case, for the first time since early March 1996. This telephone call coincided with a major crisis in the relationship of the specialist Child Protection unit with the Children and Families Division, which came to the attention of the new DSS2. It is clear that the organisational rivalry and confusion about who should decide what should be done during a Child Protection process continued. At this stage of this Inquiry I merely note the situation.

7.1.2. The lack of clarity about responsibility for such action was raised in an E-mail on 17.6.1996 from CP1 to AD1 and AD2. *"Sandyridge. Please find attached report which concludes this section's involvement in this matter. Please especially not*[e] *the section entitle*[d] *outstanding action. There is a need for immediate decisions about how the task identified are going to be carried out and who is going to do it. They cannot wait."*

7.1.3. There is a section headed: *"4.00 Outstanding issues*
4.1 .... The issues that remain to be dealt with are operational issues, and without a named member of staff from the operational divisions to link with it has at times been difficult to achieve the necessary action in planning for children, and to further the investigation. It may therefore be preferable for [AD1] *to liaise with .... Police at Assistant director level, as they continue their enquiries, as she is in a position to ensure the action which is required. ...*

4.5 [A local authority's] *Legal Services have asked us along with themselves and* [another local authority] *to send a letter to the DOH outlining our concern about the continued non-registration of satellite units with particular regard to this case. The appropriate person needs to be identified to send this letter. ...".* However tentative the proposals in this E-mail, they demonstrate a recognition that the Department had to work as a unit on Child Protection matters. The following day AD2 sent a copy of the E-mail to DSS2, stressing its importance.

7.1.4. On 19.6.1996 AD1 sent an Email to AD2, DSS2, and another senior officer: *"Re Issues arising from Sandyridge Only just managed to get into email so sorry we didn't get chance to discuss. I think we do need to discuss this given the memo that* [MCP&QA2] *sent me regarding her decision to withdraw the service of CPO's from the area for such things as assisting in the chairing of investigating allegations of abuse against staff because she is annoyed by my questioning of the process used ..".* Plainly, the gulf between the work of the two Divisions was deep.

7.1.5. AD2 replied to AD1 the same day: *"Re CPO matters the email from* [MCP&QA] *comes as a surprise to me as no nothing* [sic] *of the case that is being referred to. However, what it raises is vital need to clarify responsibilities. It appears* [DSS2] *is free at 2.30 on Monday* [ie 24.6.96] *and I have booked us in then so we can properly and corporately agree who does what, when etc on these matters. According to* [AD1's secretary] *you are free then ?"*

7.1.6. On 24.6.1996 AD2 sent an Email to MCP&QA2: *"Meeting with CPOs Following my meeting with* [DSS2] *and* [AD1] *I would find it useful to meet with you and all CPO's to discuss some* [of] *the issues that came up. Is there any chance of everyone getting together sometime on Friday?"* A meeting had obviously been held between DSS2, AD1 and AD2. It was explained to me that the subject-matter related to the role of the Child Protection specialists as independent chairs of case conferences, when their views were not being accepted by the operational Areas. AD2 told me that he told the Child Protection specialists that they had to keep going back and showing their independence as advisers, but that the responsibility for action lay with the Areas. DSS2 took the same view.

7.2. Change of Home and of Social Worker for Alan

7.2.1. Despite the minuted decision of the third Planning Meeting that *"1. An alternative placement is to be sought that will meet Alan's numerous needs. This should be done in a planned way",* Alan was moved from his Home in an emergency transfer to an unsuitable new placement. It was unfortunate that Alan's previous social worker had just left, and her successor did not take up her responsibilities until a few days after Alan's move. This may be the cause of the default in planning, but it is not a justification of it. Such gaps cannot be exceptional. The need for a new placement for Alan had first been discussed in April, eight weeks previously, and had involved several levels of Area hierarchy up to, and including, the Assistant Director. The new social worker (to whom I will refer as 'SW2') was a senior practitioner, and was Alan's social worker from July 1996 until June 1998.

7.2.2. Alan's new placements were later described in a Case Review of 30.8.1997: "... *Alan was placed at S... Homes by Night Duty, he remained there for two weeks. It then became apparent that he could not remain there because of the homes registration criteria, that the home was registered for Black children and Alan is White and although this did not cause a problem for Alan and the other residents, the Management of the home became concerned that if there was a visit from the Registration and Alan was there it may jeapodise* [sic] *their registration, having checked this with our Placements Section it was agreed that Alan should move.*
Alan was then moved to C.... Care, where he remained for only a few days. ..... It was after this that a request was made to remove Alan. He was then placed at C for a short term and then moved to his current placement. Alan has settled into his placement ..."

7.2.3. A Transfer Summary of Alan's case, dated 23.6.1996, contains no direct reference to Alan's disclosure the previous January, nor to any of the intervening decisions. The written objectives for the new social worker were: to transfer Alan to the care of the Young Adults Team (Alan was now 14 years old); to prepare for Alan to be cared for by another member of his family; to encourage Alan to undertake some training; and to build a relationship with Alan. TM1 added: "*Discussions need to take place with me re as to level of support he needs ...*". A Supervision Note relating to SW2 and Alan's case, dated 2.7.1996, and signed by TM1, included an instruction: "*Once settled in new placement begin life story work.*" This was in implementation of the minuted decision of the third Planning Meeting: "*Life Story Work to recommence once in new permanent placement.*" It was never carried out. Unfortunately, the senior Team Manager in the Area Office became ill, and TM1 then 'acted up'.

7.2.4. SW1 had left notes in the current file which adequately explained the background to Alan's case, but SW2 told me that her objectives were confined to those I have just set out from the Transfer Summary. It may be that TM1's concurrent temporary new duties were the cause of SW2 not being continuously and clearly supervised on the instruction to begin Life Story Work when Alan settled in his new placement.

7.3. The First Attempt to Reinstate a Child Protection Process

7.3.1. On 29.7.1996 MCP&QA2 sent an E-mail to AD1:
"[SW1] *sent a memo to* [CP1] *before leaving the Department regarding Alan. I will give you a copy. Basically my question is whether Alan's therapeutic needs are being met given that he disclosed sexual abuse. I don't know whether other children were implicated and what their therapeutic needs are and I don't know whether as usual there may be any insurance implications.*
As the matter seems to have been addressed by you and [MCP&QA1] *I am not particularly anxious to relook at it, just to bring the memo to your attention for your decision given the questions overleaf.*
I am writing this as if you can remember it I hope you can."

7.3.2. Here was an informal attempt to bridge the organisational gap within the Department in dealing with Alan's case. I have been informed by the Council's Insurance Manager that there is no record of any reference to the Insurance Section by the Social Services Department about the potential significance of Steven Forrest generally, or of Alan's situation in particular. Internal protocol, well known to managers at this time, required that any potential claim should be notified via the Section. I do not at present know why this relatively simple responsibility was overlooked by the Social Services Department.

7.3.3. I have been told by MCP&QA2, the sender of this E-mail, that the phrase *"the questions overleaf"* was intended to refer to the issues raised in the memo from SW1 to CP1 referred to at the beginning of the E-mail (see paragraph 6.17.3. above). Whatever ambiguity such wording might have introduced to the reader becomes irrelevant, since AD1 told me that she had not received a copy of this memo when she replied on 30.7.1996, although she had asked for it. This failure of communication on such an important matter is difficult to understand.

7.3.4. I was told that this E-mail was intended as a tactful way of opening up the case for a new Child Protection process, at a time when the new DSS2 was supporting the chairing of Planning Meetings by specialist Child Protection Officers. It is clear to me that this is precisely what should have happened in a competently organised Department. It is also clear to me that the circumstances which had been outlined in SW1's memo to CP1 of 14.6.1996 came within the identical term of MCP&QA2's Job Description as that in MCP&QA1's Job description: "*To chair planning meetings and child protection conferences that have across divisional and directorate significance. To provide professional advice and make appropriate decisions on complex child protection issues and to ensure that the Assistant Director C&F Care Division is informed of any specific difficulties.*" The formal status of MCP&QA2 entitled her to be included in a proper discussion of the situation, but that discussion did not take place.

7.3.5. On the following day, 30.7.1996, AD1 replied by E-mail to MCP&QA2, although she had not, she told me, received a copy of the memo to which the E-mail to her had referred: *"Thanks for the memo. We did hold planning meetings and took advise from the paediatrician who specialises in HIV work. We considered other children but the advise was that the risk was so minimal that there was little to be gained by interviewing the one other child. Alan was receiving therapy and Lambeth Health were prepared to offer more.* [TM1] *is the TL Area 8."* This reply does not deal fully with the three issues raised in MCP&QA2's E-mail, i.e. Alan's therapeutic needs, whether other children were involved, and whether there were insurance implications.

7.3.6. The note made at the second Planning Meeting by the Consultant Paediatrician relating to "*the one other child*" was "[TM1] *and* [SW1] *will discuss* [Alan's situation] *with* [the Consultant Child Psychiatrist] *also as other child was implicated and is also a Lambeth child, he too may be included in any subsequent therapy".* The Consultant Paediatrician told me: "*In relation to the comment in SSD files that there was little to be gained by interviewing the one other child, my notes indicate that we did consider him so that he could also be included in any similar therapy set up for Alan. Therefore I believe that implicit in this action is the need to talk to the child whether that involved a formal interview or not."* The absence of proper Minutes of the first two Planning Meetings as a basis for action was a continuing cause of confusion of recollection.

7.3.7. I have not yet pursued the reason for this limited response by AD1 to a matter which had been raised with another Division by SW1, one of AD1's subordinates, as a matter of concern. MCP&QA2's E-mail had openly raised Department-wide concerns, necessarily involving both Divisions. Because of the nature of the reply, MCP&QA2 then arranged for the subject matter to be raised with her Assistant Director on his return from leave. In manuscript there follows on the copy of the E-mail to AD1 which MCP&QA2 sent to AD2: *"You will note I didn't query the Procedures at the time. It doesn't seem wise to given status & previous experiences of having done so."* Again, evidence of organisational tension.

7.3.8. On the same day, 30.7.1996, there was an exchange of E-mails between MCP&QA2 and AD1, in which AD1 welcomed the proposal that MCP&QA2 and CP1 should have a 6-weekly 'slot' at AD1's weekly meetings with the Area Managers about *"a range of things including the outcome of audits, policy procedure changes, conference analysis etc. ..".* Co-operative work did take place across the two Divisions.

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

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

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

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

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

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

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

7.4. Another Placement for Alan

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

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

7.5. The Second Attempt to Reinstate a Child Protection Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.6. The Third Attempt to Reinstate a Child Protection Process

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

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

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

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

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

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

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

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

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

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

"HIV/AIDS Case

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

2) CHs issues/Planning meetings commissioning

- who is leading on investigations to outside world

- investigative work to be done by CP section"

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

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

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

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

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

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

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

7.8. The end of the Child Protection Process

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

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

B. Main Conclusions on Section 7

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

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

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

SECTION 8. POLICE INTERVENTION AND BELATED ACTION

A. The Non-Confidential Detail

8.1. General Matters

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

8.2. 1997 SSI Report

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

8.2.2. The following extract is, by coincidence, a good description of Lambeth's care of Alan throughout his 13½ years in their residential care system:
"8.5 We found instances of considerable drift ranging from 2-10 years where decisions for permanency had been taken but the plans had not been implemented. The most severe was that of a child who was known to the department at age 2, was eventually looked after at the age of 4 and was still in the system at age 14 having had a series of placements. ...

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

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

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

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

8.3. Change of Team Manager

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

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

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

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

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

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

8.4. Change of Social Worker

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

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

8.5. Resumed Child Protection Activity

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

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

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

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

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

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

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

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

8.6. Departmental Overview Resumed

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

8.7. An Independent Inquiry

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

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

8.8. Steven Forrest's HIV Status Confirmed

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

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

8.9. This Inquiry

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

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

8.9.3. On 12.12.1998, Alan became 17 years old.

B. Main Conclusions on Section 8

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

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

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

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

APPENDIX

ALAN'S LIFE JOURNEY

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

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