INDEPENDENT INQUIRY
CHILD SEXUAL ABUSE

Children in the care of the Nottinghamshire Councils

Investigation Report

July 2019

2019

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A report of the Inquiry Panel
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CCS0619509552 07/19

Printed on paper containing 75% recycled-fibre content minimum.

Printed in the UK by the APS Group on behalf of the Controller of Her Majesty's Stationery Office.

The following amendment was made to this report on 1 August 2019:

Pages 146 and 149: The core participant Michael Summers, formerly ciphered as F52, has previously waived his anonymity and references have been updated.

Contents

Executive Summary

This is one of three investigations by the Inquiry into the nature and extent of allegations of sexual abuse of children in the care of local authorities. The primary purpose of this investigation was to examine the institutional responses to such allegations of Nottinghamshire County Council, Nottingham City Council, and other organisations such as Nottinghamshire Police and the Crown Prosecution Service, and to consider the adequacy of steps taken to protect children from abuse.

These two councils were chosen because of the high level of allegations of sexual abuse of children in their care over many years. The Inquiry received evidence of around 350 complainants who made allegations of sexual abuse whilst in the care of the Councils from the 1960s onwards, though the true scale is likely to be higher. This is the largest number of specific allegations of sexual abuse in a single investigation that the Inquiry has considered to date.

For more than five decades, the Councils failed in their statutory duty to protect children in their care from sexual abuse. These were children who were being looked after away from their family homes because of adverse childhood experiences and their own pre-existing vulnerabilities. They needed to be nurtured, cared for and protected by adults they could trust. Instead, the Councils exposed them to the risk, and reality, of sexual abuse perpetrated primarily by predatory residential staff and foster carers.

In residential care, there were poor recruitment practices, few qualified staff and little in-service training. This was compounded by overcrowding and low staffing ratios. It was as if anyone could carry out the important work of being a substitute parent to damaged children. In some instances, a sexualised culture existed in residential homes, with staff behaving wholly inappropriately towards children, paving the way for sexual abuse. Whilst set standards of conduct and child protection procedures were put in place, there was little proper training provided to help staff understand their employers' requirements, nor action taken against those who did not comply. Staff ignored these standards and procedures with impunity.

Nevertheless, it must be borne in mind that, regardless of all other considerations, the sexual abuse of children should have been regarded by all staff as a criminal offence.

Residential care carried little priority with senior managers, even when they were aware of escalating numbers of allegations of sexual abuse. Whilst there were some improvements over time, with awareness of the problem improving, directors of social services and children's social care failed to fully address the issue in both residential and foster care. Nor were elected members informed of the scale of the abuse.

Neither of the Councils learned from their mistakes, despite commissioning many reviews which made clear what changes were needed in their care systems to stop the sexual abuse of children.

During the 1970s, 1980s and 1990s, physical violence and sexual abuse occurred in many of the Councils' children's homes and in foster care. This included repeated rapes (vaginal, anal and oral), sexual assaults, and voyeurism. Harmful sexual behaviour also occurred between children in both settings.

Between the late 1970s and 2019, 16 residential staff were convicted of sexual abuse of children in residential care, 10 foster carers were convicted of sexual abuse of their foster children, and the Inquiry is aware of 12 convictions relating to the harmful sexual behaviour of children against other children in care. The offences in residential care took place in Beechwood and a number of other children's residential units, including the following 12 establishments: Hazelwood, Skegby Hall, Edwinstowe, Sandown Road, Wollaton House, Hillcrest, Risley Hall, Greencroft, Beckhampton Road, Woodnook, Amberdale and Three Roofs.

Some of the convicted offenders are detailed below:

> Two offenders, Norman Campbell and Christopher Metcalfe, were convicted of sexual assaults against children in both residential care and foster care.
>
> Patrick Gallagher was convicted of 55 counts of sexual abuse committed between 1998 and 2010 against 16 children, seven of whom were in care. He was given 13 life sentences, with a minimum of 28 years' imprisonment.
>
> Robert Thorpe was convicted in 2009 of several counts of indecent assault and unlawful sexual intercourse with a girl under 13 who was being fostered by his friends. He was given five years' imprisonment.
>
> Dean Gathercole was convicted of six counts of indecent assault and three counts of rape of two residents at Amberdale in the late 1980s. He was given a prison sentence of 19 years in 2018.

Accounts of abuse include:

> L17 was raped on "*four or five occasions*" by staff member Colin Wallace, who was later convicted. She was made to masturbate Wallace in a communal lounge in Beechwood, where other children and staff were present.
>
> P2 was in foster care in the 1960s, and was raped by her foster father on camping holidays.
>
> P13 was sexually abused between 1979 and 1981 by the 21-year-old brother of his foster mother and was forced to masturbate him and perform oral sex.
>
> A76 spent 16 years in care in 21 placements. She was abused by older boys in several children's homes and was the victim of rape and sexual assault.

Over the years, as local authority boundaries changed, responsibility for some of the services referred to in this report moved between the County and the City. The Inquiry selected three case studies to examine in detail the responses of institutions to sexual abuse of children in the care of the two councils.

Beechwood

Beechwood operated for 39 years, from 1967 to 2006, and was run for periods by the City and County. It was run first as a remand home, then as an observation and assessment centre, and later a community home. In common with residential care across England at the time, it was poorly resourced and managed. Care staff were predominantly unqualified and received little, if any, training. Even with these similarities, however, no other residential homes in Nottinghamshire have had the level of allegations of sexual abuse which have been made about Beechwood staff.

It was not a safe environment for vulnerable children. Staff were threatening and violent, physical abuse was commonplace and children were frightened. Sexualised behaviour by staff was tolerated or overlooked, allowing abusers such as John Dent, Barrie Pick and Andris Logins to flourish. Managers at Beechwood, notably Ken Rigby, were either complacent or deliberately ignored the plight of children under their care. There were only two disciplinary actions taken when allegations of sexual abuse were made, and those were inadequate. When the City took over the running of Beechwood in 1998, the staff environment had not improved and children and young people were still at risk of sexual abuse. The City allowed Beechwood to continue operating for a further eight years, when it should have been closed much earlier.

As one example, L29 was remanded into the care of the City in 2005 and placed at Beechwood for four months, when he alleges he was repeatedly abused by a male member of staff. In 2015, he came forward to the police and felt that they believed him. He had not received an apology from the City, which made him "*very angry*". He said, "*I don't see any future for myself. I understand that I had problems before Beechwood, but, in my opinion, Beechwood put me where I am today*".

Foster care

This case study considered the institutional responses to sexual abuse in foster care from the 1960s to the present day. Foster care has been, and still is, the most common placement for children in the care of both of the Councils. The overall picture from the mid-1970s to the 1990s shows an inconsistent approach to the recruitment, assessment and support of foster carers, and the supervision of children's placements. When allegations of sexual abuse were made, there was too much willingness on the part of Council staff to take the side of the foster carers and to disbelieve the child. There was no effective or rigorous assessment of individual allegations.

In one particularly shocking case, in the 1970s, the County returned children to foster care after the foster carer pleaded guilty to the sexual assault of his two nieces. In 1985, a County foster carer (who was also a residential care worker) admitted sexually assaulting a foster child, after previous allegations against him had been regarded as "*malicious*" by children's social care. In January 2014, NO-F77 was convicted of sexually abusing children in foster care, having fostered over 30 children in the care of the County between 1998 and 2012 although there had been previous allegations of sexual abuse, most significantly in 2000, when social workers concluded that they had "*no doubt*" that the abuse did not occur. Foster children were left at risk by the County, resulting in preventable abuse.

There was also sexual abuse by City foster carers. For example, Raymond Smith was deregistered as a foster carer in 2004 following allegations of sexual abuse by children in foster care and was, in 2016, convicted of sexually abusing a child not in care. By this time it was noted that, during Smith's time as a foster carer, there had been allegations "*by a number of young people of a sexual nature*".

L35, who was physically and sexually abused whilst in foster care in the 1980s, was angry "*that the foster carers were allowed to get away with abusing children in their care for so long and nothing was done about it. No one took foster children seriously … there was no punishment for the foster parents. They got away with everything.*"

Despite improvements, there continue to be weaknesses in foster care practice in both Councils.

Harmful sexual behaviour

For most of the period under review in this investigation, harmful sexual behaviour between children in the care of the Councils has not been well understood by professionals involved with children in care. Between 1988 and 1995, five separate reports into harmful sexual behaviour in five County community homes were conducted. In one home, all children resident over a 12-month period were found to have been exposed to harmful sexual behaviour. Policies and procedures were established but the issue was not viewed holistically across the five homes, so the work was largely wasted and learning was lost.

D31, a victim of harmful sexual behaviour at Greencroft when she was aged 12, told us of five incidents of sexual abuse involving older male residents. She had been placed at Greencroft with much older children which, along with a failure to monitor risks posed by other children and a lack of guidance for staff, left her at risk of abuse.

Neither of the Councils have a satisfactory approach to addressing the issue of harmful sexual behaviour of children in care. The County has taken steps to audit its practice. The City provided very little evidence to the Inquiry about its current practice, or of any recent steps taken to improve it, notwithstanding the inclusion of harmful sexual behaviour as a case study in this investigation. Despite present, widespread awareness of the issue, there is no national strategy or framework for the prevention of, or response to, harmful sexual behaviour between children in care.

Nottinghamshire Police

In 2011, Nottinghamshire Police initiated Operation Daybreak to investigate allegations of non-recent abuse of children in residential care. However, this was not adequately resourced, the police did not treat allegations with sufficient seriousness, and valuable time was lost. In 2015, Operation Daybreak was subsumed into Operation Equinox. Since that time there have been a number of prosecutions, bringing increased confidence amongst complainants in the force's commitment. Nevertheless, only now have Nottinghamshire Police begun to address weaknesses in its approach to child protection, as identified in recent HMIC (known as HMICFRS from summer 2017) inspection reports.

Apologies, acknowledgment and support

The Councils have taken different approaches to apologising for non-recent abuse and acknowledging past failures to protect children in their care. Whilst the County have made a public apology, the City have been guarded and slow to apologise or express appreciation for the level of distress felt by complainants. An example of this was the reported comment, in 2018, from the then City Council Leader that "*we will apologise when there is something to apologise for*". This was crass and caused avoidable upset.

Provision and consistency of support and counselling for those who have suffered sexual abuse in care remains an issue.

Recommendations

We make recommendations covering issues such as risk assessments of current and former foster carers and residential care staff, and the approach to harmful sexual behaviour.

Pen portraits from children in the care of the Nottinghamshire Councils

This investigation received many accounts of sexual abuse from those who were in the care of the Nottinghamshire Councils. A selection of these are set out here, and others are referred to throughout the report.

D6

D6[1] was born in 1995 and taken into foster care in 2005 after a horrific experience at home. He was in the care of the City, which, whilst retaining responsibility for him, placed him in foster care in Yorkshire with NO-F70, via an independent fostering agency. Multiple allegations of abuse were made against NO-F70, but investigations were dropped quickly and NO-F70 moved with D6 to the Isle of Wight.

Following the move, social work visits to D6 became "*sporadic*" and were often cancelled. D6 told us of being physically assaulted and intimidated by NO-F70 and then, in 2007, sexually abused by him. D6 was eventually removed from NO-F70's care after two allegations of child sexual abuse were made against NO-F70, although there was no investigation at that time into whether D6 had also been abused by NO-F70.

In 2017, D6 reported his abuse to the police but there was some confusion about which force should be investigating it. The abuse resulted in D6 trying to take his own life on a number of occasions, and standing outside the City's offices having covered himself in petrol. He told the Inquiry:

> "*I am still full of fury about what NO-F70 did to me. I don't understand how someone with an allegation of underage sexual assault made against them can have been allowed to continue to foster children.*"

L29

L29[2] was born in 1990. In 2005, he was remanded into the care of the City and placed at Beechwood for four months. He alleges being forced to perform oral sex on a male member of staff, NO-F61:

> "*He would give me things such as fags and money, before and after the abuse. I think this was his way of getting me to comply and keep the abuse a secret.*"

[1] D6 5 October 2018 20/19-84/7
[2] L29 3 October 2018 153/1-156/10

L29 would run away to escape the abuse and, on occasion, would be returned by the police. He did not tell them what was happening with NO-F61 as he did not trust them. He came forward again more recently to the police, in 2015, and says that he felt they believed him. He had not received an apology from the City, which made him "*very angry*":

> *"I don't see any future for myself. I understand that I had problems before Beechwood, but, in my opinion, Beechwood put me where I am today."*

L35

L35[3] was born in 1982 and was placed in foster care with NO-F116 and NO-F117 in 1987. She had previously been physically and sexually abused at home; in 1989, a number of adults in L35's family were convicted of abuse against her, her siblings and cousins.

In foster care, L35 was physically and sexually abused. She said that NO-F116 "*would sometimes touch me between my legs. I remember being sat on the sofa and he would put his hand down my trousers. He never forced himself on to me but would make me touch his penis and him touch me.*"

L35 disclosed the abuse in 1989, but did not leave the placement for another six months. An investigation by the police and children's social care was conducted subsequently into allegations from her and others. L35 was not interviewed. The foster carers were not prosecuted, although L35 was told that they would not be allowed to foster again. L35 is angry that the foster carers "*were allowed to get away with abusing children in their care for so long and nothing was done about it. No one took foster children seriously. We made disclosures. There were various investigations and to an extent we were believed but there was no punishment for the foster parents. They got away with everything.*"

N1

N1[4] was taken into the care of the County in 1982, aged 12, having been sexually abused at home. She was placed at Beechwood for around 18 months, during which time she was sexually abused by Andris Logins, a member of residential care staff. She described how Logins was "*really friendly*" towards her, recalling that "*He was the only person there that was nice to me.*" She told us of a number of instances in which they had sexual intercourse at Beechwood and said "*All, if not most, staff members at Beechwood knew about the abuse but failed to prevent or report it.*"

After leaving care, N1 turned to drugs, drink and "*prostitution*" and was living a "*really dysfunctional life*". She only told the police about the abuse in 2012 when they contacted her as part of their investigation into Beechwood. She was very positive about her treatment by the police, who updated her regularly. Logins was convicted in 2016 of sexually abusing her and others.

D22

D22[5] was born in 1969 and taken into care in 1978. He had various different placements, including two at Beechwood in 1978 or 1979 and in 1984. At Beechwood, he was sexually abused by two male members of staff, NO-F29 and another.

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[3] L35 4 October 2018 154/7-156/6
[4] N1 3 October 2018 1/9-54/7
[5] D22 3 October 2018 145/19-148/19

> *"I remember that both men abused me on multiple occasions. They both touched me inappropriately. They both forced me to masturbate them. They both forced me to perform oral sex on them."*

D22 also recalls being sexually abused by two male members of staff at Skegby Hall, as well as being physically and racially abused there. At South Collingham Hall, another children's home, he was sexually abused on three occasions by an older boy, including one rape, one attempted rape and an incident of sexual touching.

He did not tell anyone about the sexual abuse at the time. He did not think he would be believed:

> *"I never wanted anyone to find out what had been done to me. As a young black kid, I didn't know who to turn to or who to trust. I remember that I tried to run away from Beechwood and the staff caught me just down the road. I think this happened about three times. I remember that I told them that I didn't want to go back to Beechwood."*

He also says at times he blamed himself: "*The abuse I suffered has always been a source of shame and embarrassment for me. The thought of talking about it has been, and still is, very frightening.*" In the last 10 years he has contacted solicitors and reported his abuse to the police, who have kept him updated about their investigation.

A76

A76[6] was born in 1969 and spent 16 years in care, moving placement 21 times, including both children's homes and foster placements. She was raped twice by an older boy at one children's home: "*He told me that if I told anyone about what he had done, he would beat me until I was dead.*" She tried to tell a female staff member but was "*just too scared*". She was also sexually assaulted by another boy at the home, but did not report it:

> *"I never stayed in one place long enough to feel like I had any one adult who I could trust to report what had happened to me at the time."*

A76 noted that, in her social services records, there was a letter from a social worker dated February 1990, which stated that "*her experiences in care were not a credit to the department*". A76 told us, "*With the greatest respect, this feels like the understatement of the century. I was treated appallingly by Social Services and they know it.*"

L48

L48[7] was born in 1964 and admitted into care in 1969. In 1971, he was placed in foster care with NO-F275 and NO-F358. He moved with them to Cheshire, but remained in the care of Nottingham City Council. He was sexually abused by NO-F275 but, as he was not able to see a social worker alone, felt unable to disclose the abuse.

His next foster placement was with NO-F276, who sexually abused him when he was aged 11 and treated all of the foster children as "*slaves*". L48 was unable to disclose the abuse as he was frightened people would not believe him and the abuse had made him confused about his sexuality.

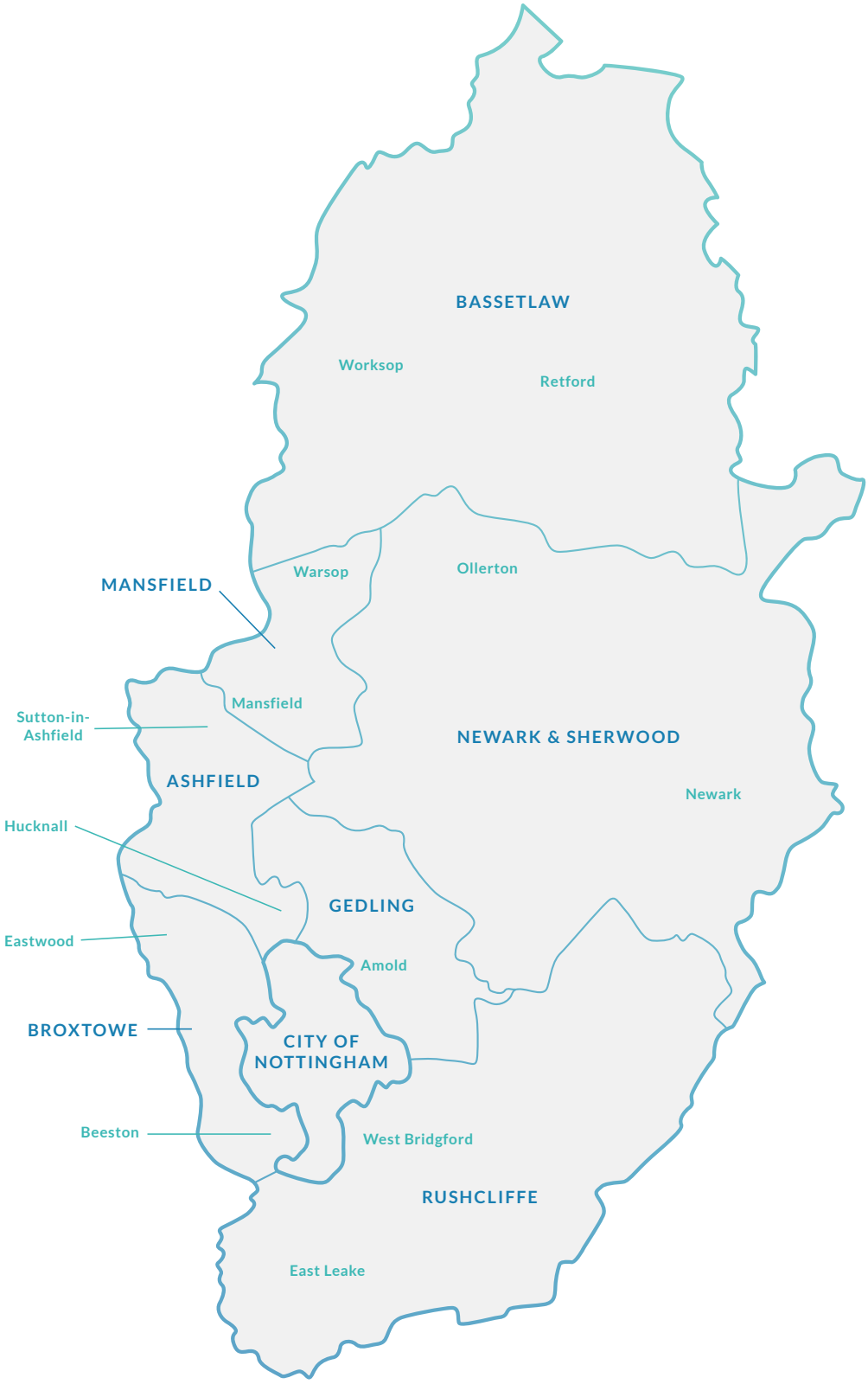
[6] A76 5 October 2018 113/10-121/12
[7] L48 4 October 2018 1/6-48/24

He first reported the abuse to the County's children's social care service in 1985, but felt that he was not believed from the outset. He withdrew the complaint. He complained to the County again in 2015 and felt believed by Steve Edwards (then Service Director for children's social care), who organised counselling and for him and other complainants to give talks to social workers and foster carers about their experiences in care and the lessons to be learned.

In 2017, NO-F275 was acquitted after being charged with abuse of L48. L48's sexual abuse allegations against NO-F276 were investigated by the City's Safeguarding Children Board, which found that they were unsubstantiated. L48 found the process followed by the Safeguarding Children Board to be "*insulting*".

Part A

Introduction



Nottinghamshire

Introduction

A.1: Background

1. This is the second of three investigations considering the sexual abuse of children in the care of local authorities.[8] In this report, we focus on children in the care of Nottingham City Council (the City) and Nottinghamshire County Council (the County) (together, the Councils). Specifically, we consider the nature and extent of allegations of sexual abuse of children in the care of the Councils, the response of the Councils, Nottinghamshire Police and the Crown Prosecution Service to those allegations, and the steps taken to protect children in care in light of them.

2. Until 1974, in Nottinghamshire, responsibility for children in care was divided between the County, Nottingham Borough Council (the precursor to the City) and the Home Office. Between 1974 and 1998, the County was the sole local authority responsible for all children in care across the city and the county. Since a local government reorganisation in 1998, the City and the County have been two separate local authorities. Where we refer to a geographical area including both the County and the City, we use the term 'Nottinghamshire'.

3. The two Councils are responsible for a geographical area of approximately 2,160 square kilometres.[9] In 2017, there were roughly 818,000 people living in the County[10] and 329,000 in the City.[11]

4. The number of children in care within the area covered by the Councils has fluctuated over time.

[8] The first concerned placements by Rochdale Borough Council, which reported in April 2018 – see *Cambridge House, Knowl View and Rochdale, Investigation Report*, April 2018 – and the third concerns children in the care of Lambeth Council, for which public hearings will take place in 2020.
[9] https://www.nottinghamshireinsight.org.uk/d/184228
[10] https://www.nottinghamshireinsight.org.uk/research-areas/key-facts-about-nottinghamshire/
[11] https://www.nottinghaminsight.org.uk/research-areas/key-facts-about-nottingham/

Table 1 **Number of children in care per 1,000 children**

	England	Nottinghamshire County	Nottingham City
1973[a]	6.8	3.9	14
1989[b]	5.7	8.6[c]	15.9[d]
2002[e]	5.4	3.1	9.5
2009[f]	5.4	3	7.9
2013[g]	6	5.4	9
2018[h]	6.4	4.8	9.1

[a] NSC000526_4; [b] NSC000104_20-21; [c] This figure includes children who were located within the City area but were in the care of the County (NSC000104_21); [d] This figure does not relate to children who were in the care of the City (which did not exist at that time), but to those who were in the care of the County and located in the City (NSC000104_21); [e] Statistics of Education: Children Looked After by Local Authorities, Year Ending 31 March 2004, Volume 2: Local Authority Tables, Department for Education and Skills, March 2005, pp5–6; [f] Children Looked After in England 2009–2013; [g] Children Looked After in England 2009–2013; [h] Children Looked After in England 2014–2018

The City's consistently higher proportion of children in care is likely to reflect its higher levels of deprivation.[12] Both Councils saw a significant reduction in these numbers between 1989 and 2002, as more community-based services for children were developed.

5. In terms of residential care provision, the City now has seven registered children's homes (managed within children's social care) and, since 2015, has had no children's homes with more than four long-term beds.[13] It also places children in its care in 19 children's homes run by private or voluntary organisations,[14] but a "*high proportion*" of children in residential care are placed outside the City, in children's homes run by other local authorities, due to a lack of available placements.[15] The County has six registered children's homes[16] and, as at March 2018, had 93 children who were placed in children's homes, 79 percent of whom were in privately-run homes.[17]

6. Foster care has long been the preferred placement for the majority of children in care. The most recent figures suggest approximately 63 percent of children in the care of the County,[18] and 73 percent of children in the care of the City,[19] are in foster care. Similarly, of those in foster care, 43 percent of those in the County and 56 percent of those in the City are placed through independent fostering agencies.[20]

7. In early 2010, local media in Nottingham reported that a number of people who had spent time in children's homes between the 1970s and the 1990s alleged that they had been sexually abused by staff. As the number of allegations increased, Nottinghamshire Police initiated a dedicated investigation, Operation Daybreak, which is now part of the ongoing Operation Equinox. By 2014 or 2015, the media focus shifted to the apparent lack

[12] For example, the City was the eighth most deprived district in England in the latest Index of Multiple Deprivation (2015). By contrast, the County was ranked 98th.
[13] NCC003691 para. 3.122, 3.90
[14] NCC003691 para. 3.88
[15] NCC003691 para. 8.7
[16] NSC001235 para. 3c.i.28; including children's homes for three or four children and short-break children's homes for between eight and 16 young people with disabilities (The Big House, Minster View, Caudwell House, Oakhurst, Lyndene, West View).
[17] Response to Freedom of Information Request 28.01.19
[18] NSC001235 para. 1.3; NSC001474 para. 4f.1
[19] NCC003691 para. 3.135; Nottingham City Council Corporate Parenting Board July 2018, pp13–14
[20] NSC001474 para. 4f.1; NCC003807 para. 3.9

of outcomes from the police investigations or action by the Councils. Locally, there was a widespread perception that the allegations had not been properly investigated, as there had not been (at that time) any prosecutions as a result.

8. Between the late 1970s and 2019, in Nottinghamshire, the Inquiry is aware of:

- 16 staff convicted of sexual abuse against more than 30 children in residential care;
- 10 foster carers convicted of the sexual abuse of approximately 25 children in their care;[21]
- three foster carers convicted of the sexual abuse of seven children not in their care;
- two relatives of foster carers convicted of sexually abusing two children in foster care; and
- 12 convictions in relation to harmful sexual behaviour between children in care. This figure only includes those cases which we know resulted in a conviction or a caution. We do not have an accurate number of substantiated cases. There are large numbers of allegations which were regarded as substantiated at the time by the County's children's social care service, and some in which charges were recommended. However, we do not have evidence of convictions in these cases.[22]

Further detail of these convictions is included in Annex 3.

A.2: Nature and extent of allegations of sexual abuse

9. The sexual abuse of children in the care of the Councils[23] was widespread in both residential and foster care during the 1970s, 1980s and 1990s.

10. The sexual abuse alleged in this investigation varies widely. It includes repeated rapes and other sexual assaults, related physical abuse, voyeurism and sexually inappropriate physical contact. The abuse was carried out by a range of perpetrators, including residential care staff, foster carers and their relatives, and children in care. Some allegations relate to single perpetrators, whereas others concern sexual abuse by more than one perpetrator at the same time. Several complainants make a number of allegations of sexual abuse during their time in care, including within the same placement.

11. Children in the care of the Councils have also been victims of child sexual exploitation.[24] By the mid-to-late 1990s, the County and then the City began to address this issue, including the introduction of a joint protocol with Nottinghamshire Police, a multi-agency group on sexual exploitation and a Home Office pilot project.[25] (This report does not consider child sexual exploitation in detail, as this will be addressed in a separate investigation within the Inquiry.[26])

[21] Including two who were also residential staff.
[22] See NSC000438_019 and NSC000104_107
[23] From 1974 to 1998, children were solely in the care of the County.
[24] Until the mid-to-late 1990s, this was often regarded, and referred to, as prostitution.
[25] NSC000054; NCC003691 para. 6.34; NSC001235 para. 6j.11; NSC001642. This work led to the award of a National Social Care Award (CQC000038_21).
[26] Relevant evidence will be considered through the Inquiry's investigation into Child Sexual Exploitation by Organised Networks

12. In addition to evidence from complainant core participants, the Inquiry has reviewed information from police investigations, civil litigation claims, disciplinary investigations and foster care investigations. Around 350 individuals report having been sexually abused whilst in the care of the Councils from the 1960s onwards. This includes 259 accounts of sexual abuse in residential care,[27] 91 in foster care[28] and 89 accounts of harmful sexual behaviour.[29] Of the 71 complainant core participants who provided a statement to the Inquiry but were not called to give evidence, 57 make allegations of sexual abuse in residential care and 18 in foster care, and 13 give accounts of being the victims of harmful sexual behaviour by other children.[30]

13. The true number of children who suffered sexual abuse in the care of the Councils is likely to be higher than these figures. There are multiple barriers to disclosure during childhood, many of which continue into adulthood. Additionally, there are very few remaining records from the Councils regarding their response to allegations of sexual abuse before the 1980s, and none from the police, because records have been destroyed in accordance with the record retention policies of the day. If a child did report sexual abuse at the time, it may never have been recorded. The absence of records therefore does not mean children were not being sexually abused during this period, simply that we do not have documentary evidence.

14. In some cases, there have been convictions for sexual abuse of children in care, as well as dismissals or disciplinary action taken against staff members, deregistration of foster carers and the settling of civil claims. In others, complainants were not believed, alleged perpetrators died before allegations were reported, or children's social care, the police or the Crown Prosecution Service decided not to take any action.

A.3: Case studies

15. In order to investigate the institutional responses to allegations of child sexual abuse in Nottinghamshire, including the barriers to disclosure, the Inquiry selected three case studies.[31]

15.1. Beechwood was initially a remand home, then an observation and assessment centre, before being designated as a children's home in 1984. Since 2011, it has been the subject of extensive police investigation into allegations of sexual abuse, as well as a focus of the local media. It is also the single institution with the largest number of allegations of sexual abuse made to the Inquiry.[32] Although a large number of allegations of child sexual abuse had been made in recent years, there was little evidence of allegations being made or responded to at the time. This case study illustrates the barriers to reporting faced by children in care.

[27] INQ002577; INQ002574
[28] INQ002575; INQ002574
[29] INQ002576; INQ002574; a number of complainants make allegations across residential care, foster care and harmful sexual behaviour.
[30] INQ002574
[31] *Notice of Determination on Selection of Case Studies*, 28 February 2018, as provided for under paragraph 3 of the investigation's Definition of Scope
[32] INQ002574; INQ002576; INQ002577

15.2. Foster care, throughout the period under review, has been the primary placement for children in care. Complainant core participants made 26 allegations of sexual abuse in foster care[33] and there were a substantial number of documents dealing with the Councils' responses to complaints made at the time.

15.3. Harmful sexual behaviour between children in care does not appear to have been the focus of any public inquiry in the UK. However, it is estimated that between one-third and two-thirds of allegations of child sexual abuse in the UK are made against young people under the age of 18.[34] In Nottinghamshire, five internal investigations were conducted into harmful sexual behaviour between 1988 and 1995 in five separate children's homes.

16. In addition, there were many allegations of sexual abuse falling outside these specific case studies, which relate to other residential homes (such as Amberdale, Skegby Hall, Greencroft and Hazelwood). These are recorded in summary tables,[35] and institutional responses to some of those allegations are addressed further below.

A.4: Methodology

17. The methodology adopted by the Inquiry is set out in Annex 1. Core participant status was granted under Rule 5 of the Inquiry Rules 2006 to 96 core participants, including 88 complainants who alleged they were sexually abused whilst in the care of the Councils.

18. The overarching issues considered in this investigation derived from the scope of the investigation set by the Inquiry[36] and the Terms of Reference for the Inquiry set by the Home Secretary.[37] These were to:

(a) establish the nature and extent of allegations of sexual abuse of children in the care of the Councils and barriers to the disclosure of such abuse;

(b) analyse the institutional responses to allegations and how these have changed, with a particular focus on our case studies;

(c) reach conclusions as to what happened, holding institutions to account for past and current failings; and

(d) make recommendations as to what can improve the situation in the future.

19. After three preliminary hearings, public hearings were held over 15 days in October 2018, including seven days of hearings in Nottingham.

20. At the public hearings, we heard accounts from 12 complainants about their experiences as children who had been sexually abused in care.[38] An additional 71 complainant core participants provided written evidence of their experiences, with parts of each read into the record during the public hearings.[39]

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[33] INQ002574
[34] *Workforce perspectives on harmful sexual behaviour, Findings from the Local Authorities Research Consortium 7*, National Children's Bureau and Research in Practice, p14. Additionally, between one-quarter and one-third of all sexual offences are estimated to be committed by young people under the age of 18 (INQ002045 para. 1.2).
[35] INQ002574; INQ002577
[36] Nottinghamshire Councils investigation Definition of Scope
[37] Inquiry's Terms of Reference
[38] 2 October 2018; 3 October 2018; 4 October 2018; 5 October 2018; 26 October 2018
[39] INQ002574

21. Evidence was provided by institutional witnesses about a range of factual matters. These included: broad questions about the level of managerial scrutiny of residential homes and foster care; how the Councils conducted investigations into staff and foster carers accused of sexual abuse; whether they followed through on what the investigations revealed; and, when they did commission internal reports, how effective the Councils were in carrying out recommendations intended to protect children. Other issues included why children found it so difficult to disclose sexual abuse, what happened when they did disclose and the individual experiences of adults disclosing childhood abuse.

22. Various institutions, including the Councils, Nottinghamshire Police, the Crown Prosecution Service, Ofsted and the Department for Education, also provided corporate statements and documents.

23. The Inquiry commissioned a report from Professor Simon Hackett, an expert on harmful sexual behaviour between children. He is Professor of Child Abuse and Neglect at Durham University and, over the course of the last 20 years, has undertaken a series of research studies and written a variety of articles and books on harmful sexual behaviour. Professor Hackett was asked to provide his opinion on a number of topics, including the developing understanding of harmful sexual behaviour between children, the evolving response to the issue and the barriers to disclosure of this type of behaviour.

24. The Inquiry reviewed a large amount of witness and documentary evidence, which was disclosed to core participants where relevant. Due to the lack of evidence in relation to earlier periods, this report covers the period from the late 1960s to date.

25. References in this report such as 'NSC000102' and 'NSC000102_10' are to documents or specific pages of documents that have been adduced in evidence and can be found on the Inquiry's website. A reference such as 'Hicks 19 October 2018 142/8-23' is to the hearing transcript which is also available on the website; that particular reference is to the evidence of Rhona Hicks on 19 October 2018 at page 142, lines 8 to 23.

Part B

Context

Context

B.1: Introduction

1. Throughout this report, when referring to staff within the Councils who had a statutory responsibility for children, including children in care, we have referred to children's social care. Until 2006, this work was carried out by social services departments, and after then by new children's services departments.[40] The terms 'children's social care' or 'children's social care service' are used throughout for consistency.

B.2: Child protection issues in the early 1990s

2. In the late 1980s and early 1990s, a *"deep rift"* arose between Nottinghamshire Police and the County's children's social care service following a major child abuse investigation involving an extended family in Broxtowe.[41] The investigation led to 10 adults being charged in February 1989 with 53 offences of indecent assault, incest and cruelty against 23 children. In December 1989, a joint enquiry team of police officers and social workers warned that "*there could be a total breakdown of Police/Social Service relationships with incalculable consequences*".[42] By September 1991, the "*extent of this antagonism, and the damage ensuing from it, was … considerable*".[43]

3. In 1991, Her Majesty's Inspectorate of Constabulary (HMIC) and the Department of Health's Social Services Inspectorate (SSI) conducted a joint inspection of child abuse investigations in the County.[44] Although only seven of the 20 cases inspected concerned children in care,[45] the inspectors criticised a lack of training and made a number of recommendations, including that all child sexual abuse investigations should be undertaken by trained officers within Nottinghamshire Police's Family Support Unit (FSU), supported by specialist children's social care staff. They also said the Area Child Protection Committee (ACPC)[46] needed urgently to disseminate revised procedures and provide appropriate training to ensure implementation.

4. Between 1990 and 1995, there was a crisis in the County's child protection capability:

> **4.1.** There were more than 800 'unallocated cases' in 1990,[47] leading to the Department of Health threatening to intervene.[48] This was reduced to zero by the end of 1991.[49]

[40] NSC001235 para. 3c.i.25
[41] INQ002051 para. 37
[42] Nottinghamshire County Council Revised Joint Enquiry Report
[43] NSC000177_8
[44] NSC000184
[45] NSC000184_14
[46] ACPCs (previously Area Review Committees) were multi-agency forums bringing together social services, the police and other agencies to safeguard children. Their remit included developing and agreeing policies and procedures. ACPCs were replaced by Local Safeguarding Children Boards under the Children Act 2004 (see Area Child Protection Committees).
[47] Children for whom children's social care had opened cases but had not allocated a particular social worker (DFE000819_24-25).
[48] DFE000819_21-23
[49] DFE000965_1

4.2. There were 14 child deaths reported to the SSI between 1990 and 1992.[50] One death generated significant publicity, which intensified in December 1993 when the County decided not to start disciplinary proceedings against the social workers involved in the case, and promoted them.[51]

4.3. In 1994, two highly critical internal and external reports on child protection in the County were published.[52]

As a result, the SSI considered there was "*a serious problem*"[53] and the Health Minister had "*very great concerns about the poor performance … in the protection of children at risk*".[54]

5. The County also identified "*serious weaknesses*" in its children's social care service in 1994, with services not meeting the required standards of the Children Act 1989, weak information systems, abandoned internal training programmes, poorly kept records and inadequate recruitment practices.[55] Both David White, the County's Director of Social Services, and Joan Taylor, Chair of the Social Services Committee, subsequently resigned.[56]

6. In September 1994, an SSI inspection concluded that the children's social care service "*had not yet safely established a competent child protection service for children and families in Nottinghamshire*".[57] The SSI became directly involved in 'monitoring'[58] children's social care until August 1995, when the SSI decided that sufficient progress had been made.[59] A further SSI inspection in December 1995 commented that "*considerable efforts had been made … to transform a dismal child protection investigative service*".[60]

7. The Broxtowe investigation occupied significant time and focus,[61] and diverted attention away from child abuse investigations.[62] As a consequence, children in care were not given sufficient priority, despite the large number of investigations and prosecutions into the sexual abuse of children in residential and foster care. There was an unwarranted assumption that they were protected by the carers themselves.[63]

B.3: Governance

Management within the Councils

8. Although management structures have changed over time, staff within the children's social care service have had day-to-day responsibility for all children in care in Nottinghamshire. The Director of Children's Services within each of the Councils now has "*professional*" responsibility for the leadership, strategy and effectiveness of children's services. This includes securing the provision of services to address the needs of children

[50] DFE000965_1
[51] DFE000965_3-4
[52] *Strong Enough To Care?* Chief Executive's Working Party, July 1994 (NSC000241); *Report of the Inspection of Nottinghamshire Social Services Department's Child Protection Service*, Social Services Inspectorate, September 1994 (NSC001160).
[53] DFE000963_3
[54] DFE000819_1
[55] NSC000241
[56] White 8 October 2018 124/1-18; INQ002051_13
[57] NSC001160_58
[58] This would happen when the SSI had particular concerns about the performance of a local authority (*The Social Services Inspectorate: A history*).
[59] CQC000007; CQC000020_1-2
[60] NSC001170_15
[61] White 8 October 2018 127/18-31/3
[62] INQ002051 para. 37
[63] White 8 October 2018 135/22-136/4; 147/24-148/5

and young people.[64] The Youth, Families and Social Work Division of the County's Children and Families Department is responsible for all children's social care within the County, including fostering and children's homes.[65] In the City, management oversight of children's homes and fostering placements is the responsibility of the Head of Service for Children in Care, who operates within the Children's Integrated Services directorate.[66]

The role of elected councillors

9. The way in which elected members have exercised governance responsibility for children in care has varied over time. Since 2004, both the County and the City have a councillor charged with specific accountability for children in care.[67] That elected Lead Member for Children's Services has political accountability for the leadership, strategy and effectiveness of children's services. This includes setting the priorities for children's services and providing support and challenge to the Director of Children's Services.[68]

10. Collectively, councillors act as the 'corporate parent' for children in care, which requires them to act in the best interests of children in care and ensure that they are kept safe.[69] Councillors also receive regular reports about children in care, including annual reports from the Fostering Service and the Independent Reviewing Officer service.[70]

Oversight of children's homes

11. The oversight of the Councils' children's homes has also developed over time:

11.1. Since the early 1990s, internal 'inspections' have been required by children's social care every month.[71] These were undertaken by children's social care managers until 2014, since when they have been undertaken by an independent person appointed by the Councils.[72]

11.2. From 1991 to 2004, children's homes were also inspected by an 'arm's length' body (structurally independent of those managers responsible for the operation of social services).[73] This involved at least two visits per year – one announced and one unannounced.[74]

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[64] This is a statutory role under s.18(1) of the Children Act 2004 which is held by Colin Pettigrew for the County and Alison Michalska for the City; *Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services*, Department for Education, April 2013

[65] NSC001235 paras 3c.i.25-3c.i.28; Children and Families Structure Chart, Nottinghamshire County Council, June 2018

[66] NCC003691 paras 3.57, 3.124

[67] NCC003691 paras 3.11, 4.5-4.7; NSC001235 para. 4a.16. In the City, this was, until May 2019, the Portfolio Holder for Early Intervention and Early Years (Councillor David Mellen) and is now the Portfolio Holder for Children and Young People (Councillor Cheryl Barnard); in the County, it is the Chair of the Children and Young People's Committee, currently Councillor Philip Owen.

[68] *Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services*, Department for Education, April 2013; *Applying corporate parenting principles to looked-after children and care leavers*, Department for Education, 2018; *Lead member role and key relationships*, Local Government Association, 2015

[69] The seven corporate parenting principles were introduced by the Children Act 1989.

[70] INQ002628 para. 23. Independent Reviewing Officers (IROs) are social workers who have a duty to ensure that care plans are legally compliant and in the child's best interests. See 'What is an IRO?'

[71] For example, see NSC000393. These visits were known as Regulation 22 visits under the Children's Home Regulations 1991, then Regulation 33 visits under the Children's Homes Regulations 2001, and are now Regulation 44 visits under the Children's Homes (England) Regulations 2015

[72] Regulation 43 Children's Homes (England) Regulations 2015

[73] Regulation 28 Children's Homes Regulations 1991

[74] Regulation 28(2)-28(4) Children's Homes Regulations 1991

11.3. Since 2000, all children's homes have been required to register with the registration authority (currently Ofsted).[75] To maintain registration, a children's home must have a statement of purpose, a children's guide and prescribed policies and procedures, as well as prescribed staffing ratios and qualifications.[76]

11.4. Elected councillors have also made visits to homes on a regular basis (called 'rota visits') since the 1970s, and have reported their findings to a committee.[77] These visits vary in their effectiveness, with witnesses describing them as "*next to useless*"[78] and "*widely perceived as a token*".[79]

B.4: Response to allegations of child sexual abuse

Policies and procedures for responding to allegations of child sexual abuse

12. The first national guidance specifically addressing child sexual abuse was in 1988, in *Working Together*.[80] This was followed by 1991 guidance accompanying the Children Act 1989, which included the sexual abuse of children in care.[81]

13. Earlier, between 1974 and 1984, the County issued a succession of memorandums, procedures and guidance for its social services, dealing with "*neglected or battered children*" and non-accidental injury.[82] The County's 1978 'Policy and Procedure Guide (Community Homes)' stated:

> "*Instances of abuse of clients coming to the notice of any member of staff must be reported immediately … The Officer-in-Charge must report all suspicions, or complaints regarding abuse of clients, to the appropriate Homes Adviser …* "[83]

When investigations into allegations of sexual abuse by staff in children's homes were conducted in the 1980s, they broadly followed the 1978 guidelines,[84] although the approach was inconsistent.[85]

14. Policies dealing with child sexual abuse developed over the years:

14.1. In 1984, new multi-agency child abuse procedures within the County included responding to allegations of child sexual abuse made against foster carers, but did not apply to residential care.[86]

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[75] Care Standards Act 2000
[76] Care Standards Act 2000, section 11; The Care Standards Act 2000 (Registration) (England) Regulations 2010; The Children's Homes (England) Regulations 2015. See also *Introduction to children's homes*, Ofsted, July 2018
[77] NSC000451_26-33; NSC001235 para. 3a.18
[78] Tipping 24 October 2018 120/17-25
[79] INQ002957 para. 3. In March 2019, the County decided to cease carrying out rota visits and replace them with a new Governance Board to oversee the County's children's homes. It will still carry out visits but under new guidance, and will consider all reports on Regulation 44 visits (Rota Visits by Elected Members).
[80] NSC000938
[81] EWM000463_35-38. Prior to that, from the 1930s, the Home Office maintained a list of people considered unsuitable to work in approved schools (HOM002409_1, 7) and this was later extended to cover Local Authority Remand Homes and children's homes. There was some Home Office guidance in place from the 1950s relating to "*allegations of indecent practices*" by staff in approved schools (EWM000463_16-17).
[82] NSC001235 paras 3c.iii.1-3c.iii.5
[83] NSC000046; INQ002007 paras 2.27-2.29; Jones 8 October 2018 57/1-58/18
[84] NSC000106; NSC000490
[85] NSC000229; NSC000105_35
[86] NSC000075

14.2. Specific guidance was issued in 1991 on responding to sexual abuse in residential care, both in the County[87] and across England and Wales,[88] following the Children Act 1989.

14.3. The 1992 Nottinghamshire ACPC procedures required an independent investigation by a senior member of staff if an allegation of abuse was made against either a member of residential care staff or a foster carer.[89] The safety of any other children in a foster care household was also to be considered.[90]

14.4. The ACPC procedures emphasised three separate strands to the investigation of allegations against staff: child protection, disciplinary proceedings and criminal proceedings. They clarified that insufficient evidence to support a prosecution "*does not mean that action does not need to be taken to protect the child, or that disciplinary procedures should not be invoked and pursued*".[91]

14.5. From the 1990s onwards, allegations against foster carers generally led to their suspension pending full investigation by children's social care. Other foster children were placed elsewhere and no further placements were made in the interim.[92] Concerns or allegations about a foster carer could lead to their deregistration, sometimes following a recommendation from the fostering panel.[93] Although allegations of sexual abuse should have triggered a review of the foster carer's suitability,[94] reviews did not always happen where the police had decided to take no further action.[95]

14.6. By 2004, the County published guidelines on conducting disciplinary investigations into staff[96] and the City began using their Local Safeguarding Children Board procedures.[97]

15. Both Councils now require all allegations of sexual abuse to be reported to the local authority designated officer (LADO), a role introduced by the Children Act 2004.[98] The LADO is responsible for overseeing the multi-agency response to allegations of abuse made against adults working with children, "*based on professional judgement on the balance of probabilities*".[99]

16. In residential care, the Interagency Safeguarding Children Procedures (which apply to both Councils) set out the steps to follow when allegations of abuse are made against staff.[100] The County[101] and the City[102] also have their own complementary procedures for

[87] NTP001473_119-233, which were multi-agency procedures, reviewed and updated regularly. See for example 1992 (NTP001473_1-118), 1994 (NSC000077), 1997 (NSC000058) and 2001 (NSC000079).
[88] EWM000463 para. 93
[89] NTP001473_63
[90] NTP001473_63
[91] NTP001473_67
[92] Stimpson 17 October 2018 12/6-11
[93] Stimpson 17 October 2018 5/3-13. There are also examples of this process of deregistration as far back as 1983 (NSC000348_7-8).
[94] Jones 8 October 2018 27/16-23
[95] See, for example, NSC000353 and NSC000368
[96] NSC000124
[97] NCC003691 para. 3.145
[98] See section 17 of the Children Act 2004. The DfE now – following *Working Together* (2015) – uses the term 'designated officer' instead, although LADO is still used by local authorities. County: NSC001235 para. 3c.iii,13-14. City: NCC003691 paras 3.140-3.142; NCC003807 para. 4.1
[99] NCC003807 para. 4.2
[100] Allegations against staff or volunteers, updated January 2019
[101] Managing allegations/concerns in relation to adults who work with children, updated July 2018
[102] Allegations against staff and volunteers, updated November 2018

responding to allegations of abuse. These include multi-agency strategy meetings to discuss the allegations and any parallel disciplinary process or police investigation.[103] If no police investigation or social care enquiry is necessary (or once they are completed), the Councils must consider whether to take disciplinary action.

17. In foster care, all local authorities must set out the procedure to be followed in the event of any allegation of abuse or neglect against foster carers.[104] Detailed standards for handling allegations are set out in the 2011 *National Minimum Standards*.[105] The County's guidance on allegations against foster carers includes the assessment of the seriousness of the initial information, suspension of the foster carer, the continued placement of children, how to react to resignations and the holding of strategy discussions.[106] In the City, when information is received that a child in foster care is suffering or has suffered significant harm, the child's social worker will be informed, a multi-agency strategy meeting will take place and an investigation may follow that can result in the deregistration of the foster carer.[107]

18. For both Councils, the framework for responding to allegations of non-recent abuse of a child in care is broadly the same as for recent allegations, although a number of additional considerations apply.[108]

Notification to local safeguarding board or partnership

19. Between 2006 and 2018, where abuse or neglect of a child was known or suspected and the child had died or been seriously harmed, the Councils' Local Safeguarding Children Boards (LSCBs) would be notified and would make a recommendation if they decided a serious case review or some other form of review was required.[109]

20. LSCBs were, in many local authorities, replaced by Safeguarding Children Partnerships from 2018.[110] Since then, the Safeguarding Children Partnership or LSCB undertakes a "*rapid review*" and considers whether a child safeguarding practice review (the replacement for serious case reviews) is required. Because the criterion of "*seriously harmed*" must be met, not every case of known or suspected sexual abuse of a child in care will be considered by the Safeguarding Children Partnership,[111] and because of the additional criteria, even fewer will proceed to a review.

Notification to councillors

21. Historically, councillors would receive verbal reports from the Director of Social Services in relation to allegations of sexual abuse, although the extent of this varied. For example, the County's Social Services Committee received regular but limited information about disciplinary investigations of staff accused of sexually abusing children in residential care.[112]

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[103] Allegations against staff and volunteers, updated November 2018
[104] The Fostering Services (England) Regulations 2011, section 12
[105] *Fostering Services: National Minimum Standards*, Department for Education, 2011, pp44–46
[106] NSC001133; NSC001341; NSC001235 paras 3c.iii.15; 6k.8
[107] City: Allegations Against Foster Carers
[108] INQ001813_10-11; Interagency Safeguarding Children Procedures, 'Historical and Non-Recent Abuse' (updated July 2015) Historical Cases of Abuse (County, updated January 2017)
[109] The Local Safeguarding Children Boards Regulations 2006, Regulation 5; *Working Together 2015*; NSC001235 para. 3c.iv.10; NCC003691 para. 3.148
[110] Children and Social Work Act 2017, Children Act 2004 (as amended) and *Working Together* 2018
[111] Interagency Safeguarding Children Procedures, 'Child Safeguarding Practice Reviews' (January 2019)
[112] INQ001934 para. 141. They also received updates on the progress of some criminal prosecutions of staff members for the sexual abuse of children in care. They would not necessarily have learnt of allegations made against foster carers because "*in one sense, they're employees, but in another sense, they weren't*" (White 8 October 2018 137/4-7).

Within the City, until the mid-2000s, councillors were informed of serious allegations of sexual abuse of children in care, although there was no formal system in place requiring this.[113]

22. In terms of today's practice, the County introduced ("*about two weeks*" before Councillor Owen, Lead Member for Children's Services in the County, gave evidence to the Inquiry[114]) a protocol for notifying the Lead Member of relevant incidents using an incident notification form.[115] This covers all allegations against members of staff but not all allegations against foster carers or of harmful sexual behaviour[116] and, while a log is to be maintained of all notifications, the level of detail provided will be decided in each case.

23. The City's Lead Member for Children's Services until May 2019, Councillor David Mellen, received verbal reports about allegations of sexual abuse of children in care, although he was not "*involved in the detail*".[117] He thought the last such notification was about two years before our October 2018 hearings,[118] but was fairly confident that he would be told of all allegations.[119] The City did not have a written notification protocol at the time of the hearings.[120] Neither of the Councils has a process by which there has been regular reporting to the Lead Member of the number of allegations of sexual abuse of children in care and the response to those allegations.

Notification to external agencies

24. Since 2001, local authorities have been required to report 'notifiable events' to Ofsted and its predecessors, including the instigation and outcome of any child protection enquiry involving a child in residential care.[121]

25. There are now a number of notification regimes applicable to children's social care, including the following:

> **25.1.** As set out above, allegations of sexual abuse of children, including those in care, where the child "*has been seriously harmed and abuse or neglect is known or suspected*",[122] must be notified to the local Safeguarding Children Partnership or Local Safeguarding Children Board and to external agencies such as Ofsted.[123] Since 2018, the national Child Safeguarding Practice Review Panel must also be notified if a child dies or is seriously harmed and abuse is known or suspected.[124]

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[113] INQ001838 para. 5.5
[114] Owen 23 October 2018 187/2-20
[115] INQ002630; INQ002628 para. 33. Prior to this, the relevant officer would use their "*professional judgement*" as to which matters to bring to the attention of councillors (NSC001235 para. 3c.iii.26).
[116] Allegations against foster carers or of harmful sexual behaviour would only be included if the child was deemed to be "*seriously harmed*" or the case was considered "*likely to attract public interest or media attention*" (INQ002630_2).
[117] Mellen 24 October 2018 84/2-20
[118] Mellen 24 October 2018 82/17-23
[119] Mellen 24 October 2018 87/24-88/3
[120] NCC003807 para. 10.10; Mellen 24 October 2018 88/4-6. However, since then, the City has developed a written notification protocol covering all allegations against staff and foster carers (but not of harmful sexual behaviour). The protocol is still under review (https://www.iicsa.org.uk/key-documents/12159/view/NCC003812.pdf).
[121] Children's Homes Regulations 2001, Regulation 30 and Schedule 5
[122] Under *Working Together* 2015, pp74–75 and *Working Together* 2018, p82
[123] *Working Together* 2018
[124] Section 16C(1) of the Children Act 2004, as amended by the Children and Social Work Act 2017

25.2. The manager of a children's home must notify Ofsted, the Department for Education (DfE) and the local authority of "*serious events*". These include suspected involvement in sexual exploitation (including harmful sexual behaviour) and any allegation of abuse against the home or a person working there.[125]

25.3. Children's social care must notify Ofsted of various matters relating to children in foster care, including the "*instigation and outcome of any child protection enquiry involving a child placed with foster parents*".[126]

25.4. If allegations are substantiated and the perpetrator is still working with children, a referral must be made to the Disclosure and Barring Service.[127] Similarly, if the alleged perpetrator is a qualified social worker, allegations of sexual abuse must also be referred to the Health and Care Professions Council.[128] This does not apply to all residential care staff, as not all are qualified social workers.

B.5: External inspections

26. Until the 1980s, the Home Office and the Department of Health carried out occasional inspections of children's homes. Responsibility for the inspection of children's social care then varied over time.

26.1. In 1985, the SSI was established to inspect social services (including children's social care) in order to "*improve effectiveness and efficiency and to promote necessary development*". However, its focus was on the provision of social services as a whole; it rarely conducted specific inspections of individual children's homes and did not undertake dedicated inspections of fostering services.[129]

26.2. From April 2002, the National Care Standards Commission (NCSC) was responsible for registering children's homes and fostering services and then carrying out inspections after registration.[130] They carried out some,[131] but did not establish a programme of regular inspections.

26.3. The SSI and NCSC were subsumed in April 2004 into the Commission for Social Care Inspection (CSCI), bringing registration, inspection, regulation and review of all social care services (including children's homes and fostering services) under the remit of one organisation.[132] It was only from this point onwards that there were regular external inspections of children's homes and fostering services.

26.4. The CSCI and then Ofsted inspected children's homes at least twice per year.[133] From 2004 to 2013, the Councils' fostering services were subject to specific and regular inspections by the CSCI and then Ofsted, carried out against the framework of the national minimum standards.[134]

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[125] Children's Homes Regulations 2015, Regulation 40(4); DFE000962 para. 109
[126] Fostering Services (England) Regulations 2011 Schedule 7 and Regulation 36
[127] *Managing Allegations/Concerns in Relation to Adults who work with Children*, updated July 2018, para. 9
[128] Health and Care Professions Council Employer referral
[129] *The Social Services Inspectorate: A History*, Department of Health, 2004, pp1, 11
[130] *National Care Standards Commission Account 2001–2002*, The Stationery Office, 2003
[131] Such as those carried out into Beechwood in 2002 (see Part C).
[132] National Care Standards Commission Account 2001–2002
[133] NSC001235 para. 8a.31-32
[134] Introduced in the Care Standards Act 2000 and updated in the *Fostering Services: National Minimum Standards* (2011)

27. In April 2007, the registration and inspection of children's services became the responsibility of Ofsted.[135] Between 2007 and 2013, Ofsted conducted separate inspections of each local authority's services in relation to "*protection, care, adoption and fostering*".[136] This changed in 2013 to one single inspection framework,[137] including fostering services in a broader assessment of services for children in care.[138] This regime, criticised as an ineffective method of evaluation,[139] was replaced in 2018 with the Inspection of Local Authority Children's Services (ILACS) framework.[140] Local authorities will continue to be inspected every three years but will also receive up to two "*focused visits*" between inspections that will look at specific issues. The less positive the outcome, the greater the number of follow-up visits and inspections that take place.[141]

B.6: Police approach to allegations of child sexual abuse

National developments

28. As set out in the report by the Crime and Security Research Institute at Cardiff University, commissioned by the Inquiry, the national approach to police investigations into allegations of child sexual abuse has developed over time.[142]

28.1. From 1963, Home Office circulars referred to the need for police forces to work with local authorities in relation to children in need of care, protection and control. By 1988, sexual abuse was included in the definition of child abuse, joint working with social services was expected and the paramount consideration was the welfare of the child.

28.2. By the end of the 1990s, all forces had child protection units, which "*normally*" took primary responsibility for investigating child abuse cases. As a minimum, they were required to investigate all allegations of child abuse within the family or against a carer.[143]

28.3. In the 2000s, both the Laming and Bichard Inquiries[144] criticised HMIC for not taking a sufficiently active role in child protection through its inspections of police forces. The Laming report also recommended that police officers in child protection roles should hold senior rank and have appropriate qualifications.

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[135] NSC001235 para. 8a.32
[136] NSC001235 para. 8a.32; *The new Ofsted framework for the inspection of children's services and for reviews of Local Safeguarding Children Boards: an evaluation*, Ofsted, 2014, p4
[137] *The new Ofsted framework for the inspection of children's services and for reviews of Local Safeguarding Children Boards: an evaluation*, Ofsted, 2014, p4
[138] *Framework and evaluation schedule for the inspections of services for children in need of help and protection, children looked after and care leavers*, Ofsted, 2017, p7
[139] Multi-Agency Inspection of Child Protection: A Position Paper from ADCS, LGA and Solace (2015)
[140] *Inspecting local authority children's services from 2018*, Ofsted, 2017
[141] OFS008346 para. 58; *Inspecting local authority children's services from 2018*, Ofsted, 2017
[142] EWM000464
[143] As asserted in *Working Together* 1999 (NTP001481 para. 3.58).
[144] The Victoria Climbié Inquiry: report of an inquiry by Lord Laming (2003) followed the abuse, neglect and murder of Victoria Climbié. The Bichard Inquiry (2004) concerned child protection measures, record keeping, vetting and information sharing in Humberside Police and Cambridgeshire Constabulary, following the conviction of Ian Huntley for the murders of Jessica Chapman and Holly Wells.

28.4. Since 2010, there has been a significant increase in the volume of allegations of non-recent sexual abuse, and an HMIC thematic review of child protection in eight police forces in 2014–15[145] found that some forces were struggling to manage rising investigative demands with "*systemic weaknesses*" and high workloads.

Nottinghamshire Police

29. Practices in Nottinghamshire Police have also developed over time.

29.1. In the 1970s, allegations of child abuse were investigated by officers in its Criminal Investigation Department (CID), who would make decisions on whether to prosecute and report outcomes to children's social care.[146] Under multi-agency child abuse procedures in the County from 1984, police investigations[147] were to include regular contact with children's social care and attendance at case conferences.

29.2. The force's first specialist resource – the FSU – was established in 1988 to investigate child abuse allegations (although the CID continued to investigate some cases). It expanded over subsequent years to include a referral unit as a dedicated point of contact for all cases referred to the police by children's social care.[148] In 1994, the FSU was renamed the Child Abuse Investigation Unit (CAIU)[149] and, by 1995, according to the SSI, it had the most officers per capita of all police units in the country specialising in child protection investigations.[150]

29.3. There have been various iterations of procedures and guidance for Nottinghamshire Police on the investigation of child sexual abuse, including in 1992,[151] 1997[152] and subsequently.[153] In 2006, the force published its first specific Child Protection Investigation Procedures, which stated that a thorough investigation was required in all cases of alleged sexual abuse. The CAIU was responsible for investigating all allegations of sexual abuse of children in care by a foster carer or residential care staff member, where the complainant was still a child at the time of the allegation being made. Allegations of non-recent child abuse, where the complainant was over 18 years old at the time of the disclosure, were investigated by the CID.[154]

29.4. In 2011, Nottinghamshire Police formed a Public Protection Department, bringing together "*the various strands of police business that feature vulnerability and safeguarding*", including the CAIU, child sexual exploitation and Operation Equinox.[155]

30. However, a number of recent inspections and reviews identify serious failings concerning Nottinghamshire Police's investigations of allegations of child sexual abuse (including child sexual exploitation) and its relationship with the Councils.

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[145] *In harm's way: The role of the police in keeping children safe*, HMIC, July 2015
[146] NCC003691 para. 6.22; NTP001536 para. 22
[147] NSC000075_40-41. These procedures applied only to abuse in the home (including foster care).
[148] NSC000184_15; NTP001536 paras 24, 27
[149] NTP001536 para. 31
[150] NSC001170 para. 1.33
[151] NTP001473_1-118
[152] NTP001474
[153] NTP001536 para. 15; NSC000082
[154] NTP001536 paras 126-127; NTP001495_11-13
[155] NTP001536 para. 35

30.1. A peer review[156] of Nottinghamshire Police's child sexual exploitation capabilities in December 2014 found that "*Social care and police appear to be working well together*". However, it also noted a "*structural divide between City and County working*" which was creating barriers to joint working, and that "*Care Homes and Private providers are apparently engaged with more effectively in the City than the County, largely because of dedicated police post in the City, match-funded by social care … The County approach needs to replicate this standard.*"[157]

30.2. An HMIC report in February 2015 identified a backlog in child protection cases. For example, there were delays in investigating an allegation of sexual assault made by a 10-year-old boy in foster care. Poor investigations were attributed to a "*lack of capacity and the high volume of work*", with "*an increase in the number of historic abuse cases*". Inspectors said that "*much more needs to be done*"[158] and made a number of recommendations, including that the force (together with children's social care and other relevant agencies) carry out a review to ensure that it was discharging its statutory responsibilities.[159]

30.3. A follow-up inspection, published in February 2016, found that Nottinghamshire Police had implemented some recommendations but "*had not undertaken an audit of child abuse and sexual exploitation cases to improve standards*". It also noted that "*non-specialist staff, such as frontline officers, were investigating child protection cases without having received training in how to manage them effectively*".[160] In response, the force implemented an action plan.[161] When asked why some of the recommendations were not acted upon earlier, the Police and Crime Commissioner for Nottinghamshire, Paddy Tipping, told us:

> "*the Nottinghamshire Police didn't fully embrace the findings of the 2014 study. They thought it was unfair and misjudged and didn't pay sufficient attention to providing the reports and actions that were necessary in the three and six months that were asked for by the inspectorate*".[162]

This was ultimately an issue for the Chief Constable, who is responsible for directing and controlling the force,[163] but it is also one of the Police and Crime Commissioner's "*key roles*" to hold the Chief Constable to account.[164]

30.4. In August 2016, as part of national recommendations for forces to review each other's public protection arrangements, Lancashire Police carried out a peer review of Nottinghamshire Police. While it noted "*real strength*" within the staff and some "*positive relationships*" with social care, it also identified "*significant concern regarding the staffing levels of the public protection team*" and "*staff dealing with child protection were under pressure and managing high levels of work, comments such as 'we are waiting for something like baby P to happen' … appeared common place*".[165] This led to the creation of a multi-agency sexual exploitation panel and a cross-authority perpetrator panel,

[156] Peer reviews involve an evaluation by officers and specialists from another police force.
[157] NTP001514
[158] NTP001510
[159] NTP001510_30-31
[160] NTP001512
[161] NTP001538
[162] Tipping 24 October 2018 146/4-12
[163] The Policing Protocol Order 2011
[164] Tipping 24 October 2018 122/8-13; INQ002570 para. 14
[165] NTP001515

both attended by the "*Police, Social Care and the Charitable/Voluntary sector*".[166] The force also restructured its Public Protection Department, dividing it into three thematic portfolios – (a) children – including the CAIU, child sexual exploitation internet abuse and 'Working Together' teams, (b) adults – including rape and domestic abuse, and (c) quality, compliance and strategy – to "*Ensure the implementation of national best practices and recommendations from the various sources of scrutiny*".[167]

30.5. In 2016, the HMIC PEEL report rated Nottinghamshire Police as 'inadequate' in its effectiveness in protecting vulnerable people from harm and supporting victims, a deterioration since the previous report.[168] The 2017 PEEL report rated the force as 'requires improvement' on protecting vulnerable people (although its overall assessment was 'good').[169] The Police and Crime Commissioner told us that he was "*surprised, disappointed and more than a little irritated, in that it had been made very clear through a succession of HMIC reports that there needed to be improvements in this area.*"[170]

31. Chief Superintendent Robert Griffin of Nottinghamshire Police told us that the majority of the issues identified have now been addressed.[171] In particular, a number of the difficulties faced by the force were connected to the "*investment of resource into Public Protection. There is a lot of reference in these documents to child abuse being under-resourced, and we put that right.*"[172] The force, he said, now takes "*a much more holistic approach to vulnerability*".[173] It also tracks all HMIC[174] recommendations, under the leadership of the Deputy Chief Constable. As at September 2018, there were 44 separate ongoing 'actions' in response to recommendations, covering eight areas, including children in care, investigations, child sexual exploitation and delay.[175]

32. As at October 2018, the sexual abuse of children in care continued to be investigated by officers within the Public Protection Department, either by Operation Equinox (for non-recent abuse) or by the CAIU.[176] Nottinghamshire Police has a specific procedural guide on the investigation of sexual abuse[177] and the 'Child Abuse Investigation Procedure PD513',[178] as well as multi-agency procedures.

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166 NTP001541
167 NTP001539_7; NTP001536 para. 222
168 *PEEL: Police effectiveness 2016* (INQ001036). A PEEL report is an annual assessment carried out by HMICFRS of police effectiveness, efficiency and legitimacy.
169 *PEEL: Police effectiveness 2017* (NTP001694).
170 Tipping 24 October 2018 149/5-9
171 Griffin 25 October 2018 211/9-14. This is also reflected by the most recent PEEL report, published after the conclusion of our hearings in October 2018, in which Nottinghamshire Police were assessed as 'Good' for protecting vulnerable people (*PEEL: police effectiveness, efficiency and legitimacy 2018/19*, HMICFRS, 2019).
172 Griffin 25 October 2018 207/13-208/9
173 Griffin 25 October 2018 209/18-210/15
174 Since 2017, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).
175 INQ002570 para. 66
176 INQ002371 paras 8, 13
177 INQ001968
178 NTP001498

B.7: Crown Prosecution Service approach to allegations of child sexual abuse

Background to the Crown Prosecution Service

33. The Crown Prosecution Service is responsible for prosecuting cases investigated by the police in England and Wales.[179] It was established by statute, which set out that its functions included taking over the conduct of criminal proceedings instituted by the police, giving advice to the police, and instituting and having the conduct of criminal proceedings where appropriate.[180] It is independent of government and, as "*an objective referral authority*", is only able to act on the information provided by the police.[181] Its role is to make "*independent and objective decisions about the prospect of a jury convicting of a criminal charge*".[182]

34. Prior to the formation of the Crown Prosecution Service in 1986, the police were responsible for investigating most crime, deciding whether to prosecute and conducting the prosecution.[183] When the Crown Prosecution Service was established, it took on responsibility for deciding whether to prosecute and for conducting the prosecution[184] after the police had decided to charge a suspect.[185]

35. Since 2004, the Crown Prosecution Service has made charging decisions[186] in all but minor cases.[187] It does so in accordance with *The Code for Crown Prosecutors* (the Code),[188] as well as its *Guidelines on Prosecuting Cases of Child Sexual Abuse*.[189] Prosecutors may authorise a charge or continue a prosecution against a suspect only where the 'Full Code Test' is passed,[190] that is:

- there is a realistic prospect of conviction and
- the public interest requires a prosecution.

Since 1986, in cases of sexual offences against children, where there is a realistic prospect of conviction then "*there will seldom be any doubt that prosecution will be in the public interest*".[191]

36. There has been concern about the low number of prosecutions resulting from Operation Daybreak. Sue Matthews (the Crown Prosecution Service reviewing lawyer for Operation Equinox) explained that every case is different and must be considered individually.[192] While it has been accused of 'cherry picking' cases to prosecute,[193] the Crown Prosecution Service "*in a sense do have to cherry pick*" as it is only those cases where the test is satisfied that can be prosecuted.[194]

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179 CPS002848 para. 1
180 Prosecution of Offences Act 1985
181 CPS004657 para. 3
182 CPS004657 para. 1
183 Other than a small number of serious and complex cases, which were referred to the Director of Public Prosecutions (CPS004382 para. 6).
184 Prosecution of Offences Act 1985; *The Review of the Crown Prosecution Service*, June 1998, at para. 3
185 NSC000077_34
186 Different phrases are used to describe the decision about whether an alleged perpetrator should be charged, including "*preferring criminal charges*" (NTP001473_156), "*charging decision*" (CPS004382 para. 127), "*prosecution decision*" (CPS004382 para. 86), and "*authorise a charge*" (CPS004382 para. 76xiv).
187 Following the implementation of the Criminal Justice Act 2003
188 The Code for Crown Prosecutors, CPS, 2018. The first Code was dated 1986, and the current edition is its eighth (CPS002784; CPS002790).
189 CPS002811
190 CPS002788
191 CPS002784
192 Matthews 23 October 2018 35/21-36/5; CPS002790
193 INQ002609 para. 45; Coupland 24 October 2018 177/20-178/25
194 CPS004657 para. 7

Decisions to prosecute

37. The factors that the Crown Prosecution Service takes into account when deciding whether to prosecute are set out in the Code[195] and in prosecution guidance.[196] Witnesses in this investigation referred to a number of considerations in cases of child sexual abuse:

37.1. Failure to disclose earlier: Ordinarily, the Crown Prosecution Service will not refuse to charge solely because a complainant has not disclosed their abuse previously. Allegations of non-recent and institutional abuse are "*common*" and there are "*good reasons*" why such cases do not come to light at the time.[197]

37.2. Complainants' previous convictions: Convictions must be disclosed to the defence and so may be used to allege that the complainant is dishonest or untruthful.[198] It is an "*essential*" part of the prosecution case to explain to the jury the circumstances behind any relevant offending by a complainant, which may be a reaction to abuse or because the complainant is under the influence of the abuser.[199]

37.3. The credibility of children: Until 1994, juries were generally warned by the judge of the risk of convicting a suspect in cases of alleged sexual abuse based on a single complainant's evidence, as the "*credibility and credit of the child will often be of limited value*".[200] However, since at least 2009, the evidence of a child has been regarded as no less reliable than that of an adult.[201]

37.4. Corroboration: Although prosecutors should consider whether there is any credible evidence suggesting a false allegation, "*prosecutors should guard against looking for 'corroboration' of the victim's account or using the lack of 'corroboration' as a reason not to proceed with a case.*"[202]

37.5. Mental health, drug and alcohol issues: The Crown Prosecution Service now recognises, in its guidance, that some complainants may have particular mental health vulnerabilities.[203] Similarly, while drug or alcohol dependency may impact on a complainant's ability to give evidence, the Crown Prosecution Service may still prosecute such a case.[204]

37.6. Previous sexual history: While it is not uncommon for records in historical cases to describe complainants as 'promiscuous', this should not now be a relevant factor in making a charging decision.[205]

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[195] CPS Code 2018
[196] CPS002802; *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018)
[197] CPS002800_12-14
[198] CPS002811 para. 61
[199] *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018) para. 62
[200] CPS002791. This practice, known as a 'corroboration warning', was abolished by the Criminal Justice and Public Order Act 1994, confirmed in R v Makanjuola [1995] 1 WLR 1348.
[201] CPS002802_4
[202] *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018)
[203] *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018) paras 57, 113
[204] Matthews 23 October 2018 46/10-19
[205] As recently as 2000, this was still used as a factor by the Crown Prosecution Service in a decision about whether to prosecute Dean Gathercole, a former residential care worker (CPS004387 para. 48), although since 1999 there has been a general prohibition on the admission of evidence of, and questions about, previous sexual history (CPS Guidance on Rape and Sexual Offences – Chapter 4: Section 41 Youth Justice and Criminal Evidence Act 1999).

37.7. Contemporaneous records: Prosecutors must ensure that complainants who have been in care are not disadvantaged by the fact that they will likely have a great deal of information recorded about them.[206] Records or the absence of records need to be treated with caution.[207] In non-recent abuse cases, records are often incomplete, though this should not be a bar to prosecution.[208]

37.8. Simultaneous civil claim: Complainants may bring a civil claim for the abuse at or around the same time that a criminal prosecution is being considered. Though the defence could question whether there is a financial motive for the disclosure, civil litigation should not impact on a charging decision unless there are substantial conflicts between the accounts given in the civil litigation and to the police.[209]

38. A decision not to prosecute (or to take no further action) does not mean that the abuse did not take place or that the Crown Prosecution Service has concluded that it did not happen. The question is whether or not the prosecutor could conclude that there was a realistic prospect of conviction, bearing in mind that the criminal standard of proof is high.[210] A second opinion may be obtained on decisions to take no further action or discontinue cases involving rape or serious sexual offences.[211]

39. After the Crown Prosecution Service decides (generally speaking) whether to authorise charges following allegations of child sexual abuse, it is the police who are responsible for informing complainants about the decision whether or not to prosecute.[212] A complainant is entitled to a review of that decision.[213]

40. It is possible for a decision to take no further action to be subsequently overturned, for example, if new evidence becomes available or if the original decision was "*obviously wrong*".[214] This decision is made by a Chief Crown Prosecutor for the relevant area or, if made as a result of a challenge under the Victims' Right to Review scheme, by a Deputy Chief Crown Prosecutor.[215] For example, the Crown Prosecution Service decided in 2006 to take no further action in relation to NO-A286's allegations against Stephen Noy but, in 2014, this decision was overturned and charges authorised because there was additional evidence relating to the complainant's mental health and another witness had come forward.[216]

B.8: Operations Daybreak, Xeres and Equinox

41. Since 2010, Nottinghamshire Police has been investigating allegations that former residents of children's homes in the City (Operation Daybreak) and County (Operation Xeres) were sexually and physically abused. These investigations were combined in 2015 into Operation Equinox.

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[206] *Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated November 2018) para. 53
[207] Matthews 23 October 2018 41/18-42/15
[208] Shallow 22 October 2018 110/6-15
[209] Matthews 23 October 2018 22/4-24
[210] Matthews 23 October 2018 12/12-21
[211] CPS002802_26; *Thematic Review of CPS Rape and Serious Sexual Offences Units*, HM Crown Prosecution Services Inspectorate, 2016 – from 2006 this was a mandatory requirement but, since a Crown Prosecution Service internal review in 2016, it is now discretionary.
[212] *Code of Practice for Victims of Crime*, Ministry of Justice, 2015, p22
[213] Either under the police or Crown Prosecution Service's Right to Review Schemes (*Code of Practice for Victims of Crime*, Ministry of Justice, 2015, p23).
[214] Matthews 23 October 2018 19/7-20/6
[215] Reconsidering a Prosecution Decision, CPS Legal Guidance
[216] Matthews 23 October 2018 18/11-21/17; CPS003406; CPS003423; *The Code for Crown Prosecutors*, CPS, 2018

Operation Daybreak

42. Following receipt of two civil claims by the Councils in December 2009 and June 2010, alleging physical abuse at Beechwood,[217] a multi-agency strategy meeting was held in August 2010[218] and Nottinghamshire Police's CAIU subsequently started an investigation. Initially, limited progress was made, although alleged victims and perpetrators were interviewed.

43. In June 2011, as a result of further allegations received,[219] Nottinghamshire Police initiated Operation Daybreak, a dedicated investigation into allegations of non-recent abuse at Beechwood from the 1960s onwards. All allegations of sexual abuse were to be investigated,[220] but allegations of physical abuse were only to be pursued if the suspect still worked with children.[221] The investigation was extended in 2013 to include other City children's homes.[222] In terms of scale, there were approximately 15 allegations of sexual abuse made to Operation Daybreak in 2011, 20 in 2012, 20 in 2013 and 40 in 2014.[223]

44. However, evidence from witnesses involved in Operation Daybreak, and from reviews carried out at the time, suggest that its progress was hampered by three main issues:

44.1. The lack of a dedicated Senior Investigating Officer (SIO): Detective Inspector (DI) Yvonne Dales, the initial SIO of Operation Daybreak, retained responsibility for the CAIU at the same time.[224] The lack of a full-time SIO to supervise and control the investigation on a day-to-day basis had a negative impact[225] and it was not until January 2015 that a full-time dedicated SIO (DI Pete Quinn) was appointed.[226]

44.2. Staffing: Staffing levels were "*at a minimum*" from the outset.[227] Concerns about the impact of insufficient resources were raised as early as September 2011[228] and subsequently by team members and in independent reviews.[229] An October 2014 peer review identified "*current resources*" as "*insufficient to manage the demand*".[230] The Police and Crime Commissioner was aware that Operation Daybreak was under-resourced but was assured at the time by the Chief Constable that it was manageable.[231] However, Nottinghamshire Police now accepts that resourcing for the scale of the investigation was "*wholly inadequate*" and affected the "*pace of the investigation*".[232]

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[217] Two earlier and similar claims had been made, in 2002 and 2007 (NCC000308_3).
[218] NCC003691_77-78 para. 7.33; NCC000301; NCC000302
[219] NCC000304
[220] NTP001653
[221] NTP001519_36
[222] Dales 22 October 2018 25/10-26/10; NTP001641
[223] NTP001487_2
[224] Dales 22 October 2018 59/2-19
[225] NTP001519_44-45
[226] Dales 22 October 2018 16/21-17/3
[227] NTP001650; NTP001645; NTP001653; Dales 22 October 2018 6/18-10/11
[228] NTP001653
[229] November 2012: NTP001650, December 2012: NTP001641, March 2013: NTP001645, April 2013: NTP001645, August 2013 (independent review): NTP001517, July 2014: NTP001649, October 2014 (independent review): NTP001518, May 2015 (independent review): NTP001519
[230] NTP001518
[231] Tipping 24 October 2018 123/7-125/16
[232] Griffin 25 October 2018 189/6-190/4

44.3. Attempt to scale down the investigation: Despite requests for more resources and the increasing numbers of allegations, senior officers requested in 2014 that the investigation be scaled down or even closed down.[233] An external review in October 2015 recommended that the investigation should continue.[234]

Senior officers in Nottinghamshire Police should have ensured that the investigation was prioritised and adequately resourced.

45. There was "*really, really helpful*"[235] early engagement between the police and the Crown Prosecution Service, with the reviewing lawyer also involved in providing early investigative advice such as whether to reinterview a complainant or which lines of enquiry needed to be followed.[236] There was no overall policy about how cases were to be approached; each case was judged on its own merits.[237] On completion of an individual investigation, the Operation Daybreak SIO assessed "*whether the evidence available provided a reasonable suspicion that the offence had been committed*".[238] If not, no further action was taken and the complainant was informed. If the test was passed, a comprehensive advice file was sent to the Crown Prosecution Service, which decided whether to charge based on the 'Full Code Test'.[239]

46. A number of files were passed to the Crown Prosecution Service for a decision on whether to authorise charges. However, there were no prosecutions for sexual abuse during the lifespan of Operation Daybreak.[240]

46.1. In September 2012, the Crown Prosecution Service concluded that there were too many problems with each allegation against three suspects (NO-F2, NO-F1 and NO-F10), including concerns about collusion between complainants.[241]

46.2. A single allegation against John Dent[242] did not proceed to charge in February 2013, due to inconsistencies with the dates of the alleged offence and issues of identification.

46.3. In June 2013, the Crown Prosecution Service determined there was no reasonable prospect of conviction in relation to NO-A86's allegations of serious sexual abuse by staff members, and that her allegations of rapes and murders of residents by NO-F11 were "*not true*".[243]

46.4. In June 2014, a decision was taken not to prosecute NO-F1 for sexual abuse at Beechwood and Ranskill Gardens.[244]

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[233] NTP001649_1; Dales 22 October 2018 47/13-48/9; INQ001986 para. 22; INQ002431
[234] INQ001780 paras 6.1-6.7; NTP001518
[235] Dales 22 October 2018 18/13-23
[236] CPS004386 paras 20-21
[237] Matthews 23 October 2018 35/21-36/5
[238] INQ001780 paras 3.11-3.13
[239] NTP001519_5. The full code test is outlined at paragraph 35 above.
[240] Although subsequent convictions, such as that of Andris Logins, were achieved as a result of investigative work done during Operation Daybreak.
[241] CPS002612
[242] CPS003332_24-30 – John Dent, who worked at Beechwood in the 1970s, was convicted of sexual offences against four complainants and sentenced to seven years' imprisonment (NTP001519_27; INQ001683).
[243] CPS003415
[244] CPS003386

A review by East Midlands Police in May 2015 found all of the Crown Prosecution Service decisions not to prosecute to be "*understandable*"[245] and supported most of the SIO's decisions not to proceed with cases.[246]

Operation Xeres

47. In 2014, Nottinghamshire Police received more than 10 allegations of non-recent abuse in relation to children's homes in the County.[247] In early 2015[248] the force launched Operation Xeres to investigate allegations of non-recent abuse at nine children's homes previously managed by the County.[249] However, by June 2015, Operation Xeres had also stalled due to "*staffing issues*".[250]

Operation Equinox

48. In August 2015, Operations Daybreak and Xeres were merged to form Operation Equinox,[251] in order to ensure a more consistent approach to investigating allegations and to amalgamate resources. In total, as at March 2018, 832 allegations of sexual or physical abuse had been made to Operation Equinox by 355 different complainants against 559 suspects, 63 of whom had died.[252]

49. In some cases, the police decided that no further action should be taken as the threshold for passing the case to the Crown Prosecution Service was not met.[253] In others, the Crown Prosecution Service concluded there was no realistic prospect of conviction.[254] There have been several successful prosecutions arising out of Operation Equinox.

49.1. Andris Logins was convicted in March 2016 of four counts of rape, 12 counts of indecent assault, and one count of child cruelty, related to his time as a residential care worker at Beechwood in the 1980s. He was sentenced to 20 years' imprisonment.[255] As he was a registered social worker at the time of his conviction, he was removed from the social work register.[256]

49.2. Barrie Pick, a former member of staff at Beechwood, was convicted in December 2017 of the sexual abuse of a male resident between 1976 and 1977, and was sentenced to six years' imprisonment.[257]

49.3. Dean Gathercole was found guilty in May 2018 of six counts of indecent assault and three counts of rape at Amberdale in the 1980s. He was sentenced to 19 years' imprisonment.[258]

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[245] NTP001519_13, 18, 25, 29
[246] NTP001519_30, 31, 32, 33, 45
[247] NTP001487_2
[248] NTP001542; NTP001536 para. 40
[249] INQ001876 para. 14; NTP001536 para. 40
[250] NCC000084
[251] NTP001536 para. 40; NTP001689; INQ001876 para. 15
[252] INQ001667
[253] INQ001780 paras 2.28, 3.11-3.14
[254] For example CPS003377; CPS004386; CPS003375
[255] INQ001671; INQ001682
[256] INQ001154
[257] INQ001688; CPS003381; CPS004386
[258] INQ003771

49.4. Myriam Bamkin was sentenced to 30 months' imprisonment in June 2018 after pleading guilty to having sex with a 15-year-old male resident at Amberdale in 1985. In his sentencing remarks the judge noted that, although a member of staff reported the concerns at the time, "*The head of the unit appeared to have told that member of staff to keep it to himself and it was swept under the carpet.*"[259]

49.5. Christopher Metcalfe, a former member of staff at Skegby Hall and a foster carer, was convicted in September 2018 and sentenced to two years and nine months' imprisonment for indecently assaulting two girls.[260]

49.6. David Gallop, a former social worker for the County, was sentenced in October 2018 to 21 months' imprisonment for sexually abusing a child in the 1970s when the child was placed at Hazelwood.[261]

49.7. Michael Robinson was convicted in January 2019 of sexually abusing boys at Hazelwood in the 1980s and was sentenced to eight years' imprisonment.[262]

50. In May 2018, the police carried out an analysis to try to identify whether any collusion took place between suspects or offenders whilst working at Beechwood and whether any collusion could be considered to be a "*Paedophile Ring*".[263] Six alleged or convicted offenders – John Dent, NO-F29, NO-F1, NO-F11, NO-F49 and NO-F2 – were reviewed.

> "*The combined results support the hypotheses that a small and limited level of collusion may have taken place between suspects but the evidence is not robust enough to support the existence of a Paedophile Ring.*"

As Chief Superintendent Griffin explained, some of the six suspects were working together at the same time and therefore had had the opportunity to act together. However, it was not possible to conclude that they had in fact done so.[264]

51. Operation Equinox remains ongoing.[265] Chief Superintendent Griffin told us that Nottinghamshire Police has established a dedicated non-recent child abuse investigative team which will continue beyond the lifespan of Operation Equinox.[266] It is unclear whether this will continue indefinitely or how it is to be structured.

[259] INQ003778
[260] https://www.nottinghampost.com/news/local-news/former-teacher-71-jailed-historical-2087382
[261] https://www.itv.com/news/central/2018-10-11/former-social-worker-jailed-for-sexual-abuse-40-years-ago/
[262] https://www.nottinghampost.com/news/nottingham-news/former-childrens-home-boss-locked-2471885
[263] NTP001654
[264] Griffin 25 October 2018 195/1-196/5
[265] For example, in February 2019, Nigel Pipe was charged with 27 counts relating to sexual abuse of children at Skegby Hall between 1965 and 1969, whilst he was Housemaster (*Nottingham Post* 1 February 2019).
[266] Griffin 25 October 2018 197/8-198/13

Part C

Case study: Beechwood

Case study: Beechwood

C.1: Introduction

1. The investigation's first case study concerns Beechwood Children's Home, which was comprised of four units: The Lindens, Redcot, Enderleigh and a central administration and teaching block. The case study examines institutional responses to child sexual abuse and barriers to disclosure of allegations. It also considers the changing function of the home, the environment for the children resident there, and changing internal management arrangements.

2. A large number of allegations of sexual abuse have been made against members of staff at several children's homes across the County and City over a number of years.[267] Beechwood was selected as a case study, amongst other reasons, because it had been the subject of an extensive police investigation and was also the subject of the largest number of allegations of sexual abuse by complainant core participants made to the Inquiry.

Beechwood Children's Home, mid-1980s

[267] INQ002577; INQ002574

C.2: Allegations of abuse at Beechwood

3. Five witnesses gave their accounts of being sexually abused at Beechwood at our October 2018 hearings and around 35 other complainant core participants provided statements,[268] a summary of which were read into the record. Additionally, 100 further accounts of sexual abuse were collated from police interviews, civil litigation claims and other records.[269] Nottinghamshire Police recorded 166 allegations of sexual abuse at Beechwood between 1968 and 2005, the vast majority relating to abuse in the 1970s and 1980s.[270]

4. The range of abuse alleged at Beechwood includes the following:

4.1. A79 was in Beechwood twice in the 1960s and early 1970s. During each placement, he says he was raped by a member of staff.[271]

4.2. P18 was placed for a "*few nights*" with her siblings in The Lindens between 1968 and 1970, when she was between five and 10 years old. She remembers being taken out of her bed at night by a male member of staff. She says she would be taken to another room where he would touch her all over her body and make her touch his groin. This happened several times.[272]

4.3. D10 was in Beechwood between 1971 and 1972. He alleges that he was taken from a dormitory in the middle of the night and brought to an office by a male member of staff where he was forced to the floor and raped.[273]

4.4. D7 was placed in Enderleigh for three weeks in 1977, aged 15. She says John Dent sexually assaulted her; in one incident he attempted to rape her, and in another she was digitally penetrated. Dent let D7 know that he had control over where she would go after Enderleigh, and she "*felt very alone*".[274]

4.5. C21 was placed in The Lindens for nine months in 1977, when he was aged 14. He alleges that he was raped by NO-F29 in a laundry room and indecently assaulted by him in the showers. It made him feel "*Sick, dirty and, ashamed. And fearful it might happen again.*"[275] NO-A320,[276] D22[277] and L50[278] also allege that NO-F29 indecently assaulted them. D35[279] alleges that NO-F29 was one of two members of staff who raped him. All were at Beechwood in the late 1970s and early 1980s.

4.6. L17 was placed in Redcot for almost a year in 1979, aged 11. She says she was raped by a member of staff, Colin Wallace, on "*four or five occasions*". She also alleges she was made to masturbate Wallace when other staff were in the room so she thought

[268] INQ002574
[269] INQ002577
[270] NTP001657: it is not clear whether this refers to the total number of allegations, or the total number of complainants making allegations.
[271] INQ002574
[272] P18 3 October 2018 140/17-144/18
[273] INQ002574
[274] D7 2 October 2018 67/15-103/19
[275] C21 2 October 2018 154/20-179/8
[276] INQ002577
[277] INQ002574
[278] INQ002574
[279] INQ002574

they must have known what was going on. She described the impact after she left care, saying that people in the community "*know you are damaged. So they find that it's easier to groom you, and as soon as I came out of the children's home that's what I encountered.*"[280]

4.7. N1 was placed in Beechwood in 1982 when aged 12. She was groomed and raped by Andris Logins, a member of staff.[281]

4.8. L23 alleges that in 1984, when she was placed at Beechwood aged 16, she was raped in her bedroom "*on around three occasions*" and sexually assaulted in the communal toilets by Andris Logins: "*He would pull me around, pin me down and suck my neck to give me love bites.*"[282]

4.9. L27 was in Beechwood in 1994 to 1995. He alleges that he was forced to perform oral sex on multiple occasions as well as being indecently assaulted by NO-F363 and another staff member.[283]

4.10. L29 was placed in Beechwood for four months in 2005, when he was 15 years old. NO-F61, a male member of staff, allegedly forced him more than once to perform oral sex on him. Once, when L29 resisted, NO-F61 punched him in the face.[284]

4.11. In 2005, L51 alleged that NO-F7 behaved towards her in a "*sexual manner*" by rubbing himself against her on a number of occasions at Beechwood in 1985.[285]

5. Many complainants told us that, by giving their accounts of abuse, they wanted to ensure that the same did not happen to young people now in residential care.[286]

C.3: Residential care

Introduction

6. For the purposes of this report, we use 'children's homes' or 'residential care' to refer to all residential children's homes, including observation and assessment centres.[287]

7. In England, around 40 percent of children in care in the mid-1970s were placed in residential care.[288] Numbers have continued to decline over the last 40 years, with 11 percent of all children in care in England in residential care by 2018.[289] The capacity of a children's home also reduced over time, from more than 10 in 1985 to fewer than seven by 1995. By 2016 the average was four.[290] The age of those placed in residential care has progressively increased, so that by 2012 most children were over the age of 12.[291] From

[280] L17 2 October 2018 105/22-153/20
[281] N1 3 October 2018 22/3-34/4
[282] L23 3 October 2018 148/20-152/25
[283] INQ002574
[284] INQ002574
[285] INQ002574
[286] For example, L48 (L48 4 October 2018 48/7-14) and D7 (D7 2 October 2018 102/5-6).
[287] Children's homes are more generally a subset of residential care, which has also included Approved Schools (which became Community Homes with Education), Observation & Assessment Centres (O&A Centres), Secure Units, speciality homes and others.
[288] *Residential Care in England*, Sir Martin Narey, 2016, p6
[289] Children looked after in England, year ending 31 March 2018, p7. This includes children placed in secure units, children's homes and semi-independent living arrangements.
[290] *Residential Care in England*, Sir Martin Narey, 2016, p8
[291] See *Living in Children's residential homes*, Berridge & others, 2012, p4

the 1980s, children in residential care tended to be older (over 10 years old). The policy was to place younger children in foster care.[292] These national trends are reflected in Nottinghamshire.[293]

8. In his report for the Inquiry,[294] Professor David Berridge identified a number of related themes in the development of residential care in England, including:

- the stigma of being in care and the perception that children are in residential care somehow due to their own fault;
- residential care within children's services "*receiving less attention than it requires and its deficiencies remaining unaddressed for too long*";
- the professional and social isolation of residential care workers, with a lack of professional development resulting in "*outdated, insensitive or harmful practices*";
- "*very often, local government oversight of residential homes has been inadequate*" and external oversight only gradually introduced; and
- the concentration of particularly vulnerable groups of older children and adolescents previously neglected and physically or sexually abused for "*predatory men*".[295]

These themes are apparent throughout the Councils' residential care provision, including at Beechwood.

Developments in residential care in the County and the City

9. Residential care provision by the Councils suffered from persistent problems over the years, including low staffing ratios, lack of qualifications and training, poor standards of accommodation, inadequate resources and insufficient external supervision.[296]

10. A 1975 report from the County's children's social care service found that children's homes offered low levels of supervision and support to mostly "*untrained*" staff, who were in turn isolated. There were more children in residential care than there were beds. High numbers in care were said to be due to a "*low level of preventative work*". Social workers did not have sufficient contact with children in children's homes because they believed that children were "*safe*" once they were in care. Recommendations included training for residential care staff, and increased funding for both residential care and for preventative work.[297]

11. There were more than 200 unused places in County children's homes by 1983. To reflect this fall in placements, an overall reduction in the number of residential places was proposed, including closing some homes and replacing them with specialist homes. The aim was to improve the quality of residential care by having fewer children in each home,[298] providing a more effective service for those placed.[299]

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[292] INQ004256 *Children in the Public Care*, Sir William Utting, HMSO 1991, pp28–29.
[293] See for example the County's 1984 re-evaluation of its residential care provision in the face of falling numbers (NSC000240).
[294] EWM000463: 'Children's Residential Care in England', December 2017.
[295] EWM000463_46-50
[296] See, for example, NSC000104
[297] NSC000526_7, 17, 20-21
[298] NSC000240
[299] NSC000438_1-4

12. By 1990, the County was "*in the middle of a crisis in residential care*". There was high staff turnover, an increasing use of temporary staff due to recruitment difficulties, low levels of qualified staff and low staff morale. The contraction of the residential sector had led to the grouping together of children with serious problems.[300] David White (the County's Director of Social Services from 1989 to 1994) considered that by this point residential care had been operating at an unacceptable level for some time. The County was putting its "*most vulnerable youngsters in the hands of those perhaps least qualified and able to care for them*".[301] Denis Watkins (the County's Assistant Director of Social Services in the late 1980s and early 1990s) said that in the late 1980s the County aimed to have 10 percent of residential staff trained, demonstrating its "*dire starting point*".[302]

13. Around this time there was an increasing understanding and awareness across England and Wales of the risks of sexual abuse committed by residential care staff. This was first acknowledged in national guidance *Working Together* in 1988,[303] followed by more detailed guidance in 1991 to accompany the Children Act 1989[304] and in a national review of residential care in 1991 by Sir William Utting.[305]

14. With anxiety growing among councillors, senior officers and residential care staff that existing provision of residential care was "*failing to measure up to the demands being placed upon them*", the County established a Residential Child Care Working Party[306] to review the County's residential care.[307] It produced a report in May 1992, *'As if they were our own': Raising the Quality of Residential Child Care in Nottinghamshire*,[308] which concluded that the County's residential care was of an "*unacceptable standard*" and that some young people faced "*the prospect of violence and sexual abuse within our care*".[309] If the risk of children being sexually abused by residential care staff had not been apparent to the County's children's social care service from earlier disciplinary cases, it should have been as a result of this report.[310]

15. The report made 79 recommendations.[311] A team was formed in January 1993 to implement the recommendations.[312] By March 1993 police checks before recruiting staff and procedures for complaints and reporting abuse were in place.[313] However, in January 1994, financial constraints were thought "*likely to impact on the developments in residential care*" being introduced. Despite this, plans were put in place to restructure community homes, including reducing the number of residential placements, increasing staffing ratios, and increasing investment in substitute family care.[314] A number of homes were closed by December 1994 and resources reinvested into "*residential and alternative care*".[315]

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[300] INQ001811 para. 37; NSC000438_13-27
[301] White 8 October 2018 153/18-154/7
[302] INQ002731 para. 2.2. Similar issues were identified on a national level in the 1992 Warner report, including the concentration of more challenging children in residential care and the "*largely unqualified and often untrained workforce*" (EWM000463_43).
[303] NSC000938
[304] EWM000463_35-39
[305] EWM000463_40
[306] Chaired by the County's Chief Executive and including senior officers, an Officer in Charge of a community home, a Children's Rights Officer from Leicestershire, and others (NSC000104_3, 7).
[307] NSC000438_28-33; NSC000104
[308] NSC000104; NSC001235_64-69 para. 5g
[309] NSC000104_7-9
[310] NSC000104_79
[311] NSC000104_123-127
[312] NSC001318; NSC001235 para. 3c.i.22, 5g.11-5g.19
[313] NSC000943
[314] NSC001235 paras 5g.14, 5g.16
[315] NSC001235_68-69 paras 5g.16-5g.18; NSC000943

16. From 1998, when responsibility for residential care was divided between the Councils, the City introduced its own designated training programme for those working with children, including child protection training.[316] Between 1999 and 2001, a new training programme for staff in County children's homes was introduced, including for working with children who had been sexually abused.[317]

17. Both the County and the City made efforts in the early 2000s to "*create a culture*" that encouraged children in residential care to raise concerns,[318] including a complaints process, an advocacy service, social worker visits, councillor rota visits,[319] as well as the appointment of independent visitors.[320] However, take-up of the complaints process was low, as noted by the Social Services Inspectorate (SSI):

> *"A number of young people we met said that they did not bother to complain, 'as it didn't get you anywhere' and 'nothing happened'. There was no evidence to confirm this was an accurate reflection of the situation but it is clearly a perception that the council will need to address."*[321]

18. The City introduced a multi-agency placement panel by 2011 to consider the needs of children before placement and to keep placements under review.[322] Residential care had also been reconfigured to 'small group' homes in the City,[323] leading to better outcomes for children in residential care.[324] A serious case review in 2011 (following the suicide of a 15-year-old in the care of the City, discussed in Part E) recommended a programme to address deficiencies in the "*identification, assessment and management of cases where there is emotional abuse, sexual abuse*". The "*key priority for change*" was to strengthen processes for children in care, including identification and management of safeguarding concerns, and profiling of high-risk children to ensure appropriate levels of support.[325] In November 2011, the City introduced a Children in Care Profiling Tool to identify the most vulnerable children in care.[326]

19. By 2015, the County had implemented quality standards for children's homes with improved levels of staff training, including mandatory training on child sexual exploitation.[327]

C.4: Background to Beechwood

20. The history of Beechwood demonstrates the extent to which the issues impacting on residential care more generally created an environment where vulnerable children could be and were abused, and faced difficulties in disclosing that abuse.

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316 NCC003691 para. 6.10
317 NSC000929. The training courses available to staff in the County between 1981 and 2018 are set out at NSC001241; NSC001282; NSC001274
318 NSC000913; NCC000599
319 See Part B.4.
320 NCC000019; NSCP and NCSCP Interagency Safeguarding Children Procedures
321 NSC001167_50
322 NCC003788_127-128
323 NCC003788_127-128
324 NCC003691 para. 3.120
325 NCC003788_136-138
326 NCC000399_2
327 NSC001238_6

21. Allegations of abuse at Beechwood generally began to emerge in 2010 and were the catalyst for the police initiating Operation Daybreak in 2011. In 2012, 50 former residents of Beechwood brought civil claims in respect of their allegations of non-recent abuse at Beechwood.[328]

22. Despite a large number of allegations of sexual abuse by former residents, including from those who say they reported their allegations at the time, over the 39 years Beechwood was open there are only two recorded instances of an institutional response to allegations of sexual abuse made against staff. Colin Wallace was dismissed and convicted of unlawful sexual intercourse in 1980.[329] NO-F47 resigned whilst under disciplinary investigation in 1998.[330] As a result of allegations made to the police more recently there have been three convictions of former Beechwood staff members: John Dent in 2001,[331] Andris Logins in 2016[332] and Barrie Pick in 2017.[333]

23. Records and witnesses refer to 'the Beechwood complex', 'Beechwood', and to the various individual units (Redcot, The Lindens and Enderleigh). From 1996 the official name of the home was changed to '379 (or 387) Woodborough Road'.[334] For consistency, we have referred to 'Beechwood' throughout this report.

C.5: Beechwood: 1967–1980

Composition and function

24. Beechwood opened on 1 November 1967[335] as a one-unit "*remand home for 20 boys*".[336] By 1976 it consisted of four units: The Lindens, Redcot (originally a separate children's home), Enderleigh (opened in 1967 as a remand home for 18 girls), and a central administration and teaching block.[337] Enderleigh closed in 1978,[338] leaving Beechwood with Redcot and The Lindens. In 1979, Redcot became a mixed unit,[339] whilst The Lindens continued to be for boys only.

25. Beechwood was not intended to be a children's home for long-stay or short-stay placements. It was initially a remand home,[340] then by 1974[341] an observation and assessment centre (O&A centre)[342] for children who had committed an offence and been remanded to the care of the local authority.[343] In practice, emergency family placements would also be sent to Beechwood.

[328] NCC003691 paras 7.51-7.58
[329] NSC001234; NSC001229
[330] NCC000130
[331] INQ001670
[332] INQ001154_1
[333] INQ001688
[334] NSC000096_2
[335] DFE000724
[336] DFE000723_4
[337] NSC000450_3
[338] Following a report, discussed below, entitled 'The Future of Enderleigh' (NSC0001378).
[339] NSC000463_7-8; NSC001474 para. 2c.3
[340] Governed by the Remand Home Rules 1939 and Remand Homes Rules 1970
[341] The Cessation of Approved Institutions (Remand Homes) Order 1973
[342] Governed by the Community Homes Regulations 1972
[343] Children and Young Persons Act 1969 section 23; NSC000457_3-4

Map showing location of Beechwood units

25.1. As an O&A centre, its purpose was "*to provide information as to the personality, social functioning, health, educational attainment of the child*" to decide where they should be placed.[344] At Beechwood, boys would be placed in The Lindens after being remanded from court. Following educational and psychiatric assessments and a case conference, a report would be provided to the court (ideally within six weeks), which would then decide whether to make a care order, with or without a placement decision. Boys would then be moved to Redcot, awaiting a long-term placement in a children's home or in foster care. Where no placement decision had yet been made, ongoing reviews would

[344] NSC000526_12

take place to determine the appropriate placement. If placements failed, often the child would be returned to Beechwood,[345] the effects of which, "*cannot fail to be damaging*",[346] as the County recognised in 1975.

25.2. In practice, Beechwood accommodated children on remand even after it ceased to be a remand home. It also had children placed on an emergency basis or awaiting long-term placement. This mixed cohort of children, with different challenges and needs and with ages ranging from 10 to 17 years old, produced "*further tensions resulting in difficult and sometimes very aggressive behaviour*".[347]

25.3. Mark Cope (a residential care worker at Beechwood at the time) recalled the change from remand home to O&A centre "*was really difficult … people couldn't forget the former role*"[348] and described Beechwood as a "*holding unit*" for children.[349] As a result, there was a lack of opportunity to form any nurturing relationships with children.[350] Staff at The Lindens complained to a senior manager in 1978: "*How can you properly assess a child for court or placement procedure against a background which is a threat to many types of children?*"[351]

The nature of O&A centres, such as Beechwood, created a difficult environment for vulnerable children, who had different challenges and needs. Beechwood was more like a custodial institution, rather than a children's home. It was a wholly unsuitable environment for children and young people, where sexual abuse thrived within a culture of physical violence and intimidation.

Management and governance

26. Beechwood was run by Nottingham Borough Council (the predecessor to the City) from 1967 until April 1974, when the County took over full responsibility for all children's homes under local government reorganisation. As superintendent, Jim Saul oversaw the running of Beechwood until 1981.[352] He had a deputy superintendent, a post held by Ken Rigby from 1975 to 1993. Enderleigh, Redcot and The Lindens each had a housewarden who managed the unit on a day-to-day basis.[353]

27. A Homes Advisor (later a 'Residential and Day Care Services Officer') from children's social care acted as a link between homes such as Beechwood and the local authority. Ken Rigby remembered that, throughout his time, "*I don't think we got a lot of support from … social services … We were very much left on our own*".[354]

[345] NSC001474 para. 2b.2; NSC000450_003
[346] NSC000526_15
[347] NSC000443_5
[348] Cope 17 October 2018 112/15-113/5
[349] INQ002618 para. 27
[350] Jones 8 October 2018 70/10-71/4
[351] NSC000457_3-4
[352] INQ002422 para. 7
[353] NSC000443. In the 1980s, the role became known as Officer in Charge (OIC).
[354] Rigby 9 October 2018 56/11-21

Issues

Placements

28. In 1977, the Director of Social Services noted that "*Over-accommodation is a frequent issue*" with children staying "*far longer than was appropriate or desirable*".[355]

29. Staff at The Lindens complained that their unit was being used as a placement for those rejected by other children's homes. Boys were placed:

> "*without considering the effect of such placement … for example we have a sexual offender and suspect psychopath of 16 in the same unit as a weak inadequate 11 year old boy placed by his mother … the contradictory nature of this situation is a negation of child care … What is intended for the placement of the authority's difficult children?*"[356]

30. Placement of vulnerable children alongside children who had exhibited harmful sexual behaviour without proper safeguards in place was a recurring issue at Beechwood throughout its existence.[357] Ken Rigby recalled that staff thought Beechwood was used as a "*dumping ground*", taking "*anybody that was disruptive in any sort of community home in Nottinghamshire. We had no say on who should come, and, therefore, we had to take all comers, and that could be extremely disruptive*".[358] Jim McLaughlin, a trainee residential care worker at Beechwood from 1979 to 1980, remembered separate areas had to be organised to avoid physical confrontation.[359] Mark Cope recalled that victims of sexual abuse and children exhibiting harmful sexual behaviour would be placed together, "*it was horrendous*".[360]

Staff

31. Staff at Beechwood were largely unqualified and untrained in caring for vulnerable children. Until 1979, Ken Rigby was one of only two professionally qualified residential staff.[361] Even by the mid-1990s, there was still no mandatory training programme for residential care staff.[362]

Culture

32. Many accounts of those who worked or visited Beechwood during this period were critical of its culture and environment. One member of staff thought that girls were never listened to or believed.[363] Another described The Lindens as "*strict and aggressive … the place was difficult to work at*", whereas Redcot was "*softer*" and more like a children's home.[364] Margaret Stimpson, a senior social worker at the time, found Beechwood to be "*rigid, regimented, punitive and uncaring*".[365] Rod Jones recalled Enderleigh as an "*awful place*"[366] and on one unannounced visit he found all the girls locked-in upstairs.[367]

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[355] NSC0001378
[356] NSC000457_3-4
[357] It was subsequently raised as an issue preventing admission of a child in November 1989 (NSC000444_5-6), and again arose in the 2000s.
[358] Rigby 9 October 2018 6/20-7/12
[359] McLaughlin 9 October 2018 101/7-15
[360] Cope 17 October 2018 120/18-121/10
[361] Rigby 9 October 2018 11/7-21
[362] INQ001895 para. 36b
[363] NTP001684
[364] NTP001660
[365] INQ002049 para. 17
[366] INQ002007 para. 2.16
[367] Jones 8 October 2018 72/21-73/14

33. From a resident's perspective, L17 described open violence towards residents by staff[368] and found some of the other residents to be "*highly sexual*", recalling that there was "*a lot of bullying*".[369] C21's first impression of The Lindens aged 14 in 1977 was "*fear*".[370] Others give accounts of being beaten and not having anyone to whom they could report.[371]

34. Ken Rigby did recognise, reluctantly, that "*a major part of the problem*" was staff attitudes towards the children placed in the home.[372] As Mark Cope told us: "*the way that Beechwood was managed, you were almost made to feel that they were objects … we never actually saw an individual child, it was what they'd done wrong*".[373]

Reports of and responses to allegations of sexual abuse

35. Officers working on Operation Daybreak concluded that Beechwood was "*riddled with abuse*" from the late 1960s to the late 1980s,[374] with serious sexual abuse being most prevalent in the 1970s.[375] Nottinghamshire Police recorded around 95 allegations of sexual abuse occurring at Beechwood between 1967 and 1980.[376] The abuse included rape, buggery, sexual assault, and being inappropriately touched or watched in the showers.

John Dent

36. John Dent worked at The Lindens from December 1973 to March 1975 and then as deputy housewarden at Enderleigh from March 1975 to June 1977, where he was the only male member of staff.[377] Following allegations that he had taken children to his room and caned them, Dent was investigated and he resigned in August 1978.[378]

37. In 1997, D7 reported to the police that she had been sexually abused by Dent.[379] During the police investigation that followed, 'Operation Harpoon', several other complainants alleged abuse by Dent at Enderleigh and Hillcrest. In January 2001, John Dent stood trial on 26 counts involving eight complainants, six of whom alleged abuse at Enderleigh, including D7. He was acquitted on some counts and the jury was unable to return a verdict on others. After a retrial, Dent was convicted in January 2002 of sexual abuse, including indecent assault and attempted buggery, of four complainants, mostly relating to his time at Enderleigh.[380]

38. Ken Rigby recalled finding Dent in the TV room at Enderleigh "*sitting on a settee with a girl either side of him, and he had his arms across their shoulders … he wasn't embarrassed, he made no attempt to sort of jump up … he was the only male in the room*". The girls were 14 or 15 years old. Ken Rigby's response was to warn Dent that he was "*giving mixed messages to the girls … He was very popular with the group. They liked him*".[381] He said:

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368 L17 2 October 2018 120/11-122/1
369 L17 2 October 2018 112/20-113/9
370 C21 2 October 2018 158/25-159/2
371 INQ002574: For example D36, D28, D5, L28, D35, D22.
372 Rigby 9 October 2018 53/4-54/12
373 Cope 17 October 2018 118/19-119/9
374 NTP001516_3-8
375 Dales 22 October 2018 39/11-22; INQ001780 paras 4.8-4.14
376 NTP001657
377 NTP000821. He went on to be OIC at Hillcrest (another children's home in Nottinghamshire) from June 1977 to August 1978.
378 INQ002007 paras 34.12-34.13
379 D7 2 October 2018 83/5-14
380 NTP001654
381 Rigby 9 October 2018 26/22-29/23

> *"Some of the girls in Redcot were very promiscuous, and to see how they operated around boys in the unit. Male members of staff had to be very careful and give the girls plenty of leeway, as I could put it."*[382]

The focus was on the risk to staff, rather than considering the welfare of the child and the risk of abuse to which they were exposed. As a senior member of staff, Ken Rigby would have been responsible, to a large extent, for the tone set for others at Beechwood.

Colin Wallace

39. Colin Wallace started working at Beechwood in 1978 as a residential care worker.[383] Some members of staff had concerns about his contact with girls at the home.[384] Mark Cope remembers seeing a resident, NO-A533, leaving a note for Wallace asking him to meet up with her. Mark Cope said he took the note to Ken Rigby, who instructed him to put it back and to keep an eye on Wallace. He again raised concerns when he saw a second note.[385] Ken Rigby denied that he was told about a note.[386]

40. NO-A533 was moved by children's social care to another home in December 1980 close to where Wallace lived. When she absconded from her new placement a few days later, she was found at Wallace's home.[387] Wallace admitted having sexual intercourse with NO-A533 and was dismissed in December 1980.[388] His dismissal was reported to councillors.[389] Wallace was charged with four counts of unlawful sexual intercourse and convicted in 1981.[390]

41. Ken Rigby said there was discussion amongst staff about how Wallace had been able to carry out his assaults but also *"as to the girl … in terms of her advancing towards Mr Wallace"*.[391] One staff member had said that NO-A533 *"sought attention from any male member of staff who was on duty at that time"*.[392] When asked what internal steps were taken to reduce risks following the conviction, Ken Rigby said:

> *"it was just reiterated once more that* [male staff] *had to be extremely careful – around young female*[s]*, how they presented themselves to young female*[s]*, and this was the main thing."*[393]

42. While there were no specific procedures directed at how to respond to allegations of sexual abuse against staff at the time,[394] the 1978 Policy and Procedure Guide required all suspicions or complaints regarding abuse of residents to be reported to children's social care.[395] We have seen no evidence of Mark Cope's concerns being reported to anyone within children's social care. As with the response to Dent, Ken Rigby focused on the risks to staff rather than those to children.[396]

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[382] Rigby 9 October 2018 30/21-31/2
[383] NSC001234
[384] NTP001682
[385] Cope 17 October 2018 123/11-131/6
[386] Rigby 9 October 2018 21/20-23
[387] Cope 17 October 2018 127/19-128/3
[388] NSC001234
[389] NSC001233_7
[390] NSC001229
[391] Rigby 9 October 2018 25/16-26/2
[392] Rigby 9 October 2018 23/11-17
[393] Rigby 9 October 2018 26/9-17
[394] NSC000105_35
[395] NSC000046
[396] INQ002422

Barrie Pick

43. Barrie Pick was a residential care worker at Beechwood between 1976 and 1977.[397] Mark Cope told us that he raised concerns with his manager, NO-F204, that Pick seemed attracted to the younger children in the home, but that these were not taken seriously. He felt there was generally a failure on the part of management to support staff when they raised concerns.[398] In 2017, Pick was convicted of indecent assault and gross indecency against a former resident of Beechwood, and of possessing indecent images.[399]

NO-F29

44. A police analysis in January 2018 recorded that 33 former residents made allegations of sexual abuse against NO-F29, a senior member of staff at The Lindens who worked at Beechwood from 1967 until his death in 1980.[400] The allegations included voyeurism, fondling children in the showers, digital penetration and rape.[401] Had he been alive, NO-F29 would have been the subject of serious criminal charges.[402]

45. There is no record of NO-F29 being reported to the police or investigated by children's social care during his lifetime.[403] A social worker visiting Beechwood in 1979 reported that two residents:

> "*were accusing him of homosexual activities. I interviewed* [NO-A629] *about this but all* [NO-A629] *said was that everybody knew that* [NO-F29] *was 'queer'. Mr Rigby was there as well and it was felt that there was nothing in these accusations at all apart from trying to diminish* [NO-F29's] *authority in the place. It was a very difficult time for Beechwood, the group was unsteady and* [NO-A629] *seemed to be in the middle of all the trouble that was going on.*"[404]

46. Ken Rigby said that he had heard comments about NO-F29 being "*queer*" more than once but was told by Jim Saul that they were just rumours with no foundation. He accepted this.[405] Jim McLaughlin had concerns about NO-F29 working with vulnerable children but said he would not have known who to tell given NO-F29's seniority.[406] As noted in a police report in 2015, the senior role held by NO-F29 over a long period placed him in a unique position both to abuse residents and to have influence over other staff.[407]

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397 CPS004382 para. 318
398 Cope 17 October 2018 134/24-135/17
399 INQ001688
400 NTP001654
401 INQ002574; INQ002577
402 NTP001519
403 Some complainants (such as L18) say that they told the police at the time; others (such as L50 and L24) say that they told other adults at the time (INQ002574).
404 NSC001178
405 Rigby 9 October 2018 15/3-18/17
406 McLaughlin 9 October 2018 107/13-109/4
407 NTP001519

NO-F204

47. NO-F204 held a senior role at Redcot in the mid-1970s.[408] Initially he was dismissed for, amongst other things, watching children in the shower and physically assaulting residents but this was substituted on appeal to councillors with a final written warning and NO-F204 was redeployed to Hazelwood.[409] At least six former Beechwood residents have now alleged sexual abuse by NO-F204.[410]

48. Mark Cope remembered NO-F204 standing in the shower area when children were showering rather than supervising from outside. He reported his misgivings to Jim Saul who dismissed his concerns at the time. This discouraged him from reporting "*anybody again*".[411]

Other allegations

49. The Inquiry is aware of six allegations of sexual abuse against NO-F49,[412] and allegations against NO-F52,[413] NO-F281, NO-F60 and NO-F218, all of whom worked at Beechwood between 1967 and 1980.[414] There are also numerous allegations made against perpetrators who could not be identified by complainants.[415]

50. For those residents who were able to report sexual abuse at the time, the response was generally negative. L24, NO-A451 and NO-A187 disclosed to members of staff but said nothing was done. NO-A320 alleged he was beaten by night staff after telling them that he had been sexually assaulted by a member of staff. L18 said he reported the abuse to the police but was told that they could not get involved and that he would have to report the abuse to someone else. L50 disclosed abuse to a school teacher working at the home; he recalled her simply responding "*did he?*" and that nothing then happened. L17 told us she disclosed to a staff member at her next placement but there was no response.[416]

51. A social worker visiting in the late 1970s remembered, "*there was lots of abuse reported in Beechwood and numerous complaints from children within the home. It was awful and the children often ran off to escape it.*"[417]

Barriers to disclosure

52. Other complainants who made allegations about this period were not able to disclose at the time they were abused.[418]

> **52.1.** D37 explained "*The main reason that I didn't report the abuse was that I didn't realise it was wrong … Even if I had wanted to report the abuse … who would have believed me? The staff at Beechwood were members of the community and I was just a kid.*"
>
> **52.2.** D22 said that "*The abuse I suffered has always been a source of shame and embarrassment for me. The thought of talking about it has been and still is very frightening.*"

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[408] Cope 17 October 2018 131/7-9; NSC000980_11, 13-14
[409] NSC000980_11, 13-14
[410] NTP001634_8
[411] Cope 17 October 2018 131/7-134/2
[412] NTP001654
[413] CPS003377
[414] NTP001634_5-14
[415] NTP001634_6-14
[416] INQ002574; INQ002577
[417] NTP001664
[418] INQ002574; INQ002577

52.3. D35 "*heard that it happened to others in the dorm, but we just kept our heads down and carried on. The lads just accepted what it was … I had a record of previous convictions and knew that no one would believe me. I was also scared as I knew I would get beaten if I reported.*"

52.4. A79 said that his perpetrator told him it was their "*secret*" and that, if anyone found out, he would make A79's life hell and make it "*twice as bad*" next time.

> "*There was no way I was going to tell anyone as I was scared and sure that no-one would believe me and was deeply ashamed. By this point my whole personality was being built on me being a tough guy and so I was too ashamed to tell anyone.*"

52.5. NO-A172 wanted to get a good report at Beechwood so that he did not have to stay there.

53. A number of former residents said that there was nobody to talk to about the abuse,[419] whereas others told of reporting to their social worker.[420] It never occurred to Ken Rigby that residents might want to talk to someone other than their social worker.[421]

54. Children were exposed to sexual and physical abuse and were isolated and fearful. They had no one in whom they could confide. Viewed by staff working there as a "*dumping ground*", Beechwood was neglected by senior managers, particularly Edward Culham (Director of Social Services) and Norman Caudell (Divisional Director for children's social care in the relevant local area), and councillors in both Councils.

C.6: Beechwood: 1981–1998

Composition and function

55. By 1989, Beechwood had been re-designated as a community home[422] following a recommendation in a County report into residential care in 1984.[423] It was to continue to provide 37 places, with children aged 10–18 to be placed "*normally*" for less than six months.[424] Each child was to have a designated key worker who would be "*the primary care person for the child*".[425] In line with the County's plan to reduce the number of children in residential care, The Lindens closed in 1990. From then, Beechwood consisted of only one residential unit: Redcot.[426] During the 1990s, resident numbers varied between 11 and 17.[427]

56. Beechwood was officially described in 1993 as "*a specialist children's home which takes all young people remanded from the youth court who are refused bail*", taking in children "*without notice*".[428] In reality, in addition to those on remand, it continued to take children with challenging behaviour from other homes as well as taking those in "*general welfare care*".[429]

[419] For example, D37, D36.
[420] For example, L22, P15.
[421] Rigby 9 October 2018 45/16-46/4
[422] For example, see NSC000444_1
[423] NSC000240_11
[424] NSC000240_41
[425] NSC000240_33
[426] NSC001318
[427] DFE000637
[428] DFE000637
[429] NSC001622_10

Management and governance

57. Jim Saul retired in 1981, and Jim Fenwick ran Beechwood as Principal until 1991, although he told us he had "*minimal*" contact with children in the home.[430] In around 1984, Hazel Kerr (Homes Advisor) wrote that:

> "*Beechwood is slowly evolving under the firm guidance of Jim Fenwick … It is well accepted that Beechwood will take on all-comers. They rarely, if ever reject a child.*"[431]

Jim Fenwick recalled that, when he started, Beechwood staff were "*a very much male-dominated group*" but he "*tried over a fairly long period to change this*"[432] by appointing more female staff. He said that he made staff aware of the need to use sympathy and empathy with children but recognised that he was dependent on what he was told by staff as to how children were in fact being treated.[433]

58. He also attempted to improve physical conditions at Beechwood, writing in 1989 to Denis Watkins to "*elicit … support for urgent attention to … improve the quality of life*" of children at Beechwood, adding that staff were in a state of "*desperation*".[434] He referred to a visitor who had described it as "*horrifying … how is it we can place young people in such atrocious conditions*?" Significant criticisms were still being made of physical conditions in the late 1990s and early 2000s.

59. Following Jim Fenwick's departure, Beechwood was run by a series of temporary managers before Andrew Bosworth's appointment as unit manager in 1995.[435] He considered the management culture at Beechwood prior to his arrival had been one of "*autocracy and intimidation*" and that there had been "*avoidance of issues*".[436]

60. The Inquiry has not seen evidence of any internal inspection of Beechwood during the 1980s by the County's children's social care service.

61. Annual reports into each children's home were required throughout England and Wales from 1991 onwards and within the County these were conducted by the Service Standards Unit (SSU) from 1994.[437] Although we have no SSU reports into Beechwood whilst it was run by the County, it appears that inspections were carried out.[438]

62. Also from 1991, monthly Regulation 22 inspection reports were required to be carried out by children's social care staff and reported to councillors.[439] However, as Professor Berridge noted, "*local authorities were left to their own devices about what happened to these reports, how effective were they and whether they were followed-up.*"[440] Reports on Beechwood from the early to mid-1990s regularly assessed standards of management and care as high,[441]

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[430] Fenwick 9 October 2018 122/23-123/7
[431] NSC000443_12
[432] Fenwick 9 October 2018 127/18-128/15
[433] Fenwick 9 October 2018 122/1-123/15
[434] NSC000444_3-4
[435] The job titles for those running the home changed over the relevant period (NSC000393_44-47, 56-59, 64-66; INQ001811 paras 1-2).
[436] NSC000498_19
[437] Under Regulation 28 of the Children's Homes Regulations 1991
[438] NSC000965; NSC001277
[439] NSC001235 para. 5h.13
[440] EWM000463_48
[441] NSC001619; NSC001611; NSC0001616; NSC001621; NSC0001617

despite poor physical conditions,[442] severe staff shortages,[443] and the criticisms from the Social Services Inspectorate (SSI)[444] and media reports. Many of the positive Regulation 22 reports were prepared by County Service Manager Paul Bohan, who had direct responsibility for the management of Beechwood.

63. Children's social care internal policy on Regulation 22 visits was revised in 1996, from that point requiring that any allegation of abuse made during the inspection be specifically recorded, and that inspection visits had to be unannounced and conducted by someone without line management responsibility for the home.[445] By mid-1996, inspection reports began to refer to some of the difficulties facing Beechwood. One noted that whilst "*great strides have been made in improving the systems and infrastructure in managing the Unit … attention needs to be given to raising the quality of child care*".[446] Another, in 1997, referred to children sharing three beds to a room "*putting them at risk*", staff standing guard "*to enable a female resident to be safe whilst using the shower*", and "*chronic*" staff shortages with the unit depending mainly on temporary staff.[447]

64. Reports also recorded the continued high numbers of children absconding each month.[448] A 1997 report recorded 73 incidents of children missing in one month, but said "*The Managers within the Unit and staff work closely with the local Police Officer … and all young people are rated as to their risk of vulnerability.*"[449]

65. From 1981 to 1998 only four reports of councillors' rota visits are available in relation to Beechwood, all of which date between 1996 and 1998.[450] No issues were identified in three of the reports.[451] A January 1998 report noted that there was "*a serious problem with safety of staff*" as well as with the safety of "*inmates*" (referring to residents).[452]

66. We have seen no evidence of the SSI, or any other external agency, carrying out an inspection into Beechwood between 1967 and 1998.[453]

Issues

Absconding

67. In late 1985 and early 1986, Beechwood attracted local and national media interest. There were reports of 400 incidents of absconding in 1985 (including 70 girls who had "*fled*" the home more than once in a year),[454] a girl's death following a fall from a window at the home[455] and a trial during which it emerged that girls at Beechwood had been working in a "*sex club*".[456]

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[442] NSC000393_4, 50, 62
[443] NSC001626; NSC001624_9-13
[444] DFE000651_2; DFE000647_2
[445] NSC001235 para. 5h.13
[446] NSC001627
[447] NSC001624_9-13
[448] NSC001612; NSC0001613; NSC0001614
[449] NSC001620_7-12
[450] NSC001235 paras 3b.3, 3a.18. It is unclear whether visits were carried out and not reported, or they were reported but the reports have been lost, or visits were simply not carried out.
[451] NSC001235_105 para. 6b.13
[452] NSC001622_6-10
[453] During this time there was no regime for regular inspections, but the Department of Health and SSI sometimes conducted inspections of homes (NSC001235 paras 8a.11-8a.12). Although, as discussed below, the SSI did have some oversight of the response to the death of a resident at Beechwood in 1994, no inspections were carried out.
[454] INQ0016800_1
[455] NSC000443_11
[456] INQ002407

68. This brought Beechwood to the attention of the County's Social Services Committee. Committee Chair Joan Taylor, while recognising there was a problem with absconding and the risk of sexual exploitation, suggested that "*Often girls sent to us come with a history of being involved in prostitution.*"[457]

69. Jim Fenwick did not examine the underlying reasons for absconding,[458] whilst Ken Rigby told us that girls "*absconded for all sorts of reasons*".[459] For Ken Rigby, some children at Beechwood were "*very devious in all sorts of things. Absconding was just but one of them.*"[460]

70. In March 1989, a national newspaper published an account of underage sex and drugs at Beechwood. David White reported to the Social Services Committee in April 1989 that the suggestion that there was "*extensive sexual activity amongst couples and groups of young people*" had been "*grossly exaggerated*".[461] Although a 14-year-old girl had had sex with a number of boys on different occasions, White emphasised that "*At no time did this take part against her will*". White's report was seen as a vindication of the staff: "*we were all quite delighted to receive the inquiry report and your letter that both contained a consistent underlying theme of exoneration*".[462] David White told us that he was "*ashamed by this report … in terms of the way that we, as an organisation, reported this matter … and sought to justify what we found.*"[463] The focus of the report was on the difficulties faced by the staff rather than on the vulnerability of the children.

71. Concerns arose again in June 1994 following the death of a Beechwood resident after he absconded and crashed a car.[464] The SSI criticised the high level of absconding at Beechwood, and one SSI official noted "*there could be a case for saying that Nottingham had failed to protect the welfare of the children in their care*".[465] Later that year an SSI official commented that "*It is now 4 months since* [the child] *was killed and it seems to me that nothing has been done during this period to protect the well-being of the other young people who are being looked after by Nottingham.*"[466]

Culture

72. Several complainants described physical abuse and a culture of violence at Beechwood in the 1980s and 1990s.[467] For example, N1[468] and other complainants[469] say they were made to fight one another, although Ken Rigby and Mark Cope told us that staff organised boxing matches and no child was forced to fight.[470] Some said that this culture prevented them from reporting sexual abuse either because they were scared of the repercussions[471] or because they were not believed when they reported physical abuse so did not think they would be believed about sexual abuse.[472] D33 described staff as "*very cruel*", while D34 described

[457] NSC000443_11
[458] Fenwick 9 October 2018 150/3-153/22
[459] Rigby 9 October 2018 39/20-41/12
[460] Rigby 9 October 2018 39/11-17
[461] NSC001375
[462] NSC000444_2
[463] White 8 October 2018 167/16-168/25
[464] DFE000651_3
[465] DFE000651_2
[466] DFE000647_2
[467] For example L23, L39, P12, L27, D33, D34, L22 (INQ002574).
[468] N1 3 October 2018 16/2-22
[469] INQ002574; INQ002577 – D28, D33, D36, D37, D48, D5, NO-A408, L22.
[470] Cope 17 October 2018 114/12-20; Rigby 9 October 2018 52/7-17
[471] For example D33 and L23 (INQ002574).
[472] For example D34 and L39 (INQ002574).

physical abuse as "*normal*". L22 described physical abuse from staff and other residents, and said she "*told the nice staff about the beatings and what was happening, but they didn't seem to care*".[473]

73. Concerns around the physically abusive environment at Beechwood were also raised by residents at the time. In 1987, a number of children complained to a member of the public about physical abuse at Beechwood and this came to the attention of children's social care. Jim Fenwick "*completely*" denied that staff had been taking "*children or young people into the office and slapping and knocking them around without witnesses*" and emphasised "*that this behaviour would be totally unacceptable … and does not happen*".[474] In correspondence with children's social care, Jim Fenwick defended his staff's use of "*the necessary amount of force to restrain*" one resident, whilst recognising that one member of staff had dealt with another resident "*in a manner that was not entirely necessary*". He claimed staff had "*little or no preparation or training for dealing with situations that become physical*".[475] Within children's social care, it was noted that "*residential staff are constantly vulnerable given the numbers of confrontations which take place in any working day. We are of course placed in the position of requiring appropriately to investigate any allegations made … Mr Fenwick is quite understanding of the fact that we need to fully investigate incidents that are alleged*".[476]

74. There are also recorded examples of allegations against staff of physical abuse. In 1993, NO-F3, a care worker at Beechwood, was suspended following allegations of physical assault of a resident.[477] He was charged but a prosecution was dropped in March 1994, and NO-F3 returned to work three months later.[478] In September 1995, two residents made complaints of physical abuse by staff. One said that he was physically assaulted by NO-F1, who held a senior position. Another complained that a member of staff had held his face and dragged him into the office.[479] It is not clear how these incidents were dealt with, if at all.

75. Andrew Bosworth became Unit Manager in 1995. He found that there were no restraint or incidents books kept at Beechwood, and no systems on restraint "*evident in the unit at all*".[480] He was particularly concerned about the attitudes of staff, in particular one individual who had a conviction for grievous bodily harm and who had apparently declared "*We sort people out at Beechwood*". These issues should have been picked up sooner by senior staff members and social care management.

76. Former staff denied a culture of physical violence at Beechwood. Ken Rigby said he had never had to reprimand a member of staff for their misuse of physical restraint or contact with residents in 18 years[481] and said it was children who were violent to staff and between themselves.[482] Jim Fenwick told us he never saw a member of staff being physically abusive to a child, although he remembered dealing with a complaint about a member of staff who

[473] INQ002574
[474] NSC000464_4-5
[475] NSC000464_4-5
[476] NSC000464_8-9
[477] NCC001244; NCC001246
[478] NCC001421
[479] NSC000392
[480] NSC000498_4-19
[481] Rigby 9 October 2018 54/14-24
[482] Rigby 9 October 2018 46/10-16

had threatened to hit a resident with a billiard cue.[483] For Mark Cope, the environment at Beechwood was hostile but not violent, and he recalled the home being far more relaxed in the 1980s than previously.[484]

77. However, as part of a 2011 review looking at allegations of physical and sexual abuse at Beechwood in the late 1980s, the NSPCC concluded:

> *"It is … clear from the file material that Beechwood, and particularly The Lindens, was an environment where violence, bullying and fear were common features and recording suggests that such behaviour was expected … The Lindens would certainly appear to have been an environment within which an abusing adult would be able to abuse young people successfully."*[485]

Reports of and responses to allegations of sexual abuse

78. Police records include more than 65 allegations of sexual abuse against staff at Beechwood between 1981 and 1998.[486] Jim Fenwick told us that he was "*absolutely shocked*" at the number of allegations during his time in charge and had "*no idea*" how they could have taken place. He said that he should have known what was happening in relation to "*the abuse of children*".[487] This was a serious management failure that left children unprotected.

79. L27 said he reported being sexually abused to the police but:

> *"was told to stop lying, and that I was making it up. They just didn't seem interested at all. I don't think they believed me, but I find it hard to believe that they didn't know what was happening in the home."*[488]

80. D4 was not able to disclose:

> *"I didn't think anyone could help me. No one had ever helped me before … Staff know you have no family and nobody cares about you and there is nobody to turn to. That's why you are there in the first place. You're vulnerable. You've got no family, so who's going to care?"*[489]

81. In 2005, NO-A93 alleged that NO-F7 sexually assaulted her in 1985. The allegations were investigated by the County under its disciplinary procedures as NO-F7 was working in education at the time of the allegations. However, the County decided that the allegations should not proceed to a disciplinary hearing against NO-F7.[490]

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[483] Fenwick 9 October 2018 144/14-146/2
[484] Cope 17 October 2018 114/21-115/24
[485] NCC000308_28 – the report does not specify what type of abuse is being referred to here.
[486] NTP001657
[487] Fenwick 9 October 2018 130/22-131/25
[488] INQ002574
[489] INQ002574
[490] It was considered that there was insufficient evidence based on interviews with witnesses and a lack of supporting records (NSC000501).

Andris Logins

82. Andris Logins, who worked in Redcot from 1980 to 1985, was convicted in 2016 of four counts of rape, 12 counts of indecent assault and one count of child cruelty in relation to four children at Beechwood from 1980 to 1984. He was sentenced to 20 years in prison. His lawyer said that Logins had been "*suckered into a regime he became part of*".[491] Logins was struck off as a social worker in April 2017.[492]

83. In 1991, charges against Logins for indecent assault of residents at another children's home, Sycamore House, were discontinued by the police. Children's social care took no further internal action and he was reinstated in October 1991[493] without any assessment of whether he posed a risk to children.[494]

84. In 2011, NO-A155 made allegations of sexual abuse against a "*Mr Logan*", but the police did not connect this to Andris Logins until 2015.[495] It was another former resident, NO-A61, who came forward in 2013 following press reports, who prompted a police investigation and others subsequently came forward.

85. Mark Cope remembered Logins being tactile with girls who would sit on his knee.

> "*That was actually done in front of management and anybody else who was around. He didn't hide what he was doing.*"

He did not report this behaviour as he felt there was no clear evidence of wrongdoing, but now realised that this could be described as grooming behaviour.[496] Ken Rigby admitted to us that a blind eye was "*probably*" turned towards the way Logins behaved, adding, "*but I have got no knowledge of that*". He grudgingly accepted that in his management role he too was responsible for what happened to children.[497]

Other allegations

86. Although Andris Logins is the only conviction in relation to this period at Beechwood, eight former residents made allegations to Operation Daybreak of non-recent sexual abuse by NO-F1 and four former residents made allegations against NO-F2, in relation to their employment at Beechwood between 1987 and 2000 and 1985 and 2002 respectively.[498] Both are also the subject of a substantial number of allegations of physical abuse.

87. NO-F11 worked at Beechwood for 19 years and died in 2012. He was the subject of allegations of sexual abuse from four former residents relating to the 1980s and 1990s.[499] We are also aware of allegations of sexual abuse against other members of staff relating to this period, including NO-F4, NO-F3, NO-F287, NO-F33, NO-F14, NO-F8, NO-F363, NO-F6 and others who could not be identified by complainants.[500]

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[491] Andris Logins jailed for Nottinghamshire children's home sex abuse 23.03.16
[492] INQ001154. The HCPC decided that his fitness to practice as a social worker was impaired following the conviction.
[493] On the basis that "*it was felt that the available evidence, despite the best efforts to clarify the situation, finally remained inconsistent and unreliable*". Logins' request to be redeployed outside the residential child care sector was rejected because there were "*no formal grounds to do so*". (NSC000488_14-15).
[494] NSC000488
[495] NTP001640
[496] Cope 17 October 2018 135/18-136/16
[497] Rigby 9 October 2018 32/13-33/16
[498] NTP001654
[499] NTP001654
[500] NTP001634; INQ002574; INQ002577

88. Despite the large number of allegations made to police and to this Inquiry in relation to this period, there are no records of allegations of sexual abuse made at the time. Several former residents say that they disclosed abuse at the time but were not believed.[501] P14 says she reported abuse to staff but was told that no one would believe her as she was regarded as a suicide risk. P12 says she reported to a member of staff at her next placement, but was told to "*piss off to bed*". NO-A188 said she told a staff member who believed her but told her that if she said anything "*you will make matters worse for yourself*".

89. Children continued to be exposed to physical and sexual abuse. There was a culture of violence and a lax attitude to absconding. Staff ignored the abuse of children by colleagues, whilst managers did not act to protect children. Senior managers clearly viewed Beechwood as a problem, in which the interests of staff were of greater concern than the protection of vulnerable children and young people.

C.7: Continuing problems under the control of the City: 1998–2006

90. The recently created City Council assumed the ownership and management of Beechwood in April 1998. Andrew Bosworth, who continued as manager during this change, felt that for a considerable period, senior staff were preoccupied with their own concerns for their future, and did not have any understanding of the unsettling effect on frontline staff.[502]

91. Around this time, the majority of placements at Beechwood, for 13 children aged 14 to 17 who had been bailed or remanded to care, were still "*unplanned*" and at short notice. Staff "*felt that young people were safe while in the unit … but felt that young people were at risk when out of the unit*".[503] However, for Margaret Mackechnie, the City's Assistant Director for Children's Services, with senior line management responsibility for the home, Beechwood reflected a "*youth justice approach … less caring … male dominated … there was a harshness about it*".[504] In spite of being aware of this at the time, Ms Mackechnie did not do enough to improve conditions at Beechwood.

92. Inspections and reviews of Beechwood were largely negative, making adverse comments about the lack of policies, procedures and training for staff and the physical conditions of Beechwood.[505] The number of children sharing rooms was "*unacceptable*", and the standard of accommodation was "*very poor*", which had been "*well documented in previous reports*".[506]

93. In the early 2000s, Beechwood faced the same problems that it had over the past 20 years. Alison Michalska, the City's Corporate Director for Children and Adults, told us that Beechwood should have been closed when the City took over ownership in 1998.[507] It continued to be over capacity and the mix of "*aggressive and loud to vulnerable and subdued*" residents was considered difficult to manage.[508]

[501] INQ002574; INQ002577
[502] INQ001895 para. 21a
[503] CQC000003_1-20
[504] Mackechnie 18 October 2018 111/2-112/20
[505] For example, CQC000003, NCC000867 and NCC001109
[506] CQC000003_2, 19
[507] Michalska 25 October 2018 96/3-20
[508] NCC001109_5

94. In 2001, the City's Registration and Inspection Unit identified 29 issues requiring attention at Beechwood, including addressing overcrowding, urgently reviewing placements to ensure they were appropriate and that children could be protected from bullying and other forms of abuse, and providing child protection training (which had also been identified in a previous review).[509]

95. Michelle Foster, a residential care worker at Beechwood between 2000 and 2002, told us that it was not "*an optimistic place*" for children to be.[510] Despite concerns raised in inspection reports about the lack of child protection training, she said that no training was provided on working with children who had been sexually abused or on dealing with sexualised behaviour.[511]

96. Although sharing bedrooms had been identified as a "*risk*" in 1997[512] and "*unacceptable*" in 1999,[513] it was still happening in 2002. Joanne Walker (who had been seconded to manage Beechwood) identified this as a "*grave concern*":

> "*I am aware of a previous incident of rape being perpetrated in another home with just such a situation, indeed, within the last week a young man who was placed in a shared room was urinated on whilst in bed! The horror of this happening is unspeakable. How can we give care to anyone who has been so abused by a system which allowed this to happen? … Sharing bedrooms is a source of constant friction between the young people resulting in unnecessary dangers. It is a disaster in the making and only a matter of time before a tragedy happens. I would go so far as to say this practise constitutes institutional abuse.*"[514]

Margaret Mackechnie disagreed that the sharing of rooms was "*institutional abuse*", but accepted that it was "*not good practice in a children's home*".[515]

Bronwen Cooper report: 2001

97. Bronwen Cooper, an Investigation Officer with the City, was asked to investigate allegations and counter-allegations concerning NO-F1, a former staff member of Beechwood now working in another home, relating to the period from the mid-1990s to 2001.[516] Ms Cooper said her remit was to consider "*the whole operation of the unit, the culture and practice … and whether children felt safe*".[517]

98. Her 2001 report revealed serious concerns of a staff culture of "*sexual banter*" and harassment at Beechwood.[518] She listed 10 specific allegations against staff, including an "*inappropriate relationship*" between NO-F1 and "*a young person in the Unit*". The report described a "'*macho' environment*", sexual and racial harassment and inappropriate behaviour between staff.

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[509] NCC000867
[510] Foster 18 October 2018 11/3-25
[511] Foster 18 October 2018 23/6-24/6; NCC000867
[512] NSC001624_9-13
[513] CQC000003_1-20
[514] NCC000693
[515] Mackechnie 18 October 2018 133/25-134/3
[516] NCC000294
[517] Cooper 9 October 2018 65/22-66/19
[518] NCC000294

99. Ms Cooper "*was extremely concerned that the care of the children in this situation was being neglected*" and that the behaviour of staff, particularly the sexualised behaviour, "*would have an impact on children that we knew had previously suffered physical/sexual abuse/neglect and were looking to this staff group to care for them, keep them safe and also show them appropriate boundaries*".[519] She felt that "*the whole atmosphere of the home was unsafe sexually*" making it "*very hard*" for children to be able to disclose any abuse they were suffering.[520] For Ms Cooper:

> "*there was a high level of risk of sexual abuse of residents within the home at the time of my investigation, by staff and other residents, because of the environment and culture generated by the staff group*".[521]

100. An initial draft of the report,[522] provided to Margaret Mackechnie, recommended that Beechwood be closed.[523] Closure was envisaged as temporary – while certain staff were supported and trained, and necessary disciplinary action taken against other staff[524] – but was seen by Ms Mackechnie and other managers as "*contentious*" and "*practically and politically impossible*" at the time.[525] Closure also raised "*the challenge of finding placements for children*", which was "*huge*", as well as problems with re-deploying or making staff redundant. She recognised that the behaviour of the staff was "*very concerning*" but said she had to "*balance the needs of the service and the needs of the children*".[526] Ms Cooper removed the closure recommendation from her final report, feeling "*a little pressure*" to do so. She was "*reassured*" that alternative measures would be put in place to improve the situation for residents.[527]

101. Ms Mackechnie recalled that, in response to the report, the City reduced the number of children at Beechwood and did "*the usual things you would do when there was a children's home in difficulty*".[528] Ms Michalska accepted on behalf of the City that steps taken to address problems in the home "*were wholly inadequate*".[529] Ms Cooper thought that there was a sexualised culture which created an "*unsafe environment*" for children, in which they would "*find it very hard to talk about sexual abuse*".[530] These concerns required urgent action. The response of Margaret Mackechnie and her colleagues left children in the City's care exposed to continuing risk of harm.

Events leading to closure: 2002–2006

102. In April 2002, following disclosure by a resident that she had been raped by a 21-year-old male from outside the home, National Care Standards Commission (NCSC) inspectors were notified and visited Beechwood. They recommended that Beechwood be closed "*because it was failing to safeguard and promote the welfare of the children resident there*", but within 48 hours agreed that the home could remain open provided that the number of

[519] Cooper 9 October 2018 73/5-74/13
[520] Cooper 9 October 2018 74/14-75/9
[521] INQ001800 para. 7.1
[522] No copy of the draft report was available to the Inquiry.
[523] Cooper 9 October 2018 75/18-24
[524] Cooper 9 October 2018 75/25-76/19
[525] Cooper 9 October 2018 77/11-79/10
[526] Mackechnie 18 October 2018 125/5-128/6. In a 2002 memo referring back to this time, the City stated "*Discussions did take place … as to whether temporary closure should take place, but the difficulties that this would create in terms of placement choice were assessed to be too great a risk*" (OFS008233_9).
[527] Cooper 9 October 2018 80/3-82/17
[528] Mackechnie 18 October 2018 126/24-127/14
[529] Michalska 25 October 2018 96/8-20
[530] Cooper 9 October 2018 83/7-16

residents was reduced from 10 to eight.[531] The City disputed that any recommendation to close was ever made at this time.[532] The proposed reduction in numbers does not appear to have taken place. Michelle Foster told us that in practice the number never went below nine,[533] and the NCSC subsequently reported that the City had continued admitting young people to Beechwood over capacity, resulting "*in some young people having to sleep on couches or share bedrooms against their wishes*".[534]

103. In September 2002, the same resident who disclosed in April that she had been raped, killed herself in her room at Beechwood. The NCSC formally notified the City that it had "*reasonable cause to suspect that young people are likely to suffer significant harm. We think it incumbent upon the Local Authority to carry out immediate child protection risk assessments, as the basis for providing an informed judgement about whether young people in this children's home are safe.*"[535] The City proposed relocating children to other homes, but the NCSC was not satisfied that the City had demonstrated "*adequate and due regard to ensuring the safety and welfare*" of those children, having inspected conditions and occupancy levels at the other homes.[536]

104. The NCSC's report on the resident's death[537] was critical of the City's care for her and of its running of Beechwood. It concluded that:

> **104.1.** the City failed to respond to concerns relating to risks to the resident's welfare and to notify the NCSC of "*significant events*" including allegations of sexual abuse;
>
> **104.2.** children's social care management had been advised that the resident should not remain in residential care amidst concerns that she was sexually active with a number of boys in the home and was being sexually exploited outside the home; and
>
> **104.3.** while it might "*transpire that this was a tragedy that could not have been averted*", her life in care "*was characterised by unacceptable levels of risk, neglect and vulnerability. She was being 'looked after' by Nottingham City Council because she was considered to be in need of its care and protection. In the opinion of this Review the Local Authority failed to meet her needs in respect of the care it provided to her … young people have not been cared for … in a manner likely to safeguard and promote their welfare.*"[538]

It recommended closure of Beechwood with "*immediate effect*".

105. This was the third closure recommendation in around a year. The NCSC stated that Beechwood was only to be reopened once the City could demonstrate it was "*capable of meeting the requirements of the Children's Homes regulations and National Minimum Standards*". The City was told to undertake "*a comprehensive review of all of its children's homes*", to urgently review its procedures on notification of significant events, and to formulate a plan

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[531] Other NCSC inspectors subsequently noted that the NCSC "*should have acted on the basis of the initial evidence that the service was not up to standard*" and closed the home (OFS008229_6).
[532] OFS008233_2
[533] Foster 18 October 2018 19/19-21/3
[534] OFS008229_10-11, 20
[535] OFS008170
[536] OFS008171. The City in turn set out the steps being taken to meet the NCSC's concerns (OFS008229_14-18).
[537] OFS008229 – recipients included the City's Chief Executive and Acting Director of Social Services.
[538] OFS008229_1-18

on the suitability and relevance of its existing residential child care provision.[539] It agreed to temporary closure, declaring "*There are firm plans in place to refresh all aspects of operations at* [Beechwood] *with a view to it being reopened.*"[540]

106. Michelle Foster told us that, the day before she was due to give evidence at the inquest into the resident's death, Margaret Mackechnie made it clear that she should not do so as "*it wouldn't be good for the children if the public found out that they were taking drugs and having sex*". She was told that if she went ahead she would lose her job.[541] Ms Mackechnie did not remember specifically meeting Michelle Foster before the inquest, but did recall "*a group meeting for the staff who were going to give evidence to the inquest*". She firmly denied that she told Michelle Foster that she "*would lose her job if she said anything to the inquest*".[542]

107. Beechwood re-opened in June 2003. The City's Area Child Protection Committee (ACPC) published a 44-page overview report into the resident's death around the same time.[543] It concluded that "*no single action by a person or agency … could have prevented* [the resident's] *death*" but questioned whether "*more could have been done*" at Beechwood "*to create an environment where vulnerable young women, and men, were not liable to be sexually exploited by each other*".[544] Ms Mackechnie accepted that a similar issue had been identified in Bronwen Cooper's report two years earlier and that more could have been done.[545] There were several recommendations, including that the City develop "*Residential Care Standards, with appropriate staff development programmes, to ensure that children's homes provide a safe environment where sexual and violent behaviours … are appropriately managed*" and that the ACPC develop "*Practice Guidance and training for all agencies on assessing and working with children who have been sexually abused*".[546] Similar recommendations on the need for such guidance and training had been made as far back as 1988 and 1990.[547]

108. On receipt of the ACPC report, the Social Services Inspectorate (SSI) wrote to the City's Chief Executive highlighting the report's criticism of the lack of strategic response to incidents at Beechwood and commenting that it was very clear the child was in need of protection.[548]

109. The picture of Beechwood over the following three years, from monthly visits and external inspections, is mixed. Residents were said to present "*a high level of aggressive and challenging behaviour*"[549] and to be "*fed up with the complaints process*".[550] Some young people placed at Beechwood had "*to live with young people who are persistent offenders*", leading to attempts to coerce others into "*drug use and prostitution*".[551] On the other hand, staff were seen to be making "*concerted efforts*" to maintain positive relationships with residents, and were trained on and aware of the processes to safeguard young people.[552]

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[539] OFS008229_19-21
[540] OFS008232, which included a detailed response to the report, taking issue with many of the findings.
[541] Foster 18 October 2018 51/22-52/14. Ms Foster did in fact give evidence at the inquest and her evidence that bullying, drugs and under-age sex were rife at Beechwood was reported in the press.
[542] Mackechnie 18 October 2018 146/12-148/6
[543] NCC000297: this was a review under Chapter 8 of *Working Together* 2000.
[544] NCC000297_22, 42. The report set out some of those steps, including work by residential staff with the young people, both individually and as a group, increased staffing levels, better oversight by the Operational Manager of young people and staff, and better liaison with the field social worker.
[545] Mackechnie 18 October 2018 143/18-144/13
[546] NCC000297_43-44
[547] NSC000101_10-11; NSC000102_33
[548] OFS008244
[549] OFS008157
[550] OFS008164
[551] OFS008164
[552] OFS008166

110. By 2006, there was little evidence of positive relationships between staff and young people, and the home was still in a poor physical state.[553] The Commission for Social Care Inspection (CSCI) wrote in February 2006 to Margaret Mackechnie identifying concerns that residents were exposed to "*a variety of risks in terms of self harm and harm to each other*". The City was required "*to take immediate action to address these issues and to ensure the safety of all persons in the service*".[554]

111. Subsequent inspections record an improved picture – in September 2006, the overall rating was 'good'.[555] By the end of the year Beechwood had no residents, with a "*proposal currently being made to close the Unit*".[556] It appears to have been finally closed in late 2006 or early 2007.

Reporting of and responses to allegations of sexual abuse

112. Approximately 10 allegations of sexual abuse have been made relating to the period from 1998 to 2006 at Beechwood,[557] including from:

112.1. L43, who told staff in 2002 that he had been sexually assaulted by an older boy and the police were involved. He was told by a member of staff that if he went along with a prosecution he would be moved further away from his mother's home. He told us that he felt both very let down and unsafe, not least because for a period his abuser stayed in the home.[558]

112.2. L29, who said that he tried to tell a social worker about his abuse by a staff member in 2005, but felt like she was ignoring him as she changed the subject.[559]

113. There is evidence of only one allegation against a staff member being made at the time in relation to this period. NO-F47 was suspended in October 1998, following an allegation of an "*inappropriate relationship*" with a male resident, and resigned before the disciplinary hearing.[560] There were no documents on her file to suggest that a disciplinary investigation was concluded, despite guidance on the need to continue investigations following a resignation.[561]

114. Andrew Bosworth's understanding of the low number of allegations made at the time can be seen from a complaint he made in January 1999 about two inspectors from the City's Registration and Inspection Unit:

> "*There seemed to be a continued pursuit of trying to find some form of abuse of young people, then a denial of being allowed to make a complaint. This preoccupation had been recognised by several staff members including myself. There was simply nothing to find because we do not abuse young people or deny them the opportunity to complain about issues at any time.*"[562]

[553] Gregory 18 October 2018 175/25-176/10; NCC002170_34-36
[554] OFS008199
[555] OFS008206
[556] NCC002170_59-61
[557] NTP001657; L43 3 October 2018 54/25-90/15; OFS008182; OFS008180; NCC000351; NCC003542
[558] L43 3 October 2018 54/25-90/15
[559] INQ002574
[560] NCC000130
[561] NSC000105_50; NSC000473_4; INQ001712_11
[562] INQ000195

Andrew Bosworth said that this showed he was *"prepared to challenge issues in an open and professional manner"*.[563]

115. Beechwood was allowed to carry on operating dysfunctionally. Supervision of staff was negligible. The physical environment was overcrowded and unsuitable. Children were subject to bullying and harmful sexual behaviour. Margaret Mackechnie, the City's senior manager with responsibility for Beechwood, failed to address these problems. When the City took over the management of Beechwood in 1998, it should have been closed.

C.8: Response to allegations against staff at other homes

116. From 1985 onwards, there have been several allegations of sexual abuse made against staff in residential homes other than Beechwood. Although the response to allegations developed over time in line with changes to policies and procedures (see Part B), there were persistent issues that continued to arise in the handling of such matters.

117. The Inquiry received around 60 allegations of sexual abuse against staff at homes other than Beechwood in relation to the period prior to 1980, with just under half saying that they disclosed at the time.[564] There is only evidence of one member of staff being disciplined or prosecuted for the sexual abuse of children during this period.[565]

1980–1989

118. In March 1985, Michael Preston was sentenced to nine months' imprisonment for sexually abusing a resident at Three Roofs Community Home, where he had worked as a member of care staff. At his sentencing, the judge said:

> *"It appears … that the officer in charge of the children's home and other persons in the social services, were well aware of the temptations to which you were subject, and yet they took no steps to relieve you of your responsibilities in order to protect the child … It seems to me extraordinary that you were not dismissed at a much earlier stage, and on the face of it culpable responsibility for the assault lies with your superiors as well as upon you."*[566]

As a result, an enquiry was carried out by the County and a report sent to the Chair of the Social Services Committee in June 1985.[567] It found that the Officer in Charge (OIC) at Three Roofs had significant concerns about Preston's behaviour with the child, but they were satisfied that he had not known about Preston's attraction to the child. The OIC reported his concerns to his line manager, Tony Dewhurst, but was told he could not dismiss Preston.[568] The enquiry found that the OIC should be counselled but not disciplined. They found that his manager Tony Dewhurst had not been sufficiently perceptive when interviewing Preston and had failed to hear the *"distress signals put out"* by the OIC. As a result, the enquiry recommended that Dewhurst should undertake training on recruitment.[569]

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[563] INQ001895 para. 37
[564] INQ002574; INQ002577
[565] In 1975, Malcolm Henderson resigned from his post at Skegby Hall before being convicted of indecently assaulting a 12-year-old, for which he received a two-year probation order (NSC000204).
[566] INQ001215
[567] NSC000490; NSC001235 paras 3b.8, 5a.7-10
[568] NSC000490_9
[569] NSC000490_11

119. Amberdale was another community home for 22 children, which opened in 1975 and closed in 1996. In 1986, a formal inquiry was carried out after Gerry Jacobs, Assistant Principal at Amberdale, was dismissed and sentenced to nine months' imprisonment for indecent assault of a resident. The inquiry found that the abuse had "*finally opened Amberdale to scrutiny*";[570] it criticised the autocratic regime, supervision levels, and children's social care's management of the home. It made 29 proposals, including the introduction of a clear, explicit and easy complaints procedure for children.[571]

120. In September 1986, NO-F147 was dismissed from Wollaton House following an admitted sexual relationship with a 16-year-old resident. There was no prosecution as, until 2003, there was no criminal offence where there was 'consensual' sexual activity between a residential care staff member or a foster carer and a 16 or 17-year-old child in their care.[572] NO-F147's appeal against his dismissal was rejected by councillors, although they requested consideration of possible alternative employment within the Council.[573]

121. In 1987, David Marriott, a residential care worker at Skegby Hall, was sentenced to two years' imprisonment for four counts of indecent assault against two boys and was dismissed from his role.[574] Following this, Councillor Tom Butcher wrote to other councillors[575] that he had:

> "*identified two facts that I believe show a lack of urgency, even complacency, over the number of sexual offences by staff on children in their care. 1. Is the fact 7 members of Social Services staff have been involved in such offences over the past two years, and 2. after 14 months they appear to have failed to implement a Home Office circular intended to protect children.*"[576]

He asked for enquiries to be made "*about offences committed by … staff, the number of complaints received and how they are dealt with, etc*".[577] There is no evidence of a response by the County to the issues raised by Councillor Butcher. If a councillor removed from the detail of operational matters had such concerns, the Director of Social Services (at this time, Edward Culham) and senior officers familiar with the cases must have known something of the scale of sexual abuse in residential care.

122. In 1988, Dean Gathercole faced charges of sexual assault of girls at Amberdale, where he worked as a residential care worker. No evidence was offered at trial and Gathercole was discharged.[578] A disciplinary hearing accepted his account that the allegations against him were unfounded but concluded that his actions prior to the allegations had been inappropriate.[579] In May 2018, Gathercole was found guilty of six counts of indecent assault

[570] NSC000106
[571] NSC000566_9-13
[572] For example in the cases of NO-F151, NO-F143, NO-F159, NO-F413, NO-F46. In 2003 it became an offence for an adult to "*engage in sexual activity*" with a person under the age of 18 with whom they are in a "*position of trust*" (Sexual Offences Act 2003, sections 16-18).
[573] NSC000499; NSC001235 para. 5b.3-4. See below for a discussion of councillors' involvement in disciplinary appeals.
[574] NSC000212
[575] INQ000275_2
[576] The Home Office circular requiring checks on foster carers and staff with responsibility for children was eventually implemented with effect from 1 January 1988 (NSC000130; NSC000936).
[577] INQ000275_02
[578] NSC000202_3-4
[579] NSC000202_7

and three counts of rape against two girls at Amberdale in the 1980s. One of the victims had reported the abuse in 2000, at which point the Crown Prosecution Service had declined to authorise charges.[580] He was sentenced to 19 years' imprisonment.[581]

1990–2009

123. In the early 1990s, according to Diane Kingaby, who was responsible for managing several children's homes in the County at the time, children's social care managers were "*instructed to tell social workers that they should try anything to avoid their child coming into residential care as they were more likely to be sexually abused than not*".[582]

124. Between 1990 and 1995, five members of staff were dismissed from Amberdale following allegations of sexual abuse, although two of the dismissals were subsequently overturned on appeal:

124.1. In 1990, NO-F151, a residential care worker at Amberdale, was dismissed four days after she had allegedly sexually abused a male resident. She was not formally interviewed or suspended before her dismissal. A subsequent report concluded there was an "*error of not protecting a young person in our care, from the wholly inappropriate sexual relationship which took place*" and "*further questionable judgements*" after the nature of the relationship had been disclosed.[583] Staff suspicions about NO-F151's relationship with the child were not referred to senior management, case note entries recording concerns had been amended because it was felt they "*could possibly be libellous*", and there was insufficient supervision of both NO-F151 and the victim.[584]

124.2. In March 1992, NO-F158, a senior member of staff at Amberdale, was suspended following allegations of sexually abusing a resident. NO-F158 remained under suspension for almost three years and was eventually dismissed in February 1995. NO-F158's appeal against dismissal was rejected later that year.[585]

124.3. In May 1995, NO-F153 was dismissed for an inappropriate relationship with a female resident and for destroying her diary which contained entries relating to that relationship.[586] Another member of staff, NO-F37, was dismissed for removing the child's diary, which also included allegations against him. At the time Amberdale "*was an establishment in some crisis*"; there had been "*a breakdown of trust between management and some staff*".[587] After an appeal to councillors, NO-F37 was reinstated with a final warning.[588]

124.4. In August 1995, NO-F161 was dismissed following allegations of sexual abuse of a resident, having earlier been acquitted at trial in October 1994. Sandra Taylor, who chaired NO-F161's disciplinary, wrote to Stuart Brook (the County's Director of Social Services at the time[589]) setting out various issues "*which give me cause for grave*

[580] CPS004384
[581] INQ003771
[582] INQ002957
[583] NSC000220_19
[584] NSC000220_1-20
[585] NSC000951; NSC000512; NSC001431
[586] NSC000500
[587] NSC000231; NSC001430
[588] NSC000231
[589] Stuart Brook had only recently taken over from David White, who had resigned in July 1994 in the wake of the publication of *Strong Enough To Care?* Chief Executive's Working Party, July 1994 (NSC000241).

concern as to the welfare and safety of children in the care of the authority".[590] These included: (i) lack of knowledge and adherence to child protection procedures amongst residential care staff at all levels; (ii) lack of attention given to the wellbeing of the complainant; and (iii) the fact that although one of the complainants had disclosed abuse on three occasions previously, none of the disclosures had been properly recorded or investigated. Although there is no evidence of a formal response to Sandra Taylor's letter, steps were taken by the County over the next five years to improve its recruitment, selection and training of staff.[591] NO-F161's dismissal was later substituted for a final warning by councillors on appeal in March 1996 and he was re-employed in a different post.[592]

125. Sandra Taylor also highlighted the fractious relationship between children's social care management and trade unions. During NO-F161's disciplinary hearing, children's social care was criticised by a trade union representative for taking a positive "'*child centred' approach*" and placing the interests of the child above the interests of staff.[593] Stuart Brook described the relationship as an "*exceptionally difficult*" one.[594] He recollected that a "*culture of opposition*" lasted through the mid-1990s and "*delayed progress*".[595]

126. During the same period, following an inspection of Amberdale, an SSI report in March 1993 raised concerns about the time taken to progress disciplinary issues.[596] A "*radical change*" was sought. The SSI maintained that staff should be suspended automatically following allegations of abuse made against them, but David White, the County's Director of Social Services, thought this unrealistic "*in the light of the number and nature of allegations made*" and that with each allegation "*the Service Manager investigating will consider the appropriate manner of keeping child and staff member out of contact while inquiries are made which will include considering suspension or temporary movement to another Unit*".[597] In June 1995, the SSI conducted another inspection, concluding that young people were not at risk at the time of the inspection, but that the unit was performing very poorly.[598] The SSI recommended that Amberdale be closed. It was closed in 1996.[599]

127. Other significant cases during the early 1990s included:

127.1. In 1992, an internal enquiry was carried out by two children's social care managers after the conviction the previous year of Norman Campbell for buggery and indecent assault of children in residential care.[600] Campbell had been a residential care worker and foster carer in the County in the 1980s. The enquiry report was critical of the County's approach to a disciplinary investigation into previous allegations, in 1988. There was an apparent "*lack of understanding about the behaviour of sexual abusers and victims of sexual abuse*". Additionally, the concerns of members of staff about Campbell's behaviour and relationships with children had been dismissed.[601] The report concluded that it was "*unfortunate that the disciplinary process, as it related to Norman Campbell,*

[590] NSC000189_42-49
[591] INQ002480 para. 21E
[592] NSC000189; NSC001433; NSC001235 para. 5j.7
[593] NSC000189_48-49
[594] INQ002480 paras 5.62-5.63
[595] INQ002480 para. 5.63
[596] NSC001162
[597] NSC001162_2
[598] NSC001155
[599] It subsequently reopened as Clayfields in 1997.
[600] NSC000506. Issues relating to foster care are addressed in Part D.
[601] NSC000103_22ff

could be criticised as having the effect of protecting its senior managers and ultimately the Department from the repercussions of acting on their beliefs about him".[602] The authors suggested that lessons could be learned by a second, external, enquiry reviewing the County's management of its staff working with children in care.[603] David White decided against it, but was unable to explain to us why he did not take up the opportunity to do so.[604]

127.2. An October 1993 enquiry into events at Hazelwood Community Home during the period 1979 to 1985 found that children's social care had been "*more dedicated to the furtherance of staff employment rather than the care and protection of children*". There was an "*over-emphasis on the criminal process*" and police investigations,[605] despite procedures requiring that child protection investigations and disciplinary procedures be considered separately.[606] In particular, the report identified a failure to properly notify the Department of Health of persons deemed unsuitable to work with children[607] and a failure to follow through with disciplinary proceedings where there had been a decision not to prosecute or where an employee had resigned prior to the conclusion of disciplinary proceedings. It was noted that "*Allegations made by children towards members of staff at the moment are dealt with on an individual basis*" and there was no overall evaluation. Between June 1992 and February 1993, there had been 14 known allegations against staff of abuse in community homes which pointed to a clear need for "*rigorous Departmental oversight of these matters*".[608] The report recommended that all allegations of staff misconduct towards children needed to "*be monitored and reviewed, and that this be carried out in one place – Social Services Personnel.*"[609]

127.3. In December 1994, NO-F162, who worked at Wollaton House, resigned before the conclusion of a disciplinary hearing following alleged sexual abuse of a female resident.[610] The disciplinary process was not seen through to a conclusion, despite the need for this being highlighted in the Hazelwood report the previous year.[611]

128. Until 2010 in the City[612] and 2017 in the County,[613] appeals against disciplinary sanctions for residential care staff – including for child sexual abuse – were heard by councillors. Rod Jones (Senior Professional Officer (Child Care)) recalled that in the 1970s and 1980s successful pursuit of disciplinary proceedings was sometimes made more difficult by the councillors, who "*took a staff centred approach rather than one which put children and*

602 NSC000103_35-36
603 NSC000103_36
604 NSC000154_59; White 8 October 2018 180/9-181/10
605 NSC000105_42
606 NTP001473_67
607 In October 1993, the County did write to the Department of Health with a list of 10 former staff members who had been dismissed or had resigned in relation to allegations of child sexual abuse, asking for them to be entered on a file of "*persons deemed unsuitable for work with children and young people*" (Gerald Jacobs, Norman Campbell, NO-F142, NO-F143, NO-F147, NO-F148, NO-F149, NO-F150, NO-F151 and NO-F152) (NSC000234_30-34; NSC001235 para. 5h.8).
608 It is likely (but not explicit) that this figure included allegations of physical abuse.
609 NSC000105
610 NSC000473
611 NSC000105_50
612 NCC003691 para. 7.8
613 NSC001235 para. 5b.10, 6g.2

vulnerable people first",[614] and that such decisions had "*a marked effect on the confidence of managers to deal with errant members of staff*".[615] We have seen examples of cases in which councillors overturned dismissals for child sexual abuse and substituted a warning.[616]

129. Rod Jones told us that a culture of protecting staff "*was very much the case in the late '70s and the early '80s*", persisting until the late 1990s.[617] Helen Ryan, a County Investigative Officer in the mid-1990s, recalled how it was "*not unusual for residential managers at all levels to see protecting and supporting staff as their priority*".[618] In terms of councillors overturning disciplinary decisions on appeal, Rod Jones was "*very aware … that assistant directors would come back from disciplinaries saying, 'That was a waste of time. They're not supporting us. They're taking a personnel line'.*"[619] In the Hazelwood report, one recommendation was to review disciplinary processes to ensure that "*the personnel/employee oriented bias is addressed*".[620]

130. In 1995, the County took steps to respond to some of these matters by establishing two posts of 'Investigative Officer' to conduct staff disciplinaries and other investigations.[621] Stuart Brook acknowledged this was "*in direct response to … the increase in the number, complexity and range of investigations*", recommendations from recent reports, and the 164 staff disciplinaries[622] over the previous three years, with the majority involving alleged abuse or malpractice by staff.[623] It was hoped that the posts would provide a "*central management perspective*" on investigations.[624] Previously, disciplinaries were conducted by different service managers across the County's nine different districts, leading to "*a lack of consistency across the whole department*".[625]

131. In January 1996, following NO-F162's conviction and imprisonment for physical abuse, Rod Jones (then the County's Head of Children and Family Policy) wrote to Stuart Brook highlighting several lessons relating to NO-F162's case, including the need:

- following allegations of abuse, to "*consider whether there is a need for wider investigations*" and "*ongoing monitoring of risk to children*";
- for a managerial decision where a staff member resigns before the conclusion of a disciplinary investigation; and
- where a child retracts a serious allegation, to get a report to assess possible influences.[626]

There is no evidence of a formal response to the letter. Stuart Brook said the points raised by Rod Jones were already set out in guidance to staff at the time.[627] Further, a seminar on 'Liability, Prevention, Apologies' was held by the County in January 1998, attended by various managers within children's social care and from the County's legal, service standards and risk and insurance teams. The seminar reiterated the lessons identified in Rod Jones'

[614] INQ002007 para. 35.2
[615] INQ002007 para. 33.20
[616] NO-F204 (1979), NO-F37 (1995), NO-F161 (1996), NO-F163 (1999), NO-F46 (2000).
[617] Jones 8 October 2018 98/17-99/14
[618] INQ001799 para. 1.28
[619] Jones 8 October 2018 98/14-99/14
[620] NSC000105_50
[621] NSC000944_9-20
[622] This figure appears to relate to the whole of the County's Social Services Department and therefore would not have been limited to allegations involving children.
[623] NSC000944_9-15
[624] NSC000944_9-15
[625] Brook 24 October 2018 17/19-18/22
[626] NSC000473_1-5
[627] INQ002480 para. 30

memo from January 1996, including the need to consider wider investigations, the approach to take when a staff member resigned before the conclusion of an investigation, and the approach to retractions.[628]

132. There were several other disciplinary investigations into alleged child sexual abuse by residential care staff from 1990 to 1997, including:

132.1. The dismissal and conviction of Steven Carlisle in November 1990 on three counts of indecent assault against children in care at Woodnook. Previously, following a disciplinary hearing in September 1989, there had been no further action taken due to insufficient evidence.[629]

132.2. Five dismissals of residential staff following allegations of child sexual abuse between 1990 and 1994.[630]

132.3. Four resignations (one each in 1990 and 1991, and two in 1997) following allegations of child sexual abuse. In only one of these was the investigation concluded after the resignation.[631]

132.4. NO-F163's dismissal being substituted for a final warning on appeal in 1999.[632] He had previously been investigated in 1993, with no further action taken.

132.5. Three formal warnings (one in 1992, two in 1995) and one final written warning in 1997.[633] In the latter, NO-F413 was not dismissed because "*in 1983, there was a lack of clear guidance given to* [him] *as to the role of a houseparent*" and "*there may have been a lack of clarity about the boundaries of relationships at that time*".[634]

132.6. Two cases (in 1996 and 1997) in which no further action was taken.[635]

133. In 1997, the County produced a report on the *Safety of Children in Public Care*,[636] which noted that there was still no system in place (10 years after Councillor Butcher raised the issue, and four years on from the same recommendation in the Hazelwood report) for collating details of the number of investigations of alleged abuse concerning foster carers or residential workers.[637] Stuart Brook thought that the issue of collating investigations was addressed following investment in an *"integrated child care system"*.[638] We have not seen any evidence of the collation of allegations or of steps taken to identify trends or patterns of abuse.

[628] INQ001712; INQ001714
[629] NSC000507
[630] NSC000504_4; NSC000371; NSC000508; NSC000195; NSC000485
[631] NSC000234; NSC000486; NSC001332; NSC000493; NSC000496
[632] NSC000513
[633] NSC000482; NSC000503; NSC000491
[634] NSC000491
[635] NSC000487; NSC000492
[636] This report was produced in response to the requirement of Sir Herbert Laming to review provision and safeguarding processes across the country.
[637] INQ002480 paras 6.15-6.18
[638] INQ002480 para. 6.19

134. Following the local government review in 1998, the County and the new City Council each took sole responsibility for the children's homes within their area. There were far fewer disciplinary investigations into allegations of sexual abuse in residential care than in the previous decade.[639] In five cases in which there were disciplinary investigations, there were decisions to take no further action (two in 1999, and one each in 2000, 2003 and 2006).[640]

135. In November 2000, NO-F46 was dismissed following an investigation by the City which found that he had a sexual relationship with a resident of Redtiles both in 1991 and subsequently after she had left the home. The dismissal was overturned on appeal and NO-F46 was reinstated with a final written warning.[641] There were concerns about the way in which a previous investigation into NO-F46 had been conducted by the County.[642]

136. In 2003, a report into Edwinstowe Hall Community Home[643] looked at non-recent allegations of sexual and physical abuse.[644] This is the only report prior to 2011 that had sought to evaluate the extent of abuse over a lengthy period in a children's home. It concluded that there had been no pattern of abuse at the home and that the number of allegations was no higher than would have been found in any establishment over a 30-year period. A disciplinary investigation into non-recent allegations of sexual and physical abuse against a member of staff there, NO-F41, concluded with a decision to take no further action.[645]

2010 onwards

137. In May 2011, NO-F1, who previously worked at Beechwood and Ranskill Gardens, was dismissed for a relationship with a former resident, then aged 23, including sending her sexually explicit text messages.[646] An allegation that NO-F1 had sex with the young person when she was in the care of the City was not upheld.[647]

138. In 2014, NO-F190 (a support worker at a privately run children's home) was dismissed following allegations of child sexual abuse.[648] In September 2015, NO-F190 was acquitted on all of the charges against him.[649]

139. One of the recent convictions arising from Operation Equinox was of Myriam Bamkin in June 2018 for abuse whilst she was a residential care worker at Amberdale in the late 1980s. When the allegations were made in 2016, Ms Bamkin still worked for the County, but held the role of Fostering Team Manager, from which she was then suspended. During that suspension, in May 2017, Ms Bamkin resigned.

140. Contrary to the Council's own guidance since the 1990s, no disciplinary investigation was carried out and no conclusion reached, either prior to Ms Bamkin's resignation or after her conviction. At least, after she was convicted, the County should have come to a formal

[639] This may be due to a lower residential care population. For example, in 1990 there were 380 children in residential care in the County (NSC000438_019), whereas in 2005 the County only had 14 places in residential care (NSC000702_3). It may also be due to improvements in vetting and the recruitment of staff (NSC001235 paras 6a.18-6a.27).
[640] NCC000125; NSC000214; NCC000332_2-3; NSC000209; NSC000175; NSC000174_5-6
[641] NCC000610; INQ002438_10-11
[642] NCC000610_1-3
[643] This operated as a residential care unit for children of mixed ages from 1967 to 1994 (NSC000108_3).
[644] NSC000108
[645] NSC000489
[646] It was noted that the City had responsibility for young people up to the age of 25.
[647] NCC000127; NCC002300
[648] NCC000189; NCC000190
[649] CPS004382 paras 552-556

conclusion that if she had not resigned, she would have been dismissed for gross misconduct. This approach was taken by the County as far back as 1990 (NO-F142)[650] and 1997 (NO-F164).[651] The County referred Ms Bamkin's case to the Health and Care Professions Council (HCPC) in 2016. As at April 2019, the HCPC had not yet made a determination about her fitness to practice.

141. Although there have been far fewer reported cases in recent years, the author of a 2011 serious case review into the death of a young person in the care of the City echoed the evidence of David White about the County's approach in the early 1990s:[652]

> "*The assumption cannot be made that because a child is Looked After by the Local Authority that they are safe or that their needs are being fully met … Professionals, including carers themselves, need to be prepared to think the unthinkable, and recognise that Looked After Children may be abused whilst in care and are very unlikely to disclose such abuse.*"[653]

City Council Historical Concerns Project

142. In an example of a recent attempt to look broadly at allegations of abuse against staff, in November 2014, the City initiated a Historical Concerns Project to review the employment records of current and former employees (and so not foster carers) who had worked with vulnerable groups "*to identify patterns of behaviour that may be of concern*".[654] Alison Michalska said that when she took up her appointment, she was uncomfortable not knowing who might historically have posed a risk to a child or who might currently be a risk to a child.[655]

143. The final report,[656] published in June 2016, noted:

143.1. 75 current employees and 60 former employees were rated as high or medium risk;

143.2. four current employees and 24 former employees were the subject of allegations or concerns about sexual abuse of children;[657] about 15 related to children in care (one current employee and about 14 former employees);

143.3. 14 current employees received disciplinary sanctions to "*better safeguard service users*", some of which took into account previous misconduct where this suggested a pattern of inappropriate behaviour;

143.4. 12 former employees were referred to the Disclosure and Barring Service and a number were subject to police enquiries and were progressed for investigation by the City; and

143.5. that "*as a result of the review of historical employment records, the Council should have a high degree of confidence that appropriate action has been taken in respect of individuals that have and potentially could cause harm to vulnerable service users*".

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[650] NSC000504
[651] NSC000493
[652] White 8 October 2018 147/24-148/-5
[653] NCC003788_105, 136
[654] NCC000340
[655] Michalska 25 October 2018 80/6-11
[656] NCC000340
[657] NCC003708

144. This review was a positive step to have taken and appears to have provided some reassurance that alleged perpetrators did not simply evade scrutiny because of bad practice applied at the time.

145. The level of abuse at Beechwood was serious and prolonged. Sexual abuse of children in residential care was also widespread in the Councils' other children's homes, particularly in the 1980s and 1990s. The abuse was never properly addressed by the Councils.

Part D

Case study: Foster care

Case study: Foster care

D.1: Introduction

1. The investigation's second case study examines the institutional responses to allegations of child sexual abuse in foster care in the Councils as well as the barriers to disclosure of those allegations.

2. Fostering is the provision of care in a family home to a child unable to live with their own parents. For many years, it has been regarded as the preferred placement for the majority of children in care. It can take many forms, including emergency, short and long-term placements, short breaks, family and friends (kinship) care,[658] fostering for adoption, and specialist therapeutic care.[659] A local authority placing a child with foster carers has a continuing statutory duty to safeguard and promote the child's welfare.[660] Where a child is in foster care but not in the care of the local authority, this is generally known as 'private fostering'.[661]

D.2: Allegations of abuse

3. Over the last 40 years, 10 foster carers in Nottinghamshire have been convicted of sexual abuse against children in their care,[662] whilst four have been acquitted and several others deregistered following allegations. The Inquiry has received 75 individual accounts of sexual abuse in foster care in Nottinghamshire over this period, primarily drawn from statements and interviews given to the police and from investigations by the Councils.[663] Additionally, 23 complainant core participants made allegations of sexual abuse in foster care,[664] five of whom gave evidence at the public hearings.

4. The Inquiry received a number of accounts about abuse in foster care, including:

4.1. P2 was in foster care in the 1960s. She was raped by her foster father on two separate camping holidays with her foster family.[665]

4.2. P7 described regular sexual abuse by NO-F277 in a private foster placement from the age of eight until she left the home aged 26. She came to accept that the sexual abuse – which included rape – was part of her life.[666]

[658] Formal kinship care is when a child in the care of the local authority is placed with a relative or another adult connected to the child. This can include grandparents, siblings, godparents or close family friends.
[659] http://www.gov.uk/foster-carers/types-of-foster-care
[660] Children Act 1989 _section 22
[661] Private fostering is where a child is cared for by someone who is not their parent or relative and is arranged between a parent and a carer. It has been subject to regulation by local authorities under the Foster Children Act 1980 and subsequent statutory regulations in 1991 and 2005. It has been subject to *National Minimum Standards* since 2005.
[662] Bernard Holmes, Michael Chard, NO-F141, Norman Campbell, NO-F64, Douglas Vardy, Patrick Gallagher, NO-F77, Stephen Noy and Christopher Metcalfe. There have also been three foster carers convicted of sexual offences against children not in care (NO-F106, William Boden and Raymond Smith), and two relatives or friends of foster carers convicted of sexually abusing children in foster care (NO-F119 and Robert Thorpe).
[663] INQ002575
[664] INQ002574
[665] INQ002574
[666] P7 4 October 2018 112/18-122/22

4.3. L45 was sexually abused in foster care by NO-F57 in the late 1970s when she was around 10. She was also abused by Robert Thorpe, a friend of the foster family, both in the foster home and when she was moved to Beechwood, aged 14. She disclosed the abuse to staff, but despite this he continued to visit her and to rape her. Thorpe was convicted in 2009 of four counts of indecent assault and five counts of unlawful sexual intercourse against her, and sentenced to five years' imprisonment.[667]

4.4. During her foster placement in the 1970s, L47 was regularly indecently assaulted by her foster father, NO-F276.[668]

4.5. P13 was sexually abused by the 21-year-old brother of his foster mother when he was in foster care between 1979 and 1981. He forced P13 – then aged 11 – to masturbate him and perform oral sex on him, and on other occasions he lay behind P13 and simulated sex.[669]

4.6. F37 was sexually and physically abused by NO-F235, her foster carer, in the 1970s and 1980s from when she was a young child until she was 15. NO-F235 regularly touched F37 indecently and went on to rape her.[670]

4.7. L48 was aged six when he and his brother were placed with NO-F275 and NO-F358. In addition to regular physical abuse, L48 was made to touch NO-F275's penis.[671] In his next foster placement, aged 11, L48 was indecently assaulted by NO-F276, culminating in attempted anal rape.[672]

4.8. L35 was in foster care in the 1980s. Her foster carer NO-F116 would touch her between the legs. She added: "*He never forced himself onto me but would make me touch his penis, and him touch me. NO-F116 would hit me with the belt if I refused to do so.*"[673]

4.9. L37 was placed with a foster family in 1986. One of the foster carers, NO-F36, digitally penetrated her in the bath. Two sons of NO-F36 digitally penetrated her, inserted objects into her anus and raped her.[674]

D.3: Background

5. Since the 1950s and until at least 1990 the County had a consistently higher percentage of children in foster care than comparable local authorities.[675] In 1975, 40 percent of the 2,082 children in the care of the County were in foster care[676] and by 1999 this had risen to 64 percent of children in care.[677] This rose further to 86 percent in 2003[678] but reduced to

[667] INQ002574
[668] INQ002574
[669] INQ002574
[670] F37 3 October 2018 94/20-139/8
[671] L48 4 October 2018 10/14-11/8
[672] L48 4 October 20/21-21/19
[673] INQ002574
[674] INQ002574
[675] NSC000438_23 para. 20; NSC001235 para. 3c.ii.2
[676] NSC000914_12
[677] NSC000920_1
[678] NSC001167 para. 3.8

63 percent in 2018.[679] In the City, 69 percent of children in care were placed in foster care in 2004,[680] rising to 73 percent in 2018.[681] The same proportion (73 percent) are in foster care across England.[682]

6. Both Councils have used independent fostering agencies (IFAs, ie private and voluntary providers of foster care)[683] since the 1990s to supplement local authority foster carers. By 2018, 43 percent of children in foster care in the County and 52 percent in the City were placed with IFAs.[684] Foster carers working with IFAs are subject to the same levels of assessment, supervision and training as local authority foster carers.[685]

D.4: Developments in foster care

7. The County undertook its first significant review of fostering services in 1975. The review recommended a co-ordinated approach across the County, an 'examination' of the recruitment and selection process of foster carers and of the level of support given to existing foster carers, and the introduction of a professional foster carer scheme.[686] The County subsequently created a dedicated fostering unit,[687] to recruit, train and support foster carers and to match children to carers. This was followed by guidance in 1979 on 'The recruitment, selection and support of foster parents'.[688]

8. During the 1970s and 1980s, the County provided group home fostering, in which foster carers would care for up to 19 children at a time,[689] even though the 1975 review cautioned against reliance on such homes.[690] One witness characterised these as "*unregulated and unofficial children's homes*".[691] In 1989, a joint police and children's social care report in the County recommended that, "*wherever possible*", children who had been abused should not be placed together and that the use of family group foster homes should therefore cease.[692] Between 1975 and 1989, at least two group home foster carers were subject to allegations of sexual abuse.[693]

9. In May 1996, the County examined the provision of alternative family care services, including fostering and adoption. It concluded that "*the current system is not working well enough … no change is not an option*";[694] there was a need for "*consistent good practice from all child care teams*".[695] However, a "*significant number of recommendations*" had not been implemented by the time of a follow-up review in 1999.[696]

[679] NSC001235 para. 1.3; NSC001474 para. 4f.1
[680] Children looked after at 31 March by placement, 2004 to 2006 (Table 4)
[681] NCC003691 para. 3.135
[682] Children looked after in England, year ending 31 March 2018, p7
[683] INQ002431 para. 91
[684] NSC001474 para. 4f.1; NCC003807 para. 3.9
[685] Fostering Social care common inspection framework (SCCIF): independent fostering agencies
[686] NSC000526_1; 17-19
[687] NSC000447_3-5
[688] NSC001235 para. 6k.2
[689] NSC001235 paras 3c.ii.7-8; NSC000521_80-86
[690] NSC000526_1; 17-19
[691] INQ002608 para. 6(c); Jones 8 October 2018 32/11-33/6
[692] Joint Enquiry Team Report part 5, recommendation 11
[693] NSC000371 (F141); NSC000432 (F116 and F117).
[694] NSC000931_4-5
[695] NSC000931_7
[696] NSC000920_1-7; NSC000945

10. Until 2000, the County devolved fostering services to a number of localities,[697] resulting in apparently differing responses to allegations across the County.[698] For instance, there are examples in Newark of a more child-centred approach,[699] whilst in Mansfield the approach taken in some cases appeared to be more focused on the interests of the foster carers.[700] In 2000, the management of the County's fostering teams was centralised within the County's Regulated and Corporate Parenting Services.[701]

11. Following the 1998 local government reorganisation, many carers living in the City area chose to continue to work with the County, creating for the City an "*immediate shortage of placement availability and choice for children in care*".[702]

12. From 2002, the Councils were subject to national minimum standards relating to their management of fostering services.[703] New national fostering service regulations came into force in 2002 and 2011,[704] as did regulations on statutory visits.[705] A new external inspection regime was also introduced, as discussed below.

Recruitment

13. From the late 1970s onwards, prospective foster carers applied to the County in writing, with references. Their assessment over three months included a series of interviews. Two social workers prepared assessment reports, the relevant fostering panel made a recommendation and a senior manager made the final decision on approval.[706] If successful, foster carers would be 'registered', usually with placement criteria recorded such as the age range of children, their previous history (for example, in some instances foster carers would specify that they would not want to take children who had been sexually abused) and the length of placement. In some cases, selection criteria and standards were not followed.[707]

14. In the last 20 years closer scrutiny has been applied to applicants' background history and to their motivation for fostering.[708] Reference checks became more wide ranging, including interviews with ex-partners and children formerly cared for by the applicants. It is now standard to explore with prospective foster carers the possible motivation for wanting access to children as well as the extent of empathy towards abused and vulnerable children.[709] After approval, a risk assessment is carried out to identify the child's needs and match them with foster carers. Where a child has been abused or has previously abused others, children's social care will try to obtain a lone placement to reduce risk.[710]

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[697] From 1974, 13 areas (six in the City and seven in the County) – NSC001235 paras 3c.i.7, 3c.i.9, 3c.i.10 – then from 1992 to 1998, nine Districts – INQ002007 para. 1.11.
[698] INQ002007 paras 27.8-27.10
[699] For example, NO-F111 (NSC000433_1-25, 40-48).
[700] For example, with NO-F108 and NO-F77 (Austin 19 October 2018 117/8-118/25).
[701] NSC000003_13-14
[702] INQ001984 para. 2.2
[703] *Fostering Services: National Minimum Standards* (2002)
[704] The Fostering Services Regulations 2002; The Fostering Services (England) Regulations 2011
[705] The Care Planning, Placement and Case Review (England) 2010 and The Care Planning and Fostering (Miscellaneous Amendments) (England) Regulations 2015
[706] NSC000447_3-5; NSC000002_67; NSC000351. This is now done by a countywide fostering panel and the final decision is made by an 'Agency Decision Maker' (NSC000972 para. 30; Blackman 17 October 2018 151/18-152/6).
[707] NSC000526_1; 17-19
[708] NSC000003 para. 133; NSC000002 paras 325-326: see also NSC000002_67-70
[709] NSC000002_67-70
[710] Austin 19 October 2018 108/2-18

Training and standards

15. By the mid-1980s, training was offered to foster carers but it was not mandatory.[711] There was a reluctance to engage in training by some foster carers who were subsequently found or alleged to have sexually abused children in their care.[712] Even in the 2000s, a reluctance to take up training was not a bar to continuing to foster, particularly if foster carers were experienced.[713]

16. All foster carers must now undergo induction training, meet certain standards within 12 months of approval and undertake ongoing training, which includes keeping children and young people safe from harm.[714] Sonia Cain, the City's Fostering Service Manager, thought that there should be more mandatory training.[715]

17. Since 2000, there has been a career pathway for approved foster carers in the County with increased payments according to evidence of learning and skill. The City has an accreditation scheme to support improved training and reward those foster carers who accommodate children requiring higher levels of skill or support.[716]

18. Since the Care Standards Act 2000, foster carers have been subject to national minimum standards.[717] These require "*the child's welfare, safety and needs*" to be at the centre of all decisions regarding their care.[718] When Jayne Austin became the County's Fostering Service Manager in 2002, she found instead an emphasis on the carer's needs.[719] By contrast, when inspecting the County's fostering services in 2004, the Commission for Social Care Inspection (CSCI) noted the then "*child-centred*" approach of its fostering panel.[720]

Supervision and review of foster carers

19. In the 1970s, a child's social worker would supervise both the child and their foster carers. As the social worker's primary concern was the child's welfare, this often resulted in foster carers feeling unsupported.[721] By the late 1980s, foster carers were allocated a separate fostering support worker (or 'supervising social worker') who provided support for the foster carers as well as scrutinising their skills and practice. Since 2002 there has been mandatory professional supervision of foster carers[722] and supervising social workers have been required to conduct at least one unannounced visit to foster homes each year.[723]

20. All foster carers have been subject to an annual review by the Councils since 1991,[724] which initially consisted of a team manager's review of the supervising social worker's report.[725] Since 2002, reviews have included a meeting between the carers and fostering team managers.[726] Annual reviews have been carried out since 2016 by a fostering

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[711] NSC000002_71-72. Between 2002 and 2011 it was "*expected*" (NSC000002_30).
[712] For example, Patrick Gallagher (see NSC000002_27), NO-F127, NO-F111.
[713] NSC000002_71-73
[714] Fostering Services (England) Regulations 2011, Regulation 17; *Fostering Services: National Minimum Standards; Training, Support and Development Standards for Foster Care*
[715] Cain 19 October 2018 30/11-31/7
[716] INQ001984 para. 13.4
[717] The current standards being set out in *Fostering Services: National Minimum Standards*, Department for Education, 2011.
[718] DFE000962_13; *Fostering Services: National Minimum Standards*, Department for Education, 2011
[719] Austin 19 October 2018 100/21-102/18
[720] NSC000967
[721] NSC000357_8
[722] NSC000003_13; NSC000002_70
[723] *Fostering Services: National Minimum Standards*, Department for Education, 2011 – see standard 21(8).
[724] Foster Placement (Children) Regulations 1991, Regulation 4.
[725] Austin 19 October 2018 103/15-104/4
[726] NSC000002_118-119

independent reviewing officer[727] (with further reviews if any allegations are made). Children's views of placements – including the foster carers' biological children – form part of the annual review.[728]

Visits to children in foster care

21. From 1955, social workers were required to visit foster homes once every two months in the first two years of placement, and every three months thereafter.[729] This was the primary check on the quality of care that children were receiving. However, several complainants, who were in foster care in the 1960s, 1970s or 1980s, told us that they were not visited on a regular basis, if at all.[730] Social workers were also required to carry out reviews of the child's welfare every six months.[731]

22. From 1991, the frequency of social work visits increased, with an initial visit after one week, and then every six weeks for the first year and every three months thereafter.[732] The expectation was that social workers would speak to the child alone, without the foster carers present, to give the child the opportunity to raise any issues. Team managers would check whether this had been done.[733]

23. Steve Edwards (the County's Service Director for Youth, Families and Social Work) and Sonia Cain were confident that social workers now see children alone in the County and City.[734] Since 2010, regulations have required that a child in care must be visited every six weeks unless the placement is long term.[735] In long-term placements, visits need only to be every three months (or every six months, after the first 12 months in the placement, if the child consents to this).[736] The Councils' visiting standards go slightly further than the six-week minimum required by regulations, requiring more frequent visits for long-term placements.[737]

Out-of-area placements

24. The use of out-of-area placements – where a child in the care of one local authority is placed within another authority's geographical area – is widespread across England and Wales and is subject to DfE statutory guidance.[738] Placements should be as close to the original local authority as possible, so that greater support can be provided.[739] In the past, where a child was placed in an out-of-area foster home it was common for the authority in which the child was placed to be asked to visit the child, but this is now less frequent. Under

[727] A fostering independent reviewing officer works for the local authority, but without line management responsibility for the supervising social worker or the foster carer (Edwards 23 October 2018 137/6-15; Cain 19 October 2018 34/21-35/5; NSC001235 para. 3c.iii.19).
[728] Cain 19 October 2018 32/10-35/5; Austin 19 October 2018 106/15-21
[729] From the Boarding-Out of Children Regulations 1955, which remained in force until they were replaced by the Boarding-out of Children (Foster Placement) Regulations 1988
[730] F37 3 October 2018 95/19-96/19; L48 4 October 2018 9/19-22; INQ002574 (L47, P1, L49); INQ002575 (NO-A184). The Gallagher Serious Case Review found that children did have opportunities to see professionals on their own in the 1990s and 2000s, but these professionals frequently changed (NSC000002_84 para. 422).
[731] Boarding-Out of Children Regulations 1955, Regulation 22; Boarding-out of Children (Foster Placement) Regulations 1988, Regulation 8
[732] Foster Placement (Children) Regulations 1991
[733] Cain 19 October 2018 8/1-9/24
[734] Edwards 23 October 2018 145/9-21; Cain 19 October 2018 8/1-9/24
[735] Those children in a placement in which they are expected to remain until the age of 18.
[736] The Care Planning, Placement and Case Review Regulations 2010 – see regulation 28.
[737] NCC003807 para. 3.3; Michalska 25 October 2018 65/9-66/21; Nottinghamshire County Council – Social Worker Visits to Looked After Children
[738] Out of Authority placement of looked after children: supplement to the Children Act 1989, DfE, July 2014
[739] Cain 19 October 2018 19/23-22/23

current practice, the child will retain their social worker, who will continue to conduct the required regular visits. Sonia Cain told us that fostered children who move out of the City may not be visited *"as frequently as they should"*.[740]

25. When City foster carers move to another area,[741] the City notifies the relevant local authority and will discuss support and training for the foster carer with that authority's fostering team.[742]

D.5: External inspections

26. Until 2013, fostering services were inspected independently of other children's services and against national minimum standards set out in legislation.[743] Between 2004 and 2011, the Councils' fostering services received broadly positive assessments from these external inspections.

26.1. CSCI's inspection of the County in 2004[744] was positive. It found *"clear lines of management"* and the use of risk assessments to keep young people safe and minimise risk. A guide for children in placements, including a section on how to raise concerns, was *"excellent"*. The County kept a *"centrally collated management system of numbers and outcomes of allegations of neglect or abuse of a child in foster care"*.[745] Serious incidents and child protection issues had, where required, been notified to the National Care Standards Commission (NCSC). Foster carers found training to be *"excellent"*.

26.2. The City's fostering service received a similarly positive report from the CSCI in 2005,[746] meeting all eight standards concerning the welfare of children in foster care. All foster carers had completed child protection training prior to approval.

26.3. In 2006, the County was found to have met the majority of the standards on which it was assessed.[747] Assessment and reviews of foster carers were completed to *"a high standard"* and there were increasing training opportunities (including on safeguarding and caring for abused children). However, recording of information by carers was *"wholly inappropriate"*.[748] The City was advised to ensure all foster carer placements had been adequately assessed and approved, and to provide better support to carers located outside Nottinghamshire.[749]

26.4. In 2008, the County's service was rated 'satisfactory' by Ofsted, but with concerns raised about record keeping and record management. The fostering panel was now independent and there were risk assessments in relation to bedroom-sharing arrangements for young people who had been abused or had abused others, alongside *"robust"* initial risk assessments for all children placed with foster carers.[750] The City's

[740] Cain 19 October 2018 23/17-25/14
[741] We did not hear specific evidence from the County on this point, as we did not receive any allegations of recent sexual abuse in out-of-County foster placements.
[742] Cain 19 October 2018 19/23-22/23
[743] *Fostering Services: National Minimum Standards* (2002), published under sections 23 and 49 of the Care Standards Act 2000 and alongside the Fostering Services Regulations 2002
[744] NSC000967
[745] Introduced following the Children Act 2004 – see Austin 19 October 2018 114/9-19. We have not seen evidence of the existence of this management system.
[746] OFS008047. Of the 21 national minimum standards assessed, they met 14, partially met five and did not meet two.
[747] NSC000956_29. They met or exceeded 18 out of 22 of the national minimum standards assessed.
[748] NSC000956_28
[749] OFS008049; OFS008050
[750] NSC000964

service was rated as 'good', with new policies on managing allegations, although central records relating to allegations and complaints did not contain sufficient detail. For example, dates of allegations and outcomes of investigations were not recorded.[751]

26.5. By 2011, the County's fostering service had improved to 'good'. Allegations were being taken seriously and placement planning, risk assessments and safe caring policies were 'good'.[752] The City's fostering service was also rated as 'good'.[753]

27. Since 2013, Ofsted has inspected children's services as a whole, rather than fostering services as a separate function.[754]

27.1. In 2014, the City was rated 'requires improvement' overall. Specific criticisms of its fostering service included insufficient information provided to foster carers about children being placed with them, and a need to ensure "*there is sufficient technical knowledge and expertise*" within its fostering and adoption service.[755]

27.2. The County's 2015 inspection[756] found most children to be living in stable placements and cared for by skilled foster carers. The fostering panel was "*effective*", with members receiving annual appraisals and performance development plans.

27.3. In November 2018, shortly after the conclusion of the Inquiry's public hearings, the City was rated as 'requires improvement' across its children's social care services.[757] In relation to fostering, Ofsted found that "*A small group of very young children have been left vulnerable in unsuitable private fostering arrangements*" with insufficient management oversight. Children's needs were said generally to be met, but those with complex needs experienced too many moves before finding stability. Plans to increase the range of local foster carers were progressing well, but decisions on matching them with children were not well recorded. By contrast, foster carers were supported well and were assessed to be of a high quality. Carers valued their supervising social workers and the quality of training and support provided.

27.4. A 2019 inspection of the County was a 'focused visit' and therefore did not look at fostering services.[758]

D.6: Responses to abuse

1970–1979

28. In the 1970s, the County had no policy or procedure in place for responding to allegations of sexual abuse against foster carers. The Inquiry has evidence of only three examples of institutional responses to allegations of sexual abuse in foster care, all of which show serious failings by children's social care:

[751] OFS008048
[752] NSC000003_14 para. 47; OFS008045
[753] OFS008034
[754] *The new Ofsted framework for the inspection of children's services and for reviews of Local Safeguarding Children Boards: an evaluation*, Ofsted, 2014
[755] OFS008020
[756] OFS007990
[757] Nottingham City Council, Inspection of children's social care services (2018)
[758] Focused visit to Nottinghamshire County Council children's services (2019)

28.1. Foster carer NO-F106 pleaded guilty to indecent assault of his two nieces, aged 8 and 11, and was given a three-year probation order in October 1976. Two foster children were returned to NO-F106 the following month. For at least two years, foster child NO-A272 and the foster carers were left "*without proper monitoring and advice*". NO-A272 subsequently made allegations of sexual abuse in relation to this period.[759]

28.2. F37 alleged she was abused by NO-F235 and told not to speak to social workers. After she ran away in 1974, she told a social worker "*how unfair*" NO-F235 was. She did not disclose the sexual abuse at the time because she did not think she would be believed.[760] NO-F235 denied the abuse when questioned in 1975 by children's social care following F37's later disclosure. No further action was taken.[761] By the time F37 disclosed to the police in 2015, NO-F235 had died.

28.3. In 1978, a "*meeting at County Hall*" considered allegations that foster carer NO-F234 had sexually abused a child in his care, aged 10, but was inconclusive in light of the foster carer's denial. The social worker's view was that "*a more searching enquiry could only be destructive*" to the foster carers and the complainant. No further girls were to be placed with the foster carers. It was noted that NO-F234 "*should in future take care*".[762]

29. In other instances of alleged sexual abuse in foster care during this period, complainants felt unable to disclose. For example, while in the City's care in 1972, L48 moved to Cheshire with his foster carers where he was sexually abused by his foster carer, NO-F275. L48 felt unable to disclose the abuse as he was not seen alone by a social worker. L48 was then sexually abused by his next foster carer, NO-F276, in 1975. L48 was again unable to disclose the abuse as he was worried he would not be believed and the abuse had made him question his own sexuality.[763]

1980–1989

30. From 1984, there were procedures governing child sexual abuse in foster care within the County.[764] They were not consistently applied:

30.1. In October 1985, NO-F138, a County residential care worker and foster carer, admitted indecently assaulting a foster child, NO-A325, from the age of 14. The abuse had been reported three months earlier, but the allegations were initially regarded as "*malicious*" by children's social care. The 1984 multi-agency child abuse procedures were not applied by either the police or children's social care until NO-F138's admission, despite three prior opportunities to investigate (including two reports of abuse of another child, NO-A326, in 1984). As a result, children were left at risk of abuse. Following his admission, NO-F138 was dismissed in March 1986 for "*a serious violation of trust*" and "*putting his sexual needs before those of a child entrusted in his care*".[765] Inexplicably, he was given 10 weeks' notice "*in view of the unfortunate background*".[766] An inquiry into this case in 1986, commissioned by Edward Culham, the Director of Social

[759] NSC000357_8
[760] F37 3 October 2018 94/20-139/8
[761] INQ002414
[762] NSC000367
[763] L48 4 October 2018 1/6-48/24. He added that when he eventually did disclose in 1985, he was not believed.
[764] NSC000075
[765] NSC000229_6
[766] NSC000229_7

Services, concluded that "*no officers who had been involved had got a grip of the situation*" and that "*close relationships*" between senior officers and NO-F138 had "*impaired judgements*".[767] In reality, the County's response was biased in favour of the perpetrator and protection of their own staff. The police only cautioned NO-F138 for his abuse of NO-A325, taking no action in relation to the abuse of NO-A326.[768]

30.2. The police failed to apply the procedures in 1986 when NO-A257, then aged 15, alleged that her foster father NO-F97 had sex with her when she was "*half asleep*", leaving money by her bed. She ran away and disclosed the abuse to her social worker. Given NO-A257's "*history of prostitution*", the police considered the abuse as her "*plying her trade rather than being harmed*". After "*considerable delay*", no further action was taken. Children's social care noted the delays and raised concerns at the police "*ridicule*" of NO-A257, recording that "*the needs of children rather than* [NO-F97's] *must be uppermost in our minds*". NO-F97 and his wife were removed from the list of specialist foster providers, but the couple were still to be considered for short-term placements.[769]

30.3. Procedures were followed when in March 1988 a foster carer (NO-F129) was deregistered and later that year stood trial but was acquitted.[770] He had been charged in late 1987 with the sexual abuse of two foster children. Following the acquittal, Rod Jones (then Principal Assistant – Child Care) gave a statement to the press saying that children's social care believed the girls and that, notwithstanding the acquittal, they would not be placing any more children with NO-F129.[771]

31. In 1989, a significant case of abuse by a foster carer was prosecuted, leading to an internal report and a considered response from the County. The internal report was prepared for David White, the Director of Social Services, in advance of the trial of Michael Chard. Chard was charged with sexually abusing a child in foster care over several years in the late 1980s. The report identified a number of failures by children's social care, including:[772]

31.1. Chard was allowed to foster children on his own from 1978, without proper assessment or sufficient scrutiny of his suitability to do so.

31.2. As well as being sexually abused by Chard, one child in his care, NO-A242, was also regularly sexually abused by her respite carer (NO-F88)[773] despite a social worker raising concerns about NO-F88's behaviour with children's social care in 1977, and recommending that no further children be placed with him.

David White acknowledged an "*increasing need to accept that the sexual abuse of children is a significant problem and that assessment practices and subsequent proceedings will need to be continuously improved.*"[774] In August 1989, Chard was convicted and sentenced to three years' imprisonment.[775]

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[767] NSC000229_10-15; NSC001235 paras 3c.iii,7, 5c.5
[768] NSC000229_4, 11, 13, 18
[769] NSC000352_1-20
[770] NSC000375
[771] INQ002007 paras 2.84; 12.1
[772] NSC000360_10
[773] Police believed NO-A242's complaints about this in 1988 but NO-F88 was not prosecuted because of his ill-health (NSC000360_9-12; NSC000344). The children remained in the placement because, although the children's social care believed that NO-F88 abused the children, it was felt that his wife would be more protective than ever.
[774] NSC000985_47
[775] NSC000360_13-17

32. Following this investigation and the cases which led to it, children's social care circulated a memorandum to senior managers in March 1989. Managers were asked to ensure that "*there is no doubt in the minds of your senior officers*" that child abuse procedures applied to all children in care, with "*no exception*".[776] Detailed investigation guidelines relating to abuse in foster care were also prepared.[777] These specified that carers' registration was to be reviewed after any investigation and, following a case conference, a senior manager would decide whether a placement could continue, whether other children were at risk, or any other necessary action.[778] Training was to be provided to foster carers on how their behaviour might be interpreted by a child, as well as on dealing sensitively with abused children placed with them.[779]

33. Rod Jones also reminded all foster carers of the risks and responsibilities involved in foster care:

> *"Any person with reason to believe that a child has been abused should bring this to the attention of the Area social worker … In the few occasions when this happens within foster care, the child still gets first consideration … "*[780]

1990–1999

34. Approximately six months after Chard's conviction, in February 1990, another foster carer, NO-F141, was charged with sexual offences against three foster children. Over 25 years he had fostered 400 children, including a large number of teenage girls who had previously been sexually abused. NO-F141 admitted offences against one child, but denied the others, calling the girls "*liars*". The 10 children then placed with NO-F141 were moved.[781]

35. A number of investigations of abuse in adoption or foster families prompted children's social care[782] to prepare an internal monitoring report (the Davis report).[783] It was widely circulated, including to David White, the Chair of the Social Services Committee (Joan Taylor) and one other councillor.[784] Rod Jones described the extent of abuse in foster care set out in the Davis report as "*considerable*".[785] It recorded 10 allegations of sexual abuse between April 1989 and March 1990.[786] Some led to prosecution or deregistration, but in others there was no formal action or the outcome was unknown. While the report noted positive steps taken by children's social care over the previous 18 months (including a revised policy and procedure guide, training strategies and a monitoring process),[787] it highlighted concerns about what had happened in practice. This included staff dismissing allegations by prejudging the complainant or inappropriately taking the side of the accused foster carer. Recommendations included introducing an improved code of practice on investigation of allegations, increased training of foster carers, and a requirement to have an ongoing

[776] NSC000944_1
[777] NSC000985_10-12; NSC000985_48-49
[778] NSC000985_49 para. 6; NSC000985_12
[779] NSC000985_49 para. 7
[780] NSC000944_2
[781] NSC000985_8-9; NSC000371_1_3
[782] NSC000985_17-18
[783] NSC000977_101-118
[784] NSC000977_102
[785] INQ002007 para. 2.88
[786] NSC000977_112-118 including some explored above.
[787] NSC000977_103-104

and monitored central record of allegations of carer abuse.[788] We have seen no evidence that these recommendations were implemented, other than a brief section on foster care included in the 1992 ACPC Child Protection Procedures.[789]

36. When asked about his views on the level of abuse in foster care at this time, David White (the County's Director of Social Services from 1989 to 1994) explained that he had had no direct involvement in the day-to-day running of the fostering service.[790] Abuse in foster care was not an area he had focused on because it had not been brought to his attention as frequently as other matters.[791]

37. Rod Jones thought there was a misplaced belief that foster carers were "*exceptional carers*"; consequently abuse was more likely to remain undetected. Barriers such as shame and threats from perpetrators prevented foster children from disclosing abuse.[792]

38. Similar issues to those identified in the Davis report were raised by the case of Norman Campbell, a residential care worker who was approved as a foster carer in 1987.

38.1. At the time of his approval as a foster carer, concerns were raised by two children's social care staff about Campbell's close relationship with NO-A197, a child who he was seeking to foster. These concerns were known by those considering his application. Campbell dismissed the concerns as "*racist*". A meeting was held, at which the staff members who had raised the concerns were left feeling "*belittled*" and "*chastised*" by the response of children's social care managers Tony Dewhurst and Paul Bohan.[793] In May 1988, another child (NO-A198) alleged that he had been sexually abused by Campbell. There were no applicable child protection procedures at that time as NO-A198 was regarded as a "*child outside the home*".[794]

38.2. Following a police investigation, the Crown Prosecution Service did not prosecute and disciplinary proceedings found NO-A198's allegations "*not proven*"[795] but both the County's Child Protection Officer and the police believed NO-A198's account. Campbell returned to residential social work as deputy officer in charge of a children's home. The fostering panel relied on a previous positive assessment in deciding that Campbell should be allowed to continue to foster.

38.3. Further children alleged sexual abuse by Campbell in 1990 and in the following year he was sentenced to six years' imprisonment for sexual abuse of three children, including NO-A197.[796] Tony Dewhurst now accepts that he and others had not been "*sharp enough*" to realise what was happening.[797]

39. David White notified the Social Service Inspectorate (SSI) in 1991 about the Campbell case, drawing attention to the steps that had been taken since and to the fact that guidance on sexual abuse by non-family members was now included in the ACPC procedures.[798] The

[788] NSC000977_108-111; Jones 8 October 2018 41/7-20
[789] NTP001473_63
[790] INQ001934 para. 74
[791] White 8 October 2018 135/1-136/4; INQ001934 paras 73-76. (Although he acknowledged that he was sent a copy of the Davis report: NSC000977_101-118)
[792] INQ002007 para. 29.13
[793] NSC000103_8-13, 27-28
[794] NSC000103_22
[795] NSC000103_21
[796] NSC000154_22-26; INQ001220; INQ002406
[797] INQ002731 para. 17.4
[798] NSC000164_1-2

SSI suggested an enquiry be carried out by an external "*consultant*".[799] An internal review was instead undertaken and in July 1992 made numerous recommendations, including that any allegation involving a foster carer should prompt a formal review of both the carer and the placement (noting that this had already become children's social care policy in the County) as well as more rigorous assessment and approval of foster carers. Echoing the Davis report in 1991, the review recommended a central monitoring system of allegations against foster carers (and children's social care employees).[800]

40. As at September 1994,[801] the ACPC Child Protection Procedures referred to a "*monitoring process for alleged carer abuse*".[802] The system was to be operated by a specific member of staff with details of allegations of abuse against foster carers and the outcome centrally recorded. An annual report was to be supplied to a senior manager detailing "*numbers, outcomes and trends in carer abuse*". Despite this, other than the Davis report in 1991 and one monitoring sheet from 1992,[803] we have no evidence of central monitoring of allegations until 2004.[804] Had the model of the Davis report in 1991 been followed, this would likely have increased the understanding of the scale of sexual abuse in foster care, the steps needed to address it and improved the institutional response. Even this would not have been sufficient. There should have been monthly reports on numbers and outcomes to senior managers, councillors and the ACPC, and a system allowing for proper scrutiny of that information.

41. Following the Campbell case, there is evidence that children's social care was aware of 11 further instances of allegations of sexual abuse in foster care in the County over the next six years.[805] In many of these cases, action was taken by the County in response (such as moving the child or deregistering the foster carer). In one case, however, a foster carer was allowed to return to his employment working with children without further assessment after an investigation could not substantiate the allegations.[806] Only two of the 11 cases led to convictions of foster carers,[807] although children's social care or the police had serious concerns or thought abuse had occurred in several others.[808] In one case, in which Douglas Vardy was convicted of sexually abusing three foster children, it was identified that one victim, NO-A256, had been removed from her family because of abuse and then been sexually abused in each of her three foster placements.[809]

[799] NCC003089
[800] NSC000103
[801] NSC000077_162-167
[802] NSC000077_166-167
[803] NSC000977_15-16: this listed allegations against County childminders and carers, including six allegations of sexual abuse in foster care in 1991. None had the outcome or comments recorded.
[804] Introduced following the Children Act 2004 – see Austin 19 October 2018 114/9-19
[805] NO-F64 (NSC000373); NO-F196 (NSC000977_22-46); NO-F118 (NSC000370; NSC000474); NO-F130 (NSC000376); NO-F126 (NSC000358); NO-F109 (NSC000362); NO-F116 and NO-F117 (NSC000432); Douglas Vardy (NSC000351); NO-F108 (NSC000368); NO-F98 and NO-F99 (NSC000353); NO-F111 (NSC000433).
[806] NSC000368_27; Stimpson 17 October 2018 25/1-26/18
[807] NO-F64 (NSC000373); Douglas Vardy (NSC000351). There was also one conviction of the son of foster carers (NO-F119 – NSC000370; NSC000474).
[808] NO-F196 (NSC000977_22-46); NO-F118 (NSC000370; NSC000474); NO-F130 (NSC000376); NO-F126 (NSC000358); NO-F111 (NSC000433).
[809] NSC000351_10

2000–2009

42. The allegations received during this period primarily concerned non-recent sexual abuse. Under procedures at the time, allegations of non-recent abuse were to be responded to in the same way as contemporary allegations, including prompt referral to social services, discussion with the police if appropriate and a strategy meeting to plan the way forward.[810]

43. Between 2002 and 2006, there were at least seven cases in which allegations of sexual abuse of children by their foster carer were reported to police and investigated but did not lead to conviction.[811] Crown Prosecution Service guidance at the time, which has since been revised, required prosecutors to consider the relevance of previous sexual history[812] or the possible motive for making allegations.[813] In one case where a foster carer was acquitted, one of the complainants had disputed the accuracy of entries in records about him being happy with the alleged perpetrator and this was considered to fatally undermine his credibility.[814]

44. In 2002, NO-F114 and NO-F115 were arrested following allegations relating to sexual abuse in the late 1970s. Two complainants had disclosed the abuse in 1983, but no further action had been taken despite children's social care at the time believing the allegations. It was noted in 1983:

> "*Presumably therefore, what* [NO-A91] *says* [NO-F114] *did with her is true. It was agreed that neither girl should know about today's discussion, and that there would be no point in pursuing it further.*"[815]

A strategy meeting in 2002 concluded that there was no attempted "*cover up*" by children's social care employees who had known of the disclosures at the time. No action was taken against them. The response in 1983 had allowed NO-F114 to continue fostering, exposing children to further risk. Following an initial decision to prosecute in 2002, the case was ultimately discontinued due to "*insufficient evidence*".[816] The reasons are unclear.

45. In 2004, the Crown Prosecution Service decided not to charge NO-F191 with sexually abusing her former foster child, NO-A394. The allegations were considered to be "*substantially undermined*" as NO-A394:

- had made previous allegations which were referred to children's social care but did not repeat the allegations when interviewed by the police;[817]
- admitted sexually abusing other children in the placement;[818] and
- would likely be accused of making the allegation to seek revenge on NO-F191 for ending contact with him.[819]

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[810] NSC000079_180
[811] There was one conviction of a foster carer, William Boden, in 2002, for offences over a 20-year period against children not in care (INQ001673).
[812] CPS002792: the Crown Prosecution Service Prosecution Manual 1996 states that "*The character of the complainant cannot be ignored when considering an alleged sexual offence. Such evidence may be relevant to the question of consent.*"
[813] CPS002787_5 para. 5.3e: the Code for Crown Prosecutors 2000 required consideration of the witness's background, including whether they may have any motive or relevant previous convictions.
[814] NSC000365; NTP001636_21-25
[815] NSC000369 4
[816] NTP001636_11-15
[817] Police investigators thought that he had been "*primed*" not to say anything, but would, in any event, be cross-examined on the basis that he had made "*previous unproven allegations*" (NTP001178_1).
[818] NTP001178_1
[819] NO-A394 was not happy in the foster placement and was placed elsewhere, but NO-F191 decided to stop fostering and end all contact with NO-A394 (NTP001178_1).

Although these features were not uncommon, Sue Matthews (a Senior Crown Prosecutor) said that they would still cause her concern today if she were advising on the case.[820] NO-F191 resigned from fostering following the allegations but children's social care continued with their own investigations. NO-F191 was deregistered in 2005 following a unanimous recommendation from the fostering panel.[821]

46. In 2003 and 2005, the Crown Prosecution Service concluded that there was insufficient evidence to prosecute Raymond Smith for alleged sexual abuse of two fostered children (aged 10 and 13), due to undermining evidence in social services records and from other witnesses.[822] Smith had privately fostered over 100 children during the 1980s before becoming a local authority approved foster carer in the 1990s.[823] He was deregistered as a foster carer by the City in 2004,[824] but no documents are available regarding the response to these allegations. It does not appear that any wider enquiries were carried out by the City at that time,[825] nor was the matter reported to the NCSC as required.[826]

47. In 2014, further allegations of non-recent abuse were made against Raymond Smith. In response, Smith "*minimised the allegations*" by saying that one complainant "*had been 15 years old at the time and that he was a man and enjoyed it*".[827] It also emerged that in 1981, Smith had been found in bed with a 15-year-old boy by his ex-wife.[828] Strategy meetings recorded that "*During their tenure as foster carers, allegations were made against Ray Smith by a number of young people of a sexual nature*" and "*it is uncertain why Mr and Mrs Smith were approved as long-term carers*".[829] This was a serious failure. Ultimately, in 2016, Smith pleaded guilty to indecent assault of a different child (who was not in care) and received a two-year suspended sentence.[830] We have not seen any evidence of the City, as required, notifying their Local Safeguarding Children Board (LSCB) about the case,[831] nor of consideration given by the LSCB as to whether the case should be subject to a serious case review or internal practice review into how Smith had been approved as a foster carer and had remained approved for so long. An independent review should have been carried out.

48. In 2006, NO-A286 again disclosed (having retracted her initial allegations, made in 1988) that she had been abused in the late 1980s by her foster carer, Stephen Noy, who was no longer fostering. A series of strategy meetings concluded that the allegations remained unproven.[832] The Crown Prosecution Service decided not to prosecute due to concerns about NO-A286's credibility, partly on the basis of her poor behaviour as recorded in her social care records.[833] In 2013 another complainant came forward alleging abuse by Noy, who was then charged in respect of both. Noy was convicted and sentenced to 17.5 years'

[820] Matthews 23 October 2018 10/20-13/10
[821] NTP001178; NSC000910
[822] INQ001780_17-18
[823] NCC000594_2
[824] NCC003691 paras 7.22-7.26
[825] Relevant procedures required those undertaking investigations into allegations of abuse to be *"alert to any sign or pattern which suggests that the abuse is more widespread or organised than it appears at first sight"* (NSC0000079_178).
[826] Fostering Services Regulations 2002, Schedule 8
[827] NCC000594_3
[828] NCC000594_8
[829] NCC000594_4, 13
[830] NCC000594; NCC003691 paras 7.22-7.26; CPS004382 para. 523
[831] The Councils were required to notify Ofsted and their LSCB of notifiable incidents.
[832] NSC000372_1-17, 36-59
[833] CPS004382_87 para. 548; Crown Prosecution Service guidance now advises greater scepticism about such records and states that children who have been in care should not be disadvantaged by the extent to which their behaviour is recorded (*Child Sexual Abuse: Guidelines on Prosecuting Cases of Child Sexual Abuse* (updated Nov 2018) para. 53).

imprisonment in 2015.[834] Again, we have not seen any evidence that the County notified Ofsted or their LSCB of the case, nor of whether consideration was given to a serious case review or internal practice review by the County's LSCB. Such a review should, at the very least, have been considered.

49. In 2006, following allegations against foster carer NO-F70 of harassment and child sexual abuse which were not pursued by the IFA responsible for the foster carers,[835] NO-F70 and his wife moved to the Isle of Wight[836] with D6, then aged 10 and in the care of the City (although he had been placed in Yorkshire). Once on the Isle of Wight, D6 was physically, psychologically and sexually abused by NO-F70. Visits by City social workers became sporadic and were regularly cancelled. D6 was eventually removed from the foster placement in 2009, after others made allegations of sexual abuse against NO-F70. There was no investigation by the City into whether D6 had been abused, nor strategy meetings held to consider whether any other children placed with the foster carers might have been abused. D6 disclosed the abuse to Nottinghamshire Police in 2017, who mistakenly thought the abuse had occurred in Yorkshire so passed the case on to that force and ceased contact with D6. Chief Superintendent Robert Griffin commented this was "*not good enough*".[837] This is true of the response of both the City and the police.

2010–2018

50. This period is marked by two significant cases in the County – Patrick Gallagher and NO-F77 – each involving sexual abuse of foster children by their foster carers. Both cases led to reviews of practice. Over the same period, there were also a number of other allegations of sexual abuse against foster carers which show problems with the Councils' institutional responses.

51. Patrick Gallagher and his wife were respite foster carers for the County from the late 1980s.

51.1. In 2006, a child who had been placed with them disclosed to his permanent foster carer that Gallagher made him watch pornography. There was no prosecution but, following a children's social care investigation, the Gallaghers wrote to children's social care to say they wanted to resign from fostering. Children's social care refused to accept the resignation and instead decided to formally deregister the Gallaghers in the same year, following the fostering panel's recommendation.[838]

51.2. Further allegations emerged in November 2010 following Mrs Gallagher's death. Patrick Gallagher quickly admitted offences in the face of overwhelming evidence, including video tapes.

[834] CPS004382_88 para. 551
[835] INQ002785; INQ002784. See paragraph 6 above.
[836] INQ002785; INQ002784
[837] Griffin 25 October 2018 202/22-203/7
[838] NSC000380_1-11; 113-116

51.3. In May 2011, Patrick Gallagher pleaded guilty to 55 sexual offences, including rape, committed against 16 boys between 1998 and 2010.[839] Gallagher received 13 life sentences and was to serve at least 28 years. He abused young boys on an "*unprecedented scale*" and did "*incalculable*" damage.[840] None of the abuse was detected over this 12-year period.

51.4. A serious case review was commissioned, written by Peter Maddocks,[841] and published in December 2011.[842] It focused on the seven children who had been in the County's care when abused by Gallagher, aged between eight and 14 at the time of the abuse. In addition to identifying significant barriers to disclosure faced by the children, key findings included:

- The initial assessment of the Gallaghers as foster carers was more rigorous than required by the standards of the time, although there would be greater scrutiny now.[843]
- The Gallaghers were consistently reluctant to undergo training.[844] This would not be accepted now and should not have been accepted at the time, at least not after the introduction of national minimum standards in 2002.[845]
- In 2006, the police were insufficiently involved and children's social care proceeded without focusing on the allegations from a child protection perspective, but these failures made no difference to the outcome.[846]
- In hindsight, there had been a failure to recognise and respond to the potential significance of behaviour exhibited by some children and of Gallagher's behaviour. Both highlighted the importance of training and the need for specialist social workers and police officers to be involved in discussions about the significance of behaviour displayed by children and adults.[847]
- Social workers often did not see the children in placement at the Gallaghers.[848] Much of the social work case-recording had focused on the physical environment rather than more complex information such as the child's views, wishes and feelings.[849]

The serious case review recommended more therapeutic and support services for victims and survivors.[850] Phil Morgan, the County's Fostering Team Manager for the Mansfield District at the time, thought that children's social care "*got off the hook*" with the serious case review. He thought that children's social care should have acknowledged their failures in safeguarding, fostering and not identifying the abuse at any time over 12 years.[851] We agree.

[839] CPS002694; CPS004382_39; NSC001235_84 para. 5n.2
[840] https://www.bbc.co.uk/news/uk-england-nottinghamshire-13527480
[841] Peter Maddocks was appointed in June 2011 as the "*independent author*" (NSC000002_17).
[842] NSC000002
[843] NSC000002_66 para. 308
[844] NSC000002_27 para. 110
[845] DFE000962_13; NSC000003_13
[846] NSC000002_76-82
[847] NSC000002_59 para. 296.cc
[848] NSC000002_88 para. 449
[849] NSC000002_88 para. 451
[850] NSC001235_86 para. 5n.10
[851] Morgan 17 October 2018 93/10-94/9

51.5. Additional complainants came forward after Gallagher's conviction; he received a police caution as the Crown Prosecution Service decided it was not in the public interest to pursue another prosecution given that he was never going to be released.[852] Chief Superintendent Griffin thought Gallagher should have been charged with those additional offences as it would have made a positive difference for the complainants.[853]

52. NO-F77 and his wife NO-F76 were foster carers from 1988 until 2012, fostering over 30 children in that time.[854]

52.1. In 1995 and 1998 reports of sexual abuse and sexualised behaviour were made to NO-F76 about NO-F77 regarding two children in their care (NO-A203 and NO-A200). NO-F76 passed the allegations to their supervising social worker Mrs Chris Middleton, who failed to take any action in response.[855]

52.2. In 2000, NO-A200 reported to a care worker that he had been sexually abused by NO-F77. This led to a multi-agency investigation. Phil Morgan urged colleagues to keep an "*open mind*" about whether NO-A200 may have fabricated the allegation, and that four incidents involving NO-F77 and NO-F76 over a long period as foster carers was "*not bad going*".[856] Although he told us that he regretted this almost immediately,[857] these phrases, taken together, amounted to inappropriate language for a professional to use in a formal meeting about sexual abuse and indicated a presumption against the child's truthfulness. Such comments are likely to have prejudiced a proper consideration of NO-A200's allegation from the outset.[858]

52.3. NO-A200 did not retract his allegation, despite being given the opportunity to "*change or retract his story*",[859] but the police took no further action due to concerns about NO-A200's credibility.

52.4. The strategy meetings concluded that "*the allegations cannot be substantiated nor can they be dismissed*".[860] The "*differing professional views*" as to whether the abuse was likely to have taken place should have been resolved.

52.5. Mrs Middleton felt it would be unfair for NO-F77 and NO-F76 to have to stop fostering,[861] but failed to raise at the strategy meeting that allegations had been made against NO-F77 in 1995 and 1998. She and Mr Morgan concluded they had "*no doubt*" that NO-F77 did not abuse NO-A200 and in a report for the fostering panel "*strongly*" recommended they were reapproved as foster carers.[862] Although Kathy Swift, chair of the strategy meetings, expressed "*reservations*" about NO-F77 and NO-F76 continuing as foster carers in a letter to the fostering panel,[863] the views of Mrs Middleton and Mr Morgan were given precedence over a thorough investigation.[864]

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[852] NTP001696. DC Hicks agreed with this decision (Hicks 19 October 2018 161/1-7).
[853] Griffin 25 October 2018 191/9-193/9
[854] NSC000003_4
[855] Morgan 17 October 2018 59/13-61/11; NSC000003_20-23
[856] NSC000434_1-10: this included allegations of physical abuse.
[857] Morgan 17 October 2018 64/16-65/1
[858] Morgan 17 October 2018 62/3-63/21
[859] NSC000434_13
[860] NSC000434_14-17
[861] NSC000434_16
[862] NSC000434_27-34; Morgan 17 October 2018 71/10-73/13
[863] NSC000434_35-36
[864] Morgan 17 October 2018 80/1-17

52.6. The fostering panel was convened, with Mr Morgan as a voting member even though this was a conflict of interest given his previous involvement.[865] Mrs Middleton presented the case in favour of NO-F77 and NO-F76's continued registration, and no one presented the opposing view.[866] The panel agreed unanimously that NO-F77 and NO-F76 should be reapproved. No consideration was given to reassessment of NO-F77's continued suitability to foster,[867] although the couple were to receive training on "*sexual safety*".[868]

52.7. In 2012, NO-F77 was witnessed exposing himself to a five-year-old foster child and another fostered child then disclosed that she had been sexually abused by him. By this time, NO-F77 and NO-F76 had fostered over 30 children. NO-F77 was suspended from fostering by the County and multi-agency strategy and planning meetings were held.[869]

52.8. An internal practice review was carried out in October 2012 and was critical of the County's response.[870]

- The supervision of NO-F77 and NO-F76 was undertaken by the same social worker (Mrs Middleton) from 1988 until 2010:

  > *"The relationship … was much too focused on support to the carers and when allegations were made the response was to defend the carers … there was intolerance to receiving information that contradicted accepted and long established beliefs about the competence and capacity of the carers".*[871]

- Safeguarding procedures should have been invoked on a number of occasions, but the supervision of NO-F77 and NO-F76 by children's social care was poor.[872]
- There was a general assumption that once a carer was approved, they would be trusted. This approach presented a "*risk of abuse to children*".[873]
- There was a need for children in care to have access to systems for raising concerns and complaints.

  > *"The strongest measure for safeguarding children is to ensure that every looked after child understands how to raise concerns, is given access and support to talk to people and can have confidence that their concerns will be treated seriously irrespective of their history and background."*[874]

- Much of the file records concentrated on the difficulties children were presenting to the carers, rather than any challenge to the foster carers or focus on what they were doing.[875]

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[865] Morgan 17 October 2018 73/14-75/7
[866] Morgan 17 October 2018 75/8-25
[867] Morgan 17 October 2018 77/16-78/5. In 2000, there was no requirement to conduct a full reassessment following allegations (NSC000077_164), but this was identified in the Internal Practice Review in 2012 as something that should happen going forward (NSC000003_40, 42).
[868] NSC000434_37-41
[869] NSC000434_42-104
[870] NSC000003 – by the same author as the serious case review into Patrick Gallagher.
[871] NSC000003_33-34 paras 140-141
[872] NSC000003_35 para. 149
[873] NSC000003_35 para. 153
[874] NSC000003_40 para. 187
[875] NSC000003_32 para. 133

- The fostering panel's decision in 2000 was "*flawed and unwise*". The panel were provided with imbalanced information, influenced by the "*defensive alliance*" supporting NO-F77 and NO-F76.[876]

The report made six recommendations,[877] including to ensure independent oversight of the management of complaints and concerns, and to bring forward proposals for rotating supervision of foster carers. The County considered the feasibility of the latter recommendation in October 2012 and concluded that instead of automatic rotation of supervising social workers, there should be routine consideration of a supervising social worker's involvement with foster carers.[878]

52.9. The findings of the internal practice review were regarded as "*extremely concerning*" by senior managers in children's social care.[879] We would have expected Phil Morgan's conduct to have been subject to a disciplinary investigation, as should that of Mrs Middleton had she still been employed.

53. The case of NO-F77 illustrated a culture within certain fostering teams that the interests of foster carers outweighed those of the children placed in their care. In NO-F77's case, it meant that he was allowed to go on to abuse other fostered children.

54. These examples highlighted significant failures in practice. Although it ultimately led to the two foster carers being deregistered and convicted, no action was taken against the supervising children's social care staff. In response to the Gallagher and NO-F77 cases, in 2012 the County sought to evaluate its approach to its foster care practice by commissioning an external independent audit of 19 cases of allegations against foster carers, of which six cases caused "*some concern*".[880] The audit concluded there was a lack of robust management within the fostering service. It also identified cases in which procedures were not followed, recording was inadequate and there were unexplained delays in responding to allegations.

55. Subsequent audits were then carried out into randomly selected foster carer files in January 2013. The audits recorded good adherence to most policies, procedures and national minimum standards, but noted there were some problems with supervision visits and a lack of unannounced visits.[881] Jayne Austin (Fostering Service Manager) responded to the audit reports' criticisms in a report in May 2013, pointing out what she considered as good practice that was ongoing.[882]

56. In June 2013, NO-F77 and NO-F76 were deregistered following the unanimous recommendation of the fostering panel.[883] The panel noted that had full information been provided in 2000 (for example the allegations in 1995 and 1998) the outcome would have been different at that time. In January 2014, NO-F77 was sentenced to eight months' imprisonment.[884]

[876] NSC000003_39 paras 174-180
[877] NSC000003_40-42
[878] NSC001349
[879] Morgan 17 October 2018 83/5-85/19
[880] INQ001812
[881] NSC001348
[882] NSC001352; Austin 19 October 2018 137/10-17
[883] NSC000434_113-116
[884] NSC000434_96-104

57. In 2016, further allegations against NO-F77 were made, this time by NO-A302.[885] The Crown Prosecution Service decided not to prosecute,[886] but strategy meetings found the allegations substantiated. There was a delay in informing NO-A302 of this due to concern about conflict between the County's safeguarding process and perceived risks of civil claims.[887]

58. In 2011 and 2012, there were two cases in which the County's fostering service and fostering panel considered there to be too much risk for them to allow the foster carers to continue fostering. This was different from the approach of the Independent Review Mechanism (IRM) panel, which focused more on the consequences of any decision for the foster carer and whether the allegations could be substantiated.[888]

58.1. In August 2010, allegations of sexual abuse in foster care were made against NO-F165. The police and children's social care agreed that the allegations were credible, but in December 2010 the Crown Prosecution Service decided not to prosecute. In June 2011, NO-F165 was deregistered following the unanimous recommendation of the fostering panel.[889] In response to NO-F165's appeal against deregistration, in October 2011, the IRM panel recommended that his approval to foster should continue, having found that the County had disregarded the views of an experienced social worker who knew the carers well and that there were "*serious flaws in the child protection investigation*". It concluded that the reason for refusal appeared to have been based on children's social care's best interests, rather than their "*duty of care*" to NO-F165. The IRM panel did not refer to risk, which should have been the primary concern when considering safeguarding.[890] In light of the IRM's recommendation, the County's 'Agency Decision Maker'[891] decided that NO-F165 and his wife were suitable to continue as foster carers, although training and careful supervision were required.[892]

58.2. Following harmful sexual behaviour between two children in different foster families in 2012, the foster carers of the child exhibiting harmful sexual behaviour were deregistered due to their failure to properly assess the risk posed by the child exhibiting harmful sexual behaviour. In 2013, the IRM panel again recommended that the decision be reversed, and that the foster carers be allowed to continue fostering.[893] This recommendation was rejected; the deregistration was upheld on the grounds of flawed management of risk, lack of trust and "*serious failure to safeguard both your own looked after child and another looked after child in spite of knowing the risks posed, resulting in serious harm*".[894]

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[885] NO-A302 had formerly been fostered by NO-F77's brother-in-law (NSC000434_120-159).
[886] CPS003412
[887] Morton 23 October 2018 94/20-95/15
[888] Since 2009, foster carers who are deregistered can appeal to the Independent Review Mechanism – a statutory body currently run by Coram Children's Legal Centre on behalf of the DfE. IRM panels will include a minimum of five members, who have professional or personal expertise in adoption or fostering (Independent Review of Determinations (Adoption and Fostering) Regulations 2009).
[889] NSC000378_1-26; 45
[890] NSC000378_27-35
[891] An Agency Decision Maker is someone employed by a fostering service provider (such as a local authority) to make the final decision about whether to approve or continue to approve a foster carer (and if so, on what terms) following a recommendation by the fostering panel (INQ001853 paras 2-5).
[892] NSC000378_27-40, 46-49. The Agency Decision Maker is required to take the recommendations into account, but can come to their own view.
[893] On the basis that: they had shown long-term commitment to, and understanding of, children in care; they had shown willingness to reflect and learn from their practice; they were experienced carers who had shown the ability to meet the needs of challenging young people; and they had remained child-focused throughout their fostering career (NSC001607).
[894] NSC001602; NSC001589

59. Following these cases, there were a number of other allegations of sexual abuse in foster care. The responses showed failures in joint working, including inconsistent approaches to decision-making, cases not being passed by the police to the Crown Prosecution Service for a charging decision, cases not always being referred to the fostering panel, and apparent failures to notify Ofsted or councillors.

59.1. In 2012, NO-A161 disclosed that she was sexually abused by her foster carer, NO-F35. The police considered there was insufficient evidence to pass the case to the Crown Prosecution Service and the multi-agency strategy meetings concluded that the allegation was "*unfounded*". NO-F35 was able to continue fostering without the required referral to the fostering panel to assess his continued suitability.[895] Further allegations against NO-F35 were made by NO-A160 in 2014. By this time there were around 10 allegations of sexual abuse against him (including those by NO-A159 in 2007[896]). The police considered the allegations to be unsubstantiated and decided to take no further action without referral to the Crown Prosecution Service. Despite this, the City took a thorough approach to evaluating the risk posed by NO-F35, and commissioned the NSPCC to carry out an independent investigation and risk assessment. This concluded in March 2015 that NO-F35 posed an unacceptable level of sexual risk and should not be allowed to care for vulnerable children.[897] In August 2015, further allegations of sexual abuse against NO-F35 were made by NO-A159 and NO-A163. These allegations were regarded as credible and the Crown Prosecution Service decided to charge NO-F35.[898] In May 2016, the fostering panel unanimously recommended termination of NO-F35's registration as a foster carer.[899] In 2017, he was acquitted of all charges.

59.2. In May 2015, a child in foster care (NO-A779) with the City disclosed to her teacher that she had been in a sexually abusive relationship with a 27-year-old male when she was aged 15.[900] Her foster mother was aware of the sexually abusive relationship but decided not to report it as she had wanted to deal it with 'like a "normal" family'. It was decided that the foster carer was suitable to continue as a foster carer, and that it was in NO-A779 and her sister's best interests to continue in the placement given the need for stability. The matter was never referred, as recommended in the foster carer review, to the fostering panel to consider the carer's continued approval.[901] This was questioned by the fostering panel following the foster carer's resignation in January 2017.[902]

59.3. In December 2016, NO-A104 alleged to children's social care that he had been sexually abused by his former foster mother, NO-F80, in the 1980s.[903] The Crown Prosecution Service received legal advice from external counsel that NO-F80 was unlikely to be convicted, despite the complaint being credible, because NO-A104 had previous convictions, a troubled background, mental health issues and had made a

[895] NCC000593_1-16
[896] NCC000593_3
[897] NO-F35 had said, as part of the assessment, that sexually abused children could prevent the abuse from happening, that some were capable of leading adults on and that some make up allegations for attention (NCC000316_1-11; NCC000593_48-55).
[898] NCC000593_56-94; CPS003393
[899] NCC000593_95-101
[900] NCC000293_18-40
[901] NCC000293_18; NCC000293_25
[902] NCC000293_37-38; NCC003811 para. 11
[903] NSC000361

number of allegations. Sue Matthews, the Crown Prosecutor, decided not to charge NO-F80.[904] The County's subsequent decision that the allegations were unsubstantiated had not, it was said, been influenced by the Crown Prosecution Service decision.[905]

59.4. In September 2017, allegations of sexual abuse were made by a child placed in 2015 against his previous foster carers, NO-F423 and NO-F424.[906] There was an initial failure to hold an emergency strategy meeting and, although contact was made with the police and the complainant was interviewed, children's social care told the foster carers about the allegations two days before the police saw them. Following a meeting of the fostering panel in May 2018, NO-F423 and NO-F424 were deregistered as foster carers. In February 2019, the Crown Prosecution Service decided not to charge the alleged perpetrators. We have no evidence as to whether the case has been considered for a child safeguarding practice review or if a notifiable incident form was sent to Ofsted. Councillor David Mellen was not formally notified but was told by Alison Michalska during a meeting which was not minuted.[907]

59.5. In December 2017, NO-A626 alleged that he had been sexually abused by his foster carer, NO-F292. The allegations were considered to be unsubstantiated following a multi-agency strategy discussion and a joint police and children's social care investigation. Notwithstanding this conclusion, in February 2018, the County followed the serious incident notification process by notifying Ofsted, and the fostering panel was to review NO-F292's approval as a foster carer.[908]

60. The extent of sexual abuse in foster care in the 1970s and 1980s was compounded by poor decison-making in those cases where disclosure had been made. Some known perpetrators were permitted to remain as foster carers and then went on to abuse again. Despite the County's assessment of the prevalence of sexual abuse for children in foster care in the early 1990s, David White, the Director of Social Services, failed to take any effective action.

[904] Matthews 23 October 2018 41/12-42/15
[905] Morton 23 October 2018 102/6-8
[906] NCC000293_4-17
[907] NCC003811 para. 16.1
[908] OFS008121

Part E

Case study: Harmful sexual behaviour

Case study: Harmful sexual behaviour

E.1: Introduction

1. The investigation's third case study examines the institutional responses to, and barriers to disclosure of, allegations of harmful sexual behaviour between children in the care of the Councils.[909] The Inquiry has been assisted with these issues by Professor Simon Hackett, Professor of Child Abuse and Neglect at Durham University, an expert on harmful sexual behaviour between children.[910]

2. In this report, we use the term 'harmful sexual behaviour' to refer to sexual abuse between children, whether children of different ages or children of a similar age. This reflects Professor Hackett's view that this behaviour may be harmful to others but also to the child responsible for that harm, and it is therefore less stigmatising than other terms.[911]

E.2: Allegations of harmful sexual behaviour in Nottinghamshire

3. The Inquiry has received 95 accounts[912] of harmful sexual behaviour, including:

3.1. P16 was sexually abused, including rape, by another child in a children's home "*some decades ago*". He ran away, becoming a victim of child sexual exploitation.[913]

3.2. P7 was sexually abused by another child in her foster home in the 1970s, who threatened to disclose that she was being abused by the foster father. P7 was scared that this would lead to her being taken away from her two siblings.[914]

3.3. P3 was sexually assaulted by a male resident at a children's home in 1978. She described the continuing effects of the abuse: "*Sometimes when I meet men, they know I've been abused and they ask me if I have been a prostitute. They assume that I have because I have been abused. This makes me feel really confused; as if my abuse has made me worthless*".[915]

3.4. A76 was raped twice by one older boy and sexually assaulted by another in a children's home in the 1970s and 1980s.[916]

[909] Notice of Determination on Selection of Case Studies, 28 February 2018
[910] Hackett 25 October 2018 1/22-48/19; INQ002045
[911] Hackett 25 October 2018 6/16-8/20; INQ002045_8-9
[912] INQ002576; INQ002574; and oral evidence from P7, P16, D31 and L43.
[913] P16 26 October 2018 3/22-4/23
[914] P7 4 October 2018 124/15-125/3
[915] INQ002576; INQ002574
[916] A76 5 October 2018 113/10-121/12

3.5. P5 gave an account of being sexually abused by two of her brothers in the 1970s and 1980s. This included forced oral sex and sexual touching, at the children's home where she lived and when they would go home at the weekend.[917]

3.6. P1 was sexually assaulted by the son of his foster carers in the 1980s, including forced oral sex.[918]

3.7. L46 was sexually assaulted by a female resident at a children's home in 1987, who inserted her finger into L46's anus in the course of bullying her. This was recorded in her social services records.[919]

3.8. D31 was sexually abused on around five different occasions by older boys at Greencroft Community Home between 1989 and 1991, including sexual assault and rape.[920]

3.9. D46 was sexually abused by two older boys at a children's home in the 1990s.[921]

3.10. L43 was sexually abused at Beechwood in 2002, by another resident who was one year older than him. This included attempted anal rape and sexual touching. He reported the abuse but felt unsafe and confused. He described the impact of the abuse as "*everlasting*".[922]

E.3: Understanding harmful sexual behaviour

4. Professor Hackett's expert view was that there are a number of key points to assist in understanding harmful sexual behaviour:

4.1. A child presenting with harmful sexual behaviour is likely to act it out to varying degrees over a period of time. That behaviour might range from normal and "*developmentally appropriate*" on the one hand and "*highly abnormal and violent*" on the other. Understanding this range can help professionals to respond appropriately to the risk presented by that behaviour.[923]

4.2. Though in each case intervention is needed,[924] it is important to distinguish between: (i) 'abusive' sexual behaviours that are manipulative or coercive where the victim is unable to give informed consent and (ii) 'problematic' sexual behaviours that have no intended victim but which may have a developmental impact on the children exhibiting the behaviour or cause them rejection or distress, or increase the risk of their victimisation.[925]

4.3. Harmful sexual behaviour exhibited by younger children should be approached differently to that exhibited by adolescent children. Younger children's behaviour is more likely to be a direct consequence of having been abused.[926]

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[917] P5 3 October 2018 156/11-159/22
[918] P1 5 October 2018 103/24-109/10
[919] L46 5 October 2018 97/12-101/9
[920] D31 5 October 2018 11/10-19/18
[921] D46 5 October 2018 101/10-103/23
[922] L43 3 October 2018 67/18-90/5
[923] Hackett 25 October 2018 3/13-4/13; INQ002045_6-8, 10
[924] Hackett 25 October 2018 5/24-6/15
[925] INQ002045_8
[926] Hackett 25 October 2018 17/12-19/4; INQ002045_35

4.4. A history of having been sexually abused is one of several possible pathways which may lead to harmful sexual behaviour. Around half of those children exhibiting harmful sexual behaviour have themselves previously been sexually abused.[927] However, of children who are victims of all kinds of abuse, the vast majority do not go on to sexually abuse others, and victims should not be labelled as potential abusers. Trauma, suffered through other experiences as well as sexual abuse, is a key indicator and causal factor for many children exhibiting harmful sexual behaviour.[928] Another pathway is general anti-social attitudes and beliefs which can link with sexual bullying.[929] There are examples where harmful sexual behaviour appears to have been part of a culture of bullying and inappropriate behaviour.[930]

4.5. Most children exhibiting harmful sexual behaviour no longer do so by their mid-twenties. Previous assumptions about adolescent sexual offending being 'addictive' are not borne out by recent studies.[931]

4.6. Children abused by their peers are more likely to be abused by a group than by an individual. One incident of being abused by a group may lead to "*a kind of chain effect*" of further abuse by other members of the group.[932]

4.7. The fact that children have exhibited, or been the victims of, harmful sexual behaviour may be identified by adult perpetrators who "*pick out*" those vulnerabilities and use them to abuse the child.[933]

The prevalence of harmful sexual behaviour

5. It is generally accepted that up to two-thirds of allegations of child sexual abuse are made against young people under the age of 18.[934] Figures from 2017 show almost 30,000 reports of harmful sexual behaviour over the previous four years in England and Wales, with annual figures almost doubling in that time.[935] The "*overwhelming majority*" of cases of children exhibiting harmful sexual behaviour do not result in a prosecution or caution.[936] Around half of sexual abuse cases in residential care are of harmful sexual behaviour.[937]

6. However, these numbers are likely to be an under-representation of the true scale. This is a result of the barriers to reporting, the variable ways of recording harmful sexual behaviour, and because the issue has only relatively recently been acknowledged and understood.[938] In Professor Hackett's view, there is a "*high likelihood that peer sexual abuse in care has been downplayed by professionals who have seen it as exploratory adolescent sexual behaviour*".[939]

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[927] Hackett 25 October 2018 20/19-25/2; INQ002045 45-48. Around two-thirds have experienced some form of abuse, including physical, sexual and emotional abuse.
[928] Hackett 25 October 2018 22/19-25/2; INQ002045 _43-44
[929] Hackett 25 October 2018 19/8-20/18; INQ002045 _37-38; INQ003565_62-63 paras 228-238
[930] For example, the abuse of NO-A89 (NSC000103) and L46 (5 October 2018 97/12-101/9).
[931] Hackett 25 October 2018 20/19-21/6; INQ002045_39-40
[932] Hackett 25 October 2018 45/16-46/7
[933] Hackett 25 October 2018 46/8-20
[934] *Workforce perspectives on harmful sexual behaviour, Findings from the Local Authorities Research Consortium 7*, National Children's Bureau and Research in Practice. Additionally, between one-quarter and one-third of all sexual offences (of children and adults) are thought to be committed by young people under the age of 18 (INQ002045 para. 1.2).
[935] INQ002045_20-21
[936] Only 26 percent of these cases resulted in criminal justice interventions (see INQ002045 para. 4.4).
[937] INQ002045_58
[938] Hackett 25 October 2018 2/23-3/12; INQ002045_4
[939] INQ002045_58-59 at para. 7.25

7. Many accounts of abuse reviewed by this Inquiry were given in interviews during Operations Daybreak, Xeres and Equinox or in disciplinary cases, none of which focused on allegations of harmful sexual behaviour.

Harmful sexual behaviour in relation to children in care

8. Harmful sexual behaviour between children in care has not been extensively researched, despite a large number of children exhibiting such behaviours subsequently entering the care system.[940] In Professor Hackett's view, the mistaken belief that most children who commit sexual offences will continue to do so through adolescence and into adulthood has led to an "*overly risk-averse approach*" to children coming into care who had previously exhibited harmful sexual behaviour.[941] The "*developing sexuality and sexual behaviour*" of children in care is often subject to scrutiny in a way in which children in the family home is not, so there can be an assumption that they are more prone to exhibiting harmful sexual behaviour.[942] However, for some children, coming into care can stop further harmful sexual behaviour, as they will have been removed from an abusive or sexualised home environment.[943] This does not remove the need for a robust risk assessment when making placement decisions and formulating care plans in all cases in which a child has exhibited harmful sexual behaviour.[944]

9. Professor Hackett has produced a model showing the relevance of the care environment and the attitudes and responses of staff in understanding harmful sexual behaviour.

E.4: Policy and practice developments in Nottinghamshire

10. The Councils' understanding of and approach to harmful sexual behaviour mirrors, to a large extent, the national picture. In 1990, the County was aware that a significant number of children known to be exhibiting harmful sexual behaviour were in its children's homes.[945]
1970s and 1980s

11. The County's first Policy, Procedure and Practice Guide for Community Homes in April 1978 included guidance on responding to children in care suspected of involvement in unlawful sexual intercourse.[946] Rod Jones, Senior Professional Officer (Child Care), clarified the guidance later that year:

> "*Clearly where this is experimental horseplay (for want of better words) there is no question of the Police needing to be involved … Where a child has been the subject of U.S.I. or serious homosexual or other activity and the staff have good reason to believe that an offence has been committed – then the policy is that the Area Director should consider informing the Police immediately. As I understand it, the policy also states that only the Divisional Director has the power to agree to withhold information from the Police.*"[947]

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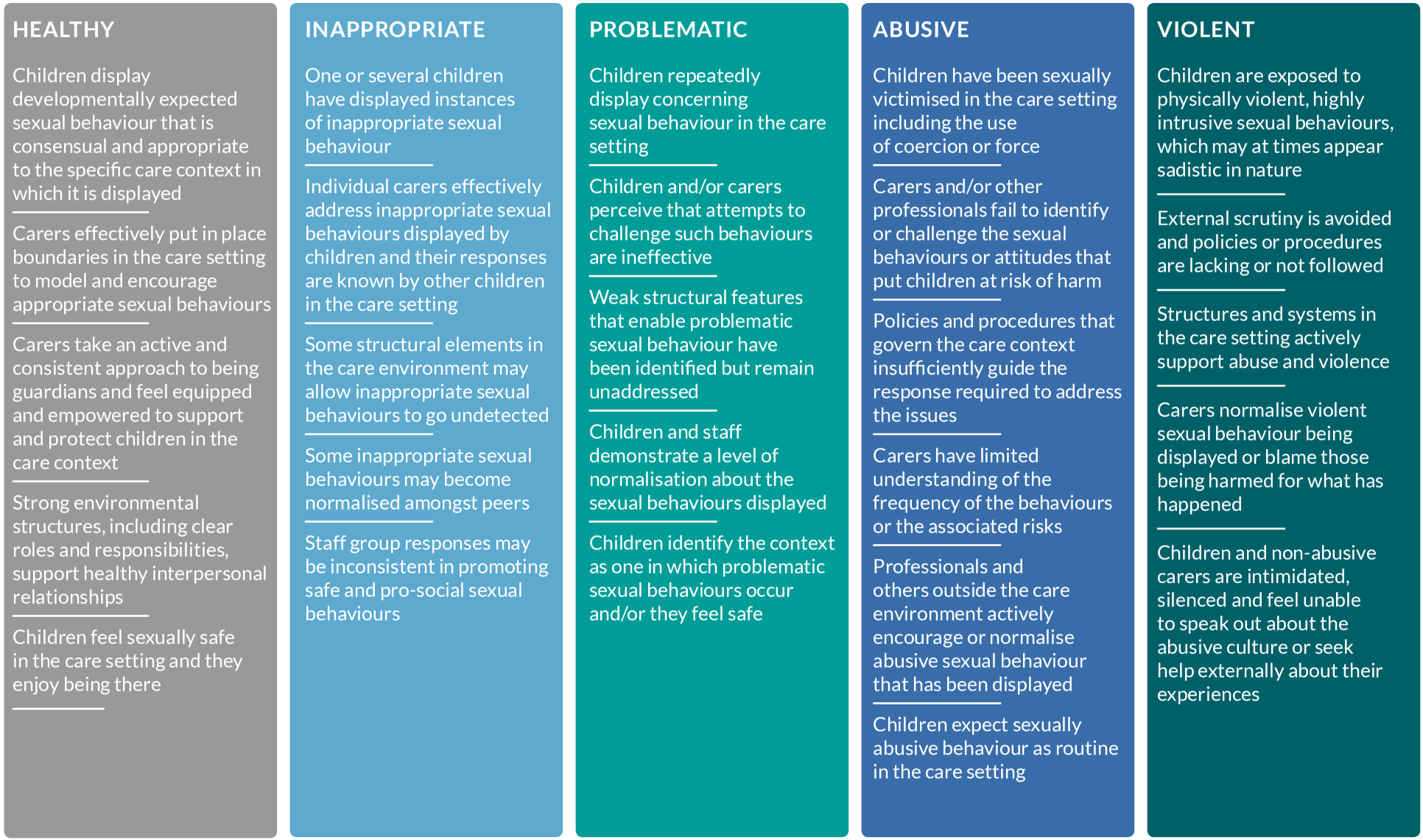
[940] Hackett 25 October 2018 26/4-22; INQ002045_53. Around one-third of those referred to specialist services between 1992 and 2000 after exhibiting harmful sexual behaviour were then placed into care (Hackett, S., Phillips, J., Masson, H. and Balfe, M., 2013. 'Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers', *Child abuse review* 22(4), pp232-245).
[941] Hackett 25 October 2018 27/23-28/6; INQ002045_54
[942] Hackett 25 October 2018 29/1-22; INQ002045 _55
[943] Hackett 25 October 2018 26/23-27/14
[944] INQ002045 paras 9.18-9.20
[945] At a meeting on the issue of "*Kids being abused by kids*" (NSC001228_9).
[946] NSC000046_107. 'Unlawful sexual intercourse', in this context, involved sexual activity between a male aged 16–18 and a female aged 13–16 (Sexual Offences Act 1956, section 6).
[947] NSC001331



Derived from the work of Firmin and Hackett, 2018

A context continuum model of care settings and harmful sexual behaviour

12. Following an internal inquiry into an allegation of harmful sexual behaviour at Amberdale Secure Unit in 1988 (discussed further below), a multi-agency Adolescent Sex Offenders Group was created and met from October 1989 "*to develop services designed to address the risks presented by male adolescent sex offenders*".[948]

1990s and 2000s

13. Between March and September 1990, the Adolescent Sex Offenders Group undertook a range of work regarding harmful sexual behaviour and made a number of findings:

13.1. An increasingly high level of reporting of sexual offences carried out by adolescents,[949] as shown for example by a snapshot[950] of 380 children resident in children's homes in Nottinghamshire on one particular day in June 1990. This found:

- 32 children (8 percent) had been sexually abused by other residents (of those 26 had also been sexually abused before entering care and six were sexually abused for the first time by other residents);
- out of 79 children (21 percent) who had been sexually abused before entering care, 16 had gone on to sexually abuse other residents;
- 23 children (6 percent) had been placed in care having already committed sexual offences; and
- 15 children (4 percent) committed a first sexual offence whilst in care.

David White, the County's then Director of Social Services, was "*astounded to find the number who had been subjected to abuse … However we're probably not untypical of Departments generally.*"[951]

13.2. A "*lack of departmental and multi-professional guidelines and resources*" which meant that "*what happens in each case is a matter of chance*".[952]

The group proposed setting up a new unit to work with adolescent sex offenders and sought the implementation of guidelines for staff,[953] and joint police and children's social care investigations in response to allegations of harmful sexual behaviour.[954] Although the placement of abused children alongside children exhibiting harmful sexual behaviour was common practice across England and Wales in the 1990s,[955] the group recommended in 1990 that "*adolescent sex offenders should no longer be housed with other children without very careful consideration of the risks*". It also provided a definition of "*sexual abuse by juveniles*" and identified an "*urgent*" need to develop treatment services for young offenders.[956]

[948] INQ002764_3. The group included David Fisher (a member of staff at Amberdale), Judy Holloway-Vine (as she was known then, a social worker), a member of the Community Health Team, and an educational psychologist. See also DFE000707_4-7
[949] DFE000707_9
[950] NSC000102_27-29
[951] INQ002642_6
[952] DFE000707_9
[953] DFE000707_10-11. The same recommendation, regarding the development of practice guidelines, was made to senior management and councillors two years earlier, in the 1988 Amberdale report (NSC000101_11), but it had not been implemented.
[954] DFE000662_2-5
[955] Hackett 25 October 2018 34/6-35/9; INQ002045_61-62
[956] DFE000662_2-5

14. The 1991 Area Child Protection Committee (ACPC) procedures in Nottinghamshire appear to have drawn on the group's work (as well as on the national *Working Together* guidance in 1991, which referred for the first time to harmful sexual behaviour[957]). The procedures included guidance on 'Abuse between children and young people'. Those exhibiting harmful sexual behaviour were to be seen as children who may have been abused, and placement decisions had to take into account the risks they posed to other children. Joint investigation procedures were to apply to allegations of harmful sexual behaviour in children's homes.[958]

15. A "*landmark*" National Children's Home report about harmful sexual behaviour in England, Wales and Scotland, published in 1992, considered for the first time on a wide scale the issue of children and young people who sexually abuse other children.[959] It noted "*an absence of policy, practice or ethical guidance to assist practitioners*" with young people demonstrating harmful sexual behaviour, and that much sexually abusive behaviour went unreported or unrecognised, or was simply not formally dealt with by the criminal justice system. A model was proposed to establish the range of sexual behaviours which a child could demonstrate.[960]

16. The 1991 ACPC procedures highlighted the need to consider risks around placement because of concern about harmful sexual behaviour between children in residential care.[961] Despite this, in 1992, a County working party report entitled *'As if they were our own': Raising the Quality of Residential Child Care in Nottinghamshire* concluded that a failure to monitor admissions into residential care had led to:

> "*young people who have been sexually abused being placed at risk by being accommodated with young people who have committed sexually abusive acts*".[962]

It found that 80 percent of sexual abuse within community homes was committed by young male residents against young female residents.[963]

17. The report noted that the work of the Adolescent Sex Offenders Group in monitoring those exhibiting harmful sexual behaviour and providing them with treatment had "*helped to project Nottinghamshire as a lead Authority in recognising and responding*" to their needs.[964] The working party recommended an additional "*systematic and informed service*" for adolescent sex offenders, but funds were withdrawn three weeks before the service was due to start.[965] This was despite the report's warning that:

> "*In the absence of such a service the problem continues to increase with real cost to the young people, both offenders and victims, and the possibility of the County Council being held liable for claims of compensation becomes more concerning.*"[966]

[957] INQ002045 para. 3.11 – although the phrase 'harmful sexual behaviour' was not used until very recently.
[958] NTP001473_136-137
[959] AFC000067; Hackett 25 October 2018 10/9-11/1; INQ002045_15-16
[960] AFC000067. The model is explained by Professor Hackett's more recent diagram.
[961] NTP001473_137
[962] NSC000104_19. This report was produced at a senior level, with the working party led by the County's Chief Executive, Michael Lyons.
[963] NSC000104_104
[964] NSC000104_79
[965] NSC001380_2
[966] NSC000104_79

18. By this point, two years on from the 1990 survey,[967] *'As if they were our own'* included some statistics on the 285 children in residential care:

- 90 children (32 percent) had been sexually abused before coming into care;
- 11 children (4 percent) had been placed in care as having been abused and were subsequently abused by other residents whilst in care; and
- five children (2 percent) had been sexually abused for the first time by other residents whilst in care.[968]

19. In 1997, an ACPC project on 'Children who sexually abuse other children' reviewed 57 alleged incidents of harmful sexual behaviour in the County over a six-month period, four of which involved children in residential care.[969] Responses to harmful sexual behaviour remained inconsistent.[970] Although most cases had been referred for investigation, in some child protection procedures had not been followed. It proposed "*further briefing or training*".[971] In a March 1997 progress report to the ACPC, the Project Manager drew attention to the fact that "*the scale of the problem*" of harmful sexual behaviour was "*bigger than initially thought*", and that there was "*no consistent approach for dealing with these children*". She proposed setting up a panel with the aim of diverting children away from the criminal justice system.[972] By 1998, "*both the City and the County each had established their own respective panels*" (subsequently known as assessment and early intervention panels),[973] to which the majority of cases were referred, usually by the police or children's social care.[974]

20. The County's Child Protection Practice Guidance was also updated in 1997, in relation to responses and support to both victims of and children exhibiting harmful sexual behaviour. It also included guidelines on what was 'normal' sexual experimentation and what was abusive.[975] However, this does not appear to have been accompanied by training for residential care staff or foster carers.[976]

21. National interagency procedures and a practice framework for assessing children and young people with harmful sexual behaviour (Assessment Intervention and Moving On (AIM)) were introduced in 2000.[977] The framework became best practice and was in use by the Councils by the mid-2000s.[978]

22. By 2005, the County was carrying out risk assessments of children exhibiting harmful sexual behaviour,[979] which were provided to the foster or residential home where the child was being placed.[980] The County's process changed in 2006,[981] from local individual assessment and early intervention panels to a strategy meeting approach with multi-

[967] NSC000102_27-29
[968] NSC000104_107
[969] NSC001325_6
[970] NSC001380
[971] NSC001325_10
[972] NSC001328_9-10
[973] NSC001474 para. 3b.8
[974] NCC003792; NSC001326
[975] NSC000058_137-148
[976] INQ002434 paras 4.6, 11; INQ001895 para. 29a
[977] Hackett 25 October 2018 11/25-12/12
[978] INQ002045 paras 4.32-4.37; NSC001474 para. 3c.2
[979] See, for example, NSC001438_10-18
[980] Edwards 23 October 2018 150/7-152/17
[981] Following work done by the County's Child on Child Abuse Steering Group between 2003 and 2006 (NSC001596).

agency planning and assessment. The assessment evaluated the level of risk posed by children exhibiting harmful sexual behaviour to other children in the same household or establishment including younger or more vulnerable children.[982]

23. Over the next few years, the City funded a part-time post in relation to harmful sexual behaviour[983] and sought to intervene early to prevent future incidents.[984] In practice, a large number of children arrested for sexual offences in the City were still not being referred to the assessment and early intervention panel. There was substantial delay in referring cases and, where cases were referred, the panel often had little or no information about the victim or the impact of abuse.[985] The panel could only recommend, rather than direct, that children's social care take decisions, including the placement of children exhibiting harmful sexual behaviour.[986] Although police attendance was "*a useful and effective process ensuring best outcomes for victims and alleged young perpetrators*",[987] it was infrequent.[988]

24. Since 2007, the Councils' safeguarding boards have produced cross-authority guidance on 'Children who display sexually harmful behaviour'.[989]

Recent developments and present day

National developments

25. In 2013, a Criminal Justice Joint Inspection[990] identified concerns about the effectiveness of multi-agency working with children and young people who had committed sexual offences. It found little evidence of oversight, gaps between policy, procedures and practice, and no evidence that implementation of procedures had been monitored or reviewed.[991]

26. Professor Hackett referred to 2014 research which suggested that victims of sexual abuse and children exhibiting harmful sexual behaviour were still being placed together, even though placement providers had become more aware of the need to "*look very carefully*" at risks presented by young people when making placement decisions.[992]

27. In 2015, following unsuccessful attempts to formulate a national strategy, the National Society for the Prevention of Cruelty to Children (NSPCC) developed, in conjunction with some local authorities,[993] an Operational Framework[994] for harmful sexual behaviour to help

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[982] The new approach was set out in the County's 2006 'Practice Guidance on Children and Young People who Sexually Harm' (NSC001151; NSC001586).
[983] INQ001984 para. 14.2
[984] NCC003792
[985] NCC003794
[986] INQ002434 paras 10.2-10.3
[987] NCC003793
[988] NCC003793; NCC003790
[989] NSC000084_59-60. This was updated in 2014 (NSC000092) and then again most recently in January 2019 (Interagency Safeguarding Children Procedures – 'Harmful Sexual Behaviour (HSB)').
[990] *Examining Multi-Agency Responses to Children and Young People Who Sexually Offend*, Criminal Justice Joint Inspection, 2013: a joint inspection of the effectiveness of multi-agency work with children and young people in England and Wales who have committed sexual offences and were supervised in the community.
[991] Hackett 25 October 2018 37/16-38/7; INQ002045_28-29. These findings appear to reflect the position within the Councils. Between 2007 and 2013, we saw no evidence of steps taken by the County to monitor its own practice or the implementation of its procedures. The City's AEIP produced annual reports but none appeared to consider or evaluate the effectiveness of policies and procedures.
[992] Hackett 25 October 2018 34/6-35/9; INQ002045 para. 7.38 _62
[993] Including the City (INQ001981 para. 6.2).
[994] Hackett, S., Holmes, D. and Branigan, P. 2016. *Operational framework for children and young people displaying harmful sexual behaviours*, NSPCC, London. This was recently updated with a second edition: Hackett, S., Branigan, P. and Holmes, D. 2019. *Operational framework for children and young people displaying harmful sexual behaviours*, second edition, NSPCC, London

local authorities structure their interagency response to the issue.[995] Professor Hackett considered this a "*really important step forward*", giving local agencies the ability to audit their harmful sexual behaviour practice against the Framework and promote standard practice in assessment, in the availability of intervention services and in training.[996]

28. Guidance and advice on harmful sexual behaviour have been published in recent years by the National Institute for Health and Care Excellence[997] and by the Department for Education,[998] and awareness and procedures have improved. However, "*there is still no national strategy*" or model for local authorities to use in addressing harmful sexual behaviour.[999] In Professor Hackett's view, there is a need for an "*overarching strategy that actually brings together some of these principles in an overarching national framework*".[1000]

The County

29. Chris Few, chair of the County's Local Safeguarding Children Board,[1001] recognised that the County's approach to harmful sexual behaviour, as at October 2018, was not as he would wish.[1002] Nevertheless, in recent years, the County has taken steps to audit its practice, quality assure its work and develop multi-agency responses to harmful sexual behaviour cases. The 2016 audit (using the NSPCC framework) found that residential staff and foster carers were trained and able to support children exhibiting harmful sexual behaviour, but that the County had no overall picture of the scale of harmful sexual behaviour or the efficacy of its response. Recommendations included setting up an annual data return on children who sexually harm, a multi-agency audit on harmful sexual behaviour practice and the introduction of the Brook Sexual Harm Traffic Light Tool.[1003] The Traffic Light Tool is a step-by-step guide to assist professionals in understanding whether behaviour is abusive, problematic or appropriate, and to inform the appropriate interventions.[1004]

30. A multi-agency audit in May 2018 examined 10 cases of harmful sexual behaviour in the County, two of which involved children in residential care. This found delays in identifying and responding to harmful sexual behaviour, inconsistent advice given to children and their carers, an over-dependence on police decision-making, and a lack of understanding of the purpose and use of the AIM assessment. Recommendations included aligning practice across agencies, reworking local guidance and developing a model to quality-assure cases involving harmful sexual behaviour.[1005] Chris Few assured us that the County's Harmful Sexual Behaviour Panel[1006] was working on the audit's recommendations and the issues it had raised.[1007] At the time of our hearings, an action plan was still being implemented to respond to the 2016 and 2018 audit recommendations. While a number of actions had been completed (including the introduction of the Brook Sexual Harm Traffic Light Tool), annual

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[995] INQ002045 para. 3.23. The framework is directed across five aspects: responses, prevention, assessment, intervention and workforce development.
[996] Hackett 25 October 2018 14/21-15/17; INQ002045_18
[997] INQ002045_19; 32; 81-82; Harmful sexual behaviour among children and young people, NICE guideline (2016)
[998] DFE000962_27-28
[999] INQ002045 para. 3.25. This was also reflected in *Workforce perspectives on harmful sexual behaviour, Findings from the Local Authorities Research Consortium 7,* National Children's Bureau and Research in Practice, 2016
[1000] Hackett 25 October 2018 40/7-14
[1001] Now called the 'Nottinghamshire Safeguarding Children Partnership'.
[1002] Few 22 October 2018 173/16-17
[1003] NSC001373
[1004] Brook Traffic Light Tool; NSC001474 para. 3d.2
[1005] NSC001587
[1006] This was a change from its strategy-meeting-based approach, and it met for the first time in June 2018 (NSC001604; NSC001391; NSC001591_1-5; 28-34).
[1007] Few 22 October 2018 173/18-174/12

data on children who had been sexually harmed had yet to be collated and the development of new procedures and protocols was still ongoing.[1008] The County held training in 2019 on harmful sexual behaviour for all practitioners working directly with children and young people and the training team were *"overwhelmed with interest"*.[1009]

31. As of October 2018, the County notifies incidents of harmful sexual behaviour to the Service Director[1010] and the Lead Member for Children's Services,[1011] as well as Ofsted, local safeguarding partners and the national Child Safeguarding Practice Review Panel.[1012] However, on some occasions in the past the notification process was not followed.[1013]

The City

32. As at October 2018, the City's Assessment and Early Intervention Panel – renamed the Assessment of Sexual Harm Arrangements (ASHA) panel in 2014[1014] – met monthly.[1015] Its remit, since 2017, has broadened to include those whose behaviour suggested they might sexually harm other children as well as those who had done so.[1016] Although Clive Chambers (the City's Head of Service for Children in Care) told us that the City's approach mirrors the NSPCC's framework,[1017] we have not seen evidence to support this or of steps taken to understand the extent of harmful sexual behaviour exhibited by or carried out against children in the care of the City or to audit their practice.[1018]

33. The City's Lead Member for Children's Services until May 2019, Councillor David Mellen, thought that it was less likely he would be informed of a case of harmful sexual behaviour, in contrast to other sexual abuse,[1019] and he had no sense of the scale of harmful sexual behaviour in the City.[1020]

E.5: Institutional responses

34. There is little information now available about the approach adopted by children's social care or the police towards harmful sexual behaviour for much of the 1970s and early 1980s. Some incidents were recorded in children's social services files but treated as behavioural problems or adolescent exploration.[1021] As Professor Hackett commented, while even good carers and professionals may not have understood harmful sexual behaviour at this time, they should still have been concerned about the sexual wellbeing and behaviour of children in care.[1022]

[1008] NSC001609. We understand that since the Inquiry's hearings, revised policy, practice and procedural guidance on harmful sexual behaviour has been completed and circulated to staff in the County.
[1009] Minutes of the NSCB Full Board Meeting 12 December 2018, p4
[1010] Edwards 23 October 2018 152/18-153/9
[1011] Owen 23 October 2018 186/12-24
[1012] DFE000962_32
[1013] Edwards 23 October 2018 153/10-155/2; 157/6-158/2
[1014] INQ002405 para. 4.3
[1015] NCC000424; NSC001337
[1016] Michalska 25 October 2018 99/3-101/10; INQ001792 para. 5.3
[1017] Which the City worked to develop, alongside seven other local authorities and the NSPCC (INQ001792 para. 5.4).
[1018] INQ001792 para. 5.4
[1019] Mellen 24 October 2018 82/12-90/19
[1020] Mellen 24 October 2018 97/20-98/14
[1021] For example D47, L46, A76, and supported by Professor Hackett (INQ002045_63-64 para. 7.42).
[1022] Hackett 25 October 2018 42/6-14; INQ002045_83 paras 10.1-10.4

35. The County accepted that it had "*let down*" a number of children who had been sexually abused by other children.[1023] To explore the institutional response, we have reviewed five internal enquiries, carried out between 1988 and 1995, into allegations of harmful sexual behaviour at different community homes in the County.

Harmful sexual behaviour in residential care

Amberdale (1987–1988)

36. In December 1987, two female residents of Amberdale alleged that they had been forced into oral sex by a male resident, aged 15. Their allegations were investigated by the police.[1024] In January 1988 the same male resident attempted to sexually assault another female resident, and three further allegations of harmful sexual behaviour followed over the next few days. As a result, there were "*real fears for the safety and security of females in the unit*".[1025] Despite this, no steps were taken by residential staff or social care managers to address the immediate risk of sexual abuse of other children and the harmful sexual behaviour was regarded as simply part of a pattern of disruptive behaviour.[1026] In March 1988, the child was removed from the unit and placed outside of Nottinghamshire.[1027]

37. In 1988, NO-A117, a 13-year-old male resident at Amberdale, made allegations of rape and oral sex against another male resident of the same age.[1028] The child alleged to be exhibiting harmful sexual behaviour had been admitted to Amberdale following allegations that he had committed buggery and murder. As children in the secure unit were closely supervised, no special arrangements had been considered necessary to separate children exhibiting harmful sexual behaviour from other residents.[1029]

38. NO-A117's allegations were escalated to children's social care, the placing local authority for each child, the police, councillors and the Department of Health Inspectorate. The child alleged to be exhibiting harmful sexual behaviour had allegedly threatened to kill NO-A117 if he told anyone of the abuse. Steps were taken to divide the unit to separate the two children. This proved to be unsustainable and the child alleged to be exhibiting harmful sexual behaviour was moved.[1030] Despite supportive medical evidence and a consistent statement from NO-A117, the police concluded there was insufficient evidence to proceed "*in the absence of any corroborative evidence*".[1031] The internal enquiry commenced in December 1988. In interview, staff said that they did not believe NO-A117. The investigation concluded that "*the truth will probably never be known*", but that children's social care's response had been "*appropriate*" and "*in keeping with good child care practice, embracing important principles guiding work with sexually abused children*".[1032] Recommendations included training and guidelines "*to assist residential staff when they have to deal with allegations of sexual abuse between children and young people in residential care*".[1033] Although the findings and recommendations were endorsed by councillors,[1034] they were not passed on to

[1023] NSC001657 para. 144; 26 October 2018 84/8-85/9
[1024] NSC000533_2
[1025] NSC000533_3
[1026] Fisher 18 October 2018 73/19-74/6
[1027] NSC000533_4
[1028] NSC000101
[1029] Fisher 18 October 2018 75/13-76/20
[1030] NSC000101
[1031] NSC000101_3-5
[1032] NSC000101_9-10
[1033] NSC000101_11
[1034] NSC001235 para. 5d.7

Amberdale staff.[1035] Recommended training did not take place[1036] and guidelines were only introduced in 1991[1037] (by which time further harmful sexual behaviour cases in residential care had been reported).

Greencroft Community Home (1990)

39. In May 1990, children's social care management and residential staff from Greencroft Community Home (which could accommodate up to 12 children, up to 17 years old)[1038] met to discuss "*kids being abused by kids*".[1039] They discussed possible ways to protect children, including the need for ongoing counselling, for children's inductions to include a discussion about sex and sexuality, and the deployment of waking night staff.

40. In July 1990, at which point eight of the nine Greencroft residents had been sexually abused previously,[1040] two incidents of harmful sexual behaviour, three weeks apart, were reported. The first incident involved a 15-year-old male resident allegedly sexually abusing four girls aged between seven and 16 in one night.[1041] The police were involved and recommended charging the male resident.[1042] The second incident involved one of the same four girls being sexually assaulted by a different male resident.[1043]

41. One of the victims, D31 (then aged 12), told us that these were just two of a series of five incidents of harmful sexual behaviour to which she was subjected by the same male residents and others.[1044] She had been placed at Greencroft with much older children[1045] which, along with a failure to monitor risks posed by other children and a lack of guidance for staff,[1046] left her at risk of abuse.

42. An internal enquiry reported, in September 1990, that "*widespread changes*" were needed across all children's homes to contain "*the problem of child abuse*" and give children "*the protection and help they need*".[1047] Children's social care were "*overburdened*" and responses to child sexual abuse had "*fallen far short of what is needed*".[1048] It was "*unacceptable*" and dangerous to mix together sexually abused children with children exhibiting harmful sexual behaviour,[1049] and there was no guidance on how to deal with either group.[1050] More generally, advice on the response to abuse was "*based on a premise of trained, skilled professional staff, whereas less than 10% of the staff are trained and many are temporary and inexperienced*".[1051] The report made 20 recommendations, including that:[1052]

[1035] Fisher 18 October 2018 74/7-75/12; INQ001895 para. 10(a)-(b)
[1036] Fisher 18 October 2018 84/25-85/11; INQ001895 para. 10(c)-(d)
[1037] NTP001473_136-137
[1038] NSC000102_4 para. 9
[1039] NSC001228_9
[1040] NSC000102_7
[1041] NSC000102_8-10
[1042] NSC000102_12 para. 41
[1043] NSC000102_22-23. The report does not address any police investigation into the second incident.
[1044] D31 5 October 2018 11/10-20
[1045] D31 5 October 2018 12/9-12
[1046] NSC000102
[1047] NSC000102_27
[1048] NSC000102_28
[1049] NSC000102_20
[1050] NSC000102_21
[1051] NSC000102_26 para. 77. Steve Edwards, County Service Director, agreed that there was a disconnect between policy and how individuals performed on a day-to-day basis (Edwards 23 October 2018 146/19-147/9).
[1052] NSC000102_32-34

42.1. steps be taken to "*separate abused children and perpetrators*" and "*priority … given to providing separate Homes for abused and abusers*"[1053] and

42.2. children's social care issue guidance to residential staff on dealing with harmful sexual behaviour[1054] and establish a system for monitoring and evaluating sex offenders in residential homes.

The Social Services Committee approved separating victims of sexual abuse and children exhibiting harmful sexual behaviour, with one community home to be designated for work with children exhibiting harmful sexual behaviour and another exclusively for sexually abused girls.[1055] These recommendations were not fully implemented by the County.[1056]

Sandown Road Community Home (1990–1991)

43. In 1990, in the course of a police investigation, two residents at Sandown Road Community Home admitted sexually assaulting and raping other residents at the home. One was cautioned and the other was given a supervision order.[1057] One of their victims (NO-A120) had also been anally raped by a different resident six months earlier. A safe and secure placement for the victims could only be found outside the County.[1058]

44. The County failed to prevent or respond appropriately to widespread sexual abuse at Sandown Road. A 1991 internal enquiry into the quality of child care at Sandown Road by senior social workers from the County found that children's social care staff:

> "*were very concerned by the sense of inevitability that any child admitted was subject to sexual abuse or involved in inappropriate sexual activities. In one 12 month period, every child admitted was involved in sexual abuse incidents whether they had been previously abused or not. This does not appear to have been a problem since April of this year.*"[1059]

Staff had reported concerns about the management of disclosures, that staff meetings had not addressed how to manage abused children and "*the needs of the individual children in terms of counselling and protection were forgotten*".[1060] Social workers were concerned that "*staff had not been able to prevent*" the "*high levels of sexual abuse*".[1061] Requests for training and support for staff had not been responded to by Paul Bohan, Senior Professional Officer within the County at the time.[1062]

45. Sandown Road was temporarily closed that year, in line with the report's recommendations. Although the Social Services Committee were informed of the closure, there is no record of how much they were told of the abuse suffered by some of the children and staff concerns.[1063]

[1053] NSC000102_20, 32. This echoed a similar recommendation made by the Adolescent Sex Offenders Group earlier that year.
[1054] This suggests that the same recommendation from the 1988 Amberdale report had yet to be implemented.
[1055] NSC000438_13-27
[1056] AFC000068 paras 3.2-3.4; 3.11; AFC000060; AFC000069; NSC000104_78-79
[1057] NSC001495
[1058] NSC001495_8-10
[1059] NSC001502_3
[1060] NSC001502_3
[1061] NSC001502_5
[1062] NSC001502_3
[1063] NSC001494

46. There is no evidence of anyone within children's social care considering this report alongside the Greencroft and Amberdale reports despite those reports raising similar issues. Co-author of the Sandown Road report, Sue Gregory (Senior Social Worker at the time), told us that when writing the report, she was unaware of the similar issues that had been raised in the Greencroft report the previous year.[1064] This lack of information sharing was poor practice.

Hazelwood Community Home (1991–1994)

47. A former resident of Hazelwood (another community home), NO-A89, alleged in 1991 that he had been raped by three other residents at the home in 1985.[1065] The other residents were aged between 11 and 15 years old.[1066] It was known to staff in 1985 that NO-A89 had suffered serious physical abuse by other residents "*with potentially sexual content*".[1067] At the time, the other residents had remained at Hazelwood and staff were not warned of the risk they posed to other children.[1068]

48. Tony Dewhurst (a children's social care manager in the County, whose role at the time included supervision of and advice to management at Hazelwood) was said to have been aware of the rape according to NO-A89's social worker at the time,[1069] although Mr Dewhurst told us that he could not remember being informed about it.[1070] Mr Dewhurst had also allegedly described one incident involving NO-A89 as "*normal adolescent behaviour*",[1071] however it is unclear whether this related to the rape or to physical abuse suffered by NO-A89. He did notify the Social Services Inspectorate (SSI) of the allegation in November 1991, saying that "*lessons … have been learnt*". The SSI responded that "*The general question of whether community homes in Nottinghamshire are safe places in which children can live is clearly the most important factor.*"[1072]

49. In 1992, NO-A89's social worker and his key worker at the time of the 1985 assaults voiced their "*extreme concern*" to David White, the Director of Social Services, about the abuse and the response to it, including the disappearance of files, the failure to investigate staff and children's social care's failure to take responsibility for the harm caused to young people in the care system.[1073]

50. At a meeting in August 1992 between County legal and insurance officers and a children's social care manager, they agreed that:

> "*there was basically no discipline in this particular home, no action was taken against the perpetrators, there was no psychological help for* [NO-A89] *and the records of all the incidents have since been destroyed*".

It was agreed that a working party within the County should consider various issues, including "*segregation of abusers and abused or males/females*" and the reporting of incidents of abuse[1074] but no such group was set up.

[1064] Gregory 18 October 2018 169/7-171/5
[1065] NSC000983_5-7
[1066] NSC000105_4
[1067] NSC000976_1-7
[1068] NSC000980_20
[1069] NSC000105_2, 27-28
[1070] INQ002731
[1071] NSC000976_4-5; NSC000980_30; NSC000105_27-29
[1072] NSC000983_9-11
[1073] NSC000980_19-21
[1074] NSC000440_41-43

51. One of the three residents was convicted in 1992 and sentenced to five years' imprisonment. The judge commented that "*if the home had been run better by social services the offence could not have been committed*".[1075]

52. An internal enquiry was ordered by David White. Its report concluded, in 1993, that it was not possible to determine whether senior staff had been aware of the harmful sexual behaviour incidents at the time due to a lack of records.[1076] However, it concluded that insufficient control had been exerted by staff, so that "*powerful boys*" had created a culture of "*intimidation and violence*".[1077] The report also identified failures by staff to take action to prevent the abuse by responding to persistent and serious bullying of NO-A89 and to respond appropriately afterwards. Its recommendations did not address harmful sexual behaviour in community homes but did recommend training on the support needs of children who had suffered abuse and their vulnerability to abuse from other children. This was implemented.[1078]

Farmlands Community Home (1995)

53. In March 1995, a fifth enquiry was carried out, following a complaint that a resident at Farmlands Community Home, D46, was at risk. It concluded that "*particularly difficult children some with problems of sexually abusive behaviour have tended to end up in Farmlands*"[1079] and there were a number of complaints of sexual abuse between residents. The report identified a failure to move D46 and one of the children exhibiting harmful sexual behaviour, despite this being recommended by case conferences and the police. It concluded that the County failed to protect D46 by exposing him to both physical and sexual abuse. There was:

> *"no strategy dealing with the sexualized behaviour of adolescent boys. No consistent therapeutic approach and there are limitations to the service that is provided at the moment … The Child Protection Policy within residential care is both inadequate and unclear. Therefore it is recommended that a clear procedure be laid down and staff be made aware of these."*[1080]

This was compounded by there being "*no overall strategy across the County*".[1081]

54. The Service Standards Unit annual report for Farmlands that year commented:

> *"resident/resident abuse has occurred and the inspecting officers were very concerned about child protection issues in their widest sense. These concerns have been the subject of a confidential document sent to the Director of Social Services."*[1082]

We have not seen this document nor any documents setting out the children's social care response to the report into D46.

[1075] NSC000983_17
[1076] NSC000105_34
[1077] NSC000105_19
[1078] NSC000980_26
[1079] NSC001644
[1080] NSC001644_6
[1081] NSC001644_5
[1082] OFS008178_17

Wider consideration of these investigations

55. While each investigation covered different institutions and raised its own issues, they were all commissioned by the County's children's social care service about children in their care in their establishments. However, children's social care do not appear to have considered these investigations together or their wider implications. There is no record of the Sandown Road report or the Farmlands report being considered by senior managers within children's social care or by the Social Services Committee. Knowledge and learning were not shared across the County; each report was considered, if at all, in isolation, with no reference to the findings or recommendations in the preceding reports.

56. There was also no apparent attempt to disseminate those findings or recommendations to staff in children's social care. For example, Margaret Stimpson (the County's Children's Service Manager in the early 1990s, responsible for a number of other residential homes) was unaware of the risk to children in care of harmful sexual behaviour and was never briefed about events at Amberdale, Greencroft, Hazelwood and Sandown Road or the reports.[1083]

Other cases of harmful sexual behaviour in residential care

57. Between 2001 and 2005, there was a series of disclosures of harmful sexual behaviour in children's homes that were by that time the responsibility of the City:

57.1. In 2001, NO-A483, a resident at Beckhampton Road[1084] disclosed to staff that he had been raped by his roommate, who was then arrested and remanded to secure accommodation.[1085]

57.2. In 2002, L43 alleged that another resident at Beechwood had indecently assaulted him.[1086] L43 told staff but felt like he was "*talking to a brick wall*", and was discouraged from pursuing the matter with the police.[1087] He told us that sexual activity between children at Beechwood happened "*pretty much daily*" and staff did nothing about it.[1088] L43 was seen as a "*management problem*" for staff.[1089]

57.3. The same year, the National Care Standards Commission (NCSC) concluded that Beechwood was "*an environment where vulnerable young women, and men, were liable to be sexually exploited by each other*".[1090] Michelle Foster (a staff member) told us that there was no guidance or training on harmful sexual behaviour.[1091] Understaffing meant they could only manage and monitor sexual activity.[1092]

57.4. In late 2003, NO-A479, a Beechwood resident, disclosed that she had twice been pressured into having sex with a male resident and thought she might be pregnant. The male resident should have been supervised closely by staff, having committed sexual offences against young children, but this had not been possible because of staff

[1083] Stimpson 17 October 2018 41/2-42/22
[1084] The name given to Redtiles from May 1996.
[1085] NCC003543
[1086] NCC000349; NCC000350; L43 3 October 2018 67/18-68/12
[1087] L43 3 October 2018 69/6-72/3
[1088] L43 3 October 2018 65/8-17
[1089] NCC003799_2
[1090] NCC000297_22
[1091] Although at this point, staff in City children's home should have been following the 2001 cross-authority child protection procedures (see NSC000079_182-183).
[1092] INQ002673 paras 25, 46; Foster 18 October 2018 16/21-17/5

shortages. The NCSC were notified[1093] and visited Beechwood.[1094] The Assessment and Early Intervention Panel assessed the ongoing risk posed by the male resident as "*very high*" and supported a prosecution "*should there be sufficient evidence*".[1095]

57.5. In October 2003, NO-A480, a resident of Beechdale Road, disclosed he had been forced to perform oral sex and masturbation by two other residents. There was a joint investigation.[1096] One of the children allegedly exhibiting harmful sexual behaviour was removed, but the other remained in the home despite a recommendation to reconsider this by the Assessment and Early Intervention Panel. No charges were brought against the two residents[1097] and the one who remained at Beechdale Road was subsequently involved in another "*very similar incident*" with a different victim, which also did not proceed to charge.[1098]

57.6. In 2004, strategy meetings were held amid concern about sexualised behaviour of 10 children in City children's homes, including allegations of rape.[1099] The meetings were "*to try and establish whether the incidents constituted child-on-child sexual abuse, and if so who were the victims and who were the perpetrators*".[1100] Two of the children had been charged with sexual offences against children, but there had previously been separate strategy meetings for the individual children, so only "*assorted information*" had come to light. It was concluded that intensive sex education was needed for all children, and that all of the City's children's homes needed to liaise with each other regarding the children's activities.

However, it does not appear that any steps were taken to address these cases at a senior management or political level.

58. Staff lacked sufficient guidance or training on harmful sexual behaviour.[1101] Glynis Storer, the City's Practice Manager for Young People who Sexually Harm in the 2000s, said she never trained residential staff on harmful sexual behaviour.[1102]

Harmful sexual behaviour in foster care

59. Few studies have been conducted on harmful sexual behaviour in foster care.[1103] Research shows a lack of information provided to foster carers about allegations of harmful sexual behaviour made against children placed with them, and the risks associated with their behaviour. This has impeded foster carers' ability to identify or respond to harmful sexual behaviour.[1104]

60. We received evidence of four cases of alleged harmful sexual behaviour in foster care between 2002 and 2007: one in the City and three in the County. These involved multiple rapes, sexual assault and forced oral sex. There was a significant difference in age between the children allegedly exhibiting harmful sexual behaviour and the complainants in most of

[1093] OFS008182
[1094] OFS008180
[1095] NCC000351
[1096] NCC003537; NCC003538; NCC000352
[1097] INQ002434 paras 10.2-10.3
[1098] INQ002434 paras 10.2-10.3
[1099] NCC003544; NCC003536; NCC003539
[1100] NCC003536_9
[1101] Hackett 25 October 2018 29/23-30/16; INQ001984 para. 14.4
[1102] INQ002434 para. 11.1
[1103] Hackett 25 October 2018 32/3-9; INQ002045_59
[1104] Hackett 25 October 2018 41/1-42/1; INQ002045_80

the allegations. We have seen no documentary evidence relating to the response to any earlier instances of harmful sexual behaviour in foster care, but the absence of records does not mean that earlier abuse did not occur.

61. In each of the four cases, the police were notified. In three of them, steps were taken to reduce the risk of further abuse, either by ensuring no unsupervised contact[1105] or by moving the child allegedly exhibiting harmful sexual behaviour.[1106]

62. However, in one case an alternative placement could not be found for a child allegedly exhibiting harmful sexual behaviour so he remained in the same placement as the complainants.[1107] In another, the police did not pursue allegations of harmful sexual behaviour in one foster home until the same complainant made allegations relating to another child two years later. By this time the complainant did not want to pursue her original complaint.[1108] In that case, the City also failed to properly assess the risks posed or support needed by the child allegedly exhibiting harmful sexual behaviour, despite procedures at the time requiring them to do so.[1109]

Recent years and ongoing issues

63. Since 2010, a number of cases have raised issues about the way in which the Councils respond to allegations of harmful sexual behaviour. In the City, a serious case review in 2011 highlighted the need for clear governance in addressing incidents. The review also called into question the effectiveness of its Assessment and Early Intervention Panel. In the County, the variable responses to allegations showed a continuing lack of understanding amongst residential care staff of the complexities in individual cases, and the challenge in knowing what to do in practice, despite the guidance and procedures in place.

64. The 2011 serious case review followed the suicide of a child in the care of the City[1110] who had suffered sexual assaults by other residents and had displayed harmful sexual behaviour himself. It described children who sexually offend as "*one of the most vulnerable groups of children*", who needed "*robust processes*" to assess their "*levels of need, vulnerability, risks posed and appropriate interventions*".[1111] It recommended that the process of assessment should be reviewed and strengthened:

> "*to ensure that these children have a full assessment and intervention plan that supports their own vulnerability and safeguarding needs. This will include the development of clear governance and performance management arrangements*".[1112]

In spite of these recommendations, in the 2013 annual review of the Assessment and Early Intervention Panel, it was noted that meetings of the group responsible for overseeing the work of the City's AEIP had "*not taken place for some time*".[1113]

[1105] A609 – NSC001438
[1106] A607 – NSC001440; NTP001561; A610 – NSC001442
[1107] NTP001579
[1108] NCC003783; NCC003784
[1109] NSC000079_182-183
[1110] NCC003788
[1111] NCC003788_117
[1112] NCC003788_137
[1113] NCC003797

65. In 2012, the County failed in its response after a four-year-old in foster care with the County, NO-A605, was forced to perform oral sex on a 13-year-old child in care who was visiting the foster home.[1114] The AIM assessment was delayed due to a lack of trained social workers. The chair of the series of strategy meetings said that the County's response "*could be seen as negligence*".[1115] When an assessment finally did take place,[1116] it identified that the 13-year-old had been involved in an earlier incident of harmful sexual behaviour with another child which was not investigated. It was agreed that children's social care should complete a learning review into the case, but there is no evidence of what, if any, lessons were actually taken forward.[1117]

66. There were also failings by the County in 2014, when a resident in a County children's home, NO-A588, was subjected to forced oral sex and masturbation by another resident.[1118] This led to an internal investigation, carried out by an independent investigator under the County's complaints procedure following a complaint made on behalf of NO-A588,[1119] which found that "*staff at the care home failed in their duty of care*".[1120] There had been no assessment prior to placement of whether the victim would be safe at the home, and staff had not been informed about the known risks posed by the child exhibiting harmful sexual behaviour. Following the abuse, risk assessments were carried out, the complainant was moved to ensure his safety and the child exhibiting harmful sexual behaviour was closely supervised before moving to a therapeutic placement.[1121] However, the investigation found that it was unclear "*how well the incident … was investigated and how seriously it was taken in respect of lessons that could be learned from what happened*".[1122] Although it was recommended that the County acknowledge their failings and consider an apology and appropriate redress to NO-A588, it was not until 18 months later that the County made an "*unreserved apology*" for the failings which resulted in him being abused.[1123]

67. In November 2016 and May 2017, allegations of harmful sexual behaviour were made at a children's home run by a private company, Homes2Inspire.[1124] Homes2Inspire had its own safeguarding policy specific to harmful sexual behaviour.[1125] This required any concerning behaviour to be referred to social workers and other relevant agencies.[1126] Staff were only to conduct an internal investigation if the local authority gave permission and the allegation either did not meet the threshold for police involvement or the police had concluded their enquiries.[1127] In practice, whilst the Deputy Manager at the home was clear that staff would not question children, he was confused as to the distinction between an investigation and how this differed from initial fact finding.[1128]

[1114] NTP001550; NSC001435
[1115] NSC001435_29-35
[1116] NSC001435_55-58
[1117] NSC001435_101
[1118] NSC001478_1-4
[1119] NSC001478_6-13, 68-70
[1120] NSC001478_71-127
[1121] NSC001478_30-42; 48-66. In December 2014, the child exhibiting harmful sexual behaviour was sentenced to an 18-month detention centre order (NSC001478_67).
[1122] NSC001478_127 para. 7
[1123] NSC001478_129-135, 139
[1124] NCC003778; INQ000773; INQ000758; INQ000759
[1125] INQ002421_27; Yates 19 October 2018 53/10-55/13
[1126] Yates 19 October 2018 47/14-48/5
[1127] Yates 19 October 2018 50/4-6
[1128] INQ002420 para. 26; Yates 19 October 2018 64/19-65/4; 79/3-10

68. NO-A136 alleged, in October 2016, that she had been sexually abused in her previous foster placement by the foster carers' son.[1129] At the time, she was 11 years old and the alleged perpetrator 21. Nonetheless, the Deputy Manager noted that NO-A136 "*hasn't stated if this was consented or not*"[1130] despite the fact that consent would have been irrelevant.[1131]

69. Allegations of sexual abuse made against NO-A136 by a male resident in November 2016[1132] and by NO-A136 against another male resident in May 2017 were handled appropriately. In the former case, the police decided it was not in the public interest to proceed;[1133] in the latter, they concluded NO-A136's complaint was "*a hoax*". In any event, proactive steps were taken to protect the children and a detailed safety plan was put in place. This included increased supervision, extra staff, sex education, a sexualised behaviour tracking log, preventing children from going into each other's rooms and trying to ensure a family atmosphere in the home.[1134] Staff also received specific training on harmful sexual behaviour and sexualised behaviours as a result of the second incident.[1135]

E.6: Nottinghamshire Police and Crown Prosecution Service approach to non-recent harmful sexual behaviour

Nottinghamshire Police

70. Although Nottinghamshire Police had a specialist team dealing with cases of child sexual abuse from 1988 onwards,[1136] allegations of harmful sexual behaviour were excluded from its remit and were instead dealt with by its Criminal Investigation Department (CID).[1137] This was because harmful sexual behaviour does not involve a perpetrator with care of or control over the victim.[1138]

71. From 2006,[1139] certain cases of harmful sexual behaviour were dealt with by the CAIU and others by the CID, depending on the severity of the alleged offence. In any event, all harmful sexual behaviour cases should have been discussed with the CAIU, given its role in advising and monitoring the conclusions of harmful sexual behaviour investigations to ensure a consistent and appropriate response.[1140] Since 2011, all allegations of harmful sexual behaviour should be referred to the CAIU.[1141]

72. We have not seen any guidance or policy specific to the investigation of allegations of harmful sexual behaviour by Nottinghamshire Police.[1142] We were told that "*generally these cases are dealt with in a way that is similar to other cases of abuse*".[1143] Child Abuse Investigation procedures simply state that where the suspect is a child, "*this will not prevent a crime from being investigated*".[1144]

[1129] INQ000763
[1130] INQ000764
[1131] As accepted in evidence by Daniel Yates (Yates 19 October 2018 62/4).
[1132] INQ000776; INQ000773
[1133] Yates 19 October 2018 77/6-25
[1134] INQ002421_42-51
[1135] Yates 19 October 2018 91/19-92/22
[1136] The Family Support Unit (FSU) from 1988 to 1994, and then the Child Abuse Investigation Unit (CAIU) thereafter.
[1137] See, for example, NSC001497_12
[1138] Hicks 19 October 2018 141/14-142/3
[1139] NTP001495
[1140] NSC001590; NSC001608
[1141] NTP001536 para. 128
[1142] Nor is there any Operation Hydrant guidance on investigating harmful sexual behaviour.
[1143] INQ001970 para. 82
[1144] NTP001498 para. 4.8

The Crown Prosecution Service

73. Since 2009, all harmful sexual behaviour allegations must be referred to the Crown Prosecution Service for it to authorise charges.[1145]

74. The Crown Prosecution Service's approach has changed over time as it has become more aware of issues in relation to the vulnerability of both victims and children exhibiting harmful sexual behaviour, consent, adolescent relationships and public interest criteria. From 1986, when deciding whether to institute proceedings the Crown Prosecution Service was required to take into account the relative ages of the complainant and alleged perpetrator, and whether there was any element of "*seduction or corruption*".[1146] Specific guidance relating to the prosecution of harmful sexual behaviour cases was first included in the 2009 guidelines on prosecuting cases of child abuse, which required all such cases to be reviewed by a youth prosecutor.[1147]

75. More recently, Youth Offenders Guidance[1148] set out some of the unique considerations for prosecutors dealing with harmful sexual behaviour cases, which primarily affect the public interest test. It is emphasised that the overriding public concern is to protect children, rather than punish them unnecessarily.[1149] Factors to consider include: the relevant ages and the sexual and emotional maturity of the parties, the views of other agencies involved, the likely impact of any prosecution on the parties, and whether there is any element of exploitation, coercion, threat, deception, grooming, seduction, manipulation or breach of trust in the relationship. A distinction is drawn in relation to children under the age of 13:

> "*There is a fine line between sexual experimentation and offending and in general, children under the age of 13 should not be criminalised for sexual behaviour in the absence of coercion, exploitation or abuse of trust.*"[1150]

Allegations of non-recent harmful sexual behaviour

76. More than 50 complainants who were in the care of the Councils allege non-recent harmful sexual behaviour, but few have reported their allegations to the police. For those who did report to the police, some allegations have led to a decision by the police or Crown Prosecution Service to take no further action,[1151] whilst investigations into others were still ongoing as at October 2018.[1152] We are aware of only one prosecution for non-recent harmful sexual behaviour, which took place in the early 1990s and related to harmful sexual behaviour at Hazelwood in 1985.

77. L43 contacted the police recently regarding harmful sexual behaviour in 2002. He was told that there was nothing that the police could do because he did not press charges at the time.[1153] Chief Superintendent Robert Griffin confirmed that a complainant's earlier decision not to proceed with allegations would not be a bar to the police now taking his complaint forward, and that on the face of it there should have been an investigation into

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1145 And all other allegations of sexual or physical abuse involving under 18s (CPS002804_6).
1146 CPS002784 para. 8(vi)
1147 CPS002804_6
1148 CPS003476
1149 CPS003476_14-17; CPS002805_64-69
1150 CPS003476_16
1151 For example, P4, L46, A76, D38 and L22 (INQ002574). In the case of NO-A94, the police decided not to speak to the alleged perpetrator (who had been a child at the time of the alleged abuse, but was an adult at the time of the allegation) on the basis that there was no corroborative evidence and she had been a victim of sexual abuse (NTP001632_1-4).
1152 NSC000345; NTP001636_6-10; P16 26 October 2018 3-6; NTP001632_11-14, 21-24
1153 L43 3 October 2018 86/16-87/18

L43's allegations.[1154] Despite the police not pursuing an investigation in this case, Chief Superintendent Griffin had not sensed any reluctance in general to investigate non-recent allegations of harmful sexual behaviour.[1155]

78. At present, allegations of non-recent harmful sexual behaviour in care (made by adults no longer in care) are generally investigated by the adult team within Nottinghamshire Police's Public Protection Unit. If a complainant alleges non-recent abuse in care by staff and also alleges they were abused by a child, it will be investigated by Operation Equinox.[1156]

79. Neither the police nor the Crown Prosecution Service appear to have specific guidance on the prosecution of cases of non-recent harmful sexual behaviour. This means that there is no specific guidance on some of the difficult issues in these cases, such as the extent to which someone should be held responsible for offences carried out many years ago whilst he or she was a child in care, the impact of a child exhibiting harmful sexual behaviour having been abused themselves, and how the question of consent should be approached. Instead, these matters are left to individual police officers and prosecutors to consider.

80. The understanding of and response to harmful sexual behaviour between children has developed significantly over the past three decades. There had been a focus on the issue in the County in the late 1980s and early 1990s, with five enquiries into harmful sexual behaviour in children's homes, the formation of an Adolescent Sex Offenders Group, and the development of policies and procedures. Whilst the enquiries established that harmful sexual behaviour was widespread in its children's homes, the County did not address the prevalence of harmful sexual behaviour or take sufficient action to prevent and respond to incidents. More recently, however, the County has taken steps to evaluate and improve its response to harmful sexual behaviour, to better understand its scale, and to develop new approaches to its prevention.

[1154] Griffin 25 October 2018 199/22-201/1
[1155] Griffin 25 October 2018 187/22-188/9
[1156] Griffin 25 October 2018 188/13-189/1

Part F

Cross-cutting themes

Cross-cutting themes

F.1: Barriers to disclosure

1. One key issue relevant to the three case studies in this investigation, and beyond, is why so many people do not report abuse. Research indicates that up to two-thirds of children do not disclose abuse during childhood,[1157] and only around 25 percent of those who are abused disclose when they reach adulthood.[1158] For those who do disclose, it takes them on average around 24 years to do so from the time of the abuse.[1159] Older children who do disclose will most frequently do so to their peers.[1160]

Barriers for children

2. Complainant core participants, other complainants who have given interviews to the police and some of the institutional witnesses who gave evidence to us identified the barriers to disclosure they had seen or experienced. These fall into a number of broad categories:[1161]

2.1. Fear of not being believed, or of being told by the perpetrator that they would not be believed.

2.2. Being scared, threatened with violence by the perpetrator or told by them not to tell anyone.

2.3. Having no one to whom they felt able to disclose, which may be due to a lack of trust, a feeling of isolation, a lack of opportunity to speak to a social worker on their own, or not having the same social worker for a sustained period.

2.4. Feeling embarrassed, ashamed or guilty, including because of grooming.

2.5. Not understanding what was happening at the time or seeing the abuse as normal, possibly due to grooming or past abuse.

2.6. Thinking that disclosure was not worthwhile, including due to a negative response to previous disclosure or because staff were involved or implicated in some way in the abuse.

2.7. Fear of being separated from family.

2.8. Inhibition by shock, trauma or mental health problems caused by the abuse.

[1157] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, sections 4–6
[1158] NSC000002_22 para. 84
[1159] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, p22
[1160] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, pp37–38
[1161] INQ002574; INQ002575; INQ002576; INQ002577; INQ001875_19-23; INQ001876; INQ001960 para. 41; INQ001951 paras 214-221; INQ002007 paras 28.1-28.2; INQ001981 para. 8.1; INQ002480 para. 56.11; INQ002039 paras 66-70; INQ001807 paras 16.1-16.4; INQ002628 para. 60; INQ001964 para. 119; MacKechnie 18 October 2018 149/8-150/1; INQ001983; INQ001787; INQ001758; INQ001792; INQ001806; INQ001895 paras 5-7; INQ001984 paras 15.1.4-15.1.5; INQ001987 para. 19; INQ002405 para. 11.1; INQ001799 para. 150

2.9. Fear that disclosure would affect their next placement.

3. Other barriers identified by professionals[1162] included children having other priorities,[1163] feeling that they have found some stability or having an affection for the perpetrator or their family member,[1164] and fearing that they will lose control of the process once they disclose.[1165] There may also be practical issues such as disability or language and cultural differences.[1166] Having suffered neglect or abuse in the past, leading to attachment difficulties, may also inhibit disclosure.[1167]

4. A large number of complainants of sexual abuse in care have come forward as adults to this investigation or to Nottinghamshire Police but, for others, barriers to disclosure remain. These barriers may be continuations of those listed above, such as a fear of not being believed,[1168] a feeling of shame or guilt,[1169] a lack of trust in authority[1170] or fear of the perpetrator.[1171] Adult survivors may also be frightened that disclosure might have a negative impact on their relationships or that their own child might be removed by social services.[1172] They may also think that the support available will not be good enough[1173] or they may have lost faith in the strength of their claim after, for example, being unable to access their records.[1174]

5. There is little evidence available on specific barriers to disclosure of harmful sexual behaviour.[1175] Professor Hackett's view was that children were probably less likely to disclose harmful sexual behaviour than adult-perpetrated sexual abuse, in part because public education campaigns have largely focused on risk from adult perpetrators.[1176]

6. Even if a child makes an initial disclosure of abuse, the barriers to reporting discussed above may lead them subsequently to retract their disclosure.[1177] Professionals need to deal with retractions cautiously and consider the possible reasons behind them.[1178]

Impact of relationship with perpetrator or type of placement

7. The type of placement, and the relationship between the complainant and the perpetrator, can have an impact on the barriers that arise in any individual case.[1179] As a result, barriers to disclosure for children abused in care may require different considerations from those for children abused in the family home or in a religious or school setting.

1162 Including in a 2011 Serious Case Review into Patrick Gallagher (NSC000002).
1163 INQ001875_22
1164 INQ001875_22-23; INQ001983; INQ001758; INQ001895 paras 5-7
1165 Fisher 18 October 2018 101/7-102/4
1166 INQ001875_23; INQ002480 para. 56.11; *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, p43
1167 NSC000002_24, 58-59
1168 D46, L25 (INQ002574).
1169 L28 (INQ002039 para. 71).
1170 D44, D48 (INQ001984 para. 15.1.5).
1171 Coupland 24 October 2018 158/20-159/1
1172 For example L52 (Coupland 24 October 2018 159/4-160/8; NSC000002_61).
1173 Coupland 24 October 2018 160/25-161/17
1174 D6 5 October 2018 73/23-79/20
1175 INQ002045_70 para. 8.13
1176 Hackett 25 October 2018 43-44
1177 INQ001813 para. 151; NSC000507
1178 NSC000473_1-5, as was the advice in the County since at least 1996.
1179 *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, p40

8. Evidence suggests that children in care can be more vulnerable to abuse than other children, which may be due to their experiences prior to coming into care. For example, the impact of neglect may make it more difficult for children in care to distinguish between appropriate behaviour from trusted people and harmful relationships or activities.[1180] Particular barriers for children in care include:

8.1. Children may be less likely to know what abuse is, if carers feel that it is an inappropriate topic to discuss.[1181]

8.2. Those who may be best placed to provide an avenue for reporting, such as social workers, are often the same people who have removed them from their family (or other source of harm), which may make it difficult to establish trust.[1182]

8.3. Children who do disclose often do so to a relative (most likely mothers[1183]) or a friend. Those in care are away from their families and may well not be in settled placements or schools. As a result, the opportunity for, and likelihood of, disclosure is reduced.[1184]

8.4. Children may fear that if they do disclose their placement will break down, necessitating another new placement, or that they will be separated from their peers or siblings.[1185]

9. Some particular factors relevant to residential care may include:

9.1. The institutional environment has an inherent power imbalance, increasing the vulnerability of the child and making it more difficult for them to speak out.[1186]

9.2. There may be a sexualised culture within the home, including amongst staff, leading to a lack of appropriate boundaries and an unsafe environment in which children would find it difficult to talk about sexual abuse.[1187]

9.3. Physical abuse, including by staff, may inhibit disclosure by children through fear of retributive violence.[1188]

10. Specific factors affecting those in foster care may include:

10.1. Vulnerable children who experience apparent kindness and attention from a foster carer, which they may not have previously had at home, may then have conflicted feelings about disclosing abuse by the foster carer.[1189]

[1180] NSC000002_23 para. 86
[1181] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 12, Contemporary out-of-home care, p179
[1182] NSC000002_22 para. 85
[1183] *'No one noticed, no one heard': a study of disclosures of childhood abuse*, NSPCC, 2013, p24
[1184] NSC000002_43 para. 216, 58-59 para. 296 b
[1185] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 12, Contemporary out-of-home care, pp183–184
[1186] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 4 Identifying and disclosing child sexual abuse, p40; INQ001895 para. 32; INQ001984 para. 15.1.2
[1187] Cooper 9 October 2018 91/11-24
[1188] For example, see the evidence of P8, D28, D33, D48, L28, A76 (INQ002574).
[1189] *Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*, Volume 12, Contemporary out-of-home care, p183; INQ001875_23

10.2. Some foster carers become trusted by social workers and other professionals, perhaps because of the length of time they have been foster carers or the number of children they have fostered.[1190] Their reputation can then make children in their care feel less likely to be believed if it is their word against the foster carer's.

10.3. Long-term foster care will often involve care of a child over many years beginning from a young age. The depth of the ensuing relationship may act as a barrier – research suggests that the type of abuse least likely to be disclosed is long-term abuse by a carer or trusted adult which starts at a very young age.[1191]

Reducing barriers to disclosure

11. A number of steps towards reducing barriers to disclosure are set out in the Councils' Inter-Agency Safeguarding Procedures, including:

- ensuring that children feel valued and respected, and listening and responding to their concerns;
- training staff and foster carers to be alert to children's vulnerabilities;
- giving children ready access to a trusted adult outside their placement and making them aware of independent visiting and advocacy services;
- having clear, effective and accessible complaints procedures for children;
- having clear procedures for staff to raise concerns about other staff or carers, such as a whistleblowing policy; and
- ensuring that if a child goes missing, guidance is followed and steps are taken to understand the reasons.[1192]

12. In terms of the response to children, as far back as 1984, multi-agency procedures in the County stated:

> *"Almost all allegations by children of sexual abuse are true and it is important to communicate to the child at the outset that they are believed … The victim needs to hear that full responsibility for the offences rests with the offender."*[1193]

13. There are other steps which already form part of recognised good childcare practice[1194] and which may also reduce barriers to disclosure:

13.1. Children having the same social worker whom they are able to see alone on a regular basis and with whom they can establish a relationship.[1195]

13.2. Placements being regularly reviewed during unannounced visits.[1196]

[1190] NSC000002_23 para. 87, 122 para. 675 b
[1191] NSC000002_54 para. 279 b
[1192] Interagency Safeguarding Children Procedures of the Nottinghamshire Safeguarding Children Partnership (NSCP) and the Nottingham City Safeguarding Children Partnership (NCSCP) 2019
[1193] NSC000075_11
[1194] Fostering Services (England) Regulations 2011; Children's Homes (England) Regulations 2015; Interagency Safeguarding Children Procedures of the Nottinghamshire Safeguarding Children Partnership (NSCP) and the Nottingham City Safeguarding Children Partnership (NCSCP) 2019
[1195] INQ001758; INQ001951 para. 227
[1196] INQ001960 para. 42; INQ001807 para. 16.3; INQ001942 para. 9.5

13.3. Ensuring social workers, residential care staff and foster carers are able to "*think the unthinkable*".[1197]

13.4. Providing support and counselling services to children from their first disclosure of an allegation.[1198]

13.5. Providing children with age-appropriate information which sets out that some behaviour, whether from adults or peers, is unacceptable and may constitute sexual abuse, and educating them about what they should do if a friend tells them they are being abused.[1199]

13.6. Ensuring that residential staff, foster carers, social workers, children's social care managers and police officers are aware of the barriers to disclosure and of the need to take proactive steps to elicit disclosures.

> "*Professionals need to be alert to a child's attempts to begin to disclose. The information children share may be piecemeal and not necessarily evidential. What children say must also be viewed in the context of their behaviours and professional concerns in order to formulate a clear assessment of risk and plan of protective action.*"[1200]

14. Following recognised practice will assist the Councils to reduce the barriers to disclosure for children in the future.

F.2: Recent responses to complainants

15. Once complainants come forward and do disclose sexual abuse, they have then to engage with various institutions, including the police, the Councils and the Crown Prosecution Service. In this they face numerous challenges, such as interviews and investigations, giving evidence in criminal trials, obtaining their social service records, commencing legal claims for compensation, establishing contact with the Councils, and accessing support and therapy.

16. Complainants have expressed concern about the level and quality of support received during Council or police investigations, or during any criminal trial that arises, and after an investigation has concluded. Some complainants become so critical of the support that they no longer want to engage with these mechanisms,[1201] while others say they received no support and had to find it for themselves.[1202]

Responses from the Councils

17. In early 2015, the County formed a Historical Abuse Team of social workers to work with adults making allegations of non-recent abuse. This team is responsible for the County's children's social care service's enquiries into allegations[1203] and for supporting any police investigation. The team also works with the Support for Survivors Group[1204] and supports

[1197] A message currently being delivered to social workers and others in the County by three victims of non-recent abuse (INQ001951 para. 227).
[1198] INQ001983; INQ001964 paras 124-125
[1199] NSC000002_128 paras 708-709; INQ001942 para. 9.5; Dales 22 October 2018 58/12-22; INQ002045_75-76 paras 8.26-8.27
[1200] NCC003788_126
[1201] Including D10, P9, D4, D42, D5, D26, D20, L51, P1, P8, P3 (INQ002574).
[1202] D7 2 October 2018 94/22-95/25; L17 2 October 2018 149/24-151/7
[1203] Historical Cases of Abuse, Nottinghamshire County Council (updated January 2017)
[1204] Edwards 23 October 2018 126/6-14; INQ001951 para. 27

complainants, providing referrals to specialist services and producing chronologies of complainants' time in care based on the records.[1205] Although this constitutes a dedicated resource providing personalised support to complainants, it was developed "*a little late*".[1206] Funding has now been secured until at least March 2020.[1207]

18. The City has one social worker supporting police investigations, and allows the police full access to child care records. Alison Michalska (the City's Corporate Director for Children and Adults) was of the view that adults making complaints of non-recent abuse needed advice and support from adult social workers and adult specialists; she did not think that children's social workers were the right people to be involved. The City also has a single point of access for all complainants: this then signposts them to the City's support services as well as health and other services.[1208]

19. The Councils also have various partnerships[1209] which offer opportunities for survivors to share experiences, such as a therapeutic recovery service for children who have been sexually abused or exploited which has information on external support services.[1210] The City's Lead Member for Children's Services until May 2019, Councillor David Mellen, said that counselling and support "*will always be a priority … to make sure that people who have been let down are not let down again*".[1211] However, the City's view was that some counselling is better provided through the health service.[1212]

Responses from Nottinghamshire Police

Support

20. From the early stages of Operation Daybreak until at least 2013, if the police came into contact with a complainant who they felt needed support, they would direct them to their GP.[1213] DI Yvonne Dales (former Senior Investigating Officer of Operation Daybreak) accepted that this may not have been the "*best approach*", and reflected that provision of support for victims as well as directing them to appropriate support were not prioritised early enough in the investigation. There was no specific training on providing support to complainants.[1214] Since 2014, Paddy Tipping, the Police and Crime Commissioner, has been responsible for commissioning support services to which the police will direct complainants.[1215]

[1205] INQ001951 paras 20-34; Morton 23 October 2018 71/18-76/25; INQ001942 para. 4.9
[1206] Edwards 23 October 2018 122/9-13
[1207] https://www.nottinghampost.com/news/local-news/county-council-set-spend-another-2657522
[1208] Michalska 25 October 2018 67/8-69/8
[1209] For example, between 1998 and 2012, the City commissioned Action for Children to provide specialised support to children who had been sexually abused. Since then, support has been provided as part of the City's Children and Adolescent Mental Health Services for Children Looked After (CAMHS CLA) to all children in care who have suffered forms of trauma, including sexual abuse (NCC003691 paras 7.101-7.103).
[1210] NSC001235 para. 7a.12
[1211] Mellen 24 October 2018 102/7-14
[1212] Michalska 25 October 2018 76/21-77/16
[1213] NTP001517; INQ001780 para. 5.14
[1214] Dales 22 October 2018 46/3-47/5
[1215] INQ002570 paras 23-31

Contact

21. Several complainants were dissatisfied with their contact with the police during Operations Daybreak, Xeres and Equinox.[1216] This included the initial method of contact,[1217] the frequency of contact[1218] and communication during investigations,[1219] whilst some disliked the way in which they were told that no further action would be taken.[1220] However, Mandy Coupland, co-founder of the Child Sexual Abuse Survivors Group, was positive about current Chief Superintendent Robert Griffin's approach; he didn't "*butter things up*" and his way of communicating with complainants was "*helpful*".[1221]

22. Since 2005, complainants should be updated regularly by the police until an investigation is closed.[1222] During Operation Daybreak, there was no protocol on approaching potential victims. DI Dales introduced logs to record contact with complainants.[1223] DC Julie Balodis's view was that the individual officer would give the initial contact "*careful consideration*", based on the information available, although she acknowledged that "*we don't always get it right*".[1224]

23. The police are responsible for informing complainants of a decision not to prosecute and of the reasons why this decision was made,[1225] which DI Dales told us would "*ideally*" be done in person.[1226] Evidence from complainants suggests that this did not happen in each case.[1227] Since 2013, victims have had a right to request a review of a Crown Prosecution Service decision not to prosecute or to terminate proceedings.[1228]

24. In our Interim Report, we recommended that a joint inspection of compliance with the Code of Practice for Victims of Crime be commissioned.[1229] A cross-government Victims Strategy was subsequently published in September 2018, which "*commits to hold agencies to account for compliance with the Victims' Code through improved reporting, monitoring and transparency on whether victims are receiving entitlements*".[1230]

[1216] INQ002574; including P4, P5, D28, D4, P15, D5, D9, L25, L28, L31, P2, D20, P6, L22 and L51. By contrast, others thought the police had been good at keeping in contact and providing support and advice (D22 3 October 2018 148/7-10; L23 3 October 2018 151/19-22; L29 3 October 2018 155/4-6; D26 4 October 2018 168/17-169/1).
[1217] For example, arriving at a complainant's house unannounced, leaving a card asking them to contact the police, or arriving and saying that they had come about allegations of child sexual abuse (P4 4 October 2018 160/15-24).
[1218] P1 5 October 2018 108/6-13; INQ002574
[1219] For example, whether by email, text messages, voice messages or face-to-face contact (INQ002574; Coupland 24 October 2018 175/3-10).
[1220] INQ002574
[1221] Coupland 24 October 2018 176/16-177/5
[1222] Guide for Victims 2005; Balodis 22 October 2018 94/18-95/3. The most recent version is the *Code of Practice for Victims of Crime* (October 2015) which is not clear on the regularity of contact required but notes that this should be agreed at the outset in the case of child complainants (p73). For adult complainants, they should be told at the outset how often they will receive updates from the police, following a discussion about it (p19). The Code of Practice is due to be updated again; the Government's 2018 *Victims Strategy* states it will "*Provide timely and clear information to victims. We will give victims more choice in how they are communicated with, whether they want to speak to another person or communicate by email or text message. We will make sure that information is accurate and timely and we will clarify the role and responsibility of criminal justice agencies in the updated Victims' Code.*"
[1223] Dales 22 October 2018 37/24-38/6
[1224] Balodis 22 October 2018 99/23-100/25
[1225] *Code of Practice for Victims of Crime* (2015), p22
[1226] Dales 22 October 2018 37/8-11
[1227] INQ002574
[1228] CPS004382 paras 84-88
[1229] *Interim Report of the Independent Inquiry into Child Sexual Abuse*, April 2018, p53
[1230] *Government response to the Interim Report by the IICSA*, p6, para. 15

Other support

25. There are several independent survivor support groups in Nottinghamshire. The Support for Survivors Group provides a forum for survivors and their representatives to meet with local safeguarding boards, the Councils, clinical commissioning groups, Nottinghamshire Healthcare NHS, the Police and Crime Commissioner and the police.[1231] The CSA Survivors Group in Nottingham seeks "*justice for survivors*" and directs people to the correct services.[1232]

26. Whilst these groups are clearly of benefit to complainants, waiting lists for counselling and other treatment (particularly in crisis teams) are still too long, insufficient empathy is still sometimes shown by the authorities towards complainants[1233] and, in the view of one survivors group, some police officers remain untrained to deal with complainants.[1234]

Apologies

27. In the 1990s, children who had been sexually abused received apologies from the County in a small number of cases following convictions, critical findings in inquiry reports or civil claims which had been settled.[1235] More generally, however, the County was cautious about apologies, which were considered "*dangerous*" as they could amount "*to an admission of legal liability which can open up the department to legal claims*".[1236] Given the number of cases in the late 1980s and 1990s in which staff were convicted of or the subject of disciplinary sanction for sexual abuse of children, the County should have apologised and learned lessons.

28. More recently, the Councils have been willing to apologise in some individual cases where there has been a conviction, or where they are satisfied that there was abuse. For example, the County apologised to NO-A588 in 2017[1237] and the City apologised to the children in the NO-F35 case, despite his acquittal.[1238]

29. The County has apologised to those who suffered abuse while in its care. In March 2016, the Leader of the County Council made an unreserved apology to the victims and survivors of Andris Logins; while the apology acknowledged the County's failure to protect vulnerable children, it only came after Logins' conviction.[1239] In January 2018, the County apologised to all those who had suffered abuse while in its care and made a pledge about how it would act in the future.[1240] The County's public apology has been received positively by many victims and survivors.[1241] However, as acknowledged by Colin Pettigrew,[1242] the County does not always meet the terms of its pledge, in its approach to civil claims.

30. In the City, as recently as February 2018, Councillor Mellen reported the Leader of the City as saying "*we will apologise when there is something to apologise for*".[1243] It was suggested that this did not represent the attitude of the City at the time,[1244] but Councillor Mellen

[1231] NCC000337; NCC000614; NCC003652
[1232] Coupland 24 October 2018 154/14-155/1
[1233] Coupland 24 October 2018 160/18-165/12
[1234] Coupland 24 October 2018 172/21-177/10
[1235] For example, NSC000440_2, 26
[1236] NSC001610_4
[1237] NSC001478_129-135
[1238] Michalska 25 October 2018 88/8-22
[1239] INQ001682
[1240] NSC001283; NSC001235_2 para. 1.5
[1241] INQ002609 para. 50; Coupland 24 October 2018 184/5-185/7
[1242] Pettigrew 25 October 2018 158/4
[1243] NCC003688_4
[1244] Mellen 24 October 2018 103/22-107/2

signed off the minutes of the relevant meeting. Councillor Mellen accepted that this was offensive to those who were abused while in the City's care. Alison Michalska explained that the thinking was that an apology would be made when there was a conviction of an employee, ex-employee or foster carer from the City.[1245] The City did make a public apology two weeks before our October 2018 hearings.[1246] However, this apology was viewed with cynicism by some complainants and was rejected.[1247]

31. In June 2018, following an interview by the *Nottingham Post*,[1248] Alison Michalska was quoted as saying that no evidence had appeared of disclosure not being acted on and thought they had "*learnt the lessons*" from cases up to and including the 1980s. Ms Michalska disputes the accuracy of the article, but the *Nottingham Post* has maintained its position.[1249] The City should have apologised for the sexual abuse of children in its care a long time ago.

Civil litigation

32. There have been approximately 200 civil litigation claims against the County. Of these, 41 were ongoing as at July 2018 and only one had gone to trial.[1250] As at May 2018, the City had received 37 claims since 2009, of which 18 had been settled.[1251] The handling of these claims has caused further difficulties for complainants.

33. In the early 1990s, there was some dispute within the County about the extent to which staff should co-operate with claimant solicitors. There were concerns that the County's duties to children "*were in danger of being overridden by those seeking to defend the County Council from costs … There had been no overall liaison or drawing lessons to be learnt.*"[1252] In response, in 1993, the County formed a Risk Management Group (made up of representatives of social services, the County solicitor and the Risk & Insurance Officer[1253]) to respond to claims received.[1254] As learning points arose, the group met with children's social care managers to discuss those lessons, and subsequently disseminated them more widely by holding a seminar.[1255]

34. However, there remained a wariness about apologising, because of financial consequences, and staff were not authorised to admit liability.[1256] L24 said that an "*apology would mean more to me than any amount of money*" and that recognition and acceptance from the Councils would have been the "*only thing that would really help*".[1257]

[1245] Michalska 25 October 2018 89/8-25
[1246] City Council 2 October 2018 44/8-45/19
[1247] P7 4 October 2018 150/1-9; C21 2 October 2018 177/6-9; D6 5 October 2018 78/17-25
[1248] NCC003803
[1249] Michalska 25 October 2018 91/13-93/2; NCC003802; *Nottingham Post* 25.10.18
[1250] NSC001235 para. 1.4
[1251] NCC003691 para. 7.4. The City has limited or no information in relation to claims received before 2009.
[1252] INQ002007 para. 2.109
[1253] NSC000440_7
[1254] INQ002007 paras 11.12-11.13
[1255] Jones 8 October 2018 85/7-86/24
[1256] Jones 8 October 2018 89/8-18
[1257] L24 5 October 2018 130/2-10. We understand that the City has, since our hearings in October 2018, changed its policy towards apologies and that a letter of apology, along with a meeting with Ms Michalska if desired, is now sent to every claimant when their claim is resolved.

35. Some complainants were surprised that the Councils resisted their claims. L46 was "*shocked*" that the County would deny liability for sexual assault as the incident is recorded in her records.[1258] L17 told us that reliance on 'limitation' arguments (that claims could not proceed because they were out of time) made her "*really angry*".[1259]

36. The delay in settling claims also caused concern. L17's case took six years to conclude; she described the process as "*hell*" and felt that "*they were just hoping I would go away*".[1260] Delays can of course be caused by either side[1261] and it is important not to settle too quickly, before the impact of the abuse on the complainant can be assessed.[1262] However, we note that the Councils have made efforts to reduce delay for complainants, with the County reducing the time to reach a settlement from an average of 12 years in 2005 to eight months in 2017.

37. Concerns were also raised about the level of settlement offers. L43 said that the offer made to him was "*insulting*", describing it as "*like offering me a £10 note and telling me to go home and shut up*".[1263] However, how litigation is conducted is typically decided by the Councils' insurers.[1264]

38. The Inquiry will consider the approach to civil litigation, apologies and other issues related to the justice system in greater detail in its Accountability and Reparations investigation,[1265] the report on which will be published later in 2019.

Care records

39. For those in care during their childhood, the records made by social workers and residential care staff are often their only available means of understanding their past. However, there are issues surrounding the quality of records, the extent of their retention and the access given to them for those formerly in care.

40. Under national legislation and regulations, residential care staff were required to keep records from 1951 onwards.[1266] These included registers of admission and discharge and records of each day the child was resident, as well as "*events of importance connected with the home*". The most recent regulations in 2015 set out in extensive detail the information that must be provided in a child's case records.[1267] Similarly, since 1955, local authorities have been required to maintain records on children in care in foster placements.[1268] Social workers are also required to keep and maintain detailed records on the children in their caseload, most recently under 2010 regulations.[1269]

[1258] L46 5 October 2018 99/11-23
[1259] L17 2 October 2018 147/23-148/3
[1260] L17 2 October 2018 149/10-150/18
[1261] Pettigrew 25 October 2018 178/6-7
[1262] Pettigrew 25 October 2018 158/9-159/1
[1263] L43 3 October 2018 88/1-9
[1264] Pettigrew 25 October 2018 155/8-156/15
[1265] Accountability and Reparations for Victims and Survivors of Abuse
[1266] The Administration of Children's Homes Regulations 1951; Children's Homes Regulations 1991; Children's Homes Regulations 2001
[1267] The Children's Homes (England) Regulations 2015
[1268] The Boarding-Out of Children Regulations 1955; The Boarding-out of Children (Foster Placement Regulations) 1988; Fostering Services (England) Regulations 2011
[1269] Children Act 1989 Guidance and Regulations, Volume 2: Care planning, Placement and case review; Care Planning, Placement and Case Review (England) Regulations 2010 (as amended)

41. In Nottinghamshire, from 1978 onwards, County and multi-agency procedures and guidance set out the records to be kept by residential staff, foster carers and social workers in various circumstances, including when allegations of abuse were made.[1270] These were set out most recently in interagency procedures for both Councils[1271] and in the Councils' individual procedures.[1272]

Quality of care records

42. The majority of complainant core participants were in care from the 1970s to the 1990s, several of whom gave evidence of their concerns about the quality of the records kept about them during their time in care.[1273] Similar concerns were raised by children's social care management and councillors over the past four decades. For example:

42.1. We were told about poor record-keeping occurring as early as the mid-1970s, with residential staff at Beechwood failing to record events in logbooks and incident sheets.[1274]

42.2. A 1979 memo from the County's Divisional Director to senior staff at Beechwood noted: "*the full account of that incident should have been recorded in the logbook … will you please ensure that the logbooks in the Lindens and in Redcot are at all times kept fully and accurately and in particular, regard is had to the child's behaviour and the response of staff to that behaviour.*"[1275]

42.3. In 1987, County Councillor Tom Butcher wrote to the Director of Social Services expressing concern that "*records are 'not kept within the department' in relation to children in care involved in sexual offences/acts. I consider it to be an important part of managerial monitoring of problems facing children in care*".[1276] We have seen no response.

42.4. A County investigation into child sexual abuse in foster care and Wollaton House in 1992 reported that recording and organisation of residential and fostering files were poor, and that this had been happening over many years. Records were not properly organised, but also were not being kept in the first place. The authors emphasised that, "*staff should be clear that children cannot be protected if vital information is omitted, and that records are a part of the history of a child's life during any time they spend in a 'looked after' placement.*"[1277]

42.5. During the course of a disciplinary investigation in 1995, most of the records kept by Amberdale were found to be "*shoddy, partial and contained little substance to aid professional social work decision making on the children concerned*".[1278]

[1270] NSC000046_29-31; NSC000075_32; NTP001473_119; NTP001473_1-118; NSC000077
[1271] Allegations Against Staff or Volunteers, section 6 (updated January 2019)
[1272] County: Case Management and Recording; Managing Allegations/Concerns in Relation to Adults who work with Children; Children's Homes; Fostering, sections 12.6, 12.13, 12.17
City: Case Management, Recording and Supervision; Looked After Services; Allegations Against Foster Carers
[1273] INQ002574
[1274] Rigby 9 October 2018 43/6-16; Cope 17 October 2018 117/9-16; INQ002673 paras 35-37
[1275] NSC000455_2
[1276] INQ000275_3
[1277] NSC000103_6
[1278] NSC000189_47

Retention of records

43. From 1955 onwards, a local authority was required to retain the records of a child in foster care until their 21st birthday.[1279] Until 1991, the retention of child protection files or social services records for a child in residential care was at the discretion of the record keeper.[1280] Since then, records for each child in care have had to be retained until their 75th birthday.[1281] This remains the current retention period[1282] and has been applied by the City since 1998.[1283]

44. In the County, keeping "*historic records*" was viewed historically by some children's social care staff as "*the lowest priority*".[1284] During an internal reorganisation in 1985, there was "*an awful lot of weeding and destruction of files*", which led to the loss of certain information which could have been considered "*essential to keep*".[1285]

45. Similarly, most of the City's documents relating to the provision of social services before 1974 have been destroyed. Only those which the City was required to keep have survived from this period, such as admissions registers, logbooks and medical records.[1286]

Access to records

46. Access to care records is vital for individuals to understand their childhood experiences, the reasons for being taken into care and what happened to them during their time in care.[1287] For those who allege abuse during their time in care, being unable to see their records can compound the sense of being let down by the Councils.

47. Since 1998, the primary methods of obtaining records for those formerly or currently in care have been via a subject access request[1288] or disclosure in civil court proceedings.[1289]

48. On at least some occasions, the Councils have not responded appropriately to requests for access to records, particularly given their legal obligations set out above. For some complainants, the search for records and the lack of communication and explanation have been difficult and upsetting.[1290] In particular:

> **48.1.** D6 (a care leaver) submitted his first subject access request to the City in May 2015. After a long wait, he felt compelled to disclose to the City that he was a core participant in this investigation, and he only received his records days before the hearings in October 2018.[1291] The City told us that D6's first subject access request was received by the wrong part of the City, that he had not provided the necessary proof of identity and that the City had to wait for permission to release the records of

[1279] Boarding-Out Of Children Regulations 1955
[1280] NSC001235 para. 1.11
[1281] INQ002946_3; Arrangement for the Placement of Children Regulations 1991, Regulation 9, unless they died before the age of 18, in which case they must be kept for 15 years after death.
[1282] County Children's Services – Retention of Records
[1283] NCC003704_002
[1284] Jones 8 October 2018 77/6-15
[1285] NSC000980_10
[1286] NCC003691 para. 1.9; Michalska 25 October 2018 81/21-82/19
[1287] Coupland 24 October 2018 180/23-181/4; Leigh 24 October 2018 190/10-16
[1288] Data Protection Act 1998, section 45
[1289] Civil Procedure Rules 1998, Part 31
[1290] A79 5 October 2018 110/19-113/9; INQ002574: L51, P18, Q1, Michael Summers
[1291] D6 5 October 2018 73/23-79/20

D6's birth family at the same time as his own.[1292] The procedural hurdles appear to take no account of the significance to the applicant of the records, nor do they allow for prioritisation. This was an unacceptable delay.

48.2. A79 described spending "*30-odd years*" trying to get his records, making numerous subject access requests and being told that his records no longer existed. In 2000, he eventually received eight pages of information typed up by an investigation officer from the County, but did not understand how they were produced.[1293]

49. Further changes to the process have been made recently. Since 2015, the County's Historic Abuse Team have been assisting those formerly in care to access their records.[1294] Around the time of the investigation's October 2018 hearings, the City agreed to establish a new role "*dealing wholly with the provision of social care records*".[1295] Further improvements to processes are clearly required, as we identified in the Inquiry's Interim Report.[1296]

F.3: External inspections of children's social care in the Councils

50. Although local authorities should not be relying solely on external inspections to understand if their services are performing adequately, they provide an insight into changing performance.

51. The County has received variable Ofsted assessments since 2008:

- 2008: Services for children in care and the quality of residential care were rated as 'good'.[1297]
- 2010: Whilst services for children in care were 'adequate', safeguarding services were 'inadequate', with significant weaknesses in staffing and failures to protect children, resulting in an improvement notice for safeguarding.[1298]
- 2011: The County's safeguarding service was rated 'adequate' and some aspects 'good'. As a result, the improvement notice was lifted.[1299]
- 2015: Overall, the County was rated 'good', with positive comments about arrangements for the management of allegations against staff:

  "*Individual cases are managed and planned well, with timely and effective work carried out to ensure risks to individual children are assessed and addressed, as well as investigation of the adults concerned.*"[1300]

- June 2018: Ofsted commented that the County's self-evaluation of its children's social care had highlighted strengths in practice as well as areas for improvement.[1301]

[1292] Michalska 25 October 2018 84/2-85/9
[1293] A79 5 October 2018 110/19-113/9
[1294] Pettigrew 25 October 2018 161/5-7
[1295] NCC003807 para. 7.5
[1296] *Interim Report of the Independent Inquiry into Child Sexual Abuse*, April 2018, p72
[1297] OFS008002
[1298] OFS007988 (see also https://www.gov.uk/government/collections/improvement-notices).
[1299] OFS007987
[1300] OFS007990
[1301] OFS008126

- February 2019: After a 'focused visit' assessing the County's arrangements for children potentially at risk or in need of support, Ofsted's report was generally positive[1302] but it did not cover children in care.

Since 2011, the County's children's social care service appears to have shown significant improvement. It is now in 'Pathway One' under the new ILACS framework, so that it receives a short inspection about three years after the previous inspection.[1303] However, we note there has been no general Ofsted inspection of the County's children's social care service since 2015.[1304]

52. The inspections of the City have been mixed:

- 2007: The City was rated as 'adequate' by Ofsted overall, with social care services improving (including in placement choice and residential homes, which now met national standards).[1305]
- 2011: The City received a 'good' rating for safeguarding and services for looked after children. The dedicated police officer for looked after children was described as "*an outstanding example of effective support*".[1306]
- 2014: The City's children's social care service was rated as 'requires improvement' overall, including for services for children in need and children in care overall.[1307] There were too many changes of allocated social worker, inadequate supervision, poor planning and poor record keeping. However, there were positive findings in relation to the placement of children outside of the City, social worker visits to children in care and the response to allegations of abuse or mistreatment of children by professional staff and carers. Young people had access to an independent advocacy service and knew how to make complaints.
- 2017: Ofsted rated children's social care services 'good' but the progress of children in care and care leavers 'requires improvement'.[1308] The City did not always fully understand the reasons why children went missing and therefore did not always provide them with the necessary support; the City told us its practice in this regard was not yet good enough.[1309]
- May 2018: Based on a self-evaluation, Ofsted observed that "*the sense is of a strong authority continuing to manage well in a difficult environment*".[1310]
- November 2018: The City was rated as 'requires improvement' for all its children's social care services.[1311] Its self-assessment did not "*accurately identify all the shortfalls found during this inspection*". While there were areas of good practice (such as the management of allegations against staff and the identification of children at risk of child sexual exploitation), there were insufficient social workers, poor systems to support the education of children in care, delays in placing children appropriately and insufficient priority for securing adequate emergency accommodation.

1302 Focused visit to Nottinghamshire County Council children's services, letter 1 February 2019
1303 ILACS framework and evaluation criteria p7
1304 Nottinghamshire County Council: Activity, reports and ratings
1305 OFS008024
1306 OFS008019
1307 OFS008020
1308 OFS008274
1309 Michalska 25 October 2018 106/1-109/1
1310 OFS008123
1311 Nottingham City Council, Children's services inspection (2018)

Part G

Conclusions and recommendations

Conclusions and recommendations

G.1: Conclusions

1. Most institutions referred to in this report failed children who were sexually abused whilst in the care of Nottinghamshire County and Nottingham City Councils, to a greater or lesser extent. These included elected members, senior managers, frontline social work and residential staff and foster carers within both of the Councils, and Nottinghamshire Police.

Nature and extent of allegations of child sexual abuse

2. The sexual abuse of children in the care of the Nottinghamshire Councils was widespread in both residential and foster care during the 1970s, 1980s and 1990s. It included repeated rapes and other sexual assaults, as well as physical abuse. Allegations have been made against a range of perpetrators, including senior and junior residential care staff, foster carers, and children exhibiting harmful sexual behaviour.

3. Around 350 complainants have made allegations of sexual abuse whilst in the care of the Councils from the 1960s onwards but the true number is likely to be considerably higher.

Conclusions in respect of the Councils

4. Neither of the Councils learned from their mistakes despite decades of evidence of failure to protect children in care. Successive reviews, both internal and external, identified weaknesses in policy and practice relating to the protection of children in residential care, in foster care and in the area of harmful sexual behaviour. Many of these reviews included recommendations for change which were accepted but rarely acted upon.

5. Over the last 30 years, the Councils have produced policies and procedures on responding to allegations of sexual abuse of children in care. However, these policies were not generally made known to staff nor was there a checking process in place to verify implementation.

6. The County acknowledged that there was a crisis in children's social care in the early 1990s when the root cause of this crisis was the failure to recruit sufficient numbers of qualified social workers. This was not unusual at that time, but the Inquiry heard nothing of any strategies put in place to address the problem. The focus was on child protection on the misplaced assumption that children in care were sufficiently protected by the carers themselves. In the same period, there was a "*deep rift*" between children's social care and Nottinghamshire Police.

7. In the late 1980s and early 1990s, a significant number of residential care staff in the County faced disciplinary investigations for the sexual abuse of children. This should have prompted an assessment, at a senior level, of the scale of abuse, why it was happening and how the risk of abuse could be addressed. Despite occasional attempts to consider the issues more broadly, the County failed to address the risk of abuse to children in their care.

8. When proper disciplinary action was taken by the County about alleged misconduct relating to sexual abuse, some council officers expressed extreme frustration that on occasion, councillors would overturn their decisions on appeal.

9. Only qualified social workers are required to be registered with the Health and Care Professions Council. Therefore, allegations of sexual abuse are only referred to an external regulator if the alleged perpetrator residential care staff member is also a qualified social worker. As set out in the Inquiry's Interim Report, residential child care staff should be registered with an independent professional regulatory body.

10. The various chief executives of the Councils may not have been informed by their Directors of Children's Services of the seriousness of the sexual abuse occurring on their watch. Nevertheless, as heads of paid service, the chief executives should have been alert to their statutory responsibilities for the welfare of children in their care and taken a proactive leadership role.

11. There have been positive efforts by the Councils, including:

> **11.1.** The City's Historical Concerns Project reviewed the employment records of current and former employees to identify any concerns about the risks posed to children. This provided some reassurance that alleged perpetrators did not evade scrutiny.
>
> **11.2.** The County's ongoing Historical Abuse Team provides support for complainants, follows up on allegations and works with survivors groups, while the City has a single point of access for all complainants which signposts support services. This kind of engagement with survivors groups can provide clear channels of communication which reduces the risk of misunderstanding and may improve relationships with victims and survivors.

12. Provision and consistency of support and counselling for those who have suffered sexual abuse in care remain an issue. More needs to be done by the Councils, and the police need to continue to be receptive to complainants' needs. Support services are now commissioned by the Police and Crime Commissioner and the NHS also has a duty to provide such support.

13. The Councils have taken different approaches to apologising for non-recent abuse and their past failure to protect children in their care. Whilst the County have made a public apology, the City have been guarded and slow to appreciate the level of distress felt by complainants. Their approach has caused understandable upset and anger, which could have been avoided.

14. Access to records for those formerly in care has not been well handled. For some, their search for records and the lack of communication or explanation from the Councils has been distressing. For others, the procedural hurdles seem to have taken little account of the importance of these records to the complainants, with no provision for fast-tracking the process.

Residential care

15. Residential care across England was characterised, from the late 1970s to the early 1990s, as poorly resourced and managed, with residential care staff who were predominantly unqualified and received little, if any, training.

16. This is reflected by the Beechwood case study, in which we saw untrained and unqualified staff, insufficient resources and, increasingly, older children exhibiting multiple behavioural problems. In these respects, Beechwood was not an exception. However, it demonstrates the extent to which these underlying issues create and maintain an environment in which vulnerable children are at risk of abuse.

17. A significant number of children were sexually abused whilst resident at Beechwood. For example, John Dent and NO-F29 were able to commit abuse in the knowledge that children would be too frightened to speak out, or would think that, if they did, they would not be believed. Similarly, Andris Logins was able to sexually abuse residents at Beechwood because it was an environment where sexualised behaviour was tolerated or overlooked. Some staff raised concerns about the behaviour of colleagues but were not taken seriously; others witnessed colleagues acting inappropriately towards children but did nothing.

18. Despite the high number of allegations of sexual abuse against staff at Beechwood, there are only two examples of disciplinary action taken in response, both of which were inadequate.

19. During the 1960s, 1970s and 1980s, the staff were often viewed as vulnerable rather than the children, with some girls seen as creating a particular risk for male staff. During this period, Beechwood was not a safe environment for vulnerable children. Staff were both threatening and violent, physical abuse was commonplace and children were frightened. The children placed at Beechwood were not protected and supported as they should have been.

20. The reasons for high levels of absconding in the mid-1980s to the 1990s were not explored by Beechwood staff, who saw absconding as an example of "*devious*" behaviour. The risks faced by these children and their vulnerabilities were not addressed.

21. Until the early 1990s, there was a lack of sustained attention given to residential care by staff and senior managers in the County's children's social care service. The most vulnerable children were left in the hands of staff who were not qualified to care for them. From 1992, the County recognised these challenges and took steps to address them.

22. When the City took over the running of Beechwood in 1998, the staff environment had not improved and children and young people were still at risk of sexual abuse. This was not helped by overcrowding. Between 1998 and its eventual closure in 2006, there were several opportunities for the City to close Beechwood and it should have done so earlier.

Foster care

23. For the last 40 years, foster care has been the most common placement for children in the care of the Councils. The County re-organised its fostering service in the mid-1970s. For some time afterwards, recruitment, assessment, support, supervision and deregistration of foster carers was inconsistent.

24. By the beginning of the 1990s, the County's response improved, but this was not followed through. There were long-standing tensions between social workers for foster carers and social workers for the individual children who were alleged to have been abused. This is not an unfamiliar problem but what was troubling was the extent to which the support for foster carers in such situations continued over many years without any independent assessment of individual allegations. So often, the prevailing assumption was that the foster carer must always be guiltless.

25. The Norman Campbell case, which involved the sexual abuse of children in residential and foster care between 1982 and 1990, was an example of poor practice by County fostering management. Campbell's approval did not follow the established process, legitimate concerns about his motivation were ignored and he was not subject to re-approval as he should have been. His abuse of children might have been prevented had processes been followed.

26. There continues to be weakness in current foster care practice in both Councils despite improvements. These include poor joint-agency working, inconsistent decision-making, and failure to refer cases to the fostering panel or to notify Ofsted or councillors. Examples of good practice in response to allegations include the use of independent risk assessments and child-centred approaches to de-registration.

Harmful sexual behaviour

27. Between 1988 and 1995, there were enquiries into harmful sexual behaviour in five County community homes. While a multi-agency group was set up leading to the development of policies and procedures on the issue, the work of the group was largely squandered. Issues raised in individual reports were not considered more broadly or together; similarly, lessons were not learnt and recommendations not pursued.

28. Recent cases of harmful sexual behaviour in residential and foster care show problems remain with the institutional responses. There is a lack of clear governance in the City. In the County, there are still not enough social workers trained to carry out assessments of children exhibiting harmful sexual behaviour. In some instances, full investigations have not been carried out, managers have not been notified, and children not safeguarded.

29. The County has taken positive steps to audit its practice and develop multi-agency responses to harmful sexual behaviour, although their most recent audit in 2018 showed that there is still some way to go. By contrast, we have not seen evidence of the City taking steps to evaluate its practice in recent years and they did not refer to the issue of harmful sexual behaviour in their oral or written closing submissions to the investigation, despite it being one of three selected case studies.

30. There is no clear process within the Councils for ensuring elected councillors are made aware, in confidence, of serious allegations of harmful sexual behaviour by children in care.

31. Despite increasing awareness and understanding of the issue of harmful sexual behaviour across the country, there is no national strategy or overarching framework for investigating, auditing, responding to, and preventing harmful sexual behaviour (including, but not limited to, children in care). The Inquiry is carrying out further research on this issue.

Barriers to disclosure

32. There were particular barriers to disclosure for children in both residential and foster care. With regard to residential care, these included the institutional setting, a sexualised and physically abusive staff culture, and abuse being perpetrated by staff in senior positions. Specific factors affecting those in foster care included the complex relationship that can develop between the child and the foster carer, and the fear of not being believed because the perpetrator foster carer was established and trusted by professionals.

Conclusions in respect of governance

33. Despite being regularly informed of disciplinary action taken against staff (but not foster carers) following investigations into sexual abuse of children in residential care during the late 1980s and 1990s, the County councillors responsible for oversight of children's social care did not question the scale of sexual abuse or what action was being taken. This was a serious failure of scrutiny and governance.

34. County councillors are now briefed on some allegations of sexual abuse of children in care. A recently introduced protocol requires that the Lead Member for Children's Services be briefed on all allegations of sexual abuse against members of staff, but only some allegations of sexual abuse against foster carers or other children. At the time of our hearings in October 2018, the City had no written protocol on when the Lead Member should be notified of allegations of sexual abuse of children in care.

35. Continuing to the present day, neither the County nor the City has had a process by which there has been regular reporting of the number of allegations and the response to those allegations. This has meant that knowledge of the scale of allegations of sexual abuse of children in care and the response to those allegations has been limited and inconsistent.

Conclusions in respect of Nottinghamshire Police and the Crown Prosecution Service

36. Nottinghamshire Police's investigation into allegations of non-recent sexual abuse of children in residential care (Operation Daybreak) was not adequately resourced or supported from its formation in 2011 until 2015. Given the increasing number of allegations of abuse and the criticisms from internal and external reviews, senior police officers should have done more to support the operation. The police did not treat the allegations with sufficient seriousness.

37. Since 2015, when Operation Daybreak was subsumed into Operation Equinox, there have been a number of prosecutions and there now appears to be greater confidence in the force's commitment amongst complainants.

38. However, Nottinghamshire Police has consistently shown a lack of urgency and failed to address the weaknesses identified and the recommendations made in recent inspections and reviews concerning its approach to investigating child sexual abuse. Responsibility for this rests primarily with the force itself. These failings had consequences for the children involved. The most recent assessment report indicates some improvements.

39. Complainant experience of engagement with the police and the Crown Prosecution Service has been mixed. The police have had to improve how they communicate with complainants following criticisms, including the means of initial contact with complainants, the irregularity of subsequent contact, and issues with the notification that an investigation has been closed.

G.2: Matters to be explored further by the Inquiry

40. The Inquiry will return to a number of issues which emerged during this investigation, including but not limited to:

40.1. Harmful sexual behaviour.

40.2. The barriers to disclosure of sexual abuse by children, including those in care, and proactive steps to reduce those barriers.

40.3. The approach to civil litigation, including the role of insurers.

G.3: Recommendations

The Chair and Panel make the following recommendations, which arise directly from this investigation and the case studies of Beechwood, foster care and harmful sexual behaviour in Nottinghamshire and are specific to the County and the City. Other local authorities should consider the issues identified in this report and take action as appropriate to their own circumstances.

Nottingham City Council and Nottinghamshire County Council should publish their response to these recommendations, including the timetable involved, within six months of the publication of this report.

Recommendation 1:

Nottingham City Council should assess the potential risks posed by current and former foster carers directly provided by the council in relation to the sexual abuse of children. They should also ensure that current and former foster carers provided by external agencies are assessed by those agencies. Any concerns which arise should be referred to the appropriate body or process, including the Disclosure and Barring Service, the local authority designated officer (LADO) or equivalent, the fostering panel and the police.

Nottinghamshire County Council should assess the potential risks posed by current and former residential care staff and foster carers, which are directly provided by the council, in relation to the sexual abuse of children. They should also ensure that current and former staff in residential care provided by external agencies, and current and former foster carers provided by external agencies, are assessed by those agencies. Any concerns which arise

should be referred to the appropriate body or process, including the Disclosure and Barring Service, the relevant regulatory body, the local authority designated officer (LADO), the fostering panel and the police.

Recommendation 2:

Nottingham City Council and its child protection partners should commission an independent, external evaluation of their practice concerning harmful sexual behaviour, including responses, prevention, assessment, intervention and workforce development. An action plan should be set up to ensure that any recommendations are responded to in a timely manner and progress should be reported to City's Safeguarding Children Partnership.

Annexes

Annex 1

Overview of process and evidence obtained by the Inquiry

1. Definition of scope for the case study.

This investigation is an inquiry into the nature and extent of, and the institutional responses to, allegations of sexual abuse of children in the care of the Nottinghamshire Councils.

The scope of the investigation is as follows:

> *"1. The Inquiry will investigate the nature and extent of, and institutional responses to, the sexual abuse of children in the care of Nottingham City and Nottinghamshire County Councils ('the Councils'), including those cared for in children's homes and by foster carers and/or adoptive parents. The investigation will incorporate case-specific investigations and a review of information available from published and unpublished reports and reviews, court cases, and previous investigations.*
>
> *2. In doing so, the Inquiry will consider the experiences of victims and survivors of child sexual abuse while in the care of the Councils, and will investigate:*
>
> *2.1. the nature and extent of allegations of child sexual abuse of children in the care of the Councils during the relevant period;*
>
> *2.2. the nature and extent of the failures of the Councils to protect such children from sexual abuse;*
>
> *2.3. the appropriateness of the response of the Councils, law enforcement agencies, prosecuting authorities and other public authorities to reports of child sexual abuse involving children cared for by the Councils, and/or reports of child sexual abuse by individuals who were employed by or contracted by the Councils, with access to children;*
>
> *2.4. the extent to which the Councils sought to investigate, learn lessons, implement changes, and/or provide support to victims and survivors, in response to:*
>
> *a) allegations that individuals with access to children cared for by the Councils had sexually abused children;*
>
> *b) criminal investigations and prosecutions and/or civil litigation in relation to alleged sexual abuse of children within the care of the Councils;*
>
> *c) reports, reviews and inquiries into child sexual abuse and/or safeguarding; and/or*
>
> *d) other external guidance.*

2.5. the adequacy of the policies and practices adopted by the Councils during the relevant period in relation to safeguarding and child protection, including considerations of governance, training, recruitment, leadership, reporting and investigation of child sexual abuse, disciplinary procedures, information sharing with outside agencies, and approach to reparations;

2.6. the extent to which children who made allegations of sexual abuse may have had special educational needs and/or any other form of special need or vulnerability and whether that may have made them more vulnerable to sexual abuse;

2.7. the extent to which there was a culture within the Councils which inhibited the proper investigation, exposure, prevention of, and reparation for, child sexual abuse; and

2.8. the adequacy of the inspection regimes applicable throughout the relevant period.

3. To investigate the issues set out in paragraph 2, the Inquiry may identify a number of case studies.

4. In light of the investigations set out above, the Inquiry will publish a report setting out its findings, lessons learned, and recommendations to improve child protection and safeguarding in England and Wales."[1312]

2. Core participants and legal representatives

Counsel to this investigation:

Patrick Sadd
Paul Livingston
Imogen Egan
Olinga Tahzib

Complainant core participants:

D3, D4, D5, D6, D7, D9, D10, D11, D12, D13, D18, D19, D20, D22, D23, D25, D26, D28, D31, D33, D34, D35, D36, D37, D38, D42, D44, D46, D47, D48, D51	
Counsel	Caoilfhionn Gallagher QC, Megan Hirst, Mary-Rachel McCabe, Nick Brown
Solicitor	Jon Wakefield (Bhatia Best)
A73, A74, Dale Davey, A76, A79	
Counsel	Caoilfhionn Gallagher QC, Megan Hirst, Mary-Rachel McCabe
Solicitor	Kim Harrison (Slater & Gordon)
P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, P14, P15, P16, P17, P18, P19	
Counsel	Caoilfhionn Gallagher QC, Megan Hirst, Mary-Rachel McCabe
Solicitor	Debbie Heath (Instalaw)

[1312] Nottinghamshire Councils Investigation Definition of Scope

L17, L18, L19, L20, L21, L22, L23, L24, L25, L26, L27, L28, L29, L30, L31, L32, L33, L34, L35, L36, L37, L38, L39, L40, L43, L44, L45, L46, L47, L48, L49, L50, L51, L52	
Counsel	Stephen Simblet, Laura Profumo
Solicitor	Christopher Ratcliffe (Uppal Taylor)
F37, F38, F39, F40, F46, Michael Summers	
Counsel	Christopher Jacobs
Solicitor	David Enright (Howe + Co)
C21	
Counsel	Christopher Jacobs
Solicitor	David Greenwood (Switalskis)
Q1	
Counsel	Aidan O'Neill QC
Solicitor	Jessica Gladstone (Clifford Chance)
N1	
Counsel	Christopher Jacobs
Solicitor	Jonathan Bridge (Farleys)

Other individual core participants:

David Hollas	
Counsel	Not legally represented
Solicitor	Not legally represented
John Mann	
Counsel	Aidan O'Neill QC
Solicitor	Jessica Gladstone (Clifford Chance)

Institutional core participants:

Nottinghamshire Police	
Counsel	Sam Leek QC, Alice Meredith
Solicitor	Craig Sutherland (East Midlands Police Legal Services)
Nottinghamshire County Council	
Counsel	Andrew Sharland QC, Christopher Parkin
Solicitor	Geoffrey Russell (Nottinghamshire County Council)
Nottingham City Council	
Counsel	Steven Ford QC
Solicitor	Sarah Molyneux, Malcolm Townroe (Nottingham City Council)

Crown Prosecution Service	
Counsel	Edward Brown QC
Solicitor	Alastair Tidball (Government Legal Services)
Ofsted	
Counsel	Sarah Hannett, Alice de Coverley
Solicitor	James Fawcett (Ofsted)
Department for Education	
Counsel	Cathryn McGahey QC
Solicitor	William Barclay (Government Legal Department)

3. Evidence received by the Inquiry

Number of witness statements obtained:
173
Organisations and individuals to which requests for documentation or witness statements were sent:
A73
A74
A76
A79
Action for Children
Allan Breeton (Nottinghamshire Police)
Andrew Bosworth (former manager of Beechwood Children's Home – Nottinghamshire County Council)
Andrew Gowan (Nottinghamshire Police)
Anna Sains (Manager within children's social care – Nottinghamshire County Council)
Anthony May (Director within children's social care – Nottinghamshire County Council)
Brian Doohan (Nottinghamshire Police)
Bronwen Cooper (children's social care – Nottingham City Council)
C21
Carol Smith (social worker – Nottinghamshire County Council)
Carolyne Willow (Director of Article 39 charity)
Cath Carrie (Crown Prosecution Service)
Chris Cook (Chair of Nottingham City Safeguarding Board)
Chris Few (Chair of Nottinghamshire County Safeguarding Board)
Clive Chambers (Manager within children's social care – Nottingham City Council/Nottinghamshire County Council)
Crown Prosecution Service

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Daniel Yates (children's social care – Nottinghamshire County Council)
David Fisher (children's social care – Nottinghamshire County Council)
David Mellen (Councillor – Nottingham City Council)
David Philip Morgan (Manager within children's social care – Nottinghamshire County Council)
David Taylor (Nottinghamshire Police)
David White (former Director of Social Services – Nottinghamshire County Council)
Dawn Godfrey (children's social care – Nottinghamshire County Council)

Denis Watkins (Assistant Director within children's social care – Nottinghamshire County Council)
Department for Education
Derek Brewer (Nottinghamshire Police)
F37
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F39
F40
F46
Michael Summers
Geoff Ward (Department Head within children's social care – Nottinghamshire County Council)
George Norman Hanson (senior management within children's social care – Nottinghamshire County Council)
Glynis Storer (children's social care – Nottingham City Council)
Helen Blackman (Director of Children's Social Care – Nottingham City Council)
Helen Chamberlain (Nottinghamshire Police)
Helen Ryan (Director within children's social care – Nottinghamshire County Council)
James Fenwick (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Jayne Austin (Manager within children's social services – Nottinghamshire County Council)
Jenny Street (Nottinghamshire Police)
Jim McLaughlin (former employee at Beechwood Children's Home – Nottingham City Council)
Joan Taylor (Chair within children's social care – Nottinghamshire County Council)
John Mann MP (MP for Bassetlaw)
John Stocks (Chair within children's social care – Nottinghamshire County Council)
Joyce Bosnjak (Chair within children's social care – Nottinghamshire County Council)
Joyce White (children's social services – Nottinghamshire County Council)
Judy Holloway-Vine (children's social services – Nottinghamshire County Council)
Julie Balodis (Nottinghamshire Police)
Kenneth Rigby (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Kevin Flint (Nottinghamshire Police)
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Malcolm McBride (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Mandy Coupland (Co-founder of the Nottingham CSA Survivors Group)
Margaret Mackechnie (Director within children's social care – Nottingham City Council)
Margaret Stimpson (Manager within children's social care – Nottinghamshire County Council)
Mark Cope (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Maxine Leigh (Founder of Support for Survivors)
Mike Morris (Director within children's social care – Nottinghamshire County Council)
Nottingham City Council
Nottinghamshire County Council

Nottinghamshire Police
NSPCC
Ofsted
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Paddy Tipping (Police and Crime Commissioner for Nottinghamshire)
Paul Bohan (former employee at Beechwood Children's Home – Nottinghamshire County Council)
Paul Snell (Director within children's social care – Nottingham City Council)
Peter Maddocks (Independent Reviewer for Nottinghamshire Safeguarding Children Board)
Philip Owen (Councillor – Nottinghamshire County Council)
Q1
Rachel Morton (children's social care – Nottinghamshire County Council)
Rhona Keenan (Nottinghamshire Police)
Rob McKinnell (Nottinghamshire Police)
Rod Jones (former Head of Children and Families Policy – Nottinghamshire County Council)
Sallyanne Johnson (Director within children's social care – Nottingham City Council)
Sam Shallow (Crown Prosecution Service)
Sandra Brothwell (former employee at Beechwood Children's Home – Nottingham City Council)
Sarah Palmer (Nottinghamshire Police)
Sharon Wilkinson (children's social care – Nottinghamshire County Council)
Sheila Place (Chair within children's social care – Nottinghamshire County Council)
Shelley Nicholls (children's social care – Nottingham City Council)
Sonia Cain (Manager within children's social care – Nottingham City Council)

Steve Edwards (Director within children's social care – Nottinghamshire County Council)
Steve Freeman (Nottinghamshire Police)
Stuart Brook (Director within children's social services – Nottinghamshire County Council)
Sue Matthews (Crown Prosecution Service)
Susan Gregory (Director within children's social care – Nottingham City Council)
Susan Hawkesford (Manager with children's social care – Nottinghamshire County Council)
Tony Dewhurst (children's social care – Nottinghamshire County Council)
Yvonne Dales (Nottinghamshire Police)

4. Disclosure of documents

Total number of pages disclosed: 40,316	
Investigation material	38,793
Publicly available material	1,546

5. Public hearings including preliminary hearings

Preliminary hearings	
1	11 May 2017
2	31 January 2018
3	19 July 2018
Public hearings	
Days 1–5	1–5 October 2018
Days 6–7	8–9 October 2018
Days 8–10	17–19 October 2018
Days 11–15	22–26 October 2018

6. List of witnesses

Forename	Surname	Title	Called / Read	Hearing day
	D7		Called	2
	L17		Called	2
	C21		Called	2
	N1		Called	3
	L43		Called	3
	F37		Called	3
	P18		Read	3
	D22		Read	3
	L23		Read	3
	L29		Read	3

Forename	Surname	Title	Called / Read	Hearing day
	L48		Called	4
	L45		Called	4
	P7		Called	4
	L35		Read	4
	P4		Read	4
	D38		Read	4
	D26		Read	4
	D31		Called	5
	D6		Called	5
	P3		Read	5
	L46		Read	5
	D46		Read	5
	P1		Read	5
Rod	Jones	Mr	Called	6
David	White	Mr	Called	6
Kenneth	Rigby	Mr	Called	7
Bronwen	Cooper	Ms	Called	7
Jim	McLaughlin	Mr	Called	7
James	Fenwick	Mr	Called	7
Margaret	Stimpson	Ms	Called	8
David Philip	Morgan	Mr	Called	8
Mark	Cope	Mr	Called	8
Helen	Blackman	Ms	Called	8
Michelle	Foster	Ms	Called	9
David	Fisher	Mr	Called	9
Margaret	Mackechnie	Ms	Called	9
Susan	Gregory	Ms	Called	9
Sonia	Cain	Ms	Called	10
Daniel	Yates	Mr	Called	10
Jayne	Austin	Ms	Called	10
Rhona	Hicks	Ms	Called	10
Yvonne	Dales	Detective Inspector	Called	11
Julie	Balodis	Detective Constable	Called	11
Sam	Shallow	Ms	Called	11
Chris	Few	Mr	Called	11

Forename	Surname	Title	Called / Read	Hearing day
Sue	Matthews	Ms	Called	12
Rachel	Morton	Ms	Called	12
Steve	Edwards	Mr	Called	12
Philip	Owen	Councillor	Called	12
Stuart	Brook	Mr	Called	13
David	Mellen	Councillor	Called	13
Paddy	Tipping	Commissioner	Called	13
Mandy	Coupland	Ms	Called	13
Maxine	Leigh	Ms	Read	13
Simon	Hackett	Professor	Called	14
Alison	Michalska	Ms	Called	14
Colin	Pettigrew	Mr	Called	14
Robert	Griffin	Chief Superintendent	Called	14
	P16		Called	15

7. Restriction orders

On 23 March 2018, the Chair issued an updated restriction order under section 19(2)(b) of the Inquiries Act 2005, granting general anonymity to all core participants who allege they are the victim and survivor of sexual offences (referred to as 'complainant core participants'). The order prohibited:

(i) the disclosure or publication of any information that identifies, names or gives the address of a complainant who is a core participant; and

(ii) the disclosure or publication of any still or moving image of a complainant core participant.

This order meant that any complainant core participant within this investigation was granted anonymity, unless they did not wish to remain anonymous. That order was amended on 23 March 2018, but only to vary the circumstances in which a complainant core participant may themselves disclose their own core participant status.[1313]

8. Broadcasting

The Chair directed that the proceedings would be broadcast, as has occurred in respect of public hearings in other investigations. For anonymous witnesses, all that was 'live streamed' was the audio sound of their voice.

[1313] Restriction Order, 23 March 2018

9. Redactions and ciphering

The material obtained for the investigation was redacted and, where appropriate, ciphers were applied, in accordance with the Inquiry's Protocol on the Redaction of Documents.[1314] This meant that (in accordance with Annex A of the Protocol), absent specific consent to the contrary, the identities of complainants, victims and survivors of child sexual abuse and other children were redacted; if the Inquiry considered that their identity appeared to be sufficiently relevant to the investigation, a cipher was applied. Pursuant to the Protocol, the identities of individuals convicted of child sexual abuse (including those who have accepted a police caution for offences related to child sexual abuse) were not generally redacted, unless the naming of the individual would risk the identification of their victim, in which case a cipher would be applied.

10. Warning letters

Rule 13 of the Inquiry Rules 2006 provides:

"(1) The chairman may send a warning letter to any person –

a. he considers may be, or who has been, subject to criticism in the inquiry proceedings; or

b. about whom criticism may be inferred from evidence that has been given during the inquiry proceedings; or

c. who may be subject to criticism in the report, or any interim report.

(2) The recipient of a warning letter may disclose it to his recognised legal representative.

(3) The inquiry panel must not include any explicit or significant criticism of a person in the report, or in any interim report, unless –

a. the chairman has sent that person a warning letter; and

b. the person has been given a reasonable opportunity to respond to the warning letter."[1315]

In accordance with rule 13, warning letters were sent as appropriate to those who were covered by the provisions of rule 13. The Chair and Panel considered the responses to those letters before finalising the report.

[1314] Inquiry Protocol on Redaction of Documents
[1315] http://www.legislation.gov.uk/uksi/2006/1838/article/13/made

Annex 2

Glossary

CID	Criminal Investigation Department, a branch of the police which investigates serious crimes
CSCI	Commission for Social Care Inspection, responsible for the registration and inspection of children's social care services between 2004 and 2007
DfE	Department for Education
Director of Children's Services	The officer within each local authority who has statutory professional accountability for all children's services, including education and social care
HMIC	Her Majesty's Inspectorate of Constabulary: until 2017 the name of the body responsible for assessing the effectiveness and efficiency of police forces
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services: from 2017 the name of the body responsible for assessing the effectiveness and efficiency of police forces and fire & rescue services
LADO	Local Authority Designated Officer, an officer in each local authority's children's social care service to whom allegations or concerns about the protection of children are reported. Responsible under statute for investigating such complaints
Lead Member for Children's Services	The councillor within each local authority who has statutory political accountability for all children's services, including education and social care
LSCB	Local Safeguarding Children Board, a multi-agency body set up in each local authority, with an independent chair, to safeguard and promote the welfare of children in the area. From 2018, replaced by Safeguarding Children Partnerships
NCH	National Children's Home
NCSC	National Care Standards Commission, responsible for registering children's homes and fostering services and then carrying out inspections between 2002 and 2004
NSPCC	National Society for the Prevention of Cruelty to Children
Ofsted	Office for Standards in Education, Children's Services and Skills, responsible for inspections of children's social care since 2007
PEEL assessment	An annual assessment of police forces conducted by HMICFRS
Social Services Committee	A local authority committee, primarily consisting of councillors, which was politically responsible for children in care until 2000
SSI	Social Services Inspectorate, established in 1985 to improve effectiveness and efficiency of social services and to promote necessary development, including in children's social care

The City	Nottingham City Council
The Councils	Collective reference to both Nottinghamshire County Council and Nottingham City Council
The County	Nottinghamshire County Council
The police	Nottinghamshire Police

Annex 3

List of convictions

There have been various convictions for sexual offences against children over the period covered by this investigation. Convictions of residential care staff for sexual abuse of children in residential care and convictions for child sexual abuse in foster care are listed below. Where the conviction was for non-recent abuse, the timeframe of the abuse is listed along with the year of conviction. Where the conviction was for recent abuse, only the year of conviction is listed. Convictions for harmful sexual behaviour are not listed because, by their nature, those who were convicted were children at the time of the offence.

The Sexual Offences Act 1956[1316] included offences of rape, unlawful sexual intercourse with girls under 16 and indecent assault of children.

The Indecency with Children Act 1960[1317] introduced the offence of gross indecency with a child under the age of 14.

The Sexual Offences Act 2003[1318] made provisions about new sexual offences and the protection of children from harm from sexual acts and incidents connected with sexual acts.

Table of convictions of residential care staff for sexual abuse of children in residential care

Name	Nature of the offence(s)	Year of conviction	Sentence received
Malcolm Henderson	Indecent assault of two girls at Skegby Hall	1975	Two-year probation order
Colin Wallace	Four counts of unlawful sexual intercourse against a child in care	1981	Unknown
Michael Preston	Two counts of indecent assault against a resident at Three Roofs Community Home	1985	Nine months' imprisonment
Gerald Jacobs	Indecent assault of a resident at Amberdale Secure Unit	1986	Nine months' imprisonment
David Marriott	Four counts of indecent assault against two residents at Skegby Hall	1987	Two years' imprisonment
Steven Carlisle	Three counts of indecent assault against residents at Woodnook Community Home	1990	Unknown
Norman Campbell	Four counts of buggery and three counts of indecent assault against children in residential and foster care	1991	Six years' imprisonment

[1316] Sexual Offences Act 1956
[1317] Indecency with Children Act 1960
[1318] Sexual Offences Act 2003

Name	Nature of the offence(s)	Year of conviction	Sentence received
John Dent	11 counts, including rape and indecent assault of children at Beechwood and Hillcrest in the 1970s	2002	Seven years' imprisonment
Paul Wheater	16 counts of indecent assault against two residents at Risley Hall Approved School in the 1970s	2002	Six years' imprisonment
Andris Logins	Four counts of rape, 12 counts of indecent assault and one count of cruelty against children at Beechwood in the 1980s	2016	20 years' imprisonment
Barrie Pick	Two counts of indecent assault and two counts of indecency with a child against a resident at Beechwood in the 1980s	2017	Six years' imprisonment
Dean Gathercole	Six counts of indecent assault and three counts of rape of two residents at Amberdale in the 1980s	2018	19 years' imprisonment
Myriam Bamkin	Indecent assault of a resident at Amberdale in 1985	2018	30 months' imprisonment
Christopher Metcalfe	Indecent assault of two girls in foster care and at Skegby Hall in the 1970s	2018	33 months' imprisonment
Michael Robinson	Five counts of indecent assault and one count of taking an indecent photograph of a child in relation to residents at Hazelwood in the 1980s	2018	Eight years' imprisonment
David Gallop	Two counts of indecent assault against a resident at Hazelwood in the 1970s	2018	21 months' imprisonment

Table of convictions for child sexual abuse in foster care

Name	Nature of the offence(s)	Year of conviction	Sentence received
NO-F106	Indecent assault of two children not in care	1976	Three-year probation order
Bernard Holmes	Four counts, including unlawful sexual intercourse, indecent assault and gross indecency, against two children in his care	1987	30 months' imprisonment
Michael Chard	Four counts of indecent assault against two children in his care	1989	Three years' imprisonment
NO-F141	Indecent assault of a child in his care	1990	Unknown
NO-F119	Adult son of foster carer convicted of rape of a child in foster care	1991	30 months' imprisonment

Name	Nature of the offence(s)	Year of conviction	Sentence received
Norman Campbell	Four counts of buggery and three counts of indecent assault against children in residential and foster care	1991	Six years' imprisonment
NO-F64	Indecent assault of two girls in his care	1991	Three months' imprisonment
Douglas Vardy	Sexual abuse of three children in his care	1993	Unknown
William Boden	Indecent assault of four girls from the 1960s to the 2000s who were not in care	2002	10 years' imprisonment
Robert Thorpe	Friend of foster carers convicted of four counts of indecent assault and five counts of unlawful sexual intercourse with a girl under 13 in foster care	2009	Five years' imprisonment
Patrick Gallagher	55 counts of sexual abuse, including rape and sexual assault, against 16 children (seven of whom were in his care) between 1998 and 2010	2011	13 life sentences with a minimum term of 28 years
NO-F77	Two counts of sexual assault and one count of exposure against two girls. One had been in his care and the other had been in foster care with another family	2013	Eight months' imprisonment
Stephen Noy	Eight counts of indecent assault and two of unlawful sexual intercourse against two girls, one of whom was under his foster care	2015	17.5 years' imprisonment
Raymond Smith	Indecent assault of a child not in care	2016	Two years' imprisonment, suspended for two years
Christopher Metcalfe	Indecent assault of two girls in foster care and at Skegby Hall in the 1970s	2018	33 months' imprisonment

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