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.