REPORT OF THE INQUIRY INTO THE MANAGEMENT OF CHILD CARE IN THE LONDON BOROUGH OF ISLINGTON

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AND

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A REPORT COMMISSIONED BY ISLINGTON COUNCIL FOLLOWING SERIOUS ALLEGATIONS ABOUT CHILD CARE PRACTICES IN THE BOROUGH

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Finally, our thanks go to Oxfordshire County Council for their preparedness to release the time for this work to be carried out.

TERMS OF REFERENCE FOR THE CONDUCT OF THE ENQUIRY INTO THE MANAGEMENT OF CHILD CARE IN ISLINGTON

1. ***Allegations of Staff Misconduct and Inappropriate Treatment of Children and Young People***

1.1 The Inquiry team should initially identify and list all allegations of misconduct by staff employed (currently or formerly) by the London Borough of Islington and of inappropriate treatment, including neglect and abuse, of children accommodated by the Borough, including specific allegations by the London Evening Standard Newspaper in November 1992 and December 1993.

1.2 The Inquiry team should check this list against the Reports to the Council provided by [redacted] and [redacted] dated February 1993, by [redacted] and [redacted] dated July 1993, by [redacted] dated February 1994 and finally by [redacted] and [redacted] dated March 1994 and identify those allegations, the handling of which has yet to be fully and independently reviewed.

1.3 Where it is considered that allegations have been fully and independently reviewed, a synopsis of action taken as a result should be prepared.

2. ***Review of Allegations***

2.1 The Inquiry team should collate information in respect of each allegation and prepare a clear chronology of events.

2.2 In respect of each allegation the Inquiry team should comment and advise on each of the following aspects:-

i. Whether information indicates the possibility of criminal activity - if it does, the Inquiry must convey the information to the Police without delay.

ii. Whether the information indicates the need for any staff disciplinary measures.

iii. Whether the information indicates that measures are needed to protect children, or whether there should be specific reviews by the Area Child Protection Committee (under the guidance published by the Department of Health in "Working Together" under the Children Act 1989).

iv. Whether there are legitimate complaints by, or on behalf of, children's services users that remain to be resolved under the Council's complaints procedure (established under Section 26(3) of the Children Act 1989).

v. Whether the information indicates that staff grievance procedures should be invoked.

3. *Missing Files*

The Inquiry team should review the investigation undertaken for the Borough by [redacted] (and completed in February 1994). To the extent that it has not been done by [redacted] or to the extent they consider it appropriate to do this, the Inquiry team should:-

Enquire into the disappearance of relevant files in the period being enquired into, including to seek and interview persons who might be able to shed light on their disappearance. To comment and advise on the explanations, if any, for their disappearance and the possible culpability of any staff members concerned and to advise on appropriate management and/or disciplinary action.

4. *General*

4.1 The Inquiry Team should make general comments on the implications of the Inquiry for the state of practice in the Council's Social Services child care provision, cross-referencing to anything recommended in [redacted] and [redacted] July 1993 report, as necessary.

4.2 The Inquiry should report to the Council by end December 1994.

4.3 The Council should provide the Department of Health with a copy of the report.

4.4 The report should be made public without undue delay.

The allegations made by the Evening Standard and referred to in paragraph 1.1 above have also been delivered to Scotland Yard.

October 1994

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Background

In October 1992, the Evening Standard published articles in which serious allegations were made about the care of children who were the responsibility of the London Borough of Islington. **The Evening Standard reports asserted that children in care were working as prostitutes and using Children's Homes to entertain customers, that children were seduced into drugs, homosexuality and prostitution, that some children were sexually abused, gang raped, knifed and that fears of an organised child sex ring were dismissed by management and not properly investigated. The Evening Standard alleged that Children's Homes had been out of control at times with lapses in security and discipline as a result of low staff levels and poor management.**

As a reaction to these allegations and other serious issues during the period, London Borough of Islington commissioned or received no less than 13 different Inquiry reports and inspections before this final review. Such an incremental response to allegations as serious as this were not considered to be sufficient by Islington and as a consequence, this report was commissioned with the aim to pull all this work together, to explore previously unpublished dossier information provided by the Evening Standard, and to produce a final overview picture to these various and serious allegations.

This Inquiry has therefore analysed all these previous pieces of work, used the Evening Standard data, interviewed considerable numbers of staff and Councillors and has come to the conclusions contained in the report.

In carrying out this review, it became very apparent that to understand the issues presented, it was necessary to understand the history, context and culture of Islington at the time. From 1982 Islington had a series of Labour Councils with a clear political objective of establishing a decentralisation policy based on Neighbourhood offices. The implementation of that policy which in effect broke up the traditional functional organisation of the Borough, combined with much changed personnel and equal opportunities policies, **began to create an environment where the morale, management competencies and professional standards of the department declined.** These problems were exacerbated by financial considerations, the way the departmental organisation changes were imposed, the appointment of middle managers who were not qualified to manage social services practices, the poor quality of residential care management, the aftermath of industrial action and working relationships with other agencies which were not as good as they should have been. In our view, this created the conditions where poor practice and negligent management action could flourish. We are not therefore surprised that issues such as those raised by the Evening Standard and the subsequent Inquiries should have been found in a Borough like Islington.

The responsibility for ensuring the provision of a properly accountable and robust department lies with the Council of the time and its Senior Officers. It is our view that the weaknesses in the organisation indicated an amazing breakdown in communications and credibility which undoubtedly created the conditions in which the bad practice and other matters contained in this report were allowed to flourish.

There is no doubt in our mind that a "pure" Neighbourhood structure is fundamentally unable to provide the expertise, consistency, checks and balances and professional standards required of a competent Social Services function.

Allegations of Staff Misconduct and Inappropriate Treatment of Children and Young People

Personnel

The full terms of reference are set out at the beginning of this report. Our response has been to analyse all the dossiers and other information presented to us and to check lists of names of staff against Islington's personnel records. Details of the names of these staff are contained in confidential annexes to this report. **This comprehensive review listed allegations against 32 named staff involving sexual assaults on other staff, encouraging boys to be rent boys, sexual misconduct with residents, sale of drugs, poor child care, staff involvement in paedophile rings and child pornography and many other serious allegations.** Of the total of 32 staff:-

* 4 were subject to disciplinary action, following which 2 were dismissed
* 5 were subject to disciplinary process but left on ill health grounds before disciplinary action was concluded.
* 1 faced charges of child abuse
* 13 were not subject to any investigation
* 10 resigned
* 1 was dismissed
* 2 are still in post [redacted]
* 3 were from agencies

Many of these allegations involved criminal behaviour as well as staff misconduct and the standard response of any Social Services Department then and now should have been as follows:-

* **Suspension of staff implicated and a full disciplinary investigation with a concluding investigative disciplinary hearing.**
* **A review of the particular child's case on a multi-disciplinary basis supervised by ACPC.**
* **A joint Police and Social Services investigation in those circumstances where it appears there might be criminal behaviour.**

The responsibility for ensuring that such an investigative system was in place rested with the Council and Senior Officers of Islington during the period in question. It is clear that Islington did not initiate the type of investigation they should have and as a consequence the possibility remains that staff engaged in abusive behaviour are now working elsewhere in the field with potentially serious consequences. Islington should have known and acted; they clearly did not.

Equal Opportunities

We have been told that the equal opportunities policy in action at that time created a "back door" where staff could very well have been allowed to act unprofessionally and to exit Islington as questions began to be asked. We were told that at the time, there was **"an equal opportunities environment driven by a personnel perspective which became a positive disincentive to challenge bad practice. We were told it was a weak ineffective organisation which was set up for individuals to feed off for their own advantage; it was paralysed by equal opportunity and race issues."**

It is clearly crucial that all the policies and practices of a Local Authority in relation to children are primarily child centred, rather than personnel centred only, and whilst equal opportunities policies are very important, they cannot be allowed to be implemented in such a way as to have positive disadvantages of the kind outlined.

Organisational Competence

We were told of a demoralised management system, unsupported and with fragmented leadership which in parts were staffed by people not from a Social Services background and therefore who would not know what to look for and how to respond to the management of child care issues. **Clearly, such an organisation becomes a recipe for disaster.**

Agency Staff

Some of the information presented to us reflected the use of agency staff which all Authorities use. It is alleged that at least one staffing agency in Islington was run by paedophiles and heavily used by Children's Homes and therefore a natural conduit for paedophiles to infiltrate the system. The Warner Report and subsequent guidance issued by the Government in 1992/93 clearly states how Local Authorities **should** be working with agency staff and clearly the Warner Report post-dated these allegations. The Islington Inquiry, however, does raise questions of general importance about the extent of action on this and we will write to the Department of Health raising these so that they can take them up nationally.

Islington Staff

Islington notified the consultancy register at the Department of Health on very few occasions and it is arguable that most, if not all of the names in the confidential annexes, should have been notified to Department of Health. [redacted]

Recommendation

[redacted]

Recommendation

We recommend that Islington write to all Social Services Departments suggesting they review current employees who may have come via the Islington route are to be checked with Islington Council and the Department of Health Consultancy Register.

Information about Potential Paedophiles

It is clear that only a very small number of paedophiles ever get convicted and that therefore Local Authorities will not pick up their names from either the consultancy register or from police checks. Whilst we recognise that this is a difficult legal area, and one which involves policy being made by the Home Office, Department of Health and others, **we do feel that it is important that a review of how information can be exchanged is carried out if all Local Authorities are not to find staff having left one Authority now working in their own and we will write to the Department of Health accordingly.**

We were asked in the Terms of Reference to ensure that information collated in this Inquiry is passed to the Police. All the confidential information contained in the annex has not only been passed to the Police and checked with them, but with the Department of Health consultancy register too. We believe that the information presented in the annexes, together with our general commentary fulfils the Terms of Reference in relation to all matters concerning staff.

The personnel implications of this report are profound and may have far reaching consequences. Islington's response at the time was far from satisfactory and this report feels like "closing the door when the horse has long bolted".

Issues Concerning Children

The Terms of Reference 2.2 (iii/iv) draw attention to information about children. As with the personnel, we have analysed all the allegations about named children and have passed them onto Islington Social Services. A detailed analysis, which is based on cross-checking all the names presented with all the other Inquiry report, is contained in the confidential annexes setting out the allegations made against individual children and cross-referred to staff records.

The allegations about children range from allegations about disturbingly low standards of care in Children's Homes, to incompetent line management of Children's Homes and to the investigation of organised sex rings and network abuse. Twenty-five children were identified specifically. The conclusions that we and others have drawn are that:-

* **The state of some Children's Homes at the time was very poor indeed.**
* **There had been lack of investment in those Children's Homes.**
* **That line management standards throughout the complete period were very poor, often with middle managers with responsibility for children's centres not carrying out those responsibilities professionally or knowledgeably.**

Some of the allegations involved the response Islington made to allegations of organised abuse. These were checked out and investigated fully with the Metropolitan Police, Social Services Inspectorate and others and **we found that with the exception of one conviction in relation to a staff member at a residential school, Islington did investigate these allegations and we found no evidence to support assertions of organised abuse.**

Individual Children

All the individual children's cases have been brought to the attention of Islington and have been checked up to the current position. With the exception of children where there have been independent reviews, all the other children's names have been reviewed by Islington who have reported on their current whereabouts, needs for support and help. The Authority has provided comprehensive information about its involvement with these young people. **Ten children, now young adults, have all very different histories, but from the enquiries we have made it is appropriate to conclude that Islington were aware of all of them, have maintained contact where possible and where wanted and have provided or offered ongoing support and help appropriate to their individual needs and circumstances.**

Voluntary Child Care Organisations

The Evening Standard dossier reflects concern that one particular voluntary child care organisation who provided volunteer advocates to visit Children's Homes had been infiltrated by paedophiles. If this was true, it is extremely important and illustrates the ease by which people wishing to prey on young people can get access to them. **We have discussed this problem with Department of Health who have drawn our attention to the relevant circulars defining how voluntary child care organisations should embark on police and consultancy checks but we are still concerned that there might not be a consistent approach nationally to this.**

We therefore recommend:-

That all Social Services Departments review their use of such voluntary organisations and agencies and discuss with those organisations how they recruit, supervise and monitor the quality of work of their staff. We urge all Local Authorities to establish a simple "contracting system" which would include a specification of requirements, and a process of organisational audit. This might involve, for example, one Authority in the country in whose area the headquarters of such organisation exist, agreeing with that organisation to be lead in checking the organisations' professional practices. We are sure that all such organisations will see this as valuable confirmation of their organisational strength and not as something onerous and to be rejected.

We do not believe that there is anything further constructive that Islington could now do to rectify any of the inadequacies of services during the period in question.

Missing Files

We were asked to review the previous investigations undertaken on this subject and where possible to enquire into the disappearance of relevant files. The allegations specifically refer to files in relation to 3 children and a number of other general issues. We have cross- checked all the Evening Standard dossiers with [redacted] work and with work carried out by [redacted] in a report of March 1992 and present the details of this.

In respect of Child A, we found no evidence of collusion or deliberate attempts to withhold information. **We do, however, conclude that there is much evidence of confusion and poor management of written records at the time.**

In relation to Child B, there were allegations that [redacted] Police and [redacted] Social Services had been deliberately prevented from accessing file material in relation to very serious allegations involving a suspected paedophile. **Our view is that Islington did not deliberately withhold such key information although we believe that the way communications were carried out between the various agencies concerned was very poor, strung out over a long period of time and handled badly at the Islington end.**

In relation to Child C, it is alleged that key materials went missing. We know that the Social Worker concerned went missing at the same time and we can find no evidence that the disappearance of this worker and his file were in any sense part of a wider conspiracy. [redacted]

A number of other allegations are detailed in the main body of the report which we have cross-checked and investigated as much as we can. **There is no evidence to support the allegations of collusion but there is sufficient evidence to support the assertion that missing files were a feature of poor administrative systems.**

Administrative systems have been a recurrent theme in relation to all of these concerns throughout the many previous Inquiries.

Recommendation

We recommend that London Borough of Islington, as part of their new administrative arrangements, urgently review the arrangements for client files to make sure that a consistent approach is adopted and introduced across the Council as soon as possible.

General Implications of the Inquiries for the State of Child Care Practice

The Inquiry team were asked to make general comments on the implications of the Inquiry for the state of practice in child care provision. We have presented in this report a full chapter summarising previous Inquiries and independent reports over a long period of time. It is clear from reading this chapter that as they unfold there are a series of issues which consistently run as a thread through them and indicate bad and deficient practice at the time. In summary, the key themes emerged were:-

* Issues about delay.
* Practice where there was an absence of thorough consideration of facts, information, history and planning.
* An inadequate level of administrative support.
* Poor supervision of staff.
* Unavailability of expertise for complex cases.
* A lack of up-to-date training in child protection.
* Poor standards of case records.
* An absence of management monitoring and reviewing in critical case decision making.
* The confusion of roles between staff between the department and a consequential confusion of accountability.
* A lack of systems for monitoring the department's work, quality standards and implementation.

Islington did not respond as quickly and as comprehensively as it should to these various reports and there are still a number of areas not completely and satisfactorily covered which we believe should be addressed quickly.

Recommendation

We recommend that Islington undertake an audit of its supervision policy and practice to review the extent to which supervision systems are working effectively.

Recommendation

We recommend that Islington undertakes a training needs analysis and a review of training priorities against the department's training plan for 1995/96.

Recommendation

We understand that a new recording system has recently been introduced and that new file structures have been implemented. We recommend that Islington undertake an audit of the implementation of these new policies in the Autumn of 1995.

We know that progress has been made and our report sets out the position today. We know that changes have been made to address to the different issues raised in this report. We argue that as the new management system settles down, it needs to be supported by a programme of organisation and management development and we hope that Islington will support this. **We are unsure that all the lessons of the previous reviews and Inquiries have been incorporated into professional practice in Islington, although we know that Islington has made considerable strides in this respect.**

Recommendation

We therefore recommend Islington urgently review whether the arrangements now put in place for professional audit and other matters will be sufficient to see the Department over the next two years and if not to make further time available through this crucial phase.

We know that further personnel management changes have been made in Islington and that some of the problems of personnel management set out earlier in this report could still happen if personnel arrangements are not consistent and efficient.

Recommendation

We recommend Islington to review and strengthen the management of the personnel system to ensure overall control and quality checks are robust enough to meet child centred management requirements.

We have drawn attention in the report to the need for all personnel policies, including equal opportunities to be child focused and we know that there are still questions in the minds of some senior staff about whether or not the equal opportunities policy has been synchronised enough with child care needs.

Recommendation

We recommend that Islington Council formally review the equal opportunities policy in relation to its application to child care in order to remove, once and for all, any possible problems that this policy could create in addressing competency and management issues in Islington.

Conclusion

This Inquiry has sought to bring together all the previous work, and has charted an organisation in the late 1980's and early 1990's that was for many different reasons chaotic. **Such a chaotic organisation breeds the conditions for dangerous and negligent professional practices in relation to child care and the possibility that many of the allegations made were true remains. What is sad is that Islington did not systematically investigate them as they should have and as a result, the possibility remains that children have been abused and that abusers are still working in the field elsewhere.**

We nevertheless now know that many changes have been made within Islington to bring the child care function back to "centre stage" with a new Chief Social Services Officer and Head of Neighbourhood Services with newly established child care management arrangements and new managers too. We very much hope that this report ends what must be a disastrous chapter in Islington's history.

CHAPTER ONE

INTRODUCTION

INTRODUCTION

In October 1992 the Evening Standard published articles in which serious allegations were made about the care of children who were the responsibility of the London Borough of Islington Neighbourhood Services Department.

The allegations referred initially to two Children's Homes, (the Evening Standard dossiers implicated others), to the cases of a number of individual children and to the activities of alleged paedophiles operating in the area, including the possibility of organised abuse. The substance of the allegations was that children in residential care were not safe, both because staff failed to act appropriately to protect them from paedophiles and that staff themselves in some cases had been directly responsible for the abuse of children in their care, and that Residential Homes care was very poor. Furthermore, the Evening Standard claimed that some staff had tried very hard to bring these matters of serious concern to the attention of the neighbourhood and senior managers within the department, but that their concerns had been met with a lack of concern and an absence of any appropriate action.

The key anxiety raised in the press was that, because no steps had been taken to address these issues, then the children who were in the care of the London Borough of Islington remained unprotected and the adults allegedly responsible for abusing them remained free to continue their activities untouched by any Police action, prosecution, or disciplinary action. If these allegations were true, then the Neighbourhood Services Department, which in Islington incorporates all the statutory responsibilities attaching to Local Authority Social Services Departments, would have been failing in its statutory duties and responsibilities, and the matter was thus one of serious public concern.

After the appearance in the Evening Standard of these allegations, but not having access to the detailed dossiers now available and following discussions with Department of Health, the London Borough of Islington put in hand work to address the issues which had been highlighted. In particular it sought initially to ascertain that the individual identified children were safe and that their Children's Homes were achieving minimum standards of care and control. Subsequently Islington received a more general independent report on its management arrangements. In December 1993 a further series of investigations and reports was commissioned to report during the first half of 1994. Thus over a period of 18 months, (with one report going back to 1989), thirteen independent reviews/reports of various aspects of its organisation, management, and child care practice, were carried out, the main themes of which are summarised in Chapter Two.

In some cases this work raised more concerns which were expressed as allegations against specific staff, worries that other identified children had been abused and suggestions that important written evidence had been lost or even withheld from the Police. The Evening Standard itself, through its original series of articles, was approached by a number of people who raised more concerns in relation to their experience of the Neighbourhood Services Department. These concerns were collated by the Evening Standard through 1993 so fell outside the period in which the initial independent reviews were undertaken.

By the Autumn of 1994 a number of reports had been provided, various pieces of work had been done by Islington Officers, and some changes had been implemented to address such management and organisational changes as the London Borough of Islington considered necessary. However, because the previous reviews had each been commissioned to focus on specific aspects of the different concerns and allegations, Islington considered there was a need to produce an overview of all the work done to promote the safety and well being of children in Islington. This report therefore addresses these matters by detailing issues and work done in relation to allegations of staff misconduct, allegations of abuse suffered by children, availability of files and written evidence, and child protection practice - incorporating the role of the Police and inter-agency working.

The Evening Standard Reports

On October 6th 1992, the Evening Standard ran an article, the first in a two part series, called *"The Scandal at the Heart of Child Care"*. In the first of these articles the Standard stated that their information had come, at least in part, from Social Workers working in the London Borough of Islington. To quote the paper *"what has emerged is a scandalous dereliction of duty by the Council, institutionalised neglect that has exposed the most vulnerable children in its care to paedophiles, pimps, prostitutes and pornographers"*.

The additional detail offered during the rest of the article included the information that:-

* A [redacted] year old [redacted] in a Children's Home was working as a prostitute and entertaining customers in [redacted] room in the Home.
* Children in care were seduced into drugs, homosexuality and prostitution.
* That some children in care had been sexually abused by staff.
* That one young [redacted] was gang raped by [redacted] in a Children's Home.
* That a [redacted] was knifed by a pimp inside a children's unit.
* That violent men, possibly pimps, were gaining entry to a Children's Home through windows.
* That the Authority's senior managers did not respond to concerns.
* That fears of a child sex ring were dismissed by management.

Numerous individual cases were cited, in some cases in significant detail, to support these claims.

The Standard continued to follow up the story and in February 1993 it reported on the findings of the first inquiry, or more precisely, the independent management review which had been commissioned in the previous October.

The inquiry reported on sub-standard conditions in at least one Home, where basic maintenance and security work was seriously inadequate, such that outsiders could break in through insecure or broken windows and that basic standards of decoration and furnishing were similarly a long way short of acceptable....."*what we can best describe as a dump.*"

Furthermore, the Standard reported that the inquiry considered two Residential Homes to have been out of control at times, with notable lapses in security and discipline; a problem either caused or exacerbated by low staff levels in Children's Homes.

The Evening Standard continued its press coverage during 1993, reporting on further review reports, management and organisation changes, and allegations of vital files being either lost or having gone missing. In 1994 the subject of reports included the death of a [redacted] in 1993 through severe neglect while in the care of [redacted] parents, but *"known to be at risk"*.

The press reports have continued in response to significant events and developments. In March 1995 they included extensive comments on the independent report on the child death.

Evening Standard Dossiers

Our Inquiry has been provided with the two Evening Standard Dossiers lodged with the Department of Health. This report, for the first time, has checked dossier information against all the other work done.

Having gone public in this way, the paper received many further statements and allegations from a variety of sources. In addition, they had collated considerably more information than had appeared in print. The first dossier of all this background information was collated around the time of the publication of the original articles (October 1992).

Much information in this first dossier provided additional detail regarding the eight individual cases which had been highlighted in the newspaper and in many instances provided background papers to support what was published, rather than providing new information. An extract from the summary in the dossier reads:-

" *Over many years, and at practically every children's home, children have alleged abuse by named workers. Often staff shared their fears but management has been slow to investigate, sometimes refused to involve Police, and suspected staff mostly quietly resigned, even when they apparently admitted abuse*"

Further issues that were highlighted were that allegations against gay [redacted] were not followed up because, politically, gays *are "unacceptable"* in terms of disciplinary investigations. The dossier also stated that there was a background of staff not being adequately checked, for instance, against Police records of previous criminal convictions.

Allegations in the press about files going missing became more specifically allegations that the London Borough of Islington had hindered Police enquiries and withheld information from the Police. These issues are dealt with in this report in the chapter on missing files. (Chapter 6)

The information in the second dossier was collated over a period of about a year following publication of the original press articles. Some additional information was presented to the paper by members of the public or ex-staff who were prompted to get in touch by the original articles. Other allegations came either from a review of papers and files which were made available to the Evening Standard, or from enquiries and interviews with some of the key people involved.

Considerable detail of the allegations, organised in a number of sections, can be summarised as follows:-

* Files withheld or missing in respect of a criminal prosecution of an ex staff member.
* Staff dealing in drugs in a children's home.
* Files and information withheld from Police investigating another ex staff member.
* Files missing about a child in care, which may have held evidence of sexual abuse.
* Misinformation given to elected Members.
* Staff accused of abuse allowed to resign.
* Child abused by a staff member, but child's written records missing.
* Personal relationships between staff in residential care home.
* Allegations against staff in respect of children in residential care.
* Inappropriate staff promotion.
* Targeting of some staff for disciplinary action with false witness statements.
* Two foster carers were alleged as unsuitable but there was no proper review.

From our analysis of both dossiers it was possible to identify 32 staff who were the subject of allegations of abusive or neglectful behaviour towards children in their charge.

Further staff were named or identified who were said to have been involved less directly - managers who ignored reports of concerns, managers who appointed people to jobs for which they were unsuited and managers who withheld information from investigations into allegations against staff.

Detail of the investigations into the allegations against staff are dealt with in a later chapter. Similarly, the number of children who were identified as having been the subject of abuse or neglect or poor standards of care while in the care of Islington Council totalled 26 in the dossiers. However, a large number of other children were alleged to be at risk of paedophile

activity in the wider community. The investigation of allegations in respect of these children is also considered further in a later chapter.

A significant aspect of the second dossier was in respect of allegations of organised abuse involving paedophiles living in the community and deliberately targeting young people and children to become parties to this behaviour.

One set of allegations referred to the paedophile's home as the **Hot House**. Further allegations were that young people were used to recruit other children to join these *"sex rings"* and that the paedophiles used the children's home networks to access a large number of potential victims. In some cases it was alleged the abuse was not only organised but also ritualised. Some of the original press reports stated that children in residential care were in the control of pimps.

The potential for this type of situation to occur is not particular to Islington and indeed many Authorities have experience of dealing with the problem presented by paedophile activity and network abuse. The aspect of these allegations that was most serious in the case of Islington was that it was alleged that management and the Council ordered social workers to stop investigating these matters. Further, that a number of professionals from different agencies had shared their concerns but that all had been ignored or vilified for raising these concerns. (What would have been expected would have been that Islington properly investigated this. We comment in Chapter 5 on this.)

The Evening Standard said that it had spoken with a police officer who *"shared the horror expressed to the paper by social workers that Islington had refused to investigate these allegations properly"*. It was also said that there were no effective systems for collating and sharing concerns between Neighbourhood Offices in the Borough, despite the numbers of children involved and the fact that they did not all come from one neighbourhood.

One agency in particular represents children in care in a number of settings, especially in secure units. The Evening Standard dossier raised serious concerns that members or representatives of this organisation may not always have had the best interests of the children at heart: it promoted the right of a [redacted] to become a foster carer - a [redacted] who subsequently was put on trial for alleged sexual abuse of the youngster in question.

Another member of this organisation is also alleged to have promoted the fostering application of a [redacted] who went to trial; this and information from the Police led to suspicion and allegations that the organisation had been infiltrated by paedophiles who in turn were able to infiltrate other establishments who care for children and young people and, in some cases, organise the network recruitment of young people as a result.

The use of agency staff to cover vacancies/emergencies is variable across the country. In Islington it was very high, at least at times. The dossiers allege that one agency in particular lied about doing Police checks on agency staff. At that time it is said to have been run by an ex-Islington staff member who was a personal friend of one staff member with suspected paedophile links. There was suspicion therefore that the agency itself could have been infiltrated by paedophiles but more importantly that the systems were not in place to ensure that any staff

employed by an agency were free of convictions, or that the agency was required to work to specific standards in this regard.

Summary

Our work has sought to analyse the data in the dossiers and cross-check this information with work carried out by the other Inquiries. This report seeks to pull all this work together and to comment on the total picture represented by the two dossiers and outcomes of the various Inquiry reports. So far as we have been able, this is therefore a composite overview report in which we have made judgements about the issues raised in these dossiers and Islington's handling of them. This process, and the findings which have ensued, fulfill the requirements of the Terms of Reference Islington gave us.

CHAPTER TWO

SUMMARY OF PREVIOUS INQUIRIES AND INDEPENDENT REPORTS INTO ISLINGTON NEIGHBOURHOOD SERVICES DEPARTMENT

SUMMARY OF PREVIOUS INQUIRIES AND INDEPENDENT REPORTS INTO ISLINGTON NEIGHBOURHOOD SERVICES DEPARTMENT

Introduction

In addition to this report, there have been 13 other important Inquiries/inspections which in themselves commented on matters of professional and managerial management in Islington during the period covered. It is important to understand the issues that emerged from these which on reading reinforce many of the messages which have emerged following our work. These Inquiries may be summarised as follows:-

1. [redacted] **Review: Report of Panel of Inquiry**

This report was commissioned by Islington ACPC following the death of this child. The report was published in November 1989.

The issues which formed the basis of the report's recommendations in relation to Islington Social Services can be summarised as follows:-

* That the delivery of Social Services from the existing neighbourhood office structure should be urgently examined.
* That administrative support at all levels should be examined.
* That elected Members should recognise the professional concerns of the Department.
* That the training needs of the Department should be carefully examined and the problems addressed.
* That the need for proper professional support for Neighbourhood Officers and senior Social Workers should be addressed.
* That the role of specialist advisory posts within Social Services should be reviewed.
* That there should be a central index of all files.
* That the authority should address its role in relation to the Area Child Protection Committee.
* That there should be increased child protection expertise available to neighbourhood teams, perhaps through creating specialist posts.

2. **Independent Review of Child A Case for London Borough of Islington by [redacted]: Guardian ad Litem**

A report was commissioned from an independent person following identification of a case wherein an ex-staff member stood trial on charges of child abuse, and wherein there had also been a protracted and damaging disagreement between groups of staff over this person's application to foster a specific child in Islington's care.

This independent inquiry submitted an interim report in March 1992.

The author came to the conclusions (here produced in summary) that:-

* The child's wishes and feelings were ascertained inconsistently.
* Some staff thought the child's wishes should determine, rather than influence, decisions.
* There was a failure to draw together all concerns, to evaluate them and to plan accordingly.
* There was no viable care plan for the child.
* Groups of staff did not support each other, and had poor working relationships.
* There was a lack of records about supervision.
* Recording was unclear.
* There was a lack of clear lines of accountability between staff.
* Management's responses were slow and apparently ineffective.

3. **Independent Management Review into Aspects of Child Care in Islington: [redacted]**

Following the first series of reports in the Evening Standard in October 1992, two external consultants were asked to report, first on some specific aspects of children's services provision in Islington. [redacted] and [redacted] reported in February 1993. In addition to very specific findings about individual children, they reported as follows:-

* There was confusion and conflict between the roles and responsibility of different staff.
* There were conflicts between staff of style, organisation, objectives and philosophy.
* These conflicts were untouched and were not being dealt with.

4. **Report for London Borough of Islington on the Management of Child Care within the Neighbourhood Services Department: [redacted] & [redacted]**

[redacted] went on to review the management of the Neighbourhood Services Department with [redacted]. This was a second phase of the review commissioned by the London Borough of Islington in response to the Evening Standard articles.

This report - on the management of child care within the Neighbourhood Services Department (NSD) - was presented in July 1993.

Its conclusions were made in relation to the fact that the NSD had locality services, and similarly generic managers with wide ranging responsibilities and in some cases a different professional background and training.

They concluded:-

* There should be specialisms within the organisation of social work services.
* That some services needed specialist managers, including residential child care.
* That residential child care needed to be in a separate "provider" unit.
* That more specialised administrators were needed.
* That there needed to be appropriate administrative support to senior managers.

5. **Independent Investigator's Report into Complaints made by Child X: [redacted]**

One particular young [redacted] who had been in the care of the London Borough of Islington made a formal complaint. Under Children Act procedures this was investigated by an independent investigator. An independent person also had to be appointed to be satisfied that the complaint was carefully considered and to report separately.

The independent investigator identified 31 separate issues of complaint and made 64 recommendations at the conclusion of a very detailed report, which was submitted in October 1993. The main points can be summarised as follows:-

* The child experienced residential care in terms of not feeling safe, and having a feeling of dereliction and neglect while in residential care.
* There was a delay in responding to the child's allegations that [redacted] had been abused.
* There was poor practice evident in some planning processes.
* There were poor administrative arrangements for planning and review meetings, evidenced by inadequate or unavailable minutes.

* The Department's organisation did not promote services to children in the long term care of the Borough since they could not be afforded sufficient priority.

6. **Independent Person's Report into Complaints made by Child X: [redacted]**

The independent person's report, presented at the same time, added further issues in need of attention, which were:-

* That firm and clear supervisory arrangements were needed.

* That management systems were needed for managers to have knowledge of critical casework decisions.

* That a security system for files was needed.

* That important decisions should only be taken only after full planning and discussion.

7. **Independent Management Review into Missing Files: [redacted]**

Stage three of the review - that which was commissioned following the Evening Standard articles - incorporated a number of elements, one of which was to review allegations that files had gone missing.

[redacted] made an interim report on this issue in December 1993 but the issues were reinforced in [redacted] final report in February 1994. These were:-

* That the balance between practitioners and administrative support was wrong and that there was inadequate investment in good administrative systems.

* That the security of files should be addressed.

* That there should be work done on the retention of files and documents.

* That files were badly constructed and difficult to read.

* That there was a need for new technology.

* That there was patchy implementation and monitoring of policy.

8. **Independent Management Review into the case of Child B: [redacted]**

In March 1994 there was a further report into one specific child. This young [redacted] had been in the care of the London Borough of Islington and looked after in residential care homes in the Borough. Concerns that this young [redacted] had been involved in a paedophile network at this time led to a more detailed review of the way in which Islington had dealt with [redacted] case.

[redacted] report concluded that:-

* There had been a lack of urgency in responding to allegations that this young [redacted] was being abused or was at risk.

* There was no evidence of senior management activity until later on.

* Despite the involvement of a number of children and Children's Homes, there was no co-ordination at a senior level.

* There was no evidence of managers' involvement through reading files, offering supervision.

[redacted] also found evidence of some of the issues which [redacted] had identified and reported on in July 1993, namely:-

* A lack of clarity between different roles.

* Children's Homes unable to control or modify some children's behaviour.

* Case files with no indication that senior staff had any grip on events.

9. **Report of the Quality Assurance Unit on London Borough of Islington Children's Homes: Croydon Social Services Department**

As part of its response to the allegations in the press, the Neighbourhood Services Department commissioned an independent inspection of its Children's Homes by Croydon Social Services Department. This inspection work was done between June 1993 and March 1994 when the report was submitted. Many specific issues were raised, but only some of the more generalised points are included here.

Some matters were seen in a very positive light, for example the standard of written policy and guidance produced centrally, and the in-house training programme made available to residential staff. However, a number of issues were seen to be in need of attention, including:-

* Residential units seemed to be isolated and quite autonomous.

* There was little co-ordination and little sense of shared purpose.

* Lines of accountability and responsibility were confusing.

* Very high reliance on agency staff.

* Staffing ratios were low.

* The system of line management through Neighbourhood Offices often felt confused.

10. **Report on the Inspection of Child Protection Services Provided by London Borough of Islington: Social Services Inspectorate**

The Social Services Inspectorate has a programme of regular inspection and monitoring visits to look at various aspects of Social Services provision across all Local Authorities.

In August and September 1994 the SSI reported on the inspection of child protection services provided by LBI. There was a total of 66 recommendations arising from this inspection . Action was indicated in respect of all the recommendations, but the need for improvements in a number of policy areas was identified whereas others were considered to be in need of review.

* Supervision policy, practice and recording inadequate.
* Recording systems and standards required.
* Specialist child protection training needed.
* Oversight of case files by managers needed improvement.
* Revision of child protection procedures.
* Review of procedures by ACPC.
* Review of ACPC structure, ways of working, work programme, training strategy.
* Planning of child protection investigations.
* Lines of accountability to be defined.
* Information systems needed for key data.
* Documented child care strategy needed.
* Systems required for monitoring standards and for monitoring the implementation of new policies.

11. **Independent Report for Islington Borough Council into the Care and Protection provided by the Council to Child Y:** [redacted]

As a result of the SSI's inspection work, two cases were identified for independent review because they had generated questions as to the extent to which they had been managed according to procedural guidelines.

The first of these two reports was presented in September 1994. Various practice points were identified as areas where standards should have been higher:-

* There was a lack of urgency following an allegation of abuse; the complainant was not seen.

* There was no care plan for the child concerned.

* There was an absence of a needs led assessment leading to consistent care planning and monitoring.

* There was no systematic approach to quality assurance.

Other points were made which relate back to the review of July 1993. They were also made in the next independent review and are identified below so are not reported here.

12. **Independent Report for Islington Borough Council into the Care and Protection provided by the Council to Child Z: [redacted]**

The second of the two cases to be subject to an independent review, following on from the SSI Inspection, was another young [redacted] who was in the care of the London Borough of Islington and who spent some time in residential care.

The report published in February 1995 was again written by [redacted] who, in highlighting [redacted] findings, also made reference back to [redacted] earlier [redacted] report in July 1993, since many of the issues were the same:-

* Confusion of roles.

* Tortuous and poor communication.

* Acceptance of poor standards of behaviour by or towards children.

* Lack of effective control and action by managers.

* Inadequate care planning based on the needs of the child.

* Delays in pursuing agreed actions.

* Lack of clerical and administrative support to a gross degree.

* Fieldwork staff and managers overloaded with the complexity of social work issues.

* No effective system for ensuring quality outcomes.

13. **[redacted] - Death Through Neglect : [redacted]**

Finally, the last report, also published in February 1995 was commissioned from the [redacted] following a child death in March 1993. The report was commissioned by a number of agencies representing Social Services, Health, Police and Education services in Islington. It considered the circumstances relating to the death of this [redacted] child who throughout was in the care of [redacted] parents.

Various points were emphasised in the report and a significant number of recommendations made, some of which related to other agencies.

With regard to the work of Social Services personnel, some of the key issues identified were:-

* A full case history was needed but missing.
* Views of the children were needed - there was no record that they had been sought.
* Interventions had been focused on the adults not the children.
* There was a lack of consistent professional consultation or supervision (across all agencies).
* There were no supervision records.
* Case records were illegible at times, and unsigned at times.
* There had been a lack of child protection training for staff involved in this work.
* More practice guidance was needed on recognising and managing child neglect.
* Procedural and training issues for ACPC were identified.

Analysis

A number of key themes have emerged from these different reports, which span a period of six years, although the events they refer to cover a longer period in some cases.

The key themes identified from the review of all 13 reports are identified and discussed below:-

1. *There was "a lack of urgency or rather an unacceptable delay" in responding to allegations of abuse or information that children were believed to be at risk.*

Comment

Delay was identified as an issue in five of the above reports. While it is necessary to plan any investigation into an allegation that a child is either at risk, or is suffering abuse, it is also important to recognise that any such abuse can continue unless protective action is taken. The DOH guidance includes references to the need for assessment of whether there is immediate risk to the child; in which case the *" the first requirement, therefore, must be speedy action"*. Any undue delay in the process as happened in Islington is therefore contrary to the statutory obligations on Local Authorities to determine what action is needed to safeguard or promote the child's welfare (Children Act).

2. *There was an absence of thorough consideration of facts, information, history and consequent lack of planning/or appropriate planning.*

Comment

This was identified as an issue in seven of the above reports. The Department of Health produced a list of principles underlying all the legislative provisions of the Children Act. These include:-

a. that a child's age, sex, health, personality, race, culture and life experiences are all relevant to any consideration of needs and vulnerability and have to be taken into account when planning or providing help.

b. that planning is a crucial responsibility for all agencies providing services to children and their families.

c. where children may be at risk of abuse, the detail of information required to inform an assessment is set out clearly in DOH guidance (Protecting Children) first published in 1988. In Islington, therefore, there was a failure to follow the practice standards set out in relevant guidance.

3. *There was an inadequate level of administrative support, leading to an absence of or delay in minutes of meetings, poor filing systems, etc.*

Comment

The issue of the level of administrative support was highlighted in seven of these reports, the first time being in 1989. While there is an understandable view that the priority for spending public money should be on direct services, this bears further examination.

Administration is the process whereby client indexes are maintained, filing is kept up to date, meetings are minuted, minutes of decisions taken are communicated, information in writing is shared between agencies and the history of individuals who are the responsibility of the department is collated. It is therefore the process whereby previous concerns are traced, decisions can be logged in order to hold others professionally accountable, and information is made available as a basis for comprehensive consideration and planning. A number of reviews of children who have died at the hands of their carers have cited failures of administrative processes as contributing factors.

An efficient and effective administrative system is an essential part of any Local Authority's provision of professional social work services to children, and in Islington's case has been identified as seriously inadequate ..... *"to a gross degree"* in [redacted] words. We comment further on this issue in Chapter six.

4. *There was no record of supervision of staff.*

Comment

This was specifically highlighted in three reports, although supervision more generally was addressed more widely (see (5) below). Supervision is the process whereby managers are routinely appraised of developments in the situations of children and families in respect of whom the Social Worker or Residential Worker has a series of specific duties and responsibilities. It is also the process whereby the manager agrees or sets limits to various possible courses of action which could occur.

Records of supervision meetings therefore should form a clear record of decisions taken about the management of individual cases and should be a reference point for staff in the event of future difficulty or dispute. Such records can therefore be key documents in reviewing either casework planning processes or staff performance. Without requiring such records to be maintained, Islington therefore was in a position where accountability could not be properly assured.

5. *There were inadequate opportunities for professional supervision or support; there was an unavailability of expertise in a department with a wide range of functions provided by non-specialist staff.*

Comment

As well as providing accountability (above) the supervision process should help advise, inform and improve social work practice. It should also help staff manage the complex planning associated with vulnerable children, and ensure that more specialist expertise or senior management attention is involved as necessary. It is primarily a recognition of shared responsibility within the department and the way in which standards of professional practice are monitored and reinforced. Any lack of such provision would therefore have serious implications for the way in which the department's responsibilities were met. A review of Inquiry reports into deaths from child abuse has reinforced the importance of supervision as critical to the implementation of effective child protection practice.

Recommendation

We recommend that Islington undertake an audit of its supervision policy and practice to review the extent to which supervision systems are working effectively.

6. *There was a lack of up to date or specialist training for staff working in the area of child protection.*

Comment

This was identified in three reports specifically but a large number of the other identified issues could have been addressed by a more comprehensive training programme. Child

protection practice is increasingly complex in the areas of recognition, assessment, treatment, as well as in the area of procedural and legal requirements. Without comprehensive training for staff involved in this specific area of work, there can be no assurance that staff can offer a thorough, safe and professionally sound service to children in need of protection.

Recommendation

We recommend that Islington undertakes a training needs analysis and a review of training priorities against the department's training plan for 1995/96.

7. *There were poor standards of recording on case files.*

Comment

Four reports identified this issue specifically, but it is implicit in comments about administrative support, and case planning (above). Recording is the key to the work of a professional public service maintaining, as it should, a departmental record of concerns expressed, decisions reached, resources used, resources needed, special needs, strategies employed, legal action, court directions, reasons for decisions, action taken, contacts made, clients wishes and views and ultimately, for children in care, a child's history. Without such records, a department is seriously hindered in undertaking its responsibilities and managers have no objective basis on which to judge the work of their staff.

In Islington the failure of staff to maintain comprehensive client records was judged to be a feature of poor child care planning and of poor child protection practice.

Recommendation

We understand that a new recording system has recently been introduced and that new file structures have been implemented. We recommend that Islington undertake an audit of the implementation of these new policies in the Autumn of 1995.

8. *There was an absence of any indication that managers were monitoring and reviewing critical cases and decision making.*

Comment

Five reports specifically raised this issue although, again, it is implicit in comments on issues to do with accountability and quality control systems.

Social Workers are faced with a range of problems and issues, as are managers of services such as residential care. Some were complex questions associated with risk management, resource allocation, inter-agency co-operation and legal proceedings or obligations.

All managers need systems to ensure that issues of this nature are brought to their attention as appropriate. Schemes of delegation and clear reporting procedures, or need to know systems, are necessary to ensure that information about difficult or contentious issues reach the right level of management. This was not the case in Islington and thus senior managers were not always advised, as they should have been, of critical issues.

The new structure, on which we comment in Chapter seven, has a social work manager post. The postholder has responsibility for these activities which means that in time this aspect of professional management should be strengthened. In the interim, while systems are being developed, senior managers remain somewhat vulnerable in this respect.

9. *There was a confusion of roles between staff within the department and a consequential lack of accountability.*

Comment

Eight reports highlighted this as a major problem area. Any organisation to be effective needs to clarify the decision making process and lines of accountability. These must be differentiated from staff whose roles are advisory; staff must know which decisions which must be implemented and managers must be clear whether or not it is their place to act in response to any difficulties or failings they identify.

Islington had specialist staff in place in policy making or advisory roles, but who were involved or who were approached for guidance by non-specialist staff with decision making responsibilities. Similarly, at senior management level there was conflict between the geographical responsibilities of Assistant Directors and the specialist or policy lead area of responsibility they each held. Other staff were not always clear whom to approach. Lack of clarity over accountability or decision making responsibility is conducive to confusion, to decisions not being implemented or monitored, to conflict and to oversight of some important issues.

10. *There was a lack of systems for monitoring the department's work, quality standards, and its implementation of new policies and practice guidelines.*

Comment

Four reports specified this problem, although it was implicit in a number of other issues. It would be reasonable to expect managers, particularly at senior management level, to be in touch with critical issues and cases (as discussed at (8) above). Where this is the case, and where there are shortcomings in practice or procedures, managers should be proactive in initiating work to improve standards.

However, the standard of work done by any department is dependent on the systems available to managers whereby they receive regular information as to the performance of their staff. This should then inform the necessity and nature of future action. The absence of any such systems, as was the case in Islington, meant that senior managers (and thus elected Members) were ill informed as to the effectiveness of the work done by their staff and the problem areas arising from the policies and procedures operating at that time. We have commented on the way these matters are now being addressed in Chapter seven.

Summary

In the early 1990's there were 24 Neighbourhood offices in Islington, each of which developed (through positive action or default) its own standards for social work practice. Hence, there was inconsistency across the Borough and a number of key features of good professional practice were inadequate or absent. Children's services are now delivered from 11 Neighbourhood offices and it is essential that managers in the new structure follow policies that address the poor systems of the past. **Whilst we know that many of the lessons from these various Inquiries have now been incorporated in the Department's practices, we are not wholly convinced that the changes Islington has put in hand over the last 12 months have been able to complete this process. Improving professional standards has to be a priority for management attention and action and extra resources for these should be made available, if necessary. In Chapter Seven we comment further on this.**

CHAPTER THREE

HISTORY, CONTEXT AND CULTURE

HISTORY, CONTEXT AND CULTURE

It has become increasingly apparent to us as we have carried out this investigation that it is impossible to understand the allegations contained in the Islington dossiers without understanding first the type of organisation that Islington was in the early 1990's.

Political Objectives

In the 1982 Local Government elections, a Labour Council was elected with very clear political objectives for how it intended the Borough to be shaped and run. Central to this objective was a desire to build on the ideas of community based services by providing a network of Neighbourhood Services offices and of decentralising as much decision making as possible to such neighbourhood offices.

This decentralisation policy was central to the Labour Group's political philosophy and resulted in the creation of 24 Neighbourhood Offices across the Borough broadly responsible for managing services within their local "patches". The neighbourhood offices opened between 1984 and 1986 following investment in both infrastructure (buildings) and staff. The objectives were to have services which were easily accessible, locally accountable, and 'consumer led'. An example of one such neighbourhood office was described by a staff member as *"covering a population of 6,000 who were concentrated in a small patch of 30 streets."*

The traditional organisation of Local Government is in functional organisations i.e. Education Service, Social Services Department, etc. The imposition of a neighbourhood based structure on top of the traditional functional structure undoubtedly led to considerable differences of opinions between Members and Officers in the Borough.

The implementation of the Neighbourhood Services structure did not take in the Social Services Department until 1991; prior to that all responsibilities had been in a functional Social Services Department which had been progressively decentralised. The Social Services function was ultimately merged into the full Neighbourhood structure as the then Director of Social Services retired.

We understand that increasingly, as the neighbourhood services structure began to take effect, concerns were expressed by the then Director of Social Services about confused lines of accountability, about the statutory nature of the Director of Social Services' role within a Local Authority and the implications for the stable management of the Social Services Department. The allegations covered in this report therefore span the various phases that the Social Services Department organisation went through from the late 1980's to the early 1990's. **It is apparent from our interviews that former senior staff and senior members had very different perspectives of this and indeed faith in each other.**

We are told that, prior to the Neighbourhood Services structure being set up, Islington's Social Services Department had a good national reputation for its child care services, although some of the allegations in the Evening Standard dossiers go back to that time. Nevertheless, it is a reasonable observation to suggest that the imposition of a neighbourhood based structure on a functionally based organisation would have had serious consequences for communications, for

people understanding their roles, and for the exercise of common standards of professional practice and organisational response to issues.

Council Structure

Within the Council, there was a Neighbourhood Services Committee which fulfilled the functions of the statutory Social Services Committee. The Vice Chairs of this Committee each headed a Sub-Committee, one for Housing and one for Social Services. The Social Services Sub-Committee dealt with policy issues and effectively oversaw most Social Services work. However, the Director of Neighbourhood Services reported directly to the Chair of the Neighbourhood Services Committee, not the Chair of the Sub-Committee.

Personnel Policies and Equal Opportunities

At the time when the neighbourhood structures were being brought into force, the Borough's Personnel policies were significantly changed to focus much more clearly on equal opportunities policies.

Whilst the decentralised structure of neighbourhoods had the responsibility for the routine personnel management and administration, a central equal opportunities team had a very clear role in the exercise of standards in this field. The equal opportunities team at that time had the power to alter job descriptions, to alter job specifications, to intervene in disciplinary procedures and to judge whether Officers in Islington were indeed holding to a correct equal opportunities philosophy.

The application of the policy made far reaching changes to personnel practice. Appointing Officers could not insist on or require a reference from a previous employer and could not challenge the references given on the basis of the role or status of the referee. In other words, an applicant could provide references from two friends. An interview panel could not ask any applicant about previous disciplinary action or their absence record. Person specifications could be changed by the Equal Opportunities Unit. For example, where a professional judgement was made that a Children's Home Manager should have five years experience, under the Equal Opportunities Policy, this requirement could be significantly reduced. The identification of appointing Officers was not always clear, hence a deputy in a residential home could be appointed by a panel of three residential home managers, thus increasing the potential for collusion over appointments.

There were a number of retirements on the grounds of staff members' "ill health" and this included some staff who were subject to allegations of misconduct and some in respect of whom disciplinary proceedings were planned. It was part of the staff code within the Borough that members of staff could refer themselves to the Borough's Medical Adviser - who was the Community Medical Adviser. The adviser was independent of the Director of Neighbourhood Services and if he/she made a recommendation that a staff member should be allowed to retire on health grounds, then no-one within the Department's Personnel Section or otherwise felt they had the authority to challenge this.

In reviewing the names of staff in respect of whom allegations were made, a number were not on the permanent staff at Islington but were provided by agencies. Residential care of children requires a minimum number of staff to be available on site on a twenty four hour a day basis. When establishments are faced with gaps in the rota due to sickness, holidays or staff leaving, it is the case that agency staff are sometimes used to fill the gaps on a temporary basis. There were times when Islington made extensive use of agency staff, many of whom had left by the time concerns about them had been raised. It was 1987 before Police Checks were routinely done on agency staff used by the Borough.

Comment

There is a fine line between positive personnel practices of this kind and practices which have serious unintended consequences and we are told that, until the last 2 or 3 years, such unintended consequences had happened. We are told that the Managers said they felt that they would not be supported by Members when disciplining or dismissing people, particularly people from ethnic minorities, or from the gay community.

One person described the situation as a period of:-

"

* *Lost disciplinaries*
* *Recruitment procedures that could not challenge references from previous employers, did not ask about previous disciplinaries and did not comment on absence records.*
* *A ban on ringing referees.*
* *People frightened by the Personnel process."*

Whether or not this was true, and we have had different views expressed to us on this matter, there is nevertheless evidence from the information that we have received which suggests that disciplinary action was not triggered when it should have been and that this culture may have been part of the reason for it.

Financial Considerations

The investment in the decentralist structure with its neighbourhoods and other policies created financial pressures which appear to have been added to by normal service priorities. Islington was one of the Local Authorities in London that had serious refinancing problems in the mid/late eighties which undoubtedly put great stress on capital and revenue resources. These financial pressures pre-date the Neighbourhood system and indicate the depth of the problem.

One Manager told us that regular reports were presented to the Council on the 6 weekly Committee cycle making it clear that physical conditions and standards in the Home were very poor and needed attention - long before the Evening Standard reports. This person's view was that there was no response from Members, although we were told by another Manager that when drawn to his attention, the Director of Neighbourhood Services allocated resources to improve the fabric of Children's Homes. Whatever the truth of the matter, events subsequently have led Islington to close a number of children's centres and to invest considerably in the remainder, rectifying undoubted problems of low investment at that time.

This would seem to confirm comments that are made in other reports that investment in the fabric of Children's Homes was far from what it should have been and that the Social Services case for capital investment was not made as strongly as it might have been.

Comment

It would appear that, whilst revenue investment in staff to support the neighbourhood structure was increased, there was no corresponding investment in service infrastructure and residential personnel, which might explain the deterioration of buildings, the high use of agency staff in Children's Homes, and a feeling amongst Social Services staff that Members did not want to know about needs for greater investment in services.

Departmental Organisation

Prior to 1991, Social Services staff within each neighbourhood office were managed by a Neighbourhood Officer for Social Services (NOSS). The NOSS was in turn responsible to an Assistant Director (Social Services). However, each Assistant Director held lead responsibility for a separate client group. Hence for each NOSS their line manager had responsibility for all clients whereas other A.D.'s had the specialist policy and practice knowledge and specific client group responsibilities.

From 1991 there was a completely new Department, headed by the Director of Neighbourhood Services, who was supported by two Deputies and three Assistant Directors. Each had responsibility for a service function within the Neighbourhood Services Department (an aspect of Housing or Social Services) and line management for a group of Neighbourhood Managers, which were new posts established to run each neighbourhood office. **In most instances, these Neighbourhood Managers were not professionally qualified or indeed experienced Social Work managers. Small numbers of NOSS' were also unqualified. In our view, this is a recipe for disaster.** The NOSS posts now reported directly to a Neighbourhood Manager who had Social Services, Housing and some Chief Executive responsibilities. (see Annex for organisation charts).

The Assistant Director with policy responsibilities for services to children and families was someone to whom staff frequently referred matters of concern and who featured in the Evening Standard as a key figure in the Department's Senior Management Team. There was an implied expectation that the person in this role would respond and take action in respect of matters made known to her but, structurally, the department did not provide for this. **This person was in a key role - as the most senior staff member carried over from the Social Services Department; as a senior child care figure and someone it is alleged knew much of the problems subsequently brought to light. This person was also the key staff 'interface' with Members and on whose judgement much rested. Responsibility for much of the departmental quality of management and its responses as concerns were raised, rests with her.**

The Neighbourhood Office Service

The decentralisation of services was designed to make services as locally available and accountable as possible. The [redacted] Inquiry in 1989 identified that priority within the Neighbourhood Offices was accorded to the provision of a duty service - the ready availability of social work time for local residents who came to the office seeking help. The implications

of such a policy are that *"the Social Workers' priorities are determined by the public who come in rather than the Social Workers themselves."*

Comment

Whilst in itself it is a laudable philosophy, it cannot be the only determinant in the management of Social Services. A number of Managers expressed the view that the political and professional philosophy of the Council at that time was diametrically opposite; Members wishing to have a community based supportive philosophy with open access through Neighbourhood Services, a commitment to welfare rights and community development but a lack of appreciation of the needs for a professional culture and support for those functions of a Social Services Department which are essentially and regrettably interventionist in families' lives. We doubt whether the overall philosophy of Islington was as explicitly defined as this but there has to be some substance in the view that political priorities were not in accord with the perceived day to day service demands of the Islington Social Services function. **As a result, the basic concentration on standards and organisational "checks and balances" undoubtedly suffered.**

Neighbourhood Organisation

The Neighbourhood Manager who was put in post to carry substantial delegated authority to deliver local services was inevitably going to carry responsibility for one or more areas of service in which he/she had no professional training or expertise - this was because of the range of services brought together in the Neighbourhood Services Department.

A Neighbourhood Services Manager with Housing training and experience could find him/herself responsible for the management of one or more residential children's establishments and for a team of Social Workers. Respectively, these services were directly managed by a NOSS and a senior social worker. We were told that *"the organisation was not clear about its expectations of its staff."*

The Neighbourhood Offices themselves, or one in particular, was described by one of its staff as having reception and administrative staff who supported staff from all services. The social work duty desk was close to the cashier's desk which was always busy with people queuing to pay for their rent and council tax. There was only one private interview room and there was competition for space in which to conduct confidential interviews. For a Neighbourhood Manager, there were clearly serious matters of concern arising from not only Social Services functions but also Housing which were no doubt in competition for management time.

Comment

In such a situation, all the received wisdom about organisational change would indicate that such a radical restructuring from two functional departments to an integrated Neighbourhood Services Department would need major investment in organisational development in order to ensure that people understood their roles and responsibilities, that communication mechanisms were clear, that reporting mechanisms were clear and so on.

From what we have learned, it appears that this investment of time did not happen and as a consequence, the potential for issues dropping into "black holes" or not getting dealt with was very high. Furthermore, it is probable that various people in the middle

management structure did not understand the essential minimums that a Social Services management system requires and which we comment on later in this report.

Management of Residential Care

Management of the children's residential establishments was shared between five Neighbourhood Offices and in turn their management was shared between two Assistant Directors and a Deputy Director.

It was therefore possible, within Islington's structure, that one Assistant Director and Neighbourhood Manager held responsibility for the conduct and management of a children's residential establishment, that a separate Assistant Director or Deputy Director and Neighbourhood Manager held case responsibility for the child or young person in question, and that separate again was the Assistant Director with policy responsibility for the Borough's Social Services work with children and families.

Many reports, whose brief included management and organisational issues, pointed to the departmental structure as an important issue in determining Islington's ability to deliver effective child care and child protection services. The SSI report in June 1994, published following the inspection of child protection services provided by the London Borough of Islington , described the system and its services as determined by an approach which was *"consumer-led rather than professional/agency-led"*.

In November 1989, a report had been published by the Panel of Inquiry set up to look into the circumstances surrounding the death of [redacted] This report referred to some of the difficulties attaching to the pattern of decentralisation which had been established in Islington. One of its recommendations was that *"the whole issue of delivery of services from the existing neighbourhood office structure needs to be examined as a matter of urgency"*. The SSI reported on the management arrangements for child protection work in Islington and stated *"there is no evidence to indicate that the recommendations of the* [redacted] *case review (1989) have been acted upon"*.

It is only in the last year or so that Islington began to address these issues seriously - something they should have done from the beginning. As a consequence, deficiencies in the structure continued to dog the Borough:-

The [redacted] report pointed to some of the practical difficulties arising from the structure and facing front line staff on a daily basis:-

"There is no way that a neighbourhood office dealing with a request .... can discover that there is a substantial file on the family held in another office, except by chance. If an injured child is treated at the Whittington Hospital, there is no way they can find out whether the family is known to Social Services except by ringing up to 24 Neighbourhood Offices to find out". (P.104 Para 6.10).

Comment

It would appear that Islington took no action in respect of improving management of its residential care, that the poor management arrangements continued (including

fragmented practice and low standards) and that the expertise needed to run proper residential child care was variable at best, creating the conditions for standards of care and behaviour to decline.

Industrial Action

Between September 1992 and February 1993 virtually all social workers and senior social workers within the Borough went on strike. For those six months there was virtually no professional social work service and this undoubtedly added to the lack of credibility that the Social Services department now had amongst Members. Not only were Members unhappy at the way these industrial relation matters were carried out but the lack of staff in crucial function areas created a vacuum which was inevitably partially filled by unqualified residential care staff interpreting, in their own way, the best interests of children. The legacy of this strike is still spoken about; Members were bitter at the way it was carried out and the subsequent loss of confidence in the department; soured relationships undoubtedly added an extra ingredient into what was already a very potent cocktail of problems in the Borough.

Social Services and the Corporate Political Context

We are told that, increasingly, Social Services *"drifted away"* from the centre of *"political gravity"* and that that department was increasingly seen as arguing against the creation of the Neighbourhood Services model.

We further understand that this process to some extent continued when the Housing Department and Social Services Departments were finally merged. In other words, whilst the Director of Neighbourhood Services may have participated in corporate management meetings, there was not a good and open channel of communication between Chief Officer and Members; reports about resources in Social Services had little credibility amongst senior Members of the Council and we understand that there was very little understanding about a "need to know system" between Members and Chief Officers.

Comment

A major department such as this, so out of favour and increasingly lacking in political understanding, support and credibility, damages its changes of getting resources and positive decisions. There is evidence that this happened.

Relationships with other Agencies

For a Social Services Department to operate effectively, particularly in child care matters, it has to synchronise its operations with other important agencies such as the Police, the Health Service, the Education Service and Probation Service

Throughout our work, we got a distinct impression that a trusting and objective working relationship between Islington Social Services and those other agencies was not always the case. We are told that there were difficulties between the department and the Police when it came to investigating allegations of paedophilia; we understand that the internal organisation of Police representation on the Area Child Protection Committee did not link as strongly as it might have with the Family Protection Unit in the Islington Division of the Metropolitan Police. We have been told by some people that joint Police and Social Services investigations were actively

discouraged for a variety of reasons - something which might serve to explain why, when allegations of the kind made in the dossiers in relation to staff were made, they were not always jointly investigated.

Conclusions

Most work on organisational effectiveness in the public services charts the interaction of crucial "policy drivers" one on another and argues that if one or more of these becomes dysfunctional, then the general competence of the organisation deteriorates rapidly. These drivers are usually summarised as:-

* Political objectives.
* Organisational strengths.
* Managerial competence.
* Professional standards.
* Personnel polices.
* Financial investment.
* Interagency dynamics.

It is our judgement that at the time that these matters surfaced, that there is evidence that all of these dynamics were working to some extent disfunctionally in relation to the Social Services and, as a consequence, it is possible that this combined result created the conditions whereby the problems identified by the Evening Standard and others could have flourished.

Even if only some of these observations are true, then it could be surmised that Islington Council's Social Services function might have been characterised as:-

* Increasingly isolated from the mainstream political and corporate management of the Council and feeling unsupported.

* A Social Services environment of increasing fragmentation and little internal cohesion.

* Having a management structure which was very weak in places and which definitely felt unsupported in dealing with potential investigations and disciplinary actions.

* A fragmented social work culture where each neighbourhood devised its own particular approach and philosophy.

* A department where reporting lines were unclear and where accountability became lost.

* A personnel environment which allowed people to exploit situations if they so chose in the likelihood that any action following would be diffused and lost.

* An organisation which, through the process of restructuring and all that had gone before it, was demoralised, had few of the internal organisational checks and balances necessary in a Social Services Department and one with no overall definition of professional standards or means of achieving them.

It is possible to describe Islington at that time as a single department having broken up into 24 separate departments, each with its own management systems, its own internal communication problems; its own interpretation as to how to react to events and between them, varying degrees of knowledge about the management of Social Services; in other words, a Social Services function out of sympathy with its political masters and one which was in places demoralised and unfocused.

It is our view that these are the conditions which breed the possibility for the exploitation of children, for staff to become de-motivated and unfocused in their work and for the quality of work to slip far below acceptable standards.

The responsibility for ensuring the provision of a properly accountable and robust department lies with the Council of the time and its senior officers. It is our view that weaknesses in the organisation identified in our work and the many other reports also referred to in this document indicated an amazing breakdown in communications and credibility which undoubtedly created the conditions which the bad practice and other matters contained in this report were allowed to flourish. There is no doubt in our mind that a "pure" Neighbourhood structure is fundamentally unable to provide the expertise, consistency, checks and balances and professional standards required of a competent Social Services function. The evidence clearly shows the breakdowns and problems which followed implementation of this structure. The changes Islington has now made to the structure reflects their shift of thinking on this subject and are commented on further later in the report.

CHAPTER FOUR

PERSONNEL

PERSONNEL

The allegations made in the Evening Standard, as supplemented by the dossiers presented to us by the Newspapers and together with work done by other reviews and consultants, chart allegations of staff misconduct or negligence which could be broken down into:-

a. Directly abusive behaviour
b. Failure to discharge the duties appropriate to professional standards and the individual's managerial position.

Residential Children's Centres

Details of each of the children's centres, the staff, the specific allegations alleged to have been their responsibility and a summary of their disciplinary process and exit methods are all contained in confidential annexes to this report.

In summary, it is alleged that more than 32 staff employed by Islington Council between the 1970's and the 1990's were responsible for the following types of activity:-

* Sexually assaulting other staff
* Encouraging boys to be rent boys
* Sexual misconduct with residents
* Sale of drugs
* Sexual harassment
* Collusion with children shoplifting
* Abusive language to children
* Inappropriate contact with children in care
* Allowing men to abuse both boys and girls
* Abuse of financial systems
* Staff involvement in sex rings
* Staff involvement in paedophile rings
* Staff involved in child pornography
* Physical abuse
* Embezzlement
* Abduction of a child to [redacted]
* Staff introducing children to blue movies
* Gay staff encouraging children to engage with known homosexual organisations
* Staff having affairs with children
* Children abusing other children
* Children's Homes being used for prostitution

Only 32 of the staff are named. Others are unidentified. It must be stressed that these are allegations going back many years, many of which it is impossible now to track and to form a judgement about. All, however, are extremely serious and should have been investigated with vigour by the Council and management of the department at whatever time they emerged.

Many of these allegations involved criminal behaviour as well as staff misconduct and the standard response of any Social Services Department then and now should have been as follows:-

* **Suspension of staff implicated and full disciplinary investigation with a concluding investigative disciplinary hearing.**

* **A review of the particular child's case on a multi-disciplinary basis supervised by ACPC.**

* **A joint Police and Social Services investigation in those circumstances where it might appear that there was criminal behaviour.**

Our review took this as its starting point and sought to check the individual personnel records of all staff implicated against Islington's personnel records, against Department of Health Consultancy lists and in discussion with line managers. Clearly, we could only check those 32 staff whose names were known to us.

In summary, our investigations found:-

* Sometimes staff moved between establishments and between residential and field child care work. One at least has left the country.

* There has only been limited access to Islington's personnel files; they only have files going back 5 years and even in that case some of the files are missing.

* Agency staff were used in some of the residential units; 4 agency staff were the subject of some of the abuse allegations.

* Only 16 personnel files were seen; details of these staff were checked with the Police and the Department of Health Consultancy list. Of the total of 32 staff,

  * 4 were subject to disciplinary action, following which 2 were dismissed
  * 5 were subject to disciplinary process but left on ill health grounds before disciplinary action was concluded
  * 1 faced charges of child abuse
  * 13 were not subject to any investigation
  * 10 resigned
  * 1 was dismissed
  * 2 are still in post [redacted]
  * 3 were from agencies

  files in respect of some of these staff have been destroyed, but we are told some staff were allowed to, or asked to, resign after serious allegations were made.

* Many personnel records could not be traced at all. Some may have been agency staff whilst others simply do not exist.

* Only two members of staff are still employed by the London Borough of Islington. [redacted]

[redacted]

Recommendation

[redacted]

Disciplinary Action

Measured against the criteria for action set out above, **it is apparent from this analysis that the London Borough of Islington did not in most cases undertake the standard investigative processes that should have been triggered whenever they occurred.**

It is possible, therefore that some staff now not in the employment of Islington could be working elsewhere in the field of Social Services with a completely clean disciplinary record and yet have serious allegations still not investigated in their history.

This is a deplorable state of affairs, particularly since, were any of these allegations proven, then the possibility of paedophiles gaining access to Residential Homes in this country is reinforced. Since only a few of these investigations were carried out, it is not possible for the names of these staff to be circulated to all other employers in this field.

Recommendation

We recommend that Islington write to all Social Services Departments suggesting they review current employees who may have come via the Islington route are to be checked with Islington Council and the Department of Health Consultancy Register.

The responsibility for ensuring that such an investigative system was in place rests with the Council and the senior officers of Islington during the period in question. It is clear that Islington did not initiate the type of investigation they should have and as a consequence the possibility remains that staff engaged in abusive behaviour are now working elsewhere in the field with potentially serious consequences. Islington should have known and acted; they clearly did not.

All Social Services Departments should have implemented the Warner Report and ensuing circulars the Department of Health issued. These were:-

A. Dear Director Letter - "Choosing with care" - 7 December 1992
B. Dear Director Letter - "Selection & Recruitment" - 7 December 1992
C. LAC(93)15.
D. LAC(94)22.

The events outlined in this report largely predate Warner. Nevertheless, these issues illustrate the importance of proper implementation nationally - something we have taken up separately with Department of Health.

Equal Opportunities

We have said earlier in the report that during the 1980's, in common with many other Authorities, Islington took a very proactive approach to equal opportunities, to ensure that staff's employment prospects were not prejudiced in any way because of their ethnic backgrounds, gender or sexual preferences. Everybody working in the field of Social Services would applaud such a stance; however, with such a proactive policy come dangers of over-protection, and it is our view that this may have been a factor in the culture of Islington which prevented a much more interventionist approach by managers to allegations of this kind. Carried out appropriately this is quite reasonable; if, however, it becomes perceived as positive bias towards certain groups of staff, or indeed unfair protection, then such a positive move becomes a negative factor and a great danger in the employment of Social Services staff.

We have formed the impression from our various interviews that in the late 1980's and early 1990's, **the equal opportunities environment, driven from the personnel perspective, became a positive disincentive for challenge to bad practice.** We were told by one staff member that *"it was a weak, ineffective organisation which was set up for individuals to feed off for their own advantage; it was paralysed by equal opportunity and race issues"*. We are told that managers believed they would not be supported if they triggered disciplinary investigations involving staff who may be from ethnic minorities or members of the gay community. It cannot be a coincidence that of the 32 staff named in these records, a number fall within those groups.

It is therefore, a possibility that the policy of positive discrimination in Islington has had serious unintended consequences in allowing some staff to exploit children for their own purposes and in doing so display totally unprofessional behaviour.

All Local Authorities with Social Services responsibilities have to act in "loco parentis" for the children in their care. **It is crucial that all the policies, procedures and arrangements for Councils in relation to children are primarily child centred rather than personnel centred only**; equal opportunities policies are an excellent example where Local Authorities need to be crucially clear about the emphasis that they put on these policies and the directions they give to their staff as to how to interpret them. We believe that Islington's policies at that time were not child centred and we comment at the end of this report on our view about the current situation.

We were also surprised in our analysis at the number of staff who left, either on ill health grounds, or resigned before disciplinary action was triggered. We were told by Islington that at that time the Council's early retirement scheme was a lot more flexible than it was now. We

suspect that a number of staff left Islington by persuading the Council's Health Adviser that they were unfit to work and that therefore they should be given ill health retirements with enhanced benefits.

We comment further towards the end of this report on the current Personnel practices; this **"back door" could very well have allowed staff who were acting unprofessionally to exit Islington as questions began to be asked and again allowed them the possibility of employment elsewhere** in the Social Services field to continue their practices. It is important that all Local Authorities ensure that such "back doors" do not exist and that all staff for whom there are questions about the quality of their professional practice should be dealt with through proper competency procedures contained in Council's disciplinary procedures.

We conclude by observing that the culture of Islington outlined in various parts of this report seemed to have created a Personnel environment which did not encourage intervention as proactively as it should have in investigating and dealing with serious allegations of abuse in Islington Social Services Department. It is crucial in all Local Authorities that Personnel procedures are clearly synchronised with the needs of a Social Services Department and the publication of the Warner Report drew attention to this in 1992. Our comments at the end of the report about the current situation describe our views about the potential for this happening in the future.

Management Responsibilities

Whilst it is the responsibility of the Council itself and its senior managers to engineer a climate where positive industrial relations policies can be implemented, it is the responsibility of the line managers to ensure that they are carried out. For the purposes of this description, line managers are Heads of Homes, Neighbourhood Officers of Social Services (until 1991) and then Neighbourhood Managers.

In investigating these allegations, therefore, we have interviewed the line managers involved in the running of services covered by this report. Twenty-four managers could all have had management responsibility for children looked after who were cared for in foster homes and in up to 10 Children's Homes in the Borough and other specialist placements elsewhere. Each children's establishment was the responsibility of a manager who in turn was responsible to a NOSS (subsequently Neighbourhood Manager). Geographical considerations meant that five Neighbourhood Managers and three Deputy or Assistant Directors were responsible for the management of residential child care.

Other key players were Policy Advisers, Inspectors and Professional Practice Advisers; many of the people who at times held one or more of these posts have been alleged as having failed to act appropriately, failed to respond to concerns or failed to pass on information as necessary.

We have interviewed the key managers and their names are set out in the confidential annex to this report. It seems inconceivable to us that allegations of the kind outlined at the beginning of this chapter could not have surfaced to their level. In our view, if they did know, they should have initiated the action outlined earlier in this chapter; if they did not know, then they should have done and it is upon this that we wish to comment.

There have been a depressingly large number of reports in recent years about the management of residential child care in this country. What is clear from them all is that the external management of residential child care is no easy task. Knowing what goes on behind a front door requires a large degree of experience and expertise and a degree of determination and openness by all concerned.

In our investigations we have been told by some staff that managers knew and did nothing about it; other managers have said they did not know at all and people did not "surface" these matters. Given the extent of the problems, not only outlined in this chapter but in other reports which comment on the quality of the fabric of the buildings, it cannot have been anything but the case that the line managers have to share the responsibility for the inaction by Islington during those years.

We were told, for example, by one line manager that [redacted] knew nothing about these allegations and believed that the quality of the care provided was adequate, yet another line manager who subsequently took over that area told us how critical [redacted] was of the lack of supervision systems, of the lack of care of children, of the poor state of fabric of the buildings and so on. We are told by a residential worker that [redacted] explicitly [redacted] concerns both to middle and senior managers and no action was taken. Reports were said to disappear into a "black hole".

Whilst we can have some sympathy with the difficulties of middle managers in any organisation who have repeatedly drawn the deficiencies of the service to the attention of their senior managers and Council only to have them ignored, this in itself is no reason not to continue to pursue these matters.

The political, financial and operational culture of the organisation already described sets out an environment where some middle managers believed that, had they intervened, they would not have been supported and indeed perhaps criticised themselves. Hard though it is, this is no excuse for inaction.

It is possible, therefore, to conclude the existence of some kind of managerial vacuum or weariness amongst managers working in what must have been at certain times a very demoralised department with poor and fragmented leadership, if that. Again, however, whilst understanding these dynamics, it cannot be ignored that line managers should have visited those Homes, should have taken necessary action, should have spoken to children, should have had proper supervisory systems, should have had proper appraisal arrangements, should have carried out spot checks, and should have responded to allegations as serious as the ones made and now investigated.

Given the breakdown in the total organisation from the top to bottom, it is impossible to blame single middle managers alone; the whole organisation has to take responsibility for the quality of its operation. We will comment later in this report on the changes Islington have made to strengthen the management of its Children's Homes and to ensure that properly qualified managers now run Islington's remaining Children's Homes.

Agency Staff

All Local Authorities need to use agency staff to ensure cover for sickness, leave and other temporary problems and Islington was no different in that respect. The Evening Standard dossiers, however, assert that at least one staffing agency in Islington was run by paedophiles and was heavily used by Children's Homes and was therefore a natural conduit for paedophiles to work within the system.

We have no means of knowing whether this is true or not but it is clear to anybody working in this field that if one uses agency staff in a residential setting, and the agency does not itself carry out proper personnel policies, then this is a conduit which could be exploited by people who wish themselves to exploit children.

This is a matter of obvious concern, not just in relation to Islington but in relation to all Social Services Departments and employers in this field. Employment practices in relation to residential children's staff were commented on heavily by the Warner Report and all Local Authorities were expected to work through and implement that report systematically. Islington NSD itself has implemented this report.

Warner recommendation 7 clearly states *"Employers who wish to use agencies should satisfy themselves that they represent good value for money, and do not have an adverse effect on the resources available for the care of children; and should require any agencies used to adopt selection and appointment procedures as rigorous as those for directly employed staff."*

All Local Authorities received circulars of guidance on this should inform management practice. In the light of this Inquiry we will ask the Department of Health to remind all Local Authorities of the crucial importance of this.

The events outlined in this report clearly pre-date the Warner Report and we understand that Islington have, as part of implementing the Warner Report, satisfied themselves of this matter. We would suspect, however, that nationally there might have been a differential approach to the detail of implementing this recommendation and that it is theoretically possible that agencies may not be as scrupulously regulated as Warner might have wanted. In our view, such a local regulatory process would involve checking employment records, checking the quality of interviewing and all the other practical validations that could be carried out, including periodic spot checks. This is obviously a further matter for general consideration by the Department of Health and one which we will draw to the Department of Health's attention separately.

Department of Health Consultancy Register and the Metropolitan Police

The Department of Health has a Consultancy Register. It is utterly dependent on all Local Authorities carrying out proper investigations of the kind outlined in this chapter and notifying them properly of such names. It is usual general practice that names are only submitted to the consultancy register where people have proven disciplinary action against them. The "ground rules" for the consultancy register are not however that specific, in that it is open to Local Authorities who genuinely believe there to be some doubt about employees possible behaviour to be included on the list. However, in employment law terms, particularly since staff are notified that their names are put on the register, this is difficult to define and in Islington's case

it is clear that, because so many disciplinary investigations were not carried out, that many of the names that might have been added to a consultancy register have never been done so. This again seems to be a matter of general importance and we understand that the Department of Health are reviewing the use of the consultancy register. We will therefore bring this matter to the attention of the Department of Health separately.

In Islington, many staff about whom there were suspicions left before the "net" closed on them and as such might have escaped notification and gone to employment elsewhere in the country. This, of course, is a particular problem in large urban areas such as London where staff working in one Authority could leave and go to work with another with a perfectly clean sheet despite there being questions about their competence and professional standards.

We realise that the issue of exchanging information about employees behaviour is a particularly sensitive and difficult area when there are no criminal convictions or confirmed disciplinary actions. We do, however, know that a large number of men involved in paedophile rings do have clean records and clearly, therefore, have the potential to move within the children's' world. We also know from our discussions with the Metropolitan Police that in the routine course of their enquiries, they collect much information which may have relevance to the employment of staff in Social Services departments but which cannot be shared with them. **It is entirely possible, therefore, that in this country, there are staff working with children about whom Social Services departments have no knowledge, but about whom the Police have very serious, albeit unconfirmed, information.** All the names of the staff in the confidential annexes have been notified and checked against the DOH Consultancy Register.

It is equally important that even wider child care considerations are reviewed. The Evening Standard dossiers allege that at least one member of staff implicated in their investigations is currently involved in running an [redacted] for children in another part of the [redacted] **Whilst recognising the legal difficulties that this area poses, it is our view, however, that the Department of Health, The Home Office and the Metropolitan Police should review such matters to find methods of improving the interchange of information between relevant agencies about people who might use any number of means to access children.**

In this context, there is also the question of the quality or otherwise of the voluntary organisations child consultancy service. We have not looked into this but have talked to at least two voluntary organisations who are uncertain as to the accuracy and the completeness of this service. it is our view that Department of Health should review the working of this register alongside these other matters.

The annexes set out all the information that we have been able to gain about the staff names identified within this Inquiry. We have asked the Department of Health to check this list against their consultancy list which they have now done. Given the type of information presented in the confidential annexes:-

Recommendation

We recommend Islington now review the evidence presented and consider whether some, or all of these names, should be added to that consultancy list.

CHAPTER FIVE

CHILDREN

Conclusion

The tables set out in the confidential annexes summarise as far as we can the routes by which the 32 staff left Islington. The table of course is incomplete because of the incompleteness of personnel records and the large numbers of agency staff who might have been working in the Borough during the period concerned. **It is clearly unsatisfactory that so few of these cases were properly investigated against the criteria set out earlier in this chapter. It is quite possible that some of these staff are still working in the children's field and that children might consequently still be at risk. Hence the recommendation above about referring these names to the consultancy list.**

What this review shows is a classic case study of an organisation lacking the culture, philosophy and managerial infrastructure to work in and intervene in highly sensitive child care matters. There is evidence that over ten years Islington Council were not as well informed as they should have been and, where they were, they did not intervene as proactively as they should have. It is our view, therefore, that were these allegations true, some children were not cared for properly and that some staff escaped disciplinary and possibly criminal investigation.

CHILDREN

The Evening Standard Allegations

The allegations made to the Evening Standard are contained in:-

* Press articles published in October 1992.
* Background and supporting information in dossier one (1992)
* Further allegations and supporting information in dossier two (December 1993).

The numbers of children who were subject of these allegations came to a total of 26 who were named, plus others who were either unnamed or referred to by first names only (and thus not possible to follow up). Details are set out in the confidential annex. The original press articles in 1992 highlighted eight children, to whom the paper referred by other names, but these children were identifiable to Neighbourhood Services staff who worked with them. These children were mainly living in residential Children's Homes in Islington.

The allegations in the press included:-

* Children working as prostitutes
* Boyfriends staying in Children's Homes for girls.
* Pimps having access to children in Children's Homes.
* Children's Homes out of control.
* Children being attacked in Children's Homes.
* Staff taking no action; not protecting children in care.

Other allegations, involving a wider group of children were:-

* Paedophiles having access to children in care.
* Organised abuse of young people.
* Networks of children in residential care subject to sexual abuse.
* Recruitment of children for prostitution through residential care links.

Allegations as to the way in which the London Borough of Islington discharged its responsibilities to children in residential care included:-

* Poor physical standards.
* Inadequate staffing.
* Buildings unsafe and insecure.
* Senior managers unconcerned/taking no action.

Residential Care for Children

While the concerns of the Evening Standard were for the direct care and protection of a number of children, it was clear that the issue of residential care was a key element in the concerns raised. Issues about staffing levels, staff management, access by visitors, the control of children within Residential Homes, and the physical state of the buildings were all matters which were

highlighted. These issues were of key importance in meeting the Authority's primary duty to offer care and protection to young people in its establishments.

One of the staff who visited Islington's Children's Homes in late 1992 described the physical state of the buildings as poor and in particular (in two Homes):-

* *Rain coming into bedrooms through the roof.*
* *Mattress on the floor in a bedroom.*
* *Broken mirrors.*
* *Torn sheet for a curtain.*
* *No carpet or appropriate floor covering.*
* *Insufficient chairs for residents to sit down at dining table.*
* *Dining table filthy with congealed fat and grease.*

The Neighbourhood Services Department commissioned a review of its Residential Homes. Initially [redacted] and [redacted] were asked to report on the issue of control in the two establishments that had featured in the press in October 1992. Their report confirmed a number of areas of serious concern. In particular, [redacted] and [redacted] found:-

* A shocking state of disrepair in one Home.
* Poor physical standards with 2 establishments.
* Long delays in attending to basic repairs and maintenance (3 months for a simple repair).
* Young people sexually abused while in the care of the Local Authority.
* Young people sexually abused by other young people in care.
* Lack of clarity about the function and purpose of residential units.
* Lack of support from senior managers.
* Low priority given to arms length inspection.
* Inappropriate personnel policy - allowing staff to move on rather than face disciplinary investigation.
* Confusion and conflict about roles and responsibilities.

Line Management

In the chapter on Personnel we have concluded that allegations made about neglectful or abusive care of children by staff were not always investigated. [redacted] and [redacted] in their report of 1993, provided evidence of poor quality child care management in Islington in the 1990's. We also found evidence of poor middle management at that time.

These factors all lend support to the argument that there was poor management of residential child care which created the conditions within which the sexual exploitation of children, by staff, pimps, or paedophiles, could have taken place. The absence of robust management systems would mean that there were insufficient checks and oversight of care practices, leaving children vulnerable in a number of ways.

Neighbourhood Officers (NOSS) and, after 1991, Neighbourhood Managers had responsibility for the management and supervision of the managers of Children's Residential Homes (Superintendents) with NOSS' reporting to them. Responsibility of these middle managers included visiting the establishments on a regular basis (monthly) to review their operation and the standards of care which existed, and to report accordingly.

[redacted] and [redacted] reported that:-

* Staff felt they got little support and direction from external managers.
* Staff felt frustration at the lack of progress in achieving repairs, redecoration and improvements.
* Staff needed access to more senior managers where the usual line management channel was ineffective.

In addition, this Inquiry was told:-

* Senior Managers with responsibilities for Children's Homes did not visit them nor considered it part of their role.
* Reports on the poor state of Homes were submitted by Neighbourhood Officers but no action resulted.
* There was a division of responsibility between Neighbourhood Officer/Assistant which perhaps confused the lines of accountability.
* There was a substantive difference of view expressed between Neighbourhood Officers as to the extent of the poor state of repair of the Residential Homes..
* Neighbourhood Officers did not routinely speak to children cared for in Residential Homes.
* There was a significant change of postholder in the ANOSS post, with a number of staff 'acting up' and a consequential loss of continuity.
* There were concerns about two superintendents of Children's Homes and their lack of management ability.

The role and responsibilities of line managers outside a residential establishment is now set out in Children Act legislation and guidance. While immediate line managers have a responsibility to visit, inspect and report on all aspects to do with the running of Children's Homes, Senior Managers have a responsibility to read these reports and to take action to address problem areas. Where particular or serious problems are identified, or where they are persistent, they should initiate appropriate concerted action to ensure a comprehensive departmental approach to achieve a resolution.

In the light of current knowledge we have no doubt that in many respects the quality of middle management was ineffective. This could clearly have created a situation within which children's care could have been seriously deficient, as alleged.

Organised Abuse

The nature of paedophile activity and network abuse is that young people who are involved are frightened and intimidated by their abusers and thus feel unable to tell others what is happening, since they do not trust in the ability of Police or Social Services systems to protect them. Hence

the identification of those who may be involved is something which initially occurs because of staff noticing changed or worrying behaviour, patterns of movement, circumstantial evidence such as children having unexplained sums of money, or reports from other people. The numbers of children thought to have been involved is thus arrived at through reviewing a number of reports from a range of staff over a period of time rather than direct reporting or allegations made by the young people themselves.

In one of Islington's Neighbourhood Offices, reports were written over a period of 18 months naming children who were thought to be involved in organised, network abuse. Discussions and liaison with other professionals led to the names of a large number of children being considered as having possible links or connections, and thus the possibility that they also were at risk of abuse. A total of 61 children were thus named as possible victims.

During 1990 networks associated with suspected adult abusers were considered. A series of meetings were held involving key Social Services staff and Police. Subsequently Police interviewed a number of children and two of the adults. No charges resulted. An ACPC working party was set up and met during late 1990/early 1991. Among other things, this working party effected liaison over all the individual children whose names had been included in the list of those for whom there was serious concern and relevant information was shared. There were working relationships with the Police which is a key element of protecting children and the Police undertook certain enquiries on the basis of the information gained, but had no grounds to take matters further.

Late in 1991 allegations were received that a further network existing involving a number of other adults and implicating these adults in what would be, if true, extremely serious counts of criminal behaviour. These allegations included reference to organised ritual abuse.

In October 1991 an ACPC Policy Sub-Group agreed to set up an inter-agency working party to co-ordinate investigations into these matters. This met at least seven times between November 1991 and August 1992 and involved Social Services, Education, Police, Health, Probation and the Borough's Legal Section. The Police set up a 'major incident procedure' to co-ordinate their investigations.

The allegations of ritual abuse were part of the second dossier which was passed by the Department of Health to the Metropolitan Police. We have discussed these allegations with officers from New Scotland Yard. They have advised us that these matters were fully investigated by the Police who worked with Islington child protection team. Some other allegations were investigated by Golders Green Police.

Islington Police advised this Inquiry that they concluded that: *"there was insufficient evidence to support the allegation of network abuse at that time."* Scotland Yard officers have told us that despite full enquiries *"there was insufficient evidence on which to base any criminal proceedings"* and no basis for them to make any further enquiries in this regard.

Islington ACPC were thus fully involved in reviewing the allegations of network abuse. The SSI also confirmed their understanding that, under the auspices of Islington ACPC, these matters had been fully examined by inter-agency working groups.

The Department of Health guidance on the management of allegations of organised abuse was not published until October 1991, when it was included in the second edition of Working Together. The key requirements as set out in the guidance included (in summary form):-

1. Management to be at a senior level.
2. ACPC to agree procedures.
3. Investigation process to be agreed on an inter-agency basis.
4. Investigation of criminal activity should not be at the expense of children's welfare.
5. Senior Managers should supervise the inter-agency investigation.
6. Resource issues should be addressed.
7. There should be regular strategy meetings.

The minutes of the inter-agency working groups have been made available to this Inquiry. They are not detailed but do demonstrate that Islington ACPC did meet, in broad terms, the expectations identified by Department of Health guidance. This was achieved through the establishment of an inter-agency working party on two occasions, in response to two sets of allegations.

Conclusions

Within any locality team of social workers with responsibilities to children, there will be a number of children identified who have suffered, or who are at risk of, abuse. It is a different matter to assert that there are links between them and that a network exists leading an abuser from one to another. The allegations in the Evening Standard supported the view that there was organised abuse in an area of Islington at that time.

As shown above, Islington Police were involved in the investigation of these allegations. While it was clear that some individual children were at risk of abuse, the Police found no evidence of connections between these such as would support the assertion that there was organised abuse. The Neighbourhood Services Department in Islington triggered the setting up of interagency working groups reporting to the ACPC to coordinate investigations into these allegations. Should there be a similar set of allegations today, Islington ACPC procedures are clearer as to what should happen, senior management accountability is more tightly defined, and timescales would be tighter.

With the exception of one conviction, in relation to a staff member [redacted] Islington did investigate these allegations and found no evidence to support the assertions of organised abuse. The Social Services Inspectorate has reviewed the paperwork and has come to a similar conclusion.

Independent Reviews of Individual Children

(a) An independent review was set up late in 1992 whose brief included a report on the welfare of the original eight children featured in the Evening Standard. This report was presented in February 1993, and was reported to the Neighbourhood Services Committee on 22 February 1993. The welfare of these children was further followed up and reported to the Committee and to Senior Managers in 1993, to the SSI in November 1993 and again to Senior Managers in February 1994.

With one exception, these young people are now young adults (aged 18-25). Their welfare, counselling and support needs have been addressed in detail; provision has been linked to their own wishes (in one case the young person clearly wanted no further contact) but appropriate ongoing support and help has been made available to others. The younger child was not in residential care (as were the others) but there has been ongoing help and involvement with the carers for this child, and specialist help for the child.

There have been a number of independent reports and reviews additional to, and separate from, the review undertaken by [redacted] and [redacted]. In some cases there were specific issues which caused the circumstances of individual children to be looked at in considerable depth.

(b) One of the eight children above was a young person in respect of whom the issues of case planning and protection and substitute care had exercised a number of staff over a significant period in 1990/91. Islington commissioned an independent review to look into these matters and the subsequent report was presented in March 1992 - long before any allegations appeared in the press. The report highlighted a number of points requiring management attention, particularly in the areas of cases planning, administration and record keeping, and - most importantly- the Department's duties to plan for the child's safety and welfare even where these were in conflict with [redacted] wishes.

c) A second child sustained a series of moves between residential establishments both within Islington and outside. As a result of these moves [redacted] came into contact with a number of different care staff where concerns were raised. [redacted] subsequently made some specific complaints against Islington. These were addressed by the complaints process, leading to an independent report from the investigating officer, and a separate report from the independent person (as required by Children Act Complaints Procedures).

These reports were submitted in October 1993. They were considered by the Neighbourhood Services Complaints Panel in March 1994, as a result of which some, but not all, of the complaints were upheld. In respect of those that were upheld the Department made apologies and offered compensation.

There were a total of 31 complaints made on behalf of this young person; the resultant report listed a total of 64 recommendations. These covered a wide range of issues, including matters of organisation, policy and administration. The particular matter of most immediate importance to this young person was that there was a delay in responding to [redacted] allegations that [redacted] had been abused.

The allegations were in respect of past abuse while in a different placement. Delay in a matter of this seriousness might have led to a consideration of disciplinary procedures against the relevant staff, but the report indicates that the Authority's arrangements for undertaking work of this kind were in need of review. It also concluded that the staff who would have been expected to carry out this work had neither the specialist skills nor the resources to undertake it. Secondly, the report concluded that Islington failed to

provide a good standard of care for this young person while [redacted] was resident at a Children's Home, but that this was attributable to a range of issues rather than the specific actions of individual staff. It was for these reasons that the Department accepted corporate responsibility rather than identifying the need for disciplinary action against individual staff members. The responsibility was clearly that of elected members and officers at the time.

The main report itself identified examples of high standards of professional practice as well as examples of poor practice. The author stressed that some good quality work had been done, although good practice was not in evidence throughout.

d) There was concern that a third child was involved in network abuse. As discussed earlier in this chapter, there has been significant information about the possibilities of network and organised abuse in the Islington area, and in particular the alleged activities of pimps and paedophiles who were thought to be targeting groups of vulnerable children. Other Police and Social Services Departments have recognised that children in residential care can offer easy targets for others seeking to exploit children sexually, either directly or through prostitution.

The name of one young person featured particularly in such concerns. Islington commissioned an independent review of [redacted] situation and of the management of [redacted] case during a period of particular concerns. This report was submitted to the Neighbourhood Services Case Review Sub-Committee which was held in June 1994.

It pointed to a number of issues which at the time (1991/92) had not operated to secure the best care and protection for this young person, among others, and referred to matters which had been highlighted in the Evening Standard: namely, the role of Senior Managers and the management of Children's Homes, but it also pointed to some lack of clarity for responsibility and accountability within the organisational structure. Other matters included the procedures for investigating organised abuse (an issue for ACPC) and the involvement of other agencies, particularly the Police.

e) The Child Protection Inspection by the SSI led to them having specific concerns about two individual children and the way in which their cases had been managed. These two children have each been subject to an independent review by [redacted]. The first of these two reports was presented in September 1994, followed by the presentation of the second report in February 1995.

[redacted] conclusions were that, in respect of the first child:-

* Inadequate protection for this young [redacted]
* Work not in line with ACPC policies and procedures.
* Inadequate protection at times as required by other statutory provisions.

and in respect of the second child:-

* Islington failed the test of good parenting.
* Child protection meetings not held with sufficient urgency.
* Failure to follow C.P. procedures.
* Delay in investigating concerns.
* Failure to undertake full and immediate assessment of risk.

Other Identified Children

The Evening Standard collated a significant amount of information which came to their attention in a variety of ways through the end of 1992 and throughout 1993. Compiling the information took a considerable amount of time and was finally achieved in November 1993. It was not available at the time that Islington commissioned its third series of independent reports in December 1993.

In some cases individuals contacted the Evening Standard directly to report their own experiences as children in the care of the London Borough of Islington. In other cases these experiences were reported second hand but ranged from direct abuse by staff, to systems within which people had felt neglected or uncared for.

In some cases names were not given, or only first names were available. Some allegations went back 15 years or more. Despite the fact that some of these allegations were extremely serious, the combination of timescale and lack of detailed information has made it impossible to pursue detailed enquiries in some of these cases. Others have had to be pursued through the review of personnel issues in individual residential establishments, so in some cases it has been possible to look at some allegations in other ways. Some young people were involved in giving evidence in a disciplinary hearing against a member of staff about whom they made allegations of misconduct.

All the other children have been reviewed by Islington who have reported on their current whereabouts, welfare and needs for support and help. The Authority has provided comprehensive information as to its involvement with these young people. Ten children, now young adults, have all very different histories but from the enquiries we have made it is appropriate to conclude that Islington staff are aware of all of them, have maintained contact where possible and where wanted, and have provided, or offered, ongoing support and help appropriate to their individual needs and circumstances.

Analysis

Some of the children who have been subject to independent review have long complex histories and significant needs for help as a result. The review we have undertaken shows that these needs have ultimately been addressed as far as is possible by Islington staff. However, it is sadly the case that for some of these young people there were long periods when they were receiving inadequate care and protection and hence were experiencing further distress and damage. There are inevitably limits to the extent to which current interventions can address the effects of past wrongs.

Allegations Concerning Foster Carers

The Evening Standard alleged that one foster carer, a [redacted] had been rejected "as suspect" by the Islington fostering team, but that [redacted] had been approved as a foster carer for young offenders under a special scheme. As a result of our subsequent enquiries, we are told care was properly approved and that the first young person placed was aged [redacted], but [redacted] stayed on once [redacted] was 18. Subsequently a young person aged [redacted] was placed there. After some months, the carer was approved to continue to care for this second child only, on a long term basis, but after the fostering panel had recommended that the application be refused. However, the Police check was clear and there was no history of abuse. The approval was subsequently given by a senior officer who rejected the panel's recommendation. This process has now been changed so that no recommendation of the fostering panel can be rejected without the approval of the Chief Social Services Officer. The carer was later the subject of some allegations of inappropriate behaviour and [redacted] approval as a carer was terminated in 1994.

A second Evening Standard allegation concerned a foster carer who was said to have a large extended family. The safety of children in this foster home was an issue because of other family members who were alleged to have criminal convictions, including offences against children. Some allegations were also made against the foster carer directly.

These carers were first approved in 1981. Allegations against the extended family first came to light in 1991. The fostering panel considered the carers in May 1992 by which time the concerns about them had been considered. The panel recommended their approval as long term carers at that time. There was a further review in 1993 after further allegations but no evidence found to substantiate any concerns.

Comments

In both these cases, these carers have been subject to an approval process. The process itself, whereby a panel's recommendation could be changed by a senior officer, has itself been altered. Concerns have been investigated, and in one case this has led to de-registration for the carer (termination of approval). **It is regrettable that procedures for approval were not tightened up earlier but we are clear that this has now been addressed.**

Voluntary Child Care Organisations

The Evening Standard dossiers reflect concern that one particular voluntary child care organisation providing volunteer advocates to visit children in Children's Homes had been infiltrated by paedophiles. If this was true, then this is extremely important and illustrates another "back door" whereby people wishing to prey on young people can get access to them round the back of standard Local Authority procedures. The details of this organisation and the Evening Standard allegations have been passed on to the Department of Health and it is our expectation that they will take a rigorous position in relation to this (and any other organisation) in checking how robust, or otherwise, this organisation is in relation to its recruitment of such volunteers.

This case, however, raises an obvious and extremely important general point. That is, that across the country there are many such organisation doing extremely good work with young people and with the growth of the Children's Rights Movement, the demand for independent visitors and advocates is likely to grow. Anyone can set up a "voluntary organisation", recruit volunteers and work with children. If they are not competent organisations they can easily be infiltrated - another "back door". **The question that this particular case raises is, how robust is the regulatory and vetting framework within which such organisations work?**

We are told by Department of Health that the following circulars define how voluntary organisations, police and consultancy checks should be carried out:-

HOC 42/94
LAC 94/22

There is undoubtedly therefore a framework which Local Authorities and Voluntary Organisations could work within jointly to ensure that the potential for such problems occurring in the future is reduced.

Recommendation

That all Social Services departments review their use of such voluntary organisations and agencies and discuss with those organisations how they recruit, supervise and monitor the quality of work of their staff. We urge all Local Authorities to establish a simple "contracting system" which would include a specification of requirements, and a process of organisational audit. This might involve, for example, one Authority in the country, in whose area the headquarters of such organisations exists agreeing with that organisation to be lead in checking the organisations' professional practices. We are sure that all such organisations will see this as a valuable confirmation of their organisational strength and not as something onerous and to be rejected.

Conclusions

We have concluded above that allegations of organised abuse were investigated but not substantiated. With regard to all the other matters, the overall picture presented by enquiring into the allegations concerning the abuse or neglect of children is **one where there was no strong ethos of promoting children's rights and protecting children at risk. The welfare of young people, particularly those in residential homes, received insufficient time and attention at management levels and children were not afforded basic standards of accommodation or care.**

The reasons for this are partly due to the inadequacy of personnel policies, addressed elsewhere, and partly due to the failure of management. Chapter three describes an organisation wherein lines of communication and accountability were confused and where specialist management or expertise was lacking, hence creating a context within which management inaction (at a number of levels) could persist. The lack of any sound infrastructure for supervision, accountability and proactive management created similarly inadequate and unstructured responses to vulnerable children.

CHAPTER SIX

MISSING FILES

MISSING FILES

There were a number of references made in the Evening Standard to missing files, but more specifically the allegations were that information had been deliberately withheld or that files had been removed and that this was with the knowledge of, or at the instigation of, Senior Managers. The cases involved allegations of misconduct and abusive behaviour by residential staff and there was concern that they were being protected.

Initially, three specific cases were cited as gross examples of files going missing; detail was provided in the Evening Standard dossiers but Islington were aware of the main thrust of these allegations and initiated an independent inquiry. The allegations were:-

Child A

* Residential log book missing - deliberately hidden by residential staff.
* Residential files - withheld by a Senior Manager.
* Social work file withheld - only made available to Police after pressure and subterfuge.
* Fostering file withheld by Senior Manager.

Child B

* Information withheld from Police.
* Only partial files shown to Police - selected information edited out.
* Specific information never shown to Police.

Child C

* Social work file lost containing key information and allegations against known abusers.

Other allegations which appeared in the Evening Standard dossiers which have not previously been made available to Islington were as follows:-

Child D File material relating to network and organised abuse

* Much relevant material about alleged abusers was missing from files shown to original inquiry.

Child E

* A photo showing an injury was removed from the file.

* A letter detailing serious concerns was missing.

Child F

* Allegations against a [redacted] could not be pursued because the child's file had gone missing.

Child G

* Information about a vulnerable young [redacted] was not maintained and communicated properly to Police and other departments.

Child H

* Social Worker's notes about the suitability of a staff member as a proposed adopter had gone missing.

Child I

* Child's residential files missing, where child made allegations against a Residential Worker.

Child J

* Reports on the state of children's Residential Homes were withheld from the Neighbourhood Services Committee.

Comment

The outcome of any investigation into these allegations would need to determine whether or not there was evidence of collusion. In practice, this would mean whether it could be shown that staff had acted deliberately to withhold or destroy relevant information which could be used in police enquiries and court proceedings against staff. The alternative would be that there was significant incompetence and inefficiency, leading to files being lost and papers being misplaced.

The three specific cases referred to at A - C above were the subject of an independent investigation by [redacted] reported in February 1994 and [redacted] report was in turn presented to the Borough's Social Services and Health Policy Sub-Committee on March 15th 1994. [redacted] report refers to these three cases identifying the children involved as A, B and C. This report has followed this form of reference.

Further detail of the allegations did appear in the Evening Standard dossiers, but [redacted] did not have access to these dossiers. Nor indeed did Islington Council. [redacted] was therefore not in a position to enquire into all the questions that the Evening Standard's allegations

subsequently raised. [redacted] wrote a general report on these issues which did not specify all the primary interviews which [redacted] had undertaken.
We have sought access to [redacted] records which [redacted] has provided in general terms. However, [redacted] has not been able to provide the specific detail of individual interviews because of the original promises of confidentiality given to interviewees. We have not undertaken primary interviews to re-cover this ground as regards child A and Child C, but we have undertaken primary interviews in relation to the allegations surrounding the case of child B.

Child A

The case of this particular child was subject to two independent reviews. The first was commissioned in 1992 and was undertaken at the same time as an ex-staff member was brought to a criminal trial. Various allegations refer to a number of different files which existed in relation to this young [redacted]

The author of the first independent review was [redacted] The first report was commissioned by Islington because of serious concerns about the case planning process. In particular there were differences of view between staff which led to delay and confusion, and ultimately to a situation where plans were not in accord with the Authority's duty to protect Child A and promote [redacted] welfare.

The table below identifies those files that were identified and seen by each of the two independent reviews and also clarifies those staff interviewed by the second review in furtherance of the independent inquiry.

File	Seen By [redacted] Report 11.3.92	Seen by [redacted] Report Feb 1994	Staff Interviewed by [redacted]
1st Residential Home	Some papers Diary Entries	Early file missing. Too early to be critical in case.	None
2nd Residential Home	One case file subsequently 4 volumes of senior log.	Log book initially missing. Subsequently found by deputy and given to Assistant Director. Assumed it was available to Court.	Head & Deputy of Residential Home
Fostering File [redacted] fostering application)	One file seen	Did not see. Assumed it went to Court.	Fostering Officer
Neighbourhood Office family file	Saw volumes 2, 3, 4	No	Social Worker
Neighbourhood Officer ring binder	Received and seen part way through Inquiry.	No	
Supervision Notes (missing)			Head of Home Supervisor

[redacted] enquiries did not enable [redacted] to arrive at any firm conclusions as to the reasons for various files going missing. [redacted] did not find that the 2nd residential home had deliberately withheld relevant records; [redacted] could identify no reason for the supervision notes going missing. [redacted] was clear that many relevant records had been taken to Headquarters or had been in the possession of Headquarters staff but [redacted] report states that [redacted] had no reason to believe that they had been deliberately withheld or misplaced.

The differing reports of the numbers of the different sorts of files and the timing of the first independent review have created confusion which three years on is difficult to clarify. The first independent reviewer felt that [redacted] access to files was affected by them being needed at short notice prior to the trial. Those preparing for the trial felt that they were hindered by the fact of the first independent reviewer having the files at [redacted] disposal.

The different accounts appear contradictory or at least confusing in terms of the total number of files which should have been available at that time. However, we interviewed Islington Police who were clear that their main concern in relation to the trial was to have the social work file available. They cannot be clear what was in files they did not see, but they have no reason to believe that any residential records could contain information which would have been critical to the prosecution.

The social work files were held and used by the Social Worker at the local neighbourhood office. It was these social work files which could have been critical to the criminal prosecution and it was these that the Police were anxious to obtain. Although there was a delay, they did obtain them in advance of the trial. The Police have told this Inquiry that the trial ultimately ended part way through but that this was unconnected with the availability or otherwise of social work files or Social Services records. Therefore, we have not initiated any further primary interviews as regards this matter.

[redacted] enquiries led him to conclude, among other matters, that the *"filing system was chaotic"* and that the *"standards of recording were poor"*. In chapter two, we identified that a total of seven independent reviews and enquirers had commented on the administrative systems in Islington and the problems arising from some under-investment in this regard. In addition, [redacted] has learnt, and has reported to this Inquiry, that many confidential files held in the Assistant Director's office were destroyed by mistake. [redacted] has also reported to this Inquiry that a *"master set of child care files was inadvertently destroyed in May 1993"*. [redacted] report concluded that *"there does not appear to be any deliberate withholding of information or obstruction of other agencies"*.

Comment

We have accessed all the information available to us and analysed it as well as we can. Unfortunately the trail is now very cold and without repeating the detailed brief given to [redacted], including primary interviews with all concerned, we cannot be certain that Islington did (or did not) properly investigate these matters. It is a pity that [redacted] work was not able to be more specific two years ago.

Analysis

At this distance, it would be impossible to prove any deliberate attempt to withhold information. However, there is a lot of evidence to the effect that administrative systems were poor, files could be moved between personnel without proper tracking systems, and that the maintenance of comprehensive records was not a high priority.

In respect of the criminal trial in 1992, and the information available to the Police at that time, the Police are of the view that they ultimately received what was necessary for their purposes. [redacted] as an independent reviewer also saw a whole range of files about this case, although [redacted] did feel some papers were missing, but he did see considerably more files than [redacted]

Islington Police told us that they had no evidence of collusion among Social Services staff in Islington. They also told us that they do not think that the collapse of the trial was related to the absence of some of the files. Undoubtedly, some files did go missing and it appears that this happened at Assistant Director level. **However, on the basis of the above, and especially on the basis of our interview with the Police, this Inquiry concludes that there was no direct evidence of collusion, but considerable evidence of confusion and poor management of written records.**

Child B

The Evening Standard made allegations that information was withheld from Police who were investigating a suspected paedophile and [redacted] suspected abuse of a child in Islington's care. Police and [redacted] Social Services sought access to the ex-employee's file and to the child's file but important information/papers were allegedly *"withheld"*. Given the seriousness of these allegations, we carried out our own interviews with [redacted] Police, [redacted] Social Services and the senior officer involved from Islington.

The request for information from Islington was conveyed in a letter to a senior officer in Islington in April 1992. At the time the relevant staff in [redacted] (investigation team) met with the Islington officer, only part of the information requested was available. This did not include the key elements which would have been of most assistance in the inquiry.

Subsequently, Islington provided more information as requested, some was provided in correspondence, some was provided at a second meeting. Some information was never made available:-

* the original of a letter
* a specialist therapist's report
* some information/dates from a residential log.

The Islington officer stated that [redacted] could not trace this outstanding information and [redacted] elieved it to be missing, not traceable.

The investigation team have no way of knowing if it was ever on the files they saw, or whether the senior officers they met had ever seen or had possession of these papers.

The senior officer in Islington wrote a lengthy internal memo in November 1993 in which [redacted] said:-

"[redacted] believed [redacted] had seen the letter from the child's mother on the file but could not be certain. [redacted] did not believe that the specialist's report had ever existed. There was a discussion between the worker and the specialist but no direct interview with the child and the worker's note of the discussion was on the file".

There was no formal representation to Islington from either the Police or from [redacted] Social Services to the effect that they believed they did not receive full co-operation at the time. They were concerned however when information they sought was subject to delay or was not available, partly because they were told *"off the record"* that some information which could incriminate staff had been removed from key files in Islington. Ultimately they did receive most of the information they sought but felt the process was time consuming, and unhelpful. They also had expectations that there would be detailed records in respect of a number of matters according to the standards obtaining in their own authority at that time.

The following year, staff from both agencies contacted the Director of Neighbourhood Services and were interviewed by [redacted] in furtherance of his "missing files" enquiry. They made representations to the effect that Islington's records were poor and did not contain key information. In particular, *"there were not records pertaining to specific incidents after 23.5.1986. They were surprised that these records did not exist and reported this to the independent inquiry".*

There appears to have been an expectation of full co-operation on one side, and on the other, an expectation that full details of the ongoing investigation would be given. In fact, both sides were disappointed and each had their expectations met only in part, but each went as far as they felt the circumstances could warrant. Ultimately, the information that was not available appears to have been a function of the poor standards of recording and files that existed in Islington at that time.

Conclusion

The central question is whether or not the London Borough of Islington deliberately withheld key information. **Our view is that they did not, and nor do [redacted] Police have any evidence to support this view. It is undoubtedly the case that the process whereby information was provided was unhelpful and frustrating and it is easy to see how suspicions arose that this may have been for reasons other than inefficiency. Given the potential seriousness and implications of the allegations, the Islington senior officer could and should have sought the whole file from the Neighbourhood Office from the beginning. [redacted] could then have identified relevant information at the onset instead of trying to undertake this through the offices of a neighbourhood manager. This was a serious error of judgement on [redacted] part.**

Child C

A social work file in respect of Child C went missing. The Evening Standard alleges that this included disclosure statements (allegations that [redacted] had been abused). The Social Worker went missing at the same time. The implication was therefore that the social worker had gone missing, taking the file with [redacted] The file related to just over a year of this young [redacted] life,

in late 1989 and the whole of 1990. In 1989, the young [redacted] had left a residential school placement about which [redacted] had expressed a lot of unhappiness and given some indications of inappropriate behaviour by staff.

It would be reasonable to expect that the period after the move would be the time that this child felt able to confide more detail of [redacted] experiences to [redacted] Social Worker. Such allegations can sometimes pave the way for a criminal investigation but without the file there is no way of knowing whether this was so in this case.

There were a series of complaints made in respect of this young [redacted] and these were subject of an independent investigation. The investigation undertaken by [redacted] in 1993/94 reported that *"the Social Worker failed to return to work after Christmas (1990) and was believed to be off sick. Informal enquiries were followed by formal measures and the matter was passed to Industrial Relations. It took time for it to become apparent to the Department that the Social Worker had left without notice. Some files were missing from the Neighbourhood office and it was assumed that the Social Worker had failed to return them. Steps were taken to retrieve the files without success."*

The Social Worker who disappeared was someone who only had been employed for a few months and was not named in relation to any other allegation or concerns. The worker and the file disappeared at the same time. The worker is known to have gone abroad and attempts have been made to trace [redacted] The London Borough of Islington considered, with its legal advisers, what action they should take, including whether to involve the Police. It is not clear to us if the [redacted] Police were involved but a representative of the social work authority in that country was made aware of the worker's unprofessional behaviour. There was correspondence between Islington and relevant social work authorities in [redacted] but the response from these enquiries did not enable Islington staff to establish any direct contact.

At the time of [redacted] enquiries, the independent investigator and the independent person had already submitted their reports. [redacted] reviewed much of this work in so far as it was relevant to missing files but initiated no new enquiries. [redacted] conclusions were that *"this was a regrettable incident but it is difficult to think what Islington could have done to anticipate it, or any new procedures that would prevent a recurrence. It may point to the need for better security, but the hope must be that the incident was a bizarre and one-off event."*

Analysis

There is no evidence that the disappearance of this worker and [redacted] file were in any sense part of a wider conspiracy or that it was orchestrated by others with something to hide.

Conclusion

The social worker who disappeared, assuming [redacted] also took or 'lost' the file, acted unprofessionally and irresponsibly, and without a proper duty of care to the information in [redacted] possession and gained through [redacted] professional activities. **In such a situation we would expect that Islington would have undertaken as proactive a series of enquiries and actions as soon as possible. Islington did take some action in advising the [redacted] Social Work**

Department of its concerns but we believe that they should have involved the Police from both countries from the outset.

Other Allegations

As indicated above, some allegations made by the Evening Standard which had no connection with these three cases but which none the less raised issues about the availability of certain files or papers and questions about how or why they had gone missing.

D) Material Relating to Network Abuse and Organised Abuse

There is a large amount of material relating to both individual children, inter-agency working groups, and Islington's response to these allegations. The specific allegation is that much material was missing from the files that were shown to the original inquiry.

A review of these particular issues was not specifically within the terms of reference for the original inquiry. The issues have been subject to review since by the SSI and have also been reviewed in relation to this report. There is no evidence that relevant material was withheld from the ACPC working groups convened to look at two major cases of alleged network and organised abuse, and the availability of comprehensive information from the neighbourhood office is commented on in the minutes of the inter-agency meetings. The SSI confirmed that their understanding is that *"these matters have been fully examined by inter-agency working groups under the auspices of Islington ACPC."*

E) A Photograph of Injuries and a Letter about a Particular Resident

The allegations made in the Evening Standard were that a letter to management was missing, and a photocopy of a photo of knife injuries was missing from information given to the original Inquiry (conducted by [redacted]. The original allegation in the press was that a young [redacted] had been knifed by [redacted] suspected pimp whilst in the Children's Home. The young [redacted] was interviewed by [redacted] and [redacted]. They have told us that there was no dispute as to the fact that an attack took place involving a [redacted] acquaintance who had a knife. A number of details differed between the Evening Standard allegations and the information given to the Inquiry, including where the injury was sustained. However, there was no doubt that an attack took place, and no doubt in their minds that the residential establishment was insecure and thus unsafe. Thus they did not consider the photo would have added to their concerns about this case which were already very high. The original photo was in the possession of the parents. [redacted] and [redacted] did not see it, and on the basis of the above we have not initiated any specific enquiries as to where the photocopy of the photo was at the time of their Inquiry.

The other allegation was that a warning letter to management was missing, but the allegation was not clear as to whether the letter was missing from the file or the papers given to the Inquiry (or both). The Evening Standard dossier contains a photocopy of this letter, which identifies a number of concerns about this young [redacted] and the residential home in which [redacted] was placed. It was dated June 1991, and after this length of time we have not initiated any specific enquiries as to its whereabouts. However, the concerns identified were all reflected in the review work done by [redacted] and [redacted].

The implication of the letter going missing was that management had sought, or may have sought, to remove evidence that they had been told how bad things were in the residential home. The letter was sent to the NOSS who was responsible for the Home, who told us that [redacted] visited on a monthly basis and spoke with staff regularly. Hence the responsibility for the standards within the Home was clearly with the Head of Home and the NOSS; similarly, other managers were responsible for reviewing the care and protection afforded to the young [redacted]. They remain fully accountable and this cannot be diminished by the absence of this particular letter.

F) **Allegations Against a Head of Home**

One ex-resident, now an adult, has made allegations against a head of home but the file which existed when [redacted] was a child in the children's home is missing.

Any allegation involving serious abuse and made to a member of departmental staff should have been reported to the Police by the staff member concerned. The file evidence would not itself provide the basis on which to initiate criminal proceedings although it may have provided the basis on which to make further enquiries. However, it would be possible for the victim to approach the Police to report the incident(s) even now. The Superintendent has been subject to a review as detailed in the chapter on specific personnel. It appears he was one of a number of staff who were allowed to resign once concerns had been raised.

G) **Information About a Vulnerable Young [redacted] was Withheld from Police and Agencies**

The allegation in the Evening Standard was that a young [redacted] from the London Borough of [redacted] was placed in an establishment run by Islington but that, when [redacted] went missing, relevant information and papers were not passed on to the Police. This was of particular significance because the Police later established clear evidence of the young [redacted] involvement with a paedophile ring. Enquiries have been made with both the London Boroughs of Islington and Hackney, but the original assertion - that the young [redacted] was placed in an establishment run by Islington Council - is incorrect. [redacted] did use a hostel run by a voluntary body which happened to be in Islington's area but this was not with the knowledge, nor was it the responsibility, of Islington Council.

H) **Social Workers Notes about a Proposed Adoption**

The allegation made was that a staff member was an unsuitable person to adopt a child in care, but that the Social Worker's notes about this had gone missing.

The young person in question is one of several whose care and welfare have been the subject of enquiry and review since it became clear that they were named in the Evening Standard dossier. In this case there was an allegation against a staff member, who then became subject to an investigation. The staff member left [redacted]

The Social Worker's concerns are thus reflected in subsequent events which attracted appropriate management attention in relation to an investigation even though the notes themselves may not have been available. Whether or not the notes went missing, the

impact on subsequent case decisions would have been limited. It is not possible to comment on the reasons for these notes going missing, if they did. However, the need for more secure and robust administrative systems has been identified by previous reports. The need for further examination of Islington's administrative service is discussed later.

I) **Resident Claimed Abuse by Staff at a Residential Home**

The Evening Standard alleged that a resident alleged abusive behaviour on the part of more than one staff member but the files of this resident, who left more than 10 years ago, are said to be missing.

The staff member in question admitted the incident when challenged and left [redacted] employment [redacted] Islington's records state that the Police were involved but there was no disciplinary process. Islington are clear that while such an outcome was possible 10 years or so ago, their policies would be different today and that the matter would be dealt with through a disciplinary process.

A second allegation implicated a second staff member some two years later. [redacted] Islington's records state that [redacted] was investigated by the Police, charged and prosecuted. It is not possible to investigate the allegation of files going missing after some ten or more years. However, as commented on elsewhere, administrative systems need to ensure that the security of files is assured.

J) **That Reports were withheld from Committee**

The Evening Standard alleged that reports describing the poor state of Islington's Residential Homes were kept from Committee Members.

In November 1992, a report was written by a Neighbourhood Manager in respect of one particular home which were not submitted to the case review sub-committee on 5.11.92. Similarly, reports on a number of residential homes by a member of the Inspection team were not presented to Committee. Why this happened and whether this was an isolated incident is not known. However, given the concerns about the Homes, this is unacceptable.

Analysis

The basic question to be addressed is whether there was an organised attempt within Islington's Neighbourhood Services Department to withhold information about staff and to impede or prevent proper investigation into cases where staff were subject to allegations of abusive and/or criminal behaviour towards children. The alternative would be that the records and administrative systems within Islington were of such poor standard that files could not be maintained in proper security and that records were inadequate and incomplete. **There is no evidence to support the allegations of collusion, but there is significant evidence to support the assertion that "missing files" were a feature of poor administrative systems.**

In addition there will be some matters, including the allegations of network abuse for example, where a number of officers in different office bases will have had proper cause in furtherance

of their duties to review file material, and indeed there is evidence that some reviews were undertaken by staff in headquarters. To move files between offices safely and track them efficiently requires a comprehensive and robust administrative system such as did not exist in Islington.

In relation to the above issues, therefore, it is necessary to be clear that in such circumstances it would be extremely difficult to prove intentional loss of or removal of papers.

There is significant information from a variety of sources to the effect that the administrative and filing systems in Islington suffered from very limited staff time. Filing was frequently very out of date; the filing task was shared between different staff; misfiling was not uncommon, administrative and secretarial support was extremely limited or non-existent.

One report identified a lack of administrative and clerical support *"to a gross degree"*. In addition, the Neighbourhood Office system would have increased the fragmentation of available records between local offices, residential establishments, specialist services such as fostering, the Personnel section, and their policy advisors and Senior Managers in the Headquarters section.

Conclusions

It is clear that there were a number of cases where the subsequent enquiries by Islington at the time should have been more proactive. Some allegations go back so many years that it is now impossible to determine these matters or achieve any certain conclusions.

It is not the intention of this report to minimise the seriousness of reports or files going missing for whatever reason. Even files that go missing through administrative failings or oversight create a serious situation; if papers go missing through someone's intentional act, then this would constitute an extremely serious disciplinary matter. **There is, however, no evidence to support the allegations of collusion in this way. Where papers or files did go missing for whatever reason the issues which were of concern were still able to be addressed through other avenues.** Hence the availability of papers may reflect on the accountability of the Borough in terms of documentation and written evidence, but would not preclude the issues being surfaced and addressed by staff, both within the Borough and in other agencies.

Administrative systems are a recurrent theme in relation to the concerns expressed about Islington's organisation and management. Previous inquiries have identified that in relation to administrative systems, work is needed on:-

* Centralised client index
* Security for files
* Filing systems
* Recording policy and practice
* Construction of files
* The level of clerical and secretarial support
* Retention policy for files
* New technology
* Information systems for key data

In all our dealings with professional services we have expectations that minimum standards will be maintained. The public has a proper expectation that a Local Authority will maintain accurate, up to date and thorough records of all its dealings and that these will be kept securely and in safety.

We understand that the London Borough of Islington has recently undertaken a review of its administrative service which resulted in the introduction of dedicated reception staff and a 'lead' administrative officer in each of the 12 neighbourhood areas. We also understand that a typing service review is being carried out and that a new client index system is being introduced. Nevertheless, despite all of this, many of the issues raised in the various Inquiry reports referred to, not least of those in relation to the tracking of paper files themselves, refer to the need for a stronger and more consistent filing system. We are uncertain that in Islington today the effects of any changes are such as to fully address all the issues listed above.

Recommendation

We recommend that London Borough of Islington, as part of their new administrative arrangements, urgently review the arrangements for client files to make sure that a consistent approach is adopted and introduced across the Council as soon as possible.

CHAPTER SEVEN

THE POSITION TODAY

THE POSITION TODAY

Introduction

The matters contained in this report particularly refer to the events of the late 1980's and early 1990's, although some go back many years before that. Our report has charted the culture and organisation of Islington at that time. We believe it is particularly important to complete this Inquiry by reflecting on the position in Islington today in relation to the many matters already raised. In Chapter Three we outlined the dynamics which determine the competence or otherwise of organisations:-

* The political objectives
* Organisational strength.
* Management competence.
* Professional standards.
* Personnel policies.
* Financial investment.
* Interagency dynamics.

The Political Situation

When the Evening Standard articles were first published, Members told us that they had no prior knowledge of the state of management in Islington Social Services Department and that indeed in some respects, Member/Officer relationships were very poor, if not at breaking point. Comments such as *"The department had drifted a long way from the corporate centre"* and *"the department had developed a reputation for poor management and negative attitudes"* were made.

Today there is a new Chief Social Services Officer and senior team responsible for child care services and there is a new head of Neighbourhood Services. From the work we have carried out it is clear that there is a heavy commitment by the Members of Islington Council to put things right and to put Islington's sad history behind them. We know of the investment in residential child care services and the way they have adapted the neighbourhood structure to reflect the professional needs of a modern child care service. We know from the Chief Social Services Officer of open access to the Leader and Committee chairs and much improved trust and credibility existing between senior Members and Senior Officers in the department. We know that there are for example regular meetings, that there is a "need to know system" in place and that the Council has spent a considerable amount of time thinking through the criticisms that have been made of it. It is our view that the department is now very much more to the centre of the corporate and political management arrangements in Islington and that this position creates the basis for future strengthening and development of the service.

Organisational Arrangements

Many of the previous reports outlined in section 2 drew attention to the inadequacies of the management structure. We have found similar criticisms of people not knowing their jobs, of roles and responsibilities being confused, of inexperienced staff holding management positions in child care. The position today seems to be very different. In the last six months the Council

has responded to these criticisms by making significant changes to the child care management structure of the department. Details of the structures in 1990, 1991 and 1995 are set out in the Annex One. This new structure aims to create a clear line of accountability from top to bottom for the professional management of child care work in the Borough and we believe it goes a long way to meeting the deficiencies outlined in previous reports.

There seems to be an unambiguous management and disciplinary line; there are specific posts in the organisation responsible now for the management of residential child care, for child protection, for standards and systems. All of these moves undoubtedly strengthen Islington's organisation and should create the conditions whereby criticisms of the past in relation to inadequate management, professional standards and controls should not arise.

Management Competencies

The department is currently finalising appointments to all the new posts in its management structure; some are staff redeployed from the old organisation, some are new and undoubtedly therefore will not carry the "baggage" of the past. Again, this is a positive move and should lead to stability in the organisation. **We would, however, counsel warning at this time.** There is inevitably going to be a period, perhaps for the next two years, as new people settle into new jobs and as a new professional and managerial culture settles in, that different standards and problems of communication will still arise.

Furthermore, the criticisms levelled in this report and others about the old method of organisational change could still stand. It is our view that as the new team settles in **they need to be supported by a process of organisation and management development aimed at helping them understand their roles, build their management strengths and develop a cohesiveness as a team. We very much hope that Islington Council will support the Social Service function in that respect.**

Professional Standards

Professional standards have been criticised in many of the reports listed in Chapter two. These reports draw attention to fragmented approaches to social work across 24 different neighbourhoods (now 11), to different understandings of the requirements of child care practice and to deficiencies in training, supervision and the general infrastructure of child care management.

The new child care structure certainly puts into place the infrastructure for this to be tackled and Islington are to be applauded for that. However, until this new management team settles down and systematically works through this agenda, the potential still exists for many of the problems identified to be repeated. Structures themselves, of course, do not deal with professional practice. We know that there are specific posts in the structure aimed at providing this kind of support and would share Islington's view that these are essential; we are, however, worried that there is going to be a period before such a team matures and finally puts things on a totally satisfactory footing. **We are not sure that all the lessons of the previous inquiries are yet learnt and that practice change has consequently followed.**

We understand that the NSPCC has seconded a member of staff who will begin auditing child protection and child care files and examining standards of professional decision making and case recording. This person is outside the line of management and will be working the equivalent of one day per week and reporting to the Chief Social Services Officer.

We also understand that an "expert" in the Children Act has been commissioned to revise the Islington reference group to ensure that procedures are brought into line in Islington and that work is well underway on standards for social work with looked after children and family placements. We are told that Islington is signing up to the Youth Justice Standards derived from joint work with other Inner London Authorities and are looking to adopt standards on leaving care along the lines of those produced by the first key organisation. Given the current position, it is clear that Islington have accepted the need to build on the lessons of previous Inquiries and they have started in a confident manner. We are not sure, however, whether one day per week from the NSPCC will suffice in the next couple of years.

Recommendation

We therefore recommend Islington urgently review whether the arrangements now put in place for professional audit and other matters will be sufficient to see the Department over the next two years and if not to make further time available through this crucial phase.

Personnel Arrangements

This report has shown how the devolved management system in Islington has created a fragmented personnel system. We know that further devolution of personnel functions is being carried out and many of the problems concerned with the personnel issues in this report have been because of the lack of a tight coordinated and effective approach to personnel matters.

It is crucial that personnel records and personnel procedures in child care are managed properly and

Recommendation

We recommend Islington to review and strengthen the management of the personnel system to ensure overall control and quality checks are robust enough to meet child centred management requirements.

Equal Opportunities

We have drawn attention in this report to the need for all personnel polices, including equal opportunities, to be child focused first and foremost. We have been told that Islington implemented the Warner Report thoroughly and have no reason to doubt that. Nevertheless, we are not at all certain that the equal opportunities climate has sufficiently changed so as to avoid some of the problems of the past. We know that the Chief Social Services Officer is still unhappy with some aspects of this policy.

Recommendation

We recommend that Islington Council formally review the equal opportunities policy in relation to its application to child care in order to remove ,once and for all, any possible problems that this policy could create in addressing competency and management issues in Islington.

Financial

We know all Local Authorities suffer from particular financial difficulties and we do know that Islington have invested over £800k in the refurbishment of residential homes, that they have closed some units and improved the rest. We know that the Borough has increased its investments in fostering and adoption and that it now has a children's plan which, as time moves on, will grow in strength and importance. We trust that Islington Council will ensure that future investment levels of children's services are at an adequate minimum to avoid the difficulties and problems of the past.

Interagency Considerations

The main interagency consideration of importance in this field is the role and functioning of the Area Child Protection Committee which is chaired by the Chief Social Services Officer. We are told that the ACPC is now working effectively and has a system of reviewing interagency practice. We are also told that the Neighbourhood Services department has a system whereby child protection coordinators audit child protection practice, chair child protection conferences and other Council reviews. We believe that from our discussions with Islington Police, relations are now much better than they were a number of years ago and provide the basis for continuing improvement on all sides.

CHAPTER EIGHT

CONCLUSIONS

CONCLUSIONS

This review has charted the impact of important changes in Council policy and practices in Islington in the 1980's and how they created an environment which may have allowed the bad practices alleged by the Evening Standard to go unchallenged. **When the allegations became public Islington did not respond as they should have on many counts.**

In Islington's case laudable Council policies had a massive impact which substantially weakened the department's capacity to manage its professional infrastructure, its internal checks and balances and organisational competencies to provide care for vulnerable young people. Many Local Authorities are similarly tempted to seek to merge departments and to give a different emphasis to their Council policies. There is nothing wrong with this and indeed much to be applauded but the major lesson to be learnt from the Islington review is that such action cannot be taken without it being carefully planned and implemented in an objective and professional manner.

The Islington case clearly identifies the enormous number of "back doors" and other means that paedophiles could, if they so choose, use to access young people. **The lessons of this report refer primarily to the Social Services; the same principles apply to the Education service and indeed any organisation that has access to young children.** We very much hope that the Department of Health will draw these matters to the attention of other organisations in the child care field so as to initiate a review of the strength or otherwise of this country's child care protection systems.

Islington has undoubtedly suffered from many years of reactive responses to individual problems and cases - 13 Inquiry reports covering this short period alone. **Each of these issues has been dealt with as a "straw in the wind"; no-one looked for the haystack which was undoubtedly blowing.** One lesson for all Local Authorities is that they need the capacity to openly discuss and review issues as they emerge to ensure that, in so doing, they are not only dealing with one part of a wider problem.

The Islington case illustrates the necessity for there to be a clear understanding of the minimum requirements of overall competence of Social Services department. We know that the Department of Health and Audit Commission are developing a profile for future "joint reviews" looking at the total competence of such departments and we hope that this report will add something to that debate, particularly those parts of this report which show the interaction of different factors within an organisation and how they can lead to major difficulties. **It is our view that any such joint reviews should not simply look at separate activity but at the whole picture and the inter-relationship between all of these factors.**

Islington today is in our view dramatically different from the department that it was in 1992. It is sad that a department with so many good and committed staff has suffered so many years of loss of credibility and organisation trauma; the department today is in a much more robust state of health. If the patient were described as "critically ill" in 1992, it is our view today that it is now "well on the mend". We have great admiration for Hannah Miller who clearly carries the statutory Director of Social Services' responsibilities, together with Jean Dolphin as new executive head of the combined department, and their staff who are now putting into place many of the things that are needed to bring Islington back to being a highly competent and successful child care organisation. We very much hope that this report will help the patient recover completely.