REPORT OF THE SIGNIFICANT CASE REVIEW – PHASE 2

THE SEXUAL ABUSE OF CHILDREN IN RESIDENTIAL CARE

EXECUTIVE SUMMARY

Stella Perrott

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INTRODUCTION AND BACKGROUND

INTRODUCTION

All the victims were looked after by the local authority at the time of the offences and were living in residential care homes – Home A (an open residential facility) and Home B (a secure unit). Y was a member of staff in both homes.

In July 2015, the Edinburgh Child Protection Committee commissioned a Significant Case Review (SCR). The Review has reported in two phases. The first phase examined reviews, inquiries (including the Edinburgh Inquiry), policies and procedures that were relevant within the time frame of the SCR. A summary of the Phase 1 work and findings can be found at Annex A. The second phase examined the facts of the case.

CONCERNS AND INVESTIGATIONS

REPORT 1: 1997

REPORT 2: 1999-2000

REPORT 3: 2006

REPORT 4: 2011

FINDINGS, ANALYSIS AND LEARNING

CHILD VULNERABILITY

The victims were known to agencies – health, education, social work and police, in the years before they were accommodated and all had been subject to some abuse. Most of the allegations of abuse were not believed, thought to be exaggerated or interpreted as a sign of delinquency. By the time the victims came into care and in the absence of adults to safeguard them, they had developed their own strategies for protecting themselves by running away from home, truanting from school or, in one case, spending the day riding the buses. In doing so they were exposed to other risks including alcohol or drug misuse and risk of sexual exploitation.

None of the victims came into care in a planned way. They were usually accommodated after refusing to go home or their parents refusing to have them home.

Prior to, and while the victims were in care, agencies (health, residential care, social work and police) addressed the symptoms of potential abuse such as going missing, drug and alcohol misuse, premature sexual activity and mental health problems

without much exploration of the underlying causes. Following abuse by Y the reasons for the victims' distress and deteriorating behaviour were not addressed.

The quality of social workers' involvement varied. Three of the victims had social workers who were reliable and took active steps to improve the victims' situations while one social worker was notable for their lack of effort on the victims' behalf. Two victims did not have a named social worker for a long period, including after they were accommodated and one victim's social worker was 'de-allocated' due to staff shortages at the critical point of her moving to Home A. She was without a social worker for eight months.

There was evidence of high quality engagement from the Throughcare and Aftercare Service, although those who left care before 2003 (when the service came into being) did not have access to this. Similarly, the introduction of a looked after nurse and improvements in mental health services through Edinburgh Connect both of which were introduced in 2002, improved the quality of care. Education services to looked after children were poor throughout the period and many of those looked after did not have access to full time education.

The victims were highly vulnerable to being sexually exploited or abused when in residential care and the risks were very evident. The warning signs were understood and many professionals (including residential care officers, see below) were very concerned to protect the victims and to help them. Other professionals judged them to be badly behaved and appeared disinclined to intervene other than to challenge them. Those staff (from all agencies) that made an effort had a mixed response. The mistrust of agencies by the victims ran deep and they perceived previous agency involvement as ineffectual. The transient nature of professional care made it difficult for bonds to form. Some workers were able to overcome these earlier barriers and the victims began to trust them with some confidences, though not about Y's abuse.

> **Learning Point 1**: The victims were vulnerable to abuse pre, during and post care and within and out with the institution because their needs had not been properly acknowledged or fully responded to when they were younger and while they were in care. They could not trust adults in authority to protect them.

GROOMING AND OFFENDING

Y was considered by the victims and staff to be a good member of staff. He was visible and available in the unit, often doing things with young people such as playing pool. He took them out of the unit for coffee and to football or other outings and was helpful in terms of providing lifts and getting practical matters sorted out. He was a good listener who responded to the victims' problems. He was available and sympathetic after an upsetting phone call home or a bad day at school. As well as building good relationships with the victims, he was more generous than many other staff with treats such as sweets or cans of drink from the locked treat cupboard in Home A.

He did not indulge in any crude or borderline sexual language, flirt, come too close or engage in any other sort of activity that might have alerted the victims or staff to the risk of unwanted touching. He did 'toy fight' (play fight) as did other staff, even after it was banned from the unit because of concerns that it could result in abuse.

There was an element of surprise in his abuse. The victims were always alone with him when the initial advance was made and it did not appear to the victims that he engineered these encounters. He left the victims presents in their rooms.

In the presence of any other child or member of staff he behaved as a good staff member, engaging appropriately with the victim but as soon as he was alone with her he immediately tried to touch them.

Y was recruited over twenty-five years ago at a time when informal methods of recruitment were common. It took the local authority five months to request a police record check.

> **Learning point 2:** Y could and should have been dismissed early in his career. Although his sexual abuse was well concealed, indicators of the risks he posed lay in other transgressions

THE RESIDENTIAL ENVIRONMENT

Home A was not an environment that ignored, condoned or supported abuse. Although Home A was not an abusive environment, there were some elements that made abuse more likely. Insufficient staff and the layout of the unit meant adult supervision and involvement with children was spread thinly and Y's activities could be much more readily hidden from colleagues' sight. Low staffing, excessive time spent in the office and close relationships between residential care officers discouraged young people from believing that the staff were there *for them*.

Staff did not take effective action to intervene in disputes and bullying. Bullying and peer aggression undermined the victims' confidence in themselves and in the unit as a whole. In the absence of effective action to protect the most vulnerable or the creation of an environment in which sexual integrity and wishes were respected, weaker residents, and girls in particular, were more vulnerable to abuse. Placing boys who had a history of abuse or held derogatory views of girls with vulnerable girls (or boys) was indicative of a lack of concern or thought about the wellbeing of the most vulnerable children and young people.

Home B posed a different set of safety problems. The high levels of supervision and early staff intervention meant that victims felt safe from their peers and also from themselves. The young people at Home B were at risk from punitive and sometimes painful measures of control by staff members. Many were also subject to isolation and removal of personal possessions, often unnecessarily and often for unnecessarily long periods. We consider this practice abusive. If not understood as abusive by staff and managers at the time, it was seen as undesirable and at the end the period of the SCR, concerted efforts were made to reduce the numbers of restraints and the length of time children were kept isolated. However, residential care managers told the SCR that significant change did not occur within the period of the Review.

MANAGING INVESTIGATIONS

When the children were younger, concerns were dealt with as child protection or welfare concerns or behavioural problems. The allegations of abuse by Y were dealt with as disciplinary matters; child protection concerns; an unspecified concern; and, a criminal allegation. Concerns about men in the community were mostly dealt with as child welfare concerns and allegations against peers as criminal allegations. Enquiries, irrespective of the route through which they were investigated, were rarely extensive and protective action was dependent on clearly evidenced allegations with victim/witness co-operation. The approach was highly legalistic and procedural with little or no attention paid to the child's experience or the implications of this for future safeguarding.

TRAINING, SUPERVISION AND QUALITY/SKILLS OF STAFF

Residential staff said they did not feel competent to tackle many of the issues with which they were faced. It seems they largely took a 'common sense' approach to tackling problems such as warning the victims about the dangers of their behaviour. There was little by way of an understanding of the reasons for the behaviour or what might be the best approach both at the time and for the longer term. Concerning behaviour was treated as a management or control problem. The effects of reward/ punishment approaches were short lived and the victims all had to move when the staff exhausted their repertoire of responses.

Considerably more training took place over the course of the 2000s than the preceding decade. At the end of this SCR period training was introduced in Home B to help staff understand and respond to children's behaviours. This changed the approaches of some staff but we were told that the major gains did not take place until after the period of the SCR.

The supervision policy was updated following the Edinburgh Inquiry but there was resistance to full implementation by some staff, including Y, and supervision appears not to have been fully and consistently embedded into management routines in Home A until the end of the 2000s. At Home B, over the whole period of the SCR supervision was more regular.

MANAGING POOR PRACTICE

The Unit and senior managers had, over the years, concerns about some members of staff whom they thought might have been behaving badly or inappropriately towards children. Managers told us it was very difficult to dismiss an employee, and other than in only the most well evidenced and serious cases was it supported by legal, HR and medical advisors. We concluded that had some of the incidents we heard about been referred to the police as crimes, such as thefts from the unit or some allegations of assault by staff, for example, the case for dismissal may have been much stronger and arrived at much sooner. We have also noted that managers did not include in the disciplinary decisions clear expectations of the behaviour they expected to see and the measures that would be put in place to determine whether these were being met and improvements achieved.

MANAGING QUALITY

External managers (senior managers in the local authority who do not work in the residential unit) were supportive and keen to progress improvements across the sector. They were open to hearing about problems and did make efforts to resolve them. They listened to external agencies such as Edinburgh Connect, Barnardo's, the Looked After Children's nurse and the Children's Rights Service in order to understand better the experience of children in the units. How this translated into improvements is less clear.

External managers received some reports relating to use of residential and secure care, complaints and the work of the Children's Rights Service as well as inspection reports and internally commissioned reports, such as one on restraint. After the Edinburgh Inquiry the Council also commissioned progress reports on the implementation of the Inquiry recommendations but did not evaluate the impact of these measures on the quality of care and there was no record of whether changes led to anticipated improvements. The authority also found additional resources to improve the fabric of the buildings but improving the quality of care started from such a low base that effort did not keep up with need.

We found no lack of willingness to identify and try and resolve problems but saw little sign of any substantive improvement in the period of the SCR. In particular, the office based culture at Home A and over-zealous discipline and control at Home B persisted as problems throughout this period.

While abuse by Y was hidden and undisclosed, the impoverished environment at Home A and the aggressive regime at Home B within which abuse was able to occur were known to the local authority (or would have been very evident to those wishing to enquire). Senior staff and elected members did not set out a clear understanding of the quality of care they expected to see or identify the measures needed to shrink the distance between reality and aspiration.

> **Learning point 3**: The environment in which the victims were living was not a safe one. Improvements and initiatives to improve the quality of staff and quality of care were too slow and insufficiently embedded to impact positively on the care of the victims or prevent a committed abuser from exploiting and manipulating environmental weaknesses.

CHILD DISCLOSURE

None of the victims disclosed to staff, in the first instance, the abuse by Y. In some cases the abuse only came to light during the investigation. In the cases that were raised at the time, the information came through other young people. In two cases, the abuse was strongly denied by the victim.

When the abuse was first reported or alleged many staff did not believe the victims and some staff thought that the victim was causing trouble or was attention seeking, even when the concern came to light through a third party or the victim denied it.

There were no indications that anyone working with the victims understood how children might be groomed or the likelihood of initial denial or retraction. When those investigating the abuse found they had insufficient information to pursue the case further, or the victim denied the abuse, they closed the investigation and the matter was not something that was ever raised again. Had professionals 'dug a bit' (summarised by the victims as: being interviewed away from the unit; being given plenty of time to let the story unfold; more inquisitive questioners) the victims may have disclosed. They wanted to, but they needed to know they would be believed and would be safe afterwards.

Learning point 4: Professionals from all disciplines were insufficiently inquisitive about the source of the victims' distress, challenging behaviour or symptoms of sexual abuse/exploitation and they were also insufficiently informed by knowledge of barriers to disclosure and how offenders groom children and their environment[1]. This knowledge gap contributed to the narrow scope of enquiries and inability of agencies to uncover the truth.

STAFF RAISING CONCERNS

We are confident that had staff observed abuse by Y, they would have reported it. We are also confident that had staff seen any other abuse, such as physical abuse, they would have reported that too. The staff at Home A found the unit manager receptive to receiving concerns and believed that they were dealt with, if not always effectively. We are less confident that concerns would have been reported at Home B, having seen less evidence of staff reporting concerns or confidence in management's responses.

CIRCLE OF DISBELIEF

Figure 2 below sets out our analysis of the circle of disbelief. As each allegation is confirmed as being unfounded, staff's belief that most are unfounded is reinforced, thus perpetuating the disbelief of children.

[1] Sorenson, T., & Snow, B. (1991) found that in 72% of cases of full disclosure of sexual abuse, children at first denied abuse (see pages 39-44 of the Supporting Papers to the Phase 1 Report).

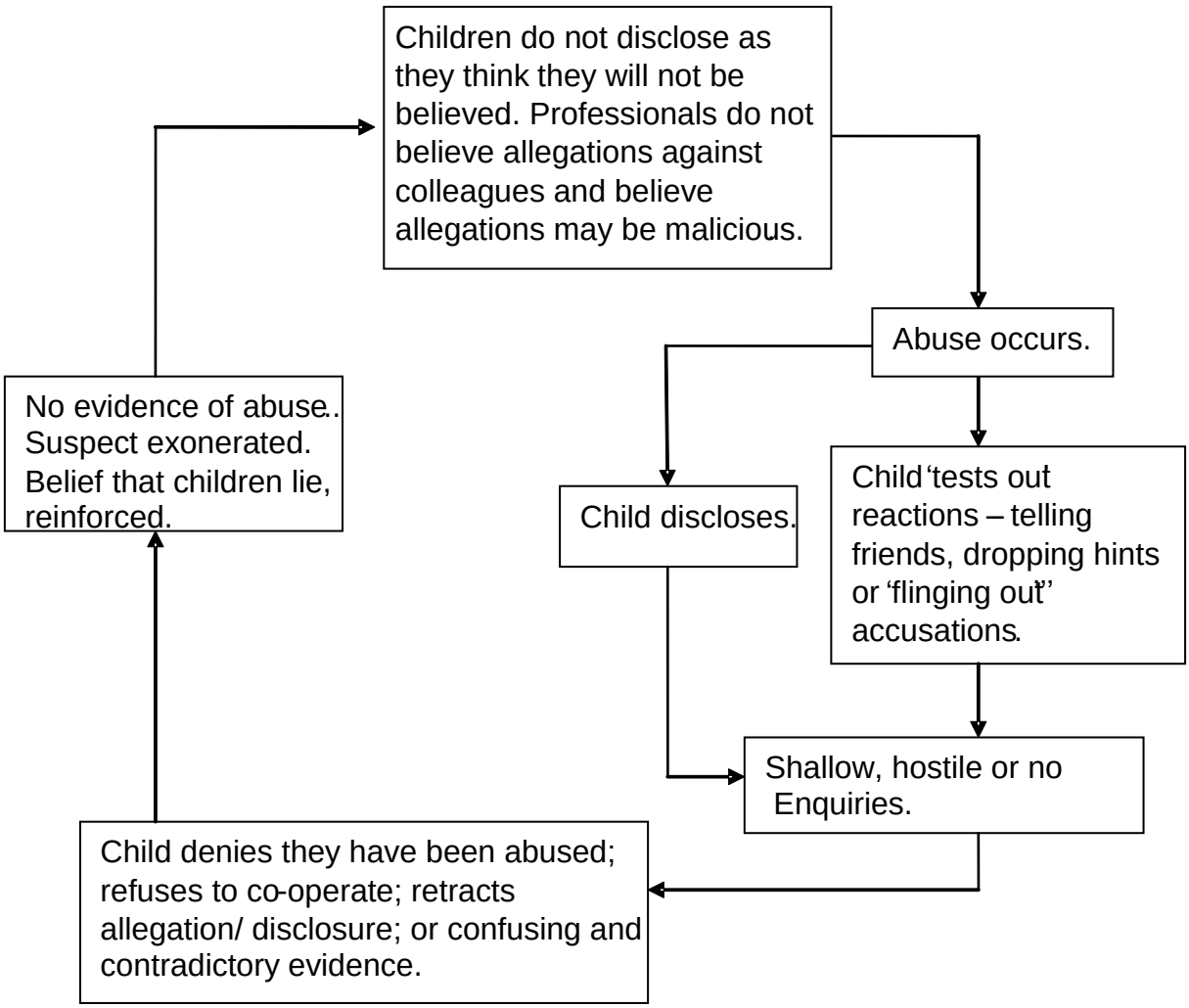

Fig. 1 Circle of Disbelief

It is against this backdrop that the difficulty staff have in identifying and raising concerns needs to be understood. Staff at Home A were very alert to the behaviour of staff about whom they already had an uncomfortable feeling, or appeared to them to be 'creepy', and reported any suspicious behaviour. All those who worked with Y trusted him completely with the care of children and felt no need to be vigilant when working with him. This deep trust may have led to disbelief in accusations and too ready an acceptance of any information that confirmed his innocence. The belief that young people make false allegations was reinforced by the exoneration of Y. To have seriously engaged with the possibility that he might have been abusing children would have taken a monumental readjustment in everyone's understanding of and relationship with him. It would have required staff and managers to recognise that they too had been duped and groomed by him.

Learning point 5: Lack of any visible indications of abuse, staff's dependence on and trust in Y and a deep belief throughout the system that

many allegations are false, combined to make Y's sexual abuse unknown to and unsuspected by staff. Although professionals recognised the symptoms of child sexual exploitation/abuse, they did not consider whether the source of abuse might be a colleague.

RESPONSES AND INVESTIGATIONS

There were four responses and investigations. Two were undertaken by social work. One was undertaken jointly by police and social work and one was undertaken by the police as a single agency.

In addition, there were many other enquiries into abuse prior to the victims coming into care and while they were in care (unrelated to Y).

Excepting the investigation that resulted in conviction, all the responses or investigations were inadequate. We found little evidence of agencies, individually or collectively:

- planning how best to conduct the enquiry in the light of the available information and informed by what is known about sex offending;
- identifying the likely barriers to disclosure and how these might be overcome;
- considering the likely impact of the investigation and its aftermath on the young person and how this should be managed and the young person supported;
- actively seeking corroboration following a disclosure;
- reviewing safeguarding and support needs/plans throughout the case and, in particular on the closure of the criminal investigation.

When child protection enquires were instigated (both before and after the victims were accommodated), Initial Referral Discussions (which should have addressed these matters) were limited to noting the need for an investigation and a joint interview.

> **Learning point 6**: All types of enquiries (child protection, criminal and disciplinary), both prior to and while the victims were looked after, were insufficiently deep or broad to get to the truth of the abuse the girls experienced.

Except in one case, all the enquiries (pre and post entry into care) into abuse by adults resulted in insufficient evidence to charge. This closed the case and protective plans were not instituted. The outcomes were poor in all the cases with the situation being worse for the victims after disclosure.

We found examples of sensitive and caring practice and most of the staff involved with the victims did what was expected of them at the time. It was the failure of the system, overall, that led to the poor outcomes in this case.

The characteristics of the system: the length child protection and disciplinary investigations took; the prohibition on discussing an alleged offence; the automatic exchange of information as a child protection concern; the difficulty in establishing

corroboration resulting in 'insufficient evidence' to charge a suspect; and, the intimidating nature of inquiries all contributed to poor outcomes.

The impact of these features of the system and the needs of the girls were not considered when planning or undertaking the work. Agencies embarked on an enquiry because it was required but with no planning on how the potentially damaging elements might be managed. Residential care staff, who were mainly responsible for managing the consequences of this, needed more help in how best to support the victims and what to say to them about enquiries.

> **Learning point 7:** Child protection systems, which should have protected the victims and brought offenders to justice, contributed to the harm the victims experienced. The likelihood of poor outcomes, particularly reluctance to disclose, insufficient evidence to charge a suspect and further harm, were not properly anticipated and managed.

On the whole, professionals followed required procedures and worked together to a greater or lesser degree. They exchanged information when they should have, met to agree and review inter-agency plans and wrote reports. There are no indications that any occasional lack of inter-agency working or adherence to procedures had any impact on the outcomes of these cases. Conversely, the focus on agency requirements and procedures led to professionals paying insufficient attention to the experience of the girls or understanding their perspectives.

The victims' sexual vulnerability was identified but no plans were put in place to reduce it. Problems such as drug and alcohol or mental health problems were not always recognised but when they were, the response was to offer access to another service. Often, the victims did not need additional services (and they already had a great number of professionals involved with them).

> **Learning point 8**: Agency practice was too dependent on procedures and guidance, which limited professionals' understanding of and responses to the girls' experience. The victims needed skilled, empathetic and knowledgeable professionals with time to undertake their responsibilities.

CONCLUSIONS

The abuse started because Y ***chose*** to abuse young people in his care. He did not join an organisation (Home A) where abuse was rife or acceptable, and by the time he started work at Home B he was a committed abuser.

Although Home A was not an abusive care home, there were some aspects of the environment that increased the risk of abuse:

- low levels of staffing and insufficient oversight of, and involvement with, the young people on the unit, created opportunities for Y to groom the victims and spend time with them alone;
- failure to tackle bullying and sexually aggressive behaviour by peers effectively left the victims exposed to risk and lacking in trust that staff could protect them;

- staff and managers were insufficiently alert to the possibility that Y might be abusing children and made insufficient enquiries into the victims' deteriorating behaviour.

In Home B, some aspects of the environment also increased the risk of abuse:

- high levels of physical measures of control that were, or verged on being, abusive;
- the closed nature of the environment and young people's high dependence on staff for their every need.

The abuse was also able to start because:

- Y had access to the most vulnerable children and the local authority did not dismiss him when the grounds to do so became clear;
- The victims' vulnerability to sexual predation was not adequately addressed;
- agencies did not work together to increase resilience or develop safeguarding strategies that recognised abuse might come from any source, including staff.

Y was able to continue his abuse for so long because:

- the experience of the girls prior to coming into care left them mistrustful of authority and child protection agencies and this, coupled with the sophisticated grooming and silencing methods of Y, meant they were unable to disclose his abuse of them;
- agencies and professionals did not explore with the victims, in sufficient depth, the reasons for their behaviour and distress, the focus was on modifying their behaviour;
- agencies and professionals were ill equipped to work effectively with the young people for whom they were responsible, for example, in working with problems such as child sexual exploitation, running away, drug and alcohol problems and building resilience;
- there was a belief in the innocence of colleagues and the propensity for children to lie or cause mischief through false accusations;
- enquiries and investigations were inadequate and discouraged disclosure;
- 'insufficient evidence' of abuse was treated as evidence of no abuse.

FOCUS FOR CHANGE

We make no recommendations. We have noted that implementing the recommendations of the Edinburgh Inquiry and other reviews became an end in itself without reflection on the overall quality of care or outcomes for children. We have also noted that following inquiry and other reports a number of procedures were introduced, each good in themselves, but adding to a child protection and criminal justice system that did not safeguard children or meet their needs. Rather than implement a set of recommendations, agencies should consider the distance between the findings of this report, current practice and their own aspirations for children's services and then take steps to bridge the gap.

In the light of these findings, we identify the following priority areas:

- Listening and paying close attention to children's experiences and responding to their needs as understood by them.

- The quality and management of enquiries and investigations of concerns (criminal, child protection, disciplinary).

- The quality of care for children who are looked after away from home.

- Ensuring those who work with children are suitable.

Also, in Phase 1 of the SCR we recommended that:

- Current record retention and destruction policies should be reviewed to ensure that life changing decisions, and the reasons for them are recorded and retained.

The findings from Phase 2 indicate that this recommendation should be extended to staff records, particularly in respect of disciplinary or criminal investigations.

The women who participated in the Significant Review have expressed their wish to be kept informed of the actions agencies intend to take following the Review.

SCR REVIEW TEAM

Stella Perrott:
Lead Reviewer (Chair)

Andrew Gillies:
Professional Advisor/Reviewer, Communities & Families, City of Edinburgh Council.

Sean Byrne:
Lead Officer, Edinburgh Child Protection Committee

Morag Bruce (until May 2016) / Julie Marshall (from May 2016):
Detective Inspectors, Edinburgh Division Public Protection Unit, Police Scotland

Moyra Wilson (until September 2016):
Senior Education Manager, Schools & Community Services, City of Edinburgh Council

Scott Dunbar:
Senior Manager, Communities & Families, City of Edinburgh Council

Paul Mulvanny:
Locality Reporter Manager, Scottish Children's Reporters Administration

Charlotte Kirk:
Consultant Paediatrician, NHS Lothian

Margaret Monan:
Clinical Nurse Manager, Child and Adolescent Mental Health Service, NHS Lothian