OXENDON HOUSE
A CASE TO ANSWER?

Report of the Independent Inquiry - August 1994

Members

BRIAN ROYCROFT CBE
L .A. WITHAM

Clerk to the Inquiry
EMMA ROMER
(Barrister)

Published by Bedfordshire County Council
1994

ERRATA

1. **Contents**

   (i) Paragraph 5.13 is at page 19, not page 17
   (ii) Chapter 19 begins on page 119, not page 118

2. **Chapter XI - Child Protection Procedures**

   (i) Paragraph 11.2 reads from "The first meeting of the Child Protection Strategy Group ... investigate the matter in the future." It should be read as if it were at the top of page 64, not in the middle of page 62.

3. **Chapter XII - Deliberations**

   (i) Delete paragraph 12.3 on page 73, this is repeated on page 74.

4. **Chapter XVIII - Protest and Response**

   (i) Paragraph 18.12
   Appendix 14 is the statement of Mr Tim Sanders, not the motion of the 29th November UNISON Annual General Meeting.

   (ii) Appendix 15 is the motion of the 29th November UNISON Annual General meeting not the statement of Mr Tim Sanders.

5. **Chapter XX - Conclusions**

   (i) Paragraph 20.32. All reference to the National Union of Teachers (NUT) should read National Association of Schoolmasters and Union of Women Teachers (NASUWT).

6. **Appendix Thirteen - Page xxxvii**

   (i) Paragraph beginning "Taking into account...." please insert the word not into last sentence in bold which should then read "**It is for this reason that the Committee was unanimous in its decision that Oxendon House should <u>not</u> re-open unless there is a permanent dispersal of the staff group and that previous residents do not return there.**"

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PREAMBLE

The Inquiry began work on 3rd February. Major witnesses required some time before their evidence could be presented and supported by full documentation. Following extensive preliminary meetings, the Director of Social Services began presenting evidence on 14th March, the Trades Unions on 28th March , and the Police on 29th March. At the conclusion of the Inquiry it has received evidence from 85 witnesses in interview and 48 written statements, some of which were followed up by interview. These include letters from members of staff at Oxendon House and from members of the public. Since these are not the subject of analysis elsewhere in the report the contents have been drawn together in two summaries which are appended to the report (Appendices One and Two). We have also viewed video recordings of interviews between the police and children, and of anger counselling. Some witnesses have seen us several times and some for several days; for some it has been an ordeal. We would like to express our thanks to all of them for their patience as we struggled to make sense of a very complex situation.

The witnesses we have interviewed have included councillors, members of the public, staff at Oxendon House, senior and middle management of the Social Services Department, retired staff, psychiatrists, experts in child care and therapeutic methods, teachers from Oxendon House, Trades Union Officials, and the Police. We have also met a number of children and received evidence from them in several forms.

We presented an Interim Report to the Social Services Committee in April, and the conclusions of that report remain valid. The relevant outstanding recommendations are included in this final report.

The final report is in four parts. The first part describes the history of Oxendon, and the work and practices in the days before closure. The second part describes events as we perceive them, over the critical time from May 1993 to February 1994. The third part contains our conclusions and the fourth our recommendations.

The exchange of information between witnesses has raised particular problems. Much of the information held by Social Services and the Police is confidential, and covered by restrictions due to the Child Protection and Criminal Investigation Procedures. As far as possible, and through negotiation, all appropriate information has been exchanged.

Whilst we have described throughout the report Oxendon House being closed, we do not imply permanent closure. We have used the names of key witnesses and experts, but maintained anonymity for others. We have avoided identifying any child, and have referred to them throughout as masculine. We hope we have not offended any young resident of Oxendon by describing all as children; we fully appreciate that many are young people and indeed now young adults, but again this preserves anonymity. We wish them all well for the future.

B. Roycroft C.B.E **L. A. Witham**

21st July 1994

ACKNOWLEDGEMENTS

We should like to thank the Bedfordshire County Council Social Services Committee for its firm commitment to our Inquiry. The Chief Executive, Mr Denis Cleggett and The County Solicitor, Mr Roger Wansborough have given patient support whilst respecting absolutely our independence.

We have enjoyed full co-operation from the Social Services Department, the Trades Unions, and the Police, and thank all the staff and officers who have given their time unstintingly. We have also had great interest from the public and their participation in our Inquiry has been of great value.

We should like to thank Ms Catherine Winstanley for organising our information and documentation, a formidable task, and Mr Terry McKewan for logistical support. We offer special thanks to Mrs Gladys Winch who has organised our office, and to the typists, Ms Maggie Glenister, Mrs Paula Hollowell and Miss Louise Keane, who have supported her.

Finally to Ms Emma Romer, Barrister, who has been Clerk to our Inquiry, we express our gratitude for her efficiency, energy, and hard work, but especially for her wisdom. She was ably supported at times by Mr John Cooper, Barrister.

PART I

OXENDON HOUSE - A CASE TO ANSWER

I. INTRODUCTION

1.1 Oxendon House is a Residential Home in Leighton Buzzard. It accommodates twenty one children and is part of the child care facilities essential to the duties laid upon the County Council by legislation. For convenience we shall call it Oxendon.

1.2 On 30th September, 1993, the Director of Social Services took steps to close Oxendon temporarily, immediately dispersing the children, and placing all the staff on leave of absence with pay. His decision to close the Home was to enable child protection investigations to be conducted jointly with the Police concerning the management and conduct of the Home, and in particular examine the evidence presented to him that the regime in the Home might be abusive to children. He also had received specific allegations relating to one child, and less specific allegations affecting others.

1.3 After a major investigation conducted by the Police with the aid of social workers drawn from neighbouring authorities' action was taken on several fronts. Firstly, five members of Oxendon staff were suspended. Secondly, thorough investigations by the Police were conducted which failed to identify any substantiated cases of criminal abuse by any individual member of staff against any child or young person. Thirdly, the County Council instigated disciplinary proceedings against four suspended members of staff and these also resulted in no action being taken and the suspensions were lifted. The fifth member of staff remains suspended pending this report, and finally the Director and the Police consulted with an expert on child abuse before the above mentioned inquiries were concluded, and as a result of these consultations, the Director reported to the full Social Services Committee on 2nd November. After listening to the Director the Committee decided that the present group of staff would be dispersed permanently and not return to Oxendon.

1.4 A vigorous debate ensued about these decisions and the manner of their implementation resulting in a resolution of the County Council on 16th December which lead to the setting up of an Independent Inquiry by the Social Services Committee. The terms of reference and a description of the way in which we have conducted the Inquiry are set out in Appendix Three.

1.5 Critics of the actions have pointed out that no individual member of staff has been found guilty of abusive practices; that the practices which are alleged to have constituted institutional abuse were known to the management of the Social Services Department for years, and supported or condoned; that the peremptory closure of the Home could have been avoided, and that by closing the Home in this manner the children were undeniably distressed; and finally the treatment of the staff was unfair and insensitive. Broadly these criticisms constitute the case to be answered by the Social Services Department whilst criticisms of the style of management, care practices conducted by mainly untrained staff, the apparent high levels of violence within the Home and the restraint procedures form the basis of the case to be answered by the staff.

II. BACKGROUND

2.1 Local authorities became responsible for the care of children deprived of a normal home life under the Children Act of 1948, and further legislation widened the responsibilities to include adoption, services to prevent the need for children to be received into care; child protection; and the care and rehabilitation of young offenders. The legislation was consolidated and advanced by the Children Act of 1989 which introduced new principles of great importance as well as improving the practice of child care, the Courts, and interagency co-operation.

2.2 In the early days of the welfare state the responsibilities rested with Children Committees and their departments led by children's officers. Resulting from the recommendations of the Seebohm Report Social Services Departments were established in 1971 in Counties and County Boroughs. The policies of these departments set by a Social Services Committee are implemented by professional staff led by the Director of Social Services. A further reorganisation took place in 1974 when the restructuring of Local Government amalgamated some authorities and changed the boundaries of others.

2.3 The present boundaries of the County were set in 1974 when the former County Borough of Luton was integrated within Bedfordshire and the population has grown from 481,700 in 1974 to 536,000 in 1992 (mid year estimate).

However, in 1992 the number of children aged 0-17 years in the population was 133,109

2.4 The political control of the Council can best be described as stable yet divided between the three major parties. It has been a hung council since 1981 and no one party has had sufficient members to exercise decisive leadership. Yet the impression given to us is of co-operation between the parties which ensures that the main business of the Council is conducted in a reasonably civilised and efficient manner. A system of representative panels exists to bring together the leaders of each party in each area of activity to ensure the full involvement of Councillors with the Chief Officers in discussing the development of policy and handling of urgent decisions. Clearly, such a system adds to the workload of officers and requires great trust on all sides. The system also has disadvantages that cannot be avoided, such as less informal involvement between officers and members which can lead to a better understanding of the service by elected representatives.

2.5 The County Council has a good reputation for sound management, advance planning, and financial control. This was confirmed through a Management Letter to Members by the District Auditor at the conclusion of his audit of the Council's accounts for the year ended 31st March, 1993

He says:

"The Authority is well managed and is coping successfully with the level of change which continues unabated despite financial resources remaining limited.

Fundamental changes in the Council's management structure continue as it responds to the challenges of the future and to the full implementation of the arrangements that recognise the developing roles of the commissioning strategic planning function and accountable support services.

Legislation affecting Care in the Community, colleges of education becoming independent and schools seeking GMS status are still having far reaching effects in terms of financial resources, staffing and the approach to the management of services"

2.6 Since its establishment in 1971, and restructuring in 1974, the Social Services Department has been regarded as a stable and well managed organisation. Mr David Clifton was appointed as Director at the inception of the Department and held this position until 1989 when the present Director joined the department after extensive experience in the voluntary and statutory fields. The department survived reasonably well the various reorganisations, but in 1993, had to face another upheaval created by the administrative requirements of Care in the Community Legislation. The changes needed careful planning, substantial restructuring, training programmes for staff of all levels, and embraced a new concept separating the purchase of services from the provision. This programme of change was happening in other authorities simultaneously and resulted in many changes of personnel at management level throughout the country, some people retiring early and others moving to new jobs in other authorities. There is no evidence to suggest that Bedfordshire suffered more or less than any other local authority in this process.

2.7 For many years Bedfordshire received more children into care than the national average for County Councils. In 1985/86 for example Bedfordshire had 6 children in care for every 1000 under the age of 18, which was equal to the national average but above that of comparable counties (5 to every 1,000). Bedfordshire also spent more on the care of children than comparable authorities largely through the recruitment of social workers involved in preventive care and residential social workers in children's homes. Yet the expenditure per child in residential care until recently was below the national average, suggesting perhaps low expenditure on buildings and maintenance.

2.8 Over the last decade the national profile of children in care has shown a marked drop in numbers and an increasing proportion of children placed in foster care. This is reflected in the Bedfordshire statistics, partly due to the drop in the total number of children as a proportion of the population, but also due to the success of measures to support vulnerable families in the community. The County has introduced a number of innovative schemes to divert young people from delinquent paths and a number of family support programmes. The national scene, again reflected by Bedfordshire, has been for the average age of children in care to rise and thus present a serious challenge to the traditional residential homes by introducing more teenagers damaged and disturbed to the system.

2.9 The Children Act 1989 was greeted with enthusiasm by the Bedfordshire Committee and the Director. A Review of the Children's Services was published in 1990 which set out a blueprint for these services over the next

decade, including a model of residential care more appropriate to the new challenges and philosophies.

2.10 Finally, both the County Council and the Trades Unions suggest that employer/employee relationships over this period of change have been largely good, this despite the fact that some of the mechanisms for consultation were inappropriate in this case. This makes it more surprising therefore that events around Oxendon engendered such bitter animosity between the Oxendon staff and supporters and the Council. This bitterness was no more apparent than in the war of words conducted in the media, and it is said that truth is the first casualty of war. Unfortunately misleading statements were made in the course of these events, undoubtedly unintentionally, which fuelled mistrust. This mistrust affected the manner in which decisions were made and carried out, and contributed to the need for an independent Inquiry. We sincerely hope that not only our report, but also the manner in which we have conducted our Inquiry, will help to heal these rifts and restore to normality the excellent services provided by the County for its vulnerable children.

III. OXENDON HOUSE

Historical Background

3.1 Leighton Buzzard is a small town with a mixed economy, a population of 32,600, a full range of educational facilities for children and young people, but limited job prospects for school leavers. The town is 20 miles from Bedford and there is some feeling that it is distant both geographically and in the thoughts of the decision makers in County Hall. The northern part of the town gives an impression of affluence with well tended estates and a number of large properties in spacious grounds. In 1963 the County Council opened a Home, with Remand Home status, for 12 boys in an adapted House to meet the needs of a growing population of children in care. Six years later an extension was completed which increased the number of residents to 24 - all boys. The limited education was provided on the site and relationships with the community were reputed to be good.

3.2 The implementation of the Children and Young Persons Act 1969 brought a change in policy and practice. With the reduction in the number of young people, especially boys, being sent to Community Homes with Education (until 1969 called Approved Schools) the County Council had to make more provision available within its own resources. It did this in two ways - buying places in voluntary Homes or other local authority Homes, and by creating more places of its own. Vital to the success of this policy was the requirement to assess the needs of each individual child and in 1973 Oxendon at the request of the Children's Regional Planning Committee became a Regional Assessment Centre for boys. This work was badly disrupted when the building was destroyed by fire in 1974 but the important task was transferred temporarily to a vacant house unit at Carlton House Community Home with Education on the premises. Obviously the number of places was reduced during this time to 18 boys.

3.3 The remains of the old building were knocked down apart from a few outhouses and a purpose built Observation and Assessment Centre erected on the same site, opening in October 1978. The concept had changed in the light of new thinking and the Home was designed to accommodate 30 children of both sexes in House Units. It had its own schoolrooms and teaching staff. The children were not expected to stay long in the Home but after assessment, normally six to twelve weeks, be quickly moved on to permanent Homes or foster homes. However, the practice did not always keep pace with theory and very difficult children stayed much longer than anticipated. There was a strong demand in the Region for specialist accommodation to contain difficult children and those with unstoppable tendencies to abscond. A six bedded secure unit, (to serve the whole region) was opened in 1981 attached to Oxendon and managed as part of its operations.

3.4 To the surprise of some, but the delight of everyone involved, the Children and Young Persons Act began to work and fewer children were being received into care, and many fewer placed in Community Homes with Education on the premises. Mr Clifton, the Director of Social Services at the time had a background in Child Care and saw the opportunity to create a facility which could offer remedial help to children with the most severe behavioural difficulties. These young people were disruptive in ordinary residential homes, impossible to place in foster care, and needed a high concentration of staff time to educate and care. Although relatively small in number these children caused an immense amount of pressure within the child care system of the County, and considerable expenditure if they went "out county".

3.5 The Social Services Committee approved Mr Clifton's plans and in September 1983 Oxendon was designated as a long term treatment unit, with education on the premises, still with 30 places, and still with the Secure Unit attached. There was a strong commitment by the Social Services Committee to make a success of this venture and evidence of this was seen in the unusually high staffing establishment, a feature maintained at Oxendon throughout its existence.

The Secure Unit

3.6 The Secure Unit was an integrated part of the Oxendon operations for nine years. It operated under special rules governing the care and control of the young people who were only placed there after Orders made by the Courts or in some other particular circumstances. A panel was required consisting of Councillors and independent persons who visited every month, sometimes more frequently, to inspect the circumstances in which the young people were being held, and listening to any complaints by them.

3.7 The Secure Unit was also subject to inspection by the Social Services Inspectorate. Three such inspections took place during its existence and detailed reports submitted to the County Council. These reports will be dealt with in detail later but at this stage it is sufficient to point out that the first two reports in 1986 and 1987 were largely favourable. However the report of 1989 severely criticised many aspects of the work and brought about the decision to close the Secure Unit.

Oxendon House 1989 to 1993

3.8 For a period of time in the late 1980s and until 1991 Oxendon took managerial responsibility for the Children's Home in Oakwood Avenue, Dunstable. This was regarded as another unit of Oxendon. The numbers at Oxendon were reduced to 21 children when Oakwood Avenue again became autonomous, but the staff levels were maintained as for 30 children. All witnesses confirmed that Oxendon was regarded as the establishment which catered for the most difficult children requiring residential care in Bedfordshire. The Home was represented by a Senior Member of staff at the County-wide allocation meeting and was seen to take the young people who were rejected by other establishments, or were found to be beyond the control of other Homes. Some witnesses told us that they thought Oxendon staff seemed particularly interested in offering care for children who had suffered abuse, whilst the Oxendon staff pointed out that a very high proportion of children allocated to them had suffered abuse at some stage of their previous life.

3.9 During the 1980s and early 1990s, there is no doubt that Oxendon built up a remarkable reputation as a residential establishment for containing and helping young people with acute behavioural problems. Mr Clifton, before he retired, took a close personal interest in its work and many witnesses told us that it was regarded as a centre of excellence. We became accustomed to witnesses from a variety of backgrounds describing Oxendon as "The Jewel in the Crown".

3.10 Yet is clear from the evidence of other witnesses that some doubts began to creep in. Witnesses told us that they felt there was a degree of arrogance at Oxendon, that they were elite, above the rest of the residential Homes. Oxendon was unwelcoming to visitors, did not like their work to be closely examined, were not willing to take training, and that some of their practices needed reviewing. It was described by some as having a 'macho' regime, proud of the fact that it coped with the most difficult young people.

3.11 Mr Tim Hulbert, who holds a Diploma in Social Administration and trained in Community Development at the National Institute of Social Work Training, is a Director very much in the mould required of today's complex managerial challenges. On his appointment he faced the task of implementing changes to enable "Care in the Community" to be put into place. He is not a social worker by training as was his predecessor, but he assured us that his restructured department in 1993 placed a qualified social worker of considerable experience in direct control of residential care. However, this meant that Mr Hulbert was more dependent on the professionalism of his middle managers to supervise Oxendon. As he has pointed out to us his personal involvement with Oxendon might have been less than his predecessor, but his interest and concern was no less. Ms Youngson took up her appointment as Assistant Director in charge of residential care on 14th June, 1993 and following an incident which raised her anxieties she began to sense some of the concerns that were growing around Oxendon.

Oxendon House - the Building

3.12 The premises stand in a pleasantly landscaped site in the midst of an exclusive residential area. They comprise a main building with a separate school block and other buildings that were once part of the original House. The living accommodation for the children is based in three separate units each of which leads off a central concourse, which in turn is connected to administrative, kitchen and laundry areas. Interviewing facilities are provided in the administrative area and there is a conference room which can be reached without passing through the living area. The central concourse doubles as a recreation area and has a modern high timbered ceiling but has a hard floor.

3.13 The individual units are based on an open plan concept in which the dining areas open onto the central concourse. Each unit has its own lounge area. Boys' bedrooms are on the ground floor (3 singles and one double) and the bedrooms for girls on the first floor (2 singles and one room for 3). There are no formal staff rooms as the staff are expected to be with the children when they are on duty. There is a staff sleeping -in flat next to the Conference Room. When the building was first designed the practice of staff living on the premises was falling into disrepute because of the extra pressure it put on staff and their families. However Oxendon was rebuilt with staff accommodation in several blocks within the grounds comprising 9 houses and flats. From the late 1980s these premises became vacant as staff responded to their own wish to own their own property, and as it became more difficult to attract people to live "on the job". Eventually all the property became vacant and we were told that it was only after much pressure from the Oxendon staff that some of this accommodation was made available for preparing children for independent living.

3.14 The Secure Unit is approached from a door outside the main block. It comprises six secure rooms around a recreational area, with accommodation for a dining room, and staff sleeping. It is a cheerless and barren sight now it has been empty for five years but we can appreciate how difficult it must have been to create a homely and caring atmosphere. There appear to be no plans, or resources, to use this block for any constructive purpose, but occasionally it had been used for Anger Counselling and storage.

Critique of the Oxendon Premises

3.15 Clearly we have only had the opportunity to visit the premises when they were empty, but we have also formed impressions from questioning witnesses who worked there, visited there, or are experts in the field of child care. We also heard the views of some of the residents.

3.16 Designed in the late 1970s they still reflected the type of residential care more familiar to those who remember the Approved School system or institutions catering for quite a large number of children. They were also designed to provide short term care for Observation and Assessment. The building has many institutional features which are difficult to overcome, for example:

- the large noisy, and somewhat bare central concourse;
- central kitchens which provide the food for each unit, and are unsafe to allow the children to enter and cook for themselves; or share in the events which often make a kitchen an informal centre of activity;
- dining areas which are lacking in homeliness and lead onto the main concourse, hence contributing to the "Kings Cross effect" of this area;
- the design of the living units is not compatible with the creation of a homely, cosy environment;
- the administrative entrance makes a formidable institutional welcome;
- there are few facilities for young people to be taught independent or personal skills in the units, i.e. cooking or personal laundry;
- the site is remote from the town and has no public recreational facilities nearby, hence creating a dependency on the institution. Yet the building is well maintained and clean; there are no signs of graffiti or vandalism.
- we were told the building felt cold inside, even in summer.

3.17 On our visits to Oxendon we were struck by the poor state of the decor, the lack of softening features such as wallpaper, stair carpets, or carpets that were of better than hard wearing industrial quality. We were assured by staff and residents that the walls had been covered with art done by the children, but there was little evidence of any more serious attempts to personalise the rather bare and painted walls. (We thought it was ironic that the only staircase that had a carpet lead to the Conference Room, and that this was the only public room with wallpaper).

3.18 At this stage of our report we make no attempt to apportion blame for this state of affairs except to say that the original design of the building was not conducive to creating a homely atmosphere that would enable the best therapeutic work to be carried out. Nor was the furnishing likely to create a comfortable feeling within the units; chairs and settees were more suitable to a public space than private living accommodation. Was this due to severe financial restraints within the county as some witnesses told us, or as other witnesses suggested was this because the staff felt the children would not value reasonable quality furnishing - an allegation vigorously denied by the staff? We were told by staff that in the past few years when they sought replacements they were only offered furniture and soft furnishings from Homes that had closed. Much of this, they alleged, was unsuitable.

IV. OXENDON HOUSE - The Staff and Management Supervision

4.1 Whilst the design, structure and siting of a residential Home is of great value it pales into insignificance beside the importance of having the right staff. Much has been written, which we do not intend to repeat, about the special personal qualities required to undertake residential work with children and young people. These qualities are not in themselves sufficient to perform the particularly demanding tasks of the staff group at Oxendon. They need:

- Enhanced personal skills
- Regular supervision and monitoring of performance
- Access to skilled advice and new methods
- Work within a well-managed setting
- Have clear objectives
- Be guided and firmly managed by the Social Services Department

4.2 We propose to examine how these requirements were met, but first it is worth reflecting on the remarkable stability of the internal management of Oxendon. Mr Eddie Jones was appointed Principal of Oxendon in December 1971, having previously been deputy. Mr Trevor Mead was appointed deputy in May 1972. These two men worked together for twenty years until Mr Jones became ill in April 1992. Mr Mead was then appointed Acting Principal, a post he continued to hold after the retirement of Mr Jones at the end of December 1992. Mr John Wallace was appointed in January 1983 as Deputy Principal with particular responsibilities for education. The Domestic Warden, Mrs Doris Jones had held this post since 1980 having previously been deputy. All of these senior staff had worked in other residential positions prior to Oxendon, and clearly comprised a management team of great experience.

4.3 We have carefully questioned the witnesses who gave evidence to us, and apart from one relatively minor incident, have been unable to discover formal or informal complaints made about the performance of this team by the management of the Social Services Department.

Organisation - Staffing Complement

4.4 On 30th September 1993 there were 51 staff on the payroll of Oxendon House. Not all of course were directly involved with the care of children, and there appeared to be clear demarcations between roles. Those directly involved with the care of the children were:-

The Principal and two deputies
Three housewardens
21 residential social workers
6 night staff

4.5 This group of staff were organised into three different work patterns. Firstly each child care unit had a team of residential social workers led by the Unit Leader, this meant 7 staff for 7 children. Each child had a key worker allocated from amongst this group of staff, and a key senior member of staff. Secondly, all the residential social workers apart from the night staff were organised on a shift basis to cover the period 7.30 a.m. to 10.30 p.m. and on a seven day basis. (Residential staff work 39 hours per week but do overtime when the needs of the children require it). The Housewardens are the people in charge of caring over the whole establishment during a shift, and are therefore also working on a shift basis. Thirdly, the Principal and his deputies had managerial and supervisory responsibilities which occupied most of their days; they also had the task of arranging and chairing family and case conferences representing Oxendon at allocation meetings, and on a rota basis were on call for any special emergencies out of the normal working hours. For example therefore at 7.00 p.m. in the evening there would be 4 care staff on duty in the building. There would be one Housewarden covering the whole establishment and one Senior Officer on call.

4.6 In addition to the Care staff there were:-

2 clerical assistants
2 cooks plus a vacancy
domestic staff with duties varying from cleaning to laundry work
1 caretaker

The domestic staff were organised under the guidance of Mrs Jones and were not expected to have a role in relation to the children.

4.7 The other vitally important group of staff with relationships with the children were the teachers. On 30th September, under the guidance of the Deputy Principal there were:-

1 senior teacher
5 teachers and one temporary appointment

Clearly their main duties reflected a typical school day. The teachers did not have duties in the evening or weekend and were not expected to be involved with the recreational pursuits outside the normal school curriculum.

Appointment of Staff

4.8 The responsibility for recruiting and appointing staff to Oxendon lay with the line manager. Over the years, as we shall see later, the structure of the department changed and the line manager was changed several times in 10 years. Those line managers, who regarded this duty as very important, and it was only one duty amongst a mass of responsibilities, took part in the selection process of key staff with diligence. The Principal would be left to make appointments amongst domestic staff without interference, but would be expected to involve the line manager on all others. At times the interview would be conducted by the senior staff who would seek approval for the appointment from the line manager.

Familial Relationships amongst the Staff

4.9 An unusual feature of the staffing situation at Oxendon was the large number of staff who were related to each other. At the time of closure there were 7 staff with relationships through marriage or family and one married to a former member of staff. This situation has caused much comment, partly we are told because such situations are against County Council policy. We have not been shown anything written which sets out this policy, but concur that generally there is much merit in such an approach. In their applications for posts candidates must declare if they are related to elected representatives or officers of the Council.

4.10 How did it come about that there are so many familial relationships? In the first place a number of the senior staff have been in the service since the 1960s when such situations were commonplace and indeed joint appointments of husband and wife were the norm. This is the case for Mrs Jones and her husband, the former Principal, Mr Eddie Jones. Probably the same circumstances apply to Mr and Mrs Mead but the remaining members of staff have no such history. Yet we were told by the Acting Principal and by successive line managers that all appointments were sanctioned by a manager. It is true that there are family traditions towards social work just as there are to teaching, medicine or the law and we were told that employment opportunities are not good in Leighton Buzzard so the opportunity for alternative jobs is poor. Equally there are problems in recruiting people for this type of arduous work and relatives are often the most suitable candidates applying.

4.11 If the Council believes that the employment of close relatives at the same work place is bad for sound working practices then it is the duty of the appropriate managers to ensure that this does not happen. We can only presume that this situation has occurred with the full knowledge of middle management, who ought to be aware of the Code of Professional Ethics produced by the British Association of Social Workers, which addresses this issue.

4.12 We asked many questions of both the staff and managers for examples where this feature became a problem. There were no clear examples quoted to us but an underlying suspicion that it was bad practice and added to a feeling that Oxendon was treated as something different and could act outside the normal rules.

Qualifications and Formal Training

4.13 It is a matter of great shame to our whole national system of Child Care that the number of staff who are formally qualified is such a small proportion of the total. Some studies suggest that only 16% of the total staff in residential care for children have relevant qualifications, and a significant proportion of these are, understandably, in senior positions. Bedfordshire has no advantages over other authorities in this matter; indeed the national picture seems to suggest that County Councils are at a slight disadvantage to cities in this respect. Despite national reports like Warner, and the report on standards in residential care led by Lady Wagner the increase in training places has taken place only slowly.

4.14 Bedfordshire clearly signalled its desire to have more qualified staff in the excellent Child Care Review produced in 1990 and adopted by the Committee as the blueprint for services over the next decade. Following the study the department undertook after the publication of the "Pindown Report" the Committee endorsed the objective of having all residential staff trained within five years. We strongly commend the intentions but are disappointed to find little progress so far to implement them. This study also recommended introducing staff appraisal, external monitoring of performance, and more external support for residential care.

4.15 On 30th September, 1993, we understand that there were a total of 12 staff qualified in child care working in residential settings for children throughout the county. Of these 6 were based at Oxendon. One of the staff who has recently obtained qualifications told us that he had been obliged to fund the training himself as the county did not have the resources available to help him. On 30th September 1993 there were 104 residential staff in Children's Homes in Bedfordshire. Eight of these were in some form of training. Seven of the twelve staff qualified were officers in charge or deputies.

4.16 There are three further points we would want to make on this issue:

a) Full time training is very costly to support; not only the salary and fees for the student have to be found but also the cost of replacement whilst the student is away. The drive by the County to improve the situation came at one of the most difficult times for local government finance.

b) Staff who have become qualified have not been content to stay in residential work, they have become fieldworkers and managers. This has had a negative effect on the training programme and also contributed to the unfortunate view that residential work is of lower status than fieldwork.

c) Whilst the managers who have had line responsibility for supervising Oxendon over the years have had social work qualifications, few can add to this by having experienced residential work in depth.

Staff Supervision (Internal)

4.17 A very structured system of staff supervision was established early in the 1970s, and with few alterations continued until the closure. We were given evidence to support the view that this system was well managed and appreciated by the staff. Responses to the interviewers for the aborted Review of Practice in August/September 1993 implied the staff felt supported professionally and personally. Some doubts about the degree of personal support offered in these supervisory sessions were suggested by some witnesses who felt that counselling through personal crises was carried too far.

4.18 However, there is no doubt that supervision was organised, regular, and attended to practice, administrative, and personal issues. It was an undoubted Oxendon strength. We felt reassured that in the two years before closure Dr James Atherton was involved in advising the Oxendon management. His authoritative book on Supervision was a basis for the management to use their structure as effectively as possible. We are left with one major anxiety, who was supervising the supervisors?

4.19 The system ran as follows:

a) Every member of the Residential Care Staff was supervised by someone senior to themselves. Supervisory sessions took place fortnightly. This concentrated on personal performance, administration and personal matters.

b) Key workers were supervised by Key Senior Workers on casework with the children. This seemed to be organised on an ad hoc basis.

c) Each house unit had a weekly meeting of all available staff, held on a Wednesday, and chaired by a Housewarden or Senior member of staff. This covered issues related to individual children, child care practice, organisation of the unit and educational or recreational issues.

d) There was a monthly meeting of all staff in the Conference Room. We were told that as well as management and administrative matters, practice issues were discussed regularly.

V. OXENDON HOUSE - The Child Care Practices

5.1 Each child at Oxendon was the centre of a caring network. Living in one of the three "house units" the child had a key worker drawn from amongst the unit staff. This key worker was the consistent figure offering care and concern to the child and the one person that the child was expected to turn to with any problems or requests. The key worker had the particular responsibility for adding extra sensitivity to the relationships between adult and child, and to spend time fostering this with the child in a way which built, through affection and trust, a relationship which healed past wounds and prepared for future challenges. The key worker must be confidante and a friend, advocate, intermediary and the link between the child and his field social worker, and the child and his family.

5.2 The role of the key worker is not without conflict. The child who has suffered rejection from a caring adult will test and test again, the relationship which the care worker tries to foster. The child will make demands for attention, sometimes desperately, which compete with the worker's other relationships. The child may seek love yet rebuff attempts to give him affection, and illogically be angry and hurtful to the person trying hardest to help him. The key worker has patiently to create trust and demonstrate that this relationship will survive the testing, yet also make it clear that anti-social behaviour is not acceptable. There is a very delicate balance for the key worker to achieve between understanding the causes of bad behaviour and taking a firm line to control it.

5.3 The staff at Oxendon were very conscious that many of the children placed in their care had suffered the abuse of indifference from their parents. Parental indifference is manifested in many ways, but one of the most difficult for children to understand is parental indifference to bad behaviour or lack of control. This often leads a child to further aggression, violence, self destructive behaviour, or to depression and withdrawal. The key worker has to recognise and compensate for the indifference whilst endeavouring to build self control into the child's patterns of behaviour. When self control does not work the child must learn to expect that there will be a penalty to pay for bad behaviour.

5.4 Oxendon also appointed two other key workers known to the child. Firstly there was a key teacher responsible for liaising with the care staff and overseeing the educational programme for the child, including preparing for any further education that may be required on departure. Secondly there was a Senior Key Worker appointed to support the others through supervision and to act as a point of complaint or appeal by the child.

5.5 The staff worked on a shift system as has already been pointed out, so it was inevitable that key workers would not be present throughout all the daily routine, and of course staff had holidays and other tasks which took them away from the children in their unit. This required excellent communication systems to ensure that information was passed between staff at appropriate handover times, and that records were kept of events significant in the lives of each child and each unit of children. Each unit kept a Day Book in which events were recorded, and staff were expected to arrive early for their shifts to give themselves time to read these and any other communications.

5.6 It is inevitable that sanctions against poor behaviour sometimes need to be applied. It was clear from our questioning of the Oxendon staff that informal methods were preferred, and used first wherever possible. They felt punishments should be rapid in response and above all appear to be just. The measures approved and used most frequently were curtailment of leisure activities, imposing domestic chores, extra school work, increased supervision, and "grounding". We found no evidence that disciplinary measures prohibited by the Department of Health were used. Until 1991 the interview rooms were used occasionally to exclude a child up to a maximum of 48 hours. This practice stopped by the intervention of the Director when it came to the attention of the Assistant Director, Mr Jeremy Ambache through a report from a social worker. Since that time the interview rooms have only been used to contain children for short periods of time, and always in the presence of staff.

5.7 In our discussions with children about discipline, and in the interviews conducted during the Review of Practice in August and September 1993 there were no serious complaints about discipline. Some children admitted in retrospect that they needed punishment and they thought the punishment appropriate. Some complained that it was too frequent, and some too hard. We did not feel that any complaints required further investigation.

5.8 Health care in a Home like Oxendon is most important, particularly as many of the children have not had consistent health care in the frequent moves they have suffered previously. Apparently an excellent relationship existed with a local GP practice which we were told was very pro-active in the pursuit of good health amongst the children. Dr S Watkins gave evidence to the Inquiry and struck us as a doctor with real concern for her young patients at Oxendon. She would not, we surmised, tolerate poor practice amongst the staff. She would keep a wary eye for signs of ill treatment from any source and would refer patients on to consultants where appropriate. She was sometimes frustrated at the slowness of the child guidance services to respond, this not being their fault but due to a lack of resources. She also deeply regretted that Dr Frances Milne, who had been consultant psychiatrist to Oxendon had not been replaced when she retired in 1986.

5.9 The educational facilities were well resourced in terms of skilled and experienced teachers. They had established an informal liaison with the Education Department for advice, and had been the subject of inspection by H.M.I. when the secure unit was visited. They were able to tailor their work to the needs of individual children and we heard evidence of remarkable progress made by some. They endeavoured to provide a combination of remedial teaching with the normal curriculum range. The H.M.I. complemented their work and we were impressed by the evidence of their organised teaching practices.

5.10 Witnesses from amongst the staff and social workers told us of the efforts to maintain contacts between a child and his family. There were no set visiting times although visiting during schooltime was frowned upon. Parents visited the children either in an interviewing room or in the child's unit as appropriate. Regular family conferences were held in which the parents met with the staff of Oxendon, the field social worker, and the child. These were recorded and kept as part of the Child's Plan. When children went home on leave it should always have been part of the Child's Plan agreed with the field social worker; we found no evidence to suggest that the practice was not strictly adhered to.

5.11 There were regular visits from field social workers to children on their case loads resident in Oxendon. We also heard that Oxendon "chased up" social workers to visit children. We spoke to a number of social workers. Some said they found visiting Oxendon easy and pleasant, and they usually met the child in the unit. Sometimes they would take the child out for a pizza or hamburger to make an opportunity to talk to the child alone. They met no resistance to these trips. Other social workers gave evidence to us to suggest that they found Oxendon unwelcoming, they rarely got past the administrative corridor, and mostly saw their child in one of the interviewing rooms. Councillor Mrs Roden reported to the Social Services Committee on 2nd November that her experience on a recent visit to Oxendon supported her view that the staff were reluctant to let visitors talk to the children. She refers to a particular incident which Mr John Wallace told us involved a child with difficult problems on that day. It is difficult to evaluate these differing opinions. It might be suggested that the more confident social worker insisted on seeing the child in his living place, the less confident found the entrance to Oxendon forbidding and unwelcoming. There is a strong contrast between Oxendon and other Homes where stepping inside the door brings you straight to the living areas. Whatever the truth the atmosphere of unfriendliness felt by some people added to the belief that Oxendon was insular and unwelcoming to outsiders.

5.12 Some child care practices at Oxendon need particular attention, as they have been the cause of concern, but in this report we do not intend to deal with the everyday run of activities as these differed little from those of any institution of this kind. Those that have attracted our attention are:

5.13 Restraint of children - without doubt some of the children resident at Oxendon displayed behaviour which was aggressive to others and sometimes a danger to themselves. Sometimes such behaviour has been threatening or disturbing to other children, and sometimes damaging to the building and furniture.

We were given evidence of children who caused serious injury to themselves (i.e. cutting their wrists or face), attacked or bullied other children, broke furniture, televisions , and were violent towards staff. On one occasion 3 children who had been glue sniffing indulged in an episode of uncontrollable violence breaking 32 windows and causing other damage. We are also aware of assaults on staff resulting in injuries, occasionally serious.

5.14 Such behaviour requires a response from the staff:

a) to protect other people;
b) to protect the child concerned and;
c) to protect staff;
d) to avoid serious damage to property

In our discussions with the staff they were at pains to point out that physical restraint of children was only used when every other method had been tried.

5.15 For example: a child behaving violently would firstly be talked to on the spot hoping that reason and a calm approach would prevail. The communication skills of the staff, particularly those of talking and listening, would often be successful and most incidents were, according to the staff, satisfactorily dealt with in this way.

Secondly, other children might be discreetly moved out of the area of the disturbed child, to reduce the risk to children and the risk of further provocation.

Thirdly, the child would be taken somewhere away from others to "cool down". Often this would simply be another room in the unit or classroom block but sometimes the child would be taken to one of the side rooms or interview rooms in the administration area.

Fourthly, the staff might put their arms around the child to offer protection and security - but not unless the child agreed or asked.

Fifthly, the staff might put their arms around the child without consent to control and restrain and introduce calmness into a violent situation.

Finally, the staff may have to resort to holding the child firmly, often forcing the child into a sitting or lying position on the floor until the child calms down. This may also be accompanied by removal to the interview room.

5.16 In accordance with procedures every incident of violence and restraint at Oxendon was recorded, was discussed with the senior staff, and the child counselled about the event afterwards. Details of violence and restraint were sent at monthly intervals to the Line Managers of Oxendon. Copies of Incident Reports were also sent to the field social worker of each child. Oxendon appeared to have been meticulous in its application of restraint procedures.

5.17 In 1991 ***THE CHILDREN ACT 1989 GUIDANCE AND REGULATIONS, RESIDENTIAL CARE,*** it says:

Good Order and Discipline:

1.83 "Physical Restraint should be used rarely and only to prevent a child harming himself or others or damaging property. Force should not be used for any other purpose, nor simply to secure compliance with staff instructions. Homes should have a particularly clear policy on how and when restraint may be used. Training should be provided and managers should regularly and formally monitor staff awareness of the rules governing this aspect of their duties. Where children in homes have suffered particularly damaging experiences and have difficulty in developing self control or good personal relationships which diminish the need for physical restraint it is important that sufficient able staff are employed to ensure that the children are dealt with sensitively and with dignity".

5.18 This was not one of the Department of Health's most helpful documents. It left many areas of handling aggression and violence vague and uncertain in a child care population of increased complexity. The Department acted quickly by producing another piece of advice in 1993.

5.19 In December 1992 Bedfordshire Social Services Department issued **POLICY STATEMENT AND PRACTICE GUIDELINES FOR THE PREVENTION AND MANAGEMENT OF VIOLENCE**. The document is comprehensive and sets out preventative methods, methods of dealing with violence, counselling, recording and monitoring. Some extracts are worth highlighting as they have particular significance to events at Oxendon.

Bedfordshire Social Services Department accepts its responsibilities for the safety of its staff who, in the course of their work, engage in activities where acts or threats of violence may occur. As a result, the Department is fully committed to reducing the risk to staff by:-

1) issuing clear policies and procedures;
2) introducing preventive, protective and supportive measures;
3) assisting staff deal with the effects of violence.

"The Department is aware that staff dealing with violent incidents or with potentially violent clients, in certain situations, may be subject to complaints about their conduct. Management will investigate complaints, without prejudgement, based on the policy and practice guidelines."

"Violence must always be dealt with promptly and sensitively"
"Record all incidents. This is the way to build up an accurate picture of what is actually happening."

"All incidents of violence must be reported by staff to the Line Manager. Line Managers have a responsibility for ensuring the report "Confidential Staff Report on Violence" is completed and a copy sent to the Area Manager and Personnel Manager."

"The Department will provide a range of training opportunities to provide staff with the skills to alert them to potentially violent situations, the causes and the preventive measures".

"It is normally expected that anyone who assaults a member of staff or damages property should face up to the consequences of their actions and be subject to the due processes of the law".

5.20 It is our view that this is a helpful document published by the Department to enable all staff in vulnerable situations to work within a clear policy and with practical guidelines. Its implementation however is dependent on training and monitoring by management. We questioned the management and staff of Oxendon closely on their understanding of this document and its philosophy. We are satisfied that there was sound understanding of the policies and practice, but apart from induction training, there appeared to be a shortage of "in depth training" in this field. It is worth adding that this document was the culmination of previous policy statements issued before December 1992, of which Mr Eddie Jones was a key participant author.

5.21 In April 1993 the Department of Health published **GUIDANCE ON PERMISSIBLE FORMS OF CONTROL IN CHILDREN'S RESIDENTIAL CARE.**

This document was produced recognising that children placed in children's residential homes have tended to be older and more severely disturbed than their predecessors. The new document recognised that the Guidance and Regulations issued under the Children Act mentioned above did not go far enough. They did not offer enough positive advice about the control of often volatile children, and there was increasing concern that the government may have gone too far in stressing the rights of children at the expense of upholding the rights of parents and professionals supervising them. The whole document is of value to professional residential staff but we reproduce Section Five in its entirety in Appendix Four

5.22 In summary, we are aware that Oxendon cared for a lot of children who had a history of aggressive behaviour and violence before admission, and therefore methods of restraint would, at times, be necessary when all other preventive means failed. Advice and Guidance was available from the Department of Health and from Social Services. Induction training was provided at Oxendon and some by the Department. Incidents were recorded on appropriate forms and passed to line managers and field social workers.

5.23 There appears to be no lack of understanding that Oxendon had a lot of problems; indeed a joint report by the Chief Constable and the Director of Social Services on 5th March, 1992 to the Social Services Committee and Police Committee referred to this issue: extracts are printed below

"Recent concerns have been expressed from a number of sources, including local residents and the Police at the behaviour of young people living in residential establishments. These include the frequency of absconding, offending and challenging behaviour within establishments.

There are also concerns within the Social Services Department at staff's ability to deal with testing, violent and anti-social behaviour.

The incidence of problematic behaviour

Figures from Oxendon House and Houghton Lodge show that the number of young people involved in violent incidents or in absconding, has remained relatively constant on a month by month basis for sometime. There are however considerable variations in the total number of such incidents which is due to one or two children being responsible for a high number of incidents in a particular month.

Car theft by Oxendon residents during 1991 was similarly due to a small number of residents offending repeatedly. Now that these individuals have left Oxendon the problem has returned to normal proportions.

Houghton Lodge and Oxendon House have traditionally taken the young people most likely to show the most problematic behaviour. A relatively new phenomenon is the increase in absconding and disruptive behaviour at other establishments such as the Barns and Holmefield.

The number of Bedfordshire children in residential care has fallen from 148 to 108 over the past year. One consequence of this is that residential establishments are dealing with a greater concentration of young people who display difficult behaviour. It is agreed that increased use of secure accommodation is not a solution, partly because of the shortage and cost of such places, but also because they only provide a means of "containment" for short periods without any real long term improvement in behaviour of young people. In a few cases secure accommodation is used to provide young people at extreme risk with a short term placement. The development of a 12 place secure unit is planned at Oxendon House by 1994.

The strong public and Department of Health reaction to the Staffordshire "Pindown" report whilst drawing attention to the difficult issue of what sanctions may be applied to young people in care who demonstrate unacceptable behaviour, has so far done little to assist Social Services to deal with these problems. Moreover staff are left with few options in controlling behaviour".

5.24 The records kept by the Oxendon management show that 204 incidents of violence were reported in the course of 21 months. Of that number some 150 involved restraint. Both the Police in their report to the Child Protection Strategy Group and Mrs Kahan later referred to this number as a matter of concern, but we have been unable to trace any means of judging this figure against comparable statistics. Neither the Department of Health, the Bedfordshire Social Services Department, the Trades Unions, the Police or other experts have brought any comparable data against which we can reach a judgement.

It is very important to recognise however that a high proportion of these violent incidents and the subsequent restraint can be attributed to seven children, five boys and two girls. They account for two thirds of all incidents in 21 months and their history shows violence prior to admission to Oxendon, and in two cases after discharge. We are also aware that some incidents occurred which were not the subject of recorded Incident Forms. Fifteen of the incidents involved the Police assisting the staff or investigating allegations of violence.