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.

Physical Contact between Children and Staff

5.25 Many children who are admitted to residential care have had poor or disturbing physical relationships with adults. This often inhibits their natural maturing process, and creates difficulties in their relationships with both other children and those adults who are caring for them. It is therefore both helpful and natural for the staff of a Home to create an atmosphere where normal physical contacts can be developed subject to certain safeguards. These contacts might include cuddling children, putting arms around them in a friendly fashion, occasional goodnight kisses on the cheek, and a certain amount of "horseplay" between boys and staff. The safeguards must be fully understood by all the staff involved; no physical contacts should occur without the full consent of the child and preferably initiated by the child. No physical contacts should occur that may cause embarrassment to the child, either in the company of others or alone. Contacts between male staff and female children should avoid the erogenous zones touching, and similar advice should ensure that female staff do not cause sexual feelings to be aroused in boys. Indeed all male/female and female/male contacts between staff and children must be very carefully handled.

We recognise, as have previous reports and guidelines, that physical contact is a difficult area to advise on and a difficult area to control. Sometimes staff are faced with demands for contact which are difficult to refuse, children will leap onto their backs, throw their arms around the neck or waist of staff, or initiate "horseplay" to attract individual attention. To immediately rebuff the child can cause emotional pain, and may lose the opportunity to strengthen the relationship. The staff must judge whether the contact is appropriate and suitable for the moment and the child, not always easy in the heat of the occasion.

5.26 It is also important that staff protect themselves from being involved in occasions which might be interpreted as abusive. For example physical contact should only be with the consent of the child. Staff and children should not be alone when contact takes place. Staff should not be drawn into physical contacts which might have a sexual interpretation.

5.27 Oxendon staff worked within a regime which encouraged "good" physical contacts between staff and children. In their evidence to us the staff expressed strongly the view that so many of the residents had bad experiences, particularly from sexual abuse, it was important to respond by offering healthy contacts. Several witnesses said that some of the girls needed reassurance that men could touch them without wanting to touch their breasts. We learned therefore that cuddling children was regularly used, and that children would often sit on the laps of staff. It was usual for some children to receive a "good-night kiss" on the cheek, often when they were in bed or before going to bed. The staff assured us that they would not cuddle or kiss children without their clear agreement, and that there were some children who did not want such attention. Often, we were told, the children would chose to sit on the laps of staff by their own initiative. It was common for the teenage girls to sit on the laps of the male staff and embrace, especially on meeting. Formal counselling sessions would often conclude with a cuddle, we were told, to reassure the child after a difficult time.

5.28 We questioned not only the care staff but also the managers about the policy towards physical contact. Mr Mead (Acting Principal) felt very secure in the policy, which he argued was vital to an institution which was attempting to work in a therapeutic way towards damaged children. He said that physical contact depended on creating trust and that the adult should take the responsibility of showing trust first. He recognised dangers to the staff but felt that the firm supervision structure enabled senior staff to control the situation. Mr Jones (Past Principal) equally supported the policy but was a little more cautious about the need to keep a tight control to protect the staff. Mr Bob Paine (Acting Deputy Principal) was very much in favour of showing trust in the child when cuddling them, and offering real affection through physical contact. He usually finished his counselling sessions with children, mainly girls, with a cuddle.

5.29 Other witnesses volunteered some anxiety about the physical contacts displayed at Oxendon. Mrs McNamara, (Acting Principal) said she felt very disturbed by the amount of touching between staff and children, and particularly was concerned to see the teenage girls sitting on the laps of male staff. Ms Sarah McLinden expressed surprise and worry about an occasion when she saw a number of the children respond physically to staff including sitting on laps. Ms Youngson was worried by the amount and quality of contact and several social workers were concerned. SSD 1 was anxious that the relationship between male staff and female children was too tactile.

5.30 Mrs Kahan pointed out that a certain amount of the right contact was undoubtedly beneficial to the child, but she expressed her concerns firmly about the male/female touching, and emphasised the need to be especially careful with adolescent children.

5.31 Another feature of the physical contact policy was a form of "horseplay" between the male staff and male children called PLAYFIGHTING. Again we questioned the staff and the Managers of the home quite extensively about playfighting. This was not an organised activity but a spontaneous response to a situation where the child sought physical activity which brought rough play between him and a member of staff. Sometimes this occurred in the house units or the gymnasium, but more often playing football or in the grounds.

Staff claimed it was a way to release tension in the child, or simply to use up an excess of energy. It was known to the children and staff as "playfighting", but perhaps it would not have attracted so much attention had the word "fighting" not been part of the description.

5.32 Finally in seeking evidence about the policies concerning physical contact we talked to a number of children, viewed the videos made by the Police when interviewing children, and read statements from children. There were some children who did not like close physical contacts with staff and said so! Some children liked these contacts and encouraged them. Those who did not want contact, and wished to preserve their essential privacy, claimed that they could refuse contact and this would be respected. We found no evidence that physical contact was forced upon children. However particularly in the case of Playfighting there was evidence that staff had carried the contact too far. A witness talking to the Police on video claimed he was nearly strangled by a member of staff on one occasion, and due to the lack of oxygen "had the best buzz of his life".

5.33 In summary we found from the evidence presented to us that at Oxendon there was a clear policy towards creating close physical contacts with children as an aid to forming sound personal relationships. The policy grew over a period of time and was not something presented to the department for approval on a particular date. As far as we can ascertain the policy has been practised for at least ten years, and has been open for inspection or approval by anyone who was interested. As with many other things, the management of Oxendon were not trying to hide this practice, indeed they were proud of the relationships they created with difficult children. The management believed that there was no danger in this as it was controlled by a structure of supervision. Yet there was evidence which suggested that some of the practices may have contradicted the advice on handling relationships between staff and children of the opposite sex. Many people were worried about this style of care at Oxendon, but few seemed to take action.

Massage

5.34 A particular form of physical contact practised at Oxendon has excited much interest because of one incident and because of the public perception of the practice - massage. We have explored this subject in depth and heard the views of managers, experts, staff who practised massage and those who received it.

5.35 The first thing we just state is that the "massage" practised at Oxendon was not massage in the true definition used by trained masseurs today. The evidence given to us from those who gave "massage" and those who received it make it clear that usually only the neck, shoulders and upper back were gently rubbed, very occasionally the feet but no other parts of the body were touched. It was often carried out when the child was fully clothed, and sometimes as part of the "settling down process", when the child was in bed. Not all of the staff carried out "massage" and it was only given to a child on the specific request of the child. Only one member of staff had received training to give massage, and she also gave the girls beauty classes and training in applying make-up.

5.36 It was not easy to determine when "massage" was first used at Oxendon, Nobody could remember a point at which it became one of the accepted practices. It became apparent that "massage" was helpful in settling children down, especially in an evening and bedtime, and is also another acceptable means of making physical contact between the child and an adult. The practice was not very extensive in that only a few children would receive "massage" each evening - sometimes none at all. Most of the children liked "massage" but we heard of a few who refused it, and it was not forced on them. Many of the staff would not give massage, simply because they did not like to do so and the management did not insist.

5.37 The fact that Oxendon practised "massage" on the children was certainly known to line managers by 1990. Massage in the full sense of the word was and still is practised in other County Council residential and day care homes but not in children's homes. The incident on 31st May 1993 which caused the practice to be reviewed across the Social Services Department was a breach of common sense, not a sensational piece of illegal practice as suggested in some media comments. The Review of Massage is a good step to ensuring that the use of massage is controlled to protect both the client and the worker. When it is further refined this document can form the basis of good practice thus enabling a valuable therapeutic tool to be properly used for the benefit of all Social Services users.

5.38 In summary, like a number of things at Oxendon, the practice was not accurately described by the rather grand title; this was not massage but "neck rubbing". It was not likely to be harmful even when practised by unskilled hands, but could be helpful and restful to excitable and restless children. It should only be used in carefully controlled situations, and only at the request or agreement of the child. Neck rubbing should never be given to a child of the opposite sex alone in his room, or when the response of the child is unpredictable. Neck rubbing in these circumstances could suggest to an adolescent child an opportunity to carry the relationship beyond accepted bounds.

Counselling

5.39 Vital in the treatment of any child who has been damaged is the opportunity to talk about events in his past life, and his feelings about the present. The availability of trained skilled therapists to undertake this task is limited, and counselling by untrained staff can be in itself damaging. We examined therefore, with great care, the work which was undertaken at Oxendon under the description of Counselling. We approached the evidence presented to us with some scepticism as we have learned that, as in the case of massage, titles at Oxendon do not necessarily accurately describe the function.

5.40 Residential social workers must be good listeners. All children like to talk about their experiences. For the children at Oxendon talking releases tensions and fears about the past and present and enables them to come to terms with these events and face the future. Residential workers cannot, and should not, deflect the wish of the child to talk simply because they are not trained counsellors. They must listen and respond when the child is ready and needs to talk. They must respond with great care, sensitive to the danger of releasing feelings which they cannot interpret, and offering understanding which they cannot support. It is vital for residential workers to know when they have reached the limits of their skills and how they should seek the help of skilled therapists to counsel the child.

5.41 Should formal counselling be undertaken in a residential setting like Oxendon, it should take place only within clear guidelines, be conducted by trained counsellors, and supervised by people qualified to do so.

5.42 Until 1986 Oxendon had the benefit of the advice and services of Dr Frances Milne. She was a child psychiatrist of many years experience, a skilled communicator and respected for her work with both children and staff. It would appear that she exercised discreet control over the sensitive work with difficult children, and referred those children with problems that could not, or should not be handled by the staff to the Child Guidance Clinic. She directly advised staff and gave overall guidance to the managers. Her retirement was a particular blow to Oxendon as despite considerable efforts by Mr Clifton a replacement could not be obtained. Mr Eddie Jones told us that Oxendon felt exposed by her departure.

5.43 We cannot ascertain exactly when the staff at Oxendon started counselling in the manner we shall describe, except that it was some time after Dr Milne retired. Probably like many other practices it developed gradually in response to the vacuum left by Dr Milne and because we were told that it took a long time to get appointments at the Child Guidance Clinic. By February 1989 when Mr Eddie Jones wrote a memo to Mr D Law (Assistant Director Operations) setting out the work of Oxendon, and summarising the staff support for dealing with difficult behaviour he includes individual counselling by the key worker as one of the tools for supporting children. About this time Mr Jones, to his credit, determined a set of guidelines for counselling, and these have been the structure followed for at least four years.

5.44 Oxendon defined counselling by structure rather than by skills. Counselling sessions were offered to children, and only in <u>one</u> circumstance were they obligatory. In their evidence to us the staff who undertook counselling assured us that it only took place when the child has specifically asked for it. This rather begs the question as to how the children found out about counselling, and whether in the description of the practice any pressure was put on them to try it. Children also confirmed that counselling was at their request, but we were left with a feeling of some anxiety that the intention to give the child choice was sometimes subsumed in a pattern of counselling sessions from which escape was difficult. Another child told us that he wanted to stop counselling and did so without contradictory pressure from the Counsellor.

5.45 Counselling was conducted in a session set up by appointment; in a private place; undisturbed; and recorded by the counsellor. Draft notes of each session were discussed and agreed with the child before they were sent to be typed. We understand that alterations were sometimes made at the request of the child. The typed notes of each counselling session were then sent to the field social worker of the child and a copy was placed on the child's file at Oxendon. Therefore from the time this procedure was introduced a large number of field social workers, and perhaps senior social workers, knew that the practice was used at Oxendon to help the child on their caseload. Indeed in evidence to us field social workers remarked on the fact that counselling was discussed at Case Conferences and family meetings.

5.46 There did not appear to be any set criteria as to which members of staff conducted counselling sessions. We already know that the number who were qualified in social work was only six, but qualifications in social work are not regarded as appropriate alone for formal counselling. The records of counselling show that it was undertaken by staff with no formal qualifications, nor indeed any in-service training in the subject. One member of staff had attended a short course provided by the Training Department which she felt equipped her for counselling. Not all care staff at Oxendon undertook counselling, but some seemed to spend a considerable part of their time in counselling sessions Mr Bob Paine, for example, was regarded by his colleagues as a skilled counsellor and embarked upon some lengthy patterns of counselling with some children. Mr Trevor Mead (Acting Principal) also counselled children, especially those who had suffered disturbing sexual experiences before being admitted to Oxendon.

5.47 It appeared that there was no structured process which linked a child wanting counselling to a particular counsellor. This resulted in children being counselled sometimes by staff who had routine care of him and on others by staff who had little regular contact. It would appear from the notes available to us that much of the counselling was undertaken by male members of staff, perhaps 70% of the total and that male staff frequently counselled girls and occasionally female staff counselled boys. We could find no evidence that children were offered alternative counsellors.

5.48 We have looked carefully at the structure of the counselling sessions, as set out in the notes. We find it difficult to discern a structure which would have clear objectives and points of review. We were worried that some of the vital issues raised by children did not seem, from the evidence of the notes, to be addressed in an appropriate manner.

5.49 In examining the content of the counselling sessions we could not avoid the conclusion that sexual abuse figured largely in the matters which were discussed. Counselling about events in the child's home was important, and relationships within Oxendon with peers and staff were regularly discussed. Past experiences were disclosed and feelings exposed for recognition and discussion.

5.50 Undoubtedly, in the regular staff meetings and in individual supervision sessions between senior staff and the care workers the issues around counselling were raised and discussed. In evidence to us it is clear that the managers and staff took the task of counselling very seriously, but did not have the advantage of their work being monitored by a trained therapist.

5.51 In summary the evidence presented to us displayed the staff of an institution coping with disturbed children, trying to find means of helping their charges come to terms with the awful experiences many suffered. We do not doubt the sincerity of the staff involved but the practice left us with so many worries that we sought the views of the National Children's Bureau. We asked them to examine a sample of counselling notes, evaluate the practice, and give us their expert opinion on value to the children involved. We review their report in our conclusions. We are, of course aware that there are now many criticisms aimed at the counselling practices at Oxendon. Again, as in other matters, Oxendon staff were quite open about their practice, and many people both knew and supported the work., indeed on one occasion a senior member of staff Mr Wes Cuell complimented Mr Bob Paine on his counselling with one child that resulted in the exposure and conviction of an abuser in another institution.

5.52 It is also easy to confuse counselling with the normal and accepted practice of staff having helpful private discussions with the children in their care. We felt however that the evidence presented to us by the staff themselves, and by the Social Services Management clearly described attempts at therapeutic counselling.

5.53 Another form of counselling used infrequently at Oxendon was known as Anger Counselling. This form of work is aimed at helping an individual learn to understand what causes uncontrollable anger outbursts in themselves, and to find the internal means of exercising control. It is a form of counselling becoming more popular in the treatment of young people in trouble, and training courses now exist to prepare staff to undertake this work. Bedfordshire Social Services Department paid for Staff 8 (Housewarden) to attend a course in London. The Director of Social Services said in evidence to us that he believed this course was to enable staff to cope with their own feelings of aggression, but Staff 8 believed it fitted him to undertake Anger Counselling at Oxendon. We have examined the prospectus of the course and believe it does both!

5.54 Staff 8 began Anger Counselling in 1992. He structured his sessions according to his training, and normally undertook them in the company of another member of staff. They were held in a room in the unused Secure Unit, and appropriate equipment was available. We have heard evidence from staff and children about these sessions, and have viewed a video prepared by Staff 8 of typical sessions. We have also taken the trouble to see an anger counselling session taking place in an institution in another local authority.

5.55 In summary, we believe Anger Counselling took place about fortnightly, only with children who wished to take part, and was seen by the counsellor as an opportunity to teach self restraint in a relatively pleasing and invigorating manner. It differs little from the accepted technique of taking children into the gym or onto the play area to work out their aggressions in a vigorous game, except it was aimed to help those children who had severe problems of self control or found mixing with other children a problem.

VI. SUPERVISION OF OXENDON HOUSE BY THE SOCIAL SERVICES DEPARTMENT

6.1 Supervision is vital to both the performance and control of a large residential establishment. Until the re-organisation in 1993 this supervision was undertaken in a traditional Social Services fashion - through a hierarchical structure from the Director down to the area manager who had to day to day operational responsibility.

6.2 Mr Hulbert, as we have already noted, was less inclined than his predecessor to be closely involved in the operations of Oxendon. He visited the Home several times, the number is in dispute as some say he visited only once and the Visitors Book is far from accurate. We accept his version of his visits, but far more important is the question of whether he kept himself informed of the activities of Oxendon and whether he was kept informed by others! The evidence presented to us suggests that he was well aware of the objectives of Oxendon and of the difficulties experienced with the children. The Child Care Strategy of 1991 set out a role for Oxendon implicitly and his joint report with the Chief Constable highlighted the control problems of Homes like Oxendon and Houghton Lodge (later closed). The working party on the Department's response to Pindown and again the documents on the training strategy emphasised the need to increase both the number of qualified staff and the number attending In-Service courses. Mr Hulbert was well informed on strategic issues but we found little evidence that he, or the Social Services Committee were kept informed of day to day operations. There were few regular reports to either, perhaps because Oxendon was regarded as so good at doing such a difficult task - the jewel in the crown. When the crisis of September 1993 broke Mr Hulbert was unaware of some of the practices at Oxendon, although they were well known to some of his senior staff. He was unaware of massage practices, one to one counselling, anger counselling, the policy on physical contact, and was surprised by the level of restraint used by staff to control the children. A Director of Social Services cannot be expected to be aware of detailed practices and events in each area of his wide responsibilities, but it is regrettable that his senior managers felt it unnecessary to inform him of the general picture of Oxendon. He must ultimately be responsible for the professional practice in his department and he cannot monitor or sanction what he does not know.

6.3 Until 1993 the residential and day care operations were headed by an Assistant Director, who was a member of the Departmental Management Team. It was his job to advise the Director and the Committee on policy issues and to ensure implementation through middle management. There were three holders of this post from 1988 through to 1993 when re-organisation created the Commissioner/Provider split and a new post of Assistant Director Direct Services was appointed. There is plenty of evidence to show that Mr Derek Law and Mr Jeremy Ambache took the task of managing a wide range of services very seriously, and were keen on their job, but understandably they delegated to the Area Manager the task of day to day supervision of establishments. Mr Wes Cuell held the post of Assistant Director, Operations, for only a brief period but was much more involved as Area Manager.

6.4 The key line manager was the Area Director and his assistant the Service Group Manager. From 1985 until 1993 Mr Wes Cuell held this post for two spells totalling over five years. Mr Terry Jones held the post from December 1990 to November 1992. They were responsible for ensuring that the Department's policy for Oxendon was carried out effectively, by supervising and advising the management of Oxendon, appointing staff, controlling the budget, supporting training and monitoring the admission and discharges of children. Implicit in these responsibilities was the task of monitoring, inspecting and approving the child care practices; indeed this might be regarded as the most important role. All the line managers were qualified social workers, though their direct experience in residential work was limited - this is not unusual in Social Services Departments. However, the training of these officers should enable them to determine the quality of care that they perceived, and certainly to distinguish between abusive practices and those which are acceptable.

6.5 From 1984 through to his retirement in April 1993 Mr Bryan Stonham was the Service Group Manager. He was replaced in the re-organisation by SSD 1.

An unusual feature of the relationship between the Line Managers and the managers of Oxendon was the salary imbalance. The Principal and Deputy of Oxendon were paid on protected salaries dating back to Approved School and Remand Home conditions. These salaries are very favourable compared with residential salaries today, and well above the rates paid to those who had responsibility to supervise them. At times the salary difference approached £5000 in favour of the Oxendon managers, and well above all the other residential homes. We have no evidence that this caused any personal problems between the Line Managers and Oxendon but again it contributed to the aura that Oxendon was something very special.

6.6 The two officers who had most contact between 1984 and 1993, Mr Cuell and his assistant Mr Stonham were regular visitors to Oxendon. Both took part in the staff meetings and were involved in the recruitment and appointment of staff. When the Secure Unit was operating Mr Cuell would visit weekly and as well as inspecting the conditions would take part in reviews of the children. Mr Cuell knew all the staff by name and had lots of contact with the field social workers who placed children at Oxendon. He found time to talk to many of the children and in his evidence to us said that complaints from children, or their social workers were rare, and usually around issues connected with their home rather than life at Oxendon. He was concerned at the problems of recruiting appropriate staff, particularly those who had training. Many new staff, he said, were either young people with little life experience or middle aged ladies with no formal training. This often meant that training courses were not very appropriate. He and Mr Stonham had anxieties as to whether the staff fully understood some of the practices they were undertaking, but both stressed that Oxendon was always up front about their work. Mr Cuell had urged Oxendon management to fully document violent incidents, and always record incidents requiring restraint. He believed that Oxendon did this more punctiliously and accurately than other establishments. Mr Cuell and Mr Stonham made a point of checking the records of restraint regularly, investigating through the staff any matters of concern, and sent records to County Hall. Mr Cuell and Mr Stonham in

their evidence told how they were satisfied that internal supervision of staff was regularly carried out. Everyone, Mr Cuell said, had access to one to one supervision and he believed this process to be supportive to the staff and protective to the children.

6.7 In their evidence to us, it is clear that the line managers felt that they were giving good support to Oxendon. Mr Cuell and Mr Stonham in particular spent some time visiting the house units as well as taking part in Management meetings. They had many other responsibilities, but probably Oxendon got more than its share of time. This was not the feeling of the managers at Oxendon. They said to us that they felt unsupported, isolated, and that there was little interest in Oxendon after the departure of Mr Clifton. They respected the efforts of Messrs Cuell, Stonham and Mr Terry Jones but the Department as a whole had little time for Oxendon. All agreed, the line managers and the Oxendon managers, that little information was seen in County Hall by either the Committee or the Director about their work and their problems. The line managers knew about the restraint policy and urged good records to be kept. The Service Group Managers knew about masage, and about the gradual growth of one to one counselling, but actually saw little of this in practice. Mr Cuell told us he was not aware of massage or counselling. Their anxieties, mentioned above, might have been greater had they done so! Our inquiries have not been able to find any structure or practice by which the line managers were expected to report to either the Director or Committee, hence perhaps the uncertainty within which certain practices grew without top management approval.

6.8 It is interesting to reflect on the evidence of some informed outsiders on the relationship between Oxendon and the Department management. The evidence of some social workers suggested that they and others were so relieved that the most difficult children were being contained that few questions were asked about the means. Dr Milne thought Oxendon was thriving up to her retirement but she criticised top management for indifference and failure to understand. Dr James Atherton, who advised the Oxendon management for two years up to 1993 decribed the relationship as "benign neglect".

6.9 In summary we found that there was a great willingness of middle managers to support the management at Oxendon. This to some degree compensated for the lack of contact with the senior managers at County Hall. However, the management supervision concentrated on administrative issues. A combination of factors meant that the supervision of day to day child care practices was superficial. Firstly, there was a belief that Oxendon knew best about these practices, perhaps contributed to by the Oxendon staff themselves. Secondly, the line managers were inexperienced in residential care and had heavy workloads in fieldwork, including the hazards of child abuse. Thirdly, the practices grew almost unnoticed over time, and fourthly, there was little input from outside consultants on child care matters.

VII. SUPPORT FOR OXENDON HOUSE FROM INDEPENDENT CONSULTANTS OR EXPERTS

7.1 An establishment charged with the difficult tasks given to Oxendon needs not only adequate supervision from the Department, but also the benefit of consultants to stimulate and monitor their practices. Such experts can be of inestimable value to advise on the management, training of staff, care practices and the treatment of individual children. Throughout its existence Oxendon has had the benefit of help from the Child Guidance Clinic in Luton for children referred by Dr Watkins, but inevitably there have been resource problems and appointments can take a long time to be arranged.

7.2 At an early stage Dr Frances Milne became involved with Oxendon. She was highly regarded by the staff who involved her in issues relating to management as well as consultation on the care of the children. Dr Milne devoted at least two sessions a week to Oxendon and had a profound influence on the way the supervision of staff and the child care practices developed. Not only in her evidence to us but also in the evidence of others it was clear that Dr Milne was committed to a high quality of care. She helped the staff work out a philosophy towards physical contact with children, and encouraged them to believe it was good to touch children at appropriate times in appropriate ways. Dr Milne is quoted in the evidence of staff to us as introducing them to the concept that children have a right to be controlled. She supported the development of the key worker system, and of one to one working to enable children to talk about their experiences.

7.3 Not all the evidence of the work of Dr Milne is uncritical. Some told us that she created too much dependency on her by the management, and others that she became more involved with the management issues than the treatment concerns for which she was appointed. Interesting evidence was given by us by Dr Harris-Hendriks consultant to South Bedfordshire Hospital Trust and an Honorary Consultant to the Royal Free Hospital . She outlined to us the skills which she believed a consultant psychiatrist could offer Oxendon:

- management and supervision of child care practice
- consultation and treatment of individual cases
- training of staff

In her view however psychiatrists should not be drawn into management and supervision roles. Dr Harris-Hendriks believed that there was a tension between the Social Services and the Health Authority after 1986 because Social Services wanted a replacement for Dr Milne to continue the support for management and supervision rather that for the treatment purposes for which a consultant psychiatrist is trained. It had been suggested to Dr Harris-Hendriks that Oxendon needed a psychiatrist to lend credibility to the operations; she would not collude with this. She was also surprised that, given the degree of difficulty presented by the children, the number referred to her for treatment was so small, only five in the past three years. However Dr Harris-Hendriks supports the philosophy founded at Oxendon by Dr Milne that children have the right to be contained and the right to be controlled through proper systems and restraint. She reminded us that children of thirteen and fourteen years often behave as children of four or five, and may need to do so! Yet at Oxendon the drive to provide an understanding and

therapeutic environment could well have created a system which overruled the rights of children.

7.4 A number of staff at Oxendon had learning experiences at Bedford College and met Dr James Atherton. He agreed to act as a consultant to the staff at Oxendon, and we understand that the expenses for this were borne from the training budget. Dr Atherton is a recognised expert in residential care, and as well as producing several authoritative books in social work he was a member of the Wagner Committee which made recommendations on the quality of residential care for all age groups. In his evidence to us Dr Atherton was very supportive of the staff, and he stressed the commitment of the management to supporting therapeutic work with children despite the burdens of serious disruptive behaviour. He confirmed our belief that the Home was very well managed internally in administrative terms and he added to the growing evidence that more training should be provided on an in-service basis to inexperienced staff. Dr Atherton frankly admitted that he saw very little of the day to day working in the Home, and that his consultancy was largely used to advise the managers. He did not witness the physical contact policy first hand, nor see the counselling notes. Had he had more knowledge of both practices we feel sure that his experience would have lead him to question them more, and perhaps his contribution to the Wagner Committee might have lead him to ask more searching questions about the physical structure of Oxendon.

7.5 In summary Oxendon was supported by two very knowledgeable experts, but we question whether they were used appropriately or to the best advantage. They seemed to be sidelined to management issues and were given little chance to use the questioning skills which might have offered a more valuable critical appraisal. They were used to support the very aspect of Oxendon which was probably most efficient. On the other hand witnesses argued that this was necessary to fill the vacuum left by the failure of the Department to support Oxendon.

VIII. SOCIAL SERVICES INSPECTORATE

8.1 A valuable source of independent views for our inquiries was drawn from the inspections carried out by the government controlled Social Services Inspectorate. They do not routinely inspect the residential homes of local authorities, a task which is left to the authorities themselves, but have a duty to report to the Secretary of State on Secure Care provisions. The Secretary of State issues approval for the operation of Secure Care Units at their advice. So three inspections of the Secure Unit at Oxendon took place in March 1986, July 1987 and February 1989. Whilst focusing on the Secure Unit their comments on the open unit and the style of management of the whole of Oxendon are interesting. They are summarised below:

8.2 **March 1986** This report covered both the Secure Unit and the Open Units. It was largely a complimentary report commenting on the successful transition from being an Observation and Assessment Unit to a long stay Home. "The caring atmosphere and purposeful ethos of the centre reflected the undoubted competence and ability of the centre's senior management group. Junior and middle-ranking staff's attitudes and actions denoted the existence of a secure and supportive framework. In turn children were experiencing a commendable quality of care, and forward planning to meet their needs was good in the main". It commented favourably on the stability of the management and on the pattern of supervision for the staff. The education programme was commended.

Criticisms were made about Oxendon, largely around the institutional features of the building. The Local Authority were asked to consider what steps could be taken to soften the atmosphere, particularly in the central concourse area, possibly with the introduction of suitable carpeting!

8.3 **July 1987** This report only studied the work carried out in the Secure Unit. Again it was largely complimentary but commented upon the inadequacy of certain design features in the secure unit asking the Local Authority to make proposals for upgrading; these were considered essential. The close working of the teachers with the Secure Unit is praised but the failure to find a replacement for Dr Milne is considered very unfortunate. It also made recommendations about records and the duty of the Local Authority to define methods of control.

8.4 **February 1989** The inspection was carried out by two SSI inspectors accompanied by a consultant psychiatrist and an HMI of schools. The report was very critical of the style of management of Oxendon stating "that appropriate management by the Area Manager is frustrated by a culture in Oxendon that resists any form of change and which resorts to "shroud waving" when faced with unpalatable facts or opinions. The Area Manager is in effect disabled from carrying out his role by the culture". The report went on to suggest that a management vacuum had been filled by the previous psychiatrist and that she had provided "information, support, supervision and direction that should properly have come through line management". The report supported the view that Mr Cuell the Area Manager was doing his best against resistance to change and that Dr Harris-Hendriks was correct in resisting the efforts of the Department to recruit her to do this job.

The report goes on to be very critical of the Review system, and particularly of the culture surrounding the methods of treatment, stating firmly that dependency on one method of treatment was not appropriate. There was also a very critical comment on the failure to invoke the Child Protection procedures in connection with a girl who had been raped prior to admission to Oxendon.

Finally, this report notes that despite being requested to do so, the Local Authority for various reasons, has failed to address the urgent need to prepare plans to improve the accommodation in the secure unit.

8.5 In summary we might conclude that there is some inconsistency in the reports from the Social Services Inspectorate. Is it conceivable that the quality of management so fulsomely praised in 1986 can have altered so drastically three years later, despite the fact that exactly the same personnel are involved? Can the methods of treating children be of commendable quality in 1986 and criticised for relying on one treatment method in 1989? Perhaps the standards expected by the Social Services Inspectorate changed or perhaps the later inspectors were addressing different issues and faced the reality of an establishment being overtaken by changes that were not easy to absorb. What is not in dispute is that the Local Authority had not acted upon the request to upgrade the accommodation, and therefore faced the prospect of closure of the Secure Unit. The Local Authority should also have taken seriously the criticisms of the management style, for whatever inconsistencies might have been apparent in the SSI reports, the suggestion that management supervision was "disabled" should raise alarms in senior staff. We believe this was a serious oversight on behalf of the Department.

PART II

ACCOUNT OF EVENTS AT OXENDON FROM MAY 1993 TO FEBRUARY 1994

IX MATTERS OF CONCERN

9.1. A major re-organisation of Bedfordshire County Council's Social Services department, including changes in senior management posts and senior managers, took effect on 1st May, 1993. As part of that re-organisation, Ms Mairi Youngson moved from a post with Suffolk Social Services to take up the newly created post of Assistant Director (Direct Services) with Bedfordshire. To fulfil the objectives of the re-organisation, part of her brief was to review the provision of services to the community.

9.2. She was appointed in March 1993. Her Suffolk appointment was subject to to termination on three months' notice and she started work in Bedfordshire on 14th June. She told us that before doing so, she visited and stayed at three different residential establishments in the County to gain understanding of the client viewpoint. One establishment she chose to visit was Oxendon. It was not chosen for any particular reason. She also spent five days familiarising herself with the Social Services Department.

A Visit to Oxendon

9.3. She visited Oxendon on 13th May and stayed overnight. She told us that she found the staff very open and welcoming. But she was surprised that Mr Trevor Mead, the Acting Principal, made no effort to meet her and she felt that Mr John Wallace, his Deputy (Education) seemed to keep a close eye on her. Mr Mead told us that he was off duty that evening and therefore Mr Wallace met her. Mr Mead said that he did meet her there the following morning but Ms Youngson does not recall this. Ms Youngson told us that she was told by staff during the evening that massage of the neck, shoulders and back of children took place and she was given a demonstration. She said that one of the night staff expressed concern to her about this practice. After the visit Ms Youngson mentioned her own unease to the Director. Other matters also concerned Ms Youngson. She said she did not find Oxendon House homely. In the absence of soft furnishings, the design of the building made it echoey and very noisy. She thought the environment was sparse and there were few home comforts such as posters, carpets and soft furnishings. During the evening she said she sensed an atmosphere of tension among the children and staff in the central recreation area of the Home. Towards the end of the evening a girl resident threw food and was restrained by staff. A boy resident attempted to pull staff from her and was himself restrained by two male staff who removed him from the area. Ms Youngson said that two male staff paced the area jangling keys from their waists in what she felt was a provocative manner. We were told by the Oxendon staff that there was a standing instruction to staff that keys were to be kept out of sight. Perhaps the action of the two staff was a direct response to the incident. Mr Wallace told us that he saw no key jangling

whilst he was present. The Housewardens told us they were the only ones with bunches of keys. Afterwards the atmosphere calmed down and everyone went to bed. Ms Youngson said that in contrast, at breakfast the following day, she witnessed absence of control of the children's behaviour. Food was thrown about and children threatened each other and MsYoungson. This produced no comment from staff. Oxendon staff told the Inquiry that they had found Ms Youngson very appreciative of their work and were surprised subsequently to learn that she had misgivings. We comment that this was a brief visit. We expect that when in July, instructions were issued banning the use of massage, Oxendon Staff would have reflected on what Ms Youngson saw during her visit.

The Massage Incident

9.4. On the 31st May, a serious indecent assault was committed by a teenage male Oxendon resident (Child A) upon a female member of staff (Staff 1). Staff 1 was the only senior member of staff on night duty and was responsible for the whole establishment, aided by two female night staff and with access to a Deputy Principal in event of emergency. Staff 1 had been on duty about nine hours when the actual incident took place.

9.5. The following account of the incident was provided by Staff 1 in December 1993. At the key moment she was the only adult present. The incident arose out of the massage practice. Child A was a highly disturbed youngster with a history of threatening behaviour, violent offending and sexual abuse. On the Sunday evening in question he had absconded with another boy. Both had returned about 10.45 p.m., after other children had settled in bed. They were very uncooperative on their return. Both began wandering around the building trying to unsettle the other children. Staff 1 called in the Deputy Principal and the four staff tried to settle the two youngsters. Both had been drinking but were not seriously drunk. It was after 2.00 a.m. before the boys finally went to their own rooms and to bed. Child A had a history of being difficult to settle at night. Whilst Staff 1 was outside Child A's closed bedroom door, Child A said he was now in bed and asked for a massage. The other staff on duty knew where she was. Staff 1 agreed because she expected he would become unsettled again if he was not relaxed. With the door open she gave him a brief neck rub while he lay on his stomach with blankets up to his armpits. She had often done this and it had worked with this child in the past. At this stage the bedroom light was on. She went to leave the room and, as far as she can now remember, turned off the light. He then called her back for a goodnight kiss. The practice was that this was given only at a youngster's request and on the cheek. The outside corridor and kitchen lights threw some light into the room leaving it in semi darkness. She went to him and leant over him to kiss his cheek and he pulled her forcibly towards him. The serious indecent assault then took place. She managed to get away and left the room quickly. She advised the Deputy on call what had happened. She decided to press police charges as the boy's behaviour had to be challenged if her colleagues were not to be put at risk in future. The following morning, the Deputy on call notified the police who arrested Child A and took statements. Child A was removed from Oxendon for 72 hours and an incident report was prepared by Staff 1 and the Deputy. The report was dated 4th June, 1993.

9.6 The above account differs in some respects from the account given in the incident report. The incident report states that Child A said he had drunk a bottle of whisky and his speech was slurred. The December account said that Staff 1 was aware that Child A had been drinking but he was very coherent and could hold a good conversation without slurring his speech, so Staff 1 doubted he had consumed much alcohol. The incident report states that Staff 1 went to give Child A his usual good night kiss. There was no explanation of what was meant by a goodnight kiss. The incident report states that Staff 1 went into Child A, as she normally did, and gave him a massage (massage of upper back and shoulders). Staff 1 told us that she meant it was her job to respond to the needs of young people during the night time. If a youngster asked for support, she would give appropriate support. It was part of her job. She did not just take a fancy to going into Child A's room. We point out that the reference to 'back' in the incident report is the only reference we have heard during the Inquiry regarding massage in the bedrooms but several witnesses referred to back massage of children in groups in communal areas.

9.7 Staff A complained that she received no support from senior management at County Hall who made no attempt to contact her and hear her story. She pointed out how stressful it was working with very difficult youngsters. She felt she was justified in dealing with Child A as she did and felt badly let down by the lack of support. The Director and Ms Youngson however had a very different perception of the incident. They thought the incident showed extraordinary lack of common sense on the part of Staff 1. In their view the massage had taken place in thoroughly inappropriate circumstances. The practice was causing risk to both residents and staff. Ms Youngson considered there was a lack of any degree of perception of the massage being potentially abusive of the boy or that it could place staff in difficult positions. However, we were told that the senior Oxendon staff in general, and Staff 1 in particular, were well aware of the dangers but considered the benefits bestowed by the massage justified its use. The boy had a history of sexual abuse and was known for not settling at bedtime. It was important to try and relax him and help him to sleep. In giving evidence to us Staff 1 did acknowledge that in retrospect she would not have given the boy a massage after he had had a drink. In the event Child A was not prosecuted despite Staff 1's wishes being supported by Oxendon management. This incident illustrates fundamental difference of approach between Oxendon staff and the senior social services management to the nature of appropriate physical contact of staff and children which appears again during this account of events. There is one other matter which we feel obliged to mention: both the Director and Ms Youngson referred to the provocative style of dress worn by Staff 1. The Director told us that this view was also held by other staff in the Social Services Department. He had not met Staff 1 personally. Mrs Mary McNamara told us that she was concerned about the dress code at Oxendon. She found that female staff would arrive for work wearing skin tight leggings. She felt this was inappropriate bearing in mind the client group. She acknowledged that this was the accepted style for many young people nowadays whether they were slim or fat. The Service Manager and Line Manager for Oxendon (SSD1) shared Mrs McNamara's concern about the dress code. There is no doubt that many Oxendon staff did adopt a young and casual style of dress. Staff 1 told us that for practical reasons

she wore trousers, jumper and strong shoes, never a skirt. She gave evidence to us at some length at the Inquiry along with three others. She was a young looking woman in her thirties of pleasing appearance who was a qualified teacher and social worker. She gave more than average attention to her appearance. Mrs McNamara said it was necessary to be comfortable in the work; she favoured trousers or jeans but not leggings. We comment that a young casual style seems to us to be perfectly acceptable. We believe that too much play was made upon this issue. But we accept the need to dress suitably for a male client group and maintain gender neutrality. Practicality should be the overriding factor.

9.8 Before turning to management action upon the "massage" incident, it is desirable to explain that, as a result of the re-organisation of the Department and pending the filling of new vacant posts, the Service Managers in the south of the County were largely unsupported at this time. The Divisional Manager North was endeavouring to cover both North and South. The Service Managers themselves were trying to settle into very different jobs. Ms Youngson had not yet arrived and there was no Divisional Manager (South) in post above the Service Managers. Mr Philip Morris became Divisional Manager South in mid-August but was absent from his post for much of the ensuing period. Although mentioned in several places in this report he played no significant part in the Oxendon affair. Effectively therefore Ms Youngson dealt with Oxendon without the benefit of a key support post in the south of the County.

9.9 On the 9th June, SSD 1 having consulted the Divisional Manager North visited Oxendon in connection with the massage incident and handed to the Senior Staff (in the absence of the Principal) a written instruction as an interim measure forbidding massage, kissing and cuddling by staff with children. This produced an immediate and very strong, angry reaction from staff. The following day the instruction was discussed further by the Divisional Manager North and SSD 1 with Mr Mead and other Oxendon staff. As a result, the instruction was amended so that only one to one massage by staff to children was prohibited. The Director told us that SSD1, in giving the instruction forbidding massage, kissing and cuddling had not carried out the wishes of the Director, passed down to SSD 1 via the Divisional Manager North, that massage was to be stopped. SSD 1's comment on that was that he did not know the Director was involved and had taken it upon himself to give an instruction to Oxendon. Before doing so he consulted the Divisional Manager North on the 9th June at the end of a regular weekly meeting between the Divisional Manager and all Service Managers in the County. He spoke to him briefly in the car park as they left the meeting and the Divisional Manager agreed the interim instruction which SSD 1 actually gave. He went to Oxendon the same afternoon with the instruction. We have not pursued the matter further. This episode again raised the issue of the nature of appropriate physical contact between staff and children.

9.10 On the day of her arrival, 14th June, Ms Youngson attended a Social Services Departmental Management Team meeting at which the massage incident on 31st May was discussed. The meeting endorsed her view that urgent action was needed to prevent further risks to children and staff. Accordingly, one of her first actions was to write a memorandum that day to all social services establishments introducing herself and raising the issue of massage therapy. The memorandum stated that the Department, before using massage in any social services facility, must be sure that it was appropriate, that staff were sufficiently trained and that clear practice guidelines were in place. The memorandum contained an instruction to cease massage pending a review of its use and set the brief for the review. The memorandum acknowledged that the instruction might be difficult for some recipients. Ms Youngson told us that massage therapy could be a considerable aid to relaxation and be helpful in residential surroundings although not usually with adolescent children. Careful training and understanding were required. The embargo extended to all social services establishments including homes for the elderly and day centres. The memorandum made no reference to the instructions a few days earlier regarding massage at Oxendon. We comment that the issuing of three different instructions to Oxendon on the subject of massage/physical contact in the course of a week did not demonstrate clear, consistent management. Unknowingly, however, SSD 1 had struck at the heart of Oxendon's philosophy and practice on physical contact. This accounted for the violent staff reaction, which Ms Youngson saw as unprofessional but the staff saw as a justified response to a fundamental restriction on their practice. Ms Youngson had made a firm start in her new job.

Restraint Incident - 29th June 1993

9.11 On 29th June an incident of restraint of a child occurred at Oxendon. The child (Child B), was a girl then aged 14 years who had been an Oxendon resident since 20th April, 1993. In accordance with Oxendon's standard practice the incident was recorded in various reports prepared by staff at the time. We have examined the following reports:-

a) An incident and evaluation report completed by Staff 2.

b) An employee assault form and incident and evaluation report completed by Staff 3.

c) An incident and evaluation report completed by Staff 4.

d) The daily record sheet for Child B.

The following account is drawn almost entirely from these reports.

9.12 To assist the reader in following the account of the restraint:-

- Staff 2 was a residential social worker who initially helped to calm Child B and later assisted in the restraint.

- Staff 3 was the senior residential social worker who restrained Child B.

- Staff 4 was Child B's key worker who attended Child B during most of the incident.

- Staff 5 was the teacher who excluded Child B from class.

- Staff 6 was a member of staff who merely witnessed the restraint.

9.13 On 29th June Child B was due to join the first morning period P.E. class and had been told to change into her track suit quickly. Because her unit staff did not realise she was due to have P.E. she took longer than she was allowed and the teacher, Staff 5, excluded her from the class. Child B felt the exclusion to be unfair. She was very angry and threatening towards Staff 5. Staff 4 and 2 intervened and took Child B back to her unit. Child B refused to stay in the unit kitchen or the side room and went into the lounge still very angry and threatening to hit Staff 5. She smashed a mug she had brought from the school block. She went up to her bedroom and was spoken to by Staff 4 and 2. She was still threatening Staff 5 saying staff would not always be around to protect her and she would hit her sooner or later, possibly when Child B was out with friends. Later whilst still in her room she was quieter. At the 10.00 a.m. break Staff 4 allowed Child B out into the grounds to relieve her tension and have a smoke. Staff 4 went off to discuss the exclusion with Mr Mead. Staff 3 not knowing that Child B had been allowed out, wanted her indoors as she should have been doing extra school work and brought her back to the building. We point out that Staff 3 was the husband of Staff 5. When Staff 4 returned, Child B was refusing to go back inside as she had been allowed a break. She became verbally aggressive to Staff 3. The situation escalated until Child B ran at Staff 3 pushing him twice in the chest. Staff 6 witnessed the incident. Staff 4 grabbed Child B from the rear by her arm and shirt collar. Staff 3 took hold of her around the neck and shoulders and walked her, whilst she struggled to the side room in the building. There she was held by Staff 3 and 2 who had just arrived. She struggled and did not respond to Staff 3's request that she sit down and remove her training shoes. Staff 3 and 2 lowered her to the ground and Staff 4 removed her trainers. She was held for about 5 minutes by Staff 3 and 2 in a half sitting position until calm enough for staff to let go. Staff 4 stayed in the side room with Child B and eventually she calmed down enough to go to her room and tidy up.

9.14 Later in the morning Staff 4, Child B, Staff 5 and 2, met in the side room to discuss at length what had occurred. Staff 5 explained that she could not accept threats and aggression but did accept that she had handled the exclusion badly. The unit staff took responsibility for not having reminded Child B about P.E. In future, the PE lesson would be recorded in the diary. For her part, Child B admitted that she had been aggressive but explained her reason - Staff 5 had made her feel stupid. Staff 5 then accepted her back into the P.E. class. Before the usual 4.15 p.m. meeting of children and staff, Staff 4 chatted to Child B who had done well to recover her sense of humour. They discussed the restraint. Originally Child B had felt inclined to bring in the Police but then wanted to talk to Staff 3 about how she had felt that morning. In the evening Child B's mother phoned and Child B asked Staff 4 to speak to her mother on the phone and explain the restraint. Staff 4 did so and then Child B gave her own version to her mother, saying that Staff 3 was too rough, had nearly strangled her and nobody even asked if she needed an ambulance. Later in the evening Child B filled out an official complaint form about the restraint and subsequently asked to see Mr Mead who dealt with the complaint. Mr Mead told us that Oxendon informed Child B's social worker, mother and solicitor accordingly. She admitted to smoking "pot" the night before and felt this might have affected her that morning. She agreed she needed restraining but not as Staff 3 had done it. She had declined the option of involving the police but had decided to make the complaint. We were told by Mr Mead during the course of the Inquiry that Child B decided she did not wish to take the matter further and the complaint form was signed off accordingly. Mr Mead said that he dealt with the complaint promptly although he could not remember exactly when. The incident and evaluation reports completed by Staff 2 and 4 stated there were no known injuries to young person or staff. The similar report completed by Staff 3 stated there were no injuries to staff but Child B claimed she had hurt her neck. The reports also refer to two other violent incidents involving Child B on 25th and 28th June, 1993. The various reports overlap considerably in their accounts of the restraint. The daily record sheet gives the most comprehensive account. Although the forms deal with the incident from differing viewpoints and are differently expressed, there are no significant inconsistencies between them.

9.15 During our Inquiry we interviewed the social worker (SW) from outside the County who was visiting Child B during and after her stay at Oxendon. She told us that she had arranged to take Child B out to tea on the afternoon of the 1st July i.e. two days after the restraint incident. She phoned Oxendon on the morning of 1st July and spoke to Child B's key worker. The key worker told her that Child B had been forcibly restrained two days previously and gave an account of the restraint. The key worker subsequently gave SW an Oxendon incident and evaluation report which she had prepared. SW told us that the report reflected the account she was given by telephone although it contained some additional details. SW told us that later on 1st July she met Child B and took her out to tea. They spent a couple of hours together. Child B told SW about the restraint and the account she gave tied in very closely with the key worker's account. Child B told SW that she had complained afterwards of feeling stiff about her neck and top half of her body. (She had an old injury there arising from a car accident). Child B asked SW to look for bruises which she did. The only bruise SW could see was a bruise on the underneath of her arm about the size of a 10p piece.

She couldn't see any bruises in the neck area. Child B said that perhaps bruising would show in a day or so. Child B's feeling about it at that stage was that the restraint had not been necessary and she would have calmed down if left longer. She said she felt angry and had made an official complaint. SW was aware of this. Child B felt happy that the complaint was going to be investigated. They discussed Child B returning to school and the need for her to cope with her anger. She accepted quite freely that she had a weakness of a violent temper, lost it very readily and needed to control it. Subsequently we sent to SW a copy of the incident and evaluation report prepared by the key worker and she confirmed that as far as she remembers the account in the report tallies with the account given on the telephone.

It should be borne in mind that the reports of this restraint incident were not known to the Social Services Senior Management until it was decided in September that Child B should be interviewed by the Police on 27th September and her file was obtained.

The Review of Massage

9.16 The massage review was commissioned rapidly and the review team was chaired by SSD 2, Service Manager, Northern Division. The team included a residential social worker and a resident child from Oxendon and Dr R Kathane, Consultant Child Psychiatrist, who acted as adviser to the Team. The residential social worker had attended at her own expense the basic beginners ten week course at the London School of Massage. She had been taught the techniques and practised massage at Oxendon. The team produced an initial report on 6th July. The report showed that massage therapy was widely practised in social services establishments. Generally, it was felt to have a positive value and, if management felt appropriate, should be reinstated as soon as possible. The report recommended that further work be undertaken to produce appropriate guidelines. No massage was practised in children's establishments. The review team considered that the term 'massage' should not be used to describe shoulder rubbing as carried out at Oxendon. They felt it appropriate that shoulder rubbing as an early evening recreational activity should be reinstated but again that a further report first would be needed to establish suitable controls. The team recommended that the embargo on late night shoulder rubbing should continue until a further review was completed.

We comment that we were left with the impression that the Social Services Senior Management did not really welcome the generally supportive conclusions reached by the massage review team. The team were advised by a consultant psychiatrist and their only real reservation was the need for proper guidelines and controls. The report contemplated the possibility that late night shoulder rubbing might be introduced.

9.17 Ms Youngson took the view that further consideration of the report's content was plainly needed. It did not go far enough to enable the production of any guidelines about the practice of massage. But she brought the findings to the Departmental Management Team as an interim report because of the seriousness of her concerns about massage with children and because Oxendon was the only children's establishment involved. The Departmental Management Team shared her concern and felt that some action about practice was needed.

9.18 The Director and Ms Youngson told us that during consideration of the review of massage, they became aware that a number of officers in the Department including SSD 2 had had for some time other concerns about child care practice at Oxendon. Staff were reluctant to commit anything to writing. They were worried that, if they made complaints, nothing would be done but that pressure might be exerted on them if Oxendon became aware of criticisms. Oxendon had been seen as a centre of child care excellence in Bedfordshire and departmental staff felt unable to complain or to challenge this perceived expertise. Other Senior Managers confirmed that the perception was common in the Department. The Director encouraged SSD 2 to put his views in writing.

9.19 He did so in a memorandum dated 14th July, 1993 to Ms Youngson. In it he considered in some detail the massage incident on the 31st May. He regarded massage at best as a method of calming and soothing that had much to commend it; at worst it appeared abusive, provocative and an extremely inappropriate experience in residential care. There were worrying issues about child/staff physical contact and also about the ethos of an establishment that could have allowed such behaviour to become part of its methodology and culture. In the memorandum he asked whether Staff 1 was aware that her behaviour could be viewed as abusive or whether she was carrying out the expectations of her seniors at Oxendon. If the former, what was the quality of staff supervision? If the latter, was it an example of systematic abuse albeit evolved out of poor practice rather than malicious intent? His concerns about the incident report from Oxendon included:-

a) The reference to a "usual good night kiss".

b) The appropriateness of rubbing a young man's shoulders at that time of night.

c) The description of a provocative and evocative situation.

d) That the young man was known to be violent and particularly violent to staff.

e) That he had been drinking and his inhibitions would have been lowered.

f) There was no acknowledgement that the member of staff had acted wrongly or mistakenly.

9.20 The memorandum added that SSD 2 and another member of the review team had spoken to Mr Mead about massage and raised some of SSD's concerns. Mr Mead felt that such shoulder rubbing was appropriate and that touch for young people was extremely important. Mr Mead was very open about the incident and very supportive to Staff 1, which led SSD 2 to believe that if there were a problem at Oxendon, it was systematic in nature, i.e. that it was built into the Home's organisation and practice. (Our explanation). Mr Mead had described Child B's behaviour as totally bad with no questions at all about the behaviour of Staff 1. The conversation left SSD 2 and his colleague not fully understanding Mr Mead's answers and feeling confused and concerned. SSD 2's detailed concerns were:-

a) Staff 1 was described as an experienced and good member of staff because she had been 13 years at Oxendon.

b) Mr Mead described situations where he sat on the beds of girls, to counsel them, often with the door closed and in the dark. He claimed to do this to show that he trusted them.

c) Mr Mead felt it appropriate to escort female residents in his car, often back from absconding, on his own. He was also prepared for his staff to do the same. This practice had stopped elsewhere in the County two years previously.

d) Mr Mead kept emphasising the importance of touch, particularly with abused children, using the phrase "we need to let these girls know that not every man who touches them wants to touch their breasts".

e) Mr Mead talked about the boys in terms of how to restrain them and how many staff it took to restrain particular boys.

f) Mr Mead confirmed that play-fighting happened between staff and children on a regular basis.

SSD 2 also expressed concern about a very strong statement by Child C, a boy resident at Oxendon, which SSD 2 learned of during the review of massage. Child C had stated he would rather be buggered than be at Oxendon. SSD 2 questioned whether this statement had been investigated as no explanation had been offered by Oxendon. Child C later made a statement to the police supportive of Oxendon. We acknowledge however that it would have influenced the Director and Ms Youngson at the time.

9.21 SSD 2 summed up his overall concerns about Oxendon as follows:-

a) The rights and dignity of young people in care were not being considered.

b) Was the treatment being offered to them actually taking place with their consent?

c) Could the young people object to their care and treatment whilst in care in a manner which addressed their objections (or did they just act aggressively and abscond)?

9.22 We interrupt the narrative briefly at this point to comment:-

a) SSD 2's memorandum is clearly significant in drawing to management's attention a wider range of concerns about staff/children relationships and physical contacts at Oxendon than emerged from the massage incident itself. But it did so from a limited knowledge base. The "usual goodnight kiss" did not prove significant. The memorandum made powerful criticisms of Oxendon practice on physical contact based on statements made by the Acting Principal. These weighed heavily with us and must have done so with Social Services senior management.

b) The Director and Ms Youngson had little prior knowledge of child care practice at Oxendon and were learning as they went along.

c) It was right that SSD 2 should mention Child C's comment but we do not think it is very significant. Unfortunately vulgar language at Oxendon was a commonplace and we see the statement as probably a throw-away remark. The later statement to the Police is more likely to reflect the boy's actual state of mind.

9.23 Youngson told us that she was very concerned about the overall content of SSD 2's memorandum. She felt it did seem to fit in with the general impression she had formed after her overnight stay. In the light of these matters and of the massage review, she decided that some further action was required. She discussed the situation with the Director. They agreed that a review of Oxendon working practices might be necessary and discussed the outline framework. She has stressed to us that at this stage she had not the slightest intention to introduce a process which would lead to the permanent or temporary closure of Oxendon. On the contrary she said she was concerned to put these matters to Mr Mead to test their validity and to give him a chance to put his viewpoint.

X REVIEW OF PRACTICE

An Important Interview

10.1 An interview was arranged at County Hall on 19th July between Mrs Youngon and Mr Mead with SSD 1 acting as notetaker. The Director was aware the meeting had been arranged. In our view this interview had major significance in the events culminating in the temporary closure of Oxendon.

10.2 Ms Youngson and Mr Mead have both struck us as strong personalities. Ms Youngson told us that her concern about Oxendon was such that she was contemplating the need to suspend Mr Mead from duty whilst an investigation was carried out into the various concerns which had emerged. She says she asked SSD 1 to set up the meeting as a formal interview, leading possibly to Mr Mead's suspension. As we describe later, this would have involved advising Mr Mead of the nature of the interview and of his right to be accompanied by a senior representative. She said that she told SSD 1 at length what the meeting was about and had gone through the areas she intended to discuss with Mr Mead. She asked SSD 1 to brief Mr Mead on the subject matter of the meeting. SSD 1's version of their discussion is radically different. He says that Ms Youngson spoke to him on 16th July and asked him to set up the meeting with Mr Mead. He says that he was told to advise Mr Mead simply that the meeting was about massage, to say no more and not to answer questions. At no time did she say that this was in any way a disciplinary matter or to set up the interview in accordance with the disciplinary procedures. He said he felt uncomfortable about not being able to tell Mr Mead why he was coming. This put him in a difficult position. He told us he conveyed the message to Mr Mead as he had been instructed by Ms Youngson.

10.3 Ms Youngson and Mr Mead therefore approached the interview with mutual misunderstanding of its purpose. Mr Mead was on annual leave and came specially into County Hall. He was unaccompanied. Ms Youngson said that she did not check out that he knew the reason for the interview; she was surprised he was not accompanied but did not question the position. She assumed that the meeting had been properly arranged. We comment that it would have been surprising therefore if the interview had proceeded smoothly. Mr Mead has told us that he did express his dissatisfaction part way through the meeting at the misleading information given to him regarding the purpose of the meeting. He assumed he was coming to a group meeting of officers in charge of establishments to discuss the subject of massage. Ms Youngson says that Mr Mead did not at any time express dissatisfaction. It is to the credit of both that despite misunderstanding as to the purpose of the meeting and later disagreement on what constituted good child care practice an agreed way forward was found.

10.4 Ms Youngson raised with Mr Mead many of the issues which had come to light. He said he supported the use of massage, including night massage in individual bedrooms on a one to one basis, because night was a difficult time for disturbed children and a neck rub was helpful to them. It was good for young people to have an experience of touch that did not lead to anything sexual. Child A responded well to women but would assault men. He would regularly ask for massage. On the 31st May, late night physical contact between a female staff member and a male adolescent had gone wrong but this was the first in hundreds of occasions. Mr Mead was happy with the way Staff 1 had dealt with the incident; hindsight was dangerous. He asked what staff could do when their tools were taken away. (This presumably was a reference to the earlier instructions to cease the use of massage). He saw no problem in being alone in a bedroom at night with a child. The child could refuse. There had only been one previous accusation and the member of staff then involved had left soon afterwards. Mr Mead saw no difficulty in being alone in a car with a young person on escort, of visiting alone ex-residents in their own homes, and of young people visiting his home. It was important that ex-residents maintained contact. He relied on mutual trust; but adults must trust first. There were no rules about children visiting staff in their homes. Young people needed this support. Some play-fighting was quite satisfactory. He said that the opinion of the children should be sought on the acceptability of these practices. On a different note, Mr Mead complained of lack of external management support to Oxendon.

10.5 Ms. Youngson told Mr Mead she was concerned about his style as Acting Principal, in particular, the way staff controlled the young people and the use of physical restraint. The response by managers at Oxendon to the ending of massage had been most unprofessional. Mr Mead replied that the senior staff had shown anger and this was healthy. Their outburst came from their commitment. Mr Mead explained the openness of the working at Oxendon. He had welcomed SSD 1 and their professional relationship was good. Ms Youngson said she was wanting to clarify whether Mr Mead was supporting/encouraging a way of working which could leave him open to charges of misconduct. She questioned whether young people were getting the quality of care they should have. She told us that she considered however that lack of outside help was a mitigating factor. Ms Youngson asked whether Mr Mead was prepared to work with her staff or did he want Oxendon to go its own way. She said she would like to have a full review of Oxendon. Mr Mead welcomed the suggestion. He said he was satisfied with the Oxendon way of working.

10.6 After an adjournment Ms Youngson informed Mr Mead that she was concerned how a review of Oxendon practice could be open, enabling staff to feel able to express their views. She told us that she had been advised by other Social Services Department staff that Oxendon staff would not talk openly if Mr Mead were still working at Oxendon and also that there was an autocratic style at Oxendon. She asked for Mr Mead's further cooperation, to enable the fullest review, by agreeing to work at another unit for the period of the review. She told him that as leader he was too influential and should stand back. Mr Mead agreed the proposal. That reflected favourably on him; particularly bearing in mind his understanding of why he had attended the interview in the first place. Ms Youngson stated that new working instructions needed to be issued for Oxendon. After some discussion and amendment Mr Mead accepted them as follows:-

a) No 'one to one' mixed gender work.

b) No staff in bedrooms with door shut.

c) Exclusions to be brief, dealt with quickly, and, if excluded to a bedroom, conversation with the young person to be conducted from the open doorway.

d) No massage therapy.

e) Escorts either upon returning absconders or on other escort duties to be conducted with a member of staff of the same gender as the young person or there should be two members of staff.

f) No visiting young people in their own independent living on a one to one basis. In pairs if part of the care plan.

g) No young person should visit staff in the member of staff's own home.

Ms Youngson said she would inform Mr Mead of the form of the review and of the unit to which he would be redeployed. He was asked not to communicate the details of their discussion to staff at Oxendon until staff had been advised. He was told not to visit Oxendon during the review and do nothing to inhibit the process. He was informed he had a vital role in explaining to staff why he was moving to another unit and why they should give their full help. The interview was concluded.

10.7 Ms Youngson and Mr Mead later disagreed about the notes of the meeting. Ms Youngson believed the notes were prepared for her own use and that Mr Mead was not promised a copy. She has told us she is not satisfied the notes were entirely accurate. Mr Mead believed he was promised a copy and was annoyed later when he was not given one. He said he produced his own version from memory about six weeks after the interview. He has provided us with this and, at our request, has produced a commentary on SSD1's version. SSD 1 is not clear that any decision was made at the meeting about the use of the notes he prepared. Mr Willy White, the UNISON Bedfordshire County Staff's Branch Organiser, told us that SSD 1 had told him during the review of Oxendon practice that a copy of the meeting notes had been promised to Mr Mead. That of course is not conclusive. We do not think the disagreement detracts significantly from our account of the interview given above.

10.8 We comment that the Ms Youngson/Mr Mead meeting was a key event, the only occasion on which Social Services management and Oxendon management came together and discussed child care practice. The meeting identified differences; an interim solution was imposed. It was not the occasion for full debate and attempted resolution of differences. We are very disturbed at the divergence in evidence about the setting up of the interview. SSD 1's version is corroborated by Mr Mead. We are aware of no reason why Mr Mead should favour him. Indeed his evidence contains some criticism of Oxendon practice. On the other hand SSD 1 does seem to have been pressured from both sides by two strong personalities. There are other occasions in this account of events where Ms Youngson says he failed to carry out her instructions. Clearly they did not relate well to each other. We could have understood a partial failure to set up a pre-disciplinary interview but a total failure makes no sense. We wonder whether Ms Youngson knew the procedures. We would have expected her to see and perhaps sign a letter to Mr Mead inviting him to the interview. We expect SSD 1 would know the procedure. It seems that one account or the other is a fabrication. Fortunately the interview did not break down as a result. We are left with grave concerns. What is clear to us is that Mr Mead should have had advance warning of the true nature of the interview. He was poorly treated. The episode must have given Mr Mead much food for thought.

10.9 The discussion of Oxendon practice revealed a gulf of difference on the issue of physical contact and the extent to which staff should put themselves at risk. Both must have been profoundly concerned for their different reasons. Mr Mead was open and not in the least apologetic. But we must question his right to adopt a high risk approach, particularly in a publicly funded establishment.

We think the move out of Mr Mead was a reasonable step to take although it was not absolutely essential. The new working instructions addressed the symptoms of concern but not (yet) the underlying causes. It has to be said that Mr Mead fulfilled the request to support the launch of the review.

We are much less concerned about the disagreement regarding the minutes, although it was a bone of contention between Mr Mead and Ms Youngson. It revealed again difference between Ms Youngson and SSD 1. However we obtained the various notes and put together this account.

Preparations for the Review of Oxendon Practice

10.10 The review of Oxendon practice was actually commissioned on 22nd July. It was described as a review of practice instituted because, as a result of the review of massage therapy, a number of matters had come to light which required further investigation. The review was to cover all aspects of the work undertaken at Oxendon and involved every member of staff and every child then at Oxendon, with access also to those persons who had worked or lived there in the past. A review team was set up, to begin work shortly. Interviews were to be arranged with staff and children. SSD1 had two meetings with the staff at Oxendon, on the 26th with the senior managers and on the 28th with the whole staff group. He informed the staff of the review and issued the new instructions laid down by Ms Youngson. Ms Youngson told us that she asked SSD 1 to make it clear to staff that the

review was intended to be part of a countywide review. (We refer to Ms Youngson's brief on her appointment). In evidence to us SSD 1 denied this but said he did tell the staff that the process could be extended to other residential units. This was his understanding of Ms Youngson's position. Mr White has told us that he was very clear that this was the start point of a review of all residential establishments across the County. He had doubts later however when he saw the review questionnaire forms which he regarded as specifically designed for Oxendon and not for a review across the County. We explain later that Ms Youngson denied this. Mr Mead attended the meetings with SSD 1 and encouraged staff to participate in the review. SSD 1 reported back to Ms Youngson that the meetings had been fairly acrimonious, in particular with regard to the new practice instructions. Mr White told us that the staff never accepted the logic of removing Mr Mead from Oxendon for the purposes of the review.

10.11 By way of comment we accept that all homes were to be reviewed, but it is clear that Oxendon was selected first for special reasons. We expect the brief would have developed differently but for the massage incident. SSD 1's visits to Oxendon to inform them of the review of practice was another occasion for difference with Ms Youngson. We draw attention to the staff acrimony regarding the new working instructions.

Bearing in mind Ms Youngson's concerns about Oxendon practice, we can see the advantage of asking Mr Mead to move out to facilitate the review. But it seems an unnecessary step from the point of view of keeping Oxendon running. The Home had two Deputies and three Housewardens. The senior staff could have coped adequately for a temporary period. We believe that an additional purpose of the job switch was to bring in an external influence and obtain an insight into Oxendon practice. The Department's difficulty in finding a suitable replacement emphasises the point. There is no doubt that the departure of Mr Mead made a great impression on the Oxendon staff. They became highly suspicious of the Social Services Department's intentions.

10.12 The detailed brief for the review of practice was settled on 26th July. The main objective of the review was to look further at the issues which had already been raised and to find out exactly what was going on at Oxendon. Three specific areas were to be given attention:-

a) The style of Oxendon and the expectations of users, staff, children and others.

b) Issues of gender, sexuality and physical contact.

c) Methods of working with children, their type, appropriateness and the training and support offered to staff, in these methods.

The review team were also instructed to examine what options were available to children to elect methods of treatment, whether there was the opportunity to refuse and whether channels were available to children and staff to object to any particular method. The review was mainly of the care practice rather than of the teaching .

10.13 Questionnaires were prepared for use by the review team in conducting the interviews, with separate forms for staff and children. A few interested people external to Oxendon were also to be interviewed. UNISON, who represented a large majority of the staff wrote to Ms Youngson on 4th August seeking union representation for their members at the interviews. Unfortunately, Ms Youngson had gone on annual leave. The letter was seen by the Deputy Director in her absence. He left a message with UNISON saying she was on leave but would reply on returning. We have seen no evidence that a reply was sent. The National Union of Teachers (NUT) raised the same issue in a letter to Ms Youngson dated 23rd August, the day the review team first went to Oxendon. They also expressed concern about the possibility of unfounded allegations being made against staff.

10.14 We comment that arrangements should have been made, in the absence of Ms Youngson, to deal with the UNISON request for representation. We are inclined to accept the view put to us that the review was rushed and the Team did not arrive fully prepared.

Oxendon in August/September

10.15 On 2nd August, Mrs Mary McNamara, the officer in charge of Westfield Road children's home, Dunstable moved to Oxendon as Acting Principal for the period of the review and Mr Mead moved to Westfield Road. Westfield Road is a long stay home for 6 children with a flat for senior independent living on the opposite side of the road.

SSD 1 has told us that although he was the immediate line manager of Mrs McNamara and he had known her for five or six years, Ms Youngson did not seek his opinion about the moves. He would not have recommended Mrs McNamara because her experience was of small units. He thought it was not a good decision. Placing Mr Mead at Westfield Road put him in an invidious position. He moved from the largest to the smallest children's home in the County.

In evidence to us Mr White questioned whether in considering the choice of Temporary Principal, Ms Youngson had considered using the former head of a substantial children's home which had closed. The Director's response was that Ms Youngson had looked at alternatives but there were few options. Other officers in charge had no deputy available, whereas Mrs McNamara had. The former head had been considered but was not thought the best option. The choice of Mrs McNamara was reasonable. SSD 1 had been consulted and thought Mrs McNamara a good choice. There is therefore yet another conflict of recollection between Ms Youngson and SSD 1.

Ms Youngson told us that Mrs McNamara had been given a holding brief which Ms Youngson did not change. But Mrs McNamara did implement County policy e.g. on smoking and independent living.

10.16 Mrs McNamara gave evidence to us about the way she was received on her arrival at Oxendon, about daily life there during the two months she was Acting Principal and about her impressions of the quality of child care. She arrived of course during the holiday period when no school education was taking place and she herself took a holiday whilst she was there. She told us that only seven or eight children were actually resident whilst she was at Oxendon, not the twenty one she had expected. She was told that some children were home on trial, one was living in a former staff house in the grounds and some were on home leave with foster parents. She travelled daily to Oxendon from Luton and saw very little of what occurred in the evenings. She told us that she had been given details of the review of practice. She said she had no brief to make significant changes but she was not just a figurehead

10.17 She told us that on arrival she had a friendly but discomfiting reception from Mr R Paine, the Acting Deputy; Mr J Wallace, Education Deputy was on leave. She said Mr Paine commented that she would feel out of her depth coming from a smaller establishment. They went through the daily routine of the establishment. She was given the Acting Principal's office and familiarised herself with the routine and staff rotas. She said that apart from three or four staff she had a very cold reception from both staff and children and felt extremely isolated having very little to do. She was a newcomer. She was not enabled to keep her finger on the pulse. She spent her time reading the children's files. Staff went to the two Deputies, not to her. The two Deputies kept in touch with Mr Mead; she felt he was still running Oxendon. Staff referred daily to the fact that Mr Mead would soon be back. She told us she thought they saw her as a plant. She was surprised to find that no outsiders had been past the entrance hall.

10.18 She told us she found the meal times unwelcoming and the dining rooms loud, rowdy and disorganised. She felt the staff should have been able to deal with this but they did not. She noticed that staff were able to smoke anywhere but children had to go outside the building. She described the system of meetings and said there were also "anger" meetings but she did not know what occurred. She said she regularly attended the senior staff meetings. At one they talked about their anger at the review and the replacement of Mr Mead. At another, each senior in turn expressed their distrust of her and her connection with Social Services Management. When she brought in her line manager Mr P Morris to explain her role they expressed their disapproval to any changes. Thereafter she found her working life at Oxendon difficult. After some weeks she raised with the two Deputies her concerns about meals, smoking, training of children for independent living and noise levels. The staff did not want change as they considered Oxendon worked satisfactorily. Overall she said she found Oxendon physically very cold and not at all homely and the atmosphere very institutional. She thought it was far too big and out-dated. The children did what they wanted and got away with it.

10.19 She told us that she felt uncomfortable about the nature and extent of physical contact between the children and staff, even though the children were willing. It appeared to be the norm. Mr Paine told her the young people needed to be touched because they had not received love and affection . She said she found some of Mr Paine's counselling notes upsetting. She said she found it difficult working with staff who were related to other members of staff. Dress code was another concern; we have raised that elsewhere. Mrs McNamara told us that whilst at Oxendon she only experienced one restraint; it was of a boy. She did not witness any assault but was surprised at the physical force used to effect the restraint. We have examined the chart of restraint incidents later prepared by the Police. It shows five incidents whilst she was Acting Principal. No doubt the others occurred during her absence. She told us that no report of the other four incidents was made to her.

Mrs McNamara told us that she was struck throughout her stay by the strength of the staff group. It seemed to her she had no chance of getting into the group. She told us that she reported back to her line manager on how she got on at Oxendon and was determined to discharge the job she had been given.

10.20 We raised with the senior Oxendon staff the main criticisms made by Mrs McNamara and received some vigorous denials from them. As regards her feeling isolated, Mr Wallace said that was understandable during the first few weeks but matters then improved. Mr Paine said he had told the staff he fully supported her. Mr Wallace said she was offered support and she said she valued it. They had helped her settle in and she had been involved in some meetings. Senior staff had communicated with Mr Mead to help him in running Westfield Road. The senior staff denied they were resistant to her new ideas. Meals in one unit were chaotic because one child was creating great difficulty. Meal times behaviour had been discussed with other staff and it had been intended to discuss it further with her. Staff had believed initially that she had not come with a brief to make changes. In response Mrs McNamara said she refused to be just a figure head. Both Deputies denied staff anxiety about the review of practice. There was some suspicion but staff had co-operated. Mr Paine said that he had expressed lack of trust of external management, not of Mrs McNamara but Mrs McNamara did not agree with this explanation. Mr Wallace believed that staff might have been unfriendly in the first week but not subsequently. Mrs McNamara accepted that. Mrs McNamara's suggestion about preparing children for independent living had been welcomed by staff and had been followed up, but Mrs McNamara had not been told. Some staff felt Mrs McNamara gave attention to social graces at the expense of tackling the causes of children's behaviour.

10.21 We comment that Mrs McNamara's reactions to Oxendon and the staff's reactions to her could hardly be unexpected and they seemed to find a way of co-existing in the short term. She found Oxendon very strange and they for their part had little need of her presence. This evidence is important for its description of Oxendon's life and ethos as seen by an outsider.

Review of Practice interviews

10.22 Following the summer holiday, the review team went to Oxendon on 23rd August to begin work on the review. The Oxendon staff have told us that the review team were unprepared and to start with the review was handled chaotically. Certainly they were unprepared for the staff response which was to refuse to be interviewed without union representation. It is clear that many staff were suspicious that the declared purpose of the review was not the true purpose and felt that the review was not being conducted in the right way. There was an entirely new management style. Several Bedfordshire children's establishments had been closed in recent years. Staff were deeply concerned by the temporary departure of Mr Mead, who had worked at Oxendon since 1972, and by his replacement by Mrs McNamara. They were not convinced his departure was voluntary. The senior Oxendon staff thought that Mrs McNamara's experience did not equip her to undertake the job of Acting Principal. The staff also raised the question of youngsters needing to have their social workers present when they were interviewed. The review team saw all the children on the 23rd August. Several Oxendon staff have said they were told by children that the children were instructed not to talk to the staff about the review. SSD 1 was not aware of any such instruction but said that at the interviews children were advised that the information given was confidential. Mrs McNamara told us that in fact a lot of the children who were interviewed did tell the staff about their interviews.

10.23 The initial reaction of the Director to the staff refusal was that there was no reasonable justification for union representation, as the review was only an audit of practice. Refusal to be interviewed could actually be considered as a disciplinary matter if he had thought fit but he wanted to be positive. Mr White told us that the Director was concerned that UNISON might block the review and also about maintenance of confidentiality. However negotiations took place the same day in four meetings between the Director, Ms Youngson and Mr White, at which it was agreed that Mr White would join the review team and participate in the interviews. The Director said that he had made the invitation. Mr White told us that he did not suggest that he wanted to be a team member; he felt that joining the team enabled the Director to exercise control over him. The Director told us Mr White did not express that concern to him.

10.24 However, it was agreed by Mr White that he would abide by the rules of confidentiality of personal social work information and would not be present at interviews of children without their consent. It was agreed by all concerned that in the event of circumstances being revealed that might lead to disciplinary action against the interviewee the interview would be stopped. It was also decided that if allegations of abuse were made, child protection procedures would be invoked and the review suspended. Mr White has told us that he was under the impression that the review was also prompted by the additional responsibilities placed upon the Department by the Children Act 1989 and the possibility of competition from the private sector. He has also expressed the view to us, having read during the Inquiry, SSD 1's notes of the meeting between Ms Youngson and Mr Mead on 19th July, that the review was a specific effort to get to the bottom of the Director's and Ms Youngson's concerns at what went on at Oxendon and not something that

would be used more generally. Ms Youngson on the other hand has said that the questionnaire was equally applicable to any other establishment. Ms Youngson wrote a letter to Oxendon staff on the 25th August explaining that Mr White had joined the review of practice, and that the review was not a disciplinary investigation.

10.25 Ms Youngson and the enlarged team met the Oxendon staff and youngsters on the 26th August. The staff had perceptions that the investigation was really an inquiry with a specific purpose rather than an open-ended review. The staff were given a further explanation of the review and Mr White urged the staff to give the fullest co-operation assuring them that he was satisfied with the arrangements that had been made. Thereafter the review was conducted harmoniously.

10.26 We comment that the start of the review was mismanaged. The history of previous events would have contributed to the staff's suspicions. We can understand that a statement to the children that the questionnaire information was confidential may have convinced children that they should not discuss the review with staff. The questionnaire results again provide a useful view of Oxendon activities, not an outsider's view but the views of the workforce and children rather than of management.

10.27 The interview process got under way on 27th August. Each interview was conducted by at least two members of the review team and sometimes by three. The team comprised SSD 1, Ms Hilary Eltringham (Commissioning Manager, Child Care), Mr John Graham (Care Manager, Children), Ms Sarah McLinden (Officer in Charge, George Beal House - an establishment for adults), Mr White and Ms Youngson. Ms Youngson took no part in the interviews. The questionnaires were not distributed to interviewees but were used by interviewers to give structure to the meetings. The contents of the completed forms were however checked with the interviewees. The interviews took place over a period of about 4 weeks. The team met regularly to exchange information and monitor progress. Nearly all the children and the staff were interviewed in that period. Several outside staff were also interviewed. Mr Mead was not interviewed. His interview date had been fixed but the appointment was overtaken by later events.

10.28 On 14th September, Mr Philip Morris, the new Divisional Manager South replaced SSD 1 as Line Manager of Oxendon. The change was made because SSD 1's role as a member of the review team was inconsistent with his continuation as Line Manager.

10.29 The interview results were interesting and varied. We have examined those completed questionnaires summarised by the police in October relating to all adults and seven of the children. They showed that a lot of physical contact took place between staff and children including cuddles, play-fighting, kissing on the cheek and massage as defined previously. There were also references to restraint of children. The extent of contact appeared generally acceptable to both staff and children. A number of staff expressed concerns or reservations at individual aspects of the care practice.

There was some acknowledgement that proper rules and guidelines were needed for physical contact. The management style and culture were generally accepted by staff at all levels. There was some criticism of the lack of external management input. Some staff referred to the frank outspoken atmosphere between staff and welcomed it. Senior staff, particularly Mr Mead, were well regarded. There was considerable staff anxiety about the review of practice and a widespread desire to see Mr Mead back. There was a very structured and full pattern of meetings in the running of Oxendon which made staff feel supported in their work. Staff supervision sessions included discussion of problems at home as well as at work; many staff mentioned this aspect but did not criticise it. There was a general feeling that more staff training should be undertaken and that training was underfunded. The questionnaires revealed a high degree of staff cohesiveness which is perhaps to be expected in a close knit and tightly managed institution.

The results of the children's interviews were more varied and individualistic. They were concerned about the impact of the daily regime upon them. They expressed likes and dislikes as regards individual staff. They generally accepted the extent of physical contact and recognised the need for exclusion and restraint to cope with difficult behaviour by children.

There is no doubt that the interviews provided useful material in understanding Oxendon and the quality of its child care. But they contained nothing of startling significance up to the 22nd September.

10.30 On the 22nd September, Mr Graham and Ms McLinden interviewed Child B, then aged 15, who had been involved in the restraint on 29th June. The interview lasted about 45 minutes. We describe the interview in some detail. Child B was highly critical of the style of care and relationships with staff. She said that certain staff made racist comments. As regards physical contact, she said the male staff were too tactile; they asked if they could hug her. Sometimes they would slap her on the behind in play; she would ask them to stop. Sometimes they would, sometimes they wouldn't. But she would allow one named member of staff to cuddle her and kiss her on the forehead. In answer to a standard question about how difficult behaviour was handled, she said that if she gave more than verbal abuse she would be restrained and it was not very nice. She said the staff goaded her. She described the 29th June restraint incident, being the only time she had been restrained. She did not specify the date: she said she had been given a minute by the P.E. teacher to change her track suit, had taken two minutes and was excluded from the class. She thought she was being "wound up" (goaded). She was given extra work. Shortly afterwards, her key worker gave her permission to go out for a smoke because she was distressed. A senior care worker (husband of the P.E. teacher) told her to return from the break. (It appears from Child B's subsequent interview with the police that he was not initially aware that she had been given permission to smoke.) When the key worker appeared and confirmed that Child B had been given permission, he rebuked the key worker. He pulled Child B towards an interview room putting his arm round her neck and her arm up her back. He brought her into the room and told her to sit down. She refused.

She said he kicked her behind her leg, just above the ankle which made her sit down. Another care worker kicked the other leg and the senior worker took her shoes off, just in case she ran off. Her key worker was also present. The senior tried to calm her down. She was bruised and swollen around both ankles. She showed the interviewers Mr Graham and Ms McLinden marks on her legs which she said were sustained during the restraint. She said she had filled in a complaint form but two to three months later nothing had happened. She also said that when taking her through the recreation hall to the interview room, her shirt had fallen open revealing her bra. She asked to be released to fasten her shirt but they refused. She said she had been ill treated. We interject at this point to say that this account of the restraint differed in important respects from the contemporary accounts given by the staff involved and Child B and corroborated by Child B's external social worker. But of course the two interviewers on the 22nd September were not aware of the history.

10.31 The interviewers concluded that the description they had received was of child abuse and the same day reported the statement to Ms Youngson. The same day, she checked to see whether Child B regularly made such allegations and informed the Director of the interview. The Director has told us he was struck by the fact that the incident described had simply been provided by the girl as an example of contact and that she had said she had complained but that the complaint had not been dealt with. Ms Youngson then consulted Mrs Stephanie Watson (Principal Officer, Child Protection) and Mr Richard Fountain (Commissioning Manager, South) for advice about the child protection procedures. She also obtained advice by telephone from the Social Services Inspectorate of the Department of Health. As a result the child protection procedures were invoked. We asked the Director, when giving evidence, whether the incident report forms and other records held at Oxendon had been checked to see whether they corresponded with the account given by Child B on 22nd September. He was not sure exactly when they were checked but stated that the police had obtained them before they interviewed Child B on the 27th September. He thought the incident report forms were of limited value.

10.32 We make the following comments on this restraint incident. Child B's account of her restraint given on 22nd September was felt to be an account of child abuse. That lead to a full police investigation and disciplinary proceedings and eventual decisions by the Crown Prosecution Service and Investigating Officer not to take any further action against the male staff involved. Different accounts were given on or shortly after the incident on 29th June. How significant were the differences? Should they have persuaded the Child Protection Strategy Group on 28th September to take a course of action different from the one actually pursued?

10.33 It was suggested to us that the contemporaneous incident reports were of little value. But together with the daily record sheet they give a full account. Three staff prepared reports and four were present at the incident. Two days later those reports were corroborated by SW and in effect by Child B. The restraint is described in more vivid terms by Child B than by Staff 2, 3 and 4. There is no reference in the June accounts to kicks above the ankles nor to any injury behind the legs although the incident reports provide a space for injuries to be recorded. There is reference in one incident report to Child B claiming she received a neck injury. Apart from that the incident reports refer to no known injuries. The 22nd September account says Child B was swollen and bruised around both ankles. The 27th September account (later) refers to a scraped and bleeding ankle. There were marks on both legs on 22nd September but their origin was uncertain. Child B said she had shown the bruise to her key worker 5 days after the restraint. We know the Police had the June reports at the 27th September interview but there is nothing in the evidence to indicate that the inconsistencies in the accounts regarding leg injuries were either appreciated or thought significant by the Social Services Department or by the Police. We can only conclude that they did not regard the inconsistencies as important. We tend to think that in her September accounts Child B embroidered her story and that the inconsistencies affect her credibility. Having expressed that reservation, we still think that the Child Protection Strategy Group were justified in proceeding with their investigation.

We disagree with the Director when he said he was struck by the fact that the incident described had simply been provided by the girl as an example of contact. She was responding to a standard question about how difficult behaviour was handled, if it occurred. It seems to us that the question was inviting information about restraint (among other things).

We agree with Mr White that it was unsurprising that there were some complaints bearing in mind the nature of the client group and the open invitation to comment.

XI CHILD PROTECTION PROCEDURES

11.1 At this point it is worth dwelling on the characteristics of child protection investigations and proceedings.

The Children Act 1989 provides a new framework for the care and protection of children. In any court proceedings determining any question with respect to the upbringing of a child the child's welfare shall be the court's paramount consideration. This principle of the paramountry of the child's welfare informs the guidance on the handling of child protection matters. The protection of the child and steps to ensure proper care come before the need to convict a perpetrator of abuse. Collecting and protecting evidence, if in conflict with the interests of the child, takes second place. However, there is no reason why action to protect and care for the child and to gather evidence should not take place in parallel if this principle is observed.

If abuse is suspected there are a number of possible outcomes. The abuser may be prosecuted in the criminal courts; where the abuse takes place in the home the child may be removed from the abuser and taken into the care of the local authority; if the abuser is an employee of a public, voluntary or private organisation, disciplinary action may be instigated.

11.2 The first meeting of the Child Protection Strategy Group was held on 24th September and was convened under the Child Protection Procedures for the management of organised abuse. As it happened, that day two Social Services Inspectors were in County Hall on unrelated business. The Director of Social Services and Ms Youngson told us that they discussed with them the situation which had arisen. Their clear advice was that there was no alternative but to invoke the child protection procedures. They also advised that as the other senior social services staff who might have chaired the meeting were each involved in one way or another with Oxendon, the Director should chair the meeting. We were told that the Social Services Inspectors were invited to attend the meeting but did not do so as it might have compromised their position if they found themselves having to investigate the matter in future. → TOP OF PAGE 64.

The three strands of investigation are quite separate. This is discussed at paragraphs 1.888 - 1.889 of Volume 4 of the **Guidance to the Children Act 1989** and is summarised in **Working Together** at paragraph 5.20.11:-

a) *First, there is the child protection investigation, which will be undertaken in accordance with the procedures then in place for dealing with such matters, including a child protection conference, and decisions taken on the action necessary to ensure the continued protection of the child concerned.*

b) *Secondly, the circumstances may require a police investigation of whether a crime has been committed.*

c) *Thirdly, the employer's disciplinary procedures should be invoked to ascertain whether there has been misconduct or gross misconduct on the part of the staff member.*

As is stressed in Volume 4 of the **Guidance**,

"It is essential that the common facts of the alleged abuse are applied independently to each of the three strands of investigation. The fact that prosecution is not possible does not mean that action in relation to child protection or employee discipline is not feasible or necessary.

For example, an alleged perpetrator may be found not guilty in criminal proceedings but quite properly dismissed under disciplinary action because the employer has reasonable grounds to believe that an offence has been committed; a parent accused of abusing a child may be acquitted by the criminal courts but care proceedings arising out of the same event may result in the child being taken into the care of the local authority.

Perhaps, in the case of institutional abuse or abuse perpetrated in ignorance or as a result of illness, it may be sufficient that the perpetrator(s) is (are) made aware of the abuse and satisfactorily retrained before returning to a caring task.

If none of the above is necessary, no action may be taken.

The fact that the same event can lead to different results in criminal and civil proceedings may be explained by the different standards of proof applicable. As is explained at paragraph 4.13 of **Working Together**:

"the evidential requirement of the criminal courts is proof beyond reasonable doubt that the defendant committed the offence of which he/she stands indicted. The burden of proof rests with the prosecution, i.e. the defendant does not have to prove his innocence. Proceedings for the protection of children under the Children Act take place in the civil courts which work to a lesser standard of proof that of the balance of probabilities. It is not unusual for the police or the Crown Prosecution Service to decide that criminal proceedings cannot be instigated against a person suspected of child abuse on the grounds that there is insufficient evidence to meet the higher standard of proof and for the civil courts to decide that the child needs protection from the same individual. The criminal courts focus on the behaviour of the defendant; the civil courts on the interest of the child.

11.3 The meeting was attended by two senior police officers and eight social services staff including the two interviewers, the Principal Officer,(Child Protection)and a representative of the County Legal Department. Ms Youngson gave a brief resume of events leading up to the meeting. She described the massage review and the two different forms of massage in use in establishments. She reported (we use the notes of the meeting) that the massage used in Oxendon was not felt to be appropriate and was thought to have a sexual context. Ms Youngson also explained the review of practice at Oxendon. The note of the meeting states that to date all the children had been interviewed but interviews with staff had not begun. The second part of that statement was of course incorrect. The Director has accepted that this was a mistake in the minuting and assured us that the decision taking was not affected; the staff's responses were known and had been taken into consideration. Ms Youngson summarised the findings of the review team. Part of the meeting note at this point reads:

"Massage was being used for relaxation purposes on all children at their request in a one to one situation".

Ms McLinden and Mr Graham then described the interview with Child B on 22nd September in terms which are essentially the same as Child B described to them. However the notes also refer to an allegation by Child B that staff "took the mickey" out of the way Asian children spoke. Mr Graham and Ms McLinden confirmed that there were marks on the back of Child B's legs but they could not say that they were bruises or the result of any particular injury. Child B had also stated that she was refused medical attention.

Ms Youngson also indicated that a boy, Child D, during his interview had described how staff controlled children at Oxendon House - "they hurt you, it's not nice. I had bruises once and when I said I want to make a complaint I was told to forget it". Child D was not however making a formal complaint.

11.4 The situation facing the meeting was summarised:

a) If Child B's complaints were investigated under normal child protection procedures, the review of practice must stop for the period of the investigation. Children and staff had found it very difficult to co-operate with the review team and if an investigation was instigated the chances were that they would cease to co-operate.

b) If the complaints were not investigated until after the review, management would be knowingly leaving staff, who were the subject of complaints of alleged abuse, in charge of children. After discussion it was agreed unanimously that Child B's complaints should be investigated and the review of practice suspended. The meeting was made aware that while there had been no enquiries into Oxendon there had been complaints about potential levels of violence in the past. Children were believed to have complained to the police but managers had not been able to find out exactly what was happening in Oxendon. The Director acknowledged in the past management had found difficulty tackling some of the issues that had arisen in Oxendon.

The following unanimous decisions were taken:-

a) The Social Services Department would suspend the review of practice.

b) Child B would be interviewed by the investigaton team using a social worker from another authority.

c) The Principal Officer Child Protection would organise a strategy meeting re Child B in South Bedfordshire with the workers involved.

d) The interview would be done before the end of 28th September.

e) The Police would find out their dealings with Oxendon in the past.

f) Ms Youngson would inform Oxendon that if they had any allegations or complaints they must inform the Department's Child Protection Unit.

g) Ms Youngson would write to the Acting Principal informing staff that the review of practice was suspended pending investigations following allegations of abuse by a child and that children and staff could have access to members of the review team or Ms Youngson.

h) Staff against whom allegations were made were not being suspended at present, because there was insufficient evidence of risk to others at that time. There was no risk to the complainant because she was not resident in Oxendon at the moment. Decisions about her return would be made at the local strategy meeting.

i) The meeting would reconvene on 30th September at 2.00 p.m.

We comment on the 24th September meeting.

Our first comment relates to Ms Youngson's statement, in giving a resume of past events, that the massage used in Oxendon was thought to have a sexual context. We think this phrase is liable to misinterpretation. It could mean that residential social workers and/or children were actually obtaining sexual gratification from the practice. We believe it was intended to mean that massage could be used in that way. Some members of the Strategy Group may have formed the wrong impression. We mention the point because the massage review team expressed no concern on this account. Their reservation was that there should be proper controls.

The statement, that massage was being used for relaxation purposes on all children at their request in a one to one situation, does not wholly correspond with the evidence given by Oxendon staff. They stated that whilst massage was available to all children some did not avail themselves of it and that some massage was given to children in groups in communal parts of the Home. We think the statement is defensible but does not fairly reflect what occurred.

As regards the statement, in the summary of the situation facing the meeting, that there had been complaints about potential levels of violence in the past, we point out that those relate to five incidents in or before January 1991, concerning a member of staff who left Oxendon before 1993. It was also stated in the same summary that children were believed to have complained to the police. We received no evidence during the Inquiry in support of that statement.

11.5 The decisions taken were then implemented. No review interviews were planned for the next few days and no action was taken formally to suspend the review until after the next meeting which in fact took place on 28th September. The Director has told us that he was aware at this stage that the incident might turn out to be a storm in a teacup. The Police however were clear that there was an incident of sufficient concern to warrant an investigation and to interview Child B. In evidence to us Mr White commented on the situation facing the meeting and queried the efforts which had been made by Social Services Managers to find out what was happening in Oxendon. He suggested that they just found it inaccessible.

11.6 Child B was due to return to her mother's home on 24th September and did so. Oxendon were told that she would not be returning. Mrs McNamara has told us that Child B's social worker told Mr Paine and Mr Wallace that Child B would not be returning and that they were not to contact her. Mrs McNamara reported to Ms Youngson that she overheard a conversation between Mr Paine and Mr Wallace discussing contacting Child B. This was denied by Mr Paine and Mr Wallace who pointed out to us that Mr Paine was on leave at the time. We raised the matter again with Mrs McNamara at a later interview to obtain clarification. She told us that Mr Paine did go on holiday. The discussion she had overheard was about the interview list for the review of practice. They were discussing whether Child B, who was away on leave, would be back to be interviewed. They were checking the list. This was before Child B was removed from Oxendon under the Child Protection procedures. That explanation would indicate that the conversation between Mr Paine and Mr Wallace was wholly innocent. We raised this again with the Director who said he clearly understood that Mrs McNamara's report of the overheard conversation related to a time after Child B's review of practice interview and not before. He said he had checked the statement back with Mrs McNamara some weeks later and she had repeated the same account. It was urged upon us that she would have had no reason to report back to Ms Youngson an innocuous piece of information. We find it difficult to reach a conclusion. Possibly Mrs McNamara was confused in her own mind. Clearly her account was taken into account by the Director even if it was not accurate.

11.7 On 27th September Mr P Morris telephoned Oxendon to say that the review of practice was suspended. No reasons were given.
We explain in this report how the results of the review of practice were used in reaching decisions regarding Oxendon. When the review was suspended a few interviews remained outstanding, not least the interview of Mr Mead. No management report on the review was ever prepared. The Police later prepared a summary of the questionnaires and an analysis of them in diagrammatic form was prepared in the Social Services Department. It was referred to by Ms Youngson at the meeting of the Child Protection Strategy Group on 28th September.

11.8 Mr White, as a member of the review team, thought that the team was contemplating two possible scenarios for Oxendon, either there was nothing to uncover or the team faced a highly well organised conspiracy to deny access to information. He favoured the first view being struck by the apparent honesty of staff in the interviews. He said his concerns were the lack of clarity or guidance on physical contact, concern about some of the extra-mural contact between children and staff and the staff concerns about the level of training and education. He thought it significant that of the 34 staff interviewed there were no "whistle" blowers, not even amongst recent recruits to the staff nor amongst the domestic or office staff. The Director did not accept Mr White's interpretation and drew attention to a variety of concerns expressed both by Oxendon staff and field social workers. We mention them briefly in paragraph 10.29 above.

11.9 Child B was interviewed by the police and a social worker from another local authority on 27th September. She said about herself that she had quite a temper. She had a need for privacy and personal space and did not like to be touched without her express agreement. She described the 29th June incident as "nothing big". She described the incident in terms similar to her description to the practice review team, although she said the arm around her neck was a strangehold and her face felt red "like he was strangling me". She also said that when she went to her room she found that her right ankle was scraped and bleeding and she tended to the injury herself. She said she spoke to her key worker about 5 days later and tried to show her a bruise on the ankle but was told that the key worker could not see how a bruise could only come up after 5 days and there was not enough evidence for the police. She claimed her ankle still hurt. She said that a few days after the incident Mr Mead had asked if she wanted to complain and she completed a form to go on to the line manager but had heard nothing since. She said she had previously made a complaint which she had agreed Mr Mead could deal with within Oxendon and was satisfied with the outcome. Other residents had told her that there was no point in complaining as forms were not sent off.

11.10 It is not clear from the evidence that Child B made two complaints in relation to the 29th June restraint. We have seen the completed complaint form in relation to a complaint dealt with by Mr Mead internally to Oxendon which Child B signed indicating she did not wish the complaint to be referred to the line manager. That form did relate to the 29th June restraint. We have seen no other complaint form. Mr Mead told us that there was only one complaint and he dealt with it within a day or so of the incident. The external social worker recorded her concern that a formal complaint appeared to have gone missing but there is no independent corroboration of Child B's statement that a second complaint was ever made.

11.11 Apart from the 29th June incident Child B made some new statements:

a) She had seen male staff touch other residents in a way she considered inappropriate. "Sometimes see their hands all over - so fast". This had happened to Child B twice.

b) She described an occasion when she saw a male staff member cuddling a female resident with his hands on her bottom.

c) She claimed to have been told of an incident by an ex-Oxendon resident in which the ex-resident Child K had her breasts touched by a male staff member.

d) She claimed that Oxendon had a reputation amongst the children as a place where 'staff molest the children' but she could not offer substantiation for this.

11.12 In concluding her report, the external social worker said that Child B presented throughout as a reliable witness. She was very careful to explain when she did not have clear facts or names and her story was entirely consistent with that she had told to the practice review interviewers. The external social worker had no reason to doubt that Child B was telling the truth. Mrs McNamara reported later to Ms Youngson that all the other children were aware of Child B's interview with the Police and were threatening to "get her".

11.13 The Police phoned Ms Youngson the same evening to express their extreme concern about what Child B had told them. Early the following morning 28th September, the Police asked that the second Child Protection Strategy Group meeting be brought forward from the 30th to the morning of the 28th as they believed they had to make a major incident inquiry and wanted urgent discussion. We should explain the significance of the phrase "major incident inquiry" as used by the Police. It means that the Police have to commit major resources to the investigation; it does not necessarily imply that major crime is under investigation. The distinction has not been universally understood.

11.14 The second Child Protection Strategy Group meeting was held on the 28th September. The Police were particularly concerned because, apart from the allegations of excessive force being used on Child B herself, she alleged that she had witnessed inappropriate touching of another girl. The Police viewed this as potential indecent assault and there were at least 2 other children Child B believed to have been inappropriately treated. We were told by the Director that the Police attitude was markedly different from that shown in the meeting on 24th September and that he was impressed by their level of concern. There was considerable discussion of the issues which had been raised at the previous meeting on 24th September. The Director told us there was recognition of the real possibility of institutional abuse, and that term was then used, although it does not actually appear in print until after the Director spoke to the press on the 15th October and wrote to members of the Social Services Committee on 20th October. The Director told us the meeting was hearing about frequent physical contacts in an establishment isolated geographically and managerially. There were felt to be similarities with Pindown. In these circumstances the meeting was agreed that in the interests of the residents there had to be a "major incident inquiry" as envisaged by the Police. The meeting was then faced with the question of whether children and staff could be left in place whilst the investigations were under way. The Director said that several factors were considered:

a) Whether children should remain at Oxendon and a new staff group be moved in.

b) Whether to relocate children into other homes.

c) Whether to reopen Runfold House Children's Home at Luton during the investigation.

He said there was no idea which staff might be responsible for abuse or how widespread it might be. If abusers were present in any number, the dangers of condoning the situation, of influence being brought to bear on the children, of putting them at risk of further abuse and of contamination of evidence were plainly present. The meeting concluded that there really was no alternative to a decision to separate the staff from contact with the children.

11.15 Having considered the matters of principle, the meeting took a series of decisions (recorded in their minutes) which we summarise as follows:-

a) That the individual youngsters named by Child B should be interviewed by the Police.

b) That the staff named by Child B should also be interviewed in respect of the specific allegations made (with the possibility that further staff interviews would follow at a later stage). Mr Mead would also be interviewed as the officer in control of the staff at the time.

c) That a full Police/Social Services joint investigation should be instituted in clearly defined phases the first phase to include (a) and (b) above.

d) The Police Officers and Social Services staff to be involved in the investigation team would be identified. (The three social workers were specially trained staff from nearby authorities).

e) A representative of the Area Child Protection Committee was co-opted to the Child Protection Strategy Team (Ms J. Stimec, NSPCC).

f) The investigation team would be based in the major incident room at Dunstable Police Station.

g) All children's case files, relevant personnel files for Oxendon staff including staff who had left recently, documentation as to the running of Oxendon House, including day books etc. would be gathered, made secure and accessible to the investigation team.

h) Ms Youngson would inform the Social Services Inspectorate of the investigation.

i) Parents of Oxendon children would be informed.

j) The Director would consider how the separation of children from Oxendon staff should be organised, probably by dispersing children to other appropriate locations and giving staff leave of absence.

k) The Director would inform the review of practice team that its work was suspended.

l) The Director and/or Ms Youngson would go to Oxendon personally to inform the children and staff of the suspension of the review of practice and of the institution of the child protection procedures.

m) The Director would brief the Social Services Representative Panel members and secure their support for temporary closure of Oxendon.

A note of the meeting was prepared and signed by the Director of Social Services as Chairman on the 29th September. Formal minutes of the meeting were prepared and signed by the Director on 21st October. This was a key meeting in that it was decided to launch a large scale investigation and to separate the Oxendon staff from the children. The influence of the Police may be judged from the fact that the meeting was held the same morning it was requested. We also believe they were very influential in the decisions reached.

11.16 Mr White told us that on the 28th September the review team, including Ms Youngson, met the Director who set out some of the problems that had been encountered. Mr White told us his initial view was that in interviewing children with emotional, behavioural difficulties some kind of allegation could well be expected. He said he was taken aback at the level of the Director's reaction. In evidence to us he said that the Child Protection Strategy Group had had to consider a specific allegation and some general concerns which had not been investigated. In his view it was the general concerns which had caused the closure triggered by the specific incident.

On 28th September Child B contacted Oxendon to say that she was not returning as she had made an allegation against staff as a result of the restraint in June.

XII DELIBERATIONS

12.1 The Director has told us that, having taken the view that the staff and children should be separated, there seemed no practical prospect of keeping Oxendon open and moving in a new group of staff sufficient to run the establishment properly. The Director could not even be sure that the domestics were uninvolved. Given the number of youngsters actually resident at that time it was however feasible to move them to other appropriate placements according to their individual needs. But placement decisions had not been made at that stage and the possibility that the residents would remain at Oxendon was still open. We emphasise that at this juncture a decision to close Oxendon temporarily had not finally been made although it was certainly recognised as the most likely outcome. It was Ms Youngson's understanding at that stage that she was considering relocation of about 17-18 children. This was quite small in relation to the size of the building and the number of Oxendon staff, and Oxendon was staffed for 21 children. Ideally the Police would have liked to have separated the children from each other as well as separating staff from children, although this was unlikely to be achieved for practical reasons. Assessments of each of the children had to be undertaken as a first step before any decision to effect a temporary closure could be made. Ms Youngson has told us that she was anxious that the children should be treated as individuals at all times.

12.2 The Director told us that he and Ms Youngson did specifically address the dramatic effect which separation of children and staff would inevitably have on staff and there was considerable concern for the staff about this. However, in circumstances where they simply did not know which staff might be involved in any abuse, and having regard to their primary responsibility to the children, they believed the decisions had to be taken despite the effect on the staff members concerned. Until the investigation had taken place it was not known which staff might have been involved and they could not therefore be employed elsewhere on similar work. The Director has stated however that he was anxious at all stages to ensure that the staff were treated as well as they possibly could be in the circumstances.

Ms Youngson told us that the expected course of action with regard to the staff in this situation would have been suspension pending completion of the investigation. However to be as fair as possible to staff the Director and Ms Youngson anticipated giving most staff leave of absence on full pay and only suspending those who were subject to clear allegations.

12.3 Mrs Youngson told us that following the meeting, numerous practical tasks had to be undertaken. The Director said that all those involved in the planning and execution of the separation of staff and children and temporary closure of Oxendon worked with extraordinary intensity and effectiveness to bring about the separation on 30th September. A team of officers had to be selected to deal with the immediate work in respect of the children. Again, two senior managers who would have been the obvious choices had to be ruled out because each had previously been involved in managing Oxendon. The Director and Ms Youngson agreed that the best team available would be SSD 2, Mrs McNamara and Ms McLinden. Between them, they had extensive experience of residential work, full knowledge of resources which might be available and extensive knowledge of Oxendon, its children and their needs. Whilst less senior they were available to make up the team forthwith.

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Arrangements had to be made to involve the staff of Mr Terry Jones, Assistant Director Commissioning, in the process of assessing the children and separating them from the staff of Oxendon. The fieldwork staff needed to be available for the Team to discuss the children with them and also for the children to consult with the fieldwork staff and to enable the children's views to be clearly understood when the separation did take place. Ms Youngson said she informed the Social Services Inspectorate of the developments.

12.4 Speaking of the situation at that stage, Mr White told us that there was still time to consult the former Area and Line Managers of Oxendon and stop the band wagon from rolling. The Department had disbarred itself from finding out the facts by excluding such managers, on the basis that they could be implicated in possible abuse. A huge logistical exercise was to take place. Common sense had gone out of the window. If only part of that effort had gone into checking out the facts, there would have been no closure.

12.5 Ms Youngson has given us details of the large range of matters which had to be addressed in a very short timescale to implement the Strategy Group decision and to inform all those who needed to be made aware. As regards timescale, there was to be an urgent and large scale police investigation and separation of staff and children was to take place to avoid contamination of evidence. Good child care practice required the Social Services Department to act very speedily. She told us there were inevitable and extremely inconvenient repercussions in that it was necessary to maintain confidentiality, particularly in respect of the staff and children. In addition, as far as possible, the Oxendon staff had a right to know what was happening to them before other staff knew.

12.6 The Director and Ms Youngson have told us that there were real worries that staff might attempt to put pressure on residents. They referred to Mrs McNamara's account of the overheard conversation regarding Child B which we have mentioned previously. Ms Youngson had been asked to move Child A (the massage incident) out of the County as it was believed he would be victimised if he returned to Oxendon after the massage review. They were also mindful of the staff"s refusal to co-operate with the review of practice without the involvement of the union. They said that several managers had experienced Oxendon staff unwillingness to co-operate. In their view, Mr Mead was perfectly open about encouraging (supporting) confrontation and the expression of anger. All these aspects contributed to their conclusion that staff had to be separated from children and that leave of absence was the right solution. In discussion with us, the staff accepted that they had been reluctant to accept the views of external managers on the issues put to them but refuted the proposition of general unwillingness to co-operate.

We break the narrative briefly to comment on the concerns that staff might attempt to put pressure on residents. We have already drawn attention to the conflict regarding the conversation overheard by Mrs McNamara. The significance of the statement is now in doubt although it was taken as supporting the Director's concerns prior to the closure decision being taken.

We consider the statement, that Mr Mead was open about encouraging confrontation and expression of anger, to be too harsh a view of Mr Mead's attitude. He was certainly of the view that if there were very strong disagreement that fact should be made absolutely clear. We have no quarrel with that so long as there is no breach of decorum. We would not wish staff to be docile.

12.7 It is clear that a decision to effect the temporary closure of Oxendon was not one for the Strategy Group but was one for the Director in conjunction with the Social Services Representative Panel. The Director told us that representatives of the three political groups on the County Council had been briefed by the Director about the position before the meeting on the 24th September. The Director approached representatives of the three groups again on the 28th September and obtained their agreement to his proposals to separate staff and children and to close Oxendon temporarily.

12.8 On 29th September Mr White says he contacted Mr John Findlay, UNISON'S National Officer for Social Services and sought his advice. Mr Findlay's view was that there was an over-reaction and closure was unjustified, unless the allegations very clearly involved the majority of staff. He was concerned about the level of disruption which would be caused. But Mr White said that both he and Mr Findlay were alive to the risk of a public service union possibly being seen to give succour to child abusers.

12.9 The same day, the Director spoke to Mr White to inform him of what was happening. Mr White's reaction was that the temporary closure was not necessary and that if a full police investigation were required the Director should remove the key people. The Director explained that he did not know who were the key people. Mr White said that the advice from Mr Findlay was that what was happening was a hopeless overreaction. At Mr White's suggestion the Director later spoke to Mr Findlay and explained the background. The Director told us that Mr Findlay acknowledged that there was a potential situation of institutional abuse. The Director reported that Mr Findlay accepted there was no choice but to close temporarily and said that on the basis of what he had been told, the Union would not oppose temporary closure. The Director told us he asked Mr Findlay to report back to Mr White and he did so. He also told us that this was the national UNISON view; the local view could be different. Mr Findlay's recollection is slightly different. He recalls saying that if there were prima facie evidence of abuse on the scale the Director was describing then he appreciated that the Director would have no alternative but to close the Home temporarily. Mr Findlay told the Inquiry that he received from the Director only assurances that there was in a fact a serious level of institutional abuse; two examples only were given.

12.10 The Director and Ms Youngson told us that they did consider whether they could keep some staff available, in particular the domestic staff. But they said they could not be sure, if abuse was taking place, who was responsible. Given the overriding responsibility to safeguard the children, with great regret they decided that all the staff had to be put on special leave.

12.11 Ms Youngson also described to us the assessment process. On the morning of 9th September the appointed team set about the assessment of the children. They were required first to assess the needs of the children individually. Only after that task was complete was the issue of how to meet those needs addressed. The team were particularly asked to consider why the change should be made at that moment if it were felt that change was appropriate. Ms Youngson closely supervised progress. It was identified that of the original 18 assumed residents only some 13-14 then needed attention by the team. Each child was assessed and it became clear that relatively few children would best benefit from continuing residential care. Decisions were reached on the placement of all the children.
Ms Youngson told us that since the number of children requiring residential care was substantially less than 18, it was clear that a smaller, better situated home would be much more appropriate for the children. An alternative home was needed, and if one was available, Oxendon would be closed. Runfold House was found to be available. It had been closed recently due to staff shortages but sufficient staff were gathered together to enable it to re-open.

12.12 The decision to close Oxendon was taken in principle on the late afternoon of the 28th September but it was dependent on appropriate alternative arrangements being made for the children. The decision to close became effective on 29th September, once it was established that Runfold House was available and capable of being re-opened and suitable placements had been found for the other children.

12.13 The Director and Ms Youngson have told us that they discussed extensively how best and most sensitively to separate children and staff. Where a child needed to be removed from a family the situation was bound to be stressful and difficult. There was no good outcome; the most that could be done was to do the job well. The removal of the Oxendon children was similar but on a massive scale magnifying the difficulties. The view of the second Strategy Group meeting was that the Director and Ms Youngson should go to Oxendon personally to inform staff and children. Two separate meetings were considered, one for staff and one for children. However the Director and Ms Youngson concluded that this could create too emotional an atmosphere in the Home. The primary responsibility was to the children. They considered that the presence of the staff would unnecessarily aggravate a difficult situation. Ms Youngson consulted the County Council's Director of Human Resource Strategy (Mr C Burgess) and concluded that it would be preferable to have the staff meeting at County Hall; it would be a difficult meeting for the staff and they should not have the responsibility for looking after the children at that point. It would be difficult in any case to manage the children in such an emotionally charged atmosphere. There was therefore a deliberate decision to separate the staff from the children by bringing staff to County Hall and to remove the children from Oxendon whilst the staff were absent. The staff had been told nothing of this. The Director and Ms Youngson had had to involve a considerable number of their staff, on a confidential basis, in the preparations for separation and there was therefore a risk of accidental or indeed deliberate disclosure to Oxendon staff.

In our opinion the Director and Ms Youngson were right to abandon the original idea of holding at Oxendon the two meetings of staff and children. Bringing the staff into County Hall avoided the risk of further aggravation.

XIII TEMPORARY CLOSURE OF OXENDON

Closure

13.1 At 7.00 p.m. on 29th September the senior member of staff on duty at Oxendon was contacted by the Social Services Department and told to inform all staff that they should attend a meeting at County Hall the following afternoon. He was told it would be in staff"s best interests to attend. Mr John Dixon, the NUT Regional Officer told us that Mr Wallace, the Deputy Principal, tried all evening and next morning to find out the arrangements for supervision of the children in the absence of the staff but discovered nothing. That fact alone must have indicated that something very unusual was about to take place.

13.2 Ms Youngson told us that detailed preparations were made for the supervision and removal of the children and for taking control of the premises and contents on departure of the staff. Mrs McNamara was to go to Oxendon and receive the handover from Mr Wallace. It was planned that she should then have available to her some residential social workers from Westfield Road Children's Home to assist her to take care of the children when the Oxendon staff left and the children came out of school. At the same time SSD 2 was to meet the children's own field social workers so that they could then join the children and talk to them about what was to happen. Each social worker was to check that the child was happy about where he or she was to go. Four other Social Services Department middle managers responsible for transport, supplies, finance, organisation and commissioning were also present at Oxendon during the afternoon. Ms Youngson considered that this complement was adequate and appropriate for the task. She attended the meeting with staff at County Hall.

13.3 Mr White said that on the morning of the closure the Director spoke to him and revealed his full plan for the afternoon. Mr White said that he remonstrated with the Director against the closure. The Director told us the meeting was very brief and he could not remember remonstration on that occasion. Mr White had remonstrated the previous day. However they discussed the implications for the Oxendon staff and Mr White raised the need for counselling and support. As in-house counselling would not be considered confidential, Mr White suggested the use of Independent Counselling and Advisory Service (ICAS). During the morning the Social Services Department entered into an arrangement with ICAS to provide independent professional counselling for staff who needed it. We comment that the relationship of trust between the Director and Mr White at that critical juncture enabled a valuable support to be set up for the staff.

We think it right to record that within the constraints the Director and Ms Youngson had set themselves the planned arrangements for supervision and removal of the children were adequate.

13.4 Clearly, summary removal of the children, without Oxendon staff knowledge and support, was bound to be a tricky and difficult operation with significant risk of mishap even had the carefully laid preparations worked satisfactorily. Ms Youngson told us that in the event the plan was not carried out, there was considerable disarray and some children and staff became very agitated and distressed. The residential social workers from Westfield Road did not accompany Mrs MacNamara. Mrs McNamara told us that she had offered two residential social workers from Westfield Road but the arrangement was that they would go to Runfold House to receive the children and not to Oxendon. They therefore went to Runfold House. She understood her only support would be the field social workers of the children. She was left on her own with the children as Oxendon staff were leaving to come to County Hall. Rumour was rife and the children were very keyed up. SSD 2 had to help Mrs McNamara with the children and therefore he was unable to brief adequately the field social workers as to what they were to do. They should have received more briefing from the Commissioning Staff before they arrived but the need for confidentiality had contributed to the problem and they only had a partial picture of why they were present. Then SSD 2 did not have the time to brief them properly.

13.5 Evidence of the closure was also given to us by staff and children present at the time. The exodus of Oxendon staff to County Hall was not complete. Some 45 staff attended the meeting. One residential social worker went into Oxendon on her day off. She described the distraught children as the staff departed to Bedford. One teacher was unable to get to County Hall because she could not arrange a child minder at short notice. She said it was an amazing experience after the staff left. The children were in the central recreation area. They had not been told anything. Two boys were becoming violent. She and two field social workers who were distressed and bemused, got the children into the former secure unit to find out what was going on. The children came out after 10 minutes very angry and upset and went to their bedrooms to pack their bags. The willing ones were then ushered out of doors. She said she could cope no longer. She witnessed two restraints as children came in and out of the units. Three older boys packed small bags and walked off the premises. Children started smashing windows. One child went berserk and set off round the grounds. She followed to offer him support. He was beside himself with distress. The police arrived. She said they were very good, very calm but could not help a lot because they did not know what was happening. Another residential social worker arrived at 4 p.m. after a lengthy journey. He said there were many children in the grounds; most were crying; some were angry and causing damage.

13.6 Mrs McNamara said about seven staff came back from County Hall to collect their belongings before all children had departed. That caused chaos as children tried to speak to their social workers. A male social worker said he returned to collect his clothing. He was escorted in and out. Children tried to speak to him. He said it was a melee, the most distressing day of his professional life. Another said the Police were trying to prevent damage. The field social workers did not know which child owned what baggage and some children were claiming others' property. Children at work or attending outside school returned to find Oxendon closed and could not locate their field social workers. Another returning teacher described the situation as horrendous. Carpenters were putting new locks on the doors. A security man was at the front entrance. Children were hiding in the bushes. Social Services staff were in shock and tears. A girl in the flat in the grounds was moved out.

13.7 As a precautionary measure, the local police had been notified of the intended removal of the children, but in the event had to intervene to control disturbance. A number of children were however taken away promptly and effectively to their new placements. Nevertheless, the removal was without doubt a difficult and distressing episode for everyone involved. We were told politely that Bedfordshire County Council should not have allowed this to happen. As children departed, possession was taken of files, books and documents relating to Oxendon and the premises were made secure against unauthorised entry.

13.8 As regards the immediate relocation of the children, six were placed at Runfold House, two at Westfield Road and one at the Brambles. One was placed in a hostel and three with foster parents. One was placed out-County with his girlfriend's parents and one was allowed home. Two had already been discharged and one was missing having absconded. Arrangements were also made for the continuing education of those children who had been attending school either at Oxendon or elsewhere.

Meeting with Oxendon Staff

13.9 The meeting with Oxendon staff took place in the Council Chamber at County Hall at 2 p.m. on the 30th September. In addition to Oxendon staff, their union representatives attended. The Director, Ms Youngson, the Director of Human Resource Strategy, Mr R Labe, (the Personnel Manager, Social Services Department) and Mr P Morris were present. The Director opened the meeting and informed the Oxendon staff that Oxendon was being closed temporarily for a fortnight under the child protection procedures to enable the Police to carry out the first phase of an investigation into alleged child abuse which could well involve all children and staff. The Director tried to make clear to the staff that he felt he had no alternative to the action taken and wished to acknowledge clearly that he understood the difficulties for them in the situation. He told the staff that they were not being suspended but would be placed on leave of absence on full pay for two weeks to facilitate the investigation. He said that Mr Burgess and Mr Labe were available to deal with any issues arising from the leave of absence.

13.10 The Director arranged for a tape recording to be made of the meeting using the fixed equipment installed in the Council Chamber. We have inspected the installation. It is controlled from a cabinet outside the Chamber and there is no obvious means of persons present in the Chamber knowing whether the equipment is in operation. The Oxendon staff and most, if not all, County Hall staff other than the Director did not know that the meeting was being recorded. The Director did not inform the meeting that a tape record was being taken nor did he seek the approval of the Oxendon staff or union representatives to his action. The existence of the tape was made known on 11th January, 1994 following letters from Mr Mead to Mr Alan Chapman, the Deputy Director of Social Services, asking whether the meeting had been tape recorded. The Director then explained that he had arranged for a tape record to be taken since the meeting was important and he wanted a proper record of what staff had been told. He has told us that the tape record was not transcribed until many weeks after the meeting. The recording was made on a slow running tape and has been transcribed as well as possible. But there was a good deal of noise inside and outside the Chamber and people talked together at the same time so the transcript contains a number of gaps. We have read the transcript and listened to the tape and are satisfied that the text accurately reflects the recorded speech. But we cannot be sure that the tape recorded all that was said in the meeting. Significant comments may have been missed, especially if persons speaking were poorly placed in relation to the microphones. The transcript runs to 22 pages. Mr White has told us that the existence of the transcript came as quite a revelation to the staff. In his view it was clear that the Director knew it would be a very difficult meeting and it was no oversight not mentioning to the staff that the meeting was being taped. He thought the Director had expected a very angry, sharp, possibly even violent reaction from staff but it did not transpire. He thought that the Director wanted a record of the meeting in case there was very dramatic opposition.
He said he knew that the Director with hindsight would have done differently. The NUT also told us that they regarded the taping of the meeting as a serious breath of faith and further damaged the trust of the staff in the Department. The Director told us that the taping was a deliberate choice, not an oversight. He regretted not informing the staff but considered it was right to tape the meeting.

13.11 Returning in more detail to the discussion at the meeting, the Director, without revealing details of the allegations, explained to the staff the steps leading to the decision to close Oxendon temporarily, the necessity under the child protection procedures of separating children and staff and the way that was being accomplished. He formally instructed the staff that they were not to have any contact, direct or indirect, with the Oxendon children or former residents for the duration of the investigation. The Director told us that it seems reasonably clear since the meeting that staff have been having contact with the children. UNISON have denied that staff have taken any initiative but state that children have sometimes taken it upon themselves to approach staff. The Director also informed staff that they were not allowed to contact or talk with the press without prior agreement of a member of the Social Services Departmental Management Team. He reminded the staff that breach of the instructions would result in disciplinary action being taken. He gave his reasons for the instructions and apologised for sounding heavy handed. He said there was a full scale investigation and the police were

treating it as a major incident inquiry. He emphasised the importance of keeping publicity in as low a key as possible. He said that an independent professional staff counselling service had been be set up to assist staff. He said he did not wish staff to return to Oxendon that afternoon and again gave his reasons. Arrangements would be made for staff to collect personal belongings the following morning.

13.12 In the course of the ensuing discussion with the staff about the necessity for concealing the closure from them, the Director said that he had never in his career had to make a more difficult set of decisions than he had in the previous 48 hours. He promised to keep in regular contact with staff. He said there was no hidden agenda for the permanent closure of Oxendon although he did not know what would come out of the investigation. One member of staff made the point that if management in general had had close relationships with Oxendon in the first place the situation could have been avoided. In the middle of the meeting Mr T Sanders, the UNISON Branch Secretary, in a statement which is recorded poorly, seems to have given UNISON's immediate i.e. short-term support and stated that the Social Services Department had handled the situation as reasonably as could be expected up to that juncture. The Director pointed out that one condition of leave of absence was that staff should be available for interview as part of the investigation. Staff raised matters of immediate concern about their current work and care of the children. The Director strongly advised staff not to have a lot of contact with each other and certainly not to discuss Oxendon issues. He asked staff to pass on to Mr P Morris outstanding child care issues with which they had been dealing and to hand in any official social services documents or material in their possession. In closing the meeting the Director thanked the staff for being as understanding as they had been. In giving evidence the Director told us that the meeting was hostile. He also stated that whilst the meeting had clearly come as a great shock to staff, it seemed to have been conducted in as orderly and responsible a manner as could be expected in the circumstances. As staff departed they were handed a letter from the Director dated 30th September confirming the statements and instructions given at the meeting. The letter added that staff were not return to Oxendon unless specifically authorised. The letter gave a telephone number for the Independent Counselling and Advisory Service. Long after the meeting, when the Director wrote to the children on 4th November, informing them that they would not be returning to Oxendon, it emerged that there was an important difference of recollection as to what had been said at the meeting. We deal with that dispute later.

In our view, the meeting with staff was as constructive and positive as could be expected in the circumstances. In one respect at least it was perhaps fortunate that the taping of the meeting did not come to light until the 11th January. By that time it had already been decided to hold an independent inquiry. We feel obliged to say however that the undisclosed taping of the meeting must have damaged the Director in the eyes not only of the staff but also of other officers and county councillors.

Consequential Action on Closure

13.13 The same day the Director wrote to all the members of the Social Services Committee, the Chairman of the Council and the Council's Political Group Leaders informing them of the process and action taken, stating that there were no grounds to suspend any staff and that staff would be given two weeks' leave of absence. In describing the forthcoming investigation to councillors the Director used the phrases *"major incident inquiry"* and *"major police inquiry"*.

The Director told us that it was intended at that time that the whole of the phase one interviews would be completed in two weeks and the matter would then be reviewed. It might then be possible to re-open Oxendon. In the event it took the external social workers and police officers some time to prepare themselves for the interviews and the leave of absence was extended to a further two weeks.

13.14 On 30th September also Ms Youngson wrote to all parents of Oxendon children informing them of the temporary closure and offering to meet them on the 6th October to discuss the situation. In the event only one parent appeared at the meeting. We note that the letter referred to an *"allegation of physical abuse which has led to a police enquiry"* and speculate whether this statement gave credence to the mistaken (but several times repeated) view that the closure arose solely in response to one allegation.

13.15 The media soon learned of the closure. Indeed we have been told that local radio carried a story about the closure before the end of the meeting with staff at County Hall. Following a press release on the 1st October the Director appeared on regional television on the 4th October. This was followed over the next few days by coverage in the local press. Probably arising from this publicity, an anonymous telephone caller on 4th October made an allegation of rape against Staff 7. In subsequent calls she was persuaded to reveal her identity. The caller was X a Norfolk woman and she alleged that she had been raped on two occasions during her residence at Oxendon House. Records indicated that she was a resident from July 1981 to August 1982 when she was 15 years old. The alleged offences therefore took place some eleven years before the complaint was made. We return to this allegation later in the report.

XIV THE INVESTIGATION

14.1 Following the closure, the joint Police/Social Services investigation got under way in accordance with the child protection procedures. It was named "Operation Saga". The investigation was supervised overall by a Senior Strategy Group comprising a Detective Police Superintendent, Ms Youngson and Ms Stimec (NSPCC). Working to them was an operational team of investigators headed by a Detective Inspector and the Principal Officer (Child Protection). There were three joint interview teams comprising three external social workers and three Bedfordshire Police Victim Liaison Officers to interview the children and a team of five Detectives to interview staff and other adults. The first stage concentrated on interviewing all Oxendon children resident on 30th September together with any former residents identified by current residents as being possible victims of abuse. The interviews began on 6th October. Fifteen young people were interviewed and three others refused to be interviewed in detail Two specific criminal allegations were made. The first was the original allegation made by Child B of assault occasioning actual bodily harm. The two male staff members involved were interviewed by the Police under caution. The second allegation was made by Child K, a former female resident, who alleged that during a restraint she was indecently assaulted by a male member of staff. (This was the matter referred to previously by Child B when she was interviewed by the Police and an external social worker on the 27th September). The member of staff was interviewed under caution and denied the allegation in every respect. The Police also made a full investigation of the far more serious allegation of rape made by X. She was interviewed by the Police on 16th October and made a detailed statement. Staff 7 was arrested, released on Police bail and interviewed under caution on 21st October. He made a total denial of the allegations. We emphasise that he was never charged with any offence.

14.2 In accordance with the decisions of the Child Protection Strategy Group meeting on the 28th September the Police also interviewed social services staff connected in one way or another with the allegations. From the 6th October some eleven field social workers and management staff were seen. By the conclusion of their enquiries in the third week of October, the Police had gathered together a number of concerns which were not of a criminal nature but which related to management and child care practice at Oxendon. The Police summarised some of these concerns as follows:-

External liaison
Staff interchange
Recruitment
Training
Expert overviews - psychiatrist
- psychologist
Complaints procedure
Supervision/external management
Method of inspection/frequency
Standardised procedures between homes
Monitoring

The Police's concerns incorporated the views of the external social workers working in the investigation ream.

14.3 The Police made it clear that these practice and management issues were not fully investigated as they did not form part of the criminal investigation process. The investigation team did not feel that they had the knowledge or expertise to comment fully. As regards their concern at the amount of restraint of children which took place, the Police told us that the amount seemed to them to be excessive but they could reach no clear conclusions because it was not their area of expertise. However, they considered that sufficient documentary evidence was available to highlight their concerns. The Police requested that consideration be given to seeking independent expert advice on whether their concerns revealed an abusive regime outside the criminal law. How that aspect was pursued is dealt with later but it is pertinent to say at this juncture, that arising out of the 22nd October Child Protection Strategy Group meeting, it was decided to write to all previous residents in general terms giving them the opportunity to come forward and raise any issues of concern. This was organised by the Social Services Department who arranged for ex-residents to pass on any information to the NSPCC. The NSPCC then gathered the information and sent it to the Social Services Department for action. There was a considerable response by ex-residents but there were no disclosures which required a Police investigation. We have examined a bundle of forms relating to the period 17th November to 1st December. The responses made were generally supportive of Oxendon but also contained some adverse views similar to those previously received.

14.4 During October there were two meetings of the Operation Saga Senior Strategy Group supervising the investigation and numerous discussions between them. The first meeting on 6th October reaffirmed the initial priorities set on 28th September and considered the need to extend staff leave. The second meeting on 11th October discussed disclosure of notes of counselling sessions involving children at Oxendon which had been identified in the course of the investigation. Counselling was outside the scope of the Police operation but the Principal Officer Child Protection was concerned that it might represent a type of child abuse. There had been no complaint by any child in this respect and it was agreed that the issue would be pursued by Social Services Management. In late October a member of Oxendon staff (Staff 9) was suspended from duty in connection with counselling of children.

14.5 On 13th October the Director wrote to all staff extending their leave of absence for a further two weeks from 14th October. The letter also made it clear to staff that the statement not to talk to each other was advice, not an instruction. The letter did however instruct staff to inform Mr Morris or Mr Labe if children did contact staff.

14.6 Ms Youngson told us that about the 13/14th October the Detective Police Superintendent discussed with her the nature of the information that was coming to light from the investigation and the difficulty of assessing the significance of the material in terms of practice and whether this amounted to abuse. As already mentioned, the Police considered an independent expert was needed and Ms Youngson agreed to find one. The Director contacted the Social Services Inspectorate who suggested Mrs Barbara Kahan as the foremost expert consultant in the field. It is pertinent to mention at this point that Mrs Kahan was joint author of the Staffordshire Pindown Report in 1990/91. The Director and Ms Youngson decided to approach Mrs Kahan and did so on the 15th October. She was to speak at a conference on the 18th October concerning the effects on staff of abuse enquiries in residential care establishments, the first conference of its kind in the country. The Detective Police Superintendent and Ms Youngson decided to attend the conference. Ms Youngson told us that she was keen to attend because she did not think the Oxendon staff would be able to communicate properly with her in the circumstances and she wanted to gain a better understanding of their position. She found the conference very informative and considered that the Social Services Department had managed to avoid any potential pitfalls and had taken the right decisions on the difficult aspects. Whilst at the conference, they briefed Mrs Kahan shortly on the Oxendon situation. They did not give her any papers at that stage.

The engagement of Mrs Kahan was an important step in ensuring that the results of the investigation would receive full and informed consideration. We have no doubt it was a wise and proper move on the part of the Director. It is a pity that the media promptly associated Mrs Kahan with Staffordshire by referring erroneously to suspicions of a Pindown style regime at Oxendon. This added unnecessarily to the pressure already facing both the Director and the staff.

14.7 Mr White told us that on closure UNISON set up what they term 'first stage assistance' which meant providing the services of a local solicitor who would represent UNISON members if they were interviewed by the Police. His members availed themselves of that service. Mr White said that on the 15th October UNISON'S local solicitor informed him that the allegations against Oxendon staff were trivial and he could not see why the place was closed. Mr White said his concerns at that time were about the length of the closure, the lack of information, the press linkage with Staffordshire and Pindown, the staff's reputations, the lack of appreciation of how open Oxendon was, fear that staff were being perceived guilty until proven innocent and the problems of trying to assure staff that UNISON was doing it's best for them.

Mr White told us that UNISON'S job at that stage following closure was not only to try and support the staff but specifically to try and establish the weight of evidence against the staff. He told us that UNISON had great difficulties in this respect and really made no progress right through to the meeting of the Social Services Committee on 2nd November. The Director was saying that there was a police investigation and it was not for him to reveal information. An approach to the Police, through the Deputy Director, saying that staff had a legitimate interest, elicited nothing by way of information. Mr White said Senior Social Services Management were attempting to block or restrict contact between staff and between staff and children. He said he understood the need for that and at one stage was advising staff to refer to the Department any approach by the children and not to be seen to be working together as a group when they had nothing to fear from investigation. But he said these restrictions put additional pressure on individual staff, especially as they were used to supporting each other. Mr White also told us that he thought in October that the Director very much took the view that there was a web or conspiracy to thwart access to information and to get at children and Social Services staff. He denied there was any organised web or conspiracy or any overall co-ordination by UNISON of the press coverage. He accepted he was not in a position to know about all conversations between staff or possible contact between staff and children. He said UNISON did manage their own press coverage and needed to do so. He said he had given publicity on 14/15th October to the intended misuse of an office telephonist for residential child care work but had been upstaged by the Director on 15th October raising with the media the possibility of institutional abuse. Mr White thought that much contact with the media arose spontaneously from community interest. The Director in his turn has told us that he made the media appearance on the 15th October because there had been an unauthorised disclosure to the press of the involvement of Mrs Kahan and he was being pressed for an explanation.

14.8 On the 20th October the Director wrote again to all members of the Social Services Committee, the Chairman of the Council and the three Political Group Leaders updating them on the situation. It was a long letter headed "Strictly Personal and Confidential". The Director stated that the children had been successfully relocated. Some minor staffing problems at other children's homes had been resolved. Phase one of the investigation was coming to an end and, although the Police were still investigating the allegation of rape, it was premature to consider re-opening Oxendon until a clear picture emerged from the investigation. The Police advice was that staff should not be redeployed temporarily until all the evidence had been reviewed. The letter addressed the unease and discontent of the Oxendon staff which the Director considered was perhaps inevitable bearing in mind the investigation had to be kept confidential and a close knit group of staff were on leave of absence together. He had received representations for the immediate re-opening of Oxendon. The Director referred for the first time in writing to the possibility that there was a situation of "institutional abuse" at Oxendon. He defined "institutional abuse" as a situation existing in a home, for whatever reason, where practices occur as a matter of routine or with sufficient frequency, which are outside defined practice guidelines or recognised good practice. We point out that this definition is different from that of systematic or organised abuse in that there is no element of deliberate organisation of the abuse. As regards the media , the Director stated that in view of the increasing public and staff concern he had decided in consultation with the Police, to inform the press that they were not ruling out the possibility of institutional abuse. The Director told us that this tended to increase speculation about what had been happening at Oxendon and fuelled staff concerns. The Director referred in his letter to the appointment of Mrs Kahan. He also said that some senior members of his staff had been subjected to heavy external pressure because they had been involved in the investigation.

14.9 During the Inquiry we were given particulars of this pressure. At the time of of the review of practice in late August/September Ms Youngson and another female member of staff in the Department received anonymous abusive calls of a sexual nature on their mobile phones. This was reported to the Police who could do nothing because mobile phones had been used.

XV ACTION ON FINDINGS

15.1 On the morning of the 22nd October, the Police made a presentation of their investigations and findings to the members of the Child Protection Strategy Group with the addition of Mrs Kahan, which was followed by review and discussion of evidence. In the afternoon the Group met formally (their third meeting) with Mrs Kahan as consultant to discuss the specific cases and actions, to review the strategy discussions and to plan future action.

The Group comprised the Director (in the Chair) Ms Youngson, Ms D Parkin, Barrister (of the Council's legal department), the Principal Officer Child Protection, the Detective Police Superintendent, the Police Detective Inspector in joint charge of the investigation and Ms Stimec (NSPCC) plus Mrs Kahan.

The objectives of involving Mrs Kahan were:

a) To obtain her advice in reviewing the evidence to date.

b) To obtain her advice in formulating immediate action and in identifying the nature and time of the next stages.

c) To assist the police in determining the criminality or otherwise of various care practices used at Oxendon.

d) To agree with her what her future involvement might be in connection with the forthcoming meeting of the Social Services Committee on 2nd November, in managing the staff and children, in discussing the closure/re-opening of Oxendon and in her being an expert witness for the County Council.

15.2 At the morning meeting the Detective Superintendent and Detective Inspector made a presentation using a slide projector. They ran through the events leading to and the process and results of the police investigations. They provided a picture of the regime at Oxendon which was much fuller in many respects than had been the case previously. The results of the interviews and of the examination of Oxendon documentation were available as were the views of the external social workers. At that stage the Police had still to prepare and send files to the Crown Prosecution Service (but were intending to do so) in relation to the two allegations of assault occasioning actual bodily harm and indecent assault. They had not completed their inquiries in relation to the rape allegation. During the course of the presentation the Police handed out various documents to the meeting including:-

a) A summary of main points from the Police interviews of children.

b) A brief outline of concerns expressed by Bedfordshire Social Services staff not employed at Oxendon.

c) The observations of the three external social workers engaged in the joint investigation with the Police.

d) A summary of staff responses to the review of practice questionnaires.

e) An example of Oxendon counselling notes.

15.3 The Police had taken into consideration at the start of the investigation the allegations made by Child B, the concerns about the "massage" incident in May and the incident of restraint mentioned by male resident, Child D, in his review of practice interview. Child D had said on that occasion that when he was restrained, he had sustained bruises but when he complained had been told to forget it. The Police also brought into consideration the concerns expressed by SSD 2 in his memorandum of the 14th July to Ms Youngson. The Police had access to the questionnaires of staff, children and others completed at the review of practice interviews in August/September. They produced a written summary of the interviews of 44 staff and other adults and 5 of the children. We have examined the summary against the questionnaires and consider that it is a fair resume for the purposes of the police investigation

15.4 We examined in detail the brief outline of concerns expressed by Social Services staff outside Oxendon, accepting the Police's qualification that practice and management issues were not fully investigated. The brief outline was prepared from interview notes prepared by the Police shortly after interviews with the staff. The interview notes were not therefore statements approved by the interviewees. We obtained the interview notes and compared them with the brief outline of concerns. We also met most of the staff and checked whether they accepted the interview notes and concerns attributed to them as being reasonably accurate.

There are inevitable shortcomings in a 'bullet point' summary of concerns which does not identify staff, their experience, qualifications, timescales or whether information is first or second hand. The terse comments themselves beg further questions. We did identify a few specific weaknesses but they do not detract from the overall picture presented and, if removed from the document, would not in our view have affected the decisions of the Child Protection Strategy Group. The test is whether the summary fairly reflected staff anxieties about child protection not whether it reached the standard of accuracy required in a criminal prosecution.

The presentation gave details of the practice of counselling at Oxendon. The police examination of the Oxendon documentation had revealed large numbers of notes of individual counselling sessions held by Oxendon staff with children on a one to one basis. It was clear that the Police had not obtained all the counselling notes. Most of the children counselled were female and in many instances they were counselled by male members of staff. We have described and assessed the Oxendon counselling practice earlier in this report. It is sufficient to say here that the Police were particularly concerned about the counselling undertaken by Staff 9, a male member of staff which focused heavily and frequently on the details of incidents of sexual abuse, often covering the ground repeatedly. The notes also showed that Staff 9 had on a number of occasions invited or allowed girls in an emotional state as a result of the discussions to sit on his lap at the close of the session and cuddle. The counselling practice appeared to the Police to be a matter of considerable concern.

The Police had also obtained large numbers of incident report forms prepared by Oxendon staff describing incidents involving children arising from actual or threatened violence. The Police had prepared a chart detailing in chronological order some 205 incidents from the beginning of January 1992 up to the temporary closure of Oxendon on 30th September, 1993. Some150 incidents involved restraint of children. The Police had been involved in 15 of the incidents. The chart gives particulars of the date and time of each incident, the location(s) and the child or children and staff involved and describes briefly the incident and any complaint made or injuries incurred by children or staff. We have examined the chart in detail. It is a thorough and competent piece of work. We have tested the information provided in it against separate evidence received by us regarding a number of incidents entered in the chart. We have found the chart to be accurate and balanced in its descriptions of incidents and complaints and very helpful to us. The Police expressed their concern at the large number of incidents recorded and the implications for the atmosphere in the Home and effects on children. We have dealt generally with the subject of violence and restraint earlier in this report.

We regard the summary of main points from interviews of residents, the brief outline of concerns expressed by Social Services staff outside Oxendon and the observations of the external social workers as of such significance that we append them to our report. (Appendices 5, 6 and 7 respectively). We have amended the summary of main points by deleting children's names and have omitted the comments of the external social workers on the quality of the administrative arrangements for conducting the investigation as they are irrelevant to our Inquiry; otherwise the documents appear as the Child

Protection Strategy Group saw them. To satisfy ourselves as to the manner and content of the presentation, we asked the Police to repeat their presentation to us in its original form which they did, with one difference: the Detective Police Superintendent was ill and his place was taken by another Detective Inspector who had been involved in the investigation. The Police also submitted as part of their presentation other issues of concern (of a general management nature) which we have listed in paragraph 14.2. Finally, the Police offered their own initial assessment of the results of Operation Saga in the form of two contrasting interpretations of Oxendon:-

a) Caring staff, difficult children, poor management leading to questionable practices with regard to restraint, kisses and cuddles, massage etc.

   Remedy - action by Social Services Department.

b) Abusive regime in which abusive practices have become commonplace and complaints procedures have been manipulated (or complaints suppressed) to hide the true picture.

   Remedy - full investigation

In closing our narrative of the morning meeting, it is right to point out that the investigation was substantially completed and a report back made within three and a half weeks of the decision being taken to launch the investigation.

15.5 At the afternoon meeting the Child Protection Strategy Group discussed at length with the help and advice of Mrs Kahan the information which had been gathered. We have concluded that virtually the whole text of the meeting record is essential reading. We have therefore appended to our report a copy of the minutes of the meeting and of the Director's account of Mrs Kahan's oral advice taken verbatim from the Director's evidence (Appendices 8 and 9). He told us that Mrs Kahan approved the minutes and has seen the Director's account of her advice. The only omission is paragraph 12/93 of the minutes which dealt with an administrative issue.

15.6 At this stage we do not comment on the merits of the Child Protection Strategy Group's deliberations but it is necessary to draw attention to certain matters. Minute 8/93 "Update" states that the Strategy Group at its last meeting was recognising the possible implication of institutional abuse and that that was the basis for commencement of the investigation.

We also highlight Mrs Kahan's suggestion in the same minute that the Group differentiate management issues, criminal matters and possible disciplinary actions. These are crucial distinctions with which we dealt in our account of the Child Protection Procedures. A number of important conclusions, recommendations and decisions were reached. We draw attention to the following:-

a) The agreement that there had not been systematic organised abuse but that there had been a habitual pattern of practice which had been abusive and careless of the welfare and needs of the children and that had resulted in abuse in a number of individual cases which were then subject to disciplinary or criminal proceedings.

b) The agreement that a set of management guidelines for all homes was required which should be agreed between management, staff and children.

c) That each member of staff should be given the opportunity to review what they had done and agree to change.

d) The agreement to recommend that there should be a permanent dispersement (dispersal) of staff and children and that Oxendon should not be re-opened until those conditions were met.

These matters were pursued at the meeting of the Social Services Committee on 2nd November and in the management/relocation interviews with Oxendon staff which followed in November and onwards.

15.7 During the Inquiry we met Ms Jane Stimec (NSPCC) who was a co-opted member of the Senior Strategy Team which oversaw the joint Police/Social Services investigation and also a member of the Child Protection Strategy Group after 28th September. She told us that the Social Services Department had brought in Mrs Kahan, consulted the Social Services Inspectorate, used external social workers for interviewing the children and involved herself in the Inquiry. She felt they had tried hard to be and to be seen to be open-minded and even-handed in the way they carried out the investigation. She did not feel there was any acting in bad faith or actually setting out to prove something for the sake of proving it.

15.8 Mr White also commented upon the Child Protection Strategy Group's deliberations on the 22nd October. He expressed astonishment that the Police had put forward two possible scenarios of child care practice at Oxendon. He noted that the Strategy Group had not adopted the "poor practice" scenario and questioned whether the Social Services Committee on 2nd November was offered the choice. He also referred to the agreement that a set of management guidelines was needed for all homes and questioned whether the Strategy Group had asked what guidelines were already in place.

Staff Disciplinary Matters

15.9 At this point it is necessary to interrupt the narrative of events to give a brief account so far as relevant of the Council's disciplinary procedure in cases of alleged misconduct. The procedure is spelt out in a formal document agreed with the trade unions.

The appropriate senior officer has authority to suspend an employee from duty on full pay, in cases which appear to involve serious misconduct, while the case is being investigated. Employees who are suspended from duty have the right to have a union representative or other employee present as a witness when being informed of their suspension. The employee should be informed of this right and also the reasons for suspension. The reasons have also to be communicated in writing without delay and a copy of the disciplinary procedure provided. Suspension should be sufficiently long to permit a thorough investigation which should be dealt with as speedily as possible. Following suspension, the procedure falls into two possible stages, the investigatory stage and the hearing stage.

At the investigatory stage, an Authorised Officer is appointed and he in turn appoints an Investigating Officer to look into the complaint. The employee must be advised of the Investigating Officer's appointment and given clear details of the investigation. The Investigating Officer may or may not interview the employee as appropriate although it would be normal practice in all but exceptional cases to do so. At the conclusion of his enquiries, if he considers the complaint is without foundation, he must advise the employee in writing without delay. In that event the disciplinary proceedings are concluded. If he considers there are grounds for serious disciplinary action he refers the matter to the Authorised Officer for a disciplinary hearing.

At the hearing stage, if it is ever reached, the Authorised Officer presides. The employee is given full particulars of the allegations made and evidence against him well before the hearing. At the hearing the Council's representative and the employee have full opportunity to present their case. The Authorised Officer then decides whether the allegations have been substantiated and imposes any disciplinary sanction.

15.10 The procedures were invoked in connection with five Oxendon staff and seem to have given rise to a great deal of misunderstanding and concern. An employee who is suspended should be given the reasons for the suspension, the name of the Investigating Officer and details of the investigation. Thereafter he may hear nothing further during the investigatory stage. Full particulars of the allegations and evidence against the employee are not provided unless and until it is decided to hold a disciplinary hearing. Four of the Oxendon cases did not get beyond the investigatory stage; the fifth case has been held in abeyance pending the County Council's consideration of our report.

15.11 Following suspension of the five Oxendon staff in late October, UNISON approached the Director and suggested that, if justice were to be seen to be done, the disciplinary proceedings should not be conducted by County Council staff but by external independent persons. This proposal was accepted by the Director and endorsed by the Social Services Committee and accordingly Professor N.S. Tutt was appointed Authorised Officer and Mr B.W. Steward, Investigating Officer. Mr Steward told us that following his appointment he agreed with UNISON that he would not start work until the Police had taken decisions upon their investigations. This accounts for staff being advised by the Police that no further action would be taken by them, followed shortly afterwards by a letter starting the disciplinary investigation. In our account of the disciplinary steps taken and of the outcome of the police investigations we have withheld the names of individual staff as the cases have either been abandoned or not yet concluded.

15.12 On 22nd October, the same day as the meeting of the Child Protection Strategy Group, Staff 7 was suspended from duty. This was done by letter from the Director delivered to his home address without a personal interview. The stated reason for suspension was *"allegations of criminal and professional misconduct arising from police inquiries under the child protection procedures which have led to your arrest"*.
The period of suspension was initially until 19th November. Staff 7 was instructed not to contact other staff or children and to refer any contact made with him to Mr Labe or Mr Morris. The letter stated that, despite previous advice and his agreement not to, it was understood that Staff 7 had been speaking to staff and children since the start of his leave of absence. He was told that failure to adhere to this instruction would result in disciplinary action.

15.13 On the 25th October the Director met Mr White at Mr White's request. UNISON could not understand why it was necessary to keep Oxendon closed, nor could they understand that the Director had areas of concern outside the specific allegations affecting the five members of staff who were being suspended.

15.14 On the 26th October Staff 9, Staff 3, Staff 2 and Staff 11 were suspended from their duties at Oxendon. Again, this action was taken by letter sent to the employee's home address without a personal interview. The stated reasons for suspension were as follows:-

Employee		Reasons
Staff 9	-	Allegations of professional misconduct arising from Police enquiries under child protection procedures.
Staff 3	-	Allegations that over a period of at least 18 months you were involved in a number of incidents where you used undue physical restraint and that you engaged in playfighting both actions being outside the bounds of national standards in child care practice and therefore outside the policy of the Department and which caused injury to children in your care.
Staff 2	-	Allegations of professional misconduct arising from police inquiries under the child protection procedures which have led to your arrest.
Staff 11	-	Allegations of professional misconduct arising from Police enquiries under the child protection procedures.

In each letter an instruction was given that the employee must not contact other staff or children and to refer any contact to Mr Labe or Mr Morris. Failure to adhere to this instruction would result in disciplinary action. Staff 3 told us that he was disgusted to be suspended by letter. Staff 2 has told us that the letter to him angered him greatly as he had not been arrested.

15.15 Mr White told us that on the 26th October UNISON's local solicitor wrote to him elaborating on the message given on the 15th October. The solicitor said he had sat in on a number of Police interviews, some staff being interviewed as potential defendants and others as witnesses. He was certain that no Police action would arise from the two initial allegations. He expressed the view that the outstanding more serious allegation against Staff 7 should not prejudice the immediate re-opening of Oxendon and reinstatement of all the other staff. He stated that he had no doubt UNISON would be urging that course on the County Council.

The Director however has pointed out that at that stage the Police were preparing files for the Crown Prosecution Service so that prosecution was a real possibility.

15.16 Also on the 26th October the Director wrote to all Oxendon staff, other than those who had been suspended, informing them that their leave of absence was extended for a further period up to the 30th November. He said that it was hoped that the additional period would enable the Police to conclude their enquiries and decisions could be made about the future role of Oxendon and its staff. He stated that he would be reporting to the Social Services Committee on 2nd November and would then be in a position to feed back information to them. With that in mind he would be arranging for senior managers to meet with staff over a two week period between the 8th and 19th November to discuss the implications for their future. He said he regretted not being able to tell them more until the Police had concluded their enquiries. He said he appreciated the pressures they were under and thanked them for their patience and co-operation.

XVI SOCIAL SERVICES COMMITTEE ACTION

16.1 As the date of the Social Services Committee drew near, Mr White wrote a two page letter to all members of the Committee on the 28th October and offered them the following comments, observations and requests. We summarise the letter:

a) UNISON subscribed to the temporary closure with the greatest reluctance. An alternative suggestion of removing the entire management team plus any other suspected staff had been rejected. He listed resultant strains in the Department and suggested that members would need to be convinced that no other course of action was available.

b) Analogies in the press with Staffordshire Pindown were rubbish. The Director had given assurances to the Committee following Pindown.

c) UNISON would value Mrs Kahan's opinion on the issues surrounding Oxendon and had twice asked to meet her. He asked members to endorse this urgent request.

d) Oxendon had operated under the County Council. Those people external to Oxendon with a responsibility for it were answerable if anything were wrong.

e) One of his greatest concerns was the approach of guilty until proved innocent.

f) UNISON's view was that the protection of clients must be a primary concern but protection of staff came a close second. Staff needed to feel they could act when a client was in physical danger to himself or others and receive management support if allegations arose. Staff confidence was lacking.

g) Front-line staff felt they would be made scapegoats.

h) UNISON wanted Oxendon reopened as soon as possible operating good social work practice and with confidence in management.

The Director informed us that the letter was not copied to him but he became aware of it shortly afterwards.

We comment that we have seen no evidence during the period from the inception of the review of practice in late August to the meeting of the Council on 16th December that the Oxendon staff were being made scapegoats.

16.2 Mr White also told us that on 1st November the Deputy Director wrote to him stating he understood that Mr White was holding a meeting with staff on the 3rd November. He asked for the time, place and subject matter and stated that apart from the meeting itself, he needed to determine whether suspended staff could be allowed to attend. Mr White told us that this meeting was one of a series of meetings he held with staff as it was the most efficient way of briefing them. He noted that when the Social Services Department found out about the meeting they were quite concerned as to its purpose.

16.3 The Social Services Committee of the County Council met on 2nd November. This was a normal programmed meeting but the sole agenda item taken in the afternoon was the Oxendon matter. The discussion of Oxendon lasted nearly 5 hours. The Committee, having resolved to exclude the press and the public, dealt with Oxendon in private session. The Committee considered and rejected a request for a representative of UNISON to attend the meeting during consideration of proposals relating to staff. Mrs Kahan was again present at the meeting to advise the Committee. The Police were not represented. The Director presented an oral report to the Committee. He began by outlining the duties placed upon him, the Committee and the Council by statute and otherwise, in connection with the Oxendon situation and the conflicting priorities which he had to weigh. He told us his intention was to help the Committee understand the situation better and the complexities of communicating adequately whilst fulfilling child protection obligations and protecting confidentiality of personal information. He based his account of events on the presentation made by the Police to the Child Protection Strategy Group on the 22nd October making use of an overhead projector as had the Police and using their slides. He recommended the Committee to adopt the recommendations of the Child Protection Strategy Group and also proposed the setting up of a Select Panel of Councillors to make recommendations to the Committee in March 1994. He told us that he proposed a Select Panel because the management issue needed examining at member level. Mrs Kahan also gave her views to the Committee on the situation. The decision not to reopen Oxendon at that juncture was properly one for the Committee to take. The Committee considered the issues at length giving particular attention to the difficulties which the whole process created for Oxendon staff. This was reflected in the Committee's decision that the Director ensure that communications with staff be appropriately carried out in the further conduct of the matter. The Committee endorsed the action taken to date, accepted the conclusions of the Child Protection Strategy Group and, with one qualification expressed its intention to implement fully the recommendations made by the Group. The qualification amended the Group's decision, that staff should be given the opportunity to review what they had done and agree to change, by adopting a more sophisticated form of words about counselling staff. The Select Panel was established with wide terms of reference relating to residential child care in Bedfordshire generally but encompassing any changes thought necessary at Oxendon. A copy of the minutes of the meeting is appended to this report. (Appendix 10).

16.4 Early on 3rd November, Mr White, met the Director and Deputy Director who briefed him on the meeting of the Social Services Committee the previous day. Mr White told us that the Director expressed his concern at the long time which had been taken up on the 2nd November dealing with questions relating to staff compared with the time spent discussing the children. Mr White told us that he took the opportunity to speak to the Deputy Director about the Deputy's concerns regarding Mr White's forthcoming meeting with staff. He said that later, in mid-morning, at the meeting he was able to break the news to the staff, most of whom were present. If he had not briefed them, the first news they would probably have had would have been radio and T.V. coverage on the morning of 4th November and then local newspapers reaching them late that afternoon. He told us that despite the forewarning the media coverage on 4th November was shocking and harrowing for many staff and their families given the size of Leighton Buzzard and the fact that Oxendon staff were was well known in the community.

16.5 The meeting of the Social Services Committee attracted a good deal of media interest. The Director endeavoured to issue an early press statement. He was delayed on 3rd November by the need to clear it with various interests and it was the following day before the statement was released. In the meantime there had been extensive comment in the press, radio and television. The Council's press release was extensive, without of course revealing any personal information. It described briefly the history of the closure and the child protection investigation. It quoted in full the decision of the Committee, following the findings of the Child Protection Strategy Group, that there had been an habitual pattern or practice which had been abusive and careless of the welfare and needs of the children. It differed in one respect in referring to individual cases which *"may be the subject of"* disciplinary or criminal proceedings, whereas the decision used the words *"are the subject of"*. It also set out the other key decisions about not re-opening Oxendon in its present form, permanent dispersement (dispersal) of staff and children, the suspension of five staff, the counselling of individual staff and the setting up of the Select Panel.

16.6 The Director also wrote to all Oxendon staff (other than the 5 suspended staff) on 4th November setting out the decisions of the Committee, including the setting up of the Select Panel and explaining that the Panel would consult the staff (and others), investigate management issues which arose and consider the future need and provision of residential child care in the County. He also said that now the immediate Child Protection procedures had been completed he hoped they could concentrate their efforts on resolving issues for staff. He added that the next stage was to arrange for senior managers to meet with staff during the next 2 weeks to discuss the recent decisions and the implications for the staff's future. A further letter would follow.

16.7 On the same day the Director also wrote to all children who were resident at Oxendon at closure explaining what had happened, the key point for them being that they would not be returning to Oxendon. He said that the police investigations would soon be over and the ban on meeting or contacting staff would be lifted. In giving evidence to us the Director asked us to note:

(a) that the ban was really the other way round i.e. staff not to contact children. He was not able to instruct children in those terms.

(b) as regards staff not contacting each other, there was advice not a ban.

One statement in the letter to children regarding the decision to close Oxendon temporarily, has been hotly disputed. The letter states that the decision was supported by the staff at the 30th September meeting and adds *"In fact at that meeting Trevor Mead acknowledged that management had no other choice in the circumstances"*. In evidence to us Mr Mead denied this and said that he only accepted the invocation of the child protection procedures. The Director in evidence was certain the statement had been made. The transcript of the tape contains no such statement but, as we have explained, that is not conclusive. It is possibly significant that the seat occupied by Mr Mead in the Council Chamber was not immediately adjacent to a microphone and was on the other side of the Chamber from the Director's seat.

16.8 On the 5th November Mr White received another letter dated 3rd November from UNISON's local solicitor expressing his strong belief that the closure of Oxendon was unlawful and that a declaration to that effect and injunction re-instating the staff and re-opening the premises could be obtained. He urged UNISON as the union representing the vast majority of staff to lead the action. Mr White said that he took this matter up with UNISON's headquarters and regarded it as most unfortunate that, because of other pressures upon the union, this was not followed through.

The Director's reaction to us regarding this letter was that he was not told of it at the time, that the Council believe they acted lawfully and that the closure was not a permanent closure of the Home.

We comment briefly on the views expressed by UNISON's local solicitor to Mr White in October and November about the allegations against Oxendon staff and about the re-opening of Oxendon. He was obviously advising on the information available to him at the time and did not have access to the wider concerns known to the Police and Social Services. His views therefore did not address the situation as a whole.

16.9 Mr White told us that on 3rd November union representatives sought an urgent meeting with Mrs Kahan. The Director and he had differences about arranging a meeting. The Director thought it was necessary to agree written ground rules before such a meeting could take place because Mrs Kahan had requested information on the purpose and scope of the meeting. Mr White said that, whilst he did not accept that, he did write to the Director on the 5th November suggesting some ground rules. He wanted the

meeting on 17th or 18th November; he had no objection to the Director or any other senior officer being present; he would like Mr Findlay, the Branch Secretary (Mr Sanders) and himself to attend for UNISON along with other union representatives. There was no objection to the members of the Social Services Representative Panel being present; the purpose of the meeting would be to allow them to ascertain:

a) Where and from whom and how the Child Protection Strategy Group got its information (no names expected).

b) The practices and procedures which were described as abusive and careless of the welfare and needs of the children.

c) Whether the courses of action then being followed were considered to be the best or the only ways of dealing with the situation; finally the meeting would be conducted on a cordial and professional basis. In conclusion he said he wanted the meeting to be primarily an opportunity to hear Mrs Kahan's views.

He told us that he copied the letter also to senior councillors for the three political groups because he felt the Director was procrastinating unnecessarily and he needed political support.

16.10 Mr White said the Director responded saying he had arranged the meeting and agreed it should be held at the earliest opportunity but unfortunately the earliest date Mrs Kahan could offer was the 30th November. He had arranged a 30 minute meeting for that day as suggested by Mrs Kahan. Mr White said he in turn responded on the 17th November complaining that the meeting deserved more priority and that 30 minutes was totally inadequate. He copied the letter once more to senior councillors. Subsequently, the Director and Mrs Kahan set aside an hour or an hour and a half for the meeting. The Director however asked for further information about the questions to be raised but Mr White, feeling he was getting little co-operation, did not respond.

16.11 On 7th November Mr White was quoted in the local press drawing attention to the report to the Social Services Committee in 1991 (following the Pindown Report) which gave children's homes in Bedfordshire *"a clean bill of health"*. Mr White asked then why only Oxendon staff were being targeted for examination and not the management. In commenting on that press report to us Mr White also drew attention to a letter from the Group Services Manager responsible for Oxendon in August 1991 in response to queries from elsewhere in the Social Services Department. The letter stated that no practices had been carried out at Oxendon which had not been sanctioned by himself as the line manager and additionally that the Department as a whole had been aware of and accepted such practices as appropriate. We put this point to the Director in evidence, looking specifically at the practice of massage. The Director made it clear that neither he nor the Child Protection Strategy Group knew, at the time, of the approval given by the Group Manager. That only came to light later. The Director's view was that the circumstances of the approval would not have been acceptable to him nor he believed to the Social Services Committee. he said the Group Services Manager had no right to give such authority nor his line manager to endorse it. Mr White's reaction to that was that the Director had not looked for contrary evidence which did not fit his case.

16.12 8th November the Director wrote to the 5 suspended members of staff informing them of the decisions taken on 2nd November. The letter referred to the setting up of the Select Panel but not to the proposed counselling sessions with staff.

16.13 Mr White told us he issued a press release on 9th November because UNISON were frustrated about the lack of information coming to them and thought that what was happening was grossly unfair. UNISON wanted to counterbalance the press coverage given to the Council and mount a defence for their members. He said they received quite a bit of publicity.

XVII THE MANAGEMENT/RELOCATION INTERVIEWS

17.1 Following the Committee meeting on 2nd November, Ms Youngson set about organising the staff counselling interviews to take place by mid-November. The suspended staff were excluded from interview whilst suspended. She told us that it was too time consuming for her to see all the staff herself and she decided that she should see all the senior staff with Mr P Morris and Mr R Labe. She told us UNISON objected to the involvement of Mr Morris. Ms Youngson said that she took their views into account and engaged SSD2 in his place. Mr White gave us a different account. He said he did speak to the Deputy Director about Mr Morris but did not even know he was to be involved in the interviews. The three Unions concerned, UNISON, NASUWT and NUT insisted that they should be involved in the interviews to represent their members. Ms Youngson told us that she had not envisaged the Unions being involved as the interviews were not intended to be part of any disciplinary, grievance, capability or redundancy procedure. However she said she again acceded to their request and informed staff that they were welcome to bring a friend or trade union representative with them as an observer and to seek guidance. Mr White on the other hand told us that he was totally opposed to observer status only. This difference came to a head at the first interview he attended. Ms Youngson told us that she envisaged the meetings as informal and helpful and as part of the healing process. She did however bear in mind Mrs Kahan's advice that each member of staff should be given the opportunity to review what they had done and agree to change (insofar as that was appropriate) and that the Department should try to ensure that staff did not carry the culture forward with them. In particular she said she was struck by Mrs Kahan's advice that the staff who had worked at Oxendon would need *"pretty clear indications that what went on at Oxendon will not do"*. Mrs Kahan had been very clear in her advice that if the staff remained convinced that they were not doing wrong they could set up a grievance centre wherever they went.

17.2 Ms Youngson said to us that on personnel advice she wanted to deal with this in an explicit way by asking the staff concerned to agree in writing not to go on practising the way they had been at Oxendon. However, Ms Youngson recognised that the character of the meetings had been formalised by the involvement of the Unions and decided it was necessary to prepare a script which would be used for each member being interviewed. She decided that SSD 2 who was comparatively junior, would need the script to assist him. The script was agreed with the Director and the Departmental Personnel Manager. As the script is an important document we append a copy, even though it is long. The interviews which Ms Youngson did not attend were conducted by SSD 2 and Mr Labe. We have been unable to ascertain who tendered the personnel advice to Ms Youngson.

17.3 Prior to each interview a short letter was sent to each member of the staff setting out briefly the purpose of the meeting, which was to consider the feedback from the Social Services Committee, the future of Oxendon, staff and children, child care practice issues and retraining and redeployment including facilities to be made available to staff. We call the interviews the "management/relocation interviews" to distinguish them from the review of practice interviews held in August and September. Staff did not receive the script in advance of interview nor were they or their representatives given a copy at the meeting. It was sent to them after the event in the form of "Notes of the information given at the management interviews with Oxendon House staff, and of comments made" and they were asked to sign and return an acknowledgement statement which we append to our report. We also append the script itself (Appendices 11 and 12). Ms Youngson said to us that she did not, of course, just read out the script but adapted her manner according to the member of staff. She said that her intention was that there should be room for interaction. SSD 2 and Mr Labe told us that they were quite clear from the briefing Ms Youngson gave them and from the style of the initial interviews she conducted with senior staff that the intention was to read out the prepared script verbatim and without deviation. This was to ensure everyone received the same information in a consistent manner. At various stages, during the reading of the script, there were breaks to allow comment or discussion with the representative. SSD 2 regarded Ms Youngson's interviews as more formal than the ones he conducted later. At the end of the script and after any staff response, Mr Labe talked about redeployment. SSD 2 told us that Mr White had a copy of the script after the first interview he attended.

17.4 The first management/relocation interview on the 11th November was with Mr Wallace, Deputy Principal who was accompanied by his NUT representative, Mr J Dixon. Ms Youngson described this as a relatively civilised and helpful meeting but that, from that point onwards the meetings became very unpleasant. She said that SSD 2 was also very unhappy about the staff and their attitude in general. Most of the staff were represented by UNISON and Ms Youngson told us that from the interview of the first UNISON member onwards (she directly followed Mr Wallace), the UNISON representative Mr White was very threatening and aggressive. She had the feeling throughout that UNISON hindered the interview process. Many meetings had to be cancelled and rescheduled and staff did not appear. Staff refused to sign the acknowledgement statement and refused to say that they would not practise in the same way again. She believed that the desire to be absolutely clear about not operating bad practices was interpreted by staff as the Department requiring staff to sign an admission of guilt. The Department did not see things the same way and wrote accordingly to reassure staff. Ms Youngson's intention had been to get the staff back to work by 1st December. She wanted to tie this in with the proposed staff retraining programme which she wished to start on that date. However, after the first interviews UNISON said that each member of staff wanted a month to consider their redeployment options. Ms Youngson told us that she was very surprised at this. She had initially said she would give the staff four days to consider the options. When it became clear that UNISON would not agree to that, she agreed that staff should have 14 days to consider. This period was applied to all staff whenever they were interviewed.

Ms Youngson told us that her plan was totally subverted by UNISON. However, by the end of November some 35 staff had been interviewed. The process was however hindered because over the same period some 10 staff went absent on sick leave. The interviews continued well into December until a large majority of staff had been seen. However a further 6 staff became sick around the Christmas period. Ms Youngson carried out 4 interviews with senior staff and intended to carry out later the interviews of the suspended staff. She also saw the domestic staff as a group and described that meeting as quite different. She told us that UNISON had not been so involved with them and she was able to conduct the interview the way she wanted and the staff were generally happy. Adding to that account, the Director pointed out that the interviews were as unpleasant for, the interviewers as they were for the staff. SSD 2 had commented upon the difficult staff attitude in the interviews compared with that attitude outside.

17.5 During the Inquiry, we received evidence from UNISON, NASUWT and the NUT about the management/relocation interviews. We also held one meeting with the teachers as a group and two meetings with the care, clerical and domestic staff as a group. We sought the reactions of all of them to the interviews. We received almost nothing but criticism.

UNISON and the NUT were critical of the proposal to limit the role of their representatives to that of an observer. They said they needed to represent fully the interests of their members who regarded their careers at stake. Mr White said that there were very heated discussions about this issue and the interviews were acrimonious. He said he categorically refused to accept any limitation on his role. The matter seemed to be put to one side in later interviews. He said that Ms Youngson had written to NASUWT and the NUT before the interviews saying that UNISON accepted observer status. That was not so and it gave the impression that UNISON had prejudiced the position of the other Unions by conceding the matter.

17.6 There was wide criticism of the manner of conducting the interviews. We were told the script was read out from beginning to end verbatim. Mr Fred Mulberry, the NASUWT representative, told us he was shocked by the measured slow delivery, like a charge being read out. Staff were not given an advance copy to read nor handed one at the interview. As a document it took a long time to read. This process took most of the available interview time. Staff said they could not take it all in but were then asked to comment on it. Several said they felt they were being intimidated and there was no real opportunity to exchange views. The NUT complained that the script contained general allegations with no information given as to the basis of the allegations. Without that information there was no real opportunity to respond. They regarded the meeting with their member as rather sterile. UNISON told us that the script was tendentious and untruthful in regard to external inputs, use of the side room (paragraph 4), the complaints procedure (paragraph 5), child protection procedures (paragraph 7) and sexual abuse (paragraph 8).

We were told that many members of the staff found the interviews very harrowing. Some were reduced to tears in or after the meetings feeling their years of work had been trashed. The staff said they suffered a deep sense of shock, the full impact becoming apparent when they received and digested the written Notes of Information given. A number of staff stated they had since been ill with stress induced problems. They saw signature of the acknowledgement statement as tantamount to an admission of guilt. Yet, until later corrected, they saw an implication, in the way the interviews were handled, that redeployment was conditional on signature. The teachers, domestic and office staff said they were treated in just the same way as the care staff, although their involvement with the care of children was indirect and they had little knowledge of what constituted good or bad practice. They felt they were being implicated in institutional abuse.

17.7 Mr White said he was aware of criticism that UNISON had held up the interview programme. He told us that in his view in simple logistical terms the idea of getting all staff back to work by the 1st December was unworkable. The timetable for holding interviews and arranging relocation would have been impossibly tight. The plan really subverted itself. He told us that his other work continued as normal but he cooperated and moved many commitments in his diary to attend the interviews. He said he recognised the therapeutic benefit of getting staff back to work.

When we met the domestic staff we had not then received Ms Youngson's evidence about the success of her interview with them as a group. However the general tenor of their evidence to us did not differ significantly from the evidence given by the remaining staff.

The staff accepted when we put it to them that the first few interviews had been the most difficult. Thereafter it was possible to forewarn other staff of what to expect.

17.8 County Councillor Helen Orchard, who is a member of the Social Services Committee and lives in Leighton Buzzard, wrote to the Director on 30th November about the interviews. She said she was exceedingly unhappy at the confrontational nature of the statement sent to staff. It seemed to her analogous to obtaining a confession by threat as the implications for staff who were reluctant to sign seemed very unclear. She said the script read at interview sought staff acknowledgement that the overall way of working was believed to be abusive whilst the acknowledgement statement sent for signature sought agreement that the child care practices at Oxendon were bad, before the opportunity to attend training courses or discuss fully what alternative ways of working were available. It left no room for questions of degree. It was her understanding that most if not all of the practices could be acceptable if used appropriately. A blanket condemnation was therefore neither necessary nor conducive to building good practice in the future. Staff needed assistance to know where to draw the line, not a demand for repentance. She discussed her letter with the Director on 2nd December and wrote to him again that day expressing the view that the current statement be amended.

17.9 We comment at some length on the management/relocation interviews. There was agreement all round that the interviews were a failure. We concur with that view.

To understand how that came about, it is necessary to describe the situation in early November (when the interviews were being organised) as seen through the eyes of Social Services Management and the Oxendon staff. From management's viewpoint, they had been involved in a hectic, sometimes frantic, series of events, involving the closure, the joint police/social services child protection investigation, and the steering of the results of that investigation through the Child Protection Strategy Group and the Social Services Committee. They knew all that had happened. They were under instructions to counsel each member of staff, giving them the opportunity to review the old culture of Oxendon and agree new practices for the future. They were coming out of the child protection phase and were starting to address the management and practice issues which had arisen but which required further investigation. They were wanting to press ahead quickly and get the staff back to work by 1st December. From the staff viewpoint they had been on leave of absence since 30th September with too much time to reflect on what had occurred. They had been opposed to the new rules on physical contact, suspicious of the review of practice and the departure of Mr Mead and shocked by the closure of the Home on grounds of suspected child abuse. Since the closure all information about the investigation had deliberately (and necessarily) been withheld from them, whilst media comment had flowed. Some staff had been interviewed by the

police; a consultant in child abuse had been instructed; staff had been suspended. The culmination was the letter and publicity on 4th November announcing the finding of an abusive pattern of practice and permanent dispersal of staff and children. The staff were by then frustrated by their ignorance and resentful of how they had been treated and harbouring a keen sense of unfairness that they had had no opportunity to present their viewpoints. In short management and staff were poles apart.

17.10 Against that background we doubt very much that a rapid and fruitful dialogue could have taken place. The process of accommodating other viewpoints and shifting attitudes on both sides was bound to take time. There was a great need, after the 2nd November meeting, for Social Services Management to take stock on how best to handle the post-child protection stage. They were no longer in a situation where the need to protect the children overrode the normal management processes of information sharing and consultation and decision taking. They did identify the change of mode:

"The Panel will investigate management issues which arise from the current situation" and

"Now the immediate Child Protection Procedures have been completed I hope we can concentrate our efforts on resolving issues for staff".
(Director's letter of 4th November)

"The decision taken on 2nd November was taken in the context of child protection issues without the further examination of other aspects of the situation".

(Select Panel - 8th December)

Unfortunately they did not adjust sufficiently to the restored normal management situation nor did they proceed at a pace or in a manner which took due account of the ignorance and attitudes which staff held at that time.

17.11 The approach to the staff was both unimaginative and insensitive. We endorse the criticisms of the interviews made by the staff, their representatives and Councillor Helen Orchard. If the information contained in the script had been tabled as a set of provisional conclusions and representatives of the staff and Unions invited to challenge them, a way forward could have been found. Mr John Wallace made this point to us with considerable effect during the Inquiry. We sympathise with SSD 2 and Mr Labe for the role they were expected to play in the interviews. The failure of the interviews can be judged from the tide of expression which poured forth from staff at the Inquiry, when given the opportunity, for the first time, to state their viewpoint. In expressing these views we are not suggesting that management should abdicate from telling staff clearly what is and what is not acceptable child care practice, but we are sure Mrs Kahan would not have approved the manner in which it was done. The information and concerns collected by 22nd October were sufficient to justify the child protection action. They were not sufficient to justify the indiscriminate, pontifical script put to the staff without distinction of job, seniority or length of service. They had been told they would not return to Oxendon and their careers were at stake. We hope that the information now provided by the Inquiry will provide a better basis for decision taking.

17.12 At the end of each management/relocation interview a follow up interview was offered with Mr Labe. Many staff attended to discuss personnel issues and redeployment options. All staff available for redeployment have co-operated with the process; none has been redeployed against their wishes. Redeployment was not conditional on signing the acknowledgement statement. As at 13th May, 1994 30 staff had been redeployed on temporary placements and 4 had been appointed to permanent posts elsewhere in the Department. Nine staff were on long term sick leave and one had resigned. One was on a training secondment and seven were considering redeployment options but were not yet redeployed. All temporary redeployments had been extended to 30th June 1994. We have been told that the temporary placements have worked exceptionally well. The process is continuing.

17.13 A training programme was eventually launched on 15th February, 1994 and training courses took place in May and June. One of the staff has written to us, following his completion of the training programme, drawing attention to the difficulties facing staff, particularly Oxendon staff, in coping with the course content whilst the issues surrounding Oxendon remain unresolved. He was not criticising the course trainer.

17.14 On 11th November, Staff 11 was informed by the Crown Prosecution Service that no further action would be taken regarding the allegation of the criminal offence of indecent assault made against him. On 15th November, the Authorised Officer appointed to deal with the disciplinary allegation of professional misconduct for which Staff 11 had been suspended, wrote to Staff 11 informing him of the appointment of the Investigating Officer and giving details of the investigation namely into allegations of sexual abuse and indecent assault and the use of undue physical restraint which caused injury to a child. (The allegations related to the same incident for which he had been suspended from duty on 26th October).

17.15 On 15th November the Authorised Officer under the disciplinary procedures wrote to Staff 9 informing him of the appointment of the Investigating Officer and giving details of the investigation namely into an allegation of inappropriate professional behaviour with female residents during counselling sessions which included inappropriate discussions of their sexual behaviour. He also wrote to Staff 2 in the same terms except that the investigation would be into allegations that he was involved in a number of incidents where he used undue physical restraint, this action being outside the policy of the Department, and which caused injury to children in his care.

XVIII PROTEST AND RESPONSE

18.1 Mr White told us that in November there were growing protests at the decision of the Social Services Committee on 2nd November. He said some of the children joined in. Community leaders in Leighton Buzzard raised concerns. The local Member of Parliament became involved. Mr White thought that a lot of the protests were ad hoc; he said certainly there was no co-ordination by UNISON and, to the best of his belief, no overall co-ordination by anyone. He thought it was possible some individual staff were co-ordinating but he had no knowledge of that. To illustrate his point, he said that the first time he met or spoke to Dr S Watkins, a general medical practitioner and medical officer to Oxendon, who campaigned vigorously for the staff, was on the 8th December.

18.2 The Director told us that during the closure of Oxendon and through into October there was a reasonable level of informal contact and discussion of the issues between him and Mr White. However, as October passed, the staff and unions became impatient for information as to the allegations that could justify continuing closure of Oxendon. The Director's freedom to provide information was heavily constrained by the requirements for confidentiality of personal casework and staff information and observance of the child protection procedures. But Mr White took the view that the Director and his senior staff could have been much more forthcoming from September onwards in responding to requests for information, many of which in his view raised no issues of confidentiality or child protection.

18.3 The differences between the Department and staff were aired in the local media, the war of words as we have described it. The situation escalated with the Director's public revelation of possible institutional abuse on 15th October and then the County Council's press release of the 4th November describing the findings and decisions following the child protection investigation. Speaking of this period Mr White informed us that apart from dealings with Social Services Management in relation to Oxendon, industrial relations within the Social Services Department and elsewhere in the County Council continued on very amicable terms. However during November when the management/relocation interviews were getting under way, the Director has told us that he and the Party Spokespersons of the Social Services Committee became most concerned at the adverse press they were receiving.

18.4 The Director reminded us that he had emphasised to the Oxendon staff at the 30th September meeting the value of a low key approach to the media, so as not to exacerbate the situation. He had followed that approach but the media coverage of staff concerns became very prominent and he was pressed by the Labour Group Spokesperson to explain the County Council's views. The Spokespersons of the other two Groups did not like that approach but did not want to appear disloyal. The spokespersons concluded that the reasons for the Committee's decisions and an outline of the evidence on which it was based should be given to staff and copies released to the media. As is common practice the Director drafted a letter for consideration by the Spokespersons. On 17th November the three Spokespersons wrote to all Oxendon staff (with a slightly altered version for

suspended staff) giving an extensive account of the evidence, commenting on particular care practices in the Home and giving the reasons for the decisions. The letter literally highlighted the Committee's unanimous decision that Oxendon should not re-open unless there was a permanent dispersal of the staff group and previous residents did not return there. We append a copy of the letter (Appendix 13). It was copied to the three Unions and the Social Services Inspectorate and released to the media the following day. We understand that in fact the press was already aware of the letter from another source.

18.5 Mr White described the letter to us as extremely damaging. He responded to the three Spokespersons on the 18th November and copied his response to the media. The letter dealt in turn with each of the main points raised by the Spokespersons and ended by stating that in the light of the handling of these matters the position of the Director must be in serious jeopardy. The points made by Mr White included:-

a) No staff were interviewed directly by the Child Protection Strategy Team - that might have helped to establish the facts.

b) Why, if the authority regarded certain child care practices as unsatisfactory, were they authorised or tolerated or not acted upon at a much earlier stage by external managers who were aware of them?

c) Staff and unions not being able to access the evidence against them and being treated as guilty even before the sight of same.

18.6 Mr White also commented to us on the letter of the 17th November and made the following points:-

a) As regards massage, the massage review team preferred the term 'shoulder rubbing' to describe what took place at Oxendon. Oxendon was one of twelve establishments where massage was used.

b) The report by the Investigating Officer on the use of restraint and violent incidents drew no clear conclusions as to whether the number was excessive, although the criticism had been that the number was unacceptably high.

c) The staff were appalled at the implication that physical contact was initiated for the benefit of male staff rather than female residents.

d) As regards counselling he complained that no guidance had ever been given to residential establishments to control its use.

e) As regards playfighting, Mr White complained at the juxtaposition of the sentence to the previous comment on restraint which he thought suggested that playfighting sometimes lead to restraint. Again, he said that the Investigating Officer's report made it clear that playfighting did not result in a restraint situation.

18.7 Mr White told us that the disclosure of the letter of the 17th November to the media had enormous impact on UNISON in attempting to defend the staff but even more so on the staff themselves. He said disclosure of the letter placed huge pressure on the staff and their families. He said that in partial response he appeared on local radio on the 19th November to put the staff viewpoint. He also said that the call for the Director's resignation, appearing in the local press on 21st November, was news managed by UNISON to avoid further adverse publicity against staff. UNISON felt justified in doing so because the disclosures and terminology in the 17th November letter were in his view totally out of order. The NUT also told us that the letter was reprehensible.

In the same edition a letter from the three Political Group Leaders recording their full support for the Director in relation to Oxendon also appeared. Commenting further on the 17th November letter, the Director said it was inevitable that inconsistencies of expression would creep in; it was necessary to look at the situation as a whole.

18.8 We recognise that the Council was torn between the need to shelter the staff and children on the one hand and the need to justify its own position on the other. The 4th November press release had provided a factual account of the Council's actions following the allegations of child abuse but had avoided going into details of the results of the investigation. It held a balance. The 17th November letter however sought to justify at length the Council's position. Publishing the detailed results of the investigation before they had been further examined was likely in any event to antagonise staff. But that would perhaps have been justified if the status of the child protection findings had been made clear. Unfortunately the letter was couched in partisan terms which unnecessarily prejudiced the Oxendon staff.

18.9 On 22nd November the Director wrote a long letter to the Minister of State, Department of Health giving his assessment of the current situation regarding Oxendon and the circumstances which led to the suspension of staff. The letter dealt with the history of events up to and including the meeting of the Social Services Committee on 2nd November and described the follow up action:-

a) Oxendon would remain closed pending consideration by the Select Panel.

b) Individual management interviews were being held with Oxendon staff:

c) Disciplinary procedures, using external Authorised and Investigating Officers in order to demonstrate the independence of the disciplinary process, were being set up to deal with the suspended staff.

d) The work of the Select Panel would start as soon as possible.

As regards relationships with staff, the Director said that the Unions, particularly UNISON, appeared to be trying to oppose the decision not to re-open Oxendon unless staff were permanently dispersed and the children did not return. He said that the Unions appeared to be seeking every opportunity to promote this challenge, including inappropriate use of the management meetings with individual staff. So far there was little acceptance by staff of the inappropriateness of certain practices and all were currently reserving their position with regard to redeployment.

18.10 On the 26th November, Mr J Bowis, a Junior Health Minster, in response to a Parliamentary question, made a statement about Oxendon in the House of Commons in which he incorrectly alleged that Staff 7 had been charged by the Police. The position was that he had been arrested and bailed but not charged. The statement was corrected on the 29th November. The error originated in the Ministry and the County Council did not contribute to it.

18.11 On 29th November the Director wrote to all Oxendon staff (apart from the five suspended staff) stating that it had not been possible to see all staff by 30th November and it was impracticable to return all staff to work by 1st December. The leave of absence of staff was extended to 5th January, 1994 if not redeployed in the meantime. Mr Labe offered further consultation sessions to staff to discuss redeployment.

18.12 Mr White told us that in late November UNISON were sending to County Councillors information to redress the allegations against staff. He said the views of some County Councillors began to change.

On 29th November the Bedfordshire County Staff Branch of UNISON held its Annual General Meeting and approved a motion on the subject of Oxendon. The motion set out the position of UNISON in some detail and therefore we append a copy to our Report (Appendix 15). Also appended is a statement by the Branch Secretary, Mr Sanders to Branch Members explaining the motion (Appendix 16). We draw attention to two points:-

a) This was the first mention of a request for an Independent Inquiry to investigate practice at Oxendon.

b) UNISON were talking to the Director and County Councillors rather than arguing via the media.

18.13 On 30th November the meeting took place between representatives of UNISON, NASUWT and the NUT including Mr Findlay, UNISON's National Officer for Social Services and Mrs Kahan. The three Party Spokespersons, the Director and Ms Youngson were also present. The meeting lasted about one and a half hours. Mr White told us that the meeting was a disappointment. The Unions had placed much store on the meeting but they left with too many questions and issues on which Mrs Kahan was not prepared to comment. She made it clear that her prime concern was the protection of the children. Some points raised were not within her remit or would have to be dealt with by others or by discussion between the Unions and the County Council. Mr White told us that the Union representatives gained the impression, rightly or wrongly, that Mrs Kahan was an extremely

busy consultant, moving between local authorities, attending high pressure meetings, dealing with difficult decision taking processes and with too little time to analyse and question the need for further evidence.

18.14 On 7th December Mr White wrote to all county councillors enclosing various documents for their consideration including the motion of the Branch Annual General Meeting. He asked Councillors to bear them in mind when the question of Oxendon was debated at the meeting of the County Council on 16th December.

18.15 On the same day UNISON held an open public meeting at Sandy Upper School under the slogan 'Do You Dare to Care?' to consider the Oxendon situation and gather support for the staff's case. Mr White said the meeting was advertised by poster and was publicised in the local press. He said it was well attended including staff, union representatives, councillors, members of the public, a few Oxendon children and the media.

Mr White told us that the meeting proved to be a turning point in the campaign. Regional television gave sensitive cover to the meeting and there was subsequent media coverage. He denied that UNISON actually organised the attendance of the children; he said it was conceivable that individual members might have. He told us that the meeting placed pressure upon the County Council and boosted staff morale.

No resolution as such emerged from the meeting: Mr White told us there was discussion of the way forward including finding a way ahead with the Director. At that stage both the Director and the Unions were trying to re-establish normal working relations. There was also discussion of the possibility of an independent inquiry being set up. Mr White said that he urged those attending to raise their concerns with county councillors.

18.16 The Select Panel on Residential Child Care held its first meeting on the 8th December. Mrs Kahan attended as Independent Professional Adviser. The Panel received a detailed presentation from Ms Youngson on the responsibilities of social services authorities and the rights of children and parents. The Panel then discussed the subjects which they would need to examine, agreed their work priorities, approved arrangements for the submission of evidence, identified their information requirements and fixed a programme of future meetings. They also commented upon a draft statement prepared by the Director which, with the approval of the Social Services Representative Panel, it was proposed should be made at the Council meeting on 16th December. The statement supported an easing of the Social Services Committee's approach to the permanent dispersal of Oxendon staff as a condition of the re-opening of Oxendon. The dispersal of staff should be regarded as temporary and subject to the review of each individual member of staff's situation when the work of the Select Panel was completed. The reason given for this suggested relaxation was that the decision taken on 2nd November was taken in the context of child protection issues without the further examination of other aspects of the situation. The Select Panel supported the principle of re-opening Oxendon subject to stated key criteria being met. The Select Panel also added that information on the background allegations leading to the Social Services Committee's decision on 2nd November which was consistent with the proper protection

of the children and with police procedures should be given to staff to assist them in understanding the quality of practice required in future. The Select Panel decided to ask for the Council's approval to the statement.

18.17 We refer next to a confidential special meeting of the Labour Group members of the County Council also held on 8th December. Mr White told us that the purpose of the meeting was to consider whether to change the Group's stance in relation to Oxendon. The Director told us that the meeting had been suggested by the Chief Executive as a sensible means of informing the Labour Group members at first hand of the Oxendon situation. Initially the councillors met the Director, Deputy Director, Director of Human Resource Strategy and Mrs Kahan. Mrs Kahan left eventually and subsequently the Director and colleagues followed because they were unwilling to participate during the attendance of Dr Watkins. Mr White then went in to the meeting with Dr Watkins who addressed the meeting. She left and the Director and other officers returned to make a presentation with Mr White present. The presentation was followed by numerous questions and lasted in all about two hours. Mr White thought that the presentation was very influential. Mr White told us that the Director began with an account of the massage incident which Mr White considered to be exaggerated as regards Staff 1's conduct and attire. The Director told us he regards the discrepancies as essentially irrelevant to the main issues. We draw attention to the account of the incident given at paragraphs 9.5 - 9.7. It was following the 8th December meeting that Staff 1 prepared her account described in paragraph 9.5. At that stage the Director said he would have to leave and he and his two colleagues departed leaving Mr White to present the staff's side of the story.

Mr White summarised for us the arguments he put forward; we mention only points not expressly covered elsewhere. He argued:-

a) The external managerial role at Oxendon had not been addressed significantly on 2nd November.

b) There had been strains on the child care system resulting from the closure.

c) There were concerns about the welfare of the children.

d) Of the criminal allegations, one was outstanding but the remainder would not result in prosecution and of the disciplinary proceedings none had so far resulted in any sanction.

18.18 Mr White told us that the outcome of the meeting was that the Labour members of the Social Services Committee decided to change their position and make a proposal to the County Council meeting on the 16th December. He said that subsequently the full Labour Group of county councillors met and agreed to make a change. This led in turn to the motion which was eventually put to the County Council. Finally Mr White told us that neither the unions nor the Oxendon staff had any hand in the drafting of the motion.

18.19 Mr White pointed out that initially the Director was opposed to the setting up of the Independent Inquiry but changed his mind once the Labour Group had altered their stance. The Director accepted that, saying that he was of the view that the Select Panel would have dealt adequately with the outstanding management issues. Internally, but that, once it was clear that elected members had started to shift their ground, he worked to ensure that, if possible, the County Council reached a concensus. He said he had discussed the matter with Mr White who was appreciative of the Director's support.

18.20 On the 14th December Staff 7 received a letter from the Police advising him that no further action would be taken against him in respect of the allegation of rape with an Oxendon child.

On 15th December the Investigating Officer wrote to Staff 9 stating that there was no case for formal disciplinary action against him and that his suspension was therefore lifted immediately. He also recommended that there be a management interview with Staff 9 to discuss the professional issues that had arisen and concerned Staff 9 personally. Letters in similar terms were also written to Staff 2 and Staff 11.

XIX SETTING UP OF INDEPENDENT INQUIRY

Meeting of the County Council

19.1 The County Council meeting was held at County Hall, Bedford on 16th December. Before the meeting there was a demonstration and lobby of councillors by Oxendon staff and supporters. The Director complained to us during the Inquiry that the behaviour of some of the demonstrators was quite unacceptable. A petition with over 300 signatures requesting an independent inquiry was submitted to the Council. When the report of the Social Services Committee (including an item relating to Oxendon and the statement by the Select Panel) was submitted to the Council, a motion was also put forward that the report be received subject to the Committee being asked to reconsider the Oxendon item. The terms of the motion are appended to our Report (Appendix 16). The motion was carried unanimously and the Council asked the Social Services Committee to consider the motion and any other matter relevant to the establishment of a full and independent inquiry. Although there was no substantive decision (only a reference of the motion to the next meeting of the Social Services Committee) there was a clear consensus that an independent inquiry be established.

19.2 As we draw this account of events to a close it is desirable to consider the state of communication between the Social Services Department and Oxendon staff and the Unions over the period.

During the inquiry we received many complaints from Oxendon staff, UNISON and the NASUWT about failures of communication between the Social Services Department and Oxendon staff and their union representatives. We consider here not the quality of information given and comment made but shortcomings in the correspondence process - staff letters unanswered, acknowledgements not followed up, letters gone astray. Mr Fred Mulberry, the NASUWT representative, from his perspective, regarded the Department as disorganised and suggested that this had contributed to the closure of Oxendon. There is no doubt that the Teachers' Unions did have a practical problem of recognition in the Department. Oxendon was the only social services establishment with education on the premises and some Social Services staff were not used to dealing with matters affecting teachers. Both Unions were represented at the 30th September meeting with staff. But it was the 5th November before the Director realised that they had a legitimate interest and arranged to provide them with the flow of information that went to UNISON as a matter of course. In a tense situation, correspondence failures with staff anxious about their jobs and frustrated by lack of information added significantly to the difficulties.

19.3 We raised this matter with the Director and he readily accepted that communication had been a problem in what was a very complex situation. He pointed out that the Oxendon staff and Unions were only part of a complicated network of communication which he had to endeavour to sustain. Much information was of a confidential nature and there were often complications of who owned the information and to whom it could be released and for what purposes. Confidential information properly released for one purpose could readily be used improperly and pass into other hands. His main purpose was to protect the children but he also had to protect the investigations, maintain accountability, meet staff needs and manage media and public interest. In a high profile and highly sensitive situation, this was an enormous task for which the Department was not prepared or resourced. The sheer volume of incoming communications was such that they could not reasonably be dealt with promptly. It was an impossible task even to ensure constant effective and accurate information. Some errors of judgement were made, some administrative confusion occurred and some organisational difficulties arose.

In fairness to the Director and his staff it should be said that he did succeed in circulating information to the Oxendon staff on a regular and timely basis, as he promised at the meeting with staff on 30th September.

Understandably, Oxendon staff who could not obtain a satisfactory response to their concerns tried alternative sources but this approach sometimes added to the volume of paper and confusion. A number of staff lodged official grievance complaints against the Department for various alleged failures. These added to the workload. Although staff had a Union representative, some appeared to conduct independent correspondences with the Department on matters affecting them, sometimes making inappropriate requests. Failure on one side to identify and use the single best line of communication and on the other to make it work properly contributed to the confusion

19.4 On 16th December the Investigating Officer interviewed Staff 3 regarding an allegation of assault arising from playfighting which had taken place between May and September 1993. The allegation had come to light as a result of an interview of Child 4, a male resident at Oxendon on 22nd September conducted by the Review of Practice Team. The interview did not extend to any other matters.

On 21st December the Authorised Officer wrote to Staff 7 informing him that the Investigating Officer had been appointed to investigate as a disciplinary matter the same allegations of sexual misconduct with a child in care as the Police had recently abandoned so far as criminal law was concerned. His period of suspension was extended to 14th January, 1994.

On the 22nd December the Authorised and Investigating Officers reported generally to the Chief Executive on the outcome of the disciplinary investigations which they had completed in respect of four of the staff . Their reports dealt not only with the specific cases but also with broader issues relating to counselling of children, restraint and the management of violence, playfighting and the management of the Home itself. Those latter

reports were prepared expressly for our use and they have been of invaluable help in undertaking the Inquiry. We have taken them into consideration in reaching our conclusions and recommendations.

On the 23rd December Staff 3 was advised orally on behalf of the Investigating Officer that there was no case for disciplinary action against him and his suspension was lifted immediately. Because of an oversight, the letter confirming this advice did not reach Staff 3 until the 3rd February, 1994.

On the 10th January, 1994, the Director wrote to Oxendon staff who had not then been temporarily redeployed extending their leave of absence to the 28th January. Further available consultation sessions were notified to staff wishing to discuss redeployment or any other related personnel issues.

19.5 Commenting generally on the disciplinary proceedings, we were concerned to find that none of the five staff was seen personally by a senior officer in the Social Services Department when being suspended from duty. Suspension is not a disciplinary sanction but it is an important step in any employment contract. An employee being suspended is entitled to a face to face interview, unpleasant though it may be. The disciplinary procedures require it. An interview would have provided an opportunity to tell the employee how the disciplinary procedures operated. An explanation at that stage could have avoided much of the misunderstanding, frustration and correspondence which ensued. We have no disagreement with the final decisions reached by the Authorised and Investigating Officers.

19.6 The Social Services Committee met again on 11th January and decided to support the motion put to the Council on 16th December but made two amendments:

a) Specifying April 1994 as the date of a special meeting of the Committee instead of 31st March 1994 and

b) Deleting consideration of the terms of reference of the Select Panel from the remit of the Inquiry.

The Committee also deferred the further work of the Select Panel until the report of the Independent Inquiry had been considered and approved the terms of reference and arrangements for the holding of the inquiry. A press release regarding the setting up of the inquiry was issued the following day.

19.7 On the 13th January the Chief Executive wrote to Staff 7 telling him that the disciplinary proceedings regarding sexual misconduct would not be pursued. However he added that the Investigating Officer had reported very serious concerns about the regime being operated at Oxendon and in particular about Staff 7's involvement. Disciplinary action would be taken against Staff 7 on these matters but, since the Independent Inquiry would consider the issues, it was inappropriate to proceed with a disciplinary hearing at that stage. Staff 7's period of suspension was continued until after the Inquiry has completed its work. Mr White met the Chief Executive in late January to discuss Staff 7's position and the Chief Executive wrote to Mr White providing more information regarding the concerns of the Authorised and Investigating Officers. Staff 7 remains therefore the only member of the Oxendon staff still subject to disciplinary action.

19.8 The Independent Inquiry began its work on the 3rd February and a press announcement was made to that effect. All Oxendon staff were advised by the Director by letter dated 1st February of the start of the Inquiry.

PART III

XX CONCLUSIONS

The Decision to Close Oxendon

20.1 There has probably been more progress in the last decade understanding Child Abuse that in the previous century. We have learned to recognise forms of abuse which were unheard of until recently, and the general public has had to accept that, as well as physical abuse there is sexual abuse, systematic abuse, and ritual abuse. Regrettably we have learned that where adults have power over children, they may sometimes use this power to satisfy their own drives or simply abuse through lack of self control. The adults who commit these abuses may be the subject of criminal proceedings. It is of course important to remember that the great majority of people who have the care of children neither abuse nor neglect them, but take joy from their happy childhood and normal maturation.

20.2 Some recent events, including those which lead to the "Pindown Inquiry" have lead us to identify another form of abuse, an abuse in which the perpetrators have no evil motive, but in the processes of care, abuse children through ignorance or poor practice. Such abuse may be very difficult to detect because the perpetrators may be very well intentioned, and their relationships with the children affectionate. Furthermore the abuse may take the form of over-riding the Rights of the child through depriving him of privacy or the chance to refuse unwanted attentions, very difficult to investigate and prove. Discovered largely in Children's Homes it is known as Institutional Abuse.

20.3 Defined as simply as possible, Institutional Abuse means that a situation exists in a Home, for whatever reason, where practices occur as routine or with regular frequency which are outside accepted practice guidelines or recognised good practice, and undermine the welfare and interests of the child.

20.4 It was Institutional Abuse which the Director and the Child Protection Strategy Group suspected they had identified at Oxendon House when they reviewed all the evidence on the 28th September 1993. Already they had allegations of physical abuse against child B, and she had made further allegations which seemed to suggest inappropriate treatment of other children. Anxiety had been expressed about the improper use of massage and the Director was aware of concerns about the level of violence in Oxendon.

20.5 The evidence that the Director had to evaluate was:

a) the allegations made by child B to the Review of Practice interview team
b) further allegations by child B in interview with a Social Worker and Police

c) concerns expressed from a number of sources, including Ms Youngson, SSD 2, and Mrs McNamara about practices at Oxendon.

20.6 He had to take into account:

a) he did not know which staff might be involved in the further allegations mentioned in (b)
b) the allegations about inappropriate practices might involve many staff, and would certainly implicate the managers
c) were there other allegations, perhaps of a more serious nature yet to be revealed by the joint investigations with the Police, and which staff might they implicate?
d) there were as yet no charges laid, nor arrests made.

20.7 The Director had pressure on him from several sources:

a) the Police wanted the staff separated from the children for the investigation to be properly conducted. Ideally they would have liked the children to be separated from eachother. They feared contamination of evidence unless these steps were taken.
b) he was very conscious of the recent events resulting in the Inquiries after Pindown and the case of Frank Beck. Abuse had continued in these cases through lack of prompt and decisive action.
c) The Child Protection Strategy Group had decided on the conduct of the investigation which would:
-interview residents named by child B
-interview staff
-interview all current residents and social workers who had contact with them
-secure all paperwork and relevant documentation.
d) the Police had decided to classify the inquiry as a "major" inquiry because of the resource implications.

20.8 The PRIMARY DUTY of the Director was to protect the welfare and interests of the children, this before all else. How could this best be achieved and yet enable a full inquiry to take place? The options open to him were as follows:

- Do nothing - but let the investigation continue. This was totally unacceptable as it risked further abuse to the children.
- Remove the alleged perpetrators - but he didn't know who they were.
- Replace the senior staff - the Director, he believed, did not have sufficient staff of the right calibre who were available to carry out the task.

20.9 All of these options, and permutations of them, still left the staff in contact with the children. He decided to close the Home temporarily and make alternative placements for the children after assessments had been completed on each. He realised that such a step would cause great distress to both children and staff. Careful strategies

would have to be worked out for both. Councillors on the Social Services Committee would have to be informed.

20.10 We believe that Mr Hulbert had no illusions about the difficulties which faced him in making this decision. He would have problems explaining the grounds on which he suspected Institutional Abuse, and indeed he would have difficulty in explaining publicly his actions when the need for confidentiality was paramount. He expected some public outcry, and although he had kept the Trades Union informed, he expected problems from the staff. We believe Mr Hulbert was courageous in taking a very difficult decision. We believe that his decision was correct in the light of the information then available to him.

20.11 Whilst we support his decision, we do so with some reservations about his decision not to make preliminary enquiries from amongst his senior staff, some of whom had long and recent experience of Oxendon. Mr Terry Jones and Mr Cuell were easily available, and Mr Stonham was contactable. Mr Hulbert defends his position by pointing out that they were supervisors of a regime which might prove to be abusive. His argument has some validity but faced with the gravity of the decision we think it was common sense to collect all available opinions. They were unlikely to change his views, and they would not give him any reassurances. We can only speculate (with the benefit of hindsight) what might have happened, but perhaps their counsel might have persuaded him to take more time implementing the decision thus avoiding the confusion and distress which ensued later.

Achieving the Temporary Closure 30th September 1993

20.12 We have described in paras 13.1 to 13.8 the events of 30th September. There was such confusion and distress amongst the children at Oxendon that we cannot avoid the conclusion the closure process was, as it actually unfolded, tantamount to abuse itself. It should not have happened.

20.13 The Director told us that, having taken the decision that the staff and children should be separated, there was no practical prospect of keeping Oxendon open. There were 17 children resident and it should have been feasible to move them to other appropriate placements according to their individual needs. Assessment of each child was necessary, and to comply with the requirements of the Children Act 1989 (Section 22(4)(a)) the child should be consulted, so far as is reasonably practical, about the placement. A team of experienced senior officers was established to carry out this work under the guidance of Ms Youngson. Again some officers who could have been helpful were excluded by the Director's decision that they had previous contact with Oxendon.

20.14 The Director and Ms Youngson told us they felt it was necessary to move very quickly; the timescale was important. They were worried about ongoing abuse, and the danger of evidence being contaminated . However the timescale clearly relied on excellent communications and staff being available to carry out the

work. The decision was taken that the staff would be given paid leave of absence. The Home would be closed and the staff sent home on the same day as the children were moved.
On 29th September the staff were told to report to County Hall the next day at 2.00pm but were not given any reason. Ms Youngson arranged for the field social workers to attend Oxendon to take the children to their new destinations. She says that Mrs McNamara was detailed to be at Oxendon with staff from her Home to care for the children until they were collected. Arrangements were put in hand to reopen Runfold House, a children's home that had been recently closed as surplus to requirements. SSD2 was detailed to be at Oxendon to brief the field social workers when they arrived to collect their children. The Police were informed in case there was any trouble.

20.15 The complicated exercise was doomed by three factors. Firstly the timescale was so short the team were not able to prepare all the staff properly, and the assessments of the children were bound to be inadequate. Secondly there was a need for strict confidentiality which hampered the exchange of information, and thirdly the communications between the various members of the team were inadequate.

20.16 The children were not consulted in advance about their placements. The assessments cannot have been adequate when neither the child, the residential carer nor the parent contributed to the process. Only Mrs McNamara was available and she scarcely knew the children. Records were at Oxendon and could not be used in the assessment process. Medical and psychiatric advice was not routinely sought. In the event six children were taken to Runfold House, two to Westfield, and one to the Brambles. One child was placed in a hostel, three children were placed in foster homes, one with the parents of his girlfriend, and one was allowed home. Two had already been discharged and one child had absconded to be discovered some time later.

20.17 We are concerned about the effect of the closure on the children on the day it took place, and we have examined the records of their placements and progress subsequently. We accept that the speed of closure prevented the children being consulted about plans for them. This created angry reactions by many of the children and two refused absolutely to conform with the plans prepared. Some had recently taken part in Case Conferences which confirmed long stay plans for them at Oxendon, and were, according to their field social workers, shocked at the sudden move.

20.18 Of the children who were placed in Runfold the records show several settled quite well after the move. One continued a pattern of absconding from Oxendon and ran away at least six times in two months. One is now in custody following conviction for earlier offences, and one was involved in several unpleasant incidents at Runfold. Two children who returned home have had mixed fortunes. Both are very angry, and feel guilty, about the closure - one is settling in quite well but the other has had desperate problems at home and with education. No one can cope with him and he has had numerous

placements in Homes and schools. One child in independent living was clearly unprepared for this experience, but latest reports say she is just surviving. One child who rejected angrily the plans made for him spent some nights on the sofa in an emergency situation; the field social worker reports a series of placements and breakdowns; some offending and his life being destabilised since he left Oxendon. Another placed with his girlfriend's mother spent less than three weeks before being moved on into a rented room from which he was evicted after ten days. This was followed by two months with foster parents and now a Children's Home - this child has had five placements since Oxendon closed.

20.19 It is clear that the progress of children after the closure of Oxendon is not one of unqualified success. However, we must be careful to measure the progress against what might have been expected of children known to have disturbed backgrounds before being admitted to Oxendon. We cannot avoid the conclusion that the rapid and unexpected closure has accentuated their sense of insecurity and in some cases rejection. Immense efforts were made by all the residential and field social workers to alleviate the effects and to settle the children as quickly as possible. Some are now making the progress that might have been expected but regrettably some, according to the latest reports from field social workers, are still angry, distressed and unstable.

20.20 In contrast to the experience of the children the meeting of the staff with the Director at County Hall went comparatively smoothly. It was not a pleasant occasion for anyone, but there was a reasonable exchange of information, although the staff were left with grave doubts about the reasons behind the temporary closure.

20.21 However justified the decision to close Oxendon temporarily it could not excuse the confusion of the process. The principle of putting the welfare of the children first was the key determinant in the Director's decision to close, but this principle seemed lost when the process was started. Speed was not all essential; avoiding contaminating evidence should not have been so vital that it overruled the welfare of the children. We strongly believe Ms Youngson and her team should have taken more time over their task, and we believe that it would have been consistent with good practice to have involved some Oxendon staff, under supervision, with the assessment and transfer of children. We accept that this might have made the task of the joint investigation more difficult, but the welfare of the children must come first, and the use of staff familiar to the children would have been in their interests at a difficult time of disruption in their lives.

Child Care Practices at Oxendon

20.22 There is no disputing that many of the children placed at Oxendon presented acute problems in terms of child care management. Many came from broken homes, many from single parent homes under stress, many had suffered some form of abuse, few had experienced any satisfactory educational programme, truancy was common place, many had taken drugs, and probably all had unhappy relationships with the key adults in their lives. The task of altering their attitude to

adults and other children thus changing their behaviour patterns was an immense challenge to any group of staff.

20.23 Through personal interviews, letters, statements, video recordings of interviews, we have benefited from the opinions of many children about life at Oxendon, and about those who cared for them. Inevitably for many the reason for being at Oxendon dominated their perceptions, and many protested at being there at all, but for some it was a haven from a family battlefield. We have been impressed by the number of children who volunteered the information that they were happy at Oxendon. Some who are now young adults and responded to the request of the Director to write to the NSPCC after the closure were most warm in their appreciation of the staff. Some children also expressed appreciation for the structured and organised environment of Oxendon. Many felt that they made their first real educational progress and felt positively about the schoolroom experiences.

20.24 Some children have expressed grumbles about Oxendon; some have expressed dissatisfaction strong enough to be regarded as complaints. When interviewed by independent social workers or the Police a number of complaints have emerged which needed to be taken seriously, and we shall refer to these again. Few of the complaints were surprising, and we deduced from evidence that the small and informal grumble and grouse was conscientiously dealt with by the staff. However we have doubts about the effectiveness of the system which dealt with more serious and formal complaints. A Complaints System existed and we have no doubt was drawn to the attention of the children, but it was rarely used, and even more rarely resulted in some response to the child. We can understand why the management of Oxendon attempted to deal with these complaints internally, and we do not suspect them of being motivated by cover up considerations. We recognise that they wanted to confront these issues between the staff member concerned and the child quickly and openly. The result of this policy however was to convince the children that there was no purpose in making a complaint to outside managers. We believe the management was at fault and too complacent in this matter and also that line managers should have monitored this complaints programme more effectively.

20.25 Complaints emerged through the Review of Practice and interviews with the social workers and the Police, about rough handling, about perceived injustices, about too much physical contact, and about the content of counselling. There was one complaint about racism. None of these complaints had been formalised and reached line managers for investigation.

20.26 No evidence has been placed before us that suggests that the staff group are anything but dedicated to their difficult task. We were told that they were hard working and caring in their attitudes to the children. This is a conclusion that we also reached for ourselves. It was their enthusiasm to speed the change in the behaviour patterns of children in their care which led them to adopt practices which are now being questioned. It was, for example, their determination to prevent children from damaging themselves or others which

established the restraint policies. It was their desire to help children confront the causes of their distress which was the genesis of counselling practices. It was their belief that physical contact through cuddling or massage could comfort, relax, and perhaps create healthy relationships that supported these practices.

20.27 We have commented on the administratively efficient and stable management of Oxendon. This created for the staff an atmosphere of security and support through a structured system of supervision and personal concern. We entertained some anxiety that some of the personal support offered through supervision bordered on the indulgent, and perhaps contributed to the dependency which many staff felt towards Oxendon and the management. We have doubts that we were unable to satisfy about the ability of supervisors from amongst the managers to exercise any real control over some of the practices, especially counselling.

20.28 The whole staff group were welded into a very cohesive team. This teamwork must have been very positive in mutual support and in creating a secure and uncontentious atmosphere around the children. However it was suggested to us that the same cohesiveness created a barrier for outsiders and may have been another reason many felt Oxendon was insular and unwelcoming.

20.29 Commentators reported that there was a growing self confidence amongst the Oxendon staff, particularly since the complimentary Social Services Inspectorate Report in 1986. Some witnesses suggested that not only was this self confidence misplaced but it was leading to a form of arrogance. There was, we were told, a lack of self criticism and a reluctance to recognise the criticism of others. The sharp warning in the Social Services Inspectorate Report of 1989 should have been seen as a storm cloud on the horizon and firm action taken to avoid an outburst. Perhaps this warning was missed because one Director closely associated with Oxendon retired in 1989, to be replaced by another. The Secure Unit was closed as a result of this report but the other issues were not faced; moreover they were not, we understand, drawn to the attention of the new Director.

20.30 We have to draw the conclusion that the child care practices developed from about 1986 with neither the supervision of a consultant psychiatrist, nor the close monitoring of line management. The Oxendon managers relied largely on their extensive experience and skills learned in training twenty years previously. It would appear that little training in skills was offered to them in-house, and they made limited efforts to revise their knowledge and skills to match the new challenges. It is easy to be critical of the Oxendon management in this respect, but we must recognise they were offering a haven for the most unmanageable children and did so relatively successfully through vigorous administration and staff support. Line managers had little expertise to offer in terms of residential practices, and though interested in the running of Oxendon were relieved at its efficiency and kept apart from its practices. We know that line managers were aware of the practices but sought neither the views of the Director nor the Committee on them. Both the Oxendon

managers and the line managers therefore must share the responsibility for any failures or abuses in practice which developed after the SSI Report in 1989.

20.31 We have described in detail the child care practices which have caused concern in paras 5.1 to 5.55 In reaching our conclusions about the value of these practices we have had also opinions expressed by witnesses and the views of the children themselves. Inevitably some opinions had to be based on second or even third hand accounts and often strong views were expressed to us by people who had little or no knowledge of activities at Oxendon. Equally we recognised the eagerness of staff to defend practices which they have employed for years and which seemed to them to be effective with the children in their care. We felt a particular need to exercise care in evaluating the views of the children. We recognised conflicting emotions arising from a strong loyalty to the place that had given some of the first stability in their lives, and from the understandable anger against those who were trying to exercise influence and control over them. The views of children must be listened to, but they are not always the best judges of what is good for them, or what may damage them.

1) Restraint of children

20.32 Seriously conflicting views were placed before us as to the necessity for the amount of restraint used at Oxendon. The Police in their "Concerns" presented to the Child Protection Strategy Group raised questions along with their analysis of the incidents, yet they were keen to point out that they had no relevant experience against which to measure the incidence of events. Mrs Kahan said that she thought the levels of restraint used were too high, particularly when the high staffing ratio offered other alternatives. The National Union of Teachers in a valuable contribution to our evidence, brought statistics from special schools which suggested the Oxendon picture was not too unusual. We agreed with the NUT that the statistics were not strictly comparable, but there appear to be no national statistics or information which could help us. We compared the Oxendon analysis with that of a large institution in the North where similar discussions have taken place, but again there were too many differing factors to make accurate comparisons. NUT = NASUWT

20.33 In their evidence to us the staff described many serious events where damage to children would have resulted had they not contained the position by restraining a child from further violence. They described other children being afraid of the most violent ones, and we heard evidence of the result of violent behaviour on staff and buildings. They did not deny that sometimes, on quiet reflection after an incident, they thought of better ways of handling matters. All other methods were tried before restraint was used, they assured us, and that the history of some children showed that they had run wild in other Homes before coming to Oxendon. They firmly believed that a child had a right to be controlled, and that restraint was one method, albeit a last resort.

20.34 In reaching a conclusion we have taken four key points into account -

a) Oxendon was open about its policy and probably kept more accurate records than any other county council home. Yet it is likely that there were incidents of restraint which went unrecorded. Our analysis supports this view. A total of 205 incidents of violence - involving about 150 restraints of children - were recorded in 21 months, but other evidence suggests there were a few more. The records were sent to line managers on a monthly basis; if there were anxieties they were not actively pursued.

b) The staff had a well understood system for handling unacceptable behaviour and we accept that many potentially dangerous situations were dealt with informally, and were not recorded. We were disturbed to see that the Incident and Evaluation Report Forms rarely showed the staff saw any alternative to restraint.

c) The staff were the subjects of assault on many occasions, and we have seen evidence that they have been punched, kicked, scratched, and verbally abused. A few staff have suffered fractures, severe bruising, and cuts as a result of these incidents.

d) The design, layout, and equipping of the building which made control difficult.

20.35 We have reviewed the methods by which the staff restrained children. There is very little guidance on this matter nationally or locally. Documents have been produced nationally and locally giving advice around the circumstances of restraint but there is little guidance to staff on the precise acceptable means of restraining. We feel satisfied that, by and large, an appropriate degree of physical force was used. Some children have complained about excessive force used on some occasions, but there were few witnesses, and some form of restraint appeared necessary. On some occasions children suffered bruising and we were disturbed to note carpet burns were recorded on several others. We recognised that some of the children were the size of adults, and one or two were very large, as are some of the staff. Perhaps there was a danger of the male staff feeling challenged and therefore using their strength unwisely. One incident emerged from the Police interviews with the children which was investigated formally but resulted in no prosecution or disciplinary action.

20.36 We have reached a judgement that physical restraint was probably used more frequently at Oxendon than was strictly necessary. We do so with some diffidence in the light of the points made above. Yet in the evidence presented to us we felt there was an unfortunate degree of pride in the need to use restraint with such difficult children. We are not convinced that the management at Oxendon sought to find enough alternatives. In the final analysis physical restraint is a restriction of liberty, however temporary, and the regime at Oxendon seemed to find this not sufficiently unacceptable.

2) Physical Contact

20.37 Undoubtedly comforting and affectionate physical contact between staff and children was greatly to the benefit of the latter. The Oxendon management and staff had worked out a range of contacts which, when agreeable to the children, would support a good relationship and ease tensions at difficult times for individual children. We do not wish to deny that such contacts also have benefits for the staff, who can get encouragement from the sharing of affection in a tangible fashion. In evidence children displayed little anxiety or resentment at these contacts, although there were some who were determined to maintain their personal space without being subject to touching. The evidence that physical contact took place without children's consent was minimal. Yet many who witnessed the scene were left anxious, and accounts of cross gender contacts left us and some others worried. It is particularly important to be careful about touching between adults and adolescents, but we heard from witnesses and the staff themselves of frequent physical contacts between the male staff and teenage girls. This we believe was foolish. It could give quite the wrong messages to disturbed and impressionable girls and was not preparing them suitably for conduct outside Oxendon; it also placed staff in a vulnerable position.

20.38 We conclude that a good concept, carried out with good intent, was taken to excess. We are not convinced that the children had as much choice in the matter as the staff believed. There was some indication that group pressure to conform was strong and that some children may have been persuaded to take part in contacts which they were not yet ready to accept.

20.39 This excess of enthusiasm and perhaps naiveté was seen in other caring practices. Children, who had been discharged from Oxendon, were visited alone in their own flats by staff. Children who had absconded were collected and brought back to Oxendon on some occasions by staff acting alone. We do not doubt the caring intentions but it was unwise from both the point of view of the child and the staff. Mr Mead saw nothing wrong in these situations. We suggest he was naive.

3) Playfighting

20.40 Evidence on this activity was very thin. Some children and staff did not know what we were talking about when we asked questions. We did not find anything in this activity which caused us concern, and deduced it was "horseplay" between staff and children with no sinister overtones. If it caused complaints from the children, and we were not aware of specific complaints, it was because some of the staff were big men and may have been rough. It was clear that Playfighting was always initiated by the children and not the staff. Whilst we found no particular concerns at Oxendon it is not a practice we would want to see encouraged.

4) Anger Counselling

20.41 Thorough investigation has thrown little light on this subject. We have talked to the children and staff involved. We saw a video created by the staff of an Anger Counselling session, and heard the views of a number of experts who had not seen the sessions themselves. We also saw anger counselling in another institution, not part of Bedfordshire Social Services. We were left with inconclusive views about Anger Counselling at Oxendon. We can accept that this form of counselling can be of great value conducted by trained staff in the right setting. The member of staff at Oxendon practising Anger Counselling had attended a course that seemed to equip him for this work, but the practice had not been introduced with the full comprehension of line management and with the supervision that we suspect was necessary. It was another example of keen and enthusiastic staff trying to improve their skills to help children, with little real understanding of either the value or dangers of the practice, and another example of the Social Services Department management taking little real interest in the activities of Oxendon.

5) Massage

20.42 We have summarised our views in Paras 5.34 to 5.38. This activity sprang to prominence over one regrettable incident. However the incident served to raise appropriate questions over massage and other matters. We commend the use of neck rubbing and massage in Social Service establishments. We can see great value in this practice for the elderly, the handicapped and the frail. We can see limited value for young people. We commend Bedfordshire Social Services for introducing the practice but it must be properly validated and controlled. Particularly it must only be administered for children and young people in situations approved by a strict set of guidelines, and regularly inspected.

6) Counselling

20.43 We have serious concerns about individual counselling sessions but equally we are concerned that this practice was allowed to develop and continue without being challenged or monitored by those responsible for the care of young children at Oxendon House. The fact that social workers, line managers and senior staff failed to question the practice meant that methods used within the Home were seen as acceptable. As time passed counselling became increasingly formalised and the structure within which it operated suggested that it was sanctioned and approved by the Department. There was no attempt to assess the value of counselling or its usefulness as a social work tool. There was no monitoring by which the therapeutic benefits could be assessed nor any measurements which could suggest the value in controlling or changing behaviour. We were also concerned that counselling seemed to have a confusing element of control as well as therapy.

20.44 We are not experts in counselling, but our concerns were shared by others. We sought therefore the advice of the National Children's Bureau, and in particular the views of Barbara Hearn who is the Practice Development Officer. She and colleagues examined selected case studies. We quote below extensively from the summary of the report -

"At best the counselling sessions could be described as well intentioned attempts by 'lay people' to help young people understand and come to terms with their past experiences and to help them rebuild their lives. At worst the sessions were in themselves abusive and badly managed and put both young people and staff at risk. There appears to have been an over pre-occupation with the sexual histories and behaviours of individual adolescent girls which at times appears to have been intrusive and unnecessary. Concern must also be expressed about vulnerable young women being questioned over their sexual histories and behaviour by male staff. There appears to have been no consideration given to the need for a female member of staff to be present or indeed for a female member of staff to conduct the interviews.

The usefulness of these sessions in terms of collecting evidence for child care or criminal proceedings or as a therapeutic tool is extremely questionable. The responses from the young people were often a consequence of leading questions being put by the individual staff member. In addition we can find no evidence that they added to the management of the young people's behaviour within the establishment or from the notes, evidence that the young people benefited from the individual sessions. We feel it is extremely dangerous to allow practices to develop which are based upon insufficient knowledge and which are promoted by individual staff as being therapeutic or acceptable, especially if expert support, guidance and supervision is absent. The danger is increased when credence is given to those practices by senior managers, qualified staff, and others through their complicity of silence or lack of understanding.

The fact that some young people themselves requested counselling cannot be used to justify the situation which existed. The inferred association made between counselling and 'change' for the better meant that young people were unwittingly coerced into accepting counselling as a means by which to gain acceptance by staff and by the belief that counselling was the key to change.

There appears to have been a conflict of roles as far as staff were concerned. This does not appear to have been helped by the lack of clarity in respect of the aims and objectives of Oxendon House. The boundaries between that of carer, which carries with it elements of power and control over the lives of young people, and counsellor appeared to have become blurred. As a consequence counselling was used to control behaviour. The insistence that young people who had absconded or had misbehaved remain in isolation until counselling took place undermines the voluntary contract to participate in counselling and blurs the distinction between therapy and control.

Our overall view of the documents, limited as it is by the lack of supporting or contextual material, leads us to suggest that there may be a range of

possible explanations for the kinds of work we have seen. At one level it is possible to interpret it as well meaning but seriously misguided interventions by staff anxious to contain florid behaviour by adolescent girls who were clearly traumatised by past and recent experiences. This view of events would lead us to express grave concerns regarding the management and training of staff both in the residential sector and the wider child protection sphere. We would also be concerned about the overall approach to and understanding of therapeutic work with children and young people who were subject to child protection proceedings and residential care interventions.

At the other extreme it is possible to speculate that the motivation for the counselling could have been related to personal sexual gratification, albeit vicarious, by at least some of the staff involved. Again our overwhelming concern would be that management arrangements - or their absence - never permitted this possibility to be explored. Throughout the period of the counselling there do not seem to have been concerns raised by field social workers allocated to the girls, nor by other key professionals working with them.

A closer exploration of the views of those and other staff could hold the key to establishing both the motivation issues and the operational and cultural climate in which these events were able to take place over a prolonged period.

We would suggest that any further development of counselling in a residential setting within the authority should only take place within the context of a wider strategy for therapeutic work with children and young people within the guidelines set by the Department of Health."

20.45 We would not wish to imply that all the counselling sessions were damaging or abusive; some clearly had some value to the children concerned. However we are satisfied that some were in themselves abusive and badly managed, others were intrusive and unnecessary, and the whole practice was fraught with dangers for the children and staff. There is a difficult grey area between the well meaning efforts of a Care Worker to communicate with a distressed child and formal counselling. The term counselling is loosely used in social work, and training offered for counselling is only suited to informal exchanges. Bedfordshire Social Services Department offered in-service training in counselling, and two members of Oxendon staff have attended these courses - this again can give credence to practices which require greater skills than a short course can provide.

7) Summary of Practices

20.46 From September 1983 until its temporary closure ten years later Oxendon was designated as a Home offering long term therapeutic care to children with acute behaviour problems as a result of traumatic experiences. The number of staff with appropriate training was never above 6 or about 12% of the total. Frankly some of this training was very dated by this time. Skilled support from outside was not available to help with the therapeutic practices after 1986 when Dr Milne retired. Therefore the staff developed their own practices

modelled on what they could copy from elsewhere. We cannot blame them for trying to do their best.

20.47 The Children Act 1989 Guidance and Regulations Volume 4 Residential Care gives clear instruction that *"Staff need to be appropriately competent, experienced, and qualified for their work"* **(pp.7 para 1.30)**. It goes on to add by way of example *"It would not, for instance, be appropriate for a Home to engage in family therapy unless staff involved are properly qualified and trained. In such cases, the objectives of the home should be changed to reflect what realistically can be achieved or additional support be provided from outside the home's establishment to secure the necessary skills"*.

20.48 We suggest:

a) Bedfordshire County Council was expecting too much from Oxendon.

b) In attempting to reach unrealistic goals, practices emerged, some of which were poor, some of which had questionable value, and some of which had abusive elements.

c) In unpropitious surroundings the staff still performed the simple care tasks with dedication and skill - many children benefited from their stay at Oxendon.

Action on Investigation Findings

20.49 Our conclusions about the quality of the child care practices at Oxendon lead naturally to consideration of the action taken by the Child Protection Strategy Group and the Social Services Committee upon the findings of the joint Police/Social Services Investigation. We summarised, in our conclusions upon the closure decision, the allegations and concerns available to the Strategy Group on the 28th September. That evidence was the starting point for the joint investigation. As we said in the Account of Events, the investigation was substantially completed within the following three and a half weeks. We have described the investigation at some length. We were impressed at the ground covered and information gathered in that time. But there were limitations to what could be achieved.

20.50 The first priority was to interview children and adults regarding the specific criminal allegations. By the Strategy Group meeting on 22nd October the Police had completed their enquiries in regard to two of the three allegations and the Strategy Group were enabled to consider the need for disciplinary action in relation to staff. Turning to those matters not of a criminal nature, by 22nd October some sound evidence had been gathered about some of the child care practices at Oxendon, notably restraint, physical contact and counselling but there were gaps in the information particularly in regard to the origin, supervision and monitoring of the practices. The remainder of the information (and it was substantial in quantity) also related to management and practice issues. The information took the form of concerns which had not been fully investigated or views

(sometimes at second hand) which, in many respects, could only be tested by the lengthy process of putting them to Oxendon staff.

20.51 We contrast our position as members of the Independent Inquiry. We have been supplied with copious, well prepared information from many sources. We have had ample resources at our disposal, not least the time to delve deeply into crucial aspects of Oxendon practice and management. We have had the benefit of the views of all key persons involved including virtually all Oxendon staff. No potential witness has declined to assist us. We believe the Inquiry has provided an effective dialogue with the Oxendon staff, substituting in some (but not all) respects for the unsuccessful management relocation interviews. We have also effectively undertaken part of the work originally referred to the Select Panel on Residential Child Care of the 2nd November. It cannot be surprising therefore that our findings have a sounder basis than those of last autumn's decision takers. That is not to say the we quarrel with the child protection action that was taken. We are satisfied that it was justified. After all, that was the prime objective of the joint Police/Social Services investigation.

20.52 In the Account of Events we expressed our satisfaction with the quality of the information summaries presented by the Police to the 22nd October meeting. We examined with particular care the brief outline of concerns expressed by Social Services staff not employed at Oxendon. The Police very properly made it clear that the practice and management issues had not been fully investigated. In our view, bearing in mind that health warning, too much reliance was placed by the Strategy Group and the Social Services Committee upon the various expressions of concern. Some untested evidence was treated as if verified. This shortcoming could not be made good by relying upon the undoubted expertise of Mrs Kahan, for her advice could only be as useful as the information presented to her. We are not suggesting that baseless decisions were reached but we do conclude that in important respects the findings went further than the evidence justified. We also recognise that the findings and decisions reached were, naturally, coloured by the perception at that time. In late October the extent of Police/Social Services concern must have reached its peak with the arrest and release on Police bail in connection with the rape allegation.

20.53 Our conclusions on the main decisions of the 22nd October meeting (see Appendix 8) are as follows:-

Para 13/93 - Evidence of a Network of Pressure.

As regards consistency of interview response, we find this unsurprising bearing in mind the quite remarkable cohesiveness of the Oxendon staff in both their inter-relationships and opinions. In the situation facing the staff in October we would expect them to try to find out through various means what was happening. This problem arose from the proper withholding of information during the child protection investigation. We believe it is likely that staff collaboration took place but we have received no evidence that could be described as sinister in character.

Para 14/93 - Children's Reports Describing "Normal" Situations.

We accept the basic concern but point out that whether or not a particular incident is abusive will depend on the circumstances of the case. That is as true of 150 incidents as it is of one. Restraint, for example, may well be justified. We have seen no evidence convincing us that children viewed abuse as the only way of getting affection. Many residents genuinely approved of the treatment they received and ex-residents, now adults, have written in the same terms.

We do not accept the terms of the statement that there has been a habitual pattern of practice which has been abusive and careless of the welfare and needs of the children and that has resulted in abuse (in the specific cases which were investigated). In our view the specific cases are no different from the general pattern and the child care practices need to be judged collectively, as well as on an individual basis. We conclude therefore that there has been a habitual pattern of practice, some poor, some of questionable value and some containing abusive elements. We do not overlook however the many good features of life and work in the Home.

Para 15/93 - Pindown - Recent or Not.

We have received no evidence that Pindown occurred in breach of the Director's instruction dated 31st July 1991. Proper records of restraint were kept.

Para 16/93 - Complaints.

We accept the need to review the complaints procedure. Our views are set out in our conclusions on the child care practices. Our diagnosis differs from the diagnosis in this paragraph.

Para 17/93 - Supervision.

We agree.

Para 18/93 - Therapeutic Practice - Is it Abusive?

We have commented earlier at length on these matters and support the views expressed. Our only qualification is that we received no evidence that kissing took place during counselling sessions.

Para 19/93 - Unsupported or Unaccountable Practice.

We agree.

Para 20/93 - Inter-Related Staff.

We agree and express our views elsewhere in our report.

Para 21/93 - Child Protection Procedures for Individual Children.

We comment on the statement that each member of staff should be given the opportunity to review what they had done and agree to change. This was the origin of the management relocation interviews. We accept the need to put right bad practice but in the light of our earlier conclusions we do not accept that the extent of concern was justified. Further examination was needed to ascertain the full facts and then relate them to the individuals involved.

It was also agreed to recommend the permanent dispersal of staff. In our view this was premature and went too far. It was a management issue affecting staff's careers and should have awaited a full report dealing in particular with the part played by individuals. We are pleased to see that the Select Panel at its first meeting qualified the decision.

20.54 The Social Services Committee at their meeting on the 2nd November endorsed almost in entirety the conclusions reached by the 22nd October meeting and therefore we have no need to comment separately upon the Committees resolution.

20.55 In summary therefore we support the immediate child protection decisions taken on 22nd October and 2nd November but give qualified support only to the decisions on practice and management issues. The latter decisions were taken on the incomplete information available at the time and should now be reviewed in the light of the information in this report.

Mr Trevor Mead

20.56 Mr Trevor Mead features frequently in this story and we are conscious of the fact that his future career may rest on the conclusions of this report. We believe his personal commitment and contribution to Oxendon has been immense and beneficial to the children. He clearly put the interests of the children first. He is popular and respected by the staff with whom he worked and we have direct comments from children who found him supportive and likeable. He is, however, a strong personality, which commends itself in terms of leadership but may be a disadvantage in accepting criticism and suggestions for change. He was not lazy; if anything he worked too hard. We suspect that he contributed to the self sufficiency of Oxendon which gained it its reputation for being insular. He believes he did this to support the staff in the absence of interest from the County Council. He failed to recognise dangers in some of the practices as they developed, but he was not sufficiently guided on these matters. Whilst we believe that he must shoulder some of the blame for poor practices, we feel his mistakes are more due to misdirected enthusiasm than oversight or ignorance.

PART IV

RECOMMENDATIONS

1. The principle of maintaining the interests and welfare of a child or children paramount above all other considerations must be consistently applied through all proceedings and actions.

2. The Select Panel continue to address the future of residential care for children in Bedfordshire.

3. The Social Services Committee has no more important task than overseeing the quality of care provided to children and young people in its residential homes. We suggest the Committee should refresh their minds on their responsibilities and consider establishing a sub committee or residential management committee with clear responsibility towards homes, the children and the staff. In addition, we would suggest that in setting up this quality control mechanism the Committee should involve experts from the child care field and interested members of the public to be independent partners in the process.

4. The Director remind elected members of their responsibilities to visit and inspect residential homes. He should offer training for members and consider what practical assistance is necessary to facilitate the visits.

5. The County Council has established through statute an Inspectorate to cover residential care of adults. This should be extended as soon as possible to cover all care facilities for children.

6. The Social Services Committee should consider how it might receive regular reports, perhaps from the Inspectorate mentioned above, on the objectives, practices and resources of sensitive residential and day care establishments.

7. In considering the future of therapeutic care for children the Committee should recognise that caring for these children in groups larger than 9 or 10 significantly increases the problems and reduces the effectiveness of the establishment.

8. In relation to child care practices:

(a)	Massage	-	The guidelines be published, particular staff approved after training to conduct massage, the value to children and young people be re-appraised, and the whole programme be regularly monitored.
(b)	Therapeutic Counselling	-	This practice be discontinued until the Director can satisfy the Committee that it will only be conducted by appropriately trained and supervised staff.
(c)	Restraint related to violence	-	A more effective monitoring system needs implementing culminating in information regularly being placed before the Director. More in-service training should be provided both in the prevention of violence and techniques of restraint.
(d)	Anger Counselling	-	To suspend Anger Counselling in children's homes until the Director is satisfied that the practice is sound and effectively supervised.

9. To renew efforts to gain appropriate expertise to support establishments giving therapeutic care to children. The Director will need to explore psychiatric, medical and educational fields.

10. The Social Services must maintain its commitment to training for residential staff, which might include more cost effective in-service programmes of greater depth and duration.

11. The Social Services Committee should recognise that in the staff of Oxendon they have people with commitment and skill towards caring for vulnerable children and adults. Priority should be afforded to giving them training and support to equip them for new tasks.

SUMMARY OF THE POINTS CONTAINED IN THE LETTERS FROM STAFF.

Eighteen members of staff wrote to the Inquiry. Many described press reports as causing great distress, in some cases leading to friends and family thinking they may be abusers. Leighton Buzzard is a small community and staff at Oxendon House were known as such. One said that, following the media coverage, shopping became "a nightmare" as so-called friends stood aside for her to walk through. Almost all of the staff suffered ill health following the closure. Shared symptoms were inability to sleep, the recurrence of stress-related illness, poor concentration and extreme depression. In a number of cases "acute stress reaction" was diagnosed. A number of members of staff said this put their relationships under great strain, in one case leading to marriage breakdown. It should be noted that many of the staff had a very good sick record prior to this (one, for example, had only had two days off sick in the last 11 years).

In addition, the majority of staff complained of the effect on relations. Parents and spouses were subjected to questions and comments from work colleagues. The wife of one member of staff suffered extreme depression; another suffered sickness and absence from work. Some described the distress caused to their children. Young children, seeing reports on television, found it difficult to understand why the Home at which their parents worked had been closed. Some suffered stress-related illness and a number were jeered at and teased at school. When one girl had a scratch on her face, a classmate said "Her dad must have done it. He works at Oxendon House".

Some members of staff had to cope with additional problems. One had to resign from his karate club, after ten years' membership, because he was "bad publicity". Another worked for Bedfordshire County Council on a peripatetic team caring for handicapped people. She was told that she could not work there while Oxendon House was closed because of the implications if staff were found "guilty". One of the more senior members of staff talks of what he describes as the curtailment of his career prospects. He asks what one does at 49 plus after such an experience.

A number of staff complained of irregular or bad communication from County Hall and of the unclear nature of the allegations against both individuals and the staff as a whole. Several described the distress caused by having to turn Oxendon children away from their door and by the isolation from colleagues caused by the advice of the Director not to contact one another. A number of staff wrote of the damage done to the children, some giving graphic descriptions of the day of the closure. One said that, returning to Oxendon House to collect her car, she was met by the sight of police cars and glaziers' vans . The children still there were extremely distressed.

On a more positive note, many of the staff spoke of the high level of honesty, truth and trust at Oxendon House both between individual members of staff and between staff and children. They spoke of the high level of motivation, feeling that the standard of care and time given to young people was exceptional compared to other Children's Homes. For example, extra time was offered for projects and fishing trips. A number said that they felt staff had cooperated with the Management Review and had spoken fully and honestly at it.

SUMMARY OF EVIDENCE RECEIVED FROM MEMBERS OF THE PUBLIC

Eight members of the public have written in to the Inquiry. They include: five who are close residents of Oxendon House; three local magistrates; one local businessman, whose facilities were regularly used by Oxendon residents; and one who worked professionally at Carlton School at the time Oxendon House occupied a unit there.

All of the neighbours who wrote in said that they had not encountered problems with Oxendon House. One said that management were courteous and were conscious of their need to be good neighbours. On the one occasion there was a problem, when the children climbed over a fence and pulled up his flowers, the reaction was prompt. An apology was received from the children concerned together with an offer to replant. Another reported that although there was a petition when the idea of the school was first mooted he could not remember a single complaint against the school once it was up and running. One married couple wrote that at no time since 1971, when they moved to the area, had there been any cause for alarm amongst neighbours. A second couple said that in the 30 years during which they lived close to the Home they had never encountered any behavioural or environmental problems from Oxendon House.

A number of members of the public paid tribute to the high standard of care given to the children at Oxendon House. The former member of staff at Carlton School said that there was a caring approach to children of the highest standard and that, in his honest opinion, there are few, if any, residential child care establishments in the country which could match Oxendon House for practical, pragmatic care. He also said that Oxendon House senior staff had been in the forefront of the development of good social work practice from the time he became associated with them in 1975. The staff at Carlton School learnt a lot by observing their practice and his own professional understanding of good childcare was enhanced even though he had already completed an Advanced Course on Residential Child Care. The local businessman said that the children, when they came to use his facilities, were always well behaved and disciplined and seemed to have the correct balance of "give and take" with Oxendon staff.

One of the local magistrates wrote that when she visited Oxendon House on official visits she was shown all over the building and her questions were readily answered. She said that the atmosphere was calm and ordered and it seemed that the young people were as content as could be expected when they were there by order of the Court. In fact, very many obviously regarded it as a haven and appreciated the care and the calm routine which they enjoyed. To have deprived the County of such an excellent purpose built resource, without greater thought for the damage to both staff and residents, does appear to have been a folly of enormous proportions. As a magistrate, she felt that there was no alternative locally to the services provided by Oxendon House and that they were sorely missed by the Courts. Another of the magistrates had also visited the Home. She said that she was impressed with the work being carried out there and the level of care being given to all the young people. She said that it is a very difficult task but one which was being carried out with great sympathy and understanding and which seemed to have achieved much as a result.

THE TERMS OF REFERENCE AND PROCEDURE OF THE INQUIRY

1. The Terms of Reference

The terms of reference of the Inquiry are:

(1) to report on the circumstances relating to, and reasons for, the temporary closure of Oxendon House, Leighton Buzzard on 1 October 1993, the relocation of children who were resident there, and the measures taken in respect of its staff; and

(2) to report on whether, and the extent to which, the care of children at Oxendon House prior to its temporary closure complied with good social work practice, the Children Act 1989 and guidance related thereto and on the management arrangements that were made to monitor the position at Oxendon House; and

(3) to report on whether, and the extent to which, the arrangements for the temporary closure of Oxendon House and subsequent decisions on its future, the relocation of children and measures taken in respect of staff complied with good professional child care and personnel practice; and

(4) to make recommendations on:-

(a) future child care practice at Oxendon House together with the management arrangements to be made and any additional training of staff necessary to secure that such practices are implemented and maintained: and

(b) any steps required to ensure that relationships with staff are conducted in accordance with good professional and personnel practice; and

(c) any other matter arising out of the inquiry.

2. Inquiry Procedure

A document outlining the Inquiry Procedure was circulated to witnesses before they attended the Inquiry to give evidence. The procedure was decided upon by the members of the Inquiry in consultation with the Clerk to the Inquiry. The representatives of the central parties were invited to comment before the procedures were finalised.

The document read as follows:

1. The proceedings will be heard in private.

2. Representation, whether legal or otherwise, will be permitted.

3. There will be notification of the date, time and place of each phase of the hearing as far in advance as is possible in the circumstances.

4. The rules of evidence do not apply.

5. The proceedings will be inquisitorial rather than adversarial,i.e. in general witnesses will give their evidence to the Inquiry Panel in sequence and without other persons involved in the proceedings being present.

6. The proceedings will be tape recorded and a transcript of evidence prepared from the tapes. Where for any reason it is not possible for a tape recording to be made, a note will be taken by the Clerk to the Inquiry (or other person where for whatever reason she is not present) and a transcript of evidence will be prepared from those notes. Once the transcript has been prepared it will be sent to the witness giving evidence in that part of the transcript. The witness will be required to sign it if he or she agrees that the transcript is a true record of his/her evidence. If the witness disputes any part of the record he/she should inform the Inquiry and steps will be taken to check and verify the record.

7. As the Panel discover any allegations and/or criticisms ("the case against") of persons involved in these proceedings whether from documentary or oral evidence which are in their view pertinent to the ambit of the terms of reference of the Inquiry, the persons concerned will be notified of the case against them through the sending of a letter by the Panel.

8. Where, in giving evidence, witnesses make any allegations and/or criticisms against other persons which are in the view of the Panel pertinent to the ambit of the terms of reference of the Inquiry those other persons will be notified of the case against them through the sending of a letter by the Panel.

9. A person notified under paragraphs 7 or 8 above shall be given adequate time to prepare his/her case in response. An adjournment will be granted if in the opinion of the Panel a person would not otherwise have adequate time to prepare.

10. Subject to the guidance contained in DOH Circular LAC (88) 17 entitled "Personal Social Services: Confidentiality of Personal Information", the Panel may disclose to a person under paragraphs 7 and 8 above reports or other evidence available to the Panel where

i) the report or other evidence is such that, in the opinion of the Panel, fairness requires that the person so notified should be given an opportunity to respond.

ii) The report or evidence is, in the opinion of the Panel, relevant to their decision making process.

11. If requested by a person notified under paragraphs 7 or 8 above, the Panel will, if possible, put to the person making the allegation or criticism, any questions raised by the person so notified and may inform such person of any response made. The Panel may however decline to put or may suitably modify any questions which in the opinion of the Panel are irrelevant or otherwise improper.

12. Definition: "person involved in these proceedings" includes staff, management and children concerned in Oxendon House but is not limited to these persons.

13. Whilst evidence will be given in private, the Panel expect in due course to produce a report to be submitted to the County Council which has established the independent Inquiry. It is possible, therefore, depending on the decision of the County Council, that the report will be published in full or in a condensed form and that the names of those who have given evidence or have been referred to in the report may also be published but the identities of children will be protected.

14. The Inquiry's procedure is controlled by the Panel who have produced this paper to assist persons involved in the proceedings. The Panel may find it necessary to supplement or adjust the paper as the Inquiry proceeds.

DEPARTMENT OF HEALTH

GUIDANCE

ON

PERMISSIBLE FORMS OF

CONTROL

IN

CHILDREN'S RESIDENTIAL CARE

April 1993

SECTION V: PHYSICAL RESTRAINT

5.1 Section 8 of the Children's Homes Regulations 1991 deals with control and discipline. That lists disciplinary measures which are prohibited in children's homes and includes corporal punishment. However, the Regulations do allow for action to be taken in an emergency. Section 8(3)(b) states that: **'the taking of any action immediately necessary to prevent injury to any person, or serious damage to property'** is not prohibited. By "injury" is meant significant injury. This would include for example, actual or grievous bodily harm, physical or sexual abuse, risking the lives of, or injury to, the self or others by wilful or reckless behaviour, and self-poisoning. It must be possible to show that, unless immediate action had been taken, there were strong indicators that injury would follow.

5.2 Physical restraint is the positive application of force with the intention of over-powering the child. that is, in order to protect a child from harming himself or others or seriously damaging property. The proper use of physical restraint requires skill and judgement, as well as knowledge of non-harmful methods of restraint. The onus is on the care worker to determine the degree of restraint appropriate and when it should be used. In particular, staff must be careful that they do not overreact. Training is discussed in section 11.

5.3 A staff member who has reason to be concerned about a young person who indicates his intention to leave without permission, or run away, should take vigorous action. He should give clear instructions and warn him about the consequences if he does not comply. The staff member may use his physical presence to obstruct an exit and thereby create an opportunity to express concern and remonstrate with the child, provided the principles set out in para 9.3 are observed. He may also hold the child by the arm to reinforce a point or secure the child's attention.

5.4 Where it is clear that if the young person were to leave the unit and there was a strong likelihood of injury to himself or others, it would be reasonable to use physical restraint to prevent him from leaving. However, this will only deal with the immediate problem and careful follow-up work will be necessary, probably with additional professional advice, to bring out longer term stability and prevent repeated use of physical restraint.

5.5 Physical restraint should avert danger by preventing or deflecting a child's action, or perhaps by removing a physical object which could be used to harm himself or others. Physical restraint skilfully applied may be eased by degrees as the child calms down in response to the physical contact.

5.6 The principles relating to the use of physical restraint may be summarised as follows:

i) Staff should have good grounds for believing that immediate action is necessary to prevent a child from significantly injuring himself or others or, causing serious damage to property.

ii) Staff should take steps in advance to avoid the need for physical restraint, e.g. through dialogue and diversion; and the child should be warned orally that physical restraint will be used unless he desists.

iii) Only the minimum force necessary to prevent injury or damage should be applied.

iv) Every effort should be made to secure the presence of other staff before applying restraint. these staff can act as assistants and witnesses.

v) As soon as it is safe, restraint should be gradually relaxed to allow the child to regain self control.

vi) Restraint should be an act of care and control, not punishment.

vii) Physical restraint should not be used purely to force compliance with staff instructions when there is no immediate risk to people or property.

5.7 At Annex A is a summary of operational/procedural points. Managers should ensure adherence to these, together with the principles in 5.6, in deciding the policy for their homes.

APPENDIX FIVE

OPERATION SAGA - SUMMARY OF MAIN POINTS FROM RESIDENT INTERVIEW

NAME	LIKES/DISLIKES OXENDON H.O.	RESTRAINT	INJURIES	MASSAGE	REMARKS
Child 14 yrs	-	Yes	No	-	Speaks of excessive force being used to effect restraint. Witnessed resident being restrained with arm up back and arm round throat, causing injuries.* Also refers to member of staff spitting at resident. * Not corroborated by victim who was unco-perative.
Child 15 yrs	Likes O.H.	Yes	-	-	Believes restraint is justified - supports staff actions. Does attend counselling sessions
Child 14 yrs	-	-	-	-	No interview
Child 14 yrs	-	-	-	-	No interview
Child 14 yrs	Dislikes O.H.	Yes	Carpet Burn	No	Has been restrained where arm is forced up back.
Child 15 yrs	Likes O.H.	Yes	No	No	Received and witnessed restraint, did not see or sustain any injuries.
Child 17 yrs	-	Yes	Bruising/ Carpet Burn	-	Speaks of being indecently assaulted during restraint. Also excess force used in process.
Child 16 yrs	Likes O.H.	-	-	Yes	Attends Anger Workshop - no concerns.

NAME	LIKES/DISLIKES OXENDON HOUSE	RESTRAINT	INJURIES	MASSAGE	REMARKS
Child 15 yrs	Dislikes O.H.	Yes	Carpet burns, choked	Yes	Believes excessive force used in restraint. Witnessed other residents being restrained where excess force used and slight injuries caused.
Child 15 yrs	Dislikes O.H.	No	Nil	Yes	Refers to restraint where member of staff broke his leg - thinks restraint is horrible - received massage in bedroom by female staff.
Child 14 yrs	-	-	-	-	No interview
Child 16 yrs	Likes O.H.	Yes	Carpet Burns/Choked	Yes	Speaks of being choked in a playfight which due to lack of oxygen he had "the best buzz he ever had". Received massage in bedroom at night, if requested.
Child 13 yrs	Likes O.H.	Yes	Suffered Pain	-	Speaks of restraint, which hurt, as arm forced back.
Child 15 yrs	Dislikes O.H.	Yes	Carpet burns/ fingernail marks		Believes excessive force used - arm twisted up back to point of nearly breaking. Restrained twice a week.
Child 15 yrs	Likes O.H.	No	Nil	Yes	Witnessed others being restrained with arm up back. Also staff being injured during restraint. Massage usually carried out by female staff.
Child 15 yrs	-	Yes	Cut & Bruising to ankle	-	Refers to arm up back and legs kicked away to make her sit down. Witness to male staff touching female residents inappropriately (uncorroborated). One case of racist behaviour.

NAME	LIKES/DISLIKES OXENDON HOUSE	RESTRAINT	INJURIES	MASSAGE	REMARKS
Child 16 yrs	-	-	-	-	No interview
Child 15 yrs	Likes O.H.	Yes	No	-	Believes some residents want to get staff into trouble. Supportive of staff.
Child 17 yrs	Likes O.H.	No	No	Yes	Has witnessed restraint - always resident's fault. Believes some residents think it is only way to get affection. Attends counselling sessions which are good for her. Ex-residents come back to talk (counsel), massage good - carried out by female staff. Speaks of serious injuries to staff by residents.

BRIEF OUTLINE OF CONCERNS EXPRESSED BY SOCIAL SERVICES STAFF OUTSIDE OF OXENDON HOUSE.

DOC. 25 Refers to outer clothing (trousers) being forcibly removed by staff of opposite sex.

NB Staff member concerned 'advised' that this was not acceptable.

Knowledge/complaint of restraint whereby, through rough handling, carpet burns received.

DOC. 31 Concerns Expressed:
-Closed Regime.
-Structure of counselling sessions.
-Pre-occupation with sexual abuse.
-Lack of communication.
-Shoes taken away.

DOC. 32 Concerns:
-Restraint accepted as normal.
-Staff provoke residents which then necessitates restraint.
-Philosophy that all residents have been subject to sexual abuse. Those who didn't admit it were counselled anyway.
-Unhealthy obsession with sexual abuse.
-Closed shop.
-Unhealthy relationships with female residents.
-Side room being used for restraints (sleeping in same).
-When author spoke of concerns was told, forcibly, that she must have been sexually abused (author began to doubt herself).

DOC. 39 Lot of physical contact.
Over use of restraint.
Surprised by sheer physical force used in restraint.

DOC. 41 Pushed to reveal sexual abuse.
Access restrictive.
Winding up of residents followed by restraint.
Did not feel welcome (by staff in O.H)
No point in making complaint (residents)

DOC. 46 If you want to get children into O.H mention sexual abuse.
Complaints by resident made, then withdrawn.

DOC. 51 Refers to general concerns arising out of the indecent assault by resident on female member of staff.

DOC. 60 Concerns: -Overnight stays in side room.
-Counselling sessions where residents pushed into admitting sexual abuse.
-Unqualified people carrying out massage.
- General concerns regarding practices.

DOC. 62 Access difficult.
Pre-occupation with sexual abuse.
Will not send other children to O.H
Prefers, if necessary, to send out of County.

DOC. 76 No one outside of O.H. supervising.
No fresh input.
No safety checks.
No psychiatrist supervising counselling sessions.
Training packages put forward but not taken up.
Methods were confrontational.
Lack of trained staff.

DOC. 86 Speaks of restraint in side room for 24/48 hours (stopped by 31.7.91)
Complaints by residents very low. Only one received since 1.5.93.
Massage dangerous, but no complaints received from residents.
O.H. left out on a limb.
Ineffective line management.
Had to devise own strategies.

DOC. 96 Pre-occupation with sexual abuse.
Residents provoked into assaulting staff, which resulted in resident being prosecuted.

DOC.100 Lack of training.
Lack of contact with senior management.
Concern over use of massage.
Use of side room/detention long periods
Residents outer clothing taken off by staff member of opposite sex (jumper/resident drunk/staff member advised).
Closed institution.
Does NOT believe children are being abused.

APPENDIX SEVEN

"OPERATION SAGA"

Observations of Social Workers from other Local Authorities engaged in joint interviews with Bedfordshire Victim Liaison Officers.

These observations were recorded following a request from the Senior Investigating Officer for comments on a) the conduct of the enquiry, and b) professional views on matters which had come to their notice in the course of the enquiry.

The social workers involved were:

Social Worker, Norfolk County Council.

Social Worker, Norfolk County Council.

Social Worker, Suffolk County Council.

Det. Superintendent
15th October, 1993

CONCERNS RAISED IN RELATION TO OXENDON HOUSE

SETTING

Geographically out on a limb, contributing to a general isolation.

Size of the building.

Suitability of its appropriateness as a placement for some of the young people who were sent there.

PRACTICE

Restraint appears to have been used too readily in some situations where an alternative approach may have worked. This may have created a pattern of circular behaviour.

While restraint may be necessary at times, it may be seen to abuse. It appears to have become a culture as indicated by the young people's use of the word. One young person even offered the view that it was a way of seeking affection.

Use of restraint may have reinforced the idea in some young people that violence and force are justifiable ways of dealing with problems.

There have been reports of injuries, e.g. carpet burns that, if they were correct, have not lead to medical treatment, investigation or case conferencing.

At best there seems to have been a lack of awareness of the situations staff put themselves in with regard to massage and physical contact. Particularly given the balance of power between staff and abused young people.

Recording - minor incidents and sanctions have been extensively recorded, use of massage, counselling and restraint less so.

Exclusion of social workers from the building with the exception of interview rooms.

Question use of Children's Home as a centre of therapy.

The side room appears to be viewed by the young people as a punishment rather than a location for one to work, and to prevent disruption to other residents.

There have been suggestions that residents were pressured to talk about having experienced sexual abuse. Undue emphasis seems to have been put on this matter. The subject was raised during times of distress and emotional vulnerability, e.g. when being restrained or isolated.

STAFF ISSUES

Questions are raised about qualification, training, background, supervision and line management, and accountability to senior management.

Number of couples working at Oxendon, and the strength of the staff group.

It would appear that therapies may have been used without ongoing appropriate expert supervision.

Many of the young people place at Oxendon exhibited very difficult behaviour, and staff may not have been adequately trained and supported to appropriately deal with it.

APPENDIX EIGHT

STRATEGY REVIEW MEETING ON OXENDON HOUSE

22nd October 1993, 3.30 pm
County Hall, Bedford

Present: Tim Hulbert, Director of Social Services
Mairi Youngson, Assistant Director Social Services
Barbara Kahan, Independent Consultant
Diane Parkins, Barrister, Bedfordshire County Council
Stephanie Watson, Child Protection Officer, Social Services
Supt Martin Russell, Bedfordshire Police
D.I. Andy Howell, Bedfordshire Police
Jane Stimec, NSPCC

8/93 Update

Barbara Kahan is present as advising the Strategy meeting.

This meeting of the Strategy Management Group is convened under the Child Protection Procedures and is the continuation of the meeting held on Child B.

A decision was taken at the last meeting that we were recognising at that stage the possible implication of institutional abuse. This was the basis for the commencement of the investigation.

This morning we have had the benefit of an extensive presentation of the evidence revealed from the enquiry. Staff 7 has been arrested and released on Police bail and there is now a need to look at the general view.

1. What is there that may need to be done from further Police investigation.
2. What is there which would require disciplinary procedures.
3. What issues would we want to identify and address.

Barbara Kahan suggested that we differentiate management issues, criminal matters and possible disciplinary actions.

9/93 Progress Report on Child B

Staff have been interviewed in connection with the Child B incident - no charges have as yet been brought.

The Police are in the process of preparing an advice file for the CPS - this will be ready next week and an answer will follow shortly afterwards.

Two members of staff, Staff 2 and Staff 3 are subject to a continuing Police enquiry into ABH. It was proposed that these two members of staff should be suspended on full pay providing it does not inhibit progress on the investigation.

There is also a need to stop people communicating with the children.

The group agreed to proceed to suspension of Staff 2 and Staff 3.

10/93 Staff 11 - Allegation of Indecent Assault

The alleged indecent assault happened during restraint. The child alleges that during restraint Staff 11 spoke to her and that her breasts were rubbed. Staff 11 does not recall the incident.

An advice file is being prepared for the CPS.

As Staff 11 is not on the payroll (he is a relief RSW) we may not be in a position to suspend him and he could be taken on by another county if we end his contract here rather than take disciplinary action. He is currently on a training course where he may be working on placement with other children.

The group agreed:

a) to take personal advice on how to deal with the situation
b) that we should not employ him in a relief capacity
c) that we should advise him that there are outstanding allegations which have not been resolved
d) that, after taking advice re civil liberties, we should advise his course of those allegations

11/93 Staff 7 - Allegation of Sexual Abuse

The Police have arrested Staff 7 and he has been released on Police bail. Investigations are continuing into allegations of sexual abuse of a former resident. Management has already taken steps to suspend him. Whatever the outcome of criminal proceedings there will be a need to take disciplinary action.

The Group agreed that the Police could have access to the files of those children on the basis of whose allegations files are being sent to the CPS, provided that material is not handed over or copied. Diane Parkins will liaise with the CPS in relation to such access. Diane Parkins will also advise further on Police access to Social Services Department files.

13/93 Evidence of a Network of Pressure

i. There seems to have been a consistency during the interviews from different sources.

ii. There has been anxiety, particularly from Staff 7 about evidence and how the investigation is proceeding. He is particularly keen to know why the home has been closed. He has written to Mairi, Tim and also Martin Russell requesting information.

iii. Tim received a telephone call from one of the children, Child 9, and it seemed as though he was reading questions from a list.

iv. There have also been a number of very similar questions from elected Members, questions to Robert Labe from staff and questions from the Union.

The pattern has been very consistent.

Tim believes that Staff 7 or others have liaised in an attempt to get that information and there may be an issue in terms of protection of the children. Concern was expressed that the children are being pressured by the staff; although the staff were not told of the children's whereabouts, they have found out.

Martin Russell pointed out that it is not unusual in these circumstances for pressure to be exerted.

These issues should be kept in mind in relation to the management issues to follow.

14/93 Characteristic of Children's Reports Describing "Normal" Situations

Throughout the Review and the Police investigation, children had expressed acceptance of restraint, carpet burns, choking, kissing and massage. In Barbara Kahan's experience, the descriptions in the children's reports of the situations being "normal" are unusual. The children may have viewed abuse as the only way of getting affection. If so, this is worrying. The external social workers' report identified this as a problem. Barbara felt Oxendon is a regime which is clearly damaging.

The group agreed that:

a) those situations should not be regarded as normal
b) those situations may or may not be regarded as containing criminal activity
c) management should investigate the need for further disciplinary action

Barbara Kahan said that in order to prove that the children were being "set up" the Police would need an elaborate framework. Police to provide Social Services with their investigation outcomes.

The group was in agreement that there has not been systematic organised abuse but that there has been a habitual pattern of practice which has been abusive and careless of the welfare and needs of the children and that has resulted in abuse in a number of individual cases which are now subject to disciplinary or criminal proceedings.

15/93 Pindown - Recent or Not

It is not known how frequently this occurred and whether in the side room. Proper records of restraint, for whatever reason, should be kept. However, there are not records to say whether this happened though there is evidence that holding children in the side room for up to 48 hours did occur.

Barbara Kahan pointed out that if the children were prevented from leaving the room whatever the period of time then the actions were illegal.

This requires management action - there is potentially an issue of disciplinary action.

16/93 Complaints

If the Police do not deal with this issue then there is potentially an issue of disciplinary action. It is certainly a major management issue. Procedures have not been properly used. No records can be found. It is unusual not to have complaints. Concern was expressed that children's complaints may have been suppressed.

Diane Parkins asked the group to handle the Child B investigation with care. Child B is used to having nothing done about complaints she has made and has been made to feel that she is the cause of all the problems.

The meeting notes with concern the need to ensure that Child B is properly supported in terms of the complaint she has made. Stephanie Watson will ensure that the matter is handled with care.

There is an issue to review the complaints procedure and to ensure that complaints are carried out as intended.

17/93 Supervision

The issue of supervision needs a thorough examination and will be dealt with at a later meeting. Barbara Kahan noted the need to collate at a senior level in the department the reports of supervision sessions from residential and field work. It is important to have a system to ensure that issues rise to the top.

It was noted that there has been inappropriate use of supervision at Oxendon House and that clear definition is required as to the scope and purpose as soon as possible.

18/93 Therapeutic Practice - is it Abusive?

i. Restraint/holding
ii. Bodily contact
iii. Kisses/cuddles
iv. Anger workshops
v. Counselling
vi. Playfighting
vii. Massage
viii. Contact after discharge

Clearly management action is necessary to find out who, if anyone, authorised these actions and when. Clear guidelines have to be developed before any of these processes can be legitimised.

It was agreed that people who have the day to day domestic care of the children should not be providing clinical counselling, although a counselling service was lacking in Bedfordshire and that maybe this is why the staff felt they had to do it themselves.

Tim asked whether there was anything in the practices which might lead to prosecution. The Police may find it difficult to prosecute as Staff 7 has been so open in terms of recording. It is really management and a disciplinary issue. There may have been professional malpractice during the counselling sessions which were conducted by male staff with female residents, and concentrated on their sexual abuse. Kissing and cuddling during these sessions was also inappropriate.

It was agreed that a set of management guidelines for all homes is required which should be agreed between management, staff and children.

The meeting agreed:

a) there is certainly a need for clear definition about what is or is not acceptable.

b) that we would regard all of those things listed above as being unsatisfactory practices without the proper backup, professional guidance and support, but that we agree we do not feel that on the basis of the evidence currently available we have a prosecutable criminal case in relation to any individual but that we do need to look again at the evidence in relation to possible disciplinary action.

c) that we need to recognise that management action is necessary to agree working frameworks in relation to any or all of the issues in the short and medium term.

19/93 Unsupported or Unaccountable Practice

Again a management issue. It is necessary to ensure that this is not happening elsewhere and that in future mechanisms are in place for clear understanding of what methods are being used, whether they are appropriate and properly supported. A clear monitoring and reporting system must be put in place throughout the department.

Barbara Kahan feels that residential social work needs a management structure which brings it into the department. We need to give some very considered attention to the support and accountability for what is happening.

Management has to address this issue and discuss with politicians in setting up an inspection system for children's homes.

20/93 Inter-related Staff

It is not regarded as appropriate practice for married related staff or staff who are in permanent relationships to work together in the same setting. Management action is required now to stop this in all establishments.

21/93 Child Protection Procedures for Individual Children

In light of the discussion of the evidence and the things we know we need to do with regard to possible prosecution or disciplinary action, do we have any child protection issues for any particular children?

The meeting agreed that as long as children are not returned to the regime they were in before, it is not necessary to institute Child Protection Proceedings for any others of them as, if not returned, they will not be at risk. We have already removed them to a safer environment.

The meeting agreed that there should be a review of their needs in terms of the best placement for them. This is already underway. None of them should be returned to Oxendon.

Tim asked whether the statement regarding the children's safety would still stand if some of the Oxendon staff were placed in the child's new setting. It was felt that the abuser will be removed when the Oxendon regime is removed.

Barbara Kahan believes that if the staff are placed in the same setting as some of the children then the children will need to be counselled. It would be wise to avoid this. Some thought is needed to ensure that they do not carry the culture with them. There is danger of a 'grievance centre' being created wherever we do place the staff.

A decision is required on what is to happen to the children now that we have moved through this stage. It was agreed that there is not any risk to any child individually provided Oxendon House is not re-opened with the same staff and

that these children are not placed back in Oxendon. There needs to be support, counselling, training and a very clear framework for the relocation of staff to any other establishment and that their placement needs to be carefully monitored.

It was agreed that there is definitely a question about the future of Oxendon House and that we cannot make that decision at a meeting of this nature. It was agreed that it cannot open with the same group of staff and children but consideration must be given to the availability of appropriate resources in the county.

It was agreed that our first and prime objective is to provide good quality and safe services to children and then to consider the welfare of our staff. Each member of staff should be given the opportunity to review what they have done and agree to change. Some thought is needed to ensure they do not carry the culture with them.

Barbara Kahan thinks the staff who have worked at Oxendon will need "pretty clear indications that what went on at Oxendon will not do". If convinced they were not wrong the staff could set up a grievance centre wherever they go.

Training and support as well as clear management oversight will be needed to make sure they don't carry the culture they have been so involved with any further.

Tim asked the group what points should be borne in mind when putting his decision to Members:

a) an issue of having a clear purpose and being fit for purpose
b) set parameters on practices to be used
c) re-training from the old Oxendon
d) recommend that they do not place any of the children back in any new Oxendon
e) that Oxendon should not re-open with the same staff group

It was also agreed to recommend that there should be a permanent dispersement of staff and children and that Oxendon should not be re-opened until these conditions were met.

Barbara Kahan feels that we cannot put staff and children who were there back together and that Oxendon temporarily remains closed while the whole situation is reviewed. The child protection element would be too risky at this stage.

22/93 Staff Interchange / Support

It is important that staff have time to come to terms with the changes that they have to face.

There should be an appraisal with each member of staff before any new placement.

The staff will not be in any frame of mind to accept that they have done anything wrong. We have to bring them back to work but not in unsupervised work with any client group.

Other than the specific staff identified - there is not anxiety about the return to work of any other staff at this stage, subject to the caveats of not putting them with the children previously at Oxendon House - and subject of course to any further information coming to light.

The Police still wish to speak to a number of social workers and ex residents (especially Child A). The Police will then wish to hand over to Social Services, other than those issues on which they intend to submit files to the CPS.

The meeting noted the need to communicate with staff as soon as possible after the Social Services Committee.

Tim and Martin Russell thanked the group and members of their staff who had assisted on the enquiry.

Signed ..... **Date** .....

Tim Hulbert
Director of Social Services

12 saga1.93

Summary of Mrs Kahan's statement to the Strategy Group Meeting 22.10.93 (as summarised in the statement to the Inquiry of the Director of Social Services)

37 As can be seen from the Minute of the 22nd October, Barbara Kahan's advice was very clear:-

- She was concerned about the excessive use of restraint both with regard to the force used and the number of times which it occurred. She advised that in her experience the record showed only part of the reality of such incidents and accordingly the level of occurrence was probably higher than shown on the record.

- She advised that physical contact can be good, but she was particularly concerned that children at Oxendon were in a position where they could not refuse such contact and it was potentially exploitative. The environment was such that refusal was not an easily available option.

- Barbara was scathing in her views of the use of anger workshops which she regarded as having little value and stressed that if they had any value, they should not be done by a carer, but should be carried out under the aegis of an external consultant. It is perhaps worth noting that, I am told prior to 1988 (when she retired), Dr Milne, the Consultant Psychiatrist, helped to set up some of the workshops and counselling processes at Oxendon House and did oversee the activities. However, after Dr Milne's retirement she was not replaced as a resource and so there had been no such supervision for a very long time.

- Barbara was very unhappy indeed about the counselling that was being undertaken.

- With regard to massage, Barbara was not happy with it generally and for it to be provided in any circumstances by a person of the opposite gender was not acceptable at all.

- Barbara was absolutely clear in her view that the children should not be returned to Oxendon on the basis of the information then available. She believed the children were patterned to a behaviour that would be re-created in any new staff group. She was also concerned that when the staff went anywhere else they were likely to create "grievance centres".

- I recall Barbara summarising her view of Oxendon as being reminiscent of a former Approved School regime with some pseudo-therapy thrown in. She also said that in some aspects this was worse than Pindown.

Minutes of 2.11.93 Social Services Committee Meeting

Social Services Committee
2 November 1993

93/w/107 **OXENDON HOUSE (in private)**

(This matter was considered after the Committee had resolved to exclude the press and public from the meeting on the grounds that it involved the likely disclosure of exempt information as defined in paragraphs 1 and 6 of Part 1 of Schedule 12A of the Local Government Act 1972).

The Director of Social Services orally reported in detail to the Committee on the background to the current situation in respect of Oxendon House and gave details of the recommendations of the Child Protection Strategy meeting as detailed in their minutes of 22 October 1993. He also reported on proposals for the immediate future of Oxendon, on proposals in relation to staff from the Home, on arrangements for children and the continuing review of these, on arrangements for the continuation of the Child Care Strategy Review and on the programme for the inspection of children's homes.

Mrs Barbara Kahan, who had agreed to act as an independent professional adviser to the Council in this matter, was present at the meeting and gave her views to the Committee on the situation. Members expressed their thanks to Mrs Kahan for her assistance in this matter.

The Committee considered this matter at length and during their discussions they considered a request for a representative of UNISON to attend the meeting during their consideration of proposals in relation to staff. The Committee did not feel that this would be appropriate. They noted however that UNISON would be acting in an observer capacity in the proposed interviews with staff.

After a detailed discussion of the issues involved it was

RESOLVED:

1.(a) That this Committee, having received a full report of events leading to the temporary closure of Oxendon House and the joint investigation by Police and Social Services staff under the agreed Child Protection Procedures, endorses the action taken to date, accepts the conclusions reached by the Child Protection Strategy Group as detailed in their minutes of 22 October 1993 subject to 1(b) below, and intends to implement fully the recommendations made by it, as now reported to the Committee

(b) That in implementing the decisions of the Strategy Group, the Director of Social Services should ensure that each member of staff is counselled by management, giving them the opportunity to review the old culture of Oxendon House and agree new practices for the future

(c) That the Director of Social Services ensure that communications with staff are appropriately carried out in the further conduct of this matter

1. (d) That in the event of disciplinary action being necessary, the authorised officer be a Director of Social Services from another authority and the investigating officer should not be a member of the Social Services Department Management Team

2.(a) That a Select Panel be established, comprising 5 Members appointed on a 2:2:1 basis, with Mrs B Kahan acting as Professional Adviser to the Panel, Ms M Youngson acting as Lead Officer, and the Director of Social Services and other officers attending and advising as appropriate

(NOTE: Councillor J Davies was nominated to serve as the Liberal Democrat representative on the Panel.)

(b) That the Terms of Reference of the Panel be as follows:-

(i) To consider any matters relating to residential child care in Bedfordshire which it considers appropriate or necessary.

(ii) To invite views from children, staff, Area Child Protection Committee, trades unions and others on the practice of residential child care in Bedfordshire.

(iii) To consider any policy recommendations arising there from.

(iv) In the light of recent experience at Oxendon House, to consider any changes which may be necessary to management arrangements, reporting and monitoring systems, involvement of Members in Rota Visits and approval of policy changes.

(v) To receive and consider a report from the Child Care Strategy Review Group on the future need and provision of residential child care in Bedfordshire.

(vi) To consider any issues arising from the programme of inspections of Children's Homes being undertaken by the Quality Control and Inspection Unit.

(vii) To protect the confidentiality of evidence submitted to it and its findings particularly where these affect individuals either staff or children and in order to avoid undermining approved Child Protection Procedures and any Police investigation.

(viii) To make recommendations in confidence to the Social Services Committee in March 1994.

(c) That the first meeting of the Panel be arranged to take place as soon as possible.

Statement Oxendon House Staff required to sign after the Relocation Interviews

To: **R T J Labe**
Personnel Manager
Human Resources Unit
Social Services
Pilgrim House
Brickhill Drive
BEDFORD

STATEMENT

I have read the notes of the meeting held with me on 11 November 1993 and agree the following:-

(a) That they are a true record of what information was given to me, and any comments that were made.

(B) That those Child Care practices outlined as having taken place at Oxendon and which have been considered by the Social Services Committee as unsatisfactory, were bad and have no place in residential care.

(C) That there was both good and bad practices at Oxendon but that the overall way of working at Oxendon had been abusive.

(D) That I will participate in discussions with other staff, managers and children on looking at the practices and determining how to work in the future.

(E) That I will attend and participate in the programme of training events.

Any other comments:-

Signed: .....

Name (in capitals): .....

Date: .....

Please return by: 23 November 1993. RL/JF/D8/NteoxenW/p.9/15 November 1993

Statement used at the Relocation Interviews

INTRODUCTION

1. Thank you for coming today. I acknowledge from the outset what a difficult time this has been for you. It is not my intention to make that worse by seeing you, but to begin the process of making things better.

2. I regret that for some weeks now I have been unable to give you very much information about the investigation. As you know this has been because the investigation has been led by the Police into matters which may prove to be criminal and therefore sub judice; also because the matters under investigation needed to be brought before the Social Services Committee before decisions could be taken regarding the next steps.

   I am now able to discuss some of the findings with you.

3. The current position is that the Police investigation is continuing; that there is now an investigation of the conduct of some members of staff under the disciplinary procedures; that the internal investigation coming out of some of the Police enquiry is continuing, and that there is a Member select panel considering all matters regarding residential care in Bedfordshire, including the conduct of local management.

4. As you are aware from the Director's letter to you, the Social Services Committee on 2nd November met in closed session to discuss Oxendon. It endorsed the actions taken by management and accepted a number of findings of the Child Protection Strategy Group - the most relevant of which are:

   - there is no evidence of systematic organised abuse at Oxendon. However, there has been an habitual pattern or practice which has been abusive and careless of the welfare and needs of the children. This has resulted in abuse in a number of individual cases and these may be the subject of disciplinary or criminal proceedings.

   - the home should not reopen with the same group of staff

   - children previously at the home should not be returned to it

   - the purpose of any future operation at Oxendon should be clear with clear guidance on the practices to be used at the home.

   These have obvious implications for you.

5. The reason for my managerial interview with you is:

i. to draw your attention to the findings and recommendations of the Child Protection Strategy Group which I will discuss with you.

ii. to gain your acknowledgement that there were both good and bad practices at Oxendon and that external child care experts together with the Police and senior management believe the overall way of working to have been abusive.

iii. to offer you a very clear guidance and direction on what is and is not acceptable practice within your employment by the County Council.

iv. to hear from you what you believe to be your training needs as a result of what I am now asking of you in terms of changed practice.

v. to listen to any views on preferences you may have on where you work in the future.

vi. to listen to your comments on my proposals for a way forward.

If you wish to have time now to confer with your friend or representative you may.

CHILD CARE PRACTICE ISSUES

1. ACKNOWLEDGEMENT

Before I discuss the problems with you I want to acknowledge the difficulties of managing children such as those placed at Oxendon. They offer a particular challenge when they are in a group.

This challenge can be made more difficult when working with staff with different levels of experience and training.

I also want to acknowledge the good effect of some of your work at Oxendon. Some children have praised parts of their experience with you and social workers have acknowledged good as well as poor practice. In particular I believe some fieldwork staff have felt assisted by you in undertaking escort and other duties which are normally theirs.

There have nevertheless been a disturbing number of critical comments, and there are children who have been worried by the care experiences they have described

I further want to acknowledge that institutional abuse can arise from practice which has been good, and which is offered with good intent. It is possible to become part of a way of working which is abusive without realising that this is happening. Even if you have not been an active part, the fact that if you have not seen reason for concern, or not reported any concerns externally, is of itself worrying.

This is why the external inputs which is it reported were rejected by staff at the home are so important.

I am acknowledging the tremendous challenge the work at Oxendon has presented but have to tell you that the nurture and parenting which any child or young person in our care deserves has not been offered in the view of the Social Services Committee and the enquiry.

I now want to discuss briefly some of the issues of concern before moving on to my proposals for changing things to correct these problems.

2. "NORMAL" SITUATIONS

Throughout the police investigation, officers and social workers heard evidence from children of the use of restraint, or receiving carpet burns, of being choked and of the frequency of kissing, cuddling and massage. I will come to these in turn but need to inform you of the Strategy Group's findings.

Throughout the review and the police investigation, children had expressed acceptance of restraint, carpet burns, choking, kissing and massage. In Barbara Kahan's experience, the descriptions in the children's' reports of the situations being "normal" are unusual. The children may have viewed abuse as the only way of getting affection. If so, this is worrying. The external social workers' report identified this as a problem. Barbara felt Oxendon is a regime which is clearly damaging.

The group agreed that:

a) that those situations should not be regarded as normal
b) that those situations may or may not be regarded as containing criminal activity.
c) that management should investigate the need for further disciplinary action.

3. USE OF VIOLENCE AND RESTRAINT

The police have documented 153 incidents of violence or injury over the last 18 months. These involve children and staff and may in themselves lead to further disciplinary action following investigation.

The external social workers' view was that use of restraint may have reinforced the idea in some young people that violence and force are justifiable ways of dealing with problems.

Many people complain that staff have provoked restraint, and that it has been excessive in its use of force.

4. PINDOWN

There is evidence of holding children for up to 48 hours in a side room. It is believed that this policy may not be recent but external social workers report, "The side room appears to be viewed by the young people as a punishment rather than a location for one to one work, and to prevent disruption to other residents"

Barbara Kahan has pointed out that if the children were prevented from leaving the room whatever the period of time then the actions were illegal.

5. COMPLAINTS

Procedures have not been properly used. No records can be found of complaints and it is unusual not to have complaints from children.

6. SUPERVISION

This has not been used appropriately and has extended beyond the normal parameters into something more akin to therapy which it is not appropriate for managers to offer. There has not been a "feeding-up" of information gained in these sessions to management; and there are descriptions of its content regarding the sexuality of workers which are not within the normal bounds of practice.

7. CHILD PROTECTION PROCEDURES

Child Protection Procedures have not been followed. Incidents have not been reported, medical examinations do not appear to have been carried out and there appears not to have been case conferencing of reported incidents.

8. OVER INVOLVEMENT WITH SEXUAL ABUSE

Social workers and children report an excessive concern with discussing sexual abuse. There seems to be a philosophy that all residents have been subject to sexual abuse and the external social workers report that there have been suggestions that residents were pressured to talk about having experienced sexual abuse. Undue emphasis seems to have been put on this matter. The subject was raised during times of distress and emotional vulnerability, e.g. when being restrained or isolated.

9. THERAPEUTIC PRACTICE

An important statement made by the CPSG was that people who have the day to day domestic care of children should not be providing clinical counselling, although a counselling service was lacking in Bedfordshire and that maybe this is why the staff felt they had to do it themselves.

They then considered each of the following:

i. restraining/holding
ii. bodily contact
iii. kisses/cuddles
iv. anger workshops
v. counselling
vi. playfighting
viii. massage
viii. contact after discharge

and decided:

a. there is certainly a need for clear definition about what is not acceptable.

b. that we would regard all of those things listed above as being unsatisfactory practices without the proper backup, professional guidance and support, but that we agree we do not feel that on the basis of the evidence currently available we have a prosecutable criminal case in relation to any individual but that we do need to look again at the evidence in relation to possible disciplinary action.

c. that we need to recognise that management action is necessary to agree working frameworks in relation to any or all of the issues in the short and medium term.

It is my duty to inform you of the Strategy Group's findings and of Barbara Kahan's advice that what has been going on at Oxendon will not do and must stop.

AGREEMENT

I do need your agreement to review your practice at Oxendon, to agree to stop those practices described above until further guidance can be given, and to agree to take part in a programme of training which I will outline. You will be involved with management, children and colleagues in looking at those practices and determining how to work in the future under clear management guidance and supervision, but I must have your agreement to make these changes.

This does not involve changing all of your practices, much of which was good.

If you do not agree to this I will have to instruct you and we will then be in a regrettable situation which I am sure it is possible to avoid.

LETTER OF 17.11.93 FROM SOCIAL SERVICES COMMITTEE SPOKESPERSONS TO OXENDON HOUSE STAFF AND COPIED TO THE PRESS

Slightly different versions for suspended and unsuspended staff

Social Services Department

SSCRP/ts/39saga1.93

17 November 1993

Dear

OXENDON HOUSE

You will by now either have been seen in a Management Interview or have been invited to attend one to discuss your future. It was and still is our intention that you should have the opportunity for individual discussions with Senior Managers about what we regard as inappropriate practices which took place at Oxendon. However, we appreciate that for many of you the view taken by the Social Services Committee that there "there is no evidence of systematic organised abuse at Oxendon, but there has been an habitual pattern or practice which has been abusive and careless of the welfare and needs of the children", needs further explanation. Our consequent decision that Oxendon House should not re-open unless there is a permanent dispersal of the staff group, is one which seriously affects you.

We are most concerned at the mirepresentation of the issues and of the reasons for our decision which have recently appreared in the media. Primarily in the interests of the children and the staff, we have endeavoured to keep the detail of our concerns out of the headlines. The Director of Social Services agrees with us that you the staff and the public have a right to know the reasons for the Social Services Committee decision and an outline of the evidence upon which it was based. We therefore intend to release copies of this letter to the media, so that the public can also become aware of what we are doing and why. In so doing, we are not implying that you as an individual member of staff have been involved or were individually responsible for any of these practices, but rather that they formed part of the habitual practice at the Home about which we are very concerned.

The Social Services Committee on 2 November heard a summary of evidence which the Police had presented to the Child Protection Strategy Group (in precisely the same format other than that individual names had been deleted). This evidence came from joint police/external social worker interviews with the children from Oxendon. It covered several subjects including a number of

examples of inappropriate use of restraint including choking and instances which resulted in carpet burns.

It also indicated that a number of children had been given massage. Although not all the children necessarily disliked this practice, we consider it to be inappropriate as a practice for use with adolescent children in our care by whom it may be seen as sexually provocative, however carefully used.

In addition to this evidence the Committee heard that the police have charted some 153 incidents of violence or injury involving staff or children or both in a period since 1 January 1992. This log indicates in many cases inappropriate restraint being used which is clearly outside the Guidance on Permissable Forms of Control in Children's Establishments. It also showed frequent use of the side rooms. The external social workers who interviewed the children reported that "The side room appears to be viewed by the young people as a punishment rather than as a location for one to one work, and to prevent disruption to other residents". Many of the children have suggested, even if they did not complain about the restraint itself, that they were provoked into being restrained by staff. Again the external Social Workers view was that the use of restraint may have re-inforced the idea in some young people that violence and force are justifiable ways of dealing with problems.

The Committee also heard details of the event which promoted a Management Review of practice, whereby a female member of staff was giving massage to a 16 year old boy in his room late at night when he had been drinking and which resulted in an allegation being made by her that the boy indecently assaulted her. The Committee takes a serious view of this incident both in its implication for the member of staff but equally in that it represented a totally inappropriate use of massage.

The Committee heard that children had reported circumstances in which male members of staff asked female residents for "kisses or cuddles". Whilst we recognise that proper "parental" affection is an important part of residential care for children, we believe it must be used in such a way that it benefits the child rather than the adult.

We are also concerned about the use of "counselling". The Committee were aware that social workers and children report an excessive concern with discussing sexual abuse and that the external Social Workers report that "there have been suggestions that residents were pressured to talk about having experienced sexual abuse. Undue emphasis seems to have been put on this matter. The subject was raised during times of distress and emotional vulnerability, e.g. when being restrained or isolated." We also share the view of the Child Protection Strategy Group that any such clinical counselling should be undertaken only by someone of the same gender as the child and by someone who is not involved with the day to day care of the child.

The Committee also share the concern of the Child Protection Strategy Group about the way in which "Anger Workshops" were used whereby children were encouraged to express their anger, particularly taken in conjunction with

situations in which restraint was frequently used. Playfighting between staff and children is also a technique about which we have some concern.

We regard these practices as unsatisfactory without proper backup, professional guidance and support and we recognise that managment action is necessary to agree working frameworks in relation to any or all of the issues in the short and medium term. We recognise that bad practice can arise from that which has been good and which is offered with good intent.

On behalf of the Social Services Committee, we want to acknowledge the difficulties of managing children such as those placed at Oxendon and that they offer a particular challenge when they are in a group. We also want to acknowledge the good effect of some of the work done at Oxendon and that children have praised parts of their experience with you and that social workers have reported good as well as poor practice.

Taking into account all the evidence it received, the Committee was unanimous in its view that several of the bad practices explained above have developed over a considerable period, happened frequently and as such have acted as the norm for the way in which Oxendon House operated. We believe it is vital that we do not risk recreating the circumstances in which they can occur again. **It is for this reason that the Committtee was unanimous in its decision that Oxendon House should NOT re-open unless there is a permanent dispersal of the staff group and that previous residents do not return there.**

The Committee, through the Select Panel it set up, fully intends to examine issues relating to the Oxendon situation, including external management of it and to look at the implications for residential Child Care in Bedfordshire in general. The Select Panel will be inviting evidence from staff, children, trade unions and others on this and related matters. We hope the Select Panel can start its work in the next few weeks.

It is our hope that with your co-operation and that of the trades unions we can move as quickly as possible to put your best skills back to work and that extensive training programmes being developed for you and other residential child care staff will assist in making all practice better.

In the meantime however, we hope you will appreciate the serious consideration we hve given to this matter, recognising fully the distress and difficulties it has caused. However it is our firm resolve that Bedfordshire should offer the best residnential care practice possible in the interests of the children for whose protection we have a first duty.

Yours sincerely,

Cllr Patrick Hall	**Cllr Diana Wickson**	**Cllr Jenny Davies**
Labour	**Conservative**	**Liberal Democrat**

Party Spokespersons of the Social Services Committee

cc: UNISON
NUT
NASWT
David Madel, MP
Social Services Inspectorate
Dr Angus Brewer, Chairman, Bedfordshire County Council
Chris Burgess, Director Human Resource Strategy
Conservative Party Group Leader
Labour Party Group Leader
Liberal Democrat Group Leader
John Atkinson, Head of Legal and Members Services
Social Services Committee, Representative Panel

STATEMENT OF TIM SANDERS (UNISON BRANCH SECRETARY) CONCERNING THE 29.11.93 RESOLUTION.

OXENDON HOUSE

UNISON WANTS THE BEST CHILD-CARE AND THE BEST STAFF

Please see the next page for the full text of the resolution passed at our AGM on 29th November. The debate was not controversial but it felt good to have branch members rallying around staff from Oxendon House.

I think the resolution is self explanatory, but I will not let that stop me explaining it:

Firstly, it is very strong in its condemnation of how staff have been treated thus far. To be told you cannot go back to your workplace without a chance to have your say on allegations of bad practice and to have allegations given out to the media means that all 52 staff feel branded as guilty in some way, and this is not acceptable.

Secondly, however, our demands are reasonable. We want to re-open and negotiate on the question of staff's futures and we want apologies for the way they have been treated thus far. We want an Independent Inquiry, not a panel of County Councillors, to investigate practice at Oxendon.

At the time of writing we feel progress is being made in talks with senior management. We need a forum where all the views can be aired and the crucial questions debated - what support do residential staff get when trying to care for children? What guidance and training did Oxendon House get on managing violent behaviour, or cuddling residents?

Do senior managers really know how difficult it can be to provide front-line services? If a young adolescent is behaving dangerously (to self and others), you have to think on your feet and decide whether to try and restrain them. If you make a wrong decision or restrain badly, is that surprising if you were not trained? If you get into difficulties, it is not easy to break away and someone could get hurt. Usually it is staff that get hurt, and our reports from Oxendon bear that out.

There are no allegations that Oxendon House was like Aycliffe, where restraint techniques included arm locks. Or that anything like pindown occurred, which in Staffordshire was a regime of confinement, denial of recreation and confiscation of clothes in several of that County's establishments.

As far as the events in November are concerned, perhaps we can turn the department's words back on them and say that there is no evidence of systematic organised bad management and employer practice in Social Services. However, there has been an habitual pattern or practice which has been abusive and careless of the welfare and needs of staff.

We are pleased to report we are now talking to the Director of Social Services and County Councillors rather than arguing via the media. We have good support and guidance from John Findlay, UNISON's National Officer for Social Services, and are looking for a solution for the benefit of both staff and children in residential care.

However, the future is still uncertain and we need your support too.

Tim Sanders
Branch Secretary

OXENDON HOUSE, Social Services Dept, Beds County Council

THIS BRANCH:

1) Notes with concern:

a) The decision by a closed session of Beds County Council's Social Services Ctte on 2/11/93 that no member of Oxendon House staff should continue to work there.
b) That a press release issued by the County Council on 4/11/93 stated that "there has been a habitual pattern or practice which has been abusive and careless of the needs of the children".
c) That staff learned of a) and b) above via local media - letters arrived after the news had been broadcast.
d) A further new release on 17/11/93 alleged incidents of choking, carpet burns, inappropriate physical contact.
e) That UNISON has been asking for a meeting involving Barbara Kahan (child-care consultant who has been advising the Social Services Dept) since the decision of 2/11/93, but a meeting has not been arranged until 30/11/93. It has only been through much lobbying that the Director of Social Services has agreed to make this meeting longer than 30 minutes.

2) Further notes:

a) Staff have been supported by many residents/ex-residents, their parents, and a good senior medical officer involved with Oxendon House in protesting that practice has been good at Oxendon House.
b) None of the staff have been interviewed by the Child Protection Strategy Team.
c) No details are given in the news releases as to the number or frequency of incidents or the number of staff allegedly involved, thus creating an impression that all staff are guilty.
d) That one member of staff is under police investigation relating to an incident 12 years ago, not associated with the current allegations of abusive practice. Three other staff members have not had charges brought after police investigations.
e) 47 of the 52 staff from Oxendon House have had no individual action against them under the disciplinary procedure. The other 5 are still awaiting details of allegations after more than a month.
f) Staff in residential childcare have to work in extremely difficult and demanding conditions and receive very little guidance, support or training from outside their workplaces.

3) Reaffirms:

a) That abuse and neglect of service-users by staff is wholly unacceptable and should lead to the dismissal of staff perpetrating abuse and neglect.
b) That staff have the right to be considered innocent unless proven guilty, and for proper procedures to be followed in investigating allegations.

4) Believes:

a) The decision to remove all staff from Oxendon House, the lack of consultation with UNISON since 2/11/93 and the subsequent news releases amount to outrageous treatment of staff. They have all been branded as neglectful and abusive in their practice.
b) That staff in the Social Services Department can have no confidence in their Director's ability to manage industrial relations or to support staff in their work. Furthermore, there are serious doubts about his judgement in all aspects of the Oxendon House issue.

5) Demands:

a) That staff are given the opportunity to return to work at Oxendon House, unless proven guilty of malpractice.
b) That the Social Services Ctte and Director of Social Services apologise to staff for their treatment and that every effort is made to remedy the damage done to staffs' reputations.
c) That if the Director of Social Services is not willing to negotiate on these demands, he should resign.

6) Resolves:

a) To continue to fully support its members at Oxendon House and work with the NUT and NAS/UWT
b) To involve all interested members in developing campaigning and action on this resolution.

Proposed : Tim Sanders **Seconded : Betty Roberts**

Carried unanimously at the Annual General Meeting

Motion of 16.12.93 Bedordshire County Council Meeting

16 December 1993 - OXENDON HOUSE

"That the Council notes that the Social Services Committee on 2 November endorsed the decisions of the Child Protection Strategy Group to temporarily close Oxendon House, permanently redeploy the staff, permanently relocate the children and ensure that any future operation there be clear and supported by explicit policy and practice statements agreed by the Committee.

Council welcomes the decision of the Social Services Representative Panel on 8 December that:

i) the staff be redeployed on a temporary and not a permanent basis pending the outcome of a Review of Residential Child Care in Bedfordshire which shall include recent experience at Oxendon House.

ii) information on the background allegations leading to the Social Services Committee's decisions on 2 November be now given to staff.

Council also believes that the best interests of the children, staff, the public and the County Council shall be served if the Review is conducted as a matter of urgency by a full and independent inquiry. This inquiry shall:

i) be commissioned as soon as possible, in consultation with the Policy and Resources and Social Services Representative Panels, in order to report to the Social Services Committee on 8 March 1994 or to a special meeting of that Committee to be held no later than 31 March 1994.

ii) consider the terms of reference of the Social Services Select Panel on Residential Child Care as part of its remit.

iii) examine and describe the relocation of the children resident at Oxendon House at the time of temporary closure and make recommendations.

iv) examine and describe the staff management issues surrounding the temporary closure of Oxendon House and make recommendations.

v) consider any other relevant issues.

Council supports the principle of the re-opening of Oxendon House provided that the following criteria are met:

1. that there is a clear and well defined purpose of work at Oxendon, backed up by explicit policy and practice statements

2. that staff have opportunities for fully understanding what is and what is not acceptable practice and that this to be re-inforced by a comprehensive training programme for all residential child care staff at Oxendon and those from the rest of the County

3. that any disciplinary action which may arise from the recent enquiries has been substantially completed.

4. That effective systems of management control, support and oversight exist for all residential child care establishments in the County.

5. That there are in place adequate systems of recording, monitoring and inspecting practice, including appropriate and effective systems of Member involvement such as Rotat Visits and training.