Protection of the rights of children – failures in residential care in the UK
by Graham Ritchie


BACKGROUND

The post-Second World War legislative background of the protection of children has been the Childrens Act 1946, the Children and Young Persons Act 1969, and the Children’s Act 1989.

A Government White paper entitled ‘Children in Trouble’ and the Report of the Seebohm Committee on Local Authority and Allied Personal Social Services (1968) produced recommendations which were incorporated in the Children and Young Persons Act 1969 and the Local Authority Social Services Act 1970. These changes were implemented within the context of substantial local government reorganisation under the Local Government Act 1970.

Prior to this, each local authority had a children’s officer who was head of a children’s department. Child care services were the responsibility of the Home Office.

In future child care services were to be provided by a social services department headed by a Director of social services in each county council or county borough.

The role of central government in future was to be:

(1) planning the purpose of the service and ensuring that local authorities understood the strategy;
(2) ensuring minimum levels of service throughout the country; and
(3) collation and provision of information and identification of needs.

The reorganisation of social services resulted in large scale recruitment of social workers. There were scenes in council chambers where elected politicians objected to the cost of the establishment of large social service departments. Very often the new Director of these large departments was the existing children’s officer who did not have experience of managing large organisations.

CHILDREN IN TROUBLE

The White Paper ‘Children in Trouble’ made proposals based on the assumption that child neglect and child delinquency were both symptoms of the same cause of deprivation.

Paragraph six of the document states:

‘Juvenile delinquency has no single cause, manifestation or cure. Its origins are many, and the range of behaviour which it covers is equally wide. At some points it merges almost imperceptibly with behaviour which does not contravene the law. A child’s behaviour is influenced by genetic, emotional and intellectual factors, his maturity and his family, school, neighbourhood, and wider social setting. It is probably a minority of children who grow up without ever misbehaving in ways which may be contrary to law.’

It was proposed that offences committed by children between the ages of 10 to 14 should not necessarily result in prosecution. Proceedings, if any, should be brought under a civil care and control procedure. Restrictions were to be imposed on the prosecution of offenders aged between 14 and 17 years and care, protection and control proceedings were to be considered as an alternative.

CHILDREN AND YOUNG PERSONS ACT 1969

The Community Homes Regulations 1972 were made under this Act. Local authorities were required to arrange provision for the care, treatment and control of children accommodated by the local authority. The regulations did not apply to voluntary or private children’s homes or to independent residential schools.

Regulation 3(2) required each home to be visited at least once a month and a report to be provided by
the visitor. Local authority homes were to be visited by such persons as the local authority considered appropriate, whereas the visits to controlled or assisted homes were to be by a manager.

Section 24(5) of the 1969 Act required local authorities to appoint an 'independent person' to be a visitor to a child accommodated in a home who had infrequent contact with his parent or guardian or none at all in the preceding 12 months and who did not leave the home to attend school or work. The duty of the visitor was to visit, advise, and befriend the child.

COMMUNITY HOME ENVIRONMENT

Regulation 10 of the Community Homes Regulations 1972 required:

(1) The control of a community home shall be maintained on the basis of good personal and professional relationships between staff and the children resident therein.

(2) The responsible body in respect of a local authority home or controlled community home and the local authority specified in the instrument of management for an assisted community home may approve in respect of each home such additional measures as they consider necessary for the maintenance of control in the home, and the conditions under which such measures may be taken, and in approving such measures and conditions they shall have regard to the purpose and character of the home and the categories of children for which it is provided.

(3) Any approval mentioned in the preceding paragraph shall be given in writing to the person in charge of the home, save that in the case of an assisted home the approval shall be given to the responsible organisation and shall be reviewed every twelve months.

(4) Full particulars of any of the measures mentioned in paragraph (2) of this regulation which are used and of the circumstances in which they are used shall be recorded in permanent form by the person in charge of the home and the record shall be kept in the home.

Good personal and professional relationships between staff and children were often undermined by high staff turnover, poor staff training, and abusive staff.

CHILD ABUSE - GENERAL BACKGROUND

During the 1970s child abuse was usually seen in terms of physical abuse within the family or step family environment. Care proceedings were not infrequent and physically/mentally abused or neglected children were often taken into the care of the local authority.

Individual solicitors would find themselves in the role of solicitor for the local authority, solicitor for the parents, guardian ad litem, next friend and solicitor for the child.

Under the Children's Act 1989 the office of guardian ad litem was systematised.

There was a general awareness and anecdotal evidence that placing a child into local authority care was not the solution to that child's problems.

At the very least it seemed that there was a cycle of deprivation where the children of parents who themselves had been placed in care were often the subject of care proceedings.

During the 1980s sexual abuse of children was spoken of for the first time.

Subsequent local authority emphasis tended to concentrate on child sex abuse. However the events taking place in residential homes in Wales, Northwest England, and elsewhere had not fully come to light. Those events were to lead to The Waterhouse Report and to changes in the regulation of residential homes.

BACKGROUND TO 'LOST IN CARE - REPORT OF THE TRIBUNAL OF INQUIRY INTO THE ABUSE OF CHILDREN IN CARE IN THE FORMER COUNTY COUNCIL AREAS OF Gwynedd and Clwyd SINCE 1974' (THE WATERHOUSE REPORT)

Residential homes in Gwynedd and Clwyd

1974 – 1980: Police investigations in this period resulted in five convictions of care workers in residential homes. There were ten separate investigations but no general reaction of concern was triggered. The social service departments did not recognise that there was a major issue of concern. The climate of suppression within the homes and the departments ensured that there was no general awareness of the problem. Social service department co-operation with the police was minimal.

1981 – 1989: Another five convictions for sexual offences against children in care occurred. There was no general change in official social service concern.

1990 – 1996: Eight people were prosecuted and six convictions obtained.


Criticisms of the police investigations

The general criticisms are:

(1) failure to respond to and investigate individual specific complaints by children in care; and

(2) insensitivity in their dealings with absconders from children's homes and failure to adequately find out the reasons for absconsions.
A WHISTLE-BLOWER

Alison Taylor, officer in charge of a local authority home, Ty Newydd, at Bangor from 1982 to 1986, made complaints of child abuse to a councillor and unsuccessfully to her superiors in the social services department.

Ty Newydd had been a hostel for ten boys aged 16 to 21 years. The hostel closed in 1981 having been described by independent inspectors as being in an appalling physical state, including its furnishings, decoration and grounds. It was held that there was a serious failure of management in allowing the placement of young people in the care of the County Council in such surroundings and ‘then to expect them to prepare themselves for life in the community’ (Dyfed inquiry team report).

In 1982, Ty Newydd, which was a forbidding stone building right on the junction of busy main roads, was reopened as a community home for 12 boys and girls aged 5 to 18 years.

Alison Taylor was alert to abuse in residential homes and had reported to her superiors incidents from 1976 including sexual abuse of a boy resident who later committed suicide.

In 1984 at Ty Newydd, she wrote a memorandum to the Director of Social Services about an assault. The Director did not investigate the matter. Further reports about other assaults were made in July 1985 and February 1986.

After the 1986 report she was told that she was making trouble unnecessarily.

In 1986 Alison Taylor made her concerns known to local politicians and wrote to the Prime Minister Margaret Thatcher. The police were also notified.

By October 1986 a Councillor Davies opined:

‘I am of the opinion that she [Alison Taylor] is a most unfit person to be in charge of a children’s home, and that she is a blatant troublemaker, with a most devious personality.’ (Waterhouse Report).

By January 1987 Alison Taylor was suspended from her post. The Director of Social Services had written on 1 December 1986:

‘I have become increasingly concerned that the spirit of professional trust and co-operation between you and your colleagues in the residential child care sector, which is so necessary for the efficient running of that service, has broken down.’ (Waterhouse Report).

In the face of these attempts to marginalise her, Alison Taylor embarked on a campaign for a Public Inquiry. Questions were asked more than once in the House of Commons. A Chief Constable called for an inquiry.

THE JILLINGS REPORT

Eventually, rumours, anecdotal concerns, and convictions from police inquiries resulted in Clwyd County Council setting up the Jillings Report. The terms of inquiry of John Jillings, a social worker, and two others were set out in a letter dated 30 November 1994:

‘The County Council has appointed John Jillings Chairman of an independent panel to conduct an internal investigation for the County Council into the management of its Social Service Department from 1974 to date with particular reference to and emphasis on what went wrong with child care in Clwyd in the light of a number of incidents and convictions culminating in the conviction of Stephen Norris in November 1993 of further offences against children in the care of the County Council.’ (Waterhouse Report).

The panel was mandated to ‘inquire into, consider and report to the County Council upon (1) what went wrong and (2) why this happened and how it could have continued undetected for so long’. Their attention was directed to such matters as recruitment and selection of staff, management and training, suspension, complaints procedure and so on.

This report was not published on legal advice for fear of exposing the county council to libel proceedings in the absence of any absolute or qualified privilege.

This led to allegations of a cover up and the British Government decided that a full public inquiry under the Tribunals of Inquiry (Evidence) Act 1921 had to take place.

LOST IN CARE – REPORT OF THE TRIBUNAL OF INQUIRY INTO THE ABUSE OF CHILDREN IN CARE IN THE FORMER COUNTY COUNCIL AREAS OF GWYNEDD AND CLWYD SINCE 1974

The terms of reference of the inquiry were:

(a) to inquire into the abuse of children in care in the former county council areas of Gwynedd and Clwyd since 1974;

(b) to examine whether the agencies and the authorities responsible for such care, through the placement of the children or through the regulation or management of the facilities, could have prevented the abuse or detected its occurrence at an early stage;

(c) to examine the response of the relevant authorities and agencies to allegations and complaints of abuse made either by children in care, children formerly in care or any other persons, excluding scrutiny of decisions whether to prosecute named individuals;

(d) in the light of this examination, to consider whether the relevant caring and investigative agencies are doing so now, and to report its findings and to make recommendations.

APPROACH TO EVIDENCE IN THE WATERHOUSE REPORT

Evidence is subject to more flexible treatment before tribunals than before courts.
The test is that of a ‘balance of probability’ rather than the ‘beyond all reasonable doubt’ of the criminal courts, subject to certain exceptions.

In child care proceedings the approach to evidence has always been relatively flexible. Hearsay evidence is habitually allowed. This leads to occasionally undesirable situations where social service evidence and reports before the courts rely on file notes and statements made by previous social workers. The accuracy and provenance of the information put on file by the previous social workers cannot be tested. Those social workers have often moved on and subsequent social workers copy the statements and conclusions into their later reports as though they were hard evidence.

However without allowing leeway in the quality of evidence before a tribunal in child cases it would very often be impossible to reach conclusions. The weight of circumstantial, uncorroborated, and similar fact evidence before the Waterhouse Tribunal made it possible to conclude that there were disastrous failings in the quality of child care that county councils were responsible for, and that a much more effective system of regulation, inspection and control of residential homes was needed. The Waterhouse inquiry was an influence behind the Care Standards Act 2000. Regulation of residential houses, whether managed by the private or public sector, is recognised to be a failure. The Waterhouse report affirms the conclusion of the Burgner Report of 1996 into regulation of the care sector. This report highlighted a piecemeal approach to regulation. At present some 150 local authorities and 100 health authorities are responsible for regulating care services, and use widely differing regulatory standards.

The recommendations of the Burgner Report are now being implemented to create a regime that is tough, accountable and transparent. A new national body – the National Care Standards Commission – is being established to take over the regulation of social care services and private and voluntary health care from local authorities.

A detailed analysis of the provisions of the Care Standards Act 2000 and the work of the National Care Standards Commission will be provided in a subsequent paper.

Graham Ritchie MA (Cantab)
Solicitor, Associate Senior Research Fellow
Institute of Advanced Legal Studies.

The paper was given at a conference, ‘Legal Protection of Children’, held in Bloemfontein, South Africa, 21 – 23 August 2000. The author was one of two overseas speakers at the conference (the other being Peter Harris, former Official Solicitor of England & Wales). The conference formed the first in a series of four, funded under the Commonwealth Development Programme of the Nuffield Foundation. Further conferences are due to be held on the subjects of ‘Legal Responsibilities of Government and Public Organisations’ (Maseru, Lesotho, 2 – 4 April 2001), ‘Legal Protection of Human Rights’ (Bloemfontein, 9 – 11 April 2001) and ‘Legal Protection of the Mentally Ill’ (Windhoek, Namibia, currently 20 – 22 August 2001, although the date may change).