Improving Lives Select Commission

1.	**Date of meeting:**	**18 September 2018**
2.	**Title:**	**Outcomes from the Improving Lives Select Commission Workshop Session – Complex Abuse Investigation.**
3.	**Directorate/Agency:**	**Assistant Chief Executive's** **Children and Young People's Services**

4 Attendance

Present: Councillors Beaumont; Clark (Chair); Cooksey; Cusworth; Eliot; Jarvis; Khan; Senior and Turner, Julie.

Apologies: Councillors Hague; Marles; Pitchley and Short

5 Purpose of this briefing

5.1 This briefing note outlines the outcomes of the workshop session held by members of Improving Lives Select Commission on 24 April 2018 to understand the Complex Abuse Investigation.

6 Background

6.1 At its meeting of 13 March 2018, the Commission considered a report on Complex Abuse Processes. The report outlined that complex abuse procedures are used in cases where there are believed to be issues of connected, organised or multiple abuse of children. There is an ongoing large scale Complex Abuse Investigation in Rotherham which commenced in early 2017.

6.2 Following this meeting, Cllr Maggi Clark as the chair of the Commission, requested that a workshop session be held to enable Members to seek assurance and further understanding of the extent to which agencies are working effectively together to address complex abuse. This was held on Tuesday 24 April 2018.

6.3 The Commission thanks the following officers for their co-operation with the planning and delivery of the workshop.

- Emma Wheatcroft, South Yorkshire Police
- Sam Davies, Rotherham Clinical Commission Group
- Vicky Schofield, Head of First Response, CYPS
- Mel Meggs, Deputy Strategic Director, CYPS (Apologies received)
- Phil Morris, Business Manager, Rotherham Local Safeguarding Children's Board (LSCB) (Apologies from Christine Cassell, Independent Chair)

7 The following key issues were discussed:

7.1 In what circumstances were complex abuse procedures used?

- Officers detailed that complex abuse procedures are used in cases where there are believed to be issues of connected, organised or multiple abuse of children. This may occur where multiple children (across more than one sibling group) are

abused by a single perpetrator or when multiple, connected perpetrators are involved in abusing children in some "organised" way. Complex abuse investigations are governed by the same legislative principles as all other investigations of child abuse (Section 47, Children Act 1989 and Working Together to Safeguard Children Guidance[1]). The local authority therefore has a statutory duty to investigate where there are reasonable grounds to believe that children are suffering or likely to suffer significant harm, taking all necessary action to ensure their welfare as a result.

- A feature of the current investigation was the significant number of children and young people who were experiencing neglect. Examples were given of children and young people from a number of inter-related families being left hungry or dirty, without adequate clothing, health care or supervision. The neglect also extended to children being put in danger or not protected from physical, sexual or emotional harm.
- It was noted that the effects of neglect can have a wide-ranging, long term impact on the physical, psychological and emotional well-being of the child or young person. While its impact can be particularly damaging in the first 18 months of life, harm is also understood to be cumulative with poorer outcomes across a range of developmental milestones for those experiencing neglect.

7.2 Which agencies were involved and at what level?

- The inquiry was instigated following the conclusion of a related police investigation into substance misuse and suspected child sexual exploitation. It commenced in January 2017 in line with the Rotherham Local Safeguarding Children Board Complex Abuse Procedure. Colleagues from South Yorkshire Police, Rotherham CCG (Clinical Commissioning Group) and Rotherham LSCB outlined their respective responsibilities under the procedure, giving examples of how they worked together to identify and investigate this type of abuse.
- Details were given of the strategic group which was set up in late 2016. The group had high level representation from relevant agencies, with agreed parameters and terms of reference, timescales of the enquiries/investigation and routes of accountability for the investigating team.
- Members asked for further details of the Operational Group established in March 2017. It was explained that the team was established which had the necessary training, expertise and objectivity to manage and conduct on a day to day basis the criminal investigations and/or Section 47 Enquiries. The group was also responsible for the deployment of staff and resources for the investigation and the subsequent ongoing care and safeguarding of the children. The group ensures that there are clear protocols in place, including a consistent strategy for sharing information appropriately and confidentially with other agencies not represented on the strategic and operational groups. Operational briefings are issued on a weekly basis outlining key developments and issues.
- Prior to this investigation, Rotherham had already established a Multi-Agency Safeguarding Hub (MASH)[2] to support multi-agency information sharing, decision making and responses to child safeguarding concerns, with key staff from partner agencies co-located. The MASH operates in a secure fire-walled environment with access to their agency's electronic data, who research, interpret and determine

[1] Since this workshop was held the refreshed Working Together to Safeguard Children guidance was published in July 2018.

[2] Involving staff from Rotherham Metropolitan Borough Council (RMBC), South Yorkshire Police (SYP), the Rotherham Clinical Commissioning Group (CCG), The Rotherham NHS Foundation Trust (TRFT) and Rotherham, Doncaster and South Humber NHS Trust (RdaSH)

appropriate information sharing in relation to children, young people (and vulnerable adults) at risk of immediate and / or serious harm. Having co-located staff meant that once the decision to proceed to the complex abuse investigation had been made, the response was co-ordinated quickly and efficiently.

7.3 How did other agencies/ part of the council which do not directly have safeguarding powers (e.g. housing, licensing or enforcement services) contribute to the investigations?

- Further details were provided of the bespoke social care team and the type of work undertaken to coordinate activity with relevant agencies. Links with community based workers and groups were highlighted as well as the close working with police and housing providers. The complex abuse investigations were focussed on a number of inter-related families who had moved to Rotherham in recent years. This had brought specific challenges in terms of language and cultural awareness. Examples were given how these were addressed by workers from different agencies.
- Examples were sought about how other agencies and Council services who sit outside social care were involved (e.g. housing, revenue and benefits, licensing or enforcement services). Instances were given of co-operation and information sharing which had assisted investigations positively.
- In respect of referrals, it was explained that prior to the complex abuse investigation being enacted, referrals were coming through from individual workers across different agencies (for example health visitors, schools or children centres), but the significance or connectivity of the cases had not been fully recognised. There was also 'soft' intelligence which had been taken in isolation rather as part of the wider picture and whilst a police operation had been enacted this had not led to the evidential thresholds for criminal proceedings to be met. A subsequent review into the police operation uncovered a level of childhood neglect present in their enquiries which resulted in the use of mapping process which identified the connectivity between some current casework that was being managed as individual cases and the potential of a wider group of children experiencing a similar pattern of significant harm. The partnership agreed that this constituted a complex abuse investigation. The investigation then took a proactive approach to identifying all known children who could be at risk and ensuring they were subject to child protection assessment and planning. This is significantly different to day to day practice which requires a referral for an investigation to be commenced.
- Assurance was given that there were good lines of communications and intelligence was shared appropriately. Members questioned how this worked in practice and sought examples of multi-agency working, particularly drawing on how referrals from different agencies were used and escalated. It was raised that poor dental health in children was often an indicator of parental neglect, however there had been relatively few referrals from dentist or dental health professionals.
- It was noted that links were developing with the Department for Work and Pensions and Border Agencies and Courts, to share information when children leave or return to the area. This was an emerging relationship and given there was no 'template' for this type of working, staff had to come up with innovative and flexible ways of engaging with families and agencies. Although good examples of joint working were given, the legal system face challenges to understand the wider context of the complex investigations and respond to the escalating risk of flight which may require rapid intervention. This was subject to ongoing dialogue and representations to ensure children were safeguarded.
- An overview was given of the work undertaken with other police forces in the UK and European judicial agencies to identify and track the criminal history of non-British nationals. Information sharing protocols had been developed which were

thought to be working well although these were subject to constant review and refinement. These processes would be monitored particularly in light of exiting the European Union in 2019.

7.4 What was the impact of the investigations on referrals to social care?

- As a result of the inquiry, there had been a significant rise in children experiencing a social care intervention. The volume of cases related to the investigation had placed considerable pressure on all agencies involved. There had also been a rise in the number children being taken into care or going through care proceedings and children being placed on a child protection plan. The officers also highlighted that a number of families were receiving early help services. Assurances were given that actions taken were appropriate to safeguard children and were decisions were made in the best interest of the child.
- As with other children in care, every effort was made to keep placements within the borough or within close proximity. It was outlined that there were no greater levels of placement disruption for this group of children compared with other looked after children. Foster carers were made aware of the issues experienced by the children and young people so that they could work appropriately to support them.

7.5 Engagement with Early Help Services

- Assessments of capacity to protect/achieve and sustain change were now routinely undertaken which would inform the course of action undertaken for each family. Many of the families involved in the investigation had engaged superficially with Early Help services; however despite these interventions the adults had not always demonstrated the capacity to protect their children from harm. In these instances, cases had been stepped up appropriately. In those cases where families were assessed that there was capacity to change, ongoing support was provided from early help to build resilience to improve parenting and to access education, health care, decent housing etc.
- It was noted that school attendance for the children and young people involved in the investigation had been problematic. There was greater consistency in the way that schools now followed the procedure to track attendance and report children who are missing.
- Protocols had been developed for missing alerts for transient families with examples given of joint working with the Border Agency. It was noted that there is no single system to record and share information nationally about children who go missing in place.

7.6 Will the changes to the General Data Protection Regulation (GDPR) have any impact on information sharing?

- It was reported that the changes to the Data Protection Act 2018 and GDPR should not act as a barrier to practitioners and agencies to share information appropriately if its purpose is to identify and provide appropriate services that safeguard and promote the welfare of children. As with current procedures, whilst consent should be sought wherever possible, there will be circumstances when it is not appropriate to seek consent, because the individual cannot give consent, or it is not reasonable to obtain consent, or because to gain consent would put a child's or young person's safety at risk. However, the roll-out of the new GDPR would be monitored to see if there are there is any adverse impact on agencies sharing information.

- Questions were asked about how information was shared with ward members about community engagement and disruption activities which may be taking place locally. It was suggested by the Committee that local ward members should be alerted in line with existing operational protocols and on a 'need to know' basis if these activities were taking place so they could signpost residents appropriately and ensure that information and intelligence pertaining to the investigation was passed on.

7.7 How is the voice of the child captured in these investigations?

- Examples were given of some of the difficulties attached to capturing the voice of the child, particularly in circumstances when the parents or carers were not fully or openly engaging with the process. The practice guidance reiterated the importance of correlating evidence from a variety of sources including observing the child in different settings and speaking to them on their own. In some circumstances further disclosures had been made once the child had been removed and placed in safety.

7.8 How was this work viewed in the recent OFSTED inspection?

- The recent OFSTED inspection reported positively of the work undertaken to help reduce risk, effective planning and tenacious social work practice working with families, many of whom do not want to engage. Members asked for further details of how the lessons and learning arising from the complex abuse process are implemented to improve safeguarding practice. Assurance was given that learning was shared and applied with case audits undertaken by the LSCB and as part as 'routine' improvement practice. OFSTED had flagged Rotherham as an exemplar of good practice in how it had undertaken this work.
- In particular, the learning relates to the way key agencies work with vulnerable children who move between local authority areas and across international borders. Specifically, procedures have been implemented around the sharing of information between agencies in different countries. Processes in relation to the identification of missing families have been developed (in order to address the issues about risk of flight during child protection processes), and skills and expertise in mapping large amounts of familial information (through the use of 'genograms') to aid assessment has increased significantly. More generally, the learning from this work is helping to strengthen social work assessments, in the context of accumulative information giving rise to concerns about children's safety.
- The practice guide for working with complex and mobile families was shared with Members which set out clear steps to follow to ensure a consistent approach is taken to investigation. Staff receive support and guidance through supervision to ensure that practice is embedded. This is corroborated through audits which had demonstrated consistent practice and good levels of information sharing and collaboration.

8 Conclusions

8.1 Having had the opportunity to question officers and partners, Members were assured that the Council and its partners working effectively within the prescribed policy for complex abuse investigations (CAI). In doing this, it was satisfied that:

- the powers available to investigate and address CAI and are these utilised fully;
- the support arrangements available for families at risks were adequate;
- there were good systems and processes in place, which were developing to meet changing circumstances;

- that there was good sharing of intelligence and learning within the Council and with its partners;
- the Council was working with other authorities appropriately.

8.2 Members also gained a better understanding of why OFSTED identified the work undertaken as part of the CAI as good practice in its recent inspection report.

8.3 The Chair thanked those present for the candid presentation and willingness to share this information to members of the Improving Lives Select Commission.

9 Recommendations

9.1 That this briefing be noted and the following recommendations be forwarded for consideration:

- That further investigations takes place to establish the low rate of neglect referrals from dental health services;
- That information is shared in line with existing operational protocols and on a 'need to know' basis with ward members for the purpose of signposting residents appropriately;
- That the appropriate agencies ensure that the GDPR does not act as a barrier to the appropriate sharing of information;
- That further representation is made by the LSCB to the CPS and relevant Court Services to raise the issue of how all agencies can take timely action to safeguard children at risk of flight;
- That a further update be submitted to Improving Lives Select Commission in 12 months' time.

10 Name and Contact Details

Report Author

Caroline Webb, Senior Adviser (Scrutiny and Member Development)

Democratic Services, Assistant Chief Executive's

01709 822765

caroline.webb@rotherham.gov.uk