Independent Investigation

Review of Cases A to O

Report

MAY 2015

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PREFACE

Jean Imray is an experienced operational and strategic senior manager who has worked at Assistant Director and Service Director level since 2007. For the last 5 years she has specialised in successfully leading and supporting Local Authorities who have been judged as having widespread or serious failures in the provision of children's social care. She has worked within the field of children's social care since 1979 and qualified as a social worker in 1988.

1.0 Introduction

This independent investigation was commissioned by Rotherham Metropolitan Council in October 2014. The letter of appointment which includes the terms of reference is appended (Appendix 1).

The Council commission requires that a thorough investigation be undertaken into a number of case studies referred to in the Jay Report on historical Child Sexual Exploitation. This investigation is to enable the Council to reach a conclusion as to whether or not there are misconduct, professional misconduct or capability matters concerning former or current employees of Rotherham MBC.

Specifically I have been asked to undertake a detailed review of case files listed by Professor Jay pertaining to pen pictures A-O, in order to identify if social care practice and reporting of any matters of concern was undertaken in line with professional standards.

I have not been asked to review or comment on any of the aspects covered by the report written by Professor Jay, the findings of which have been accepted in full by RMBC.

Discussion with Kathy Somers, Independent Consultant and Sessional Inspector for the Care Inspectorate in Scotland, who assisted Professor Jay has clarified that the summaries of cases A-O were considered to be pen pictures of the children and young people concerned rather than case studies. The purpose of the pen pictures was to 'give a fair reflection of what many victims experienced', (Jay Report 5.4). In order to achieve this, the summaries convey in one or two paragraphs, situations and events that some children experienced over many months or even years. It was not intended that the pen pictures would be used as a way of highlighting particularly poor practice on the part of individual professionals. It was also made clear by Professor Jay that cases A – O included some, 'but by no means all' of the most serious cases that were read (Jay Report 5.4).

2.0 Methodology

I have studied the report by Professor Alexis Jay 'Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013' including appendices.

I have reviewed all 15 case files held by Children's Social Care relating to the children described in the pen pictures A-O. This has included electronic records and historic paper files where these have been available. As far as possible each case has been audited against a set of practice standards using a standard audit tool in order that a judgment can be reached about the overall quality of practice in each case as well as component areas such as assessments, strategy meetings, investigations, case

recording. Where possible the individuals responsible for each element of practice have been identified.

I have accessed the available paper records that were held by Risky Business. I was informed that these files were transferred to Children's Social Care when there was an amalgamation of services in 2011. It has proved very difficult to establish with any certainty whether the Risky Business records I have seen are a true representation of what was transferred in 2011. During an interview with a former Risky Business member of staff I was told more records were held than are now readily available. In addition, triangulation of findings has been impeded by the fact that many of the historic records have been secured by the National Crime Agency who are undertaking their own investigation into historical crimes exposed by Professor Jay which may have been committed during the period in question.

Section 5 of the Jay Report in which the pen pictures A-O feature, makes reference to the source of the evidence for the chapter. While this was primarily the 66 case files read by the Inquiry Team it included cross checking with a small number of letters from and interviews with parents and a small number of interviews with young people who had been sexually exploited. The Inquiry also had access to the minutes about individual children discussed at the Sexual Exploitation Forum between 2004 and 2006 and centrally held minutes of strategy meetings that discussed groups of children and groups of perpetrators. The numbers of children discussed in all these minutes ran to many hundreds of children being exploited and others who were at serious risk. The remit for this investigation has limited the scope to a review of the Children's Social Care case files and the available Risky Business files concerning the 15 A-O children with some reference to other information where indicated in those files.

I have consulted with Kathy Somers who undertook many of the case reviews on behalf of Professor Jay. I am extremely grateful to her for the time she has taken to point me to where I would be able to locate specific detail in some of the cases, and for explaining the aspects of the pen pictures that were changed in order to protect the anonymity of individual children and their families.

Findings have been triangulated with Police records where these have been relevant to a particular line of enquiry following agreement with South Yorkshire Police Public Protection Unit.

Progress in concluding the investigative work has been hampered by both the difficulties encountered in accessing records, and in identifying an accurate history relating to staffing structures and service establishment in place over the period of time covered.

In order to understand professional standards and expectations applied in Rotherham during the relevant time periods I have reviewed policies and procedures both current and historic, where these have been available.

I have considered the relevant Ofsted reports and other external reports covering the period in question in order to gain an understanding about the context in which services were operating insofar as that context might impact on front line social work practice. This includes the recently published DCLG inspection report.

I attended a meeting in March 2015 with the Health and Care Professions Council in order that they could hear first-hand about the nature and extent of the investigation. Those representing the HCPC acknowledged that the approach taken and the rigour of the process was appropriate in their view. It was helpful to learn that, notwithstanding the consideration of the Warner ' Public Interest' principle, the HCPC Assessment of Fitness to Practice would be one based on ' current impairment'. It was recognised that the majority of the cases identified were historical in nature.

3.0 Summary of Findings

As other reports have concluded, the experience of abuse and exploitation that the young people concerned have suffered has had, and will continue to have, long lasting and far reaching consequences in terms of their physical, emotional and mental health and well-being from which some are unlikely ever to recover. There is already evidence that in some cases the impact extends to the next generation of children from the families involved.

There is no question that it is the perpetrators of the crimes committed against the children and young people who are responsible for their suffering. The question for this investigation is whether there is evidence within cases A - O that any Council employee was guilty individually of misconduct, professional misconduct or capability issues that resulted in the ordeal of individual children and young people being prolonged or made worse.

Having now reviewed the detail of the cases set against the backdrop of the wider organisational context described at considerable length by Professor Jay I am able to recognise a number of the themes that are made repeatedly in her report from chapter 6 to 13,insofar as they are reflected in the experiences of the children A-O. The findings of Professor Jay's report have been accepted by RMBC and as such, where relevant, have been used to inform the judgements made in this investigation in relation to operational context within which social workers and managers were operating over the period.

Extracts from the Jay Report which appear most pertinent to this investigation are appended (Appendix 2). They are mainly drawn from sections 5,6,7,9,12 and 13.

The findings of the Jay Report, as will be seen in the extracts, return repeatedly to issues to do with deficits in leadership, management and governance.

In my view, the majority of the cases A-O would be judged as 'inadequate' overall when measured against basic professional practice standards, particularly when outcomes for young people are included in the considerations.

I have found examples of specific practice that is at least 'adequate' and even, in a few instances, 'good' on the part of individual practitioners within some periods in cases A-O. There is, however, also evidence of extremely poor practice and in one case in particular what I consider to have been negligent work.

The conclusion I have reached is that, for reasons that will become evident in the body of the report, save for one case there are insufficient grounds to proceed with any action against any individual practitioner or team manager. The various and substantial organisational failings described by both the Jay and Casey reports were reflected in the cases I reviewed and it is those very failings that make it impossible in my judgement to mount any credible HR investigations into individuals who were in the operational frontline during the period in question.

That said, the failings evident in Child E were of such magnitude that a more detailed, forensic review of that case is warranted. There is in my view prima facie evidence of significant culpability by at least two social care professionals (neither of whom currently work for RMBC).

As will be seen from the following sections there has been evidence that over the period in question the Local Authority has failed to ensure that basic processes and procedures have been followed by its Children's Social Care Service. In addition I have found examples of significant deficits in the quality of case recording, record keeping, assessments and decision making. I am very aware that the LA already has a range of action plans designed to address the areas for improvement identified by Ofsted in 2014,and to respond to the recommendations made by Professor Jay and the CGI Inspection published in February 2015. I have therefore not chosen to make recommendations in response to my findings with two exceptions. These are as follows:

> *1. That the case of Child E is referred to the Rotherham Safeguarding Children's Board for consideration as a potential serious case and that a more detailed examination of all the records pertaining to Child E is undertaken by all agencies. This is so that the RSCB can determine what, if any, further action is required to address historic concerns that may continue to impact on Child E or other children in the family. This will include the need to investigate historic allegations that may not have been responded to in the past.*

> *2. That RMBC undertake a review of admission criteria and risk assessment processes in respect of admission of young people to its residential and foster care homes to ensure that young people who pose a risk to others are placed appropriately.*

The following sections set out in more detail some of themes that have emerged during the review.

4.0 Practice themes

These fall under the following headings:

1. Record Keeping
2. Response to Victims
3. Quality of Strategy Meetings/Case planning
4. Child Protection Practice and Understanding of CSE
5. Assessment
6. Team Manager Oversight and Supervision
7. Senior Manager Oversight
8. Working with Adolescents
9. Residential Care

In addition there are clearly implications relating to shortfalls in staff training and development over the period including supervision training for first line managers, however I have not reviewed any of the training schedules or impact evaluations that may have been available as this fell outside the scope of this investigation.

4.1 Record Keeping

Prior to August 2008, electronic records were very basic and were limited to contact and referral details with routine case recording sitting on paper files. Compliance in meeting expectations of the electronic system does not appear to have been robust during this period - i.e. some contact and referral records found on the paper files are reflected on the electronic system and some are not. It was a similar situation with the case recordings. In more than one case, in order to piece together a reasonable chronology of events, it was necessary to refer to at least two paper files covering the same period and cross check against the electronic record to try and ensure nothing had been missed.

Post August 2008 a new system (Electronic Social Care Record) was introduced to sit alongside the previous system which is still used to date. The shortcomings of both systems are well documented. I am aware that the council has commissioned an entirely new electronic recording system which will be implemented in early 2016.

The detailed review of case files required in order to reach sound and evidence based conclusions has been hampered by the poor quality of case recording, and in some of the older cases what appear to be missing records. In the cases concerned it is not possible to say whether records are absent because they have been mislaid or because they had never been written. In the older social care paper files case records ranging from contact and referral records to assessments and records of visits, phone calls and meetings are frequently undated and unsigned. As a result it is often not possible to establish with certainty when events occurred and who was responsible for making the record and thus who was responsible for the practice described.

Even in more recent cases that are reliant on the electronic system it has been established that the system allows a key worker to be assigned to a closed case. This means that there is no guarantee that at the point of closure or re-referral there can be any confidence that the key worker recorded was the key worker who was actually involved. In addition the system does not enable the tracking of team manager involvements. As the current ICT CCM specialist has recently explained, because of the shortfalls in the system *'…it is almost impossible to ascertain who the manager was of a particular team at a particular time…'*

It does not appear that any recording standards had been applied to the paper files I reviewed and it was rare that any case, paper or electronic, had been quality assured or signed off by a manager at the point of transfer or closure. Where cases had been signed off at these points, I was not able to find a management rationale for the decision that had been taken. There was some evidence that more recent cases were subject to a quality assurance review at the point of Child Protection Conference, but these did not appear to be undertaken routinely and were largely superficial checks that the mandatory paper work had been completed. There was no comment on quality of practice and no sense about how any shortfalls identified had been followed up.

When auditing against commonly applied practice standards the poor quality of case recording alone in the older cases would lead to an audit judgment that a case was 'inadequate'.

Early Risky Business records relating to cases A-O that I have seen to date have not always been helpful. I understand that the quality of records generally were variable but that some of the cases held by the RB team were extremely detailed and of good quality. Risky Business was a Council service and as such should have been aware of the required record keeping standards, particularly in relation to child protection matters. I was told by a former Risky Business employee that old paper files were in a better condition than I have found at the point the service was disbanded. In addition it is not clear if I have had access to same sets of Risky Business records seen by Professor Jay and her team.

During the course of the investigation I raised a query about what appeared to be strategy meeting minutes missing from children's files. I was informed that many

strategy meetings were chaired by staff from the Safeguarding Unit and when this occurred the minutes were not kept on the child's file, but were instead stored separately in folders kept by the unit. In order to test the theory I asked to be shown how the system worked using a specific child as an example. Although there was a folder with the child's name there were no minutes in the folder. The custom of storing strategy meeting minutes separate from the child's record would seem to add yet another layer of confusion and provide unnecessary possibilities for agreed actions to be overlooked. Crucially this practice, which it is understood was only stopped in 2012, highlights an important issue relating to young people's rights to have access to records held about them. Very significant decisions are likely to have been taken in respect of individual children in these strategy meetings which have never appeared on the case files. They will therefore never be seen as a result of any access to records request. For this reason alone the practice of storing strategy meeting minutes centrally in the Safeguarding Unit was fundamentally flawed.

Finally there was and continues to be poor cross referencing of information. There is important information about individual children held on the files of other children, their siblings or in at least one of the cases (Child C) an unrelated adult with no reference made on the subject child's case record. The obvious consequence of this is that matters of a child protection nature can easily be missed and this may result in safety critical decisions being made in the absence of all the relevant information.

4.2 Response to Victims

There are two key issues here - they are related but can and need to be separated out.

Firstly there was a prevailing sense, reflected very powerfully by Professor Jay, that the victims of CSE were treated as if they were consenting adults engaging more or less willingly in sexual activity. In 8.1 Professor Jay talks about children as young as 11 being '*deemed to be having consensual sexual intercourse when in fact they were being raped and abused by adults*'.

In some of the cases reviewed it is very clear from the recording, particularly in the more historic cases, that the responsibility for protecting through criminal prosecution was clearly placed with the victim themselves. In too many instances professionals insisted that nothing could be done unless victims were willing to make a specific complaint against individual perpetrators. In some cases, such as Child B, D and Child E for example, alternative options do not appear even to have been explored.

There are also references in a number of cases of children and young people either 'consenting' to sexual activity or undermining their own credibility as witnesses by continuing to associate with alleged abusers. While not always explicit, the sense that is often conveyed is that not only were children inviting their own abuse, it was also in their own power to put a stop to it. This is a theme that Professor Jay returned to

several times in her report and one that was recognisable in a number of the cases reviewed for this investigation.

The second connected issue relates to thresholds. Judgements that the police may reach when investigating alleged child abuse that there is 'no evidence that a crime has been committed' or 'no grounds to prosecute', may fail to take account of the inherent complexities and ambiguities that characterise all child protection work. (It is not for me to give a view about SYP in this regard or comment on whether they always made full use of the powers available to them in cases A-O). It does appear that in some of these cases social workers (and team managers) appeared to take their lead from police officers and as a consequence, they lost sight of their separate statutory function and the lower 'burden of proof' required for their intervention.

The over reliance on police to determine the action that should be taken in child protection matters is often manifest within local authorities where there are widespread failings within children's social care. There are clear examples of the prevalence of this attitude within cases A-O. It is indicative of a weak/inadequate service that looks to the police response to inform its own decisions, rather than being clear about their own legal duties and the statutory framework within which they work. It represents a lack of confidence in the appropriate use of professional judgment in assessing risk of actual and likely significant harm as well as a failure to acknowledge and respond appropriately to the experience of children and young people in need of protection.

Local Authority Children's Social Care is not governed by what applies in the prosecution of criminals. The statutory obligations of the Local Authority relate to the protection of children. Debates about how the powers available to the police can be best utilised to contribute to Local Authority safeguarding duties happen, and have happened, routinely at least since the Children Act 1989 but the ultimate responsibility for protecting children lies clearly with Local Authorities.

The police cannot be held solely responsible for the tone of the response to victims of CSE in Rotherham. This was something managers within Children's Social Care should have been fully aware of and should have been challenging through the various routes available.

The debates and agreements about how agencies work together to protect children usually take place in Local Safeguarding Children's Boards. Before LSCBs they happened in Area Child Protection Committees. In my experience it is highly unlikely that these bodies would not have been aware of the approach taken to the joint investigation of child protection matters and this would include a sense of the attitudes and responses that prevailed in relation to children and young people being sexually abused and exploited.

LSCBs and ACPCs are and were made up of middle to senior managers in the partner agencies including the voluntary sector. If the prevailing attitude and culture was to be challenged and changed it would have been through these bodies.

In the absence of this challenge, it is not unreasonable to suppose that practitioners and first line managers would understand that this culture, attitude and approach was sanctioned and approved by senior managers across the partnership. It would have been understood to be the way things got done in Rotherham, and there is certainly a sense of that conveyed through many of the A – O cases.

There was a reference in the records to Child A having been issued with condoms by a project called Youth Start when she was aged 12. This is not the only reference to such an occurrence. Without making any definitive judgment about this, as there maybe alternatives explanations, it is not unreasonable to think that if 12 year olds are requesting condoms then they may be sexually active. Given Child A's age this should have prompted a child protection referral. It should have been clearly understood that matters relating to safeguarding children take priority over confidentiality. This example of lack of clarity about priorities again serves to expose shortfalls in child protection practice and may also relate in some way to the prevailing attitude towards children involved in sexual activity. The fact that children asking for condoms were not referred under child protection procedures, or escalated to the ACPC for review, might suggest that while not condoned children's involvement in sexual activity was in some way accepted. It would be very unusual in my experience for the then ACPC not to be aware of the Youth Start project, and indeed the project would have been governed by the ACPC Child Protection Procedures of the time.

There had previously existed a facility within the system for practitioners to escalate concerns. In 1997 in the case of Child E the social worker formally lodged his dissent following the decision to remove the children's names from the CP register because he believed the children remained at risk of neglect. As a result of this dissention the chair referred the decision to the Case Review Sub Committee who formally reviewed the case and wrote to the social worker to thank him for raising the issue and to explain the basis of the decision reached. This was the only example of such an escalation that I identified in the 15 (A-O) cases reviewed but does demonstrate that, at least in 1997, the escalation option was in place, was understood and was welcomed. The fact that other cases were not escalated may be further evidence that at the time the practitioners and first line managers saw nothing wrong with the response that was being given to the children and young people concerned.

4.3 Quality of Strategy Meetings/Planning

There are a number of occasions where opportunities to protect children may have been missed as a result of a failure to undertake Section 47 (child protection) enquiries when there was clearly reasonable cause to suspect significant harm. There was a worrying absence of evidence of both 'strategy' and investigation in too many of these cases. This was particularly true of Child E, who was a looked after child but one in very clear need of protection.

Working Together, in all its iterations, is clear that a s47 investigation should be informed by at least one multiagency strategy meeting/discussion. This is to ensure that the actions taken are informed by the knowledge and intelligence that is available (historic and current) and that all aspects of the investigation are supported by thorough and thoughtful planning.

Even where there were multi-agency 'strategy' meetings in cases A-O, these were often not held within required timescales. They tended to focus on information sharing rather than agreeing actions (strategies) and where actions were agreed there was often no evidence on file that these had been followed through. Professor Jay makes the point (7.4-7.5) that there was a confusion of responsibilities for strategic responses and decision making for individual children. This resulted in key decisions and actions being taken about individual children in what were otherwise multi-agency meetings to determine operational strategy. These decisions did not systematically find their way onto children's case records. The other consequence may have been that these strategic meetings may have been seen to replace the strategy meeting that would be expected within any s47 investigation.

In fact I have seen very few examples where I can recognise a standard s47 investigation pathway in terms of both process and timescales, and even less where there is a sense that plans were made that took account of the needs and circumstances of the individual child or young person.

> *A standard s47 investigation pathway is as follows: 'reasonable cause to suspect significant harm' > 'enquiries' commence > strategy meeting > investigation/assessment > child protection conference considered > CP plan or children in need plan or no further action if the child is not at risk or in need.*

There have been examples in some cases where there has not even been a clear referral pathway.

A reference to strategy meetings and s47 'investigation pathways' is not about a focus on process to the detriment of practice. A child centred, victim led strategy and plan is required in order that the means by which the individual young person is going to be most effectively protected is understood and agreed by everyone concerned including, where possible, the child and family. The more complex the situation the greater the need for an effective strategy to deal with it. A strategy meeting appropriately chaired by someone with the requisite seniority, skills and experience which is attended by the relevant agencies that have information to share or a contribution to make and that is informed by the experiences of the child and family will create a space for thinking through the issues and reaching agreement about how concerns and risks can best be tackled. Such a forum gives equal weight to all voices and provides a structure within which necessary action can be taken.

A purposeful and effective strategy meeting considers the complexities of intervening in a situation where perpetrators hold all the power. On the one hand it considers what

legal and statutory means are available to disrupt and protect, and on the other it seeks to use what is known about the individual child and family in order plan the most productive way forward. This will include the steps required to safeguard the child as quickly as possible. This approach is accepted common practice on all child abuse matters and should have been common practice throughout the period covered by this investigation. When chaired by someone of the requisite seniority strategy meetings can provide the means by which problems in the system or resistance from a particular agency can be escalated to the most senior managers and leaders in the relevant organisations or directly to the LSCB (see section 4.7 on senior manager oversight for further comment on this point).

In my view the failure to comply with these basic commonly understood processes and procedures significantly undermined the protection of the children and young people concerned in a number of the cases reviewed. Child F made very specific allegations of rape and sexual assault which were repeated on numerous occasions, but these were never properly investigated despite being reported directly to the police by her parents. The allegations appear to have been dismissed as fabrication by the police on the basis that Child F had very complex problems and refused to be medically examined. The absence of a multi-agency strategy meeting to carefully consider these allegations, including the context in which they were made, resulted in the police view prevailing. The likely consequence was that significant crimes, perpetrated against a thirteen year old child, went un-investigated.

The failure to follow WT requirements in relation to strategy meetings/ s47 investigations has been identified by Ofsted inspections 2009 – 2014.

4.4 Child Protection Practice and CSE

In terms of the historic cases, the conflation/confusion of the police and the social care role suggests a failure to understand the nature of CSE and the impact on the victim. In the earliest of cases this might be explained within a national context, where recognition and understanding of CSE perpetrated by groups or gangs of men was only beginning to emerge. On the basis that Risky Business had been operating as a Council service since 1997, it would be reasonable to suppose that professional staff in Rotherham Children's Services would have a better understanding than many of their peers in other authorities.

Regardless of whether the existence of the Risky Business project or the training they provided was having an impact on the wider understanding of CSE, the grooming of children for sexual abuse is a behaviour that has been known and understood for many years, certainly pre-1997. Similarly, professional understanding about the systematic exercise of power and control by abusers over vulnerable children and adults as a means of ensuring compliance and maintaining victim silence has been used to inform practice relating to domestic abuse and child sexual abuse for at least two decades - and in some sectors considerably longer. In terms of inter-familial child

sexual abuse these behaviours would be expected to result in the child victim being confused about the true nature of their relationship with their abuser. It is not unusual for a sexually abused child to be told by his or her abuser that the sexual nature of the abuse was a sign of the child being special, and an expression of the love the adult had for the child.

This aspect of grooming behaviour used by perpetrators of CSE can be seen by the number of occasions when the victim believes that their abuser is their 'boyfriend', and that she is both special to him and loved by him. In many cases of child sexual abuse, whether from within the family or family network or CSE, the result is likely to be that the child will seek to protect their abuser and be less likely to be persuaded to give evidence against them. In addition in all types of cases once the child wants the abuse to stop the tactics used by perpetrators very often change to the use of threats; including those of violence against the victim or those closest to them. All this has been known and understood for many years in relation to the sexual abuse of children which is why it is difficult to understand why this knowledge was not applied to the many children presenting with these features in Rotherham.

There are a number of examples in A-O where there did not appear to have been enquiries made or investigations undertaken to establish the nature and extent of the risks to which children and young people were clearly exposed. The case of Child E contains very clear allegations of significant inter-generational interfamilial child sexual abuse of the most serious nature. What is unclear from the CSC records is what if anything was done to properly investigate the crimes against children described in the files both in order to prosecute the perpetrators and to protect other children. Preliminary checks with the police show no record that any of the allegations made by Child E about abuse from members of her own family were ever properly investigated.

Throughout the period under consideration 'Working Together' guidelines have applied. All RMBC inter-agency child protection procedures have been based on WT guidelines. This being the case the absence of s47 procedures being applied in a number of situations where there was clearly 'reasonable cause to suspect a child was suffering or likely to suffer significant harm' is of considerable concern. It indicates that the Local Authority was operating outside the statutory framework that sets out the legislative requirements and expectations on individual services to safeguard and promote the welfare of children.

In the cases A-O it was not the failure of professionals to respond appropriately to CSE that was the issue. The key issue was the failure to respond appropriately to children and young people who were clearly in need of protection.

4.5 Assessment

As a result of the failure to recognise the experiences of the children and young people as matters of child protection in the first instance the opportunity to consider

how to best tackle the problem of safeguarding these young people once they presented as being at risk of CSE was missed.

One of the reasons for this failure may be accounted for by the lack of proper assessment of many of the victims. Had these children and young people either been understood to be children at risk of significant harm or as children in need then their entitlement to an assessment under s47 or s17 of the Children Act 1989 might have been progressed. The Core Assessment template used by Rotherham during the period had the following practice guidance embedded: '*…s47 enquiries should be undertaken as part of a core assessment (para 5.33 Working Together 1999). Therefore a core assessment should begin at the same time as a s47 enquiry is initiated.'*

Many of the cases had no assessment on file at all, and where there were assessments found they were generally of poor quality and consisted of a superficial record of events rather than any attempt to get underneath what had happened or to understand or convey the experiences of the child and the impact that that the abuse had on them. For example in the case of Child H she had been raped, had become pregnant and had a miscarriage all by the time she was 14. This was recorded in the assessment but there was no sense that the social worker had actually talked to her about her feelings about this or what the likely impact would be in the medium to long term. There was no analysis about what had happened, why it had happened or what the consequences had been. The most that was said was that Child H was likely to need counselling to come to terms with what had happened to her. This particular assessment was unsigned and there was nothing on the records to confirm which of the social workers involved had completed the assessment.

Such assessments as there were on files also failed to convey the contributions of other significant parties who were involved with the young people. There may have been references to Risky Business being involved with the young person, but I did not see examples where the Risky Business' workers more intimate knowledge and understanding of the young person was actively used to inform the assessment.

I did not find any evidence in supervision records that the lack of assessment, quality of assessment or the testing of assessment hypotheses ever featured in any supervision discussion. The review of Child C is testimony to the problems that can arise when an early hypothesis applied to the case goes unchallenged, and is allowed to dictate the approach that is taken to the detriment of the child in question. Robust and reflective supervision in this case may have helped the workers to see the case from a different perspective leading to a different and more appropriate response.

It should go without saying that assessment is a key element of basic child protection practice. Without assessment it is not possible to construct an effective plan of intervention and protection. Without assessment it is not possible to understand what is happening for the child, what life is like for the child and what or who needs to be put in place to help and support them. It is analogous to a doctor prescribing treatment

or refusing to prescribe treatment without ever making an accurate diagnosis of the illness.

There has long been an expectation that when children are looked after assessments will be updated as required, in order to ensure that care plans set out the services and interventions that will be provided in order to meet the child's identified and changing needs. Current practice standards should require that assessments are updated on at least an annual basis. I did not find any examples of updated assessments in the A-O cohort where children had been looked after, and in some of the cases there was no assessment at all.

It is of note that a number of the children A-O had experienced varying degrees of neglect in their earlier childhood. The longer term outcomes for those with the most neglectful backgrounds in these cases appeared to have been notably worse than for those who continued to have the support of their families. It is well understood that children do better and recover more successfully from trauma when they have developed resilience as a result of positive early experiences. The failure to assess effectively resulted in lost opportunities to respond appropriately to the presenting needs of children that went beyond those needs specifically related to CSE. Equally the failure to respond appropriately to the early presentation of neglect in some cases is likely to have resulted in a failure to address the very issues that made them vulnerable to being targeted for CSE in later years.

During the period in question all local authorities would have been fully aware of the expectations in terms of assessments referenced in the various iterations of Working Together and guidance in the form of 'Protecting Children: A Guide for Social Workers undertaking Comprehensive Assessment' (1988) (the 'Orange Book') and the 'Framework for the Assessment of Children in Need and their Families 2000'. Regardless of the shortcomings of this sort of uniform guidance they did serve to underpin the principle that all plans made to protect and support children in need should be informed by accurate assessment.

Again the practice failings identified in A-O were not just about a lack of understanding of CSE they were about a systemic failure to deliver an effective statutory service.

4.6 Team Manager Oversight and Supervision

In my view very few of the cases reviewed, from the oldest to the most recent, have evidence of an appropriate level of recorded supervision or management decision making. This would be expected in all social work cases – it should have been even more evident in these cases given the levels of complexity and risk involved. Some of the older cases do not have a single supervision record or manager signature visible in the entire paper file. Electronic records show very little evidence of managers' rationale for decisions or actions taken/not taken. There were a number of examples where supervision notes were located but appeared to have been completed by

someone other than the team manager. The reasons for this were not recorded, and while some of those that were signed appeared to have been undertaken by a principal social worker the status of the person giving supervision was not always clear.

The need for management oversight, evidence of decision making and regular high quality supervision is not new; and reference to these basic requirements in managing risk and promoting positive change within families can be found in numerous academic publications, child death inquiry recommendations from Marie Colwell (1974) and Tyra Henry (1984) to Victoria Climbie (2001) and DoH, DSCF, DfE Practice Frameworks and Guidance from the 1970's onwards. Of those covering the period in question the best known, most commonly recognised and implemented across all Local Authorities during the period in question would have been Working Together (1991, 1999, 2006, 2010, 2013), 'Protecting Children: A Guide for Social Workers undertaking Comprehensive Assessment' (1988) (the 'Orange Book') and the 'Framework for the Assessment of Children in Need and their Families 2000'. All these publications reference the importance of supervision, informed decision making and case recording in child protection work.

In addition all Area Child Protection Committees and latterly Local Safeguarding Children's Boards will have had local policy and procedures in place which would have referenced expectations in terms of clarity of decision making and management accountability to a greater or lesser degree, This would have been the case in most authorities at least from the point of the implementation of the Children Act 1989 during the early 90s.

4.7 Senior Manager Oversight

With a few exceptions I have been struck by the absence of any evidence or suggestion of management oversight that extended beyond that of team manager. I have already commented on the general absence of evidence of supervision and team manager decision making which combined with an absence of any more senior input leaves a feeling, in the limited number of cases reviewed, of a powerful sense of practitioners operating in a managerial vacuum. This is particularly true of cases A–H i.e. in the earlier cases. There is some reference to senior managers being involved when cases become high profile as in attracting press attention but very little if any evidence of their greater experience, knowledge and seniority being actively used to guide and support more junior staff with individual cases and significant operational challenges.

The complexity and presenting risk in some of the cases within A-H are such that at the very least I would expect there would be evidence that advice had been sought from more senior managers. Similarly whether children were understood to be at risk of CSE or not (and actually most in A-O were) the nature of the abuse that was

suspected and the suggestion that there was often more than one possible perpetrator should have resulted in the use of 'organised abuse' procedures.

'Working Together 1999' states '….organised or multiple abuse may be defined as abuse involving one or more abuser and a number of related or non-related abused children and young people…'.

It outlines among others the following expectations:

- *involve the most senior managers from involved agencies at a strategic level. They should ensure that appropriate resources are deployed and staff are supported, and should agree upon the handling of political and media issues arising from the investigation;*

- *the police should appoint a Senior Investigating Officer of appropriate rank and experience, and should consider the use of Major Incident Room Standard Administrative Procedures and the Home Office Large Major Enquiry System;*

There are examples in the cases where team managers have chaired strategy meetings but this was not always the case. There is evidence in the case of Child B where a social worker made an unsuccessful attempt to secure a service manager to chair a strategy meeting and had to be persistent to get a team manager to chair it instead. In some cases where there is evidence of strategy meetings being held it is not stated in the minute of the meeting who was chairing or the level of their seniority.

As far as I can tell (in the absence of the records), there was reference to a more senior manager in just three of the early cases A-H. These all concerned procedural matters, and I have not found evidence in any of the cases that practice advice or guidance was sought from senior managers or offered by them. There was an example within the case of Child I where a dispute about a placement was escalated to a Head of Service and the advice given was recorded on the electronic record.

In the earlier cases where senior management involvement is noted one was in relation to a High Court application (Child A) in response to reporting in the media, one when a parent said she was going to the press to express her frustration at the lack of action to protect her daughter (Child B) and one in relation to a secure unit application (Child F).

I have been told that pre 2011, no one more senior than a team manager ever chaired strategy meetings regardless of how complex. In my experience this would have been very unusual even as far back as 1998.

Child E was a young person who was looked after by RMBC during the period in question. This young person's care history is characterised by repeated instances of abuse while in care, persistent absconding and numerous hospital admissions as a

result of drug overdose and self-harm. Even in this case, there are no obvious references to senior managers being alerted to the plight of this young person and no evidence that anyone more senior than a team manager had any direct input into the care plan for the child. Particularly in relation to Looked After Children, senior managers cannot be excused from their responsibilities because they were unaware of the circumstances of individual children. It is their responsibility to ensure that systems are in place that make certain that they do know at the very least about critical incidents. The types of incidents in which Child E was regularly involved would have been considered 'critical' by most commonly applied measures.

Of particular concern is the apparent absence of senior management oversight of admissions to RMBC residential care homes. Child E who had been raped in the first unit to which she was admitted was subsequently raped by a young person with a known history of sexually abusive behaviours who was already resident in the unit to which she was subsequently moved. Child E was 12 years of age and the young person who raped her was 16 years of age.

4.8 Working with Adolescents

Although some of the cases involved children who were as young as 11 or 12 years, the majority either were or became teenagers during the period of agency involvement.

The review of the documentation in cases A – O, save for one or two exceptions, fails to give a clear picture of the quality of the relationships that the social workers had with these young people. This may be as a result of the generally poor quality of the case recording, the lack of proper assessment on many files and the absence of supervision notes but is compounded by the number of cases where it appears there were different social workers and support workers involved. Children's Social Care records that relate to the number of contacts made with young people either by telephone or face to face meetings suggest that often they were sporadic, sometimes with several weeks or even months passing between visits. Child E was unallocated for over six months at a point in her history when she had already been raped twice while in care and was for the first time exhibiting behaviour strongly associated with CSE.

A crucially important element of effective and successful social worker intervention is the nature and quality of the relationship that is developed between the social worker and child or family they are seeking to help and support. This is never more true than when working with adolescents as any successful adolescent project with testify.

Young people who are victims of CSE are among the most vulnerable as result of the power and influence over them that their abusers cultivate. The effort and determination that is required in order to combat the consequences of CSE has to exceed the effort and determination exercised by the perpetrators to keep the young

people in their control. Workers need to be able to go to the locations where the young people congregate at the times of day when they are likely to be there. They need to be able to respond to text and phone calls from young people as and when they are needed. In other words the services provided need to be flexible and highly responsive to the needs of children when they are being groomed and exploited. They need to be designed around the lifestyles of young people and not the convenience of the service provider.

Most importantly the workers that staff CSE teams need to want to work with young people as a service area of choice. They need to like adolescents, be able to engage with them and positively enjoy the challenges that working with them brings.

Whilst I personally have not seen evidence from the Risky Business records that demonstrates that they were able to respond in the way described, the Jay Report and other accounts of how they operated gives a sense that this is what they were able to do. I can fully understand that if young people had been accustomed to this level of service and it was taken away when RB was disbanded then it would have left a considerable gap in provision and would have made the task of the newly formed but under resourced CSE team very difficult. A 'Lessons Learnt' document produced following a successful CSE investigation in another part of the country makes the following recommendations:

> - *Only when a consistent team was deployed which had the capacity to develop a trusting relationship with victims were disclosures made. Experience showed that the victim team would need to be engaged with victims for over a year with multiple contacts.*
>
> - *Avoid undue pressure to obtain victim evidence quickly. Relationship and rapport building were essential to obtaining good evidence. Social Workers and Police can be negatively viewed by the victim and months may pass before disclosures are made. This is particularly challenging when third party or other evidence provided a strong indication that a young person had been a victim.*
>
> *(Extract from 'Summary of Multi-Agency Debrief' Peterborough, July 2014)*

A failure or inability to form effective helping relationships with young people is not a disciplinary or capability issue and I make these points only because I am aware the current CSE service is under review. It will be important not to repeat past mistakes and some of the learning from this investigation may be relevant in this regard.

Finally, I have been struck by the number of cases even in this small sample where children and young people in crisis have either been seen by or been referred to a community based Child and Adolescent Mental Health Service (CAMHS). Most striking of all has been how often has been the case that these services have not been either willing or able to provide help to these young people even in times of their greatest need. Too often the diagnosis has been 'not mentally ill' attributing the crisis to

'behaviour' rather than the behaviour to the consequences of sustained abuse and trauma. It did appear that responses were more responsive and successful when young people were admitted for periods of secure care, and certainly for Child E and Child F this seemed to be one of the few occasions when they were understood to be suffering from post-traumatic stress. Child E went on to suffer from mental illness including at least one psychotic episode that led to her being sectioned under the mental health act. The long term outcomes for Child F are not known but the probability is that they would be similar.

In terms of any future provision for victims it would suggest that very careful consideration is given to the nature and quality of any CAMHS service on offer and in particular to how and where it is provided.

4.9 Residential Care

There is reference in the Jay Report about the extent to which local residential units were targeted by perpetrators of sexual exploitation and were overwhelmed by the problem. Equally there has been substantial evidence that when children were placed in residential units out of the area the outcomes were often no better, and in some cases worse because of the distance placed from home.

The experience of Child E provided clear evidence that children in residential care were not just at risk from sexual exploitation from adults in the community but were left at significant risk from other residents. Some of the evidence from the Child E records suggest that in the past either there were no safeguards applied to the residential admissions process or that there was a complete failure to comply with them. The fact that a young person with a known history or sexually abusive behaviour could be admitted to a unit alongside much younger and more vulnerable children and then allowed to remain in the light of further offences is in my view evidence of negligence. If basic safeguards were not in place to prevent this from happening from within the unit then it is little wonder that staff were unable to manage the threats that came from perpetrators from outside.

There does need to be a review of current provision to ensure that safeguards are in place to manage the admissions of children and young people into residential units.

Child E was the only case that was reviewed from A-O who spent a substantial amount of time in RMBC residential provision; however it appears that her experience of being targeted by adults intent on abusing and exploiting her was not untypical. This being the case it is hard to understand why the Council continued to place children in these units knowing that they would not be safe. The decisions to use the in-house residential provision as a first option in many cases would not have been one taken by practitioners or first line managers.

There is long standing evidence that children who cannot live with their birth families do better in family based placements such as foster care. The outcomes for young people who are admitted to residential care are the poorest of the care population.

Child E is testimony to that fact. There is no way of knowing whether she would have fared better in foster care in the long term but it is unlikely that she would have suffered two rapes in six months in the placement had that been the case. There is little, if anything, on the file that explains why Child E was placed in a residential unit so early in her care career. A few months after she had been abused in the units Child E asked if she could be placed in foster care instead and was told there was a shortage of foster carers in Rotherham.

Residential care should only ever be used when a compelling case is made that it is in the best interests of the individual young person concerned. Even then the provision in which the young person is placed has to be matched to their carefully assessed needs, which should include a time limit imposed with a view to them returning to family based care if at all possible. Residential care should never be used as a first option or because of a shortage of in house foster care.

I believe that a past over reliance on residential care and a failure to invest in foster care, including specialist foster care, compounded the difficulties experienced by young people and may have increased their vulnerability to child sexual exploitation. This represents policy decisions and would not be something that front line staff could easily influence.

5.0 Conclusions

The prime purpose of this report is to review Cases A-O with a view to enabling the Council to reach a conclusion as to whether or not there are misconduct, professional misconduct or capability matters concerning former or current employees of Rotherham MBC and my conclusions in relation to this are set out below.

However, I am aware that in the course of this report I have identified a range of significant practice concerns. To a large extent they are the same concerns identified by both the Jay report and Ofsted and I am aware that there are now in place detailed action plans designed to address the areas that require improvement. I am not therefore making any further specific recommendations save those referenced in section 3 of this report.

I have reviewed the 15 cases A-O in as much detail as possible given the challenges posed by poor records and availability of some of the files for reasons stated above. The detailed findings in relation to each individual case are available but cannot form part of this overview report because in recording the detail the identity of the individuals and their families could be revealed.

In the course of the review I have found evidence of practice that would be considered to have met minimum standards and I have seen some examples of practice within the

body of cases that would be considered good in that it exceeded minimum standards – but these were isolated interventions in what was otherwise poor quality casework.

I have found a number of examples of delay in responding appropriately to child protection concerns and many of the cases which, if subject to a whole case audit measured against basic practice standards, would be judged 'inadequate' both in terms of the quality of the intervention and the experience and outcomes of the children and young people concerned.

However to date, with the exception of one case (Child E), I have not found any examples of individual casework so poor or dangerous that disciplinary action against individual practitioners would be warranted. In some of the cases where there has been questionable practice found it has not even been possible to identify who the responsible practitioners were. There was practice in Child H that in normal circumstances would require further investigation however this case was reviewed in detail by an independent case review in 2010 and it has to be assumed that any shortfalls and anomalies that seemed to be present in the case file were exposed and addressed by both the reviewer and the review panel at the time.

I believe the practice I have reviewed is indicative of widespread systemic failure rather than anything for which individual practitioners can be held to account.

In a minority of cases, children had been left at risk as a result of delay in response or because the nature of the response was inappropriate. However it is not possible to ascribe these failings to any one individual.

In some cases where delay has been evident this has appeared to be as a result of a lack of clarity about which team should have been responsible or in one case a debate between teams about where the lead responsibility should lie. The role and status of the Risky Business service particularly during the period that covered the earlier cases does not seem clear. For example, in the case of Child A, the work was held in a statutory service while it was considered a child in need case and passed to Risky Business when there were clear child protection issues (albeit linked to CSE) were identified.

The issue of attributing responsibility is further compounded in some cases by the multiple social workers and managers who seemed to be involved. The records do not make clear the reasons for the input of different managers and social workers particularly as there are few if any case transfer or closure summaries to be found and decisions rarely explained or justified by team managers. The electronic system appears to be able to assign 'key worker involvement' to more than one person at a time and key worker involvement does not necessarily bear any relation to the social worker undertaking key pieces of work. The case of Child J among others illustrates this point.

The extent to which individual practitioners can be held to account for poor or dangerous practice is usually judged within the context in which they were operating at

the time. In any disciplinary investigation consideration would be given to a number of variables. This would include the size and complexity of caseload and the general quality of the work undertaken by the practitioner across all their cases. It would also take account of the regularity of supervision, regularity of guidance and direction given by team managers, access to clear policy and procedures, access to regular training relevant to the role and the extent to which managers and supervisors had been aware of shortfalls in practice and the steps which had been taken to support the worker in addressing them. In the historic cases finding evidence of the conditions in which social workers were operating during the specific periods will be very difficult. There is reference in the various inspection reports about the nature of practice shortcomings during many of the periods in question.

A judgement about Team Managers is even more problematic. In no small part this is because of an almost uniform absence of any evidence of management oversight, guidance or supervision in the majority of the older cases. The position is improved in some but not all of the more recent cases.

A core function of first line managers relates to the management, oversight and supervision of the cases held in the team and the practitioners working those cases. This is fundamental to how risk is managed within the service. It is very difficult to make a judgment about the quality of the oversight and supervision when there is so little recording on the case files that evidences the nature and extent of these key managerial activities.

As with practitioners, judgments made about the competence and capability of individual managers is most usually made by taking into account the quality of their managerial practice and performance over a range of tasks including evidence of the quality of their decision making, oversight and supervision in relation to the casework of their teams. In this investigation 15 single cases have been reviewed taken from a period spanning 15 years. In the absence of evidence of actual misconduct or professional misconduct, judgments about capability could only reasonably be taken by reviewing the quality of work over a range of cases and preferably over a period of time.

A view could be taken that the general lack of evidence of management input into cases of such complexity had in itself been negligent. However the lack of management oversight and poor supervision in Rotherham has featured in a number of inspections and external reviews over time suggesting the problem has been endemic in Rotherham and is not just attributable to the poor performance of individual team managers.

In Chapter 13 of her report Professor Jay commented at some length about the operational context in which services were operating over the period of her Inquiry. The Annual Performance Assessment letter for Children and Young People’s Services in 2005 stated that staff turnover and sickness absence in social services was too high. This letter is likely to have referred to conditions that prevailed during the 03/04

period. While there was some improvement during 2007, by 2008 the vacancy rate was reported as over 40% and in 2009 was 37%. Professor Jay also highlights a complex and over ambitious restructure of the service started following the changes required by the Children Act 2004. The restructure was never completed. An external review of children's services that reported in May 2009 described some of the changes imposed by the restructure as having served to create a 'complex and excessive number of teams and panels' which they said could lead to confusion and increased risk. In addition Professor Jay's report highlights that during the course of the changes towards an integrated service some of the managers appointed were not professionally qualified social workers and some lacked the child protection experience that would be required to do the job. This resulted in many front line staff being denied professional supervision.

Professor Jay's report has established a picture of a chaotic, complex and often poorly led and frequently poorly performing organisational context spanning many years, within which arguably any sound child protection practice would have struggled to be established. Within this context it is hard to see how the pursuit of individual first line managers could be justified – or indeed successful.

Had there been misgivings about the competence of such individuals there were ample opportunities in the wake of the various inspections, reviews and other reports made available to senior officers and elected members for appropriate action to be taken at the time. As previously stated the case of Child H was one of a number selected by an independent 'lessons learned' review of Operation Central commissioned by the RSCB in 2010. Child H was randomly selected to be reviewed in particular detail and a number of recommendations relating to practice were made as a result. None of these related to any individual practitioner or manager being held to account for any of the shortcomings identified.

Finally this investigation was limited to cases A-O. Some of the young people concerned had siblings (sisters) who had also been victims of CSE in Rotherham. A number of those siblings had experiences of an even more serious nature than those that were being reviewed as part of this investigation. There were many references to the situations of the siblings in the case files and it was impossible to not note that there were practice issues in these related cases. In the case of Child J, for example, there is a child protection conference record on file that is highly critical of the work undertaken in respect of Child J's family, the lack of challenge from managers and CP conference chairs, the electronic record system and the number of hand offs between teams that had resulted in the case being held by 12 different workers between 2004 and 2010. It suggests that Child J's sister was potentially left at risk as a result of some of these perceived system shortcomings. From what I can see from the records there were far more concerns about historical practice in relation to her sister than to Child J herself.

Professor Jay's report 5.4 states '*The cases described in this chapter are very typical of many of the files we read and were chosen to give fair reflection of what many*

victims experienced. They include some, but no means all, of the most serious cases we read.'

This raises a question about the justification for limiting enquiries about misconduct and capability to the A-O cases alone. However if further case reviews were to be commissioned it will be difficult to determine just how many cases should be reviewed from the 15 year period and what criteria would be used in order to select them. Perhaps more importantly there must be proper consideration given to exactly what is to be gained from the exercise given the overall findings in this report. This is not to say that any victim or survivor should ever be precluded from accessing advice and support or access to the means by which their abusers can be brought to justice and the means by which this can be achieved must be readily available and easily accessible.

There are currently wide-ranging investigations into historical CSE in progress that are being led by the National Crime Agency. These investigations are intended to address the shortfalls in previous responses to victims and survivors. While the intended outcome is that the perpetrators of crimes will be prosecuted the other aim of the work is to ensure that survivors feel they have been heard and are able to access the right level of support needed to aid their recovery.

The need for individuals to be held to account for professional failings is understood and where this is found to be justifiable should always be pursued. For the reasons stated in this report it is my view that further focus on front line practitioners will not be productive and cannot be justified particularly when such resources as are available are required to achieve the much needed improvement in the service.

I was able to share my conclusions with Kathy Somers who confirmed that in the conclusions to my report, I have accurately conveyed the findings of the Jay report with regard to systemic failures in the systems for protecting children in Rotherham, and longstanding deficits in leadership, governance and management as a result of which many child victims of CSE were left unprotected.

It is clear from this report that it is my recommendation that, aside from one those involved in one particular case, I have found insufficient evidence to take disciplinary or any other action against either the involved practitioners or team managers (problems of identification notwithstanding). However, what is equally clear is that the organisation lacked the senior professional leadership that would ordinarily be expected. Lead politicians, chief executive(s) and most importantly Directors of Children's Services and their senior management team have a crucial role in ensuring that good social work standards are understood and being met and that key statutory and regulatory expectations and guidance is being followed.

While it is not possible for senior managers to know and have oversight of every single case or the circumstances of every single child, it is nonetheless their responsibility to ensure that organisational culture and working practices are such that it is the clear

expectation of leaders that staff understand that services exist in order to safeguard and promote the welfare of children. This can only be achieved by an insistence that all services and those who work within them at all levels maintain a child focus at all times. The total absence of evidence of thinking what life was like for some of the children in cases A-O was one of the most striking features of the reviews of these cases.

With this in mind the failings I found, many of which were echoed in both the Jay and Casey reports, leave some considerable concern about leadership. Investigating those individuals who were in charge throughout the period of this report is beyond my remit but I am aware the Council has undertaken a separate piece of work on this aspect and my findings support that requirement

Jean Imray

30.5.15

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Rotherham Metropolitan Borough Council
Where Everyone Matters

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Ms J Imray
[redacted]

23rd October 2014

Dear Jean,

Appointment as Independent Investigator

I am writing to confirm your appointment as an Independent Investigator by Rotherham Borough Council. The Council requires an urgent and thorough investigation into a number of case studies referred to in the Jay Report on historical Child Sexual Exploitation that are built upon the files the council made available to Alexis Jay. This investigation is to enable the Council to reach a conclusion as to whether or not there are misconduct, professional misconduct or capability matters concerning former or current employees of Rotherham MBC.

Your terms of reference for this appointment are:

a) To undertake a detailed review of Case Files listed in the Professor Jay Report (Child A to O) to identify if social care practice and reporting of any matters of concern was undertaken in line with professional standards;

b) Where central to the investigation interview witnesses/employees to establish facts necessary to form conclusions regarding the handling of the case files and professional standards displayed;

c) To review all relevant documentation such as reports, minutes of meetings, performance inspection reports, plans and strategies that should properly have influenced the handling of the case files and the professional standards displayed;

d) To provide a report to the Chief Executive that sets out recommendations as to any appropriate further steps. This should include conclusions on the specific case files, and recommendations on further investigatory work that may be needed in respect of other case files as a consequence of what has been found.

You would also be required to present information to any subsequent formal proceedings or provide details to other Council's investigatory exercises as a result of your investigations.

The following general terms will apply to your engagement with the Council: -

- To carry out all activities with due regard to confidentiality and not disclose information related to the matters or people involved
- To respond in a timely fashion to requests for information or updates on progress
- To provide your availability within the constraints of your other work commitments
- To work as efficiently as possible to minimise costs to the Council.

The Council agrees to pay your fees of £675 per day inclusive of all expenses

I would like to thank you for accepting this assignment.

Yours sincerely,

Phil Howe
Director of Human Resources

The following extracts are limited to those which appear most pertinent to this investigation in terms of the context in which practitioners and front line managers were operating:

Section 6. Children and Young Peoples Services

- Thresholds for social care had in the past been unacceptably high.

- Risky Business made referrals to children's social care but in the early years, the response in terms of assessments, risk assessments and safeguarding was rarely good enough. At that time, there was a lack of clarity in inter-agency meetings that discussed individual children alongside more strategic issues, with no clear direction provided by senior managers

- Inspection reports described how over many years, children's social care services were typically understaffed and overstretched, and struggling to cope with demand.

- 6.4 Historically ,access to children's social care was …. problematic…..Risky Business was viewed as the main service for children who were being sexually exploited, with the result that children and young people were often signposted to Risky Business at the stage of initial contact rather than being routed through Strategy meetings and s47 enquiries.

- 6.6 There was evidence in many files that prior to 2007, child victims from around the age of eleven upwards were not seen to be the priority for children's social care, even when they were being sexually abused and exploited.

- 6.10 Over the years, assessment and care planning attracted negative comment in many of the inspections of Rotherham children's social care.

- 6.48 From the mid-1990s there were concerns about children's homes being targeted for the purposes of child sexual exploitation…….There was no appropriate management response to the problem of children being exposed to exploitation whilst in the care of the Council. Nor did we find that elected members as corporate parents were advised of the scale and gravity of the problem.

Section 7 Safeguarding

- 7.5 One of the major flaws in inter-agency meetings in the early years was confusion of responsibilities for strategic responses and decision making on individual children. This persisted until around 2007, when a dedicated manager for CSE was appointed.

- 7.25……..Poor take-up (of training on CSE) was not universal, but its frequency called into question the authority that the Safeguarding Board exercised over its members. Likewise considerable time and energy was expended on devising good policies and procedures in the mid to late 2000s, but there was rarely any reporting back or checking by the Safeguarding Board on whether they were being implemented or were working.

- 7.35 Not unreasonably, the minutes of the Safeguarding Board meetings focus on decisions rather than the details of debate. Nevertheless, over the years there appears to have been a failure to challenge policies, priorities and performance, especially those of statutory agencies. This judgement featured in the Ofsted report of 2012 and was cited by the Home Affairs Select Committee. One task of the Board is to 'ensure effectiveness', to question, to scrutinise, to demand and assess evidence. In the past this function does not seem to have been fully exercised.

- 7.41 Prior to 2007 the operational response of children's social care, together with that of the Police, would have fallen short of any accepted definition of best practice as understood at the time. One exception was the work of the Key Players group. Government guidance was clear at that time that CSE was to be dealt with as an issue of safeguarding children. However, many child victims in Rotherham were not dealt with through safeguarding procedures.

- 7.42 From about 2007, with the appointment of a dedicated manager for CSE, there was an improved focus on safeguarding children who were being exploited. This was evidenced in child sexual exploitation strategies and action plans and in a clear pathway for referral to children's social care. Nevertheless, safeguarding of individual children who were being exploited or at risk remained extremely variable. This was in line with wider weaknesses in the delivery of children's social care in Rotherham, evidenced in inspections over the years.

- 7.48 Inspection reports on children's social care over the Inquiry period included several references to the quality and frequency of supervision. It was criticised in 2003 and 2009 and again in 2011, when Ofsted described it as 'variable' and sometimes 'poor'.

- 7.50…… the considerable shortfalls that existed in historic cases, where in some instances social workers must have lacked the necessary support to work effectively with very complex cases of sexual exploitation.

Section 9 The Risky Business Project

- 9.9 The task of dealing with issues between Risky Business and children's social care lay with management. Given the subsequent histories of some of the young people who were affected, it is tragic that in so many instances management failed to do so. There were too many examples of young people who were properly referred by Risky Business to children's social care and who somehow fell through the net and were not treated with the priority that they deserved. It is almost as if the source of the referral from Risky Business was a pretext for attaching lower importance to it

- 9.10 Interviews with managers in post at that time (around mid 2000s) confirm this view.

- 9.13 …….By its nature, the project's style made a bad fit with the more structured services involved. The failure of management to understand and resolve this problem has been a running flaw in the development of child protection services relating to sexual exploitation in Rotherham.

Section12 Workforce Strategy and Financial Resources

- 12.1 From the early 2000s, Rotherham started to experience problems in the recruitment of social workers, whilst facing budgetary pressures, high levels of demand, and increasing complexity of work, including CSE. The Social Services Inspectorate commented in a 2003 report on the serious vacancy levels, and there were regular reports to the Lead Member on the impact on services of staff shortages. This became very acute in 2008-09.

- 12.3 ….. In Rotherham…. there was …… a deficit in the frontline child protection and children in need posts.

- 12.14…… spending on looked after children was especially low, possibly risky; at the same time the activity levels for children's social care showed referrals to be very high, but accompanied by lower levels of assessments and reviews

Section 13 The Role of Elected Members and Senior Officers of the Council

- For much of the time, senior officers did little to keep members fully informed of the scale and seriousness of the problem, on occasion telling members they believed it was exaggerated. In the early years a small group of frontline professionals from the Council, the Police and Health worked together on CSE, both on individual cases and on issues such as multi-agency procedures. They alerted senior staff to the scale of the abuse but were met with disbelief and left with little management support for the good work they were trying to do. There are reports that senior staff conveyed that sexual exploitation and the ethnicity of perpetrators should be played down.

- The prevailing culture at the most senior level of the Council, until 2009, as described by several people, was bullying and 'macho', and not an appropriate climate in which to discuss the rape and sexual exploitation of young people.

- 13.14 From an early stage, children's social care managers seemed reluctant to accept the extent of the problem of CSE within the Borough. There were constant difficulties over the allocation of referrals from Risky Business. In 2004, the Sexual Exploitation Forum minutes indicated concerns raised by Risky Business that some referrals they were making to children's social care were being reclassified e.g.'Teenager out of control'…….As already stated, the clear responsibility for resolving these tensions lay with those in charge of children's social care and youth services, who failed to do so over many years.

- 13.27 Ofsted's evaluation of children's social care……. started to decline. In the period April 2007 – March 2008, covered by the 2008 Annual Performance Assessment, it was judged overall as Adequate. Specifically, Management of Children and Young People's Services was judged Adequate. Important weaknesses included that management oversight of looked after children had not ensured they had been fully safeguarded.

- 13.35 By late 2009, when the Minister of State served an Improvement Notice on the Council for its children's safeguarding services, there is no doubt that the systems and operations for protecting Rotherham's children were unsafe. The Director of Safeguarding (2010-11) described what she found on taking up post. There were significant vacancies; a lot of agency staff were being used; there was a lack of management oversight; poor accountability for casework; poor monitoring of unallocated work; poor monitoring of assessment times; looked after children lacked plans in some instances; quality of practice was generally weak and the complexity of cases was very high; the quality of professional supervision was poor, sometimes provided by managers who were not social work qualified. Staff were overwhelmed, and disempowered, and felt senior staff were 'invisible'.

Despite this context, she saw no complacency about CSE. The Inquiry concluded that the quality and extent of children's social care support to the young people who were victims or at risk must surely have suffered.