Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into complaints against
Kent County Council
(reference number: 19 010 981)
and
London Borough of Croydon
(reference number: 19 020 914)

26 November 2020

The Ombudsman's role

For more than 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mrs B	The complainant
C	The complainant's daughter

Report summary

Child protection

Mrs B complains about the way Kent County Council and the London Borough of Croydon responded when her daughter, child C, disclosed sexual abuse.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused, we recommend the Councils take the following action.

Kent County Council

Kent County Council should

- pay C £1,000;
- pay Mrs B £1,000 to acknowledge the distress and impact of the faults;
- pay Mrs B £150 for the additional time and trouble she experienced pursuing her complaint; and
- remind all staff dealing with children's services complaints when the statutory complaints process should be used. It should also ensure its staff understand who can make a complaint in this process.

Kent County Council and London Borough of Croydon

Both Councils should:

- share the learning points from this case across its organisation to ensure staff are aware of their responsibilities in respect of information sharing, professional curiosity, and cross border child protection referrals; and
- conduct an audit of 50 cases closed in similar circumstances between 2018 to date. If more than 25% of those cases identify similar issues the Council should make resources available to conduct a full case audit. The full audit should review all cases closed in similar circumstances between 2018 to date.

Both Councils must consider the report and confirm within three months the actions they have taken or propose to take. The Councils should consider the report at a full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

The complaint

1. Mrs B complains about the way Kent County Council and London Borough of Croydon council responded when her daughter, child C, disclosed sexual abuse.

Kent County Council

2. Mrs B says Kent County Council:

   - delayed in offering C support and failed to provide appropriate support;
   - incorrectly considered referring Mrs B to the Local Authority Designated Officer (LADO); and
   - failed to provide Mrs B with appropriate support.

3. Mrs B says this caused significant distress to C and she missed out on the support she needed. As a result, C experienced the effects of ongoing trauma and blamed herself for her mother's distress.

4. Mrs B suffered her own distress from the way the Council failed to meet her needs. She says the threat of the LADO referral caused her significant distress, worry and loss of sleep. She also suffered significant distress because the Council failed to meet C's needs and provide support.

5. Mrs B says the Council's failures have had a significant and lasting impact on C and her family.

London Borough of Croydon

6. Mrs B says London Borough of Croydon failed to:

   - convene a strategy discussion following C's disclosure of sexual abuse;
   - carry out an investigation into the potential risk posed by the alleged offenders; and
   - share information with Kent County Council.

7. She says this caused a delayed and uncoordinated response and caused additional distress. She also says it placed other children at risk.

Legal and adminstrative background

8. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

9. We may investigate matters coming to our attention during an investigation if we consider that a member of the public who has not complained may have suffered an injustice as a result. ***(Local Government Act 1974, section 26D and 34E, as amended)***

10. Under the information sharing agreement between the Local Government and Social Care Ombudsman and the Office for Standards in Education, Children's Services and Skills (Ofsted), we will share this decision with Ofsted.

How we considered this complaint

11. We issued this report after examining relevant documents, making enquiries with both councils, and speaking to the complainant.

12. We gave Mrs B and the Councils a confidential draft of this report and invited their comments. The comments received were carefully considered before the report was finalised.

What I found

Law and guidance

13. The Children Act 1989 and statutory guidance Working Together to Safeguard Children 2018 ('Working Together') set out councils' responsibilities to safeguard children. Working Together guidance applies to all organisations and agencies with functions relating to children. It says all professionals and agencies working with children should adopt a co-ordinated and child focused approach. Working Together contains guidance on the following areas relevant to this complaint:

- information sharing;
- referrals;
- assessment;
- early help;
- strategy discussions;
- section 47 enquiries;
- organisational responsibilities;
- people in a position of trust; and
- dispute resolution.

14. The Government sets out a three-stage procedure for councils to follow when looking at complaints about statutory social services functions. The handling and consideration of complaints consists of three stages:

- stage 1 - local resolution
- stage 2 – investigation
- stage 3 - review panel

***(Department for Education, Statutory guidance for local authority children's services on representations and complaints procedures, 2006*)**

15. Section 26(3) of the Children Act 1989 sets out what may be complained about. All functions of the local authority under Part 3 of the Act may be subject of a complaint. For example, a complaint may arise because of many things relating to statutory social services functions such as:

- an unwelcome or disputed decision;
- concern about the quality or appropriateness of a service;
- delay in decision making or provision of services;
- delivery or non-delivery of services including complaints procedures;
- quantity, frequency, change or cost of a service;
- attitude or behaviour of staff;

- application of eligibility and assessment criteria;
- the impact on a child or young person of the application of a local authority policy; and
- assessment, care management and review.

Local Authority Designated Officer (LADO)

16. Statutory guidance says that every council has a duty to manage allegations and concerns about any person who works with children and young people in their area. This includes council staff, staff or partner agencies and volunteers.

17. The LADO is responsible for managing all child protection allegations made against staff and volunteers who work with children and young people in a council's area.

What happened

18. Throughout this report Kent County Council is referred to as 'Kent' and London Borough of Croydon as 'Croydon'.

19. What follows is a brief case chronology. It does not contain all the information reviewed during the investigation.

20. In June 2018, C disclosed she had been sexually abused at an address in Croydon when she was younger. Mrs B reported this to the police. The police told her it would refer the information to children's services and a social worker would contact her about support for C.

21. Mrs B says she waited for contact but when this did not come, she contacted both councils herself. She says Croydon told her she needed to speak to Kent because that was the area that they lived in. She says Kent told her to speak to Croydon because that is where the alleged offence happened.

22. Following a further police referral in September 2018, Kent contacted Mrs B and offered support through its early help provision.

23. In November 2018, C made a further disclosure of non-recent sexual abuse by a different perpetrator in Croydon. By this time C's mental health had deteriorated and Mrs B reports she made three suicide attempts. Mrs B requested a Child and Adolescent Mental Health Services (CAHMS) referral. C also went missing for a period around this time.

24. In January 2019, C's CAHMS psychologist made a referral to Kent children's services. She felt early help support did not meet C's needs. Following this referral, a social worker attended Mrs B's address to complete a Child and Family (CAF) assessment.

25. Mrs B withdrew consent for the CAF assessment, and it was not completed. She says she felt it was her parenting under scrutiny rather than C's needs. Kent closed the case in February 2019. C was to continue to attend CAHMS.

26. Mrs B asked for support for herself. Kent provided Mrs B with information about mediation and an "understanding your teenager" course.

27. In April 2019, Mrs B complained to Kent. It responded at stage one of its corporate complaints process in June 2019 and stage two in July 2019. Mrs B remained dissatisfied with its response and complained to the Ombudsman.

28. Mrs B complained to Croydon in September 2019. It responded in November 2019. The Ombudsman accepted Mrs B's complaint about Croydon,

and we decided to consider it alongside her complaint about Kent because the cases are inextricably linked.

Findings

29. These are presented under the key headings of Mrs B's complaint with the analysis of findings and relevant law and guidance.

30. Throughout the analysis of this complaint we held the below extract from Working Together (2018) in mind:

> *"Nothing is more important than children's welfare. Children who need help and protection deserve high quality and effective support as soon as a need is identified.*
>
> *We want a system that responds to the needs and interests of children and families and not the other way around. In such a system, practitioners will be clear about what is required of them individually, and how they need to work together in partnership with others."*

31. The NSPCC also highlights the importance of professional curiosity which is an important feature across all aspects of this case. Professional curiosity is about exploring and understanding what is happening in a wider context, rather than making assumptions or accepting things at face value.

The initial response

32. Working Together sets out the circumstances when a strategy discussion should be convened, the purpose of the discussion and who should attend.

33. In the case of C, the initial response appears to have been complicated by the fact there was more than one council involved. C lived in Kent, but the alleged offences occurred in Croydon. This was further complicated because the Councils were unclear of the exact address in Croydon and the possibility the alleged perpetrator may have since moved to another council area.

34. Mrs B says she was passed around the Councils because each one told her the other was responsible. We agree, neither Council took responsibility for the case. Both Councils closed the case at initial referral and there was no direct contact between Kent and Croydon until May 2020, a period of nearly two years from the initial referral.

35. In response to our enquiries Croydon said:

> *"… the Council should have held a Strategy Discussion, so that we could consider all the information and effectively plan any next steps from each agency, including any support needs for C."*

36. We find fault with Croydon for failing to convene a strategy discussion following C's disclosure. The guidance is clear about when and why a strategy discussion should be held and Croydon failed to follow the statutory guidance. This failure led to an uncoordinated response, lack of information sharing, failure to identify potential risk and poor victim care.

37. We also find fault with Kent for its initial response to the referral about C's disclosure. We reviewed the referrals, and it is clear the police informed Kent because, although the alleged offence occurred in Croydon, the victim (C) lived in Kent. This means the ongoing support needs for C were Kent's responsibility. Kent failed to consider C's needs following the referral. It demonstrated a lack of responsibility and failed to adopt a child centred approach. It failed to place C's needs and experiences at the centre of its response and decision making. This

means there was a significant delay in assessing C's needs and providing any support to C and the family.

Support for C

38. Working Together says whatever legislation a child is assessed under the purpose of the assessment is the same and the same principles of a good assessment apply.

39. When C told Mrs B of the incidents and Mrs B reported it to the police, she believed children's services would be in contact to assess C's support needs. Mrs B says she spent months attempting to get the right support. She says Kent failed to correctly assess C's needs and provide her with the right support when she needed it.

40. We asked Kent how it identified suitable support for C. It was unable to evidence this. Its response supports Mrs B's complaint the Council did not properly assess and consider C's needs. Its decision making lacked proper consideration and potentially added to C's distress.

41. The first referral to Kent was made in June 2018. Kent failed to take any meaningful action in relation to this referral. The second referral in November 2018 prompted contact with Mrs B. The Council says it assessed C's needs and decided early help was the appropriate service for C's needs. Kent's assessment fell short of the standards set out in the statutory guidance. There is no evidence Kent spoke to C between June 2018 and November 2018.

42. Kent has been unable to evidence why it considered early help to be suitable for C and how it assessed this in making its decision. This is fault and means C could have missed out on the support she needed for a prolonged period. We also think Kent's poor response to C's needs could have contributed to the subsequent deterioration in C's mental health.

Support for Mrs B

43. Whether support is provided through early help or child in need procedures, Working Together is clear the support provided is for children and families.

44. Mrs B says she also needed support following C's disclosure and Kent failed to provide her with appropriate support to enable her to support C. In her complaint Mrs B says:

> *"At no point did I request support with parenting, I requested support with understanding how to support C, who had been raped."*

45. Kent says it provided her with information about various support options and courses. Kent says it did not have a duty to support Mrs B outside of the context of the support it was giving C.

46. Kent failed to assess Mrs B's needs within the context of her supporting C. In June 2018 Mrs B asked for help following C's disclosure. It is not possible to say what support would have been put in place if a thorough and holistic assessment had taken place. But the delay and handling of the case had such a negative impact on the relationship between Kent and Mrs B that when the Council did decide to carry out an assessment Mrs B withdrew her consent.

47. We find fault with the Council for failing to properly assess Mrs B's needs to enable her to support C and adding to her distress by failing to understand her needs.

Local Authority Designated Officer (LADO) referral

48. Working Together says organisations and agencies working with children and families should have clear policies for dealing with allegations against people who work with children. Such policies should make a clear distinction between an allegation, a concern about the quality of care or practice, or a complaint. An allegation may relate to a person who works with children who has:

    - behaved in a way that has harmed a child or may have harmed a child;
    - possibly committed a criminal offence against or related to a child; and
    - behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

49. Working Together is very clear about when a LADO referral is required, in the above circumstances.

50. Part of Mrs B's complaint is about Kent telling her it may have to refer her to the LADO because of the nature of her employment.

51. The social worker recorded a concern about Mrs B not "allowing" a LADO referral. A council does not need the subject's permission to make the referral.

52. Kent recognises it was wrong to tell Mrs B it may need to make a LADO referral and it has apologised to Mrs B for the upset and distress it caused.

53. The impact of the potential LADO referral on Mrs B is evident in her complaint:

> *"Imagine the anguish and trauma I felt knowing that my child had been abused and now I may lose my job. I cannot put into words the emotional trauma this incident caused me. I was managing to be strong for my family and primarily C since 22nd June when she made the initial disclosure. However once [Worker B] came to my home and questioned my ability to safeguard children and my job (a job that I love), a job that provides for my family a job that without that income I could not pay for therapy sessions for C or our family, I was emotionally broken. I managed to hold it together outwardly because I knew if I didn't C would be let down even further."*

54. We find fault with Kent for failing to properly consider whether a referral to the LADO should be made before it mentioned this possibility to Mrs B. Had it done this it could have saved her from suffering significant distress at a time when she was already under pressure and experiencing the emotional impact and stress following C's disclosure.

Risk, information sharing and professional curiosity

55. Although both the alleged offences occurred several years before C disclosed them, that does not mean there is no ongoing risk.

56. We were concerned about the lack of professional curiosity and information sharing in this case. It is disappointing that neither Council made any concerted effort to explore the potential risk to other children.

57. Croydon were content with the police leading the investigation and took no active interest in the progress of the case.

58. In her complaint Mrs B raises concerns perpetrator A may have also been subject to abuse. Particularly because perpetrator A was also a child when the offence is alleged to have happened. This is the only reference we saw to the possibility perpetrator A could also be a victim. This further demonstrates the lack of professional curiosity displayed in this case.

59. We asked Croydon how it assessed the potential risk perpetrator A may pose to both C and other children, irrespective of the police outcome. It said because the police could not proceed with any allegations, it did not assess the risk. It did acknowledge a strategy discussion would have improved the decision making on these aspects of the case.

60. When cases involve parallel criminal and child protection investigations, a police investigation will focus on whether there is sufficient evidence to prove that a crime has been committed, whereas child protection enquiries seek to ascertain whether a child is at risk of significant harm.

61. The NSPCC says:

> *"Professionals need to remain curious about the source of children's distress, behaviour or physical indicators of abuse, even if other agencies' assessments are inconclusive and agencies such as Police and Health Services cannot evidence sexual abuse."* ***(NSPCC, learning from case reviews, 2020)***

62. We were disappointed with both Councils' attitude to the potential risk in this case. We saw no evidence it considered the risk to others or the potential that perpetrator A might also be a victim. Both Councils were too quick to pass responsibility to others and look for reasons not to take action or ownership. This attitude unfortunately continued in both Councils' responses to our draft report.

Complaint handling

63. Many complaints about children's services, made by or on behalf of children, can be considered under a special three stage procedure – the Children Act procedure. When Mrs B complained to both Councils, they should have told her whether they were going to consider her complaints through their own procedures, or under the Children Act statutory procedure. Neither Kent nor Croydon explained this to Mrs B.

64. The guidance is clear about who can make complaints, and this includes parents and those with parental responsibility. Kent did not need C's permission to apply the statutory complaint procedure in this case, it could have accepted Mrs B's complaint.

65. In response to our enquiries Kent says it used its corporate complaint procedure because Mrs B's complaint did not fall within the scope of statutory complaints procedure. We disagree, because Mrs B's complaint related to:

- the application of eligibility and assessment criteria; and
- delivery or non-delivery of services including complaints procedures.

66. Mrs B repeatedly asked Kent to assess C's needs over a number of months so they could understand what support she may need.

67. We disagree with Kent about its decision not to use the statutory procedure. We believe the initial decision to use the corporate complaint procedure was due to Kent interpreting the guidance incorrectly. Regardless of whether it had C's consent, Mrs B has a legal right to make a complaint under the statutory procedure. This case would have benefitted from independent oversight. The decision not to use the statutory procedure deprived Mrs B of the opportunity to have her complaint considered independently. Kent also missed an opportunity to learn lessons locally and more quickly.

Conclusions

68. We are concerned by the failings we found with both Councils. Although the period subject of this investigation is 2018/19, the nature of the faults and both Councils' responses to our draft report, suggests wider systemic issues rather than being simple one-off errors.

69. Croydon points out it has since received a 'good' rating in its recent Ofsted inspection (February 2020). Whilst this is a positive development it is disappointing Croydon appear to suggest this indicates the fault identified in this report is confined to the past. We feel this case is an opportunity to learn and make improvements to prevent other children and families experiencing the same issues.

70. Kent's response to our draft report concerns us. It reinforces our concerns about its lack of child focused working and its reluctance to take responsibility and ownership.

71. Both Councils should address the concerns in this report and identify learning from this case to prevent a repeat of these failures.

Recommendations

72. To remedy the injustice caused, we recommend the Councils take the following actions.

Kent County Council

73. Kent should:

- pay C £1,000;
- pay Mrs B £1,000 to acknowledge the distress and impact of the faults;
- pay Mrs B £150 for the additional time and trouble she experienced pursuing her complaint; and
- remind all staff dealing with children's services complaints when the statutory complaints process should be used. It should also ensure its staff understand who can make a complaint in this process.

Kent County Council and London Borough of Croydon

74. Kent and Croydon should:

- share the learning points from this case across its organisation, to ensure staff are aware of their responsibilities in respect of information sharing, professional curiosity, and cross border child protection referrals; and
- conduct an audit of 50 cases closed in similar circumstances between 2018 to date. If more than 25% of those cases identify similar issues the Council should make resources available to conduct a full case audit. The full audit should review all cases closed in similar circumstances between 2018 to date.

75. Both Councils must consider the report and confirm within three months the actions they have taken or propose to take. The Councils should consider the report at a full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

Decision

76. We find fault by both Councils which caused injustice to Mrs B and C. The Councils should take the recommended action identified to remedy that injustice.