

**From: Sue Chandler, Cabinet Member for Integrated Children's Services**

**Richard Long TD, Cabinet Member for Education and Skills**

**Matt Dunkley CBE, Corporate Director of Children, Young People and Education**

**To: Children's and Young People's Cabinet Committee – 9<sup>th</sup> March 2021**

**Subject: Local Government and Social Care Ombudsman Public Report**

**Classification: Unrestricted**

**Past Pathway of report:** None

**Future Pathway of report:** None

**Electoral Division:**

**Summary:** The Local Government and Social Care Ombudsman has investigated a complaint against Kent County Council and concluded that there was fault by the Council which caused injustice to the complainant. The Ombudsman has issued a public report regarding the complaint.

**Recommendation(s):**

The Cabinet Committee is asked to consider the report.

## **1. Introduction**

1.1 The Local Government and Social Care Ombudsman (LGSCO) has issued a public interest report following a complaint about the Council. The final report does not reveal the identities of the people involved but names Kent County Council as the organisation the complaint is about. A copy of the report is included (Appendix A).

## **2. Background to the Complaint**

2.1 Mrs B complains about the way Kent County Council and London Borough (LB) of Croydon council responded when her daughter, child C, disclosed an allegation of historical sexual abuse.

2.2 Mrs B says that 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.

2.3 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.

- 2.4 The Ombudsman also judged that 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. The Ombudsman also ruled that Mrs B had suffered significant distress because the Council failed to meet C's needs and provide support.
- 2.5 Mrs B says the Council's failures have had a significant and lasting impact on C and her family.
- 2.6 Mrs B says that the 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.
- 2.7 Mrs B then complained to the Local Government and Social Care Ombudsman.

### **3. The Ombudsman's Findings**

- 3.1 The LGSCO found 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.
- 3.2 The LGSCO also find fault with Kent for its initial response to the referral about C's disclosure. Although the LGSCO acknowledged that the alleged historical 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.
- 3.3 The LGSCO found fault with Kent 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.
- 3.4 The LGSCO found 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.
- 3.5 It is standard national practice for the Local Authority in which the alleged offence occurred (in this case LB Croydon) to lead the enquiry and to include any other relevant Local Authority to provide support where necessary (in this case Kent, as the family had moved).

## **4. The Ombudsman's Recommendations**

4.1 To remedy the injustice caused, the Ombudsman recommend the Councils take the following action:

4.1.1 Kent County Council should:

- a) Pay C £1,000;
- b) Pay Mrs B £1,000 to acknowledge the distress and impact of the faults;
- c) pay Mrs B £150 for the additional time and trouble she experienced pursuing her complaint; and
- d) 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.

4.1.2 Both Kent County Council and London Borough of Croydon should:

- a) 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
- b) 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.
- c) Both Councils must consider the report and confirm within three months the actions they have taken or propose to take.
- d) The Councils should consider the report at a full Council, Cabinet or other appropriately delegated committee of elected members and will require evidence of this.

## **5. KCC Response to the Ombudsman's Report**

5.1 Unusually, on this occasion KCC disagreed with some of the conclusions and suggested remedies in the LGSO's report, and the decision to publish it in its current form. In addition we have pointed out several inaccuracies and misleading statements in correspondence from the Ombudsman. In this case, while we do acknowledge some of our practice could have been better and more timely, and we have reflected that by agreeing to the suggested financial compensation to both mother and daughter, we do not accept some of the central conclusions.

5.2 In particular we do not accept the conclusions in relation to understanding thresholds for statutory services, and have not agreed to implement some of the remedies which are not legally binding on us. As you would expect, we raised these issues prior to publication, but been unable to agree a way forward with

the Ombudsman. I must stress how unusual this situation is - we can normally accept Ombudsman findings in full, agree fault, remedy and publication arrangements.

- 5.3 Although both KCC and LB of Croydon have accepted that there was a short delay in offering support exacerbated by the cross authority involvement, we are confident that actions taken in relation to ensuring the safeguarding of the individual and the offer of ongoing support, subsequently declined by the family, were the correct response and in compliance with current Government legislation and guidance as it has also been interpreted by many other local authorities in similar cases. Some of the Ombudsman's conclusions suggest we should have offered therapy services to this family that we are not statutorily required to provide, nor funded to provide, and are not provided by any local council in similar circumstances.
- 5.4 In order to provide what the Ombudsman suggests we should have, both funding of and statutory definition of services provided by local government would have to change. While this may or may not be desirable, we question whether it is in the remit of the LGSCO to make any judgement of KCC on the absence of services we and the rest of local government are not currently required or funded to provide. We do agree that the national government guidance is lacking and unclear in its current form, and have offered to work with the Ombudsman to seek greater clarity from national government in its guidance.
- 5.5 KCC worked closely with the Office of the LGSCO to highlight what we believe are factual inaccuracies in the report, the Ombudsman has taken the decision to publish report as it stands without our proposed amendments.
- 5.6 KCC also offered to include the LGSCO in its work with the DfE and the Acting Director General for Children's Social Care, Steph Brivio, to revisit the statutory guidance relating to Section 47 of the Children Act 1989. KCC explained to the LGSCO that Matt Dunkley was already working with Ms Brivio, Isobel Trowler, the Chief Social Worker and Yvette Stanley, the Director of Social Care Inspection at Ofsted about these matters.
- 5.7 KCC agreed that the LGSCO had uncovered an area where guidance in "Working Together" was lacking and was badly needed, as well as reflecting on the matter of initial Section 47 strategy discussions. Currently Ms Brivio, Ms Stanley and Ms Trowler all accept that it was common custom and practice for Local Authorities nationally to do what KCC had done with the initial referral, by passing it to the LB Croydon, where the alleged offence had occurred and therefore needed investigating.
- 5.8 The Ombudsman have welcomed the fact that we have raised our concerns with the DfE and are happy to be involved in further discussions, should we need them to be.
- 5.9 In our response to the LGSCO we highlighted the services offered to C and the application of thresholds. It was established that Kent had made direct contact with Mrs B following a second contact from the Police to ascertain her

understanding of the referral. It was acknowledged that Mrs B had indicated that she was looking for emotional support for C to “bridge the gap” before ‘C and Mrs B’ were able to access the services she really wanted which was a therapeutic intervention for them both. KCC argued that the local authority is neither funded nor has any statutory duties to provide such services, particularly to adults, however, the LGSCO concluded that in this particular case we should have done so.

- 5.10 KCC reiterated the statutory need for consent to undertake the work which the LGSCO felt was missing and outlined that a worker from the Integrated Children’s Service had met with C, who had been very clear that she did not want any intervention other than having a better relationship with her mother who she felt was unreasonably restricting her movements. Parenting and relationship support was offered for mother and daughter but turned down by Mrs B.

## **6. Actions for the Council**

- 6.1 In response to the recommendations outlined in the report CYPE has written to the Ombudsman advising that:

- 6.1.1 We have concerns regarding the auditing of similar cases, in that the definition of ‘cases closed in similar circumstances’ is vague and there are approximately 53,000 cases that fall within this time frame.

KCC has agreed to conduct an audit of 50 cases closed in similar circumstances between 2018 to date.

However, the LGSCO have stated that they will consider the next steps if the audit indicates that if 25% of those cases identify similar issues, then they may require the Council to complete a full audit of all cases. If this occurs the Council will review its position.

- 6.1.2 We have agreed to pay the compensation suggested as a remedy for the family.

- 6.1.3 We have agreed to share the learning points from this case across our organisation, to ensure staff are aware of their responsibilities in respect of information sharing, professional curiosity, and cross border child protection referrals.

- 6.1.4 We will 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.

## **7. Conclusion**

- 7.1 The Council will implement the recommendations as proposed by the Local Government and Social Care Ombudsman. We will keep in review what we intend to do, should the audit identify more than 25% of cases with similar issues.

**8. Recommendation(s):**

The Cabinet Committee is asked to consider the report.

**8. Background Documents**

8.1 Appendix A: Published Report by LGSCO.

8.2 Link to LGSCO covering statement and report:

<https://www.lgo.org.uk/information-centre/news/2021/jan/councils-urged-to-learn-from-ombudsman-investigation-into-child->

Local Government and Social Care Ombudsman [abuse-complaint](#)

**9. Contact Details**

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