8 May 2019

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Dear local partnership

**Joint targeted area inspection of the multi-agency response to abuse and neglect in Derby City**

Between 18 and 22 March 2019, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMI Prob) carried out a joint inspection of the multi-agency response to abuse and neglect in Derby City.[1] This inspection included a 'deep dive' focus on the response to child sexual abuse in the family environment.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Derby City.

This joint targeted area inspection (JTAI) included an evaluation of the 'front door', which receives referrals about children who may be in need or at risk of significant harm. In Derby City, all enquiries or concerns about children are progressed through the local authority First Contact Team, which works alongside the multi-agency safeguarding hub (MASH). In addition, inspectors undertook a more detailed analysis into the effectiveness of services for a group of children who have suffered or are at risk of child sexual abuse in the family environment. Finally, inspectors evaluated the effectiveness of the multi-agency leadership and management of this work, including the role played by Derby Safeguarding Children Board (DSCB).

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

The DSCB has successfully engaged the local area in reviewing multi-agency responses to child sexual abuse. Committed partners proactively engage in assurance and audit activity, which has contributed to improvements in the provision of services to children and families.

The role of education partners in safeguarding practice has been considerably strengthened, and the recent implementation by the police of the 'Stopping domestic abuse together' initiative has improved information-sharing with schools and colleges. Education leads offer a child's perspective that is helpful to the board's work in understanding children's experiences, particularly those children impacted by child sexual abuse. An effective MASH ensures that where risk of harm is identified, child-focused responses follow, and children are safer.

Partners demonstrate working in a culture of learning and improvement. The recent focus to learn lessons from two serious case reviews involving children affected by sexual abuse in the family has raised the awareness and profile of these vulnerable children. A dedicated web page for protecting children from sexual abuse and learning from these serious case reviews are contributing to a better awareness of the complexities of responding to child sexual abuse. Practice guidance is in development to support the workforce.

Through its significant multi-agency work, the partnership identified inconsistencies in the quality of practice for children who are affected by sexual abuse. Many improvements have now been made, but shortfalls remain. Not all relevant information is shared and not all risks to children are identified. This means that not all children receive consistently timely consideration of their needs or receive services at the right level of support

Despite a high level of trust in the partnership, there is insufficient challenge of agencies' individual plans. Inspectors found weaknesses in the agencies' front doors that were not known by the partnership. Partners are not sufficiently focused on the adverse impact on children of capacity issues that are visible across agencies. In the front door, inspectors found delays in assessing children's needs, limitations in the management of those who pose a risk to children, and insufficient sharing of information to fully assess risks to children, including those impacted by sexual abuse. The absence of a combined approach to these serious capacity issues means that children's needs and risks are not consistently known and responded to.

Joint working arrangements across the partnership are not always effective. Opportunities for partner agencies to inform the screening of referrals at an earlier stage are missed, as the multi-agency input is solely focused on child protection enquiries. As a result, early decisions for children are based on overly limited information. Thresholds for children's social care involvement are not well understood by all partners. For example, probation services do not routinely share new and potentially significant information on closed cases when new concerns

emerge, which can leave children at risk of sexual abuse. Police officers do not always identify and refer children at risk of neglect. Not all agencies who have important information about adults who may pose a risk to children are appropriately engaged in assessments for children. General Practitioners (GPs) are not always included by children's social care in information-sharing, and existing arrangements to provide assurance of safeguarding practice have not identified the improved level of engagement required of some GPs.

Performance reporting and information systems within the partnership and the DSCB are not effective at collating and sharing information about children who display harmful sexual behaviour. This restricts the partnership's understanding of the prevalence of this behaviour and the impact of interventions. Children with harmful sexual behaviour do not always have the benefit of the expertise of the youth offending service (YOS) in their risk management. The role of YOS is principally focused on those children within the criminal justice system, which is a missed opportunity to ensure that all children who display harmful behaviour have the benefit of their specialist support.

## Key Strengths

- Effective relationships in the MASH between children's social care, health and police agencies ensure a joint analysis of risk and constructive challenge from partner agencies about thresholds of intervention. Timely, well-informed strategy discussions result in swift decision-making for children who require immediate protection, including outside office hours. Increasingly, education partners are engaged in this initial analysis of children's needs and provide valuable insight into children's experiences.

- When risks of harm are clearly identified, including the risk of child sexual abuse, there is strong engagement by partner agencies in planning for children. Timely joint investigations by police and children's social care are sensitively conducted. The use of intermediaries in police interviews demonstrates a child-focused approach to gathering best evidence. Successful use of complex strategy meetings enables a good understanding of the wider risk of harm of sexual abuse and leads to appropriate safeguarding of other children who may have contact with adults that pose risk.

- A revised new-born protocol engages professionals well in both early identification of and support for vulnerable parents. Midwives participate in a range of multi-agency network meetings, including early help and child protection meetings, which ensures good information-sharing, and plans are in place to protect vulnerable babies.

- Timely completion and sharing of specialist assessments between the Management of Sexual Offenders and Violent Offenders Team (MOSOVO) and probation services improves risk management for children at risk of sexual abuse. When risk from registered sex offenders (RSOs) or persons who pose a risk of sexual harm is clearly identified, decisive action is taken to ensure their removal from the family home. This means that children are protected from further harm.

- Child-focused assessments in early help and social work describe children's experiences well and inform the understanding of risk. Culturally sensitive practice with families is improving engagement with parents and helping to support improved outcomes for children. This is clearly illustrated by the appropriate use of joint working with male and female workers and interpreters, who are used to deliver the domestic abuse freedom programme with parents.

- The weekly multi-agency vulnerable children's meeting in locality areas is a useful forum for engaging partners and sharing information. This is appropriately used to inform decisions about how children's needs can be best met. Decisions to transfer cases between services are proportionate. The effectiveness of these meetings could be further enhanced with consistent police and mental health services attendance.

- Many partner agencies have established systems and processes to support good identification of risk for children. For example, emergency department (ED) staff at Royal Derby Hospital site (University Hospital Derby and Burton Foundation Trust) have a range of prompts and care pathways to enable them to make detailed and comprehensive enquiries about children's needs and family circumstances. There is a holistic approach taken in the risk assessment practice within the Break Out Young Person's Substance Misuse Service, and a strong focus on the voice of the young person. Genograms are used effectively to support shared understanding of the whole family and identify potential risk of harm of sexual abuse. School nurse records provide a clear picture of the child's voice, underpinned by sensitive listening to children's experiences and what life is like at home. Derbyshire integrated sexual health and school nursing services make good use of the child sexual exploitation assessment tool to promote shared dialogue with young people and assessment of risk.

- Across the partnership, inspectors saw evidence of strong work in engaging children and their families. Children's voices are clearly represented in plans, and children can express their wishes and feelings to professionals. This, in turn, informs the assessment of risk and leads to supportive interventions for children who have experienced sexual abuse. The direct work undertaken with children is appropriately responsive to their needs. This is complemented by schools, which provide sensitive and well-tailored help, taking account of children's individual needs and circumstances.

- Child protection conferences are timely. The police have good systems for ensuring police representation at these important meetings. Of note is the practice of investigating officers attending conferences in complex child sexual abuse cases, when their knowledge of the investigation enhances information-sharing and decision-making. Children's outcomes improve as a result of clear, well-coordinated plans and a shared understanding of risk.

- Good relationships between children and professionals, including schools, school nurses and social workers, promote child-focused interventions and improved outcomes for children who have experienced or are at risk of sexual abuse. The intensive support provided by family visitors alongside social workers contributes to children's safety.

- Education is an area of strength for the partnership. Effective work with designated school leads has improved their understanding of the signs and indications of sexual abuse and harmful sexual behaviour. The increased confidence of school leads supports them to successfully challenge social care colleagues and contribute to children's safeguarding. Home-educated children and their carers receive appropriate advice and monitoring from the local authority, including termly visits. Suitable systems are in place to ensure that the whereabouts of most children who are missing education are known.

- Management oversight processes have improved since the YOS inspection in the summer of 2018. Well-established systems now ensure that all concerns identified by YOS staff are shared with children's social care. YOS staff are confident in making referrals, and in challenging decisions when needed. Risk and safeguarding management meetings include children's social care, which allows for the development of shared thresholds and a more coordinated view of risk. Effective information-sharing for children in youth custody is the result of good relationships between YOS and the case management teams in the Youth Offending Institutions.

- Leaders have effective mechanisms to escalate concerns with regular safeguarding assurance meetings involving chief officers and the independent chair of the safeguarding board. Secure relationships with the main safeguarding partners mean that the proposed new partnership model has been agreed. This puts the local area in a good position to steer improvements and address the shortfalls identified at this inspection.

- The chair of the safeguarding board has successfully challenged the partnership about several areas adversely impacting on children. This includes the new service for asylum seekers, where concerns about the living arrangements for children have been escalated and progressed. The board has championed new investment to offer early help to new families arriving in Derby City. This,

together with new citizenship training, is helping to identify families' needs and ensure that children are swiftly integrated into services.

- Housing high-risk offenders is critical to effective risk management. To address the gap in suitable living accommodation for these offenders, the management board for the multi-agency public protection arrangements (MAPPA) has secured funding from partners, including the police and crime commissioner, to increase capacity. This improves the ability to manage the risks of those who pose the greatest risk to children.

- Following the DSCB's inspection preparation activity, the national probation service has begun to address the weak safeguarding practice that has been uncovered. Greater management scrutiny and training, including multi-agency safeguarding training attendance, has improved the confidence of probation staff in safeguarding issues. There is significant commitment from the probation agencies to improve information-sharing. This is illustrated in the advanced planning to co-locate staff with the police and adult mental health services in the new risk and referral unit, as well as the presence of the community rehabilitation company at court.

- The local authority has reduced its overreliance on temporary agency staff and has successfully attracted social workers to permanent positions using a range of recruitment and retention methods. However, social work caseloads remain too high, and have increased since the last Ofsted inspection. Despite this, most social workers report positively about their experiences of working for Derby City. Supervision is helping them manage their caseloads, and good management support is available. The small teams create a supportive environment, which social workers value. As a result, turnover is low. Newly qualified social workers are equally positive about their training programme and capped caseloads. They value the regular supervision and support they receive, which is appropriately helping them develop their skills and competence.

- Child protection is recognised by the police and crime commissioner and Derbyshire constabulary as their top priority, and this has resulted in additional funding to increase the number of police investigators. This additional resource will improve police capacity to progress criminal investigations.

**Practice study: highly effective practice**

A major strength in Derby City is the strong multi-agency response to children when risk of serious harm is identified.

Hannah* disclosed to school that she had been the victim of sexual abuse within her family between the ages of seven and 10. The school immediately referred the matter to children's social care, and a strategy meeting was conducted on the same day. This resulted in a joint child protection investigation. Hannah was visited at school by a police officer and social worker on the same day, where she was given the opportunity, with the support of her teacher, who she trusted, to confirm the disclosure. Her mother and sister were jointly visited the same day too and the alleged perpetrator was immediately removed from the home environment.

Hannah was well supported in her achieving best evidence interview by an intermediary due to her additional needs and was subsequently supported in the lead up to the court trial. Before giving evidence, Hannah received very good emotional support from her teachers, school nurse and social worker. This was especially important because Hannah was self-harming. The perpetrator was subsequently imprisoned for the offences against Hannah and received a significant sentence. During this inspection, school staff recognised Hannah's bravery and determination and described her as 'a remarkable girl'.

*Pseudonym used to protect confidentiality.

## Areas for improvement

- The quality of referrals to children's social care across the partnership is too variable. Not all partners are using the safeguarding referral form, and the variable quality of information shared hinders the first contact team in identifying risk and making fully informed decisions. Most police referrals do not include appropriate research of police information prior to being forwarded to social care, which means that the screening decision is based on a small proportion of available police information. Local safeguarding arrangements do not include robust processes for the front door in order to provide feedback to referrers to inform ongoing work with families. This is causing extra demand at the front door because professionals seek updates by making further referrals. The verbal referrals made by GPs and the child and adolescent mental health service (CAMHS) do not support effective oversight and review to ensure that children receive the help they need.

- Decision-making in the first contact team does not always sufficiently balance a consideration of risks to children alongside the presenting needs of adults. Adult services do not sufficiently inform decision-making for children. Probation services do not share all relevant information that may contribute to an assessment of risk of sexual abuse. Youth offending case management systems are not visible to the first contact team or the MASH, which hinders the ability of the team and the hub to identify children already known and in contact with the service. Information systems between GPs and children's social care are under-developed. This means that GPs, as the primary health record holder, do not always have a complete record of concerns about children, and their important contribution to children's planning is not recognised.

- There are not enough qualified social workers in the first contact team to support complex discussions with parents about their protective capacity. Child practitioners undertake initial assessment work and make recommendations around thresholds, which is not commensurate with their level of responsibility.

- Pathways to early help for children are not easily accessible for all agencies, especially those that may have sporadic contact with families, for example police or hospitals. Families are not referred to early help services when this may be considered beneficial for children. Where families are stepped down from statutory services to early help, there is some evidence of weak contingency planning if they don't engage with services.

- The oversight of domestic abuse concerns is not sufficiently robust to ensure that all risks to children are responded to promptly and appropriately. Decisions are not always informed by wider risks to children. For example, no checks are made of people known to probation services. Although training has been delivered, the risk for babies in households where there is domestic abuse is not consistently understood by all professionals. Support from specialist services is too limited.

- Inspectors found an overreliance on the use of written agreements to manage risks to children, including those who have experienced or are at risk of sexual abuse. Despite the new practice guidance produced by the partnership in January 2019, the majority of written agreements seen were of poor quality, with unrealistic expectations on parents' ability to keep children safe from those who pose a risk to them. Some were out of date, and others were inappropriately used to manage supervised contact when a parent may be at risk of domestic abuse.

- There are inconsistent systems for strategy discussions when child protection enquiries relate to an open case. Current arrangements for holding strategy discussions between police and social care for children with an allocated social worker can, on occasion, delay joint decision-making and joint visits to children where there needs to be an immediate response to concerns.

- The completion of assessments in children's social care takes too long and children can experience long gaps between visits following child protection enquiries. The quality of assessments varies, with, in some cases, inadequate analysis of children's histories, which does not support good risk identification.

- Equally, the quality of assessments in probation services is too variable. Assessments can take too long in high-risk cases, and there is not always sufficient analysis of offenders' histories or clarity about the risks they pose to children. The potential harm to children from RSOs is not consistently considered, and probation services do not always make timely referrals when risks from adults are known.

- Concerns about children's welfare are not always appropriately analysed by children's social care. For children subject to child in need plans whose situations have not improved, there is insufficient escalation to reviewing officers at the point of closure. GPs do not consistently identify children who may be at risk of sexual abuse, and there is insufficient analysis of risk in GP reports to child protection conferences. This inhibits an understanding of children's experiences and the impact of wider family circumstances.

- Plans and minutes of multi-agency meetings are not always shared with partners, thus hindering the effectiveness of joint working, and particularly for children at risk of sexual abuse. For some children with several risk factors and multi-agency involvement, there is a lack of coordination, which means that not all risks are effectively captured in their plans. Inspectors found evidence of wider risks such as domestic abuse and neglect not being identified or acted on, which delays the improvement of children's circumstances.

- Numerous changes to social workers for some children lead to drift and delay in their plans. Lack of capacity in school nursing results in some children having inconsistent and delayed provision to assess and meet their health needs.

- Sporadic attendance by agencies at multi-agency decision-making forums for children affected by sexual abuse, outside of initial child protection conferences, means that critical decisions are made by agencies with only partial information available. This hampers partner agencies' ability to contribute to children's ongoing assessments and plans, which limits their effectiveness when criminal investigations are proceeding. The absence of key health agencies in children's planning means that the right support is not always identified and provided for these children.

- MAPPAs are not effectively used at level one. Agencies are not invited to contribute to the management of this category of high-risk offenders, which is a missed opportunity in understanding risk for children.

- The involvement of the children's sexual assault service in multi-agency assessment and planning is under-developed. The staff of this service are not invited to strategy discussions and, in some cases, it can take too long for the children's sexual assault service to share their written reports on children's medical assessments. This can delay timely and effective follow-up for these children. Health leaders demonstrate weak oversight of the provision located in Nottingham at the Queen's Medical Centre. There is limited assurance that leaders ensure that children's ongoing health needs will be met. This provider is not sufficiently engaged in learning from serious case reviews or the partnership's quality assurance work.

- A small number of children benefit from specialist 'assessment, intervention and moving on' (AIM) programmes from trained social work and youth offending staff, which address risks for children and the wider public. However, the interventions are not always timely due to capacity issues. This limits the effectiveness of AIM as an intervention, particularly for young children where incidents may have taken place some time ago.

- There are missed opportunities to share and capture important information about risks of harm to children, including from sexual abuse, which can lead to delays in identifying and addressing children's needs. Insufficient consideration by professionals of the potential risk of harm to children who display harmful sexual behaviour means that their offending behaviour can be the only focus of their intervention. The vulnerability of these children is overlooked. Inspectors also found delay in offering appropriate risk management for these children, with removal from the family home seen as the safety plan. Although the YOS service is available throughout early help services, when social workers are undertaking assessments for these vulnerable children, this support is not always considered in a timely or effective manner. This means that there is a lack of specialist input and insufficient support for these children.

- Inconsistent approaches to the recording of multi-agency information hampers information-sharing for several partners, including the police, probation and health services. Different information systems used by health agencies do not support easy retrieval, updating or analysis of information to provide a comprehensive picture of children's needs and vulnerabilities. Safeguarding information is not well shared with GPs and Derbyshire Healthcare Foundation Trust. Therefore, their databases cannot be flagged and risk of harm from sexual abuse can be masked.

- GPs are unclear about how to share children's records effectively in order to ensure that safeguarding information is known, understood and considered when children either attend or are not brought to health appointments. Meetings that GPs host to discuss vulnerable children are too inconsistent in Derby. Where

established, they have not always resulted in effective information-sharing and joint working with health visitors and school nurses for children affected by sexual abuse. More needs to be done to standardise good practice in primary care in Derby, including updating existing guidance documents

- Leaders' understanding of the effectiveness and timeliness of children's access to commissioned therapeutic services for children who have experienced sexual abuse is limited. Support for children affected by sexual abuse is too fragmented, with different access points meaning that some children wait too long. Too often, children's need for support is not identified early enough. Contingency plans are not clear for the impending change in provider for the emotional well-being service, and the waiting list for the service is growing.

- Police leaders do not undertake sufficient quality assurance activities or effectively use performance information to assure themselves about the quality of frontline officer response. This is a missed opportunity to raise the standards of practice and leads to confusion about how the police screen and risk assess police notifications to children's social care. The police staff within the MASH have not received any specific training to undertake their roles. Inspectors found weaknesses in identifying and responding to neglect.

- There are unnecessary delays in responses by the police force control centre. For example, rather than deploying an officer for incidents that are deemed lower risk, the centre tags incidents for the attention of the MASH detective sergeant, who may then have to return them to the control centre for action. Although frontline police officers recognise and refer children at risk of harm to children's social care, inspectors found potentially serious concerns where there were situations where risk to children was not recognised by the police control centre and therefore officers were not deployed. This left children potentially exposed to continued harm.

- The partnership does not have a good understanding of the changes in the organisation of probation services, which has resulted in some processes being misaligned. This includes the need for timely information exchange at court about risks to children in order to improve the management of offenders.

- Strategic work to identify children who are affected by criminal exploitation and approaches to contextual safeguarding are under-developed. Consequently, the safeguarding board is not able to monitor these children's experiences.

- The safeguarding board has insufficient oversight of the lack of take-up of multi-agency safeguarding training by some partners. In several agencies, there has been limited consideration of the impact of the poor take-up of internal safeguarding training.

- Staff within children's social care and partner agencies do not have a good understanding of when to refer concerns to the designated officer. This can lead to delays in reporting concerns or unassessed risk for professionals and volunteers who work with children.

**Practice study: area for improvement**

Risks to children of sexual abuse in the family environment are not always well understood. Samantha* is aged seven and at significant risk from a registered sex offender who has convictions for offending against children.

Prior to the offender's release from prison, there was a failure to convene a level one MAPPA. No pre-release risk assessment was undertaken. On the offender's release, there was no specialist sexual offending assessment carried out, and a delay of three weeks in the probation service's assessment of risk of harm. When this was finally completed, the assessment did not take full account of the offender's risk to children.

Following his release, information came to light that the offender was now in a relationship with Samantha's mother. Probation services did not make a referral to children's social care, as they relied on assurances from Samantha's mother that she was aware of her partner's offences and does not allow him contact with her children. Despite the challenge from the police officer, no referral for assessment was made and Samantha was left at risk of significant harm.

As a result of this missed opportunity, there was a delay of seven weeks before an adequate multi-agency approach was agreed to respond to the high levels of risk to Samantha. Samantha later confirmed that during this period she had contact with the offender.

* Pseudonym used to protect confidentiality.

## Next steps

The local authority should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the national probation service, the clinical commissioning group and health providers in Derby City and Derbyshire Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2] The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 15 August 2019. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

| **Ofsted** | **Care Quality Commission** |
|---|---|
|  <br>Yvette Stanley<br>National Director, Social Care |  <br>Ursula Gallagher<br>Deputy Chief Inspector |
| **HMI Constabulary and Fire & Rescue services** | **HMI Probation** |
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[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.