Return to an Address of the Honourable the House of Commons

dated 04 February 2015 for the

Report of Inspection of Rotherham Metropolitan Borough Council

February 2015

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Foreword

Terrible things happened in Rotherham and on a significant scale. Children were sexually exploited by men who came largely from the Pakistani Heritage Community. Not enough was done to acknowledge this, to stop it happening, to protect children, to support victims and to apprehend perpetrators.

Upon arriving in Rotherham, these I thought were the uncontested facts. My job was to conduct an inspection and decide whether the Council was now fit for purpose.

However this was not the situation I encountered when I reached Rotherham. Instead, I found a Council in denial. They denied that there had been a problem, or if there had been, that it was as big as was said. If there was a problem they certainly were not told – it was someone else's job. They were no worse than anyone else. They had won awards. The media were out to get them.

So this is why in making a judgement as to whether Rotherham Council is fit for purpose today I have set it in the context of how it has behaved in the past and its reluctance to deal with past failings.

I recognise that child sexual exploitation is hard to tackle. It is complex, sometimes thankless and very hard to get it right. But it is vital that public services face up to difficult tasks. However, Rotherham Council is a place where difficult problems are not always tackled as they should be. When faced with the solid findings contained in the report it had itself commissioned by Professor Jay, it did not accept them. And without accepting what happened and its role in it, it will be unable to move on and change.

We must not lose sight of what the failures in Rotherham have meant in practice; victims have been hurt and remain without justice, the Pakistani Heritage Community has been harmed by association , as have individual social workers, police officers, taxi drivers and other hard working people in the Council, voluntary sectors and the town of Rotherham more broadly. It has also harmed public services because what happened in Rotherham does not represent its values - of putting the needs of the most vulnerable always at its centre.

I want to be clear that the responsibility for the abuse that took place in Rotherham lies firmly with the vile perpetrators, many of whom have not yet faced justice for what they have done. I hope that this will shortly be rectified. But in its actions, the conclusion that I have reluctantly reached is that both today and in the past, Rotherham has at times taken more care of its reputation than it has its of its most needy.

Child abuse and exploitation happens all over the country, but Rotherham is different in that it was repeatedly told by its own youth service what was happening and it chose, not only to not act, but to close that service down. This is important because it points to how it has dealt with uncomfortable truths put before it. However, I propose that this report is one uncomfortable truth that will not be ignored, but that Rotherham Council will use it to embrace the change so sorely needed and ensure that from here it get its priorities right.

Louise Casey CB
January 2015

Background and methodology

Professor Alexis Jay's Independent Inquiry into Child Sexual Exploitation in Rotherham was commissioned by Rotherham Metropolitan Borough Council in October 2013 and published on 26th August 2014. Covering the periods of 1997-2009 and 2009 - 2013, it looked at how Rotherham Metropolitan Borough Council's (RMBC) Children's Services dealt with child sexual exploitation cases.

The report found evidence of sexual exploitation of at least 1400 children in Rotherham over this period. The majority of the perpetrators were described as 'Asian' by victims. Professor Jay found there was a "collective failure" by both the Council and police to stop the abuse.

A Best Value authority is under a general Duty of Best Value to "make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness."[1]

The Secretary of State may appoint a person to carry out an inspection of a specified best value authority's compliance with the requirements of this duty in relation to specified functions.

On the 10th September 2014, the Secretary of State appointed Louise Casey CB under section 10 of the Local Government Act 1999 to carry out an inspection of the compliance of Rotherham Metropolitan Borough Council with the requirements of Part 1 of that Act, in relation to the Council's exercise of its functions on governance, children and young people, and taxi and private hire licensing.

In undertaking this inspection, Louise Casey CB was directed to consider:

In exercising its functions on governance, children and young people, and taxi and private hire licensing, whether the local authority:

- allows for adequate scrutiny by Councillors;
- covers up information, and whether 'whistle-blowers' are silenced;
- took and continues to take appropriate action against staff guilty of gross misconduct;
- was and continues to be subject to institutionalised political correctness, affecting its decision-making on sensitive issues;
- undertook and continues to undertake sufficient liaisons with other agencies, particularly the police, local health partners, and the safeguarding board;

[1] Department for Communities and Local Government, *Best Value Statutory Guidance*, 2011

- took and continues to take sufficient steps to ensure only 'fit and proper persons' are permitted to hold a taxi licence; and
- is now taking steps to address effectively past and current weaknesses or shortcomings in the exercise of its functions, and has the capacity to continue to do so.

Louise Casey CB was appointed as lead Inspector but as the statute allows, the Secretary of State appointed on her recommendation, Assistant Inspectors to ensure that she had all the required skills and experience available to her to fulfil her remit. Louise Casey CB began her inspection on the 1st October 2014.

In total the inspection team carried out over 200 meetings with:

- Victims and their families
- Whistle-blowers
- Concerned members of the public
- Current and former Cabinet Members
- Current and past Councillors
- Current and past senior officers
- The Monitoring Officer
- Heads of Safeguarding
- Former Directors of Children's Services
- Current and past staff in Children's Services
- Managers and staff in taxi licensing
- External auditors
- Other local interested parties
- Representatives from the following partners:
  - Apna Haq
  - Barnsley and Rotherham Chamber of Commerce
  - Council of Mosques
  - GROW
  - Learners First
  - Local Safeguarding Children's Board
  - Rotherham Clinical Commissioning Group
  - Rotherham Diversity Forum
  - Rotherham Ethnic Minority Alliance
  - Rotherham NHS Trust
  - Rotherham, Doncaster and South Humber Mental Health Trust (RDaSH)
  - Safe @ Last
  - Schools (x 2)
  - Senior partners who have now left Rotherham
  - South Yorkshire Fire and Rescue Authority
  - South Yorkshire Police

- Voluntary Action Rotherham

Inspectors met with over 30 representatives from the Rotherham Partnership, representatives from the Youth Cabinet, and from the community sector as facilitated and invited by Voluntary Action Rotherham.

The inspection also reviewed documentary evidence, sampled cases and processes and observed practice, including:

- Approximately 320 requests for documents totalling up to 7000 documents and information
- 68 past and current cases in Children's Services
- 19 staff case files
- 22 taxi licensing cases
- Reviewing policies, procedures and practices

The Inspection team is very grateful for the cooperation of the management and support staff of the current Council in helping the facilitation of the inspection. We were treated courteously at all times. The team is also grateful that all current and former staff that we approached including frontline workers, managers, Directors and Members agreed to be interviewed. Two people declined – former Leader, Roger Stone and former Police and Crime Commissioner, Shaun Wright.

EXECUTIVE SUMMARY

Rotherham Metropolitan Borough Council is not fit for purpose. It is failing in its legal obligation to secure continuous improvement in the way in which it exercises its functions. In particular, it is failing in its duties to protect vulnerable children and young people from harm.

This inspection revealed past and present failures to accept, understand and combat the issue of Child Sexual Exploitation (CSE), resulting in a lack of support for victims and insufficient action against known perpetrators.

The Council's culture is unhealthy: bullying, sexism, suppression and misplaced 'political correctness' have cemented its failures. The Council is currently incapable of tackling its weaknesses, without a sustained intervention.

On 26th August 2014 Professor Alexis Jay published an Independent Inquiry into Child Sexual Exploitation in Rotherham. The report, commissioned by RMBC as a review of its own practices, concluded that over 1400 children had been sexually exploited in Rotherham between 1997 and 2013. The vast majority of the perpetrators were said to be 'Asian' men.

In response, on 10th September 2014, the Secretary of State for Communities and Local Government appointed Louise Casey CB to carry out an inspection of Rotherham Metropolitan Borough Council (RMBC) under section 10 of the Local Government Act 1999. The inspection would assess the Council's compliance with the requirements of Part 1 of that Act, considering leadership and governance, scrutiny, services for children and young people, taxi and private hire licensing, and whether the council 'covers up' information.

The inspection team reviewed approximately 7000 documents, looked in detail at case files and met with over 200 people, including current and former staff, council Members, partners, victims and parents.

Our investigations revealed:

- a council in denial about serious and on-going safeguarding failures
- an archaic culture of sexism, bullying and discomfort around race
- failure to address past weaknesses, in particular in Children's Social Care
- weak and ineffective arrangements for taxi licensing which leave the public at risk
- ineffective leadership and management, including political leadership
- no shared vision, a partial management team and ineffective liaisons with partners

- a culture of covering up uncomfortable truths, silencing whistle-blowers and paying off staff rather than dealing with difficult issues

Despite Professor Jay's findings, which we fully endorse, and substantial quantities of information available within the Council, RMBC demonstrates a resolute denial of what has happened in the borough. This took several forms – notable in their recurrence – including dismissal of Professor Jay's findings, denial of knowledge of the 'scale and scope' of CSE, blaming others, and denial that CSE remains a serious problem in present day Rotherham. Whilst the appointments of a Children's Commissioner and interim Chief Executive (CE) have undoubtedly been beneficial, changes in the senior management team alone will not be enough to shift things on.

Interviews with staff and Members of RMBC highlighted a pervading culture of sexism, bullying and silencing debate. The issue of race is contentious, with staff and Members lacking the confidence to tackle difficult issues for fear of being seen as racist or upsetting community cohesion. By failing to take action against the Pakistani heritage male perpetrators of CSE in the borough, the Council has inadvertently fuelled the far right and allowed racial tensions to grow. It has done a great disservice to the Pakistani heritage community and the good people of Rotherham as a result.

We have concluded that RMBC does not have strong enough political and managerial leadership to guide the borough out of its present difficulties and put it back on a path to success.

RMBC's Children's Services are failing, with a lack of clarity over priorities, repeatedly missed deadlines for the assessment of children in need of care and protection, poor decision-making, drift and delay. The dedicated CSE team is poorly directed, suffers from excessive case loads, and an inability to share information between agencies.

Perpetrators are identified, but too often little or no action is taken to stop or even disrupt their activities and protect children from harm. One of the most important partners is South Yorkshire Police, with whom inspectors expected to find a robust and equal relationship. Instead, RMBC demonstrated an excessive deference to police assurances and a failure to recognise their own role in pursuing perpetrators. This prevented the use of council powers to tackle perpetrators and a lack of scrutiny over the police's actions – actions which inspectors would also call into question.
Partnership working is ineffective. The structures are overly-complicated and do not drive action. Partners are critical that the Council is not providing a lead in these troubled times for the town.

The Council does not use inspection to learn and improve. Members are overly-reliant on officers and do not challenge tenaciously enough to ensure improvements. Meeting and action plans are numerous but unproductive, with a tendency towards inertia.

Some Members have not set and modelled the high standards expected of those in public life. Historic concerns around conduct have not been effectively tackled.
RMBC has a culture of suppressing bad news and ignoring difficult issues. This culture is deep-rooted; RMBC goes to some length to cover up information and to silence whistle-blowers.

RMBC needs a fresh start.

The good people of Rotherham and beyond

Inspectors found many committed, hardworking and dedicated staff working for Rotherham Council including frontline staff and social workers. Inspectors acknowledge that it cannot be easy for them to go into work every day intending to do a good job, amid a stream of criticism of their organisation, let alone marches from the English Defence League (EDL) in their town centre.

During the course of the inspection we came upon various individuals and organisations who were worthy of particular mention and praise by the inspection, however we were conscious that to list them in this report may cause them difficulties either professionally or personally.

However, our sincere thanks must go to two particular groups of people who spoke to us under the most testing circumstances; the individuals and whistle-blowers who came forward bravely to give evidence to us and of course, the victims of child sexual exploitation and their families who courageously recounted the awful things that happened to them.

WHAT HAPPENED IN ROTHERHAM AND WHY IT MATTERS

"I think it's quite sad, not just what happened to my daughter but how the system has responded. I was brought up to believe that when something bad happened, you told the police or social services and they help you - something would be done about it - that isn't what happened." A victim's father

Professor Alexis Jay's report in August 2014 set out a history of child sexual exploitation (CSE) in Rotherham over 16 years. The Council commissioned the report following mounting concerns from outside bodies about CSE in the town.

Over 2012 and 2013, Rotherham had been on the front page of *The Times* newspaper. RMBC's Chief Executive and Strategic Director of Children's Services had appeared before the Home Affairs Select Committee as had the police and Crime Commissioner and Chief Constable of South Yorkshire Police. The then Police and Crime Commissioner had requested three reports into the poor handling of CSE by South Yorkshire Police and sexual exploitation in Yorkshire and the North West was a live issue.

The Home Affairs Select Committee report on 5th June 2013 on CSE criticised RMBC and South Yorkshire Police.

"Both Rochdale and Rotherham Councils were inexcusably slow to realise that the widespread, organised sexual abuse of children, many of them in the care of the local authority, was taking place on their doorstep. This is due in large part to a woeful lack of professional curiosity or indifference."[2]

"We have heard evidence that South Yorkshire Police Force have previously let down victims of localised grooming and child sexual exploitation— as a result, we would expect the force be striving to redeem their reputation."[3]

In August 2013, *The Times* ran a story regarding the Deputy Leader of Rotherham Council as having been involved some years previously in the handover of a girl to police who had been a victim of CSE.

In September 2013, the Council commissioned the Jay Report and the long standing council Leader apologised to the *"young people and their families [who] have been badly let down by the Council in the past."*

Professor Alexis Jay was commissioned to establish what had happened in Rotherham. Her review's terms of reference were very wide ranging. She was to look back at the past and see whether and how things had changed today.

[2] Home Affairs Committee: *Child sexual exploitation and the response to localised grooming. Volume I*., p. 27
[3] Ibid., p. 36

Commissioning Professor Jay to come in and look at this very difficult issue appeared at face value to be a brave action by the Council. She spent over eight months in Rotherham and the published report was the result of her relentless hard work. The Leader of the Council immediately stepped down.

The commissioning of the report and later, the resignation of the Leader, are actions suggestive of a council that:

- accepts the need to examine its past
- accepts that it may have got things wrong
- has an intention to put right those wrongs
- wants to challenge its shortcomings
- and wants to ensure that nothing like this would happen again

Except that's not the Rotherham we found upon arrival for this inspection or have seen since.

WHAT IS CHILD SEXUAL EXPLOITATION?

"I want you all to...look for the child that is unhappy, that doesn't want to be at school, that has no friends, that seems to be going out an awful lot, that could be driving around in cars, has more than one mobile, that has an attitude, that seems to have a lot of boyfriends and ask yourself, is this a victim of CSE?" From a presentation given by a victim of CSE

In order to look at how effectively RMBC was tackling CSE, Inspectors needed to have a working understanding of the issue. It is, undoubtedly, a very difficult problem for public services to deal with and there are many complexities involved. But that should never be used as an excuse for inaction.

CSE is a form of child abuse in which perpetrators develop total control over their victims. It starts with a grooming process, in which victims are showered with gifts and attention. They are treated like adults, for example, by being taken out in cars. The young person can believe that the perpetrator is their boyfriend and that they are in love. This is a powerful thing, especially for young children or young people who may have difficult family backgrounds and crave love and attention. As a result, they do not complain. The grooming process isolates the victim from friends and family.

At some point, drugs, alcohol and sex may be introduced. They are forced not only to have sex with their abuser but sometimes other men too. This is coupled with more overt coercion, threats and violence. By now, victims may be dependent on drugs and alcohol, afraid of their abuser, isolated from their family and scared that they will not be believed or that worse may happen to them or their families if they make a complaint.

The consequences of CSE are appalling. Victims suffer from suicidal feelings and often self-harm. Many become pregnant. Some have to manage the emotional consequences of miscarriages and abortions while others have children that they are unable to parent appropriately. The abuse and violence continues to affect victims into adulthood. Many enter violent and abusive relationships. Many suffer poor mental health and addiction.

The predators often target children with difficult backgrounds, including those in care, who are particularly vulnerable to grooming. But they are also sometimes able to exploit those from stable backgrounds. That families, despite their very best efforts, are unable to prevent the abuse reflects the power of the abusers and the degree of control they exert.

Tackling CSE is incredibly difficult. No one should underestimate this. It requires spotting the signs, helping young people to recognise their experience as abuse and

getting them to trust public services instead of their abusers, often in the face of serious threats.

Then it requires supporting victims through the criminal justice system, where they may have to 'relive' the experience again. There are challenges in gaining sufficient evidence for prosecution. When child sexual exploitation is happening on the scale that it did in Rotherham, there will be multiple perpetrators and victims, and establishing a complete picture by fully appreciating all the links and connections, will be difficult.

CSE embodies issues which are incredibly difficult to deal with. First, serious sexual violence. Second, victims who may reject help. The grooming involved is a form of brainwashing, which means that even though the victims are being abused emotionally, physically and sexually, they can be loyal to their abuser, rather than their family or social worker. Third, the age of the victims involved. Teenage sexuality is a confusing issue for adults and adolescents alike. Many of these girls are on the cusp of adulthood and want to behave like adults but do not yet have the emotional capacity to do so. Abusers exploit this uncertainty.

Many local authorities and other services are struggling with this complex crime and as the OFSTED report[4] on CSE found few have got it right. Given all the difficulties involved, this is not surprising. But CSE is a horrifying and brutal crime with devastating consequences for victims and their families. Councils and their partners must not give up on them.

Tackling CSE effectively requires a council and its partners to mobilise their services and powers together. The Council has a duty to safeguard the victims. It also governs the landscape in which CSE is played out including many schools, care homes, parks, taxis and take away food shops. Councils have powers of licensing and regulation which can be used to disrupt illegal activity in these places and keep the community safe. This is in addition to the duties and powers of the police.

We accept all these challenges make tacking exploitation difficult. But they cannot be used as excuses. Fundamentally, this is about the rape and abuse of children by adults. Victims cannot be abandoned to their abusers. Authorities cannot claim they are powerless to act.

[4] OFSTED, *Sexual Exploitation of Children: OFSTED Thematic Report*, 19 November 2014

CHILD SEXUAL EXPLOITATION – A PICTURE IN ROTHERHAM

From a review of case files and files on police operations, information from Risky Business[5], and from victims, parents and professionals, it is possible to present a picture of sexual exploitation in Rotherham as it developed.

Vulnerable girls, most frequently those with difficult family backgrounds, and or a history of being in care, were particularly affected. Girls were as young as nine when they began to be exploited.

Perpetrators in Rotherham appear to have been largely from the Pakistani heritage Community. Perpetrators used what is known as 'street grooming' to prepare their victims for exploitation.

Some of the exploitation was connected to a nucleus of men or gangs of men who were already involved in criminal activity, including supplying drugs, trafficking, sexual exploitation and prostitution across Rotherham and South Yorkshire.

There were other less organised groups of predatory men who would seek out young girls and form emotional bonds with them. Girls would be contacted initially by phone or by text, often by a young adult male who they had met on the street, or in the shopping centre or park. These younger men who carried out the grooming weren't always the abuser. Girls were misled into believing these men were their boyfriends.

Once their trust had been gained, the girls were vulnerable to sexual abuse and were even shared and passed around other men or groups of men. Victims would start to receive phone calls from numerous other males wishing to meet them and engage in sexual acts, and be pressured by their 'boyfriend' into doing what was asked. They would be picked up in taxis and cars, from schools or children's homes or from their own family homes. Girls would go missing from home regularly and for extended periods. They would be taken to restaurants or to other properties where they would have sex with one or more men.

They were given drugs and alcohol which they then had to 'pay for' in sex. If they did not concur, they would be subject to rape, multiple rapes, rape with physical violence, and threatened with weapons.

Perpetrators in Rotherham generated real fear. They were often perceived to be connected to other forms of criminality and violence and victims and their families were too frightened to speak and did not feel the police could protect them. They were threatened and intimidated into silence. Victims and their families speak of groups of men in cars waiting outside their house or outside children's homes,

[5] A youth project – detail given later, in Section 1, of this report.

sometimes attempting to break in. Phone calls and texted threats, including threats to rape other members of the family, were described to us.

Fear was also evident at times among professionals, teachers, hostel workers and youth workers.

Some children needed to be placed out of the area and others in secure units for their own protection. The grooming was so effective that, despite the abuse and violence, victims would continue to attempt to return to their abusers.

Other patterns in Rotherham involved lone offenders targeting under 16’s. Adult males, and on occasion females, with dysfunctional lives allowed girls and boys to gather at their properties, supplying them with drink, drugs and cigarettes. Vulnerable children often became subject to sexual abuse in these environments.

RESPONSE TO PROFESSOR JAY'S REPORT - DENIAL

Professor Jay's Independent Inquiry into CSE in Rotherham was treated with disbelief and evasion of the issue.

When Inspectors commenced work in Rotherham we were struck by the overwhelming denial of what Professor Jay set out in her report. This attitude was so prevalent that we had to go back through many of the aspects of her work in order to satisfy ourselves that the Council had no grounds upon which further action could be delayed. We soon discovered, however, that RMBC has a history of denial. We deal with this later in the report.

Inspectors noted four distinct forms of denial which arose in interviews with both Members and officers. These were striking in their frequency and their similarity. Even some of the same expressions were used.

These were:

1. Denial of the accuracy of Professor Jay's methods and findings.
2. Denial of the extent of the issue of CSE, particularly in Rotherham.
3. Denial of culpability and belief that CSE was 'being dealt with elsewhere'.
4. Denial that CSE remained a significant problem, although acknowledging that it may have been in the past.

Denial of the accuracy of Jay's methods and findings

The clearest manifestation of denial was that Member after Member and officer after officer disputed the methodology of the Professor Jay's report. The numbers of victims were challenged, the cases she referred to were questioned and the interviews she had undertaken were queried.

When asked, 70% of the current Rotherham Councillors we spoke to (including those in the Cabinet) disputed Professor Jay's findings.

Officers complained that Professor Jay had got their employment dates wrong, or used the wrong job title, that she had got the attendance list for a meeting wrong, that she had not spoken to someone they considered important or had spoken to someone who had an axe to grind, or that she had not spent enough time with others.

One officer, when called to interview, brought a copy of the Jay report which he had scrutinised line by line. He then proceeded to emphasise what he believed were its flaws and inaccuracies.

Others said:

"I would challenge lots of the Jay report, we feel bruised by it. Where is our right of reply? Who is fighting our corner? People are rolling over and just accepting the report." An officer

"Some people would query the methodology behind the number." A police officer

"Too limited a source base affects the credibility of the report." A Councillor

"[I wonder] where some of the facts and figures in the Jay report came from. There were people that should have been spoken to and weren't, such as a wider group of Cabinet Members, as they're the hub of the council." A Councillor

"I don't know whether that [Jay's methodology] was right or wrong – I'm not an expert – but the least the Council should have done was get an independent verification of the report." A former Councillor

"I don't think it was a good report – while the findings were good, it skips around a bit on the details which makes it difficult to read." A Councillor

"Some of the things in Jay aren't right – things have been watered down, or we didn't get the minutes that it says we did." A Councillor

"I'm not convinced by the [report's] rigour but I recognise the themes." A senior officer

Denial of the 'scale and scope of the issue'

Person after person said that they knew about CSE but not the 'scale and the scope', and questioned the numbers of victims in Professor Jay's report. Professor Jay estimated that there were at least 1400 victims of CSE between 1997 and 2013. She states this was a conservative estimate. It was this figure that received most condemnation by Rotherham Council.

If the 1400 figure is broken down to an annual average over the period Professor Jay looked into, it comes to just under 85 children a year. Although Professor Jay did not derive her estimate from Council records as she found them too unreliable (as did we), these figures should not come as a surprise to Members or senior officers in Rotherham. In 2013-14, Rotherham's published CSE cases totalled 107[6], a similar figure to the average Professor Jay calculates over 16 years.

[6] Note that this figure is the number of CSE cases published by RMBC for 2013/4. RMBC also provided the Inspection team with a figure for their total CSE caseload, which was 207 in 2013/4.

When put like that, some officers suggested 1400 was definitely an underestimate. It does not take much to put the figure in perspective in this way. But few had. This is because refuting the numbers of children affected is not really about the numbers. It is about denial of the problem.

Inspectors were told that the numbers were an extrapolation, that they had been generated by a computer programme, and that the 1400 must have referred to the number of 'contacts' (that is, the number of people getting in touch with the Council about CSE) rather than people actually experiencing it.

"1400 is a figure not known to anybody." A Councillor

"I struggle to accept the number, but I'm not a mathematician." A Councillor

"I certainly didn't know what scale [CSE] was." A Councillor

"[is] the 1400 figure based on real girls or an estimate?" A senior politician

"We keep saying 1400 victims. But where are they?" A Councillor

"She [Professor Jay] was wrong about us knowing about [victims of CSE], and wrong about the numbers. I don't know where the 1400 number came from." A Councillor

"I thought it was probably the worst report I had read in my life. It was full of innuendo, supposition, it made statements not based on evidence; it just didn't make sense." A former Councillor

"I do wonder where some of the facts and figures in the Jay report came from. There were people that should have been spoken to and weren't… I don't feel like I've seen anything that showed where that 1400 figure had come from." A Councillor

"The 1400 figure never came to me. The Heal report discussed 50-60, a small percentage of which were CSE." A Councillor

"[I] feel very angry, [the report is] not accurate, balanced… some parts I don't accept." A senior officer

"…the Social Care team didn't recognise the 1400 number…The number of people who were victims or at real risk of CSE was much lower than was being portrayed." An officer

"Only in 2011 did I become aware of CSE as an activity, not even as an issue… the scale has come as a big surprise to me. The figures seem disproportionate with any other town that is actively looking for CSE." A former senior officer

"I had no idea whatsoever of the scale of CSE abuse that had occurred to young children in Rotherham over a period of more than a decade. I was deeply shocked and deeply saddened." Martin Kimber to the Communities and Local Government Select Committee

"While I was Deputy or Chief Constable I had no understanding of the scale and the scope of the problems that have come to light." Meredydd Hughes to the Home Affairs Select Committee

"As I indicated, Ms Blackwood, in 2010 I still was not aware of the scale of abuse that had been taking place." Shaun Wright to the Home Affairs Select Committee
The dispute over the number of victims identified by Professor Jay led Inspectors to review the numbers of victims over the period.

Inspectors first looked at the numbers based on the figures that the Council reported on each year. We found different counting methods and different things being counted. Some years it was clients while in others it was contacts, assessments or referrals. Reporting periods crossed over and there were gaps for other periods. So it was not possible to assess numbers based on RMBCs own records, leaving room for ongoing and further disputes around the number of victims of CSE.

Those denying the figures could not point to any more authoritative figure. Nor could they have done so given the very poor records. The inspection team used three different lists of children's names which had been linked to CSE and where it was reasonable to assume the children had been harmed. The three source documents were:

- A list of children known to Children's Social Care because of CSE from 2001 2013 provided by RMBC to Professor Jay
- A list compiled by South Yorkshire Police who are reviewing historic files for current police investigations
- The list of names known to the council's own CSE service (Risky Business) from 1999 – 2011

We have concluded that the 1400 figure is a conservative one and that RMBC and South Yorkshire Police (where some also dispute the figures) would do better to concentrate on taking effective action rather than seeking to continue a debate about the numbers.

Denial of culpability

Others when asked about CSE in Rotherham appeared to be content to have been in the dark. They thought that colleagues should have been dealing with it, not them.

"Each year the partnership made a decision on what they prioritised and because CSE was being dealt with by the [Local] Children Safeguarding Board, Safer Rotherham's view was that with its governance in that board, and issues being highly confidential, it would not get involved." A senior officer

"*No, you think there are good people getting on with this. Had a lot of time for XX, if they are thinking it's working, then OK. Reliant on people coming to meetings and saying: 'this is what happened.'*" A key partner

Members and officers seemed content to be told that matters of CSE were confidential and there could be no details divulged due to police operations. Inspector found it very surprising that these matters were not questioned. No one seemed even curious enough to ask for an update, let alone ask why, with all these police operations, convictions were not being secured.

"Police always said: we're on it, don't talk about it because we don't want the perpetrators finding out about our operations." A Councillor

"I understood that the area had a problem with CSE but thought that the Council had the right things in place to deal with it." A Councillor

"…but [we] were reassured that Risky Business were working away, and it [CSE] still wasn't my area." A Councillor

"I think we knew that there was a national problem, that there were a few local cases and that the police were investigating." A Councillor

Denial of Child Sexual Exploitation is still an issue

Inspectors were also told that although there used to be a problem, *"we're much better now"*. The former CE, Martin Kimber, stated at the Home Affairs Select Committee and to Inspectors that Professor Jay noted significant improvements in her report.

While it is true that Professor Jay notes recent improvements in Rotherham's services, these are heavily caveated. She cautions that there is an urgent need to improve risk assessment, manage financial and staff pressures and ensure sufficient long-term support for victims.

"There have been many improvements in the last four years by both the Council and the police. The police are now well resourced for CSE and well trained, though prosecutions remain low in number. There is a central team in Children's Social Care which works jointly with the police and deals with child sexual exploitation. This works well but the team struggles to keep pace with the demands of its workload. The Council is facing particular challenges in dealing with increased financial pressures, which inevitably impact on frontline services. The Safeguarding Board has improved its response to child sexual exploitation and holds agencies to account with better systems for file audits and performance reporting. There are still matters for Children's Social Care to address such as good risk assessment, which is absent from too many cases, and there is not enough long-term support for the child victims." [7]

Inspectors judged that this was false optimism by the former CE. It is an example of a wider culture of clinging onto anything positive within RMBC and not facing up to the truth of the situation.

*"But we're [RMBC] one of the best places for education, how did we have that if we we're so c**p? We were just at the place where we were starting to fly."* A former senior officer

"I'm more confident now than ever - lots of work since 2012 we have a multi-agency group - a MASH - we looked at Bradford. We can't compare any national data sets- there are none. I have to be confident about the numbers - 6-10 being abused at any one time." A Councillor

"Historically case-loads had been worse." A Councillor

"There's a feeling of things becoming more positive. They're making progress." A Councillor

Denial – the national spotlight

Like other local authorities, RMBC's services are subject to reviews and inspections and monitoring from OFSTED, the Audit Commission, and Central Government departments and have also been more recently subject to Parliamentary scrutiny.

However, Inspectors found that Rotherham's reaction to this scrutiny is defensive. RMBC is unable to look at itself critically and can put the reputation of Rotherham above actual services. These are patterns of behaviour which go back over time and which are as relevant to CSE as they are to the functioning of Children's Social Care

[7] Alexis Jay OBE, *Independent Inquiry into Child Sexual Exploitation in Rotherham*, p. 2

as a whole and, no doubt, other departments. An analysis of previous inspections and reports on RMBC is contained in Section 2 of this report.

This attitude of denial however was not restricted to inspections and reviews. The media - and in particular Andrew Norfolk, whose articles in *The Times* did much to bring CSE to public attention - also took a lot of criticism.

CSE in Rotherham, in some guise, was covered by *The Times* from 2010. It was on the front page of the Times in 2012 and 2013 on 6 separate occasions:

- 7 June 2012 – second story on front page: 'Officials hid key facts over girl's abuse'
- 24 September 2012 – full front page: 'Police files reveal child protection scandal'
- 25 September 2012 – front page: 'Revelation of child-sex scandal prompts calls for public enquiry'
- 10 June 2013 – second story on front page: 'Child abuse failings must lead to new law, MPs say'
- 23 August 2013 – main story on front page: 'Grooming scandal of child sex town'
- 30 August 2013 – second story on front page: 'Police face inquiries on grooming case failures'

Rather than considering the basis upon which media attention was formed, the Council preferred to assume that all negative attention was politically motivated and unsupported by any genuine evidence or concerns. This attitude was noted in several interviews:

"The accusations in the press appeared to be biased, political accusations from a newspaper – Murdoch press, with little evidence. They had felt that The Times was picking on a Labour authority on the back of Rochdale. There was no sense that it was backed up with concrete evidence." A Councillor

"In response to The Times article in September, she was told that Norfolk had a thing about Pakistani men, and that the story was exaggerated… In the early days the message was that 'Norfolk's got it in for us'." A Councillor

"There were rumours that because it was a national paper, could you really believe what it was saying, etc…? But I wasn't on the scrutiny board where it ought to be discussed." A Councillor

"There was some resistance about the article, I remember there being a discussion about it being a Murdoch press story - not to take it all as read." A Councillor

"Most of the people in Labour group were astonished – thought, it's not true. Is this bloke after some headlines that aren't there? Is it political Murdoch press?" A Councillor

"Andrew Norfolk became involved during the trial for Operation Central…Ian Hislop gave him an award for it but it is only one side of the story and it's ten years old – that's not investigative journalism…he's got his own agendas…" An officer

"Norfolk's a reporter and is aiming to sell stories, and at first I just didn't believe it. It was a shock. But it needed to be done; I don't doubt that it's the truth now." A Councillor

Even if *The Times* articles had been politically motivated (though we found no evidence in the Norfolk coverage) the fact was that Rotherham Council, rather than addressing or investigating the abuse of girls and the suggested failings of the Council and police, preferred to ignore what was being reported and declare it was untrue with no apparent grounds for doing so.

Indeed, in a report about the CSE team in 2012, the Council states*: "[in the] first of the cases referred to in The Times, [the] young person involved [was] given appropriate assessments and counselling along with support by Risky Business."* This reveals extraordinary complacency in the face of very serious allegations. It is also untrue in relation to the victim concerned.

The 'scale and scope' was clear

Inspectors concluded from reviewing previous case files, from undertaking interviews with current and former staff, Members and people who had worked in Rotherham but not for the council, from interviews with police officers and with victims and their families, that the numbers of victims and the type and the extent of the CSE problem was clear to the council.

Many of those raising the problem of CSE with the Council did not do so quietly. There were reports to senior staff, to Members, to Scrutiny committees, to Safeguarding Boards. There were externally commissioned reports about CSE that were not acted upon. Anyone who wanted to know more only had to ask.

Yet when Professor Jay brought forward the undeniable and cohesive facts of CSE in Rotherham, her report was met with denial and challenge. That children had been exploited and abused, that perpetrators had not been brought to justice, that the Council had not been able or willing to protect them was not, with some exceptions, at the forefront of many people's minds.

RMBC had commissioned Professor Jay, provided her with the terms of reference and indeed paid her to undertake her inquiry. But what we found was a case of 'shooting the messenger.' The attitude was 'it's not us at fault, it's her report.'

As we highlight later in this report, RMBC's Audit Committee risk register of September 2014 cited Professor Jay's report as the second highest risk facing the council. It is striking that the risk identified focusses not on the problem of CSE or its victims, but on the potential *for 'major reputation damage and loss of confidence in the borough'* and *'potential impact on inward investment'*.

AN UNHEALTHY CULTURE

Inspection looked at whether there was an unhealthy culture in RMBC amongst both officers and Members. Culture is hard to 'inspect.' However we conducted extensive interviews where we asked about and probed into the relevant issues. Inspectors came away with the impression of a place where some had outdated attitudes. Several people commented to us that going into Rotherham council, despite the impressive new council building, was 'like going back in time'. This is also a matter dealt with in Section 2.

Members

Historically, the political leadership of Rotherham faced little opposition in a solidly Labour town. With limited political challenge, its culture became more embedded and dominant.

Inspectors heard evidence of sexist, bullying or intimidating behaviour, attributed to some of those holding leadership or senior roles. Key figures were often talked about in interviews. Inspectors were mindful that sometimes people try to rewrite history. However, some aspects came across too strongly to have been solely revisionism.

Roger Stone dominated the political scene in Rotherham from 2003 until he stood down after Professor Jay's report in 2014. He declined to be interviewed for this inspection, but provided a personal statement to the inspection team in which he outlined his priorities for Rotherham and his leadership. These included several projects focused on encouraging regeneration.

Many interviewees agreed that his strong and decisive leadership had been very important in driving through change. However, in the same breath, many officers and Councillors reflected that he sometimes shouted and bullied to get what he wanted. The move to what is called a 'strong leader model'[8] served to cement his hold over the Council and '*fitted his personality perfectly'*.
Members and officers said the following:

"The last leader [Roger Stone] was a bully." A former senior officer

"[Roger Stone is] also a bully in my opinion… In Labour group he would impress himself on people, male or female. A lot of women have felt a sense of suppression and macho culture." A Councillor

"What Stone said, went. Everyone was terrified of Stone." A senior officer

[8] This model emerged from the Local Government and Public Involvement in Health Act 2007 and removed the right for smaller local authorities to retain their committee systems meaning that all councils have to be run either by a directly-elected mayor or through a leader and cabinet.

"In council, the biggest culture shock was the level of power Councillors had over senior officers. They would say 'if they say jump, you ask how high'." A key partner

He was clearly an authoritative figure. He would contest that he was determined to drive through the projects that would be good for Rotherham. But that came at a cost.

We were told that he decided what went to the council's cabinet, and that issues came to the Labour group only afterwards and then finally to a scrutiny committee.

"*He didn't want debate.*"" A former Cabinet Member

In addition, Jahangir Akhtar, Deputy Leader from 2011-2014, also featured as a powerful figure in politics in Rotherham. The Labour group in Rotherham votes for the Deputy Leader, and some we interviewed were complimentary about him. However, several other Members, officers and others spoke about him with a level of fear. Some were concerned when speaking to Inspectors that what they said would get back to him. Even though he was no longer on the council, he continues to have a presence and some felt he would be returning.

It was widely known that in 2003, Jahangir Akhtar had been arrested for assault when he and his brother become involved in a fight in a restaurant. He pleaded guilty to affray and was convicted. In 2013, *The Times* ran a front page story about his historic involvement in the handover of a victim of CSE. After this, he 'stepped aside' while the police looked into the matter.

"No one was surprised by the 2013 articles… Nobody was surprised… Nobody was surprised that he got suspended." A senior officer

It appears little debate was had within the Council about whether or not he was a fit and proper person to be a Councillor.

"The whole 'stepping aside' thing seemed a bit of a fudge - it wasn't clear. No special meeting was called. There was a Members' meeting that he was present at…. After [the police investigation]… he just popped back - there was no discussion." A Councillor

The problems with culture in RMBC are however wider and deeper than two former Councillors no matter how prominently they are cited. There was a degree of obvious factionalism both within the Labour group and across the Council and not enough evidence of colleagues pulling together to take a new or fresh approach. Divisions and back-biting were evident despite the serious events that unfolded in Rotherham, not only within the leading group but across the political divide.

Sexism and bullying across the organisation

The problem of sexist and bullying behaviour came up across the organisation not only regarding Members. Throughout the inspection, many female staff past and present reported witnessing or enduring sexist behaviour from senior male colleagues and from Members.

"One Mayor said that in his year of mayoral office it was his right to kiss all the pretty ladies in the office – I remember thinking, 'this is so Rotherham.'" A former senior officer

"There was a crude, macho, sexist thing. It was disappointing that it wasn't challenged by the men I respected. I was told to put up with it." A former senior officer

"I experienced sexism at RMBC, and the choice is either to make a formal complaint and possibly end your career, or find ways to deal with and just get on with it, which is what I have done." An officer

"When Professor Jay's report came out, the one thing that we found funny, that had us in stitches, was the idea that those old bunch of politicians could have a problem with political correctness! Ha ha! They couldn't be further from politically correct. They were bullies, they were sexist." A senior officer

"But I'm feeling that it's more of an issue now than it was before. I'm on the receiving end of it [sexism/bullying] now with the leadership team. Where do you go from that then?" A Councillor

In relation to the former Leader Roger Stone: *"I only went to his office once, and I knew that I wasn't going to get anywhere by raising things with him. It was common knowledge that he wasn't a fan of female Councillors – although he's not against women, he just sees Councillors as being men."* A former senior officer

Partners from outside the organisation also commented upon witnessing senior officers swearing at other officers during meetings and people being told *"you will do that whether you think that's right or not"*. A key partner

This was a culture where bullying and fear of repercussions if you spoke out was not met by any concerted challenge. However, some reported that the culture of shouting and abuse had improved with the arrival of Martin Kimber as Chief Executive in 2009, who attempted to stop people swearing in meetings. Martin Kimber highlighted occasions to Inspectors when he had to press the Leader to

apologise after he had shouted at officers and some interviewees gave him credit for that.

THE 'RACE ISSUE'

"The issue [of CSE perpetrators] was predominately Asian men and they were scared that would cause a problem. We would tell them that in the forums and they were uncomfortable. Stats on ethnicity were taken out of presentations. There was resistance to focusing on who the perpetrators were." A voluntary sector worker

There is a small but established community in Rotherham which is of Pakistani heritage which accounts for around 3% of Rotherham's population. This is referred to as 'PHC' in the Council, standing for Pakistani Heritage Community. Other ethnic minorities, including the Czech and Slovak Roma, in total account for 8% of the population.[9] Inspectors heard evidence from a range of quarters that indicated RMBC struggled historically and into the present day with the issue of race. It seems that with an intention of not being racist, their ways of dealing with race does more harm than good.

"Rotherham isn't a very PC place, I think that is why the Council overcompensated too much. It doesn't want to be accused of being racist. It is known that this happens, perpetrators have been known to say 'I'll use the race card.'" A former officer

Some interviewees talked about a historical context in which RMBC were concerned not to do anything that might be seen as 'offensive' to a minority community.

"We weren't allowed to hold forums near pubs because it might upset the Muslim people…Muslim colleagues thought this was silly…" A former officer

The problem has been that that so called 'political correctness' has cast its shadow over the actions in subsequent years.

"They (the politicians) wanted to use any other word than Asian males. They were terrified of [the impact on] community cohesion." A current officer

"[My] experience of council as it was and is – Asian men very powerful, and the white British are very mindful of racism and frightened of racism allegations so there is no robust challenge. They had massive influence in the town. For example, I know all the backgrounds to the Asian Councillors… but don't know anything about white Members. Not about race only but the power and influence – the family links in those communities are still very strong. Definitely an issue of race." A current officer

Inspectors heard a range of views and thoughts from interviewees about attitudes to race and culture that caused them concern and reinforced the conclusion that the Council could not deal sensibly with the issue. Indeed, some Councillors held racist

[9] Office for National Statistics, Census Data 2011

or wholly outdated or inappropriate views. Many of these views were known about but not challenged.

"The girls, the way they dress, they don't look 14-15 years old, the way they make up – they look more adult. They go into clubs, get served in bars, It's very difficult for me, very modern dress…..They have been fooled definitely [men in Asian Community]. The British Asians. If you have identified so many perpetrators, why have there been so little arrests? They feel British Asians have been hit by Jay." A current Councillor

"They're [people of Pakistani heritage] some of the nicest people you could meet. But there are a dozen rotten apples at the bottom of the barrel, which you have to keep a close watch on." A current Councillor

"It's difficult to ask questions regarding Pakistani heritage." A current Councillor

There was a sense that it was the Pakistani heritage Councillors who alone 'dealt' with that community. Inspectors believe this is inappropriate. It would not of course have reflected Rotherham's equality policy or indeed the 'One Town, One Community' campaign. [10]

There was a view among Members that relations with the Pakistani heritage community needed to be 'brokered' through the Pakistani heritage Councillors.
"I have listened to Mahroof and Shaukat. I'm quite happy to go into an Asian house and deal with issues." A Councillor

There was a sense that Pakistani heritage Members were handed a 'community leader' role by white Councillors who weren't sure or didn't want to deal with the issues around the Pakistani heritage community. They then were able to rescind their responsibility for their constituents as a whole.

"They weren't challenged in their views by other Members because they were seen as the experts on Pakistani heritage issues….." A police officer

The former Deputy Leader, Jahangir Akhtar, was sometimes seen to be able to 'deliver' on difficult issues for the council. Inspectors were told that he had been able to stop young 'Asian' men coming out on the streets when the EDL wanted to march in the town.

"Given the town's problems with the EDL, someone with this kind of reach and influence into the local population was extremely helpful." A former senior officer

[10] 'One Town, One Community' is a campaign with the aim of developing good interfaith relationships.

Pakistani heritage Councillors had and have (whether acquired or taken) a disproportionate influence in the council, particularly on issues which appeared to affect the Pakistani heritage community such as the taxi trade.

"I think what we're probably talking about [is] the disproportionate influence one particular community has, how it punches above its weight and the power these politicians have." A Councillor

Some claimed that Jahangir Akhtar's influence extended to the police:

"There was once a situation where a girl from a Pakistani heritage family went missing, they [Asian Councillors] went straight to the Chief Superintendent and that influenced our operations, they held a lot of power." A police officer

The key matter of concern here for Inspectors is that RMBC's inability to talk about race and the different communities in Rotherham had implications for their approach to dealing with CSE.

In Rotherham, the phenomenon of CSE emerging from the late 1990s onwards concerned a majority of white, female, adolescent or teenage victims and a majority of Pakistani heritage adult male perpetrators. Early concerns raised about CSE by youth workers and others had also repeatedly mentioned taxi drivers.

This predominant involvement of Pakistani heritage men was certainly the view of all those who Inspectors spoke to who had been close to operational work around street grooming and CSE in Rotherham in the previous 15 years. Victims shared this view. Our review of case files and strategy meetings held about perpetrators and victims as well as other information we came across, confirmed that perpetrators were usually described as being Pakistani men. This was a matter of fact.

However the wider culture in Rotherham we have described meant that from the outset the added dimension of the ethnic background of perpetrators was an awkward and uncomfortable truth which, in the view of the inspection team, affected the way that the Council (and the police) dealt with CSE.

"Everyone here will say it's not a race issue, that white people abuse too. That's true, but there is a race issue here." A social worker

"I got my knuckles rapped by [manager] on that occasion for mentioning Asian taxi drivers… she had been told [what I'd said] was controversial and not to mention ethnicity." A youth worker

Staff perceived that there was only a small step between mentioning the ethnicity of perpetrators and being labelled a racist.

"They were running scared of the race issue… There is no doubt that in Rotherham this has been a problem with Pakistani men for years and years… People were scared of being called racist." A former police officer

On the ground, individual professionals felt under pressure. "*We had specific instances where taxis were involved [in CSE]. We tried to follow it up with taxi licensing, but I can't remember how far we got. We were constantly being reminded not to be racist."* A former social worker

Another social worker recalled a strategy meeting about an exploited young person where Pakistani heritage taxi drivers were referred to as *"men of a certain ethnicity, engaged in a particular occupation."*

"If we mentioned Asian taxi drivers we were told we were racist and the young people were seen as prostitutes." A former social worker

"…you couldn't bring up race issues in meetings… or you would be branded a racist." A key partner

"The number one priority was to preserve and enhance the [Pakistani heritage] community – which wasn't an unworthy goal but it wasn't right at the time. It was difficult to stand up in a meeting and say that the perpetrators were from the Pakistani Heritage community and were using the taxi system - even though everyone knew it." A former key partner

Frontline staff were clearly anxious about being branded racist. Whether there was an element of self-censorship or otherwise, the impact of this was clear. The Council was not dealing with a serious problem right before its eyes.

Certainly this was not limited to frontline officers. There was also a clear perception among senior officers that the ethnic dimension of CSE in Rotherham was taboo.
"*They wanted to use any other word than Asian males. They were terrified about [the effect on] community cohesion. I got this sense from overhearing conversations between [senior Member] and [senior officer] ….they were terrified of the BNP."* A former senior officer

The background threat of the BNP (British National Party) or EDL (English Defence League) exploiting the problems in Rotherham for their own divisive ends may have been a rationale for not talking about the 'race issue' openly. But in fact this made it worse. Even if at some point, by some people, this was well intentioned, it has not served any positive purpose at all. It has in effect suppressed a problem that should be dealt with openly and properly.

Staff in Licensing felt that some Councillors made representations on behalf of taxi drivers. Councillor Mahroof Hussain suggested he had done this in his capacity as a ward Councillor owing to the large number of Pakistani heritage drivers in his ward. He states this may have given the impression that he was overly representing the community or the trade and that he would not place undue pressure on officers.

Staff felt that Jahangir Akhtar and Mahroof Hussain suppressed discussion for fear of upsetting community relations.

A police officer who spoke to us about a police operation said:

"We'd be at [community] meetings talking about community issues. When there we discussed targeting taxi drivers and the Pakistani heritage community in relation to CSE, we were even discussing particular families we had concerns about. These members would push back. Neither believed the extent of the problem that we were trying to communicate… They were saying to us 'it will cause a lot of community tension if they are targeted specifically'… We wanted their support…" A police officer

Other Members contributed to this silence:

"*It's difficult to ask questions regarding Pakistani heritage. Never got a response from Stone."* A Councillor

"They weren't challenged in their views by other Members because they were seen as the experts on Pakistani heritage issues…" A police officer

Rotherham's suppression of these uncomfortable issues and its fear of being branded racist has done a disservice to the Pakistani heritage community as well as the wider community. It has prevented discussion and effective action to tackle the problem. This has allowed perpetrators to remain at large, has let victims down, and perversely, has allowed the far right to try and exploit the situation. These may have been unintended consequences but the impact remains the same and reaches into the present day.

"People were afraid that they'd get into trouble if they said something that was perceived as racist….that was probably why the issue had been allowed to escalate so far, and that if someone had had the guts to stand up and say 'I don't care what colour you are, that's a child', then maybe they could have dealt with it." A police officer

THE ROLE OF RISKY BUSINESS IN TACKLING CSE IN ROTHERHAM

Rotherham's history of tackling CSE has been closely tied into Risky Business. This was a small youth project established in 1997 in response to what was then called 'child prostitution'. The approach that Risky Business took – in reaching out to victims and in collecting evidence about perpetrators – was ground breaking.

In Rotherham, a group of like-minded professionals came together (some of whom still work for RMBC) raising concerns about 'child prostitution', as CSE was then known, and wanting to take action.

Based in youth services in the council, Risky Business provided outreach work to girls and young women who would not naturally approach services for help. They provided training and undertook preventative work by talking to children about the risks and how to keep safe. The scale of their work depended on their funding but it was always small, if not 'shoestring', consisting of around 4 to 5 full-time employees at its height.

Around the same time, Irene Iverson established an organisation called Campaign for the Removal of Pimping (CROP), now Parents Against Child Exploitation (PACE). It was designed to support parents whose children had become involved in 'child prostitution' and a campaign to get authorities to take action against perpetrators. Irene's daughter Fiona had been murdered in Doncaster. Irene always held two people responsible for her daughter's death: not just her murderer, but also the pimp who groomed her daughter.

In 2001, CROP and Risky Business received Home Office funding to undertake research on supporting the victims of CSE and collecting intelligence about perpetrators to secure convictions. The project also developed training and support for specialist foster carers, introduced a 'stay-safe' scheme to protect victims and families from perpetrators at home, and developed the use of legal notices under the Child Abduction Act 1984.

Risky Business developed a picture of CSE in Rotherham. Girls they supported gave the staff information about where CSE took place and the people involved, including their names or nicknames, the cars they drove, their friends, phone numbers and involvement in drug dealing. Staff began to keep files on both the victims and the perpetrators.

But while they could collect information and support victims, they did not have the powers to tackle perpetrators or give the victims all the help they needed.
They needed social workers to intervene to protect the vulnerable girls. They needed the Council to make the known 'hotspots' safer. They needed the police to tackle the perpetrators.

Staff at Risky Business constantly and relentlessly shared what they knew with all these colleagues. They produced maps which showed the places CSE was happening, wrote reports on the victims involved, and drew on national evidence to draw attention to what was happening in Rotherham. They met with social workers and police to pass on relevant information about individual cases, particularly through a 'key players' group, and later the Sexual Exploitation Forum. In 2004 and 2005, presentations were made to senior officers in the Council and to Members to draw their attention to what was happening. By 2006, their work was informing a council-wide action plan on CSE, and Risky Business was expanded.

Risky Business was critical to the success of Operation Central, a joint operation between police and RMBC which ran between 2008 and 2010, and led to the conviction of five men for offences including rape and other sexual offences with children[11]. A 'lessons learned' report produced after this operation praised the role that Risky Business had played. The report noted that there were increased expectations on an already overstretched service and that an expanded multi agency service should be formed around Risky Business.

Operation Czar which followed swiftly on from Operation Central was run very differently. A choice was made that Children's Social Care would take the lead in working with the victims not Risky Business. The outcome was that the girls involved would not give evidence and the operation was unsuccessful. Following this, the murder of Child S and the subsequent Serious Case Review[12] also had a significant impact on Risky Business and therefore the treatment of victims and action on CSE. This is dealt with elsewhere but the result was the closure of the Risky Business service.

In 2011, Risky Business was moved fully into Children's Social Care with the apparent intention of bringing social workers into the project and creating a co-located, multi-agency 'CSE' team. However, instead of adding to the team, the social workers replaced the youth workers. The philosophy and approach behind the work no longer reflected the youth work model which had been so successful in supporting victims and in gathering information. The CSE team became an amalgamation of separate services, located in the same place, but not integrated. There is no longer effective, assertive outreach provision. The database of perpetrators was removed and given to the police.

[11] Further detail of joint police operations is described later in this section.
[12] Further detail of the Serious Case Review is described in Section 2 and Annex A.

The strengths of Risky Business

Inspectors identified three particular functions of Risky Business which seemed to be essential to an effective CSE team:

- They **collected information** about the victims and the perpetrators and through this, had a clear picture of CSE in Rotherham. This was not police intelligence but information passed on by victims. They were the only organisation who systematically collected this information. It was regularly passed on to police and council staff.

  A former Police District Commander in Rotherham reflected to Inspectors that intelligence and information is imperfect, and that police couldn't always look for clarity from people with complicated lives. They had learned from Risky Business the need to deal with soft intelligence, rumour and concerns. In the past the police looked for solid, actionable evidence, rather than fragments that could be pieced together. He felt that if he had relied on the police systems, let alone the Council ones, to feed him information, Operation Central probably wouldn't have taken place. In that sense, he said, engagement with Risky Business was a 'game-changer.'

- They **developed relationships with the victims**. The trust they developed meant that the girls involved would talk to Risky Business staff, and staff in turn encouraged them to talk to the police and Children's Social Care who had the powers to protect them. These relationships were vital to the success of Operation Central.

- They took a **proactive approach to finding victims**. The girls involved in CSE were girls who are traditionally labelled 'hard to reach.' These are not girls who would approach public services looking for help. Risky Business staff were prepared to go out and find them.

"What was happening with the girls was too complex, they were so at risk. Lots were actually being abused. We were a youth project, we weren't a child protection project. That was social care's responsibility. Our responsibility was to work with them, not to do their job. Risky Business built great relationships with the girls. That was their job. And they referred the girls, they always followed procedure in that sense. But straight away, we were having issues with getting things done once the information had been passed on. It was about ignorance and lack of awareness of the issues. Resources were an issue: there was a focus on children rather than teenagers. The girls weren't easy to deal with. They were resource intensive. They were expensive. For a long time, there was denial. There was a lot of: 'Who are you? You're Youth Workers, that's not your job' and also, there was an issue with

managers, with higher-up police. You couldn't talk to them. You couldn't convey information to them." A current officer

But the strengths of Risky Business were actually considered weaknesses within RMBC. The contribution that the youth workers made was not properly appreciated or valued. They were not accorded the professional respect given to social workers. Too often, the information they gleaned was ignored and not acted upon. They spoke uncomfortable truths that no-one wanted to hear.

Risky Business and those that established it, supported it and worked alongside it had, in the course of a decade, gone from a progressive and innovative project to one that was marginalised, reshaped and eventually closed down.
The critical work they undertook is now missing from RMBC.

The uncomfortable truth of CSE

The demise of Risky Business reflects the ambivalent attitude towards tackling CSE within the council. On the one hand, the Council wanted to be considered as a national leader on the issue. To that end, RMBC held conferences, delivered presentations at national and regional forums, and entered for awards. Yet on the other hand, they refused to look at what was really happening in the area and acknowledge either the nature or the scale of what was going on.

The inspection team identified occasions over the years where there were real opportunities to broaden and deepen the understanding of CSE but these opportunities were not only missed but closed down. Inspectors identified an ongoing imperative to suppress, keep quiet or cover up issues relating to CSE which stretched across the years.

This was a constant refrain from a wide variety of voices, including serving officers, former staff, voluntary sector employees, police officers and Members:

"There was an attitude at the time of wanting to deal with CSE, but there was a general feeling it was best done without publicity, so there would be no 'bad' publicity to Rotherham." A former senior officer

"x didn't want (the) town to become the child abuse capital of the north. They didn't want riots." A senior officer

As far back as 2001, a headmaster wrote to parents asking them to take notice of the issue of CSE. This made national newspapers and witnesses said that he had 'got in trouble for it'.

A publicity campaign to raise awareness of CSE among people in Rotherham has consistently been part of RMBC's action plan to tackle CSE since 2006. It has never taken place.

"*We put things to them, ideas for campaigns, but they were never allowed. I remember in 2006/7, a campaign we proposed, they wouldn't let us do it. They wanted to give a certain impression (of Rotherham)".* A current officer

Having invited parents of victims onto the Local Safeguarding Children Board (LSCB) Members found it difficult to 'manage' them and politely asked them to leave.

"I got a phone call from him 'I think we need a chat, let's just call it a one to one.' I thought it was to see how things were going. He told me to move on. He said, 'we think you're rocking the boat.' I did a resignation letter about a fortnight later." A Father of a victim

CHILDREN'S SOCIAL CARE FAILURE

Children's Social Care in RMBC seemed to misunderstand CSE. From very early on there was an unhealthy tension between the 'social care' aspects of helping children at risk of or experiencing CSE and that of a youth or community services approach. There are often tensions between statutory Children's Social Care and youth services. They have different roles to play and different responsibilities. In RMBC however, the tension got in the way of looking after children.

The context is that, of course, Children's Social Care has an important role in tackling CSE. As corporate parents for children in their care and as the safety net for the most vulnerable children they have statutory duties to protect children, to remove them when they are not safe - including from their parents - and powers to provide services to promote their well-being. Child protection work is framed within the context of intra-familial abuse, or neglect of younger children or protection from for example, domestic violence. Their expertise, procedures, systems and resources tend to reflect that family context.

CSE presents a different kind of picture, which necessarily involves different specialisms and expertise. The children are older. They are often seen as 'uncooperative' or 'difficult' or 'hard to engage'. The process of grooming and exploiting a child does not sit easily against an assessment process geared towards protecting a young child in a family abuse situation.

Children's Social Care did not have the monopoly on understanding how best to tackle this form of child abuse. But this was something that they either did not recognise or could not accept. Children's Social Care services operated in a straitjacket of assessments and thresholds which they were determined to fit CSE into.

Inspectors were told of attitudes such as:

"[The] message was that teenagers can run away and babies can't." An officer

"There was an attitude that we had to protect the younger children first as they were more vulnerable, and teenagers should be able to make their own decisions. And there was an element of they are choosing to do this, getting into cars in the evening." A former officer

We also heard, as Professor Jay highlighted in her report, that abuse and neglect of babies and younger children takes up a much higher proportion of Children's Services caseload.

'I know grooming goes on, and that there are gangs of males involved, but it seemed to be an overreaction as most abuse happens within the home. It's about percentage too. If 1400 have been abused by Asian gangs, what's that as a percentage of those who've been abused in their home? I worried that we'd be taking our eyes off the latter to focus on the former." A Councillor

These attitudes and views survive into the present day and are dealt with in more detail in Section 2 of this report.

Cases of CSE were not seen as a priority and they were also considered high cost. If girls needed to be accommodated for their protection, placed out of area or in some cases in secure units, this was seen as a strain on budgets. In particular, where girls were trying to get away or return to abusers, so becoming more vulnerable, these placements would not be seen as a good use of resources.

Over the years, Rotherham's children social care budget was often overspent and there was a significant pressure to keep the budget down. Financial pressures should always be considered, but the issue for Inspectors was whether there was evidence that decisions about children's safety were unduly affected by financial decisions.

We heard and saw examples of frontline social workers saying that out of area placements would not be sanctioned due to costs. Over the years, and particularly around 2009 and 2010, reports highlighted the significant costs of helping these girls. Whilst the Council invested in Children's Services in recent years, it has not properly used CSE data to ensure their resources are adequate to meet their legal duties to victims and those at risk of harm.

For girls who were involved in one of the few police operations, early strategy meetings made it clear that *"'The allocation of resources by both the police and social care will depend on the demands and progress of the investigation; the situation will be monitored. Resources are dependent on the young people giving best evidence interviews."*

The lack of understanding of CSE in Children's Social Care meant they got the law wrong, and they got the practice wrong. Inspectors judged that this constrained their ability to help these children.

There was a professional jealousy of youth services by social care which was very clear to the Inspection team. This attitude persisted despite the obvious contrast between the power and size of children social care as opposed to a small team of youth workers.

"The social care line was that these were non-social workers who didn't know what they were doing." A former senior officer

"She [social care manager] was the professional, they were the statutory service, who knew what they doing and we were just youth workers…. That attitude is not uncommon, but is not generally seen to this extent. The roles are different, there are tensions - and that's not always inappropriate - but not to this extreme. My relations with [social care manager] and [social care manager] were very frosty". A former youth service manager

"There was professional snobbery….. I was advocating for a young woman at a meeting and I was just shut up, I was told that I could sit in the meeting but that I wasn't allowed to participate. That's how you were treated." A youth worker

The issue of professional boundaries was reinforced by a lack of understanding – deliberate or otherwise – about the type of information gathered and held about the girls and the perpetrators. The information that Risky Business had was deemed 'not good enough' by both social care and the police. Information they passed on was often discredited.

"We spent months gathering information… This was in response to the message from Social Care, that we were making things up, that the problem wasn't as bad as we were saying… Risky Business used to record every detail we got from the girls! We referred them all." A youth worker

"I've sat in a meeting with police where they've said, 'we need to stop making stories sound worse than they are'." A youth worker

'the way in which [RB] collate and share information…. is very much embedded in their status as youth workers and the approach they take to sexual exploitation is similar to that they would take in incidents of anti-social behaviour or the setting up of a youth club. That is by over time mapping out networks of young people and identifying their needs and perceptions. Whilst this will fit with the intelligence gathering model of the police it may not necessarily fit so well with the social care model of thresholds and priorities.' Serious Case Review into the death of Child S

The value of the relationships Risky Business staff had with the girls was discredited by social care and the police. It seemed to Inspectors that this attitude betrayed a real undervaluing of the relationships the project had developed with the girls who were at risk of or were involved in CSE and, by extension, a real undervaluing of the girls and their experience and the information they were providing. Staff were discredited in both professional and personal terms.

'This is the type of report I would expect from a student or newly qualified worker. It places the writer at the heart of 'saving' the [young people] where all others have failed. It shows v limited understanding of the complexity of psychological damage associated with long term abuse, and takes at face value what the young person says without considering the psychological overlay.' RMBC comment written on Risky Business report

WHERE WERE THE POLICE?

How the police dealt with CSE in Rotherham over the years was not explicitly part of Inspectors' remit. However, it was not possible to review what had happened in Rotherham without also considering the police's role.

For every victim, there is a perpetrator or multiple perpetrators for which the police are responsible, particularly given the very serious crimes being committed. The police are a significant part of the response that should have been expected in relation to CSE in Rotherham.

The police were a constant presence in the development of services tackling CSE. Police staff were present at the early 'Key Players' meetings, at the Sexual Exploitation Forum and at strategy meetings about individual girls and in relation to perpetrators. From 2002, there was a police officer who had a particular focus on sexual exploitation. The police are also represented on the Rotherham Local Safeguarding Children Board (RLSCB) and would therefore be party to information reported in to them. They also participate in the Safer Rotherham Partnership which received information about CSE.

Police would also have had access to intelligence reports on CSE in Rotherham, including, from very early on reports by Dr Angie Heal, a police analyst based at South Yorkshire Police. She noted the connections between drugs and sexual exploitation in Rotherham. As well as two significant reports in 2003 and 2006, she also produced six-monthly updates. This should have put the police ahead of the game.

But between 1997 and 2013 – the period covered by Professor Jay – there were five convictions of men sexually exploiting girls and young women. In 2007, a man was also successfully prosecuted and convicted of offences against 10 boys, with 70 alleged victims identified.

The phenomenally low conviction rate came despite 'ongoing police operations' appearing as a continual theme in discussion of CSE at RMBC.

"…the message from the police was 'we're doing all we can, leave it to us, hold fire, we're working on it'. There didn't seem to be anything ulterior." A current Councillor

"Police always said: we're on to it, don't talk about it because we don't want the perpetrators finding out about our operations...they asked for things, and they were told that it was a need to know basis." A current Councillor

"[Director] stated that there were a number of ongoing cases with the police, who are wary not to give away evidence on live issues…..this operation has been going on

for a long time, but officers may not have wanted to speak… for fear of blowing the operation's cover." A current senior officer

Inspectors were left wondering what these ongoing investigations amounted to. Because, from where victims and some organisations working with them stood, there seemed to be lawlessness in relation to CSE in Rotherham. Perpetrators seemed to face no consequences. Nor were their activities disrupted. Where perpetrators are not tackled, they are likely to become emboldened and become more extreme in their behaviour.

In one victim's account, a police officer told her: *"Nothing good will come of it. I've seen your files. You lied about that man all those years ago."* He then pulled the police car over and persuaded her to drop the charges against a perpetrator. After ripping up some paperwork, he dropped her off at a restaurant where girls, including victims of CSE, and suspected perpetrators used to gather.

Inspectors wondered if some of this inaction was rooted in the attitudes of some South Yorkshire Police officers to the victims. They did not seem to believe the girls or their families or those who reported problems. They did not treat them as victims.
"The girls were blamed for a lot of what happened. It's unbelievable and key to why it wasn't taken seriously as an issue." A police officer

"There was no awareness. The view was that they were little slags." A key partner

"They didn't understand the situation, and thought that the girls were happy, or complicit in it. The sense was that if there had been any offence it had been by the girls, for luring the men in." A key partner

There were numerous occasions in which girls were not believed. They were threatened with wasting police time, they were told they had consented to sex and, on occasion, they were arrested at the scene of a crime, rather than the perpetrators.

Police did not understand the terror which many victims lived in and their consequent fear of testifying and their anxiety over whether police could protect them. Some of the crimes we were made aware of included rape with a broken bottle and girls being ordered to kiss perpetrators' feet at gun point.

"[X] was terrified when she was in the hostel. She got a text saying that if she didn't come out they'd shoot her. We called the police… Kids [staying at this hostel] are always seen as naughty kids and you could sense it as the police were coming in, 'oh, here we go again'. They said, 'well why doesn't she just switch her phone off?' I said if she switches her phone she's going to be in massive trouble. There was no understanding of the danger they were in. They were also saying, 'right then, what's the number we'll ring them.' I said 'No way, she'll be killed!' " A key partner

Police failed to act on information given to them by victims and by Risky Business, by parents and by schools and even by their own police intelligence. Risky Business passed on all their information but were invariably told it was not good enough and that it was information and not intelligence. When police actually looked at the information that attitude changed, as evidenced by the successful police work that went on around Operation Central.

"[Risky Business] produced good information. It wasn't [their] job to turn it into intelligence, that's the police's job. …. Out of the information, our analyst was able to create a huge chart about the perpetrators". A police officer

There was an absolute reliance on children to give evidence or cases did not proceed (Abduction notices were served on perpetrators if girls did not give evidence).[13] In the view of the Inspectors, this placed an enormous, often impossible, burden on fragile and vulnerable children who believed that these men were all powerful. They believed that they could not be protected. Some of the police actions suggested they were right.

From what Inspectors saw, South Yorkshire Police:

- did not use alternative ways to gather evidence
- did not use alternative strategies to protect victims
- did not make use of other tools and powers available to them
- did not work effectively with either the community safety or licensing arms of the Council to develop strategies for tackling perpetrators

These are failures which continue to date and we address these in section 2 of this report.

Even when evidence and intelligence was available, police did not follow this through. For example, while five men were convicted of offences through Operation Central, Inspectors established that this was just the tip of the iceberg. Around 80 perpetrators were identified through the intelligence and mapping of perpetrators carried out for the operation. One police officer told us that he came under pressure to hand the case on:

"….I think as a police service we could have done a better job. I remember having a conversation with someone and I said, 'what about everyone else on that chart?' I was told, 'we've got to cut it off somewhere'."

[13] Abduction Notices are covered in Section 2 of this report, under Policing.

"From a policing point of view, back then if a girl said I'm not taking a complaint forward then that would be the end of it… Back then we wouldn't go look for crime."
A police officer

Inspectors felt this summed it up.

Operation central and Operation Czar – Lessons learned

Inspectors reviewed two operations in relation to CSE. We looked at social care and CSE strategy files and spoke to a range of individuals including parents, school safeguarding officers, former Risky Business staff and police and social care staff to understand what occurred.

Operation Central

Operation Central led to the conviction of five men for rape and other offences In November 2010.

In 2008, safeguarding officers at Clifton Park School alerted Children's Social Care about one of their pupils. She gave them information about men she was seeing and threats she was receiving and named other victims.

Files reveal that the four children who eventually gave statements to the police had been known to Children's Social Care for a long period. All were vulnerable girls with troubled backgrounds. The girls were being targeted by different men and being sexually and physically assaulted, threatened and abused. (Strategy meeting files also indicated that 10 to 15 other girls were also discussed as likely victims).

Information provided by Risky Business to the police enabled a police analyst to establish links between victims and perpetrators to help the police construct the case. There were enormous hurdles to overcome before arrests could be undertaken. For example, the girls only knew the men through nicknames and the police had to check 500 phone numbers as part of the process. The children were moved out of the area to protect them from threats. Risky Business provided ongoing victim support in the difficult build up to court proceedings, to help the girls stick with the process.

Nine months after the first disclosure, eight men were arrested. Charges included rape and unlawful sexual activity with girls aged 13 to 15. Exemplary work had been done by the Crown Prosecution Service, the police, Risky Business and Children's Social Care staff to support the girls in the eighteen months before trial. This trial

lasted two and a half months and was extremely traumatic for the girls owing to relentless cross-examination by eight barristers. For example, the girl whose first disclosure had led to Operation Central had to attend court for seven days running. Understandably this caused her a great deal of distress.

Ultimately, the jury found one of the defendants guilty of rape, and others found guilty of sexual activity with a child. They received sentence of 32 years in total. Three other men who had been charged were cleared of all charges.

Operation Czar

As Operation Central was drawing towards a close, Operation Czar was starting up.

A review of social care strategy meetings on CSE reveal that throughout 2008 and 2009, multiple meetings were being held discussing 18 girls linked to one Asian male perpetrator and up to three other males. Intelligence on perpetrators came from information derived from Risky Business and a Safer Neighbourhood Team. In December 2009 the police confirmed that they had created Operation Czar.

The sexual and physical violence being perpetrated on the girls involved was extremely shocking. At one stage a girl had a gun put to her head.

File notes state: *"the identified males are assessed as predatory violent and demonstrating that they are prepared to bribe and intimidate victims/witnesses.'*

At the outset, it was felt that Risky Business should have undertaken the victim support work, as they had done so successfully during Operation Central. Many of the victims had been working with Risky Business for some time and had established relationships with staff. However, meeting minutes reveal that it was then decided that Risky Business would not be part of the joint investigation team. Instead, Children's Social Care decided to set up a team of three social workers to support the 18 victims to 'provide consistency.' The manager of this team also had to continue her existing responsibilities, so was stretched very thin. Risky Business were 'taken off the case' and it was decided to place those most at risk in care. This was done without developing a trusting relationship or preparing the girls for what would happen.

As a result, the message went round that 'if you speak to the police, they'll take you into care.' The girls then refused to give statements.

The operation was closed down just weeks after it had been set up. By March, police resources were withdrawn.

Analysis of the operations

Inspectors judged that Operation Central illustrated what can be done when the specialisms and expertise of different agencies and services are recognised and harnessed to support victims.

The police and Risky Business worked closely together on the two vital aspects – the relationship with the victims and based on that, the wider picture of the case. These were vital to the success of the investigation.

"[Risky Business] brought me a huge amount of information to look at - it wasn't intelligence but there was lots of information. When you read the stuff you became horrified. Clifton Park was half a mile from our office but if people didn't know what to look for they would walk straight past it."

"...The lucky break with Central was that we were able to build a relationship. [Risky Business] was really helpful, everyone contributed and we built the rapport with the girls. I got a call [one day] from [them] saying '[victim 1] wants to talk to you' and it snowballed from there."

Following the arrests (but before the trial) a Lessons Learned review was commissioned by the Local Safeguarding Children Board (LSCB).

The review identified the role of Risky Business: '*what RB has achieved is significant competence in specialist high profile and complex CSE work'.*

It also emphasised however that Risky Business could not and should not be the answer to everything to do with CSE. Therefore, Risky Business needed to be part of a multi-agency setting which ensured that '*the traditions of supportive youth work be sustained.'*

However, rather than following the approach adopted in Operation Central, and building on the Lessons Learned review, social care staff took the different and totally ineffective approach outlined earlier. The Lessons Learned report was ignored and the available expertise was disregarded.

It was suggested that professional jealousy between Children's Social Care and youth services which shaped the attitudes to Risky Business lay beneath this extraordinary change of strategy. Whatever the motivation, this action led to the early collapse of the case involving very dangerous and predatory men. A case which was expected to be bigger than Operation Central was thus doomed to fail before it had even got off the ground.

Inspectors did not see evidence of action being taken against the perpetrators in the absence of ‘best evidence’ interviews from victims. Inspectors found no evidence that any meetings were held to discuss why the operation had failed. Nor was a Serious Case Review undertaken as would have been expected. No review of Operation Czar was held, and there are no records of any discussions taking place over whether a review was needed.

WHERE WERE THE REST OF THE COUNCIL?

RMBC also let down victims. Inspectors saw little evidence that RMBC actually challenged their police partners about the lack of prosecutions, or followed up what was happening with 'ongoing investigations'. Nor was there evidence that they had raised the undoubted difficulties around getting CSE cases into court with the Crown Prosecution Service.

Tackling CSE is a community safety issue. Street grooming was happening in the community of which RMBC is the custodian including parks, takeaways, taxis, at the Interchange[14], in hotels, in houses, in alleyways and in the town centre. These are all areas where the local authority has a presence and has powers and responsibilities which could have contributed towards disrupting perpetrators and protecting victims, such as injunctions and powers to tackle nuisance behaviour.[15]

These powers were not mobilised. Instead, it seems the Council accepted the police assurances that they were undertaking investigations and left Children's Social Care and Youth Services to deal with CSE. This was an abdication of duty as neither social care nor Risky Business had the powers, skills or resource to disrupt perpetrators.

In Inspectors' view, the Safer Rotherham Partnership and the Community Safety Division of RMBC should have taken a much more proactive role in prevention, disruption and enforcement action against perpetrators.

In 2005, the Leader of the Council called on the community safety partnership to make tackling CSE a priority for the next three years. There is no evidence that this was taken forward. Indeed CSE does not feature in the board minutes until 2008, even after receiving the police and local authority priority reports (Joint Strategic Intelligence Assessments) which highlighted CSE as an issue from 2007.

The Partnership's Joint Action Group minutes in August 2011 note that an Action Plan from a Sexual Exploitation Group would be presented at future meetings. This was deferred three times over a six month period before a detailed discussion took place.

This corporate failure extends to taxi licensing and enforcement who failed to use their powers to tackle links between CSE and the taxi trade. Inspectors found the licensing and enforcement sides of the taxi regulation service to be unable or indeed uninterested in gripping the issue and using their powers to good effect.

[14] A bus station located in Rotherham's town centre.
[15] This issue is addressed further in Section 2 of this report.

Furthermore, the Council failed to make use of the information it had in front of it which could have been used to support concerted action against perpetrators and CSE activity. Information on CSE hotspots, on businesses of concern, on suspected perpetrators and on the links between them were all available within the Council on Risky Business's information database. There was also information about perpetrators and CSE in social care case meetings held under their procedures. This information appears not to have stepped out of the files and gone any further within the Council. The database was closed and handed over to the police in 2011/2 when Risky Business became part of social care over concerns about its compliance with 'data protection laws'. This information could have been valuable in tackling and disrupting perpetrators.

Inspectors found this to be an abdication of RMBC's duty to victims.

TREATMENT OF VICTIMS

"*It's almost as if they were second class citizens...The girls were blamed a lot for what happened. It's unbelievable and key as to why it wasn't taken seriously as an issue."* A former police officer

The treatment of victims of exploitation by the authorities in Rotherham has been historically poor in the extreme. In particular, their treatment by South Yorkshire Police and the various professionals that work in Children's Social Care has meant that they have been failed in many ways. Ultimately, they have not been given the attention, help and protection they deserved, and perpetrators have been left to flourish.

Victims who bravely spoke to Inspectors alerted us to the irrevocable harm that has been caused. They still carry what happened to them and are still suffering trauma. In many of the historic cases we reviewed, girls had ended up having babies at a very young age, some made pregnant by a perpetrator of CSE. These were children having children who they unsurprisingly struggled to care for, although some have managed well despite the odds. Many of their own children were taken into care or were the subject of child protection measures. Many victims entered violent and exploitative relationships as adults. Many suffered poor mental health and addiction.

Their experiences of exploitation and abuse need to be seen in the context of their already troubled backgrounds. Many had suffered neglect and abuse within the home.

Children's Social Care attitude to victims:

The attitudes of Children's Social Care towards the victims of CSE and consequently the treatment of them over the years betrays a failure to adapt services according to the nature of CSE, a disinclination to learn from past experience and a concerning tendency to blame the victims for the abuse they had experienced. This report covers current practice elsewhere.

Inspectors reviewed case files and carried out interviews with victims, the parents of victims and the professionals working with those who had been sexually exploited as children. Our aim was to understand what had happened to the girls and see how they had been treated by services at the time.

A number of similar issues and themes emerged from the evidence in the files, which point toward overall service failure:

- There was either no understanding of the law or a failure to apply it to the children being abused;

- There was no recognition of what CSE was, and how and why they should intervene;
- There was huge inertia in dealing with cases which were left to drift for too long, allowing the problems to escalate. When services did intervene, it was often too little too late;
- Social care thresholds were too high so that children were not getting help when they needed it. As a result their vulnerability and increased risk was not recognised;
- There was a normalisation of pregnancies, miscarriages and terminations in children under 16;
- The victims were themselves criminalised. There was no understanding that their difficult and challenging behaviour was a manifestation of the exploitation;
- Perpetrators were not pursued. Often they were believed over victims and their families;
- There was no understanding of the level of intimidation victims were experiencing and neither was this accounted for by professionals;
- Overall, there was inadequate recording in case files with no chronologies and no case summaries.

"…they dumped her there, she has no money, no food and no one from social care had been in touch' hostel in red light district, all adult women hostel, no staff at weekends or evenings, no money, no food, no support." A former officer

'Child 3, aged 13, was found by the police at 3am…in a semi-derelict house alone with a large group of adult males. She was drunk, the result of having been supplied with alcohol, and there was evidence that her clothing had been disrupted. She alone was arrested for a public order offence, detained, prosecuted, appeared before the Youth Court and received a Referral Order for which the YOT arranged 'reparation', drug and alcohol counselling, art psychotherapy and victim awareness sessions.' Lessons Learned review following Operation Central

"Don't worry- you aren't the first girl to be raped by XX and you won't be the last." A police officer to a victim

"I'll never understand why they didn't try and have a conversation with us to find out why we were dropping the charges." A father of a victim

"I was told the next day by social services what had happened and I asked 'why are you not following up' they said 'that's for the police'. They [police] said 'You need to liaise with social services… There has been no mediation or support package from social services, it has been forgotten and the care plans have nothing for the future." A parent of a victim

The Law

The age of consent is 16.

A child under 13 does not, under any circumstances, have legal capacity to consent to any form of sexual activity. Penetration of any kind would amount to rape which is punishable by up to life imprisonment.

Any sexual activity with a consenting child under the age of 16 is unlawful.

It is an offence for an adult to communicate with a child and arrange to meet them with an intention to commit a sexual offence against them, either at that meeting or at a subsequent meeting. The offence is committed when the adult meets the child or travels with the intention of meeting the child, or arranges to meet the child, or the child travels with the intention of meeting the adult.

It is an offence to arrange or facilitate sexual activity with a child under 16.

The law is clear on what constitutes unlawful behaviour with a child but this was not reflected in the attitude shown by Children's Services or the police in Rotherham.

The following is taken from a case file of a child who was being groomed and abused: K was only 13 years old yet the excerpts from her social care files plainly show that professionals did not see her as a child and neither did they see her wholly as a victim:

'K has willingly gone with N, M and unnamed man in their car to a flat in XXX. She has admitted use of alcohol and drugs and to have consented to sexual activity...'

'... K gave information about N, M and Z who drove them around and taking her to a flat in X. N put her in a bedroom and made her give blow jobs to about 5 men sending one in at a time.'

'... K presents as knowledgeable and aware of what she is doing, however, she has problems sticking to her resolutions when offered the excitement... I suggest she needs more appropriate friends and interests to fill her time.'

A section 47 report (an investigation when a child is considered at risk of harm) was written which put the responsibility for K's behaviour fairly and squarely with her.
There was no reference to her age and or that the sexual abuse was unlawful let alone any understanding of grooming or sexual exploitation. It was clear that from this victim's care files that there were repeated attempts by the family to get

protection and support for their daughter. Yet the documentation shows that the social worker assessed that there was no statutory role for social services. Between September 2003 and May 2004 the social worker made five home visits. No support was offered. In the end her family ended up moving overseas to escape the perpetrators.

The files Inspectors looked at made grim reading:

U is 15 and her case is referred from a Children's Centre following concerns that young person is at risk of CSE. It is reported there is a constant stream of older Asian men coming to the house. Her sister has a history of CSE, her mother has a history of domestic violence and her father is in prison. The young person is not attending school regularly. A youth worker completes a CSE Risk Assessment and rates her as low risk. The file note states that targeted family support work will be offered when it becomes available. There is no strategy meeting, no multi-agency discussion despite history and current risks. No support is being offered.

H discloses to her Learning Mentor that she has been assaulted by adult male and is having sex with another adult male. Mother told to ensure all children are safe and not allowed out. H is 13.

M had a termination at the age of 14 and was pregnant again at 15. She was removed from her parents to protect her and yet was allowed by her foster carer to continue the relationship with the perpetrator, even permitting him to accompany her on holiday. There was nothing on the file to suggest that the young person may continue to be at risk of suffering significant harm. Removing her from her family did not afford her better protection and in fact enabled the perpetrator greater access,

K is 18 and exceptionally vulnerable. Concerns are reported that K has gone to Oldham with 2 men known to be involved with sexual exploitation. Leaving care services do not follow through. She is not reported missing and her whereabouts are unknown.

G's parents need help to protect their daughter from CSE. They inform agencies of the circumstances, which include allegations of multiple rapes and threats of violence. They desperately want support and advice. They are told by social care that there was nothing they could do and that she had consented to sexual activity. G is 14.

I is identified as vulnerable and is known to be sexually exploited along with other girls. She is deemed high risk by police. As she has recently turned 17 she is placed by social care in a hostel in a red light district in Sheffield. She remains there

throughout the Christmas period despite police concerns. Social care say nothing can be done until the new year.

Lack of swift action to protect children and pursue perpetrators

The following case involves three sisters, X, Y and Z, and is taken from their social care files. This case exemplifies the failings of both the police and statutory agencies to take swift and decisive action against known perpetrators of CSE against vulnerable young girls. These agencies failed to protect those children despite pleas from their parents.

Case of X, Y and Z sisters, aged 14,15 and 17

X Y and Z are frequently missing from home and drinking heavily. They are behaving badly at home and in school. They are frequently in the company of older males and females.

Rotherham social care decided that X and Y were children in need of a child protection plan under the category of sexual abuse. A key worker was allocated to them in August 2009.

A day later threats were made to kill X by one of the perpetrators. The police interviewed X but did not act. Workers from Risky Business argued that X should be placed in care out of the area given the seriousness of the threats. Instead X was placed voluntarily in a local facility.

A parenting worker for the family states*: 'I have expressed...deep concerns about the safety of both these children. I have asked again why they are not being placed in care out of area. I have been told that it was down to money - no surprises really, but just not acceptable.*'

Y goes missing again in September. When she returns, the parenting worker is there. She asks the police to conduct a 'return to home' interview with Y and serve an abduction notice on the men she has been with. The police refuse, stating it would all be logged as 'intelligence'.

In the meantime, social care senior managers learn that the children's parents have told their MP that not enough is being done to protect their children.

At the end of September 2009 a strategy meeting is held. X is assessed at being at a very high level of risk and Y is assessed as having *'...been successfully groomed for sexual exploitation purposes'.* 10 other young people are also named as being

victims of these same men. A note is made to see if X will talk to police.

Mum says she cannot protect her children. Y is missing every night and is returning home with bites on her body. She has also been assaulted by an adult female.

In the face of continued inertia, a senior practitioner from the voluntary sector writes to all the senior managers at RMBC and sends copies of her letter to the police and a local MP.

The letter points out that a vast amount of intelligence has been shared by Risky Business with South Yorkshire Police about the perpetrators but this information had not been used to stop them. The letter challenges RMBC as to why, despite the girls being identified as high risk, the Council had not placed them in care out of area for their own protection. All professionals apart from social care agree this should happen.

The letter then states, *' I am writing this letter to advise you… that children under your care are not, in this instance, being protected from violent sexual abuse…[they] are…associating with men and women known to the police and known to exploit young people. I am confused as to why there is not more urgency regarding the response to this… before one of these children or another get seriously hurt'*

The letter also questions why the police are not doing more. They are not intervening, not proactively watching the residential home where X is accommodated and not arresting perpetrators.

X is not moved out of area until nearly three weeks later following a series of escalating incidents. In the meantime 10 other children continue to be exploited. One perpetrator is remanded in custody following a breach of his Sexual Offences Prevention Order. No action is taken to stop other perpetrators.

A subsequent strategy meeting records that the *'males identified are said to be predatory with information suggesting that they could become more proactive if young people speak to the police. Different factions of the police focusing on these males for different activities...*' This explains why these young people are too frightened to speak, given that there is information about these men in connection with drugs, weapons and physical violence along with sexual attack on Z.

The girls do not give evidence. No action was taken against the perpetrators.

This case, and many other cases we reviewed, showed that there was no dispute that harm had been done to these children. It was recognised that they had been attacked, raped, and abused physically and emotionally. This resulted in

pregnancies, injuries, complaints by parents, reports to the police, police surgeon examinations. But the remarkable fact is that none of this galvanised action. The failure to provide attention, help and protection to these children and prosecute those that had perpetrated these crimes is all the more shocking because of this.

'I noted two purplish bruises over the top of the lateral right thigh which were 4cm and 3 cm respectively and a yellowing bruise approximately 10cm on the inner aspect to the left thigh…Upon the posterior aspect of the right buttock there were three linear purplish bruises approximately 9cm long.' Police Surgeon witness statement

'A threatened D… and informed her he will rape her worse than he did B… E confirmed A raped B.' Email from police officer to Children's Social Care, taken from Section 47 meeting minutes

'*Other significant males: C (present when A attacked B) - left when bottle was used covered in blood.*' Note from Section 47 meeting

However, upon talking to victims, Inspectors found that the lack of action – in terms of professionals offering support and protection from harm, often combined with a lack of police action – has left victims feeling that they weren't believed or taken seriously, or deemed important enough to be taken care of, or that they were to blame.

The court process

Operation Central is rightly hailed as a success in bringing about convictions of perpetrators. However, that was not the end of the story for victims. The criminal justice process itself can be humiliating and terrifying for already damaged children, and little support is on offer to help victims through it:

"I went to court I gave my evidence and they went to prison and you can read about that in the newspapers what you didn't read is the time I collapsed before I was cross examined and was sick, the tears the nightmares, checking under the bed and in the wardrobe every night and the belief I may have done the wrong thing as no matter what he had done I knew if I could just see him he would say sorry and it would be okay, as maybe he never meant to hurt me. I have worked with risky business for nearly three years now and last year I understood that I had been groomed and abused but no matter how much everyone tells me all that no one told me how to get over him I had loved him so much and thought he loved me too."

SECTION TWO: ROTHERHAM TODAY

1. IS THE COUNCIL TAKING STEPS TO ADDRESS PAST WEAKNESSES AND DOES IT HAVE THE CAPACITY TO DO SO?

The inspection was directed to consider whether the local authority is now *'taking steps to address effectively past and current weaknesses or shortcomings in the exercise of its functions, and has the capacity to continue to do so'* in other words, whether the Council is fit for purpose.

We have been objective about where RMBC is today, but have also had to acknowledge and recognise the long shadow of the past which is still cast across much of what we found.

Background

Councils are expected to develop a strong vision for the place and the people they serve, deliver good quality universal and specialist services together with their partners, and to ensure both the highest standards of conduct and good stewardship of resources. To do this requires strong political leadership by the Leader of the Council and the Cabinet, supported by Members; and strong managerial leadership by the Chief Executive and the Senior Leadership Team, supported by officers. These leadership teams must also be working effectively together. The Leader and the Chief Executive are jointly responsible for ensuring the Council is fulfilling its responsibilities and that Members and officers maintain healthy relationships.

Judgement

To reach a judgement on RMBC's overall leadership, governance and management, we have inspected:

- governance arrangements
- how the Council operates
- how some vital services are performing
- use of resources
- the role and conduct of Members and senior officers
- the Council's capacity to tackle the failings that have been identified.

Inspectors found that on paper Rotherham has reasonable arrangements within the expected range. There is a constitution and codes of conduct, agreed decision making processes, and arrangements for undertaking statutory, scrutiny and regulatory functions.

However, we found that the overall culture, the lack of a shared strategic vision, the complexity of partnership structures and the lack of strong political and managerial leadership at RMBC were severely inhibiting its ability to tackle failings and lead the transformation of the borough.

Inspectors have concluded that the Council is failing and does not have the capacity to address past weaknesses.

We do not attribute these failings to single individuals. They rest on the collective responsibility of the Council's political and managerial leadership as a whole. Through their action or inaction, many senior managers and Councillors have allowed failings to persist over long periods of time.

The Council has taken some steps to address past weaknesses and in the last few weeks there has been an improvement in pace. We note that an Improvement Board has been jointly established by the Council and the Local Government Association to provide oversight, support and challenge.

However, such welcome progress has to be viewed in the context of:

- no current shared strategic vision
- no permanent chief executive
- no cohesive senior leadership team and several key vacancies
- a structure which does not work and is being changed
- a weak and inexperienced Cabinet
- no sense of collective responsibility to tackle CSE
- a poorly directed tier of middle managers, some of whom did not demonstrate that they had the skills, drive and ability necessary to turn the organisation around
- a history of poor performance and a tolerance of failure in Children’s Services
- a denial of past failings.

Leadership and Governance

The Council has many issues to address but lacks the necessary skills, abilities, experience and tenacity within either the Member or senior officer leadership teams.

This judgement is based on the evidence we have seen, referred to in other chapters of this report, about the way in which the Council operates and responds to challenge, in terms of:

- the way in which it has responded to inspection outcomes and issues of performance to date
- the way in which it has failed to tackle the prevalence of CSE
- the culture of the Council and its values
- Member and officer working relationships
- the management culture and performance of the Council's services specifically Children's Services and Licensing
- the inability of the political leadership to hold officers to account and for senior officers to provide appropriate information to Members
- the inability of all Members to properly represent the interests of local people and businesses, particularly by failing to effectively challenge to ensure improvements in outcomes

Rotherham Council lacks political leadership in that it is not clear what it wants to do, what kind of organisation it wants to be, and how it will get there.

The Improvement Board has recognised the need to articulate a clear vision, supported by the right people, structures, policies, plans and processes. This may mean being clear about what the Council will stop in order to do the things that it wants to do. With finite resources, tough choices have to be made and determined political leadership will be required to steer the Council through the current difficulties and a further period of very significant change.

Whilst competence might be enough to do a reasonable job in a stable authority, Rotherham Council needs outstandingly talented and determined managers to drive the changes required.

Failure to listen, learn, challenge and improve

Since 2000, Rotherham has been the subject of regular inspection and judgements by external assessors including OFSTED and the Audit Commission. Apart from a brief period in 2005/7, these have indicated significant failings and weaknesses over the period. In some cases, false assurances were taken from inspections, but

significant concerns were also raised and not addressed. The Council has not used inspection as a tool to drive improvement.

Too often, the Council has been content to settle for ‘adequate’ where in reality this meant residents, including vulnerable children and young people, were not being served well. The Council’s response has been to develop voluminous action plans and monitoring reports. But there has also been a propensity for plans to slip or be ignored and not be implemented at all, while monitoring reports are obscure and over positive.

Inspectors saw regular reports to the Cabinet and Scrutiny committees, but not the effective challenge we would expect from elected Members. The notion of challenge has been misunderstood and misinterpreted as bullish questioning. Challenge means setting aspirational targets, knowing how far to stretch the organisation, asking searching questions, drilling down into information and data, ensuring targets are kept to and agreed actions implemented. It also means recognising organisational inertia and doing something about it; identifying when people are struggling, finding out why and getting alongside them, overcoming barriers and working out solutions.

Children’s Services have not been subject to appropriate challenge and have been allowed to decline and fail.

Failure to tackle CSE effectively

The first part of this report describes how RMBC has historically dealt with CSE. Inspectors have found an organisation which seems unable to face up to the reality of CSE; unable to hold a frank and honest dialogue, either internally or with partners and the community about the nature and consequences of CSE; and unable or unwilling to take the action necessary.

Inspectors have seen evidence of meetings, reports, strategies, action plans and operations for more than a decade and yet we met senior officers and Members who expressed surprise at the scale and scope of CSE described in the Jay Report. The numbers of children affected by CSE were regularly reported to various officer and Member forums.

It is hard to accept that over these years no-one questioned the scale and scope of CSE. No-one seems to have asked why there have been so few convictions of perpetrators, nor what could be done about the perpetrators who were known to be at large and operating in the community.

The Council's managerial and political leadership did not effectively challenge the police on this issue. Nor did they take steps to identify what could be done to disrupt

the activity of perpetrators and to prevent young people becoming victims. Where concerns were raised, action was inadequate and, even today, too little has been done to support historic victims who are known to the Council.

The culture of not following up actions had profound implications for the failure to grasp the challenge of CSE. For instance, the former leader of the Council personally chaired a task and finish group in 2005 in an attempt to tackle CSE. This agreed a range of actions, such as a zero tolerance campaign, but officers never implemented the plan. Three years later, Councillors commented that the 2008 CSE action plan was almost identical to the 2006 plan with the dates changed and sent it back. But even then, not enough was done to maintain focus and sustain progress.

Inspectors found that a contributory factor was the prevailing climate of concern for community cohesion and the lack of clarity of leadership in terms of CSE and race.

In January 2015, months after the Jay report was published, Inspectors found the support for victims to be sadly lacking. Whilst the Leader should be commended for making additional funds available, the lack of a strategy to support victims, any proactive outreach, and contact with known survivors is lamentable. Inspectors have seen improvements in very recent weeks, thanks to new managerial leadership, but it is unclear whether this will be sustained.

Poor culture and values

It is too easy to blame a single individual or small number of individuals for the culture and poor public service values in some parts of RMBC today. Many of the staff we met were exemplary and tried their best in difficult circumstances. Many wanted to feel proud of the borough and felt ashamed of what had happened.

As outlined in section one, the former Leader and his Deputy were not universally popular but did bring some positive dividends to the borough. Inspectors witnessed too much retrospective political point scoring and scapegoating rather than the necessary learning required to lead Rotherham to a more positive future. Too many officers and Members have sought to apportion blame to others rather than to accept responsibility themselves.

However, it was publicly known that the former Deputy Leader had a conviction from 2003 and had been subject to a further police investigation in 2013 although this had led to no action. We heard that some Members and officers felt intimidated by him and that he had made threats. He denies this. Inspectors heard that he had made representations on behalf of taxi drivers to speed up the issue of licences in advance of CRB checks. On another occasion, officers felt he had brought pressure to bear on them which resulted in proposals to undertake unannounced safety checks on taxis being stopped. They were replaced by checks after giving ten days' notice and

the Vehicle and Operator Services Agency (VOSA) withdrew from the plans. Whether rightly or wrongly, some officers and Members felt they could not raise matters relating to Pakistani heritage taxi drivers and perpetrators because of community cohesion implications.

The former Deputy Leader was summonsed to court and had a liability order issued against him for non-payment of council tax. This cannot possibly be seen as setting the high standards rightly expected of those in public life. Two other Members also faced action for non-payment of council tax.

Inspectors found that the conduct of some senior officers and leading Members was, at times, inappropriate but went unchallenged. People claimed to have been shouted down, silenced and intimidated. This undoubtedly had wider implications in terms of what was seen as acceptable in Rotherham. However, we also note that the Council received 'Investors in People – Gold' which indicates that in some parts of the Council the culture may be healthier.

The management and performance of Council services

Inspectors found an organisation which is not corporate and which operates in silos. The inspection has not been able to look at all services and we acknowledge that some may be operating well. But there is no sense of shared ownership, particularly of the difficulties facing Children's Services. This is clearly demonstrated in relation to CSE. This is why the Safer Rotherham Partnership, the Council's community safety, taxi licensing, regulatory functions and legal tool kit have not been used to disrupt the activities of perpetrators of CSE in order to protect children. Too many senior figures sought to distance themselves from the issue.

Despite the appointment of an excellent interim CE, even since the publication of the Jay report we have found insufficient evidence of clear managerial leadership to tackle the issues it raised, nor of political leadership to ensure officers were held to account for delivering. The lack of a clear overall strategic vision has contributed to the silo culture of the Council, and one where Children's Social Care has been marginalised. The complexity of the partnership structures, the profusion of meetings, action plans and monitoring reports and the propensity to fail to follow through on agreed actions exists beyond Children's Social Care. The culture of 'keeping your head down,' of cover-up, and the level of anxiety amongst those interviewed was above what might normally be expected.

More generally Members blame officers for failure for progress and officers blame Members for lack of leadership.

There needs to be a shared ethos that no department or team can regard itself as serving its community well if the Council is failing its most vulnerable people. All parts of the Council must play a role in tackling that failure.

Can the Council tackle identified weaknesses?

Rotherham Council has failed to achieve and maintain an acceptable standard of performance over the past 14 years. Corporate governance, leadership and management have been mixed, improving at times but unable to sustain momentum. Social services' performance has declined from a high point in 2001 when it was among the top ten performers in the country. Children's Social Care maintained a good but declining performance to 2007 when it experienced a significant decline from which it never recovered. During the last seven years it has never moved above an adequate rating which in modern assessment terminology would be seen as 'requires improvement'. It hit a low point in 2009 when it was rated as poor and subject to a government notice to improve. It managed to get itself up to an adequate rating by 2011 and the improvement notice is lifted. It did not improve further and by 2014 had declined again into 'inadequate'.

Conversely, over the same period, from receiving a highly critical corporate governance report in 2000 the Council as a whole has improved at least in parts. Inspectors asked themselves whether the corporate focus on improving overall, and on winning awards for some services, has been at the cost of services for vulnerable children.

It is also possible that the improvements in educational attainment, which in part contributed to Children's Services achieving adequate overall from 2010 onward, masked the evident decline in Children's Social Care. There are some key features in the performance picture since 2009 which suggest that the notice to improve may have been lifted too quickly.

All of the concerns listed below have been found in this 2014 inspection. The table shows when and how frequently they have appeared in the past.

Area of criticism	**Date(s) of inspection report**
Lack of vision, leadership and effective management	2000, 2002, 2009, 2013, 2014
Personal development reviews and supervision	2002, 2009, 2010, 2011, 2012, 2014
Core assessments for children, procedures and timeliness	2005, 2007, 2009, 2010, 2011, 2012, 2014
Concerns re teenage pregnancies	2006, 2008, 2014
Weaknesses in social care management/safeguarding	2008, 2009, 2012, 2013, 2014
Plans, pace, not embedded	2009, 2011, 2012, 2013, 2014
Confused governance, too many groups, confusion and increased risk	2009, 2011, 2013, 2014
Access Team	2009 (x2), 2011, 2012, 2014
Social care capacity/resources/prioritisation	2009 (x2), 2012, 2014
Information/data/analysis	2009 (x2), 2011, 2014
Domestic violence	2011, 2012, 2014

The Corporate Governance Inspection of 2002 found it was: *'Not always clear how decisions are made…the quality of information provided to Members was observed as poor. The Council operates in silos…We were unable to find clear plans to reprioritise funding areas…the Council needs to be much clearer about what its priorities are. There is no link between service planning and human resource planning. There is not yet a climate of robust risk management. Financial management is sound.*'

These findings are identical in almost every regard to those of today's inspection. Recurring weaknesses have been identified in Children's Social Care. The Serious Case Review following the death of Child S, published in 2012 notes: inadequate assessment, lack of clear and timely case recording, slow and inefficient response, inadequate supervision and review, children not heard and risk assessment poor, among 22 weaknesses. The author noted that all 22 weaknesses had been features in previous Serious Case Reviews. And they remain today. Clearly Rotherham Council does not use inspections to drive improvement.

Rotherham does not learn, even in the most tragic circumstances, and it has not improved. Without sustained support and scrutiny, there's a strong likelihood it will fall back.

Top to bottom – translating political leadership into action

Organisations as big and complicated as local authorities need to have some basic arrangements in place to make sure that everything runs smoothly.

Plans and decisions

The Council's approach to strategic and corporate planning is generally in line with expected norms. The plans and strategies are much as you might expect on paper but they do not connect with reality on the ground. It is the Council's failure to drive through its actions that makes Rotherham stand out.

One illustration of this disconnection between vision, plans and practice is the Council's equalities plan and single equality scheme. The documents are clear, aspirational and include a summary of good practice. However, we found that this was not rooted in the day-to-day experience of staff. We set these matters out in more detail elsewhere in considering political correctness and race. The point here is that whilst plans and policies look appropriate, or even good, they bear little relationship to what inspectors found at the frontline.

There are too many plans and priorities and these are insufficiently connected to each other or day-to-day operations. Where decisions are made, there is insufficient oversight to ensure they are acted upon, or have the desired effect. Inspectors found evidence that Member decisions were sometimes ignored, and plans just left on the shelf.

Plans disconnected to staff

Inspectors were told that in Children's Services only "*60-80% of staff are having Performance Reviews, with HR spot checking more than anything".* Inspectors did not find this to be at all adequate. We would expect the vast majority of staff, with few exceptions, to be having performance reviews so they know what is expected of them and how their work contributes to the delivery of the Council's plans. Inspectors concluded that some staff did not understand the Council's vision; a number were clearly confused about what was expected of them and this hampered their performance in terms of day-to-day service delivery.

Plans not delivered in a timely way

Across the Council's plans, we found many examples of slippage, which demonstrate that there was, and is, inadequate managerial and political oversight of key deliverables. Reporting arrangements to the senior leadership team are not adequate and scrutiny of performance data by Members is not systematically ensuring that slippage is picked up and officers appropriately called to account.

Where slippage directly relates to capacity (human or financial), and we saw examples where this was cited to be the case, then Members need to understand the deficit and be presented with realistic options to enable them to prioritise effectively. They also need to step up to the mark to make sure they fully understand what is happening.

Reports are poor; Member challenge is ineffective

Inspectors found very little evidence that service failings were identified and addressed. The signs that Children's Social Care services were failing had been there for a very long time but the senior leadership team did not act, and Members did not look hard enough. We saw some evidence that some officers sought to keep Members at arms-length, and direct them away from concerns.

Certainly, officer reports did not always present the facts in an easily accessible way, sometimes failed to set out the full position and at times could be seen as misleading. We considered that Members did not ask probing questions to get underneath the skin of reports and data.

An example would be the Rotherham Local Safeguarding Children Board (RLSCB) report on the subject of CSE considered by Rotherham's Cabinet on 24th September 2014. Inspectors found that the document was neither easily accessible nor written for a lay audience. It was partial and assumed prior knowledge of issues. The report was not engaging. It did not seek Members' views, or present options. Instead, it encouraged Members to accept the recommendations of officers without proper scrutiny of the facts.

Omitting all details, one line states that '*all of the recommendations of the Jay report have been incorporated into the CSE plan and will be subject to future progress reports*'. This approach does not afford Members the opportunity to review the CSE plan, nor scrutinise how the recommendations have been included and, crucially, whether the actions proposed are likely to be effective.

Inspectors also found the critical analysis provided by officers in this report was poor. There were no milestones, timescales, benchmarks, evaluation or reporting on progress. This was also true in terms of data, which inspectors found was presented without any detailed analysis or explanation, nor with any real sense of scale, trends and whether things were getting better or worse. Moreover, the CSE data presented is partial: for example, indicators of triggers for CSE, including absence from school, and children accessing mental health services, are not included.

Monitoring and reporting is inconsistent and, at times, weak

Monitoring and reporting on plans is inconsistent. Officers sometimes painted too positive a picture of Council performance, or omitted important facts in their reports, that might have led to greater awareness and scrutiny by Members. For example, the monitoring report to the Self-Regulation Select Commission on 5th September 2013 on Corporate Plan Outcomes, outturn 2012/2013 reports that 'all children in Rotherham are safe'. The indicators are green throughout the year. There is no text explaining how this has been measured.

Figures for domestic violence in the borough are very high and are a known concern. A series of articles in *The Times* have raised serious issues about the Council's safeguarding arrangements. Inspection reports point to repeated weaknesses in Children's Services. Inspectors are therefore at a loss to understand how anyone in the Council, officer or Member, could accept without challenge a report stating that *'all children are safe.'*

'People have to understand the role of Members and put governance arrangements in place which allow Members to fulfil their [leadership and scrutiny] roles.' A member of the Improvement Board

Questionable priorities

The Council has not got its priorities right. It puts resources into pursuing awards when it should be focussing on sorting out the basics. In March 2014, the CSE Team received an award from the National Working Group Network for '*the longest journey under challenging conditions'*. We found this extraordinary given the failings in its core business. Performance in Children's Services as a whole has not been above adequate, in other words, meeting the minimum standards, since 2010. Surely this woeful position should have been the focus of leadership and management rather than window dressing.

"Badges and awards seemed to be important to the organisation, and they would put resource into pursuing them – something that seemed a bit out of sync with the overall reflection of the Council." A former officer

Loss of public trust and confidence

Rotherham needs to restore public trust and confidence. The need for change has to be accepted before change can begin. Those closely associated with past failures need to let others make a fresh start.

Inspectors judged it important to consider what knowledge Members had about the CSE issue and what their responsibilities were at any given time over the period that Professor Jay investigated.

For more than a decade, there have been reports and updates about CSE. These outlined the nature of CSE, how it was being tackled and the numbers of victims or young people at risk known to Council services. There have been dedicated CSE workers employed by the Council throughout this time. The Council has commissioned at least three external reports into CSE and has multiple internal reports and plans.

In 2004, the Chief Executive directed the Executive Director of Children and Young People's Services to commission the 'Report on Organisations Delivering Services to Young People with Experience or at Risk of Experiencing Sexual Exploitation'. The findings of this report caused the then Leader Roger Stone to commission a Sexual Exploitation Task & Finish group – consisting of six Councillors and five senior officials – to get CSE 'sorted'.

This group held meetings throughout 2005. In 2006, the Children and Young People's Scrutiny Panel reviewed a CSE action plan and covering report, in which the vulnerabilities of looked after children and children in foster care were highlighted. The Children and Young People's Scrutiny Panel and Rotherham Local Safeguarding Children Board considered progress on the CSE action plan in 2007 and 2008 – although it changed very little throughout this time – and received updates in 2009. In 2010, the Safeguarding Board established a specific CSE sub-group.

Across the years we found many positive plans, statements of intent and agreed actions to improve services to deal with what was recognised as a significant problem as early as 2004. However, while reviewing these reports, a pattern emerged of plans and reports being the only response to the problem. Nothing much changed on the ground.

We do not accept that Councillors with a long history in Rotherham did not know about the scale and extent of CSE. We conclude that they did not act.
The current Leader was the Lead Member for Children's Services from 2010 to 2014. We found him to be a decent, committed and hardworking Councillor. He has provided additional funding for victims of CSE (even if we do not find the current offer to be good enough).

However, we have found that he was aware of CSE, including Operation Central, and had sufficient opportunity to uncover and act on the scale of the problem. We acknowledge that he was poorly served by officers, but nevertheless, he could, and should have done more, sooner.

As Lead Member, he also knew about the long-standing weaknesses in social care and safeguarding but did not ensure improvements were delivered and maintained on a sufficient scale. The fact is that Children's Services have not been better than adequate, and have declined under his watch. As Leader since the Jay report, we have found he has not given sufficiently strong and visible leadership, or put in place a coherent strategy to deliver improvements, support victims, tackle perpetrators or restore public confidence.

Overall, Inspectors have not been impressed with the calibre and grip of leading Members. We have reluctantly concluded that they cannot be left on their own to lead the Council out of its current responsibilities.

Scrutiny and Standards

"It is effectively a club which can't be challenged." A key partner

In undertaking this inspection, the inspection was directed to consider whether the local authority allows for adequate scrutiny by Councillors. We have already commented on whether scrutiny takes place as part of the day to day operation of the Council (in other words, whether there is sufficient rigour and challenge in the exercise of its duties) and we have concluded that it does not. This section looks at the form and effectiveness of the Council's formal scrutiny arrangements.

Rotherham has an Overview and Scrutiny Management Board (OSMB) that draws up the scrutiny work programme in conjunction, produces the annual report and then receives reports back on progress and final reports of major reviews that they undertake. The OSMB would also hear any call-ins. In addition, it undertakes an annual project with the Youth Cabinet. There are four Select Commissions which report to the OSMB which are

- Self Regulation (covers financial strategy and budget decisions)
- Health (includes the statutory role)
- Improving Lives (covers children and adult social care and schools);
- Improving Places (covers the physical environment).

Overall, the Council has an adequate structure in place and some individual pieces of work have been effective. It has some examples of good practice including undertaking work with the Youth Cabinet to review the issue of self-harm.

However, it is not clear how effective it has been in holding Cabinet Members and senior officers to account for their individual performance and decision-making. Inspectors could not find much evidence of how scrutiny had changed practice or policy making.

In March 2013 the OSMB, the Cabinet and the Management Team met together to draw up the work Programme for 2013/14. This is good practice. It is unfortunate therefore that we did not see evidence that this happened 2014/15.

Inspectors reviewed two years of OSMB papers and minutes, plus the work of the Improving Lives Select Commission. OSMB meets regularly, with reasonable attendance and agenda range. They seem to adhere to the work programme of reviews. OSMB has a standard item of report updates from the four Select Commissions. Chairs of the commissions attend for their items as do some Cabinet Members.

The call-in procedure requires six Members to sign a call-in request. This seems too high a threshold for a Council which only has small opposition groups.

Inspectors could only find one call-in which is not surprising. You would not expect the Labour Members to call in their own decisions when they have other ways to raise issues. The call-in was from six UKIP Councillors in July 2014 concerning a decision to be part of a four Council broadband project. The call-in was heard at OSMB which spent some time on the issue. This seemed appropriate given the risks.

The Improving Lives Select Commission has had CSE in its work programme for the past two years and the issue was regularly considered. The meeting in January 2014 was devoted just to CSE and there was a strong turnout of Members and all partner agencies attending. The meeting considered the report of the chair of the LSCB and a suite of the other reviews and reports. Whilst it is clear that matters were considered in some detail, it is much less clear what happened as a result.

Inspectors saw little evidence of impact.

"We were asking for stuff but we weren't getting it. I felt like it was a real battle to get information." A Councillor

It's difficult to know how Member led the scrutiny function is and to what extent it is challenging Members as well as officers. Overall, whilst it appears to be a very active programme and within the normal range you would expect in terms of effectiveness, there are some concerns.

Senior officers described a difficult relationship with overview and scrutiny, a lack of detailed information to back benchers, and an in-built self-regulation of the process. Senior Members admitted that Cabinet has been unprepared to release information to scrutiny. At one point there was an instruction – lasting five months - that no information could be given to scrutiny without the agreement of the Lead Member.

"*The Cabinet had failed in not scrutinising themselves enough".* A leading Labour Councillor

Inspectors concluded that overview and scrutiny had been deliberately weakened and under-valued. The structures and processes look superficially adequate, but the culture has been one where challenge and scrutiny were not welcome.

"People did feel fearful of attending the scrutiny board and intimidated in Council meetings." A senior officer

Where Councillors have scrutinised other agencies, eg aspects of health, they have been more effective and robust. However, not enough Members really know how to get underneath information presented by officers, and the organisation has not properly resourced and facilitated effective scrutiny. It was generally acknowledged that the scrutiny team was small and disconnected from the Senior Leadership Team.

The fact that Members' services are provided informally and are in the gift of each director leaves the Member position weak and further discourages effective day to day challenge. Clearly, if scrutiny is unwelcome and only funded at the behest of those being scrutinised, it is unlikely to be effective. This is not a reflection on the officers who support the scrutiny function. In fact, despite all the barriers we found them to be passionate about the value of scrutiny and doing their best despite obstacles in the path.

Whilst the opposition in Rotherham is small, we saw limited evidence of them raising concerns and putting pressure on the leadership. In terms of CSE, we could not find evidence that the opposition had been at all effective in scrutinising and challenging, or active in getting the matter on the agenda.

Member Standards of Conduct

Member conduct is vital as it is at the heart of what is expected of those in public life and holding public office.

In Rotherham, with its chequered history, visibly demonstrating high standards in public life really matters. They need to be squeaky clean.

The Council's arrangements are generally in line with those of Councils across the country. It has an appropriate constitution, decision-making and delegation framework, and committee structure.

However, the Council has some features which are more specific to Rotherham and worthy of note. Taken individually they may seem minor, but taken together and viewed in the context of Rotherham's past, they suggest a culture of patronage and an unwillingness to tackle unacceptable conduct by some Councillors.

Cabinet advisors:

The Leader may appoint Cabinet advisors who receive a special responsibility allowance. On average up to three such appointments have been made for each Cabinet role. Large numbers of Members are therefore receiving an allowance. In 2011, the Independent Member Remuneration panel recommended that the provision of allowances for these roles together with vice chairs of committees

should cease. The Council did not accept this recommendation but the reasons for this are not recorded.

Although there is nothing improper about Rotherham's arrangements, they have led to a perception of 'grace and favour' and patronage including among leading Members.

Members' allowances:

The remainder of the scheme for Members' allowances is fairly standard. The basic allowance at £12,130pa is higher than the London basic rate but it is adjusted in line with staff pay (so has been reduced by 1.5%). This seems reasonable although it remains on the generous side.

The Monitoring Officer role:

The Monitoring Officer has a specific duty to ensure that the Council, its officers and its elected Members maintain the highest standard of conduct in all they do. The Monitoring Officer has a duty to write a report if he/she considers that any proposal, decision, or omission made by, or on behalf of the Council, is illegal or would be illegal. This is not a duty to write a report every time an allegation of illegality is made, but only if in his/her personal opinion that it did, or will occur. Inspectors were not made aware of any Monitoring Officer reports.

There is a culture where the opportunities to identify potential problems of governance or adherence to the code of conduct are missed. Inspectors found a general lack of professional curiosity or tenacity to grasp issues. For instance, we found that while there is a gifts and hospitality book for Members, no-one has the responsibility for taking an overview of the content and checking compliance. Therefore it is not routinely done.

Inspectors examined the register of Councillors' interests. In one instance we noted a potentially serious irregularity which we have raised with the CE so that the matter can be clarified or otherwise dealt with. Again, there was no systematic routine checking.

We observed that the Monitoring Officer role could be stronger and better resourced, especially given concerns about Member standards and behaviour. We are pleased to note that the Monitoring Officer now sits on the top management team.

Non-payment of Council Tax:

Following concerns raised by a whistle-blower, we found evidence that over the years, there are instances of Councillors not paying Council tax bills until reminders

or summons are issued. In some cases the Council has had to seek liability orders from the Magistrate's Court before payment arrangements have been secured from Councillors.

Inspectors found this to be entirely out of keeping with the conduct expected of those holding public office and deeply damaging to the reputation of Councillors and the Council. It is a matter that political leaders must address. In addition, the Monitoring Officer should ensure that all Councillors' Council tax accounts are checked prior to the Council tax setting meeting to ensure compliance with legal requirements on no arrears over two months.

The former CE told inspectors:

"I have found many officers and elected Members at all levels who have always conducted themselves professionally and with the appropriate demeanour in accordance with officer and Member codes of conduct. On some occasions there have been a small number that did not always have the same high standards."

CRB and DBS checks

Inspectors looked to see whether Members had been subject to appropriate CRB and DBS checks. Since the introduction of the CRB regime in 2003, very few Councillors had been checked in the role of 'Councillor' or 'Elected Member'. We found that Members had decided not to submit themselves to such checks, against the CE's advice.

Some Councillors have been checked in order to sit on the fostering and adoption panels but the majority of checks, and certainly all the recent DBS checks, have been carried out at the behest of the schools or other responsible person in the recruiting organisation for the role of governor or volunteer. The Council is compliant with the minimum requirements of the DBS regime and has clearly chosen to take a light touch. However, there has been no historic, systematic checking of Members who had access to vulnerable children.

Senior Management of the Council

"We need your help… point us in the direction of what we need to be doing." A senior manager

During the inspection:

- the CE left and an interim started
- the Strategic Director for Neighbourhoods and Adult Services (NAS) took early retirement at short notice
- the Director for Schools and Lifelong Learning left
- the former Leader resigned from the Council
- a government appointed Children's Commissioner started
- a new Director of Children's Services was appointed; and
- an external Improvement Board started to meet once a month to provide support.

The Children's Commissioner, Malcolm Newsam, was appointed by the Department for Education to help Rotherham improve the performance of Children's Social Care and safeguard and promote the welfare of children. Inspectors were impressed with his evident capability and are confident that he will play a major role in helping to set Children's Services on the right course. He will chair the Children, Young People and Families Improvement Board, which met for the first time in January 2015.

The interim CE, who is in post until May 2015, has made a good start in stabilising RMBC and filling key vacancies. Inspectors were pleased to see early work on a restructure, an improvement plan and the addition of the Director of Finance and the Monitoring Officer to the Senior Leadership Team. We also welcome the newly created post of Director of Resources. Without it, the centre has been weak and unable to effectively regulate other parts of the organisation. This should introduce strong leadership to the corporate function, which is essential as effective HR, legal, finance and communications services are all needed to help RMBC transform.

RMBC has managed budget reductions by taking the path of least resistance and letting volunteers go. This has delivered the numbers, but at a significant cost. There has not been clear planning for the future, so good people have been allowed to leave even though their skills and talents were required. The Council needs to manage its budget while also investing in talented people and vital services.

Inspectors have met some committed and dedicated third tier officers. However, the Council does not have the managerial capacity to lead its way out of the present difficulties. This has been compounded in the short term by resignations and departures, though in the medium and long term this turnover was no doubt

necessary. Inspectors were pleased to note that additional managers had been seconded in to shore up Children's Social Care, together with a significant investment in additional frontline social workers.

"We have lost our way." A current officer

Inspectors found that the Senior Leadership Team did not sufficiently look at the quality of operational delivery, operational service risks or issues. Some services in Rotherham are improving and winning accolades and awards, but Children's Social Care has been allowed to fail without effective monitoring and intervention. Senior managers pointed to these achievements in interviews as a means of 'balancing' the picture overall. We believe this is unhelpful. The scale of the failings in Children's Services cannot be weighed in the balance against even the most outstanding performance elsewhere. No council can be deemed to succeed if its Children's Social Care services are so inadequate. Officers' failure to grasp this point was a real concern to Inspectors. However, we include in Annex B a number of the Council's achievements which were highlighted by the outgoing CE and Leader.

Issues in Children's Social Care have not had the prominence and priority they should have across the Council. CSE does not appear to feature strategically, operationally or even as a risk until 2013/14. From 2010, each annual report notes pressures on the Children's Services budget and changes being made to get it under control. But the senior leadership team did not take corporate responsibility for ensuring issues were addressed.

Inspectors conclude that the CE, the Strategic Director of Children's Services and the Senior Leadership Team, as the team responsible for ensuring a good standard of performance across the Council's services, have collectively failed in recent times. The failure to properly challenge and scrutinise data, and to intervene where services were in decline, has had significant consequences for children and young people in Rotherham.

By not tackling CSE effectively, senior officers have failed children and young people, in particular the victims, and allowed the present difficulties to prevail. This failure to act has had wider consequences, including the recent marches by the EDL and a reported rise in racial abuse for the Pakistani heritage community, and taxi drivers in particular.

Finance

Inspectors interviewed the Director of Finance, Monitoring Officer, Director of HR, external Auditors, other staff and Members, including the Deputy Leader who holds the Resources portfolio. We also attended the Improvement Board when it considered the Council's financial strategy and reviewed financial plans, audit plans

and a sample of audit reports. We looked at identified weaknesses in more detail through case file sampling and further interviews.

The Council has appropriate arrangements in place for planning and managing resources. This is confirmed by annual returns and the audit of accounts. Finance staff should be commended on ensuring that significant budget reductions in recent years have been delivered in a timely manner. They have done a good job to balance the books and deliver relative financial stability. Our summary of the Council's financial position is in Annex C.

However, Inspectors found that the overall approach to finance planning was not based on a clear and political strategic vision. The Improvement Board recognises this and is working to develop one.

In the absence of this vision, the budget process has been led by finance. All departments were asked to find a quota of savings, with some protection for frontline services. This approach has delivered the bottom line, but with serious consequences. For example, some services no longer have the capacity to function effectively. We were particularly concerned about the level of funding for central regulatory functions and those which will drive transformation, like legal services, organisational development, strategy, and resources to ensure community cohesion.

RMBC did invest in Children's Social Care during recent years but did so without really understanding what was driving demand. They lacked, and still lack, the data to make robust decisions. But they did not address this.

The budget process has not sufficiently considered the overall impact of reductions. Instead, each cut has been considered in isolation. This has allowed significant weaknesses to emerge in Children's Social Care and possibly elsewhere.

"The leadership have already recognised that in many aspects the Council is not fit for purpose, the approach to the budget of salami slicing is not going to be sustainable." A critical friend

Inspectors were made aware of a number of rumours relating to grant giving, regeneration, and the failures of the Arms Length Management Organisation (ALMO) and the BT contract. We were not able to investigate these in any meaningful way given the time available but were reassured by the auditors that they were satisfied with the Council's affairs.

Human Resources

Inspectors tested human resources processes in action. We selected as an example CRB/DBS checks to ensure that vulnerable people are protected from any unsuitable

staff. Inspectors reviewed policies, procedures, the posts identified for checks and then selected staff files at random and without notice.

Ten files were sampled (six individuals in social care and four in Neighbourhoods and Adult Services). Seven files passed on first inspection, where a screen shot of an up to date CRB/DBS check was found. The three files where a record of a CRB/DBS check was not first found on inspection dated back to staff who had been employed by RMBC for a number of years. Further investigation confirmed that the CRB/DBS checks were up to date. We were pleased to find the process was secure.

However, Inspectors found several checks in NAS that were more than a year overdue despite monthly reminders from HR. These important checks and balances are not being given sufficient priority by some managers working in services where staff support vulnerable adults. At worst, it leaves vulnerable people exposed to harm. This matter needs to be urgently addressed.

Higher up the organisation, there was little awareness of the HR implications of the process of downsizing and change. The greatest risk facing any organisation is that its people are not up to the job. But this seems to have been over-looked in the relentless focus on the numbers. It was a serious concern to Inspectors that HR could not comment on the capacity of the Council to deliver its plans. It clearly must be their job to help ensure the Council has the right people with the right skills in the right jobs.

Audit function

We looked at the Council's audit plans and a sample of audit reports, both internal and external, over the past decade and found arrangements to be within expected norms.

We were concerned, however, about the overall approach to audit. For example, processes that had been highlighted as failing many times over in Children's Services (i.e. contact and referral arrangements) would have benefited from the insight and rigour of audit yet did not find their way into the plan. Some services, such as the licensing/taxi function and the looked after children's service, have not been audited in the last three years in spite of concerns raised in the media.

All areas of known weakness should be audited within a systematic programme that ensured all Council services, functions and processes were subject to review every three years, alongside the statutory audit arrangements. A greater use of audit to support improvements would be beneficial as part of a comprehensible rolling programme of reviews.

Rotherham is rife with rumours about impropriety which creates an unhealthy climate of mistrust. External audit should be directed to look at areas where persistent speculation arises in order to restore public confidence or tackle the weaknesses identified, or both.

Risk management

We looked at the Council's processes for identifying and reporting on risks, including the probability of them arising and their impact. On paper, arrangements are much as we would have expected. However, we were told that risks were not really discussed and owned by management teams.

Inspectors noted that the risk of Children's Services not improving was in the top five risks after the OFSTED report in 2009. However, it was downgraded in October 2012 and did not appear in the top five after that date. No rationale was given. Clearly, risks should not be downgraded without a proper analysis and reporting of the facts.

The service was clearly not improving. The risk register should have provided an opportunity for SLT to identify this and take action. Taking it out of the top five identified risks meant that it was no longer visible to Members. This should have been questioned at Cabinet and/or been subject to scrutiny. Inspectors saw no evidence of this.

"Safeguarding would have been on risk register. Child Sex Exploitation was reported to SLT but it was down to the lead Director to deal with it." An officer

There are no legal comments on reports relating to risk. In other words, no formal view is provided as to whether the Council is at risk of failing to meet its statutory duties.

The fact that the fall-out from the Jay report was not identified as a risk ahead of publication, and no plans were put in place to manage it, is just one indication that the way the Council identifies and manages risk could be strengthened. Even more significant is the way that the Jay report was handled through the risk management process after publication.

A report to the Audit Committee on 17th September 2014 identifies the Jay report as the second highest risk facing the Council. The risk is described as follows: '*Major reputation damage and loss of confidence in the Council; demoralising impact on employees; potential financial claims; potential impact on inward investment; short and medium term disruption/distraction from services; subsequent OFSTED and corporate governance inspections*.' It does not set out what it will do to mitigate such risks and indeed, these risks are now very real issues.

There is nothing about the risk to children.

The risk of services continuing to fail children should have been the Council's highest priority. But it was not. This goes to the heart of the culture of the Council and what senior leaders think really matters.

2. IS THE COUNCIL TAKING STEPS TO ADDRESS WEAKNESSES IN CHILDREN'S SOCIAL CARE AND ITS WORK ON CSE, AND DOES IT HAVE THE CAPACITY TO CONTINUE TO DO SO?

Inspectors were directed to consider, in light of the Jay report, which highlighted serious failings in the authority over a number of years with regard to the safeguarding of children, whether the local authority '*was and continues to be subject to institutionalised political correctness, affecting its decision-making on sensitive issues; undertook and continues to undertake sufficient liaisons with other agencies, particularly the police, local health partners, and the safeguarding board and also is taking steps to address effectively past and current weaknesses or shortcomings in the exercise of its functions, and has the capacity to continue to do so'*; in other words, whether the Council is fit for purpose specifically in relation to Children's Social Care and CSE.

Background – OFSTED Inspection

Children's Social Care in Rotherham was inspected by OFSTED from 16th September to 8th October 2014 and found to be inadequate. Their report, '*Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board'* was published on the 19th November 2014. At the same time, OFSTED published a national thematic report entitled '*The sexual exploitation of children: it couldn't happen here could it?'* referring to RMBC and other areas.

Inspectors did not duplicate OFSTED's work but checked and verified their findings by looking at those aspects of Children's Services most relevant to CSE.

In part, this was necessary because RMBC were resistant to the findings of the OFSTED report (as well as the Jay report). This was reflected in their complaints about the fairness and impartiality of the OFSTED inspection to Inspectors.

'I thought OFSTED was disgraceful when they came in and what they did… it was bound to be inadequate. [Sir] Michael Wilshaw had already written it…' a Director

The newly appointed Children's Social Care Commissioner makes a similar point:

"On my arrival in Rotherham, I was presented by a level of questioning from many in the organisation as to the "fairness" of these judgements…Given this context, I purposely met with the OFSTED Lead Inspectors. They impressed me with their integrity and transparency and I was left with no doubt that their judgements had a clear evidence base. My own assessment based on the work confirms that there are fundamental weaknesses in the delivery of Children's Social Care services and many of these are long-standing."

Inspectors met with members of the OFSTED team, scrutinised their report and tested some of their findings independently through case work, observation and interview. We agreed with their findings and concluded that they had been fair in their assessment. If anything, we found that the position had worsened since they had reported.

Judgement

Children's social care will need concerted attention over a prolonged period to reach and maintain an acceptable standard of performance. It must be a corporate and political priority, with standards and progress independently monitored.

The Council is not addressing weaknesses quickly or robustly enough through their current arrangements because they do not have the leadership, managerial or staff capacity to do so. The ineffectiveness of Children's Social Care in Rotherham is clear. The service is failing. Children in need of care and protection are not receiving it and may, therefore, be exposed to harm and prolonged neglect.

Scope of Inspection

This inspection looked at arrangements specifically relating to Children's Social Care and CSE as a litmus test for checking the robustness of Children's Services arrangements more generally. We have not considered performance in education and lifelong learning other than in relation to CSE.

Inspectors looked at:

- arrangements for managing contact and referral
- early help
- partnership arrangements (including with police, the voluntary sector, schools, missing children, and health)
- use of data and reporting
- management (including supervision)
- systems, policies and processes
- arrangements in relation to missing children and young people.

We sampled 68 historic and current case files and tracked the cases of known victims of CSE to see what happened to them in transition to adulthood.

We also looked at arrangements for supporting current and historic victims.

Children's Social Care Services

Despite many senior officials and Members talking about their concerns for the well-being of children and young people, and the priority this work was being given, Inspectors (like OFSTED) did not find the concerns translating into sufficient and effective action.

Work is not effectively joined-up either internally, or with key partners, which means children are left at risk of harm and actual abuse. Inspectors found that frontline staff were not listened to, carried too much risk and too often were unsupported in the decisions they made.

In spite of additional investment in the service, Inspectors found that there are too many priorities which means staff do not know what to tackle first. There is inadequate managerial direction which means it is easy to understand why staff feel adrift.

"When I came in I thought it was great but there are too many actions. I'm sick of saying 'there's too many actions'." A member of the Safeguarding Board

Without rehearsing the issues raised by the recent OFSTED report we did consider certain aspects carefully as their performance underpins the effectiveness of the RMBC CSE service to victims.

We were concerned to find profound weaknesses remaining in the Contact and Referral Team (CART) which acts as the 'front door' to other services. The Council has been aware of these concerns since at least 2009 but they have not been adequately addressed and the 'front door' remains 'broken'.

'The performance in respect of the completion of initial assessments and core assessments is inconsistent and often significantly delayed.' 2009 OFSTED annual unannounced inspection of contact, referral and assessment arrangements

The deadline set for Multi-Agency Assessments is still being missed in too many cases. In the OFSTED inspection the authority accepted that seven out of 18 cases audited were inadequate. In this inspection we found a similar proportion to be poor.

The IT systems supporting social workers are not fit for purpose. OFSTED first identified this failing in 2009. One of the three 'priority action' points they set out identified Rotherham's 'information systems' as being unable to provide 'up to date and accurate information on all contacts and referrals and the status of investigations, assessments and plans.' They made the same point in 2011 and again in 2014. We wholly concur with this finding.

Work to bring in effective IT systems that support social work practice needs to be given the highest priority. Information about a child's history is not always easy to find on the system and may be missed in making current decisions.

It is hard to understate how frustrating this must be for staff. It took hours for one of the specialist social care assistant inspectors to track down the details needed for a case audit. That in itself was evidence of failings.

The rapid appointment of a new Director of Children's Services is a positive step. But there is a real danger that this important appointment will be heralded as the 'fix' to solutions which no one individual can fix alone. It will not resolve the leadership, management and governance deficits which are systemic and exist in many forms across the Council and the partnership it should be leading. It is important to listen to staff to fully understand the challenges and concerns before deciding how best to fix things.

Overall, inspectors found that Children's Social Care was not sufficiently effective. Systems to record and manage cases were poor; decisions regarding individual children were not rigorously or systematically checked and too much professional practice was poor.

Whilst senior managers and Members claimed they wanted to improve the quality of Children's Social Care, we found that it has been a Cinderella service which has historically not had the focus it requires from political and corporate leaders.

For too long, staff and partners have not been listened to. Even more importantly, neither have children. Without action which is fundamental, comprehensive and urgent, it is hard to see how RMBC can fulfil their duties to protect children and young people in need of help and support.

Children's Social Care Services and CSE

Inertia is apparent at all levels within Children's Social Care. There have been a series of reports highlighting the same problems over and over again without changes being made. For example, the lack of leadership in the CSE service was highlighted repeatedly in relatively recent reports without action being taken. (September 2013 Barnardo's report, December 2013 LSCB diagnostic report, November 2013 HMIC Report, August 2014 Jay Report).

The Chair of the Rotherham Safeguarding Children Board carried out a review of RMBC's response to CSE just after he was appointed in 2013. But the recommendations made have not been implemented and many of the concerns raised, such as the CSE Team's managerial structure, are still present over a year

on. Moreover, the regular audits the LSCB carry out have little or no discernible impact on practice.

During our inspection, we raised concerns about a particular case directly to the interim Chief Executive. We were told privately that it was an appalling case but there seemed to be no mobilisation on the part of senior staff in Children's Services. The initial response was to criticise the person referring the case for allegedly getting the procedure wrong (which they had not). After that, nothing happened to that case for three weeks. At a time of heightened concern about the safety of children and of CSE, we could not understand how it took so long to address this child's case, despite it being raised by Inspectors and following interventions by the Children's Commissioner and Chief Executive. This is symptomatic of the total lack of urgency apparent throughout the system.

Bluntly, senior staff in Children's Social Care know what is wrong but are either incapable of putting it right or lack the will or capacity to do so.

Local political leadership and stated commitment to tackling the issue of child sexual exploitation has yet to translate into any meaningful changes in practice. This is a sorry position given its public profile and supposed importance to local leaders, not to mention the devastating impact it has on children and young people's lives.

Leadership, governance and management of Children's Social Care are not adequate to deliver the urgent improvements that are needed. It is likely that the Council does not therefore have the capacity to improve.

Failings of the 'social care' approach to tackling CSE

RMBC see CSE as a matter requiring a 'social care' approach only and by doing so continue to make the same mistakes. An effective 'social care' approach still requires the involvement of the whole Council and other agencies to support proper safeguarding and this is not the case in RMBC.

This fundamental misconception of how to tackle CSE sits at the root of so many of the failings we observed. By inappropriately compartmentalising CSE the Council forces artificial choices about whether children are above the threshold for a statutory intervention.

"We are trying to squash CSE into a framework where it just doesn't fit." An officer

The consequence of adopting a rigid social care model is two-fold. Firstly, too many children at risk of CSE become clients of social care (over-whelming the statutory service). Secondly and as a consequence of over-stretched resources, the nature of help on offer is not proactive in identifying and meeting their needs. The proven

success of assertive outreach work by youth workers in getting to know the girls, building relationships with them, and helping them to understand the street grooming process is lost in the necessary processes and paperwork of social work.

Of course, where children are at risk, or are being harmed, it is a matter for social care and the police. But street grooming is insidious and needs a more nuanced approach to get girls to understand what is happening to them and to tell their story. This is where outreach workers have a vital role to play but an effective outreach programme is not in place. Outreach might also address the under-reporting of CSE by boys, and children from the 'Asian' community.

Partly this reflects an ongoing debate in RMBC about whether a youth work or a social care model of intervention is most effective with victims of CSE. In fact, both are needed; a joint approach building on the professional skills of youth workers and social workers doing what they do best. Since the closure of Risky Business, managers have also seen this as an issue of 'winners' and 'losers' which means that effective joint working isn't happening.

Challenges faced by the CSE team

The absence of a clear definition and strong shared understanding of CSE in its different forms, including on-line and street grooming, has led to poor use of resources and confusion amongst CSE team workers as to the boundaries of their role. Inspectors found the policy approach confusing and the allocation of case work between social work teams and the CSE team to be arbitrary at times. The case work audit showed a lack of clarity as to the criteria a child would need to meet before receiving support from the CSE team as opposed to other social care teams dealing with CSE work.

CSE work is under-led and poorly-managed. Staff are often exhausted, over-loaded and overwhelmed by the scale of the challenge. They have been under a prolonged period of unrelenting public attention that has taken its toll. They are also sometimes unfairly made scapegoats for RMBC failures.

Some practice is unsafe. Many children and young people are simply not getting the support they need. Some staff have lost their sense of direction. Guidance is poor, basic processes are not secure and changes are not embedded and reinforced, culminating in a sense of hopelessness and frustration.

The operational team is a multi-agency team in name only. In practice, it is an amalgam of different services or organisations – the police, social workers, youth workers and voluntary sector – co-located, but not integrated, still working in their respective silos.

Concerns regarding the RMBC team identified by Inspectors included:

- One to one meetings between staff and management are not happening as regularly as required
- Regular supervision of cases is not always taking place thereby affecting proper decision-making
- Referrals must be routed through the 'front door' CART (a service which OFSTED and our Inspection found unsafe)
- The dominant use of a social work model in their CSE approach does not recognise the vital role of youth workers in prevention, which means:
- No effective outreach youth work for victims and poor prevention work.

Inspectors found one consequence of these failures was that similar age young people sharing inappropriate pictures of themselves on social media are being given the same initial response as children who are being preyed on by sexual predators. Inspectors also found that cases are waiting for days at the 'front door' (CART) before being properly assessed.

It is very difficult for individual staff members to overcome these failings, however well intentioned they are.

In addition, through the case sampling Inspectors undertook, we found examples of:

- poor decision-making
- drift
- failure to adhere to guidance
- poor or no follow up
- assessments delayed or not done
- files incomplete
- children left at risk for too long without an effective intervention.

In addition, Inspectors identified a number of practical steps that staff have raised before and could be easily addressed. These include a shortage of facilities (such as confidential meeting rooms) and equipment (too few computers and one police car). The lack of these resources hampers effectiveness and shows that this work is not being given the priority it requires by RMBC and South Yorkshire Police (SYP).

Role of the Police and other partners working with the CSE team

Concerns regarding the CSE SYP team identified by Inspectors included:

- Police officers overloaded with cases that are not (yet) a matter for them, i.e. where no crime had been committed

- Police officers have not been properly trained in CSE or social care
- Police processes and systems do not join up with social care and there is no shared understanding of how they will work together day to day
- The police do not understand social worker assessments or thresholds for intervention
- The social workers do not understand the evidence required for successful prosecutions
- There was insignificant action to tackle perpetrators (discussed more fully in our chapter on the police)

Instead of the police being able to easily access social care files via the social workers they were supposedly working with in a joint CSE team, they had to obtain information through the Freedom of Information team in an entirely separate part of RMBC. Waiting for this to be processed caused significant and unacceptable delays. This is an unusual interpretation of Section 29 of the Data Protection Act (1998) and could be easily solved by the implementation of a protocol. This sums up the total ineffectiveness of local approaches to multi-agency working.

Inspectors were told that the police 'get on with their part,' while others got on with theirs; data protection, they stated, meant they couldn't share an intelligence system.

Inspectors were also concerned about the role of other partners in the team. For example, voluntary sector staff members within the team have to refer cases via the 'front door' of social care rather than passing them on to fellow team members; and any intelligence they have for police colleagues has to be passed through the police non-emergency number (101). If there is an information sharing protocol it is not working in practice.

Young People turning 18 years old

We have serious concerns about the group of young people during their transition to adulthood: that is, over 18. It was unclear to Inspectors what happens to victims of CSE at this point. RMBC do not view these young people as victims with ongoing support needs, and instead see their role in terms of a statutory Children's Social Care responsibility which ends when the children turn 18.[16]

Some interviewees suggested that services were just turned off. Adult services did not have an effective system in place to ensure a smooth and effective transition for this vulnerable group. Indeed, the criteria for receiving adult services mean that the

[16] The Children's Act 1989 requires the responsible authority to continue to provide various forms of advice, assistance and guidance to young people over the age of 18 making the transition from care to more independent living arrangements. The duties operate primarily until the young person reaches the age of 21 unless they remain engaged in education or training where support can continue until 24. Duties include providing the young person with a PA; viewing and revising the pathway plan regularly and keeping in touch. The duty to provide accommodation and maintenance for care leavers ends at 18 however, duties to provide general assistance and other support continue.

victims may not meet the need for continued support even though they remain vulnerable, and in some cases continue to be sexually exploited.

For the past twenty years, RMBC had commissioned Action for Children to provide services for young people leaving local authority care. The service was brought back in house as of the 1st April 2014 and is in essence the 'leaving care' team. Inspectors were told that the decision to bring the service back in house was to improve consistency. It is too early to assess whether the return to direct management by the Council will improve the quality of the service. Given what we have found about the ways other aspects of Children's Services are being managed this has to be a concern.

"They've got a poster with my birthday on it when I turn 18 and then they don't need to bother with me." - A victim of CSE

CSE numbers and analysis

There is much argument in RMBC about the numbers collected by Professor Jay in her report. Inspectors believe that the 'conversation and debate' about the numbers is part of a wider culture of denying the problem and its scale. Our research, given the available evidence, leads Inspectors to fully endorse and support Professor Jay's findings. It is essential that RMBC stop debating the credibility of these figures and turn their attention to action.

The Jay report looks at the period 1997 to 2013 and concludes that there were approximately 1400 victims. This is a conservative estimate. It equates to about 85 children and young people experiencing CSE in each year covered.

During the year 2013-14 (i.e. more recently than the period that Professor Jay covered) the CSE team worked with 207 children and young people who were experiencing, or were at risk, of CSE. This figure includes cases where a child had a social worker but the CSE team was also involved, as well as cases where the CSE team took the lead.

However, RMBC's records and data collection is very poor. As such, they cannot answer questions about the scale and nature of CSE taking place today or historically. Although they are currently working to put the necessary systems and processes in place, they have known about this problem for some time and have not taken action. Inspectors are not confident this will be seen through effectively.

RMBC has also been criticised over many years for the poor quality of its social care record keeping. The full scale of the problem may therefore never be known. Although some reasonable assumptions can be made, the scant data is a very serious cause for concern.

At Annex D we have provided detailed analysis of the information we have been able to glean from records and data to support the position that there was a significant number of CSE cases (and therefore victims) and that it is likely that RMBC would have been able to account for, despite their poor data collection and analysis.

In addition, police data provides some evidence of the scale and nature of the present problem, by looking at the number of recorded CSE crimes. During the period 1 November 2013 to 31 October 2014 there were 273 CSE crimes recorded in South Yorkshire, of which 75 (27%) were in Rotherham.

The most commonly recorded crimes were:

- sexual activity with a female child under 16 (penetration) - 15 (20%);
- rape of a female child under 16 - 11 (14.7%),
- rape of a female child under 13 by a male – 10 (13.3%)
- causing or inciting a female child under 16 to engage in sexual activity (no penetration) – 10 (13.3%).

In 2013, there were 68 abduction notices served against perpetrators of CSE or those who posed a risk to children. In 2014 there were 71.

The RMBC/SYP CSE Strategy

The RMBC/SYP strategy is to some degree developed in a vacuum because information and data systems on victims are poor. The strategy is a single page supported by an action plan which is not focussed on impact and outcomes but on activities and process. Actions and milestones are not specific enough. It has seemingly been added to over time rather than being properly reviewed in the light of the Select Committee and Jay reports. As a result, it lacks any strategic coherence and is therefore highly unlikely to be effective.

As at 7th November 2014, the plan was already slipping. Only 20 of the targets were green, 25 were amber (at risk) and 4 were red (missed). Some of the targets marked green had already missed their original delivery date so a later date had been allocated. The former Chief Executive was still named as the person responsible for a number of actions despite the fact that he had already left the Council. This shows that the plan was not being used as a live document to drive improvements.

Inspectors are unconvinced that RMBC has a robust, corporately owned strategy with all partners signed up to action. The response to the Jay Review contained in the Cabinet Report on 3rd September 2014 is evidence that they still had not grasped

the severity of the situation, the need for immediate action, and a wholly different approach over the long term.

The strategy is not joined up sufficiently across RMBC or indeed with SYP and the CPS. Rather than critique the whole strategy here in detail there are some specific issues that are evidence of ineffectiveness.

Prevention Work

There is not enough capacity or expertise to do preventative work well, although those workers who have their roots in the former Risky Business make valiant attempts in the present circumstances. The Council and its partners are responding to new cases without the time to build relationships with children and young people at risk of CSE.

Training

Resources have gone into training all sorts of people over the years – including parish Councillors, business representatives, magistrates and voluntary sector workers. There is, however, no evaluation of the impact of this training which means that neither the Council, the LSCB, is in a position to judge its effectiveness or whether the money has been well spent.

Inspectors did wonder whether training – though important – was a default response and became a substitute for more effective and comprehensive action on CSE rather than just one part of the overall plan. It is easy to send staff on a training course, but unless the principles set out in the training are embedded and acted upon in the whole organisation, then it is ineffective.

"So people just ticked the box with training – if some staff from health have completed training, then as an organisation you have done it so the box is ticked." A key partner

Yet for all the priority given to training, key staff in the Council and the police had not been trained either in CSE or wider training in social care law or practice when a thorough knowledge and understanding of these issues was integral to their roles.

And despite the training provided to staff and members outside social care, many lacked a basic awareness and understanding of their role in protecting children, or as corporate parent.

Schools

Work in schools to raise awareness of CSE has declined from a high point where some young people participated in an accredited course over six weeks in school as part of the curriculum, to a reliance on one part-time youth worker plus some outreach by the Integrated Youth Support System. This is a real concern given the evident risks to young people in the area and the clear benefits of outreach work. Inspectors noted that the work with schools is of a good quality, but is not sufficient. Some schools have put their own resources into tackling CSE, which is to be welcomed.

Outreach

Action to identify victims at risk of harm is insufficiently resourced and the assertive outreach youth work which was so successful under the former Risky Business model has ceased and not been replaced. Rotherham's Integrated Youth Support Services do have detached workers in Safer Neighbourhood teams, but not with the degree of resources which has previously been invested building and sustaining relationships with girls at risk of harm. This means that victims of CSE are not being proactively identified and helped.

Community

Work with parents and the community is under-developed. No-one could tell us how the Council was engaging with the community in the wake of the Jay report. Some work has recently been done to raise awareness of CSE including the launch of a 'Spot the Signs' awareness campaign in November 2014. Whilst this is a step in the right direction, it will not make a difference in isolation.

Protection work

Our summary of Children's Services and the CSE team clearly shows that arrangements to protect children and young people are ineffective. The multi-agency partnerships which have been set up are not delivering results. There were a number of specific issues that caused Inspectors great concern.

Misunderstanding of CSE by senior management

The nature of CSE is still misunderstood and the severity of CSE has not been recognised by senior officers. It is seen as statistically less significant than neglect. While the numbers involved are far smaller, this should not be an 'either/or' issue in which victims of CSE are overlooked.

"X was more focused on other aspects of social care, not CSE. X said: 'I can't worry about CSE; everyone else is.'" A key partner

"X disregarded CSE, as it takes only 2.4% of referrals, and neglect is the bigger issue. They're missing the point, because these kids don't come to you, and even when they do the risk element is so high." An officer

No joint action

Inspectors did not find sufficient evidence of joint action for victims in part because there is no systematic method of joining up social care and health data. But information on sexual health, mental health and teenage pregnancies may all be relevant. Case work showed that children and young people were not always being appropriately referred for support and where they were, CSE was not being identified, even where it was known by other staff. This meant that thresholds for intervention were not being reached and children and young people were missing out on essential help. Victims of CSE can suffer with health issues, such as Post Traumatic Stress Disorder, and require specialist health interventions. Inspectors were told that practitioners sometimes simply don't know what to do with victims of CSE, because when certain cases were taken to CAMHS they would not 'fit' the criteria.

A robust protection strategy requires action both to safeguard the victim and tackle the perpetrator. Information is held in different parts of the Council (licensing, housing, missing children, education, youth and social care) which are simply not joined up and therefore vital action is not taken. Children are left unprotected, and perpetrators are not deterred or prosecuted. The lack of action to tackle perpetrators is dealt with later.

'Missing'

OFSTED judged RMBC's procedures for identifying and tracking children missing from home and care to be inadequate. This inspection supports that judgement. In particular, we noted problems with processes, systems, software, return from home interviews and information sharing.

'Missing' can be a significant indicator for CSE but there is no consistent process for systematically considering each child's case by RMBC or SYP. For example there is a difference in view between RMBC and Safe@Last (the organisation contracted to provide the service) about whether information should be shared and what can be shared. This is unresolved and risks inaction.

The Offer to Victims

On September 10th 2014, the Leader of the Council announced they would be making £120,000 available until the end of the financial year, which would be used to support victims of child sexual exploitation in the short term. The money was allocated as follows:

- £20,000 to GROW who are currently commissioned by Safer Rotherham Partnership to deliver services to young people and families affected by child sexual exploitation. They currently have one full time worker and with their additional funding will support 1.5 full time posts.

- £20,000 to Rotherham Women's Counselling Service and Pit Stop for Men who are a voluntary organisation for adults who have been traumatised by rape, sexual abuse or domestic violence. This funding will be used to increase the capacity of the service.

- £20,000 to South Yorkshire Community Foundation who provide funding to voluntary and community organisations to support victims of child sexual exploitation; this money simply increases the funding available.

- £49,000 to other voluntary sector organisations to help them build capacity to respond to the needs of victims of child sexual exploitation.

- £11,000 is being held in reserve to respond to other potential needs in the voluntary sector

Given that this is all short-term funding, a needs analysis is currently being undertaken by RMBC Public Health to inform longer term commissioning.

Since the 16th of December 2014 there have been further developments:

- The Rotherham Sexual Exploitation helpline is being run by the National Society for the Protection of Cruelty to Children (NSPCC) on behalf of the council. It is a 24 hour service which is open to people of all ages, for those who have suffered abuse either in the past or present.

- The Sexual Abuse Referral Clinic (SARC) has been established at Rotherham District General Hospital. It provides crisis support and has facilities for forensic medical examinations and video interviews.

- In addition, RMBC has employed a Support Coordinator along with additional 17.5 social workers, three team managers, three new Independent Reviewing

Officers and one solicitor to increase support for child protective services through court proceedings.

- The Rotherham Clinical Commissioning Group (RCCG) has appointed 1 new psychologist to help reduce waiting lists in CAMHS.

Inspectors asked for further details of support arrangements and were told that £53,000 was being allocated to Youth Start, a young person's centre that works with 7-25 year olds, to increase their capacity and to co-ordinate the support services offered to victims of abuse. The clinical commissioning group is also investing £200,000 to increase capacity in the local child and adult mental health services for therapeutic support and 'workforce consultancy'.

Inspectors are clear that victims of sexual exploitation should have access to the best possible support services: to help them escape exploitative men, to deal with the immediate aftermath, and to deal with the repercussions and rebuild their lives in the long term. The results of a lack of support is sadly evident in many of the victims we met who now, as adults, have struggled to overcome the extreme and prolonged abuse they experienced as children.

We have concerns that this package, while clearly a welcome first step, falls short of what is required. It appears to lack coherence and reflects the failure of RMBC to see the children and young people involved as victims who have been in need of such support services for a very long time.

More specifically we are concerned that:

- It is not at all clear that Rotherham has identified who and where the victims are, what their current needs are, and what services they may require in the future. They have not set out who can access support, or on what grounds, or stated what they hope to achieve through their services. It is critical that this is all scoped out properly as quickly as possible, so that the right support is available to those who need it. We are concerned that without this, the services on offer may be inappropriate.

- For example, the child and adult mental health services which have been targeted for the most significant investment have a very high threshold for referral: in other words, they are services for the most vulnerable people with acute and immediate needs. There are many other individuals who will not fit this criteria but will also be in need of support. If the criteria for referral have been changed, this has not been clear. Inspectors question whether this acute and specialist service is the right vehicle, capable of the rapid expansion required.

- No investment has been proposed in family therapy services, which will be critical to many fragile victims trying to rebuild relationships with their families, particularly where the families themselves are chaotic and vulnerable. It might be appropriate, for example, to ensure that some of the voluntary organisations are offering family therapy. It may also be appropriate to offer home visits from psychologists (there is, at present, an assumption that victims will always be approaching services, rather than the other way around). But without properly scoping the levels of need, it is impossible to accurately assess what sorts of services will be most effective.

- The proposals generally lack creativity and flexibility. They are dependent on victims identifying themselves, asking for support and trusting the very services which have let them down for so long. It is also important for those commissioning the services to bear in mind it may take a long time for some victims to come forward, and it is important they do not underestimate the long term demand on the services. It is also important for primary health services - for example, GPs or sexual health clinic staff - to be alert for clients who may be victims and to respond sensitively and appropriately.

- It is not at all clear that victims have been asked for their views on either existing or proposed services. The failure to listen to victims and respond to their needs has been a hallmark of RMBCs approach for far too many years: it is vital that they start to put this right immediately in this crucial area.

- We are both disappointed in the level of money earmarked for investment and the fact that only half of it has effectively been allocated, to just three organisations. Given what we know about the numbers of victims, potential demand could well outstrip supply, and victims who may need urgent help should not be made to wait. Again we stress the importance of a robust scoping exercise, which can be used to develop a broad range of appropriate provision, both for the short and long term.

RMBC continues to fail to understand the needs of the victims, leaving Inspectors unconvinced that the current offer will ensure victims get the support they need. To this day, we know that ex-Risky Business staff are relied upon heavily, by both the police and victims, to offer the emotional and practical support that should always have been provided by Rotherham council.

However, yet again those who are closest to the victims, both current and historic, continue to be undervalued and as such have not received any funding as part of this offer. We hope that those who have been tasked with ensuring Rotherham's victims get the help they need, recognise the value of those who have been fighting

to get the victims' voices heard and work with them in the future to gain the trust of those who have been so badly let down.

Summary

CSE has had a high profile in Rotherham since the Home Affairs Select Committee hearings in January 2013 and September 2014 and continues as a result of the Jay report, but the frontline teams trying to deal with it still lack strategic direction, management support and resources.

CSE is still seen as a social care issue rather than a corporate issue requiring the combined effort of many Council services, and those of key partners such as schools, health and the police, to combat it effectively.

These are serious failings and the Council needs to ensure that workers dealing with children in need, child protection, looked after children, and those children and young people experiencing CSE, have the necessary skills, experience and support. The current offer to victims, while welcome, still falls short.

Despite its profile and the supposed political priority CSE has been afforded, prevention and outreach strategies, efforts to protect children and young people, and work to pursue offenders are all inadequate. There is no clarity of purpose and agencies are critical of each other's way of working rather than agreeing on an effective joint approach.

3. DID ROTHERHAM TAKE AND CONTINUE TO TAKE SUFFICIENT STEPS TO ENSURE ONLY FIT AND PROPER PERSONS ARE PERMITTED TO HOLD A TAXI LICENCE?

Inspectors were directed to consider whether RMBC took and continues to take sufficient steps to ensure only 'fit and proper persons' are permitted to hold a taxi licence.

Background

Licensing, regulation and enforcement functions exist to protect the general public from harm across areas ranging from food safety to houses in multiple occupation, to licensed premises for entertainment. Safety is one of the principles of licensing which informs legislation. The safety of the public should be the uppermost concern of any licensing and enforcement regime: when determining policy, setting standards and deciding how they will be enforced.

This is nowhere more important than in taxi licensing where sometimes vulnerable people are unaccompanied in a car with a stranger. For this reason, taxi driving is a 'notifiable' occupation, so if a taxi driver is arrested, charged or convicted, or is the subject of a police investigation, the Licensing Authority must be informed.

Judgement

Inspectors have found that Rotherham has not taken, and does not take, sufficient steps to ensure only fit and proper persons are permitted to hold a taxi licence. As a result, it cannot provide assurances that the public, including vulnerable people, are safe. The inspection uncovered serious weaknesses and concerns.

Licensing at RMBC

The Licensing Authority for Rotherham is the Council. It processes applications and renewals for taxi licences, operator licences and vehicle licences. As such, it needs to:

- ensure that taxi drivers are 'fit and proper' to drive the public
- investigate any complaints about the conduct of drivers/operators and
- consider complaints when licences come up for renewal – or more urgently if need be
- ensure compliance with operator and driver licence conditions and vehicle conditions.

The licensing service in Rotherham reports to the Director of Housing and Neighbourhood Services in the Neighbourhood and Adult Services directorate

(NAS). Home to school transport has also been contracted out to taxi operators but is managed by a separate team.

There is a Member level Licensing Board which reports to full Council, and has delegated authority to determine policy and applications, suspensions and revocations of licence. The Board has recently been reduced from 25 to 5 Members. There is further delegation to the Director to undertake suspensions of licences. There is a right of appeal for decisions that are made by the Council to the Magistrates Court.

As at September 2014 there were 86 private hire operators, 840 vehicles, 52 Hackney carriages and 1158 licensed drivers in Rotherham.

In the past 5 years, the service has dealt with a total of 1100 complaints about taxi drivers. The annual level of complaints has been steady for the past three years at around 180. In the past five years the service has suspended 33 licences and revoked 26, with a further 29 revoked due to non-production of appropriate documentation.

A divided service

The licensing service portfolio covers eight other licensing areas including gambling, alcohol and licensed takeaways. The taxi service is divided into two branches:

- the Policy team deals with policy, applications, renewals, suspensions and revocations
- The Enforcement team deals with complaints and investigations

The split of these functions is not common in other licensing authorities Inspectors found evidence of conflict between the two branches, notably on what kind of evidence could be presented when the Licensing Board meets to consider whether to revoke or suspend a licence.

The two branches of licensing use different databases which do not interface, so information is not easily shared between Policy and Enforcement teams. This means that driver or operator records cannot be viewed in a single place, requires officers to request information from each other and has sometimes resulted in a licence being renewed without question when in fact the driver is being investigated following a complaint.

Inspectors found that enforcement staff do not always record complaints or information gathered on these data systems. This inconsistent recording of information on complaints has the consequence that because data on driver performance and conduct is not collected, trends are not identified and track record

data (for example identifying a series of complaints) may not be available at the point of licence renewal.

Meetings are rarely held across the entire service and some officers said that the visibility of senior leaders was poor. One officer stated that they had seen them for the first time at a briefing meeting shortly before Inspectors arrived.

Lack of policy

A number of officers had worked in other Licensing Authorities and commented to Inspectors that RMBC was behind the times as the licensing service appeared to have few written policies and attempts to draw those up would be stymied. Inspectors found that the Council's bye-laws and conditions relating to vehicle, taxi driver and operator licences seemed not to have changed since 1976, bearing out this contention.

And although there is clear documentation around procedure, there is no indication of what 'serious concerns around the activities of a licensed driver' should prompt for example an immediate suspension of an individual driver. Managers refused to be drawn on this matter, insisting that each case was different and stating that they would act on evidence from police.

Trade influence and the role of Members

Inspectors were often told that the private hire trade in Rotherham is vocal and demanding and some officers expressed the view that the licensing service seemed more geared towards facilitating the trade than protecting the public.

Members added to this pressure to support the trade. Some who had previously held taxi licences or 'badges' sat on the Licensing Board. At one point, the Board had been reluctant to hear any cases not related to matters showing up on DBS checks. That means where there were no actual convictions they would not suspend or revoke licences.

Licensing officers reported to Inspectors that they had received phone calls from Members over perceived delays in the processing of individual applications. Officers would be urged to 'stop wasting time'.

"The taxi driver is the customer and no thought is given to the passenger." An officer

There are instances of Members making representations on behalf of the trade or individual drivers. For example, one Councillor wrote to the Crown Court offering a reference on behalf of a driver who had his licence revoked. As noted earlier

Inspectors were also told that ‘no notice’ vehicle spot checks were changed to ‘10-day notice’ checks after representations from the trade and a Member intervention.

Complaints and Investigations

There are major concerns over the licensing service’s ability to undertake thorough investigations giving rise to a perception of undue weight being given to the need to protect drivers' livelihoods over and above the safety of the public.

The inspection undertook an audit of 22 complaints and found 86 per cent to be inadequate. There is inadequate investigation of some complaints and lack of tenacity resulting in cases being closed before they are satisfactorily resolved. There seems to be a propensity for informal resolution of complaints, giving the trade the benefit of the doubt and not following up all lines of enquiry including the evidence of complainants. This included a number of cases in which drivers had refused to carry passengers with guide dogs.

There has been inadequate follow through and information exchange with Children's Services and with the police on individual cases. This is despite clear efforts by some individual officers to establish good working links with related services, such as home to school transport service. Inspectors noted frustrations expressed by officers concerning feedback from police on cases which had been referred on to them to pursue. Inspectors also noted – and share – concerns expressed by officers that the service is not routinely informed by police of potential CSE concerns including abduction notices.

Officers seemed to lack curiosity over whether there are particular operators where a large number of vehicles may have fallen below standard, or a large number of drivers may have attracted complaints. As a result there is no record of the service exercising its right to place any conditions on individual operator licences where recurrent issues have been identified.

The service has set too high a threshold of evidence before considering suspension and revocation of a licence. Officers are entitled to apply a ‘balance of probabilities’ test to alleged offences by drivers, but instead appear to apply a test of ‘whether it would get past the CPS’. There are examples where the service appears to have closed cases because it believes the CPS thresholds for prosecution will not be met. There is an associated concern here that information which the service does not regard as ‘evidence’ may not be provided to other parties.

In addition, Members of the Licensing Board have not been given sufficient bespoke training on dealing with taxi hearings moreover after Member complaints the number and nature of documents being provided to Members in advance of

suspension/revocation hearings have been reduced which may diminish the quality of the judgements made and could lead to outcomes which place the public at risk.

‘Home to School’ transport scheme

RMBC operates a ' Home to School' transport scheme enabling qualifying, potentially vulnerable, children and young people to travel to and from home to schools and colleges, often unaccompanied.

The use of taxis within this scheme relies on the Council's Licensing service to ensure that drivers, vehicles and operators are properly licensed and that a driver passes the 'fit and proper' person test.

Under one of these contracts, a 21 year old taxi driver was transporting a child with physical health difficulties to and from his place of learning. The boy wrote to the Council setting out some 20 complaints about this driver including that he was:

- Swearing and shouting abuse at other drivers
- Laughing at him and mocking his disability
- Showing him sexually explicit videos on his mobile phone
- Driving dangerously and at excessive speed
- Urinating in full view of him
- Telling the young man that he was involved in illegal drugs

On receipt of this complaint a multi-agency strategy meeting was held. It concluded that this alleged behaviour could have upset the passenger and he was offered appropriate support. The driver’s contract was subsequently terminated and it was recommended that the licensing service investigate whether the driver was a 'fit and proper' person to hold a private hire driver licence.

Police investigated the complaint (after a period of time whilst the driver was abroad). They found no images on the driver’s mobile phone. After an interview with him, they concluded that he was not a risk, that the complaint had been prompted by a relationship breakdown and aspects of the complaint were about ‘laddish' behaviour. In relation to the other allegations there was insufficient evidence to bring any criminal charges.

The driver was also formally interviewed by the Council’s licensing enforcement officer who prepared a file to be submitted to the Licensing Board. It was decided that the boy's allegations relating to graphic sexual images should not form part of case papers being presented. Only the following complaints were put before the Licensing Board:

- Insulting words towards a passenger
- Urinating in view of the passenger
- Conduct of driver
- Driving with an under inflated tyre

The case was presented to the Licensing Board hearing six months after the complaint was made. The driver was represented at the hearing and he was cross examined by Members in what can be best described as a light touch fashion.

The Board agreed that the driver was not a fit and proper person but only suspended his licence for three months leaving him free to operate as a private hire driver after that time had lapsed.

"...it was strange to have a licence removed for three months. You're either a fit and proper person or you're not – you don't just become fit again after three months." An officer

The details of this case were offered to the inspection as an example of improvement in licensing practice.

Pressure on staff

Long term sickness has depleted the Principal Officer grade on the enforcement side for some time. An unresolved contractual issue over late working has meant there is no enforcement of licensing matters around the night time economy. Enforcement officer caseloads were unevenly spread and officers clearly felt understaffed, with one officer commenting that it was sometimes impossible to log off from a telephone which rang incessantly.

Licensing – a new policy?

The Licensing Board in October 2014 agreed a draft revised policy for consultation. The policy brings together various existing policies into one document and introduces some changes including requirements for drivers to achieve BTEC level 2 certificate; extending to five years the requirement for holding a UK driving licence; tougher knowledge tests; more rigorous standards for the consideration of criminality including sexual offences concerning children and vulnerable people.

This new policy is to be welcomed. However it falls short in a number of respects:

1. The Council's general enforcement policy which underpins the proposed Licensing policy does not, in our view, give sufficient prominence to the need to protect the public.

2. The guidance suggests that the authority will not normally grant a licence if an applicant has more than one conviction for indecency or is on the sex offenders register. Inspectors find this unacceptable. One conviction should be more than enough to prevent a licence being granted.

In addition, there is no reference to how the service will deal with complaints/service requests where the complainant does not want to report the incident to the police or the police decide not to investigate or prosecute because of the criminal burden of proof. Our audit of complaints demonstrate that allegations relating to inappropriate behaviour including sexual harassment were not properly investigated. In our view, the reliance on convictions alone will not provide a strong message to the trade on acceptable standards or reassure parents and the public that drivers are safe to transport their children.

The timetable for implementation seems unnecessarily elongated with implementation not expected until April 2015 with no retrospection of standards. This will mean that full application of these measures to all drivers will take nearly three years. Given the high profile of public concerns and real evidence that children have not been properly protected when using taxis in Rotherham, this seems far too long.

Service Improvement Plan

We understand that as a result of our inspection, the Licensing Service has sought to address some of issues we have highlighted by implementing a service improvement and performance management plan. The plans were not part of the inspection and we are therefore unable to comment on whether the actions identified are sufficient to address the findings of our inspection.

4. TAXIS AND CHILD SEXUAL EXPLOITATION

'[I am working with a girl] she caught a taxi to her boyfriends and she was let off the fare as she didn't have much money. He took her to McDonalds and bought her food…she realised he was much older, in his late 30s. He took her out to XXX in his taxi – she believes another young woman was locked in a room – he tried to have sex in the car…she has given the details in a statement to the police…...'

'It's not safe to use taxis.'

Inspectors were directed to consider whether RMBC, in light of the Jay report which highlighted serious failings in the authority over a number of years with regard to the safeguarding of children, was and continues to be subject to institutionalised political correctness, affecting its decision-making on sensitive issues; to consider whether RMBC undertook and continues to undertake sufficient liaisons with other agencies, particularly the police, local health partners, and the safeguarding board and whether RMBC took and continues to take sufficient steps to ensure only 'fit and proper persons' are permitted to hold a taxi licence.

Concern around taxis remains pervasive in the town. Throughout the inspection, individual inspectors frequently heard that people did not feel safe using taxis. The well publicised link between taxis and CSE in Rotherham has and continues to cast a long shadow over the vast majority of law abiding drivers who make their living from the taxi trade. So it is not only to protect potential victims from unscrupulous drivers that RMBC needs to get their house in order and regulate taxis effectively, but also for the drivers who are damned by association.

Professor Jay deemed the prominent role of taxi drivers in CSE as a 'common thread' across England and noted that their involvement was evident from an early stage in Rotherham. '*Residential unit heads met in the 90s to discuss taxis collecting girls, school heads in early 2000s reported taxis picking girls up to provide oral sex in the lunch break'* she said.

The Jay report described how the Safeguarding Unit in the Council convened Strategy meetings from time to time on allegations of CSE involving taxi drivers. She described meeting minutes demonstrating how a single operator was the subject of four meetings in a seven week period, girls having disclosed information in 2010, recording how children were being sexually exploited for free taxi rides and goods and noted three cases of attempted abduction. She also recorded that RMBC had advised that taxi drivers had only been involved in a total of four CSE-related cases (between 2009 and 2012), which had all been dealt with appropriately by the Council's licensing authority.

Licensing Authority – denial that they knew of a CSE problem

When conducting interviews across the licensing service, Inspectors asked for reflections on the Jay report, on CSE in Rotherham, on work with police and social care and on the awareness of indicators such as Abduction Notices in alerting officials that licensed drivers may have developed inappropriate relationships with underage girls. Inspectors were mindful that Licensing Authorities can suspend/revoke licences on the balance of probabilities and do not need to prove an allegation or complaint beyond reasonable doubt, or await a conviction.

In interview, the Director of Housing and Neighbourhood Services, who is responsible for the licensing service, expressed annoyance at the impact the Jay report had had on the Council and remained adamant that the four CSE-related revocations of licences quoted by Professor Jay represented the full extent of taxi driver involvement in CSE in Rotherham. He said that one of those revocations (in January 2011) had marked his first awareness of CSE as an issue. Since the inspection had been announced, he had reviewed a total of 1400 cases (on all kinds of complaints) and only eight had given cause for concern. He remained confident: *'our service is compliant with the best in the area'*.

Specifically, he stated that the concerns expressed in Strategy meetings about cases from 2010 described by Professor Jay were unfounded. He subsequently established that the information was correct; but intelligence from these meetings or from Responsible Authority meetings had not been fed up to him: *'I don't know what I don't know'*. When questioned about systems to ensure the Licensing service was made aware by police of any Abduction Notices issued against drivers, he responded *'Abduction notices mean no proof*'. Lack of 'proof' was a continuing theme: "*Rotherham is a village, professional gossip becomes fact the question for me is "what is veracity?"'* An officer

Less senior staff displayed some ambivalence. Most officers said they would not use a private hire taxi or allow their families to do so. Concerns were also expressed that children in residential units could be ordering taxis by mobile phone and that care workers could be powerless to stop taxi drivers from either grooming young women or transporting them to be exploited.

However, officers echoed the senior management view that the four cases where drivers had lost licences for CSE-related reasons represented the full extent of proven taxi driver involvement in CSE. Officers repeatedly stressed that if presented with evidence of CSE (preferably by police in the form of a conviction) they would act on it by suspending drivers. They appeared less able to grasp the notion that in the arena of CSE 'evidence' rarely appears fully formed and may need to be established by building a composite picture based on different sources of information.

Evidence that the Licensing Authority knew of taxis and CSE as a problem

In trying to assess the level of concern around taxi drivers and CSE and whether the licensing authority at the Council knew about it and responded to that concern, the inspection mainly considered documentary evidence since 2010. All members of the current licensing team were in position at that point.

Inspectors found that the Licensing Manager and the Principal Environmental Health officer had attended a meeting of the Exploitation Steering sub-group in 2010 at which there had been wide-ranging discussions under the agenda heading 'Taxi Licensing and links to Sexual Exploitation'. In November 2010, it was agreed to ' collate a small short task and finish group... in order to investigate allegations that taxi and takeaways were using their position to engage with vulnerable children'. In February 2011, a Safeguarding Manager confirmed a link had been established and that they had attended a meeting with the Assistant Chief Executive where this has been confirmed. One of the recorded actions was to invite Members of the licensing board to a national sexual exploitation conference on the Operation Central lessons learnt, planned for April 2011. The Exploitation sub-group meeting minutes confirm that the Safeguarding Board had concerns in relation to taxis and CSE and that licensing staff were aware of these.

Licensing officers were also invited to attend meetings convened by the Assistant Chief Executive, which from 2010 had considered CSE. Officers told Inspectors they had sought permission from senior management when first approached to attend the meetings. Document bundles provided to the inspection include emails discussing these meetings; senior managers were aware of the Strategy meetings and the issues of CSE and taxis raised there. The service director maintains he was not made aware and Inspectors have seen no evidence to contradict this.

Licensing officers who attended recalled being asked not to take notes and being given scraps of intelligence and asked to check up on it and report back. They ran some information through their systems. Some meetings had been general, others had focused on specific young people at risk.

‘Grid of concerns’

A grid had been produced which itemised issues of concern raised at the meetings. The grid was later provided to the Inspection team by the Council. It covered Strategy meetings in 2010 and was accompanied by a letter to Inspectors from a Senior Licensing Manager stressing that no officials had attended the meetings in question, but confirming that the Licensing service had been provided with the grid back in December 2010. This would indicate that the specific cases itemised in the grid were known within the licensing authority from that date.

Over ten Strategy meetings were listed throughout 2010. Some were multi-agency. All the concerns related to named young people, a high proportion of whom were 'looked after'. There were three or four allegations relating to unidentified vehicles or drivers, or to premises outside Rotherham. Otherwise, most allegations identified specific operators (mainly Operators A, B and C) and in some cases named drivers. Some of the named girls were involved in live police operations then underway, so information came from the police.

Concerns were raised over:

- Taxi drivers harassing or attempting to abduct young people;
- Taxis behaving suspiciously in Clifton Park (a known hotspot for CSE);
- Taxi drivers collecting or dropping off young people from residential homes in a drunken state or in possession of skunk marijuana;
- Young people reporting that they or their friends had performed sex acts in taxis for cigarettes, alcohol or money – or had been asked to do so by taxi drivers; and
- An allegation of rape and serious abuse.

Examples from the grid:

1. Child protection referral on X, by Y at Z residential unit. X's peers say she is giving out large sums of money, sometimes up to £60 to other young people. She says she is receiving money, cigarettes and alcohol in return for providing sexual acts for drivers from operator C and others. Her parents have also reported an operator B taxi waiting outside the house to collect X more than once.

2. A 12 year old girl, part of a live police investigation disclosed rape and abuse of other young females by X and describes X and his brother as taxi drivers (at Operator B). She has also made allegations against his brother. Operator B taxis have also been seen parked outside her school.

3. Park warden reported two Operator D cabs reported outside Clifton Park museum at 7.30 at night, behaving suspiciously. Registration numbers were taken down and cars checked out as Operator D vehicles.

Setting aside conflicting accounts of whether officials attended any or all of these meetings, the Council's licensing management have formally stated to the inspection team that the grid of CSE concerns was provided to them in 2010, so the clear tenor and pattern of allegations and the focus on certain operators should have been clear to them.

Responsible Authority Meetings

Responsible Authority (RA) meetings were set up in accordance with the 2003 licensing act as a forum for agencies to discuss matters in relation to licensed premises such as takeaways. The current Rotherham licensing manager chaired these meetings from 2010 and presciently chose to include taxis as a standing item on the agenda. She invited Risky Business to attend to provide intelligence on taxis and licensed premises in regard to CSE. A member of the Safeguarding board also attended most RA meetings as did a police liaison officer.

Concerns raised at RA meetings in 2010 include:

- Reports that operator E cabs are using unlicensed drivers who may be transporting underage girls around.
- Child missing over the weekend, an item of her clothing reported to be left in Operator B's office (February).
- Concerns raised by a local Councillor and local residents about a taxi transporting girls around the area who then indulge in sexual activity (Aug).
- Concerns about children conducting sexual acts for vodka or food at named shops, takeaways and pubs.
- An allegation made to police by a 13 year old against a named driver.
- A taxi driver taking two 'looked after' girls to Sheffield.
- Girls being taken to Clifton Park by taxi drivers again. Abduction Notices served against driver from Operators B and C.
- A missing 14 year old found at premises on Prince of Wales Road where an Abduction Notice had been served on the taxi driver.

Responses to concerns

Inspectors interviewed officers about specific cases discussed at RA meetings and reviewed a selection of incident files. A number of these illustrated issues of concern to inspectors.

- A customer complained that operator E was using a driver whom s/he knew to be unlicensed and a criminal. An enforcement officer opened a complaint, then closed it the following day after calling the operator who claimed the driver was his son and alleged a malicious complaint from his son's ex-partner and family. No investigation was conducted despite allegations at RA meetings (see above) that the operator's son could be involved in CSE. No action was taken for allowing an unlicensed driver to drive a taxi. Five months later a further complaint was received relating to the operator's son again driving a taxi. The complainant further stated that the son had just come out of prison and that the licensing board had previously rejected his taxi badge application in 2008 and that he had also been disqualified from driving. The

operator was said to be allowing three other unlicensed drivers to use his vehicles. The case was closed on the basis of insufficient evidence to continue.

- A social worker reported that Z, an Operator C driver, had turned up at 5am at the house of a vulnerable client with learning difficulties and refused to leave until she had sex with him. After repeated episodes the client feared she had contracted an STD and the driver was now pressuring another vulnerable person. Licensing officers were asked to make interim measures while police were informed, but no action appears to have been taken.

- A mother complained that when her daughter struggled to open a taxi door the driver told her *'you could have been raped in the time it took you to do that'*. The daughter was very upset. The system records the case was closed after the driver said his comments were taken out of context and notes the *'informant was happy with that'*. It is unclear whether the daughter was spoken to.

Interviews conducted by Inspectors about licensing investigations coupled with analysis of documents, demonstrated a failure to follow through concerns and complaints into action. Inspectors were concerned that when an investigation was passed on to the police it no longer appeared as active on the licensing database/system. This means that no record of potentially serious cases could be built up or taken into account if further complaints were made against a driver.
Investigations also appeared to have been halted on the basis of summary assessments of the quality of evidence and whether it would satisfy the CPS.

Moreover, where cases had been referred to the police, no further action by police was used as a basis for closing the case in the licensing team, even though (as has been noted above) licensing can apply lower thresholds of proof.

Officers demonstrated little inclination to take steps to convert anecdote or information into evidence, for example, by working with residential care homes to monitor taxi activities.

One senior manager cited a joint operation between licensing and neighbourhood safety officers to stand up allegations of CSE related activity in Clifton Park as an example of licensing 'going above and beyond' in its attempts to gather evidence. The operation had run for several evenings until 10pm and found nothing. This was unsurprising as officials had held a meeting with the trade to alert them it would be happening.

Inspectors were concerned that on the basis of a single, flawed and short-lived surveillance operation licensing were prepared to give Clifton Park (and the taxis which congregate there) a 'clean bill of health' in perpetuity.

Inspectors noted a repeated downplaying of low level harassment claims, *'her mother said she was probably pissed'* an enforcement officer commented, of a complaint by a young woman that a taxi driver had put his hand on her leg unbidden. The young woman herself was not interviewed.

Although Strategy and RA meeting notes repeatedly cited the same few operators in relation to CSE linked issues, when asked if any operators gave particular cause for concern in this regard, officers could not think of any.

The case of Operator B

Concerns were raised about this operator repeatedly in both Strategy and RA meeting minutes. Officers built a case (not based on CSE concerns) against the operator as 'not a fit and proper person', which was taken to the Licensing Board, which revoked both of the operator's licences (for operating and driving).
A magistrate's court dismissed the operator's appeal against the revocations. However, in advance of a further Crown Court hearing RMBC accepted a deal whereby the operator relinquished his operator's licence, but kept his driver's 'badge'. Shortly afterwards a family member of his applied for an operator's licence, which was granted and the operator continued trading under a new name. Officials continue to deal with the original operator on licensing matters. In effect the operator carried on under a new guise in full knowledge of the licensing team.

Revocations and current practice

Inspectors noted that only one of the four case studies handed over by RMBC showing revocations of licence (between 2009 and 2012) arose out of the investigation of a complaint. A mother complained after a driver followed her daughter home. Inspectors heard that the board initially refused to hear the case (because the daughter didn't attend herself) and refused to keep the driver and complainant separate when the hearing took place. Three others followed notification from police of arrests so they acted upon that notification.
Inspectors were also concerned at officers' attitude towards limousines. Limousines with over eight seats come under the jurisdiction of VOSA, not the licensing authority, but CSE related concerns had been raised at both Strategy meetings and RA meetings about one particular company. The Licensing Authority expressed disquiet that Children's Safeguarding had written to schools in advance of the prom season, advising parents that there had been CSE related concerns about limos.

This was seen as irregular and not based on ‘fact’, rather than an attempt to prevent a serious issue falling through a gap in RMBC’s jurisdiction.

Inspectors noted that RA meetings are now chaired by a senior manager from the licensing section, who will exert ‘tighter control’ of the discussion and minutes. Inspectors also witnessed a discussion at a CSE tactical meeting in November 2014 during which a senior licensing manager challenged whether taxis and takeaways in Rotherham should be included as possible areas where CSE may be occurring. Both the Chair of the meeting and the CSE coordinator pointed out that taxi and takeaways were identified as a risk nationally and there had been a historic link with CSE in Rotherham. The senior manager did not accept that there was a current problem with CSE and taxis and takeaways. Inspectors are concerned that the services' refusal to accept a link with CSE is hampering its ability to take effective action, investigate complaints properly, share intelligence appropriately or contribute to building a composite picture enabling others to take action.

5. DOES THE COUNCIL UNDERTAKE SUFFICIENT LIAISONS WITH OTHER AGENCIES?

Background

Inspectors were directed to consider whether RMBC undertook and continues to undertake sufficient liaisons with other agencies, particularly the police, local health partners, and the safeguarding board.

Councils are required by law to establish a Local Safeguarding Children Board (LSCB) a Community Safety Partnership and a Health and Well-being Board. Inspectors looked at the effectiveness of each of these arrangements.

Judgement

Inspectors have concluded that whilst the quantity of liaisons between these organisations is sufficient, the quality is not. The current structure is ineffective and is not delivering desired outcomes.

In summary, there are too many boards, too much duplication of effort and too much talking with little visible impact on services or action on the ground. There is no corporate management assessing whether the partnerships are effective and no co-ordination of activity.

Inspectors looked at liaisons on CSE specifically and found a lack of ownership and accountability from the Safer Rotherham Partnership. The LSCB hived off CSE into a sub-group which did not link back to other work on wider community safety issues. Until very recently, CSE has not been given the priority and visibility it required.

As a result, there have been significant lost opportunities for all partners to actively tackle the issue of CSE across all local public services, including health, policing and the criminal justice system; as well as through services like licensing, housing, adults and neighbourhoods in RMBC itself.

Rotherham's Local Safeguarding Children Board

LSCBs co-ordinate the work of different agencies working together to safeguard children and ensure this work is effective. The CE of the Council appoints the Chair of this Board and holds them to account.

The LSCB Chair should work closely with all LSCB partners and particularly with the Council's Director of Children's Services. This person has the statutory responsibility under section 18 of the Children Act 2004 for improving outcomes for children, Children's Social Care and local co-operation arrangements for Children's Services.

The LSCB Chair must publish an annual report which assesses the effectiveness of efforts to safeguard children and promote their welfare.

The core structure of the Rotherham Board (RLSCB) meets statutory requirements and is broadly in line with other local authorities' boards. However the Board is not as effective as it should be and this has been recognised by the Chair.

Historically, the Board has failed to identify shortcomings within Children's Services and ensure action to improve. It carries out the required audits of casework, and makes effective judgements, but these audits are not used to drive improvements in practice, and the Board does not follow up or challenge this effectively enough.
The Chair recognises RLSCB has not functioned effectively. In his oral report to Cabinet in December 2014 he acknowledged the failings of the Board and included an honest reflection of what he, as Chair, could have done differently. We welcome his candour and determination to learn. His approach is refreshing given the prevailing climate of denial.

There are two sub-groups of RLCSB accountable for CSE. These are the Child Sexual Exploitation sub-group called the 'Gold Group' which is responsible for strategy and the 'Silver Group' which is responsible for tactics. The terms of reference for these groups are currently under review. The groups have not been sufficiently effective in scrutinising arrangements, driving action and holding partners to account.

Inspectors reviewed the minutes for the last twelve months. It is clear that a wealth of information about CSE issues, soft intelligence and activity by different agencies is shared at these meetings. However, it is unclear how this information informs the overall strategies and operations for the agencies involved. Senior managers were involved in the groups but missed opportunities to take robust action on the information that was shared.

Each set of sub-group minutes is marked at the beginning with an RLSCB agenda item suggesting they have been presented to the full Board. But there is no reference to any comments or actions requested by the RLSCB in response. In other words, it is unclear what the RLSCB does with the records of the discussions. Inspectors could not see how the information was used to inform service planning, distribute resources or support partnership working.

OFSTED's report noted that the Chair had been well supported by partners and the funding for RLSCB was secure. Inspectors believe this is essential. The recent increase in funding to support performance reporting is also a welcome investment. RLSCB now needs to ensure that this delivers value for money. To date we have seen poor use of evidence to test what is, and is not, working on the ground and weak lines of accountability.

OFSTED found the RLSCB is inadequate and we concur with this finding. They found that while there has been a great deal of activity following the Jay report it has been poorly co-ordinated and change has been too slow. We note that the Chair is taking steps to address current weaknesses, but it is too early to say whether the changes will have the necessary impact. We stress that reform needs to be accelerated.

There must be clearer lines of accountability between the Board, the Chief Executive, the DCS, Members, senior leaders of partner organisation and the Improvement Board. Work needs to connect to tangible outcomes and people need to be properly held to account for delivery.

The Chair of the RLSCB is now also chairing the CSE sub-group and will lead the review of the CSE Action Plan, reporting to the Cabinet quarterly. Inspectors seriously question whether Cabinet oversight of this vital work on only four occasions a year is adequate in the light of public concern.

The Chair's initiatives are welcome steps in the right direction but, will not be sufficient to address the many failings identified. Depending on its other work programme, and how many Serious Case Reviews arise in a year, inspectors question whether the RLSCB can be truly effective in overseeing and maintaining the scale of multi-agency work required for CSE. This is a matter the Council and the wider partnership needs to keep under close review.

The Health and Well-being Board

Each upper-tier local authority has to establish a Health and Well-being Board (HWB) for its area which assesses the current and future health and social care needs of the local community, and develops a strategy which sets out joint priorities for commissioning services to meet these needs.

Inspectors reviewed the last 12 months' of minutes and found them to be satisfactory and in line with other areas. Rotherham had gone beyond the statutory minimum membership and has included NHS providers on the board. One said *"it was great that they had given the Hospital trust a seat"* (which does not happen everywhere). Their agenda is sizeable, but relevant.

However, Inspectors did hear concerns regarding whether health and the local authority were really joining up on the ground. Specific concerns regarding CSE, including mental health, teenage pregnancies and sexual health need to be tackled.

The Board was going to undertake a peer review which was welcomed by all but put it on hold until after the Jay report, and now this inspection. Inspectors hope this review ensures these matters are addressed.

The Rotherham Partnership

Local Strategic Partnerships (LSPs) are non-statutory multi-agency partnerships that have traditionally worked to local authority boundaries. They bring together representatives from the local statutory, voluntary, community and private sectors to address local concerns, discuss strategies and initiatives for the benefit of the community and drive forward change. They have not been a legal requirement since 2010. Although the Rotherham Partnership has remained, its role and relationship with other partnership groups is confused.

The last community strategy was published in 2012 (covering the period 2012-15) with an agreed list of priorities to deliver amongst the partners. The top three priorities include '*supporting those that are vulnerable within our communities*' and to '*ensure the best start in life for children and families*.' This suggests that CSE should have been relevant to the partnership but we did not find any evidence they had addressed the issue.

The general view from partners, confirmed by analysis of the structure and the community strategy, is that this arrangement is largely tactical. Inspectors found that it had focused on individual projects and initiatives rather than on developing a strong ambition for the borough. It is not clear if or how the community strategy feeds into other key plans, and it is seen as stand alone.

The Chief Executive Officers Group

Rotherham has an established Chief Executive Officers Group with Chief Executive level membership from the police, the Clinical Commissioning Group, the hospital, the fire and rescue authority, the Chamber of Commerce, Rotherham college, the voluntary and community sector and Public Health. Participants value this body as it can make decisions and address issues as well as build good personal working relationships across agencies. Its positive contribution seems to have been to promote partnership cohesion, though this does not seem to have translated into the strategic and political leadership that is required.

The minutes of this group since 2005 suggest it has been focused on delivering partnership arrangements like the Neighbourhood Renewal Fund, Local Area Agreements and Corporate Performance Assessment as well as working together on joint bids. It appears to have been effective in this role and this aspect is to be commended. The group has also considered some issues of strategic importance to

Rotherham such as the economic downturn, migration patterns, demographic and deprivation profile, and welfare reform.

From interviews with participants, we understand that this group did discuss CSE and members undertook awareness training. However, it only features on one occasion in the minutes of the Chief Executive Officers Group in April 2014, when a reference is made to Rotherham being a national leader in dealing with Child Sexual Exploitation. It is hard to see how they could have come to such a view based on the evidence we have seen, which raises significant concerns about the information and data which goes to the Group. Indeed, given the press coverage and the commissioning of the Jay report, we find the minute of this discussion misplaced and perverse. This group needs to put CSE firmly on its agenda.

Other partnership arrangements

Inspectors were told that there are: "*lots of committees and groups…loads of meetings about meetings… you need some political direction on what the priorities are."* a strategic partner

There are over 20 groups and sub-groups which are part of the Council's wider partnership arrangements in addition to the Rotherham Partnership and statutory boards. Quite how they fit together was not clear. Arrangements have been subject to many changes and now lack coherence and a sense of common purpose.

There is too much overlap and the boundaries between the Council and statutory groups (such as RLSCB) are insufficiently clear. There are too many meetings, sub-groups, task and finish groups and action plans but not enough action. Too many people sit on different groups, decision making is painfully slow and there is a general lack of pace. When decisions are made they are often delegated to individual officers and are not routinely followed up.

The overall partnership arrangements are too complex and confusing. There are problems both of overlap and duplication and of silo working. No one is bringing together the outcomes and actions from each of the boards, groups and sub-groups. The partnership itself has one funded manager who has a limited remit to help co-ordinate or communicate between strands.

Partnership working is not focused on achieving outcomes. Inspectors saw examples of processes being agreed rather than actions. But even these processes were not followed through. For example, sub-groups were set up to look into matters but without reporting back.

Some of the groups appear too large to be effective. For example, the RLSCB has 33 members and the Domestic Abuse Priority Task Group has 52 members.

"Now it is one group with a cast of thousands. The Terms of Reference runs to three pages and there are so many members that they need to bring together two rooms for meetings." A strategic partner

According to partners, the partnership manager is *"trying valiantly to pull things together"* but a more fundamental review is long overdue.

Partnerships now

Partners are committed to joint working and want to contribute to Rotherham's 'recovery'. However, the current ineffective arrangements mean it is difficult to make this most of this goodwill. The Council does not effectively act as a community leader and galvanise partners.

"What the town needs to see is some strong leadership from the top. How they are going to deal with what's happened. That should instil a bit more confidence. Leadership has to come from the politicians." A partner

"Fundamentally we need some leadership from somewhere." An officer

Partners are disappointed that the joint meeting between the Rotherham Partnership Board and the Chief Executive Officers Group on 27th November 2014, following the publication of the Jay report, did not result in a cohesive strategy and plan of action. This is just one instance of the Council failing to fulfil its community leadership role. The key action agreed was to form a steering group focused on communicating and engaging with the community. This is simply not good enough. Too much of the meeting was spent on discussing the past and there was too little focus on solutions required to tackle the existing concerns.

Partners are frustrated that the Council did not grasp the need to rebuild its credibility with the community. Partners perceive the Council as too passive and express concerns about whether it will succeed in turning leading the necessary changes. Partners expressed a strong desire to see the Council restore confidence in itself, and contribute to rebuilding Rotherham.

"All partners agreed that now is the time to go out and talk with communities in Rotherham. There needs to be a conversation; say you are sorry, support people, make people feel safe, asking you about solutions."

The Safer Rotherham Partnership (SRP)

The Safer Rotherham Partnership is the Community Safety Partnership for Rotherham. It is a statutory body required under the Crime and Disorder Act 1998.

Its mission is: *'to make Rotherham safe, keep Rotherham safe and to ensure communities of Rotherham feel safe.'* For many children and young people it has not succeeded in this mission.

The partnership is jointly chaired by the police and the Strategic Director of Neighbourhood and Adult Services. It has legal responsibility for tackling crime, antisocial behaviour, drugs and alcohol misuse.

Its principal business is driven by:

- a Member chaired board called the SRP Board;
- an Officer Executive Group comprising of partners from the statutory and voluntary sector;
- a Joint Action Group (JAG) with a number of priority sub-groups.

The remit of each group is unclear and we found little evidence of the SRP Board holding officers from the Executive Group to account for delivering SRP's priorities. Both the Board and Executive Group appear to be passive with a large number of reports being 'noted' or 'for information'. The minutes of meetings do not, of course, reflect the totality of the work being done and we have no doubt that good work is being undertaken in relation to crime and antisocial behaviour but this not reflected in the discussions taking place at a strategic level.

CSE has been discussed at different times by the partnership but senior officers told Inspectors that they saw it as a matter for the RLSCB. Joint Strategic Intelligence Assessments carried out by the Safer Rotherham Partnership from 2008/9 flagged up CSE as being an issue but it was not adopted as a priority until 2014. It is unclear why.

"I see an absence of community safety on this issue. Apart from the abduction notices, I can't see how the Council or the police did anything much" A senior partner

In April 2014, a protocol was agreed between SRP and RLSCB to clarify the relationship between the two and *'articulate the specific links and reporting arrangements between them'*. In effect, the protocol requires SRP to share its minutes and any reports on joint priorities with RLSCB. It was also agreed that annual reports submitted by the Safeguarding Board to the Council's Improving Lives Select Commission would include a focus on joint priorities. This is a step in the right direction on paper but does not ensure joint action is cemented.

The Safer Rotherham Partnership has set out four priorities for 2014/15. Priority one is *'reducing the threat and harm to victims of child sexual exploitation.'* However, RLSCB's Gold Group has sole responsibility for developing the CSE strategy and

delivery plans for the borough (working with Silver Group). Its terms of reference require it to report to the Safer Rotherham Partnership as well as RLSCB. This is bound to result in unnecessary duplication with the same officers attending a number of meetings presenting the same reports. We do not find the arrangements regarding CSE to be appropriate.

More importantly, we are at loss to understand what contribution SRP makes to tackling CSE perpetrators and to reducing threat and harm to CSE victims. South Yorkshire Police continue to lead in this area and generate a lot of the activity in relation to CSE. We are disappointed at the lack of engagement and contribution being made by the Neighbourhood Crime and Anti Social Behaviour Division of RMBC and its other Regulatory Services, an issue we explore further in the following chapter. The lack of accountability and challenge from the Board and Executive Group is doing nothing to maximise contributions from all partners.

Inspectors found that the SRP had failed to develop a strategy with police to use the full range of the Council's legal and regulatory tools to disrupt criminal activities. It had also failed to work in partnership with the CSE sub-group to ensure that CSE issues were being properly tackled.

Community Safety and Tackling Child Sexual Exploitation

Inspectors examined carefully whether there had been effective liaisons with regard to community safety across the Council, the police and other partners. In a robust partnership between equals, the inspection team would expect to see evidence of all parties working together in the interest of victims. Unfortunately, this was found to be significantly lacking both historically and currently in RMBC's approach to dealing with issues of CSE.

Rather, inspectors noted council staff's preparedness to accept long-term police assurances of the situation being dealt with, without adequate challenge or scrutiny of their actions.

While a healthy respect for other services is an important aspect of any partnership, this level of passive acceptance leads officers to neglect their own responsibilities towards victims. The Council has a role in holding the police to account, and failure to do so resulted in a failure to ensure the protection of victims and prevention of further crimes.

To this day, the Council will not publish the 2003 and 2006 police intelligence reports highlighting the extent and nature of the problem of CSE in Rotherham, due to 'on-going [police] investigations'; demonstrating the continued excessive deference to South Yorkshire Police.

RMBC does not recognise that it has an important role in tackling and disrupting perpetrators. It has failed to understand the value of the information it holds in understanding the picture of CSE in Rotherham and the identity of perpetrators. Instead, RMBC does not ask who the perpetrators are, and remains ignorant both of what tools and powers are available to them, and how to use these to reduce the risks to young people.

We accept that the police have primary responsibility for dealing with cases of breach of criminal law. However, RMBC also has an active role to play, in particular – though not exclusively - where criminal prosecution is not possible.

They have a wide variety of options available including:

- Civil Injunctions under section 1 Anti-Social Behaviour, Crime and Policing Act 2014 (these replace Antisocial Behaviour Orders (ASBOs) and Anti-social Behaviour Injunctions);
- Closure orders associated with nuisance and disorder;
- Application for an injunction under the High Court's inherent jurisdiction;
- Section 222 Local Government Act 1972;

- Exercise of the council's regulatory functions including taxis, takeaways, nightclubs, hotels, B&Bs etc.

Inspectors saw little evidence of the use of such powers to tackle child sexual exploitation. A list of powers available can be found at Annex E.

Failure to systematically consider or pursue these alternative approaches is a failure of RMBC's community safety team but also of the Safer Rotherham Partnership. The Partnership, using the combined powers of RMBC and SYP, would have been expected to take a significantly stronger role in prevention, disruption and enforcement action against perpetrators.

Abduction notices

Abduction Notices are available to the police under section 2 of the Child Abduction Act 1984 and have been used in the absence of prosecuting offenders. There is no legal or statutory basis for serving these notices, and the breach of any of the terms of the notice is not a criminal offence - although a notice can be used as evidence in support of other criminal offences and/or support applications for injunctions or other civil orders.

Given the relative weakness of abduction notices, they have been used surprisingly frequently in Rotherham. Information from the police suggested that approximately 139 Child Abduction Notices had been served in relation to 114 young people in the two years 2013 and 2014. These figures are all the more striking when compared with the relatively low numbers of prosecutions for related activity.

Although the information received was incomplete, Inspectors were concerned at their use in several situations. This included the apparent use of Abduction notices multiple times on the same individual, the use of Abduction notices where there had been allegations of rape, and the use of Abduction notices on perpetrators who had been the target of previous police operations in relation to allegations of extreme violence and intimidation.

Inspectors therefore question the basis on which Child Abduction Notices are served, particularly in the light of the fact that adherence to the terms of the notices is not monitored.

South Yorkshire Police

The role of South Yorkshire Police (SYP) falls beyond the scope of this statutory inspection, and we have not looked into their past or present actions in detail. However, inspectors felt that the critical role of SYP in tackling CSE meant that the organisation could not be ignored in this report. The police are a crucial partner in

tackling sexual exploitation. Whilst the Council has powers to deal with perpetrators, the primary role rests with the police. Unfortunately, the impression of Inspectors was that SYP's action has fallen short of what would be expected.

There is little argument that crimes of grooming and sexual exploitation are on-going in Rotherham. The number of current CSE cases being dealt with, the number of CSE related crimes recorded and the number of abduction notices served by SYP all point to the active and numerous perpetration of crimes within the town.

It seemed to Inspectors that police activity was unexpectedly low in response to these issues, and historically has been poor. There has been a flurry of recent action by the police on criminal investigations and prosecutions, which is to be expected given the high level of public scrutiny and the focus afforded by the new Police and Crime Commissioner. However, Inspectors remained concerned that once public scrutiny wanes there is a danger that historic inertia will prevail.

Without the remit to consider SYP's practices in detail, Inspectors noted the following as concerns.

Procurement of evidence

There has been excessive dependence on victims' disclosure and verbal evidence to proceed with prosecutions, placing an intolerable pressure on vulnerable young people. The nature of CSE means that these young people are likely to be frightened, distrustful, and may still consider themselves in a relationship with perpetrators, making this reliance on disclosure ineffective and unfair.

Inspectors would encourage the use of other approaches, which are beginning to be considered – such as so called 'victimless prosecutions' – in future.

Treatment of victims

The police's historic attitude towards, and treatment of, victims has been unacceptable. Young people's testimonies are ignored, victims are not offered necessary protection, and perpetrators are at liberty to continue their activities. This behaviour by SYP perpetuates the cycle of abuse and psychological distortion suffered by the victims, by reinforcing the message that no crime has been committed, and that they are to blame for their own treatment.

Inspectors are concerned that this attitude continues in the police to this day, with treatment of current victims remaining at an unacceptably low standard.

We welcome the on-going investigations by the Independent Police Complaints Commission (IPCC) into the historic conduct of some officers. We are also pleased

to see the launch of Operation Stovewood, by the National Crime Agency, reviewing major investigations into CSE in Rotherham over the period of Professor Jay's report. We hope these investigations help to deliver justice for the victims.

6. DOES THE COUNCIL TAKE APPROPRIATE ACTION AGAINST STAFF GUILTY OF GROSS MISCONDUCT?

Background

Inspectors were directed to consider whether RMBC took and continues to take appropriate action against staff guilty of gross misconduct. Inspectors took into account RMBC's response to the Jay report.

Judgement

Generally, inspectors found the Council too willing to take the path of least resistance rather than ensuring it did the right thing for individuals or the organisation as a whole.

We have concluded that whilst the Council has followed its own procedures, these have not always ensured that it has taken, and continues to take, appropriate action against staff potentially guilty of gross misconduct.

Action post Jay report

At the Cabinet meeting of 3rd September 2014, which followed publication of the Jay report, the then Chief Executive Martin Kimber acknowledged 'a desire for those at fault to be held to account', given the scale of failings which the report had identified. The Council had taken legal advice to inform how to address this issue in terms of current and former employees.

The CE said that:

- the Council had shared 'a list of individuals, currently employed by the Council, involved in child protection' with Professor Jay;
- Professor Jay ' *confirmed that in all cases no adverse comments [were] made in the course of the inquiry either through interview, written submissions or case interviews that would warrant investigation';*
- one individual had been asked further relevant questions as to their knowledge about child sexual exploitation issues;
- preliminary discussions were to take place with one further employee, '*to be concluded as swiftly as possible, and may or may not lead to further action'*.

During the inspection, the Director of HR advised that the case files for victims A-O (whose cases were highlighted in the Jay report) were being independently reviewed to see whether there are any concerns about practice relating to staff past or present. This is to be welcomed.

No Chief Officer has faced a disciplinary investigation in relation to the Jay report. The Council accepted resignations from the former CE and the former Strategic Director of Children's Services Joyce Thacker. Both received payments described by the Council as "*only that to which the officers were contractually entitled*". We were advised that a third Chief Officer has also left on similar terms. Such arrangements may lawfully be made in order to deliver the required staffing changes. Whilst this has given the Council the chance of a welcome fresh start, it has also meant that no-one has been held to account for the serious failures Professor Jay identified.

Disciplinary, grievance and severance case files

Inspectors requested all staff disciplinary, grievance and severance case files from 2008-2014. We also asked to see files for the former Director of Finance, the former Director of Children's Services, the former Chief Executive and the employee referenced by the CE on 3rd September because of their relevance to the Jay report. The former Director of Finance had parted company with the Council under the terms of a severance agreement. The other employee's case was still under review.

111 files were provided (excluding those for schools). Of these:

- 38 were categorised as disciplinary
- 42 as grievance
- 23 as severance agreements
- 7 as Dignity at Work (some of which were treated as grievances)
- 2 as Employment Tribunals

Inspectors reviewed 19 case files in detail, including the four staff specifically requested. The other 15 were chosen at random and included:

- 11 disciplinary/disciplinary appeals
- 10 settlement and compromise agreements
- 5 grievances (including one collective grievance involving 6 staff)
- 2 complaints under the Council's dignity at work policy.

The numbers do not add up to 15 as some cases had multiple issues, including racism, bullying and harassment, sexual harassment and sexism. Some cases included several complainants.

Severance payments and compromise agreements

Inspectors judged that the Council has appropriate policies and processes in place for dealing with matters relating to officer performance, conduct and grievances, which staff know how to use.

However, the case sample indicates that severance payments and compromise agreements[17] were too often used, sometimes instead of hearing grievances or disciplinary cases, which was not always appropriate.

Further evidence from the Council suggests that the case sample may have provided a skewed picture proportionate to the whole. Nevertheless, Inspectors still had concerns about the judgements being made in some of these cases.

Settlements can leave issues unresolved in the case of grievances. For example, one staff member was offered severance when she complained of being bullied. There were counter claims against her by others saying she was a bully. Because the case was not properly investigated, it is unclear whether the matter was resolved by the complainant's departure.

Where severance is used instead of disciplinary action procedures being followed through, it sends the wrong message to the workforce and managers. It may not be an appropriate use of public funds, particularly where dismissal could have occurred if due process had been followed. This was acknowledged by the Council.

One former senior manager in RMBC left under a compromise agreement having faced potential disciplinary procedures following serious allegations made by a group of staff regarding inappropriate behaviour. Inspectors believe that the disciplinary case should have been heard and the evidence judged on its merit. If the behaviour was found to have taken place then this disciplinary process would have sent a strong signal to the organisation that this behaviour was not tolerated by RMBC.

Equally, had the allegations been found to be spurious, mischievous and vexatious, this should have led to appropriate action against those making the allegations, again sending out a strong signal that such behaviour was not to be tolerated either. Instead, the employee left under a compromise agreement, both parties agreed not to discuss the matter publicly and due process was not seen to be done.

"It doesn't send the right signal… [But] this solution avoided a long winded disciplinary process." A senior officer

[17] A 'compromise agreement' is a contract between an employer and its employee (or ex-employee) that can be used in redundancy and dismissal situations. The employee will typically receive a negotiated financial sum in exchange for agreeing that they will have no further claim against the employer for any sum owed under the original contract of employment.

A number of the files inspectors examined were incomplete. Action took longer than it should in several cases and in some action was so delayed that individuals left before the matter could be resolved. Trade union representatives raised concerns with Inspectors about the timeliness of dealing with staffing matters. We concur with these concerns. Protracted and unresolved processes of this kind cannot be in the interests of either the individual concerned, or the organisation itself.

Grievance cases were too frequently dismissed on the grounds of insufficient evidence. In two cases where this had occurred, Inspectors considered there was clearly some evidence of poor conduct by managers. In another case, Inspectors noted that the disciplinary process appeared to have been concluded without seeking evidence from all third party witnesses.

At times, little effort appeared to have been put into seriously exploring issues raised through grievances. For example, a complaint about potential institutionalised racism was apparently dismissed without investigation on the basis that it was 'unsuitable for a grievance process'. We make no comment on the merit of this particular case, except that it should have been properly looked into.

Sanctions, dismissals and the role of Members

Sanctions seem generally within the expected range, although there was one case in which a manager was dismissed, where the sanction seemed severe in the circumstances. This person was reinstated on appeal but left shortly afterwards with a severance agreement.

In three of the cases Inspectors reviewed, staff that had been dismissed and were reinstated through the Member appeal process. Inspectors seriously question Members' decisions in two of these cases.

In the first, Members acknowledged grave concerns that children had been left unsafe as a result of poor decision-making by a social work manager, but chose to reinstate this manager.

In another, a manager dismissed for racial discrimination was reinstated even though Members noted that her actions had been completely inappropriate and fell well below the expected standard of conduct. Inspectors seriously question the message this decision sent out to staff in general and those who had raised concerns in particular. Inspectors question whether HR was giving sufficiently strong advice to Members.

7. DOES ROTHERHAM COVER UP INFORMATION AND SILENCE WHISTLE-BLOWERS?

Background

Inspectors were directed to consider whether RMBC covers up information, and whether 'whistle-blowers' are silenced; and whether RMBC took and continues to take appropriate action against staff guilty of gross misconduct.

Judgement

Inspectors have concluded that RMBC goes to some lengths to cover up information, and silence whistle-blowers. It has created an unhealthy climate where people fear to speak out because they have seen the consequences of doing so for others.

"I'm just worried about reprisals of a personal nature." A Councillor

"We've all been made aware of the (whistleblowing) procedure, but no-one dares ever use it, because if they did, eventually it would come back to bite them in the backside and they would be bullied out of the organisation". A whistle-blower

Cover up?

Cover up in RMBC needs to be looked at within the culture of a Council that, as has already been described, does not welcome challenge and chooses instead to 'shoot the messenger' rather than learn from mistakes that have been made. Inspectors found that RMBC, when faced with information about wrong doing or poor practice often seeks to stamp on that information and silence those who bring forward their concerns. Inspectors found that the Council's concern with its reputation leads it to cover up information which it would prefer not to be in the public domain.

The most high profile and contested example of this is the redactions made to the Serious Case Review (SCR) of Child S, who was murdered in Rotherham in October 2010 (see Annex A).

The SCR was not published until late May 2012 and was so extensively redacted that *The Times* newspaper contacted RMBC signalling its intention to publish some of the details which had been removed. *The Times'* journalist Andrew Norfolk had extensively covered CSE as a national and Rotherham specific problem from 2010 onwards. He received the un-redacted report from an anonymous source.

The Times contended that the redactions sought to minimise Child S's involvement with CSE and mask associated failure on the part of professionals within RMBC. The Council justified its redactions on the basis of seeking to protect the identities of

Child S and her family and there is some validity in the claim, although the related murder trial had been extensively covered in the media. RMBC sought a legal injunction against *The Times* to prevent it from publishing. The matter attracted criticism from the then Secretary of State for Education Michael Gove. A less heavily redacted version of the SCR was finally published in 2013.

The Inspectors have reviewed both versions of the redacted SCR and found that while the majority of redactions related to unidentified members of the family, these were relevant as they would have supported the identification of Child S as at risk of CSE. They revealed that a sibling of Child S had a long history of involvement with services and agencies, including the police, in relation to CSE. That references to this sibling were redacted minimised the visibility of that risk. Given that services around Child S, save Risky Business, were not proactive in identifying this as a risk, the redactions could be seen to corroborate *The Times'* assertion that this revealed failures on behalf of RMBC.

Inspectors are of the view that the SCR into the death of Child S minimised her involvement in CSE in a manner which was overlooked in the furore which surrounded the redactions.

In chapter 3.3 the SCR clearly stated that the information that linked both Child S and her sibling to CSE had been discounted for the purposes of the SCR. This information linked them to alleged perpetrators and included details of vehicles used, telephone numbers and addresses and other young women who associated with them. Information of this kind was held in a database and, as the SCR acknowledged, was of use to the police. However it was discounted and not included in the account of Child S's life assembled within the SCR on the basis that the information was all second and third hand and therefore unverifiable. *'For the purpose of this review it has therefore been discounted.'* No reference to CSE was included in *'A Child's Journey'* which summarises what the SCR considered to be a verifiable account of Child S's life.

The Council's legal action against *The Times* commenced amidst a climate in the Council that did not want Rotherham to be identified publicly as having a problem with CSE and its focus was the protection of the Council's reputation. The Council and its staff did not see the ongoing coverage by *The Times* as a 'red flag' moment; an opportunity to get underneath what was happening and galvanise action. Instead, it went on the defensive and viewed the coverage as a politically motivated attempt to undermine the Council's reputation.

More generally, staff told Inspectors of a culture where bad news was not welcome and difficult matters were 'taken off agendas'. Inspectors also found that key files and documents were missing and could not be provided on request. This included taxi operators' manual files so up to date information could not be provided relating

to ownership. Inspectors do not have evidence to prove that this is a cover up but even in its best light this would be poor record management.

Inspectors were told about missing files, including children's case files belonging to Risky Business that the Council could not find. Our inspection established that these files had been in an office at Riverside House, the Council's main building, for some considerable time. Professor Jay also comments on the fact that the minutes of 'key players meetings' could not be found. We are advised that the interim Chief Executive asked the Council's internal auditors to find these and within weeks, they had been tracked down. It seems that when RMBC says things are missing and lost, that they may not have looked that hard.

Whistleblowing procedures and evidence reviewed

Whistleblowing entails a worker reporting things that aren't right, such as if an organisation is conducting illegal activities, neglecting its duties, or covering up wrong doing. A worker can't be dismissed because of whistleblowing. If they are, they can claim unfair dismissal. They will be protected by law as long as certain criteria are met.

Inspectors reviewed the Council's whistleblowing procedures, called the Confidential Reporting Codes (dated 2000, 2002, 2006, 2008, 2010, 2012, and 2013); reviewed the whistleblowing investigations considered by the Standards Committee, and interviewed the Monitoring Officer and Director of HR. Twenty people contacted the inspection team directly to provide information and evidence to the inspection. This included whistle-blowers, current and former members of staff and members of the public. Inspectors met with 15 of the 20 contacts. In addition, Inspectors followed up an anonymous letter and asked senior Council officials about the climate/culture of the Council.

The Council's policies and processes appear to be appropriate and there is evidence that some recent efforts have been made to communicate these to staff.

We asked the Council to provide us with the number of whistleblowing cases over the period of the Jay report, the concerns expressed therein and the outcomes of these cases. We looked at 23 files provided which covered a wide range of matters.

Inspectors noted that it was unusual for whistleblowing reports to be considered by the then Standards Board which is normally reserved for matters of Member conduct. While it is not good practice to muddle roles in this way, we concluded that these complaints had been subject to independent investigation and report and seemed to have been appropriately handled. There was one exception when the substance of the concern had not been included in the terms of reference for the

investigation (see case study) and this was not picked up by the Standards Board when it upheld the complaint.

Staff who blow the whistle

"I stepped forward on behalf of young people … It cost me my job and my career. I feel it was worth it. I am proud to have done so despite the cost to my health and financial situation… the machine at RMBC doesn't care, won't listen and simply exists to cover up and destroy." A whistle-blower

Staff in RMBC have spoken to Inspectors of being afraid to speak out, told to keep quiet, instructed to cover up, and of a culture where "if you want to keep your job, you keep your head down and your mouth shut."

A significant number of people we interviewed were clearly afraid of what might happen to them if they spoke out.

Inspectors considered detailed evidence in three specific cases where people who blew the whistle felt they were marginalised, bullied, harassed and victimised as a result.

In two cases, whistle-blowers claimed they were deliberately restructured out, one from the Council and the other from a provider working closely with the Council under a contract. In a third case, following a similar pattern of marginalisation the person left.

Inspectors recognise that sometimes whistle-blowers may have other agendas and those who approach inspections can be aggrieved for all sorts of reasons. We have borne this in mind when reviewing the cases presented to us and have nevertheless formed a view that in these specific cases there was sufficient truth in the matters raised to be a cause of public concern.

Inspectors received evidence to show that the Council did not always do the right thing. Sometimes this was because officers were worried about the impact on the RMBCs reputation.

In the two instances we have included as case studies, there was evidence that the risk of potential harm to children was considered by officers to be secondary to hitting targets or avoiding uncomfortable press coverage. More generally, Inspectors noted that Rotherham seemed concerned to make things appear better, rather than be better.

"Threats have been made towards staff if they don't toe the line… anyone who dares say anything out of line will be dealt with at a later date" A concerned member of staff

"I fear for reprisals I will get if I came forward with the information I hold" anonymous letter to inspection team

The former CE Martin Kimber told Inspectors:

"The organisation has a well developed whistleblowing policy that was in place prior to my arrival and which is reviewed annually. It was updated in June of this year. This is administered by the Director of Legal and Democratic Services. The Council also has a complaints procedure in place and an audit capability to be able to assist with both internal and external investigations if necessary. I am unaware of any whistleblowing complaints that have been discouraged, not accepted or not pursued."

The falsification of data and the missing young people

The Council received a complaint in March 2011 that data relating to the number of young people not in education, employment or training (NEETs) was being falsified. Negative data was not input while positive evidence was, and young people were being taken off the system to make the numbers look better.

Inspectors reviewed extensive correspondence spanning over a year. It is clear that the Council was placing the onus on the whistle-blower to provide evidence, rather than attempting to establish the facts for itself. The complainant was tenacious and eventually, 15 months after the initial complaint, RMBC acknowledged they had a point. An internal auditor was asked to look into the matter. Their investigation supported the allegation that NEETs recordings had been "*consciously delayed …. to positively affect the outcome of the monthly performance calculation*". It continued "*that while this had the effect of positively influencing each month's calculation the remaining 'balance' was inevitably added in the following month"*.

However, the complainant continued to assert that the investigation was flawed: *"this falsification led to children at severe risk not receiving support. RMBC totally ignored the focus of the complaint…"* Inspectors reviewed the scope of the auditor's report. The auditor did not look at the systems or track any cases to see whether children were in fact added after the deadline, or whether others were removed from the system. In this respect the investigation scope was flawed as the central thrust of the complainant's concern, i.e. the well-being of the young people affected, was not considered.

By blowing the whistle, the complainant told inspectors they tried to bring into the light practices they thought could be adversely affecting vulnerable young people. The matter never got properly looked into, and with the passage of time, we will never fully know whether the complainant was right. But on the balance of probability, i.e. having been able to establish that figures were indeed falsified, it would be reasonable to accept that there may well also have been truth in the other assertions made. The whistle-blower lost their job in a restructure undertaken by the Council's provider.

The case of the missing laptops

Inspectors were contacted by a former employee who alleged that the Council failed to inform the Information Commissioner's Office (ICO) about the loss of possibly '*50% of children's data held by the Council at the time'*. The data was held in the 'H cache' of 21 laptops that were stolen from RMBC on 26th October 2011.

Inspectors reviewed all information the Council held in relation to this matter. The uncontested facts are that:

- there was a theft of 21 laptops from Norfolk House on the night of 26th October 2011
- there was no sign of a break in
- there was an investigation
- there was a report to Senior Leadership Team
- the Council did not alert the ICO
- the Council responded when the ICO wrote to them, on two occasions

The Council admitted that some sensitive data was lost, including that relating to victims of CSE. The investigation report shows that the matter was discussed with the police and information relating to CSE was present on the laptops, including the names of adults who may have been offenders. This much is agreed between the whistle-blower and the Council. But what is in contention is what else was on the lap-tops. The whistle-blower asserts that a large volume of other sensitive children's data was lost. He says the matter was discussed at a meeting of the Corporate Governance and IT Governance Board on 7th November 2011 chaired by ex-Councillor Jahangir Akhtar. The meeting was told that a report recommending that the data loss should not be reported was being prepared for the Senior Leadership Team. The risk of a hefty fine from the ICO was the key consideration at the time. The Council does not have the minutes of this meeting.

Inspectors reviewed a report prepared for SLT on 19th December 2011. This confirms the whistle-blowers testimony, including the loss of sensitive data.

'It is understood that some of the laptops may have had sensitive information stored on the computer's in-built hard drive (known as the 'C:\ drive') which includes the user's desktop. In addition, information held on the H:\ drive will have been 'cached' (copied) to the C:\ Drive to facilitate offline working…'

Due to the sensitivity of the information, it may be necessary to inform the Information Commissioners Office of the data loss'.

The SLT report considers the risks relating to the loss, including: '*The safety of vulnerable persons, particularly children, could be compromised if the information is accessed. The Council could also fail to meet certain statutory obligations in relation to safeguarding vulnerable children or adults.'*

The SLT report concludes:

'If we report this breach to the ICO it is likely that we will have to sign a formal undertaking to encrypt all portable and mobile devices used to transmit personal information. We may also be fined for the breach. The ICO can now impose fines of up to £500,000.'

The whistle-blower alleges that he demonstrated how easy it was to get access to these laptops. He had spent two hours on Google to work out how to get into them without a password, and he proved it could be done.

There is no minute of the 19th December SLT so we do not know whether the matter was discussed. Either way, the Council did not report the loss.

The ICO became aware of it from an article in the local Advertiser, which reported the theft but did not pick up on the data issue. In response to the ICO's enquiry, in June 2012, the Council advised him in summary that '*none of the data was sensitive personal data'*.

This was accepted by the ICO. However further information comes to his attention and he writes again. This time the Council is more specific about what is held but again they do not reveal the extent of the loss in terms of the cached H drive. Even so the ICO concludes that:

'the type of data involved in this incident appears likely to be "sensitive personal data"... and has the potential to cause significant detriment to the individuals

concerned if compromised…We welcome the remedial steps taken by the Council in light of this incident...Therefore, after careful consideration and based on the information provided, we have decided not to take any formal enforcement action on this occasion.'

Whilst it is not possible to prove exactly what was held on the H drive and therefore what was lost, evidence seen by Inspectors confirms that the Council did cover up the scale of the loss known at the time.

The whistle-blower claims that as a result of his persistence in raising the loss, he was restructured out of a role in a restructure of IT services. Our checks show that he was unsuccessful in securing a job in the restructure of IT, no suitable offer of alternative employment could be found at the same grade, he turned down a demotion and was therefore made redundant.

Annexes

Annex A: Serious Case Review into Child S – published in 2012
Annex B: List of Rotherham Metropolitan Borough Council achievements
Annex C: Findings from the Statement of Accounts
Annex D: Child Sexual Exploitation numbers
Annex E: Tools and powers available to tackle Child Sexual Exploitation
Annex F: The Inspection Team

Annex A
Serious Case Review into Child S - published 2012

One of the subjects of the failed Operation Czar was Child S. Six months after the end of that operation, in the October she was murdered. She was 17 and had a baby of only a few months old. A Serious Case Review (SCR) was undertaken by Rotherham Local Safeguarding Children's Board (LSCB) as is expected after such tragedies because of Child S's involvement with social care and other services.

Despite Child S's involvement in Operation Czar, the terms of reference for the SCR are drawn in a way that excluded broader consideration of CSE in Rotherham. The reason cited is that this issue had been addressed in a 2010 Lessons Learned Review following Operation Central – which itself lacked a description of the victims, having been produced in advance of the criminal trial.

The SCR attracted publicity in relation to the issue of redactions which are dealt with in Part 2 of this report. However inspectors were keen to look at the serious Case Review in its own right for a number of reasons: there remained conflicting views over whether Child S had been involved in child sexual exploitation and remained a subject of controversy; and the SCR coincided with the Risky Business' move into social care.

The review was comprised of a series of Independent Management Reviews (IMR) of the services which Child S had been involved with: social care, health and education, police and youth services (Risky Business). RMBC undertook separate IMRs on Children's Social Care and on Targeted Youth Services. These gave narrative outlines of Child S' involvement with the service or agency in question, followed by analysis and recommendations.

While the IMR on Youth Services (i.e. Risky Business – they call 'Project 1') acknowledged the difference between youth work practice and social care, throughout the IMR the distinction between Risky Business and Children's Social Care's respective responsibilities towards Child S are repeatedly blurred. Risky Business is judged through the processes associated with safeguarding and child protection, although this is an inappropriate and incorrect basis on which to critique a Youth Service:

'...It remains a Youth Service project that does not have the rigour of case management supervision, procedures, and systems that might be expected within the child protection system. Its competence therefore as the "Lessons Learned Review" observes is spread "too thinly in order to be the solution to all things CSE" (6.3.7)... Project 1 does not sit within the safeguarding framework and as such is not seen as part of mainstream safeguarding services.'

This of course is to miss the point that Risky Business was not supposed to be 'the solution' but had a specific and vital role which the IMR appeared to disregard.

The IMR also used social work methodology and standards to measure Risky Business's strengths. Its ability, for example, to gather the kind of information which police had relied on in the successful convictions achieved through Operation Central:

'[the way in which] Project 1 collate and share information…is very much embedded in their status as youth workers….That is by over time mapping out networks of young people and identifying their needs and perceptions. Whilst this will fit with the intelligence gathering model of the Police it may not necessarily fit so well with the social care model of thresholds and priorities.'

In this way, extensive information collected by Risky Business about Child S which may have confirmed her involvement in CSE was disregarded by the IMR, and accordingly, the SCR.

'…how this information can be interpreted by this review is problematic as no context or sources are cited and no weighting of risk is given. Information pertaining to Child S is all second and third hand and from single sources and therefore unverifiable. For the purpose of this review it has therefore been discounted.'

It should be emphasised that the SCR is very critical of other services, in particular social care in relation to how they supported Child S over the years. However, by disregarding information which may have confirmed Child S's involvement in child sexual exploitation, the basis for that criticism was minimised. Moreover, one of the three main recommendations was that the Executive Director of Children and Young People's Services should undertake an urgent review of Risky Business.

Inspectors did not see any documentation associated with the recommended review, however by the time the SCR was completed in April 2011 a decision had already been taken to integrate Risky Business fully into social care. Inspectors consider that the SCR was used to justify this decision, which appears to have resolved the traditional tension between youth work and social work models by removing youth work – and the invaluable outreach work which it enabled – from RMBC's response to child sexual exploitation in Rotherham.

Annex B
List of Rotherham Metropolitan Borough Council achievements

In their correspondence with the Inspection Team, the former Leader and Chief Executive each wished to highlight some of the council's achievements in Rotherham during their tenure. These included:

- Assisting Government through the Homes and Communities Agency to deliver on its housing programme in a town which has substantial housing need.
- Revitalising its town centre which was commended by Mary Portas through the Government's Portas Pilot programme. This increased footfall and saw a number of independent retailers open new businesses.
- Building new town centre purpose built offices at Riverside House for better public access to the council. Introducing its shared services hub at Riverside House, delivering activity for other public sector partners whilst reducing overhead costs and driving cash releasing efficiencies.
- Restoring the Town Hall.
- Brokering Rotherham United to move into a new purpose built stadium in the town
- Maintaining the Rugby Union club in the borough.
- Supporting the Government's Troubled Families initiative through its Families for Change programme
- Supporting sector led improvement and development relating to the adult social care
- Achieving gold standard for Investors in People as well as its Equalities standards.
- Introducing the Imagination Library to Rotherham (a book a month to every under 5 in the town).
- Establishing the Ministry of Food in Rotherham.
- Successfully managing to retain jobs and services in the face of continued budget reductions, including stimulating the local economy.
- Both also pointed to improvements in aspects of the council's performance.

Annex C
Findings from the Statement of Accounts

Inspectors reviewed the Statement of Accounts for 2013/14. These were submitted to the Audit Committee on 17 September 2014. The external auditors KPMG issued a judgement that these were a true and fair view of the financial position and that the accounts were properly prepared. We found no contrary evidence and therefore support the external auditor's finding.

Outturn 2013/14: On the net revenue budget of £375.745m (including schools), the out-turn was £375.595m i.e. a small underspend.

Reserves: At the end of March 2014 there were available uncommitted reserves of £10.222m which is 4.9% of spend. In addition, there are earmarked reserves of £25.467m which are committed for specific purposes. The external auditors consider this to be prudent and it is within the expected normal range.

Housing Revenue Account: The HRA is in surplus and has an investment programme in place to meet the needs of local people. They are developing 14,000 new homes over the mid-term.

Capital: The capital programme was £71.769m. This is predominantly for schools, housing and highways, transportation projects.

Pension fund: An actuarial review was undertaken in 2013/14. The fund is managed by the South Yorkshire Pension Fund. For 2014/15 the employer contribution increased to 19.5%.

RMBC is facing a challenging period with a budget gap for 2014/15 of £23m and an expected further £23m in 2015/16. The Council has a track record of financial discipline and its external auditors consider it has the capacity to tackle the task successfully.

Business rate: Under business rate retention, Rotherham retains 49% of growth in business rates. The Council recognises the need to increase income, including through business rates, and is currently consulting on a growth plan which will develop their strategy. The Council is at an early stage of this work but it will be an important factor in dealing with future gaps.

Treasury management: RMBC has a low risk approach. In 2008 Rotherham lost £3.75m in the Icelandic banks, Landsbanke and Heritable. So far £1.904m has been recovered.

Insurance provision: As at 31 March 2014 funds stands at £5.364m. Provision has been made in regards to potential for further claims relating to CSE. It is not possible to assess the adequacy of such provision.

Generally we found the council's financial practices to be sound with revenue and capital monitors frequently reported to Cabinet. Overall there is a welcome degree of financial discipline in the organisation.

Annex D
Child Sexual Exploitation Numbers

Data capture and reporting in Rotherham Council is poor. This has meant that the true scale of CSE and the degree of harm to which children and young people were exposed has not been understood. Arrangements to identify and report on the prevalence of CSE, trends, patterns and the impact of actions are not yet fully developed across the council.

There is much argument about the numbers in the Jay report. The numbers are used to deny the problem or the scale of it. The Jay report looks at the period 1997 to 2013 and concludes that there were approximately 1400 victims at a conservative estimate. This equates to about 85 children and young people experiencing CSE in each year covered.

The chart below appeared in the LSCB annual report 2009/10 and covers 5 years April 05-April 10. CSE 'clients' are those children and young people being worked with by social care because of CSE; contacts are those referred to the council's 'front door' because of risk and/or harm. The third column has been added to show children and young people being referred to Risky Business or from April 08 working one to one with them. For 05-06 there is no comparable data.

Year	CSE Client	CSE Contacts	RB Clients
April 05-06	48	62	-
April 06-07	59	72	67
April 07-08	74	80	59
April 08-09	93	117	148
April 09/10	112	149	293

RMBC does not have comparable reported figures for 2011/12 or 2012/13 but reported figures show a steady rise.

In 2013/14, the CSE team worked with 207 children and young people who were experiencing, or were at risk, of CSE. They estimated that at least 10% would have been in the highest risk, highest severity category of concern.

An audit of CSE cases in January 2014, carried out by Rotherham LSCB, showed there were 81 cases being supported by the CSE team. These actual figures are similar to Jay's estimate of around 85 a year. Of these, 2 children were 9 years old, 2 were 11 years old, 2 were 12 years old, 14 were 13 years old, 19 were 14 years old, 22 were 15 years old and 15 were 16 years old.

Annex E
Tools and powers available to tackle Child Sexual Exploitation

The following is not exhaustive, but gives an overview of some of the tools currently available to councils and the police.

Civil injunctions under Section One, anti-social behaviour, Crime and Policing Act 2014 (previously Anti-Social Behaviour Orders, ASBOs)

These are civil orders which replace and considerably strengthen the powers previously available to councils through ASBOS and Housing Act injunctions.

The new injunction powers are available against a person aged 10 or over where two conditions are met:

1. the court is satisfied, on a balance of probabilities, that the respondent has engaged or threatened to engage in anti-social behaviour
2. the court considers it just and convenient to grant an injunction for the purpose of preventing the respondent from engaging in anti-social behaviour

Perpetrators waiting in cars outside the homes of victims, perpetrators making repeated contact by phone and perpetrators waiting outside victims' schools would all fall within the definition of anti-social behaviour as defined by the Act.

These injunction powers can be used to prohibit the respondent from committing any act described in the injunction, such as contacting the complainant, or require a respondent to conform to conditions described in the injunction, such as the observation of an appropriate curfew or the establishment of exclusion zones around a victim, their family, home, or school. Powers of arrest may further be attached depending on the seriousness of the behaviour.

Properties which operate as an 'open house' where perpetrators are allowed to gather pose an obvious danger to children, who may be allowed – or encouraged – to congregate there and be supplied with drugs and alcohol.

Injunctions can be used to prevent these behaviours. Where an injunction is housing related and repeatedly breached social landlords may consider eviction in addition if it is appropriate to do so.

Closure Orders associated with Nuisance and Disorder

Closure orders are civil orders available in the Magistrates court which stop anyone entering or residing at a named property. There are three types of closure order: drug closure orders, brothel closure and anti-social behaviour closure orders.

In the case of persistent anti-social behaviour and disorder which cannot be stopped without closing the property in question, anti-social behaviour closure orders may be used by local authorities. The closure order applies to the property, not to the owner or occupier and the property does need to be owned by the Council to become subject to an anti-social behaviour order.

Application for an Injunction under the High Court's inherent Jurisdiction

Applications for an injunction under the High Court's inherent discretion may be made on the basis of evidence adduced from professionals and third parties – of particular use where a young person does not wish to provide evidence. Injunctions of this kind could be used to stop predatory men from contacting vulnerable children, being in properties or cars with children, from going to or being outside residential homes, or from entering specific public places which may be known as CSE 'hotspots'.

Evidence is assessed on a balance of probabilities. The case of Birmingham City Council v Riaz & Others has demonstrated that a High Court is likely to exercise its discretion and use its inherent jurisdiction to grant civil injunctions against perpetrators of CSE. The High Court does not have jurisdiction to attach a power of arrest to the terms of an injunction of this kind, so procedures for bringing committal proceedings would need to be fully understood.

Section 222 Local Government Act 1972

Section 222 enables a local authority to bring criminal or civil proceedings in its own name, including applying for injunctions, where it considers it expedient for the promotion or protection of the interest of the inhabitants of their area. Local authorities may use this provision to enforce their Children's Act duties – as such wide-ranging injunctions could be obtained against known perpetrators. This wide ranging power has been used by local authorities to prevent repeated breaches of criminal law and to stop car cruising and street drinking. It has also been used in cases of domestic violence. The court has jurisdiction to attach a power of arrest to any injunction made under this section.

Exercise of the Councils Regulatory Functions including Taxis, takeaways, nightclubs, hotels, B&Bs etc…

It will be evident from this report that in many cases the activities of perpetrators take place in spheres which are regulated by the Council – taxis have been the focus of particular concern. Persistent and rigorous enforcement of the regulatory functions available to the council, including the placing of conditions on private hire taxi operator licences where appropriate, would send a strong signal that the trade is

being monitored and would curtail the activities of opportunistic perpetrators whereby taxi drivers have solicited children to provide sex in return for cigarettes, alcohol or a fare free ride.

Annex F

Glossary

ALMO - Arm's Length Management Organisation
ASBO - Anti-Social Behaviour Orders
BT - British Telecommunications
CAMHS - Child and Adolescent Mental Health Services
CART - Contact and Referral Team
CE - Chief Executive
CPS - Crown Prosecution Service
CRB - Criminal Records Bureau
CROP - Coalition for the Removal of Pimping
CSE - Child Sexual Exploitation
DBS - Disclosure and Barring Service (previously CRB and ISA)
DCS - Director of Children's Services
HR - Human Resources
HRA - Housing Revenue Account
HWB - Health and Wellbeing Board
ICO - Information Commissioner's Office
IMR - Independent Management Reviews
JAG - Joint Action Group
JSIAs - Joint Strategic Intelligence Assessments
LAC - Looked After Children
LSCB - Local Safeguarding Children Board
LSPs - Local Strategic Partnerships
MASH - Multi-Agency Safeguarding Hub
MO - Monitoring Officer
NAS - Neighbourhoods and Adult Services
NEETs - Not in Education, Employment or Training
NSPCC - National Society for the Protection of Cruelty to Children
OFSTED - Office for Standards in Education, Children's Services and Skills
OSMB - Overview and Scrutiny Management Board
PACE - Parents Against Child Sexual Exploitation (previously known as CROP)
RA - Responsible Authority meetings
RB - Risky Business
RCCG - Rotherham Clinical Commissioning Group
RDaSH - Rotherham Doncaster and South Humber NHS Foundation
RLSCB - Rotherham Local Safeguarding Children Board
RMBC - Rotherham Metropolitan Borough Council
SARC - Sexual Abuse Referral Clinic
SCR - Serious Case Review
SLT - Senior Leadership Team
SRP - Safer Rotherham Partnership
STD - Sexually Transmitted Disease
SYP - South Yorkshire Police

VOSA - Vehicle and Operator Services Agency
YOT - Youth Offending Team

Annex G
The Rotherham Inspection Team

Inspector:

Louise Casey CB

Assistant Inspectors:

Feizal Hajat, OBE
Michele Harris, MBC
Sarah Kincaid, Troubled Families Team, DCLG
Lorraine Langham, CDir, FIoD, FCIPR
Mary Ney, MSc
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