Thames Valley Police and Crime Panel Sub-Committee on Preventing Child Sexual Exploitation
4 November 2015

Agenda Item		Page No
5	**PRESENTATION ON PREVENTING CHILD SEXUAL EXPLOITATION IN THE THAMES VALLEY** This presentation will focus on the extent and profile of CSE in the Thames Valley, lessons learnt and areas the Sub-Committee could look at to ensure there is a consistent approach to preventing CSE across the Thames Valley Attendees: Anthony Stansfeld – Police and Crime Commissioner Richard List – Assistant Chief Constable DCI Joe Kidman and DCI Gilbert Houalla – Thames Valley Police Documents relating to this item:- Oxford Serious Case Review Link to Oxfordshire stocktake report http://www.oscb.org.uk/2015/07/stocktake-report-into-progress-made-in-tackling-child-sexual-exploitation-in-oxfordshire/ LGA Resource Pack on Tackling Child Sexual Exploitation	3 - 330
7	**CHILD SEXUAL EXPLOITATION CONFERENCE** Iain McCracken to provide an update on a recent conference he attended on CSE. www.policycommunications.co.uk/events/cse/downloads/Policy-Communications-Tackling-CSE.pptx	331 - 362

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Local Government Association

Tackling child sexual exploitation

A resource pack for councils

Report and case studies

Foreword

Child sexual exploitation (CSE) is a terrible crime with destructive and far reaching consequences for victims, their families, and society. It is not limited to any particular geography, ethnic or social background, and all councils should assume that CSE is happening in their area and take proactive action to prevent it.

This is not just a job for the lead member for children's services or the local director of children's services. This pack is aimed at elected members at all levels. We all have a role to play in keeping children safe, and councils cannot stamp out CSE without the help of the wider community. Councillors have a key role to play in this, and should not be afraid to raise these issues within the communities they represent.

Recent inquires have again highlighted the scale of the problem, and local agencies risk seeming unaware of the true extent of CSE in their area. It is vital that all partners work closely together to develop and implement robust, coordinated activity at all stages of a child's journey, from identification to protection to treatment. Councils and their partners must use evidence and information to understand what is happening locally, develop a strategic response, support victims and facilitate police disruption activity and prosecutions.

Recent events have shown that all areas need to be prepared to respond to this challenge effectively, and there are many good examples of effective work to be found around the country for local government to share and learn from. It is vital that we learn from both mistakes and successes, and the case studies in this resource pack showcase some of the work that is already underway to improve local practice. These cover initiatives such as community engagement, regional work across local authority boundaries, building effective multi-agency partnerships and commissioning independent audits of local practice.

We have also included a summary of the key learning to emerge from recent inquiries and reviews, and advice on key lines of enquiry for councillors to pursue when assessing the quality of local practice. The resources in this pack will be updated regularly, so please do check www.local.gov.uk/cse for the latest information – including some online resources that have not been included in this pack.

Child sexual exploitation is a sensitive and complex issue and I understand that it is not an easy subject to talk about, but it is essential that we do. No council can assume that this is not happening in their area, and no councillor should assume that someone else will make sure that the necessary responses are in place. Tackling child sexual exploitation must be a priority for all of us, and the resources in this pack highlight the very real difference that councils can make in preventing this awful crime – and the crucial role of councillors within this.

Councillor David Simmonds
Chairman, LGA Children and Young People Board

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Child sexual exploitation: an introduction

What is child sexual exploitation?

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (eg food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition, for example being persuaded to post sexual images on the internet or mobile phones without immediate payment or gain. In all cases, those exploiting the child or young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social, economic and/or emotional vulnerability.

What is the scale of CSE?

Recent high profile court cases, local inquiries and reports have raised awareness of the extent of child sexual exploitation. The Independent Inquiry into CSE in Rotherham estimated that 1400 children had been sexually exploited over the 16 year period covered by the Inquiry. Ann Coffey's report into CSE across Greater Manchester identified 260 'live' investigations into CSE in June 2014, with 14,712 recorded episodes of children missing from home and care between January and September 2014.

The Office of the Children's Commissioner's two year Inquiry into CSE found that a total of 2,409 children were known to be victims of CSE by gangs and groups between August 2010 and October 2011; the equivalent of every pupil in three medium sized secondary schools[1]. It is generally agreed that these figures are an under-estimate. With each new inquiry that is published, we are becoming more aware about the extent of CSE and the scale of this horrific form of abuse in our communities.

Why do I need to be aware?

CSE has a devastating impact on children, young people and their families. It should be a concern for everyone. CSE is largely a hidden crime, and raising awareness of this type of abuse is essential to preventing it and stopping it early when it does happen.

Councils play a crucial, statutory role in safeguarding children, including tackling child sexual exploitation. However, they cannot do this alone. It needs the cooperation of the wider community and our partner agencies. Councils can use their links with police, schools, health professionals, and community and faith groups to highlight the signs and ensure people know where to turn if they have concerns. We know child sexual

1 Berelowitz, S. et al (2013). "If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner. Rochdale Oxford www.childrenscommissioner.gov.uk/content/publications/content_743

exploitation is a difficult and unpleasant subject to discuss, but having these conversations is crucial to stamping it out.

Statutory responsibilities

The statutory responsibilities of local agencies, including councils, are set out in the 2009 supplementary guidance on CSE. The 2011 National Action Plan further clarifies these, and also brings together a range of commitments from national and local partners[2]. Statutory requirements from these documents include:

- mechanisms should be in place to collect prevalence and monitor cases of CSE
- CSE is assumed to be present, and is prioritised if believed to be a significant issue
- preventative activity should be put in place, helping those being exploited and targeting perpetrators
- Local Safeguarding Children Boards (LSCBs) should have specific local procedures to cover CSE (eg a strategy).
- children and young people should be involved in the drafting of CSE strategies
- assess and identify patterns of exploitation (problem profiling) and amend interventions to reflect the local picture
- training should include warning signs of CSE, how to report concerns, how to safeguard and how to prevent
- training should also include advice on evidence gathering
- awareness-raising activities should be aimed at young people and the general public, including where to obtain help and how to report
- LSCB sub-groups should be established to lead on CSE, with close links to other groups (eg trafficking, missing children)
- LSCBs should ensure there is a lead person in each organisation to implement guidance
- arrangements should be in place for either a dedicated coordinator or co-located team
- arrangements should be in place for cross border working across neighbouring local authority areas
- there should be periodic audits of multi-agency safeguarding arrangements.

2 2011 DfE National Action Plan www.gov.uk/government/publications/tackling-child-sexual-exploitation-action-plan

Key lines of enquiry for all councillors

Evidence indicates that CSE is prevalent across the country, occurring in both rural and urban areas with perpetrators and victims coming from a range of social and ethnic backgrounds. All Local Safeguarding Children Boards (LSCBs) and councils should assume it is happening in their area, unless there is clear evidence to the contrary[3].

The experiences of Rotherham go to demonstrate the key role that the leader of the council, the lead member for children's services, scrutiny committees and all councillors have in questioning and challenging responses to CSE in their local area.

The 2014 Communities and Local Government (CLG) Select Committee report, "CSE in Rotherham: Some Issues for Local Government[4]", also highlights the vital role of scrutiny in challenging officers and the executive when there is evidence of a problem which the council has failed to address. All councillors should ask questions and ensure that plans are in place to raise awareness of CSE, understand what is happening, develop a strategic response, and support victims of exploitation and help to facilitate policing and prosecutions.

The following section suggests 'key questions to ask' of officers, the LSCB or other agencies, along with suggested points to look out for. It is not intended to be exhaustive, and local approaches will of course vary, but instead aims to provide prompts to enable discussions about how the issue is being addressed locally.

1. What is the extent and profile of CSE in our local area? How do we know?

It is impossible to develop an effective response to CSE without a detailed understanding of the scale and nature of the problem locally. Learning from national studies can be a useful aid, but cannot substitute for an in-depth understanding of local trends. The LSCB should have a clear process in place for mapping the extent and profile of CSE in its area. The mapping process should include a profile of children identified as at risk, a profile of offenders and an understanding of 'hotspots' or vulnerable locations.

2. Do we have a local CSE strategy and action plan? Are these multi-agency and how is progress monitored? How does this link to other plans and strategies?

The need for local areas to have appropriate policies and procedures to tackle CSE is a common theme of national research and guidance. These must be specifically tailored to the needs of the local area, and should

3 Safeguarding Children and Young People from Sexual Exploitation 2009, Statutory Guidance www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance

4 The Communities and Local Government Committee, (2014). Child Sexual Exploitation in Rotherham: Some Issues for Local Government. www.publications.parliament.uk/pa/cm201415/cmselect/cmcomloc/648/648.pdf

provide a framework that allows all agencies (including the voluntary sector) to identify their role and understand how others will contribute to tackling CSE locally.

It is not enough to simply have a suite of plans in place – it is vital that they are working effectively, have full buy in from all agencies and are regularly reviewed and updated. Elected members should consider what mechanisms are in place to ensure that strategies are actually implemented in practice, and how their impact is evaluated. This is where council scrutiny panels or committees can play an important role in questioning strategies, plans and progress. It is also important to consider the extent to which CSE features in other council plans and strategies, and those of partner agencies. Is there sufficient join up with the overall CSE action plan and strategy?

3. How effective is the Local Safeguarding Children Board? Are all agencies engaged at a senior level, and is CSE an area for priority focus?

CSE cannot be tackled by one agency operating alone. They will hold only partial knowledge of the issues, and will be unable to deliver anything more than a partial response. Effective responses must be built on a holistic understanding of the problem, which will only come through a shared commitment to partnership working. A multi-agency response does not develop naturally, it must be systematically embedded at all levels and fully integrated through multi-agency forums and work plans.

The LSCB is the key body for fostering and co-ordinating this multi-agency work, and an ineffective LSCB will have a major impact on the extent to which a local area is able to tackle CSE in a coordinated way. This relies on full engagement from all partners at a senior level, and elected members should question the extent to which this is the case in their local area. Do key partners such as the police and health provide consistent, high level representation at LSCB meetings, or do they regularly send junior substitutes? Statutory guidance, for example, is clear that the chief officer of police must be included on the LSCB. Is this case locally, and how often do they attend? How strong is voluntary sector engagement? To what extent are partners involved in the Board's wider work, chairing subgroups or taking actions. Is this a true partnership, or does one agency dominate proceedings?

Most LSCBs will also have a CSE subgroup of the main Board, or a subgroup that considers CSE as part of a wider remit – perhaps linked to missing children, or trafficking. Neither approach is preferable to the other, but it is important that the LSCB is able to demonstrate that the subgroup's work is both focussed and effective. The CSE sub-group should provide the LSCB with regular updates on actions taken and impact.

4. Does the relevant scrutiny panel receive the LSCB's annual report, and use this to challenge local priorities and outcomes?

Council scrutiny processes are a vital tool in holding the local partnership to account, and the annual report of the LSCB is a key document to consider when assessing the effectiveness of local work to tackle CSE. Reports should be outcomes focused, with a clear assessment of progress over the past year and identification of key priorities for the year ahead. These should be considered carefully by scrutiny members, and the panel should hold the Independent LSCB Chair to account for delivery.

5. What other multi-agency forums exist to facilitate joint working?

At an operational level, it is important to consider what other multi-agency forums are in place to encourage a holistic, coordinated response. Some areas have implemented regular multi-agency practitioner meetings with a specific focus on CSE, which can be a good way to keep a focus on local trends and profiles of both victims and offenders. Many areas have also introduced multi-agency safeguarding hubs (MASH) or similar, which co-locate partner agencies to encourage quicker and more effective information sharing from the point that a referral is received.

No individual system or structure should be seen as a silver bullet in improving responses on CSE, but it is important that members understand how these processes are contributing to wider strategic objectives and consider the impact that they have on local practice.

6. How is CSE incorporated into local training programmes, and who is able to access this training? Does this include training for a wider cohort than just those professionals working directly with children and young people, such as licensing officers, environmental health officers or elected members? Are outcomes measured, and are changes made as a result?

Tackling CSE requires all partners to understand how to identify children at risk, respond appropriately when concerns arise, and ultimately ensure that children are protected. A sustained programme of single and multi-agency training is central to this, and it is vital that knowledge is comprehensively disseminated across all channels of identification and response.

Local areas should think creatively about who should access this training, rather than simply focusing on social workers, teachers, health staff or police officers who work directly with children. Licensing officers, for example, will benefit from a working understanding of CSE risks when considering licensing applications; environmental health officers may identify potential victims of CSE when inspecting takeaway outlets; and some councils have begun to offer CSE training to all elected members. This is not to imply that this is the right approach for all areas, but there should be a clear understanding of the rationale behind offering (or not offering) training to specific groups.

The LSCB should have oversight of the local training offer, and members should question how this is operating in practice. Do all partners attend multi-agency training sessions, or is one agency conspicuously absent? Importantly, is there a robust mechanism in place for monitoring the outcomes of local CSE training beyond simply counting who attends each session? What has changed as a result?

7. Is an awareness raising programme in place for children, families and the wider community? Is this reaching the right people?

As with any form of child abuse, statutory services cannot tackle CSE without the support of the wider community. Social workers and police officers can only respond to issues that they are aware of and while

professionals such as teachers and health workers have a key role to play in identifying children at risk; it is within families and the wider community that many of the key risk indicators will first come to light. It is vital that everyone is aware of the signs of CSE and knows how to refer concerns through to the relevant agency. A coordinated awareness raising campaign is an essential means to achieving this.

Any awareness raising programme must be informed by a full understanding of the local context around CSE, and should be effectively targeted to take account of local profiles of victims and offenders. In some areas, this may involve a concerted effort to engage with particular ethnic groups; in others it may involve a targeted approach in particular wards. Members should question which groups, if any, are the particular focus for awareness raising around CSE and the rationale behind this and whether members can facilitate in engaging with particular communities.

Parents and carers should be central to an awareness raising programme, and should be equipped to understand the key risk factors that their children may exhibit. Awareness raising must also be targeted at children and young people themselves, most often through schools, to ensure they have a full understanding of the risk factors and the support available to them.

8. What support is available to current, potential and historic victims of CSE?

An effective awareness raising campaign will naturally increase the number of children and young people identified as potential or actual victims of CSE, and may also encourage adults who were abused as children to come forward for support. It is vital that sufficient services are in place to provide for the needs of these groups, and members should question what is currently available – and whether there is sufficient capacity to meet expected demand.

CSE can have a devastating impact on a child's life, and victims may present with extremely complex needs. Services must be in place to meet these needs, and may include:

- individual therapeutic work
- group based therapeutic work
- family counselling
- youth work support
- education, training and employment support
- sexual health and relationship education
- drug and alcohol support
- supported placements.

This list is not exhaustive.

Learning and recommendations from recent inquiries

In 2014 the spotlight was again shone on local level accountability in tackling CSE, with the Independent Inquiry into CSE in Rotherham highlighting widespread failure to address sexual abuse across multiple agencies. In October 2014 the Coffey Report was published, reviewing the approach to CSE in Greater Manchester. It highlighted local gaps in services and made recommendations to agencies and government about the progress still needed to address sexual exploitation across Manchester.

November 2014 also saw the publication of the Ofsted thematic inspections of eight local councils. The thematic inspections came about as a direct consequence of the Rotherham Inquiry, and made recommendations to improve local practice. The Communities and Local Government Select Committee Inquiry into CSE in Rotherham also underlined lessons for local councils, making a number of recommendations, particularly about the role of council scrutiny.

Here we identify key issues raised in these reports that all councils should be aware of, alongside some of the themes outlined in the final report of the Children's Commissioner's inquiry into CSE in gangs and groups. We have also included learning identified by the National Working Group (NWG), a third sector organisation formed as a network of over 2500 practitioners working to tackle CSE, gleaned from a review of recommendations from a large number of CSE research reports and inquiries.

The recommendations below are not an exhaustive list, but draw together common findings:

- focus on victims
- engaging with all communities
- better awareness raising and education for professionals and the wider community
- training for all professionals
- professional attitudes and use of language
- leadership, challenge and scrutiny
- coordinated, strategic responses and performance management
- disruption and prosecution.

Focus on victims

Ongoing support services

Ongoing support and therapeutic interventions that children affected by CSE may need is a recurring theme. Interventions should not be offered on a short-term basis but for extended periods of time. Interventions may include formal counselling or informal outreach based project work. Ofsted found that referral pathways to access therapeutic support were not always well developed and that CSE cases working with victims should not be closed too soon. The Coffey report suggested that further research is needed on the availability of counselling services for victims and those at risk of CSE. Councils should make every effort to reach out to victims of CSE who are not yet in touch with services and LSCBs should work with agencies to secure the delivery of post-abuse support services.

Ensuring all possible victims are considered

The Coffey report suggested that local strategies and action plans should include references to boys and young men, ethnic minority groups and groups with learning difficulties, to ensure that they are represented and not ignored in any local response, strategy or action plan. All victims of CSE must be considered in local responses.

Missing children

Ofsted raised concerns about children who go missing, concluding that not enough children were having a return interview following a missing episode. It was also found that information was not being cross-referenced, particularly if there were short missing episodes, from school for example, where children were only missing for a part of the school day, which is a CSE risk indicator.

Engaging with all communities

The Rotherham Inquiry made it clear that the council had failed to work with and engage local minority ethnic communities and in particular the women of those communities on the issue of CSE and other forms of abuse.

Both the Manchester and Rotherham reports made a series of recommendations about engaging with all communities. For example, LSCBs and all partner agencies should improve their methods of communicating with, engaging and working in partnership with all communities, including socially advantaged, disadvantaged, white and minority ethnic communities to raise awareness of CSE and address the issue of underreporting of CSE and abuse. Councils and their partners need to engage with local community organisations such as women's groups, youth groups and religious groups. Learning should be disseminated to parents to help build the resilience of children and young people and prevent them from becoming victims or offenders in online and street grooming circles.

It is important to treat parents as equal partners in most instances, to improve the understanding of CSE and minimise the risk to children and young people.

Better awareness raising and education: for professionals and the wider community

More information needs to be provided to the public and professionals about CSE. Those people in frontline community roles, such as pharmacists, school nurses, bus drivers, housing officers, shopkeepers, hoteliers and taxi drivers, should be made aware of the signs and what to do if they suspect CSE. Awareness raising campaigns also need to be clear that CSE affects both boys and young men as well as girls and young women. Councils and their partners should engage the media in a more proactive way to raise awareness about CSE and the effect on victims. Ofsted's report commended the level and type of awareness raising campaigns to safeguard children in the areas it inspected.

The Office of the Children's Commissioner recommended that relationships and sex education must be provided by trained practitioners in every educational setting for all children and young people. This must be part of a holistic/whole-school approach to child protection that includes internet safety and all forms of bullying and harassment and the getting and giving of consent.

Leadership, challenge and scrutiny

The Rotherham Inquiry found that "the Rotherham Safeguarding Children Board and its predecessor oversaw the development of good inter-agency policies and procedures applicable to CSE. The weakness in their approach was that members of the Safeguarding Board rarely checked whether these were being implemented or whether they were working." The report drew attention

to the vital importance of the challenge and scrutiny function of the LSCB and of the council itself to ensure robust responses to tackling CSE.

The Ofsted thematic inspection report highlighted that, in areas where CSE had been made a priority, local strategies were better developed and linked in to other key local strategies, such as gangs and licensing. Senior leaders and politicians generally had a better understanding of the issues in those areas, and elected members were recognised as challenging and scrutinising the work of professionals effectively. Ofsted suggested that in areas where the LSCB CSE strategy was underdeveloped and the financial and resource implications of tackling CSE were unknown: "elected members must urgently improve the quality and level of scrutiny and challenge to ensure that local authority senior leaders and partners are coordinating an effective response."

The CLG Select Committee Inquiry recommended that any council where there are credible allegations or suspicions of child abuse must investigate them and conduct a review of the response and local approach. The report also raised a number of concerns about the role of scrutiny in Rotherham, citing that nobody had checked the quality or actual implementation of strategic plans. The Committee noted that, particularly where councils have a single party predominance or where there may be strong and dominating personalities, the role of scrutiny is essential. The scrutiny function should be separated from the executive of the council to ensure there is robust challenge when there is evidence of an acute problem which the executive and lead officers have failed to address. There were also concerns about the skills and level of training for executive councillors, who were not challenging low quality reports by officers.

In our 'Key lines of enquiry' section of this report, we suggest questions that lead members, scrutiny chairs and all councillors should be asking of their officers and partner agencies to ensure that CSE is being addressed effectively at the local level.

Professional attitudes and use of language

The Office of the Children's Commissioner's Inquiry and report recommended that the use of the term 'child prostitution' should be removed from all government documents and strategies. The recent Coffey report also recommended that there should be no references to child prostitution in any documentation. This dated language has been found in a number of areas and councils should review all of their documentation related to CSE and ensure that references to child prostitution are removed.

Coordinated, strategic approaches and performance management

Councils and LSCBs require a strategic approach, with coordinated, joined up local responses to address CSE. Recommendations include joint commissioning arrangements for CSE, sexual assault, rape and domestic abuse support services; common thresholds for interventions across agencies; clear referral pathways; pooling of budgets across the police, council children's services and health services.

Ofsted's thematic inspection raised concerns that not all local areas were collecting and sharing the information needed to have an accurate picture of CSE in their area. There was a lack of evaluation about how effectively CSE cases were being managed, and therefore this could not be used to improve current practice. Ofsted highlighted a number of concerns, including: not using formal child protection procedure in cases where children and young people were identified at risk of CSE; screening and assessment tools not being used consistently; management oversight of cases not being consistent and children in need plans not being robust enough. They also suggested that dedicated CSE teams did not necessarily mean that children received improved services, as specialist CSE support was also needed in addition to a social worker.

There are a series of recommendations from the recent reports for LSCBs, including:

- The LSCB should develop locally agreed clear information sharing protocols to ensure that children at risk can be identified at an early stage.
- LSCBs must undertake scoping activity in the local area to identify the level of need in their area and ensure that service provision effectively supports young people who experience both running away and CSE.
- Every Local Safeguarding Children Board should review their strategic and operational plans and procedures against the seven principles, nine foundations and the See Me, Hear Me Framework of the Office of the Children's Commissioner's final report, ensuring they are meeting their obligations to children and young people and the professionals who work with them. Gaps should be identified and plans developed for delivering effective practice in accordance with the evidence. The effectiveness of plans, procedures and practice should be subject to an on-going evaluation and review cycle.
- CSE should be included in local performance frameworks to ensure it is a priority for all agencies.
- Governance arrangements should be clear between the Health and Wellbeing Board, the Community Safety Board and the Local Safeguarding Children Board, to ensure a coordinated approach and ownership of the local response.

Training for all professionals

The National Working Group Network report, citing Barnardo's recommendations, suggested that training should be developed for frontline staff in services for children and young people to recognise the warning signs and risk factors of child sexual exploitation and how to respond using child protection procedures. This should include understanding the elements of grooming and coercion so that a child or young person's behaviour is not dismissed as rebellious or somehow consenting to the abuse. It should also include an understanding of the sexual exploitation of Black, Asian and minority ethnic victims and different types of victim-offender models. Information about the behaviour of people who sexually offend should also be incorporated into training and awareness-raising activities.

Ofsted suggested that existing training for professionals was of a high standard, but wasn't always reaching or targeting the right people. Councils were not found to be evaluating the impact of the training to find out whether it was making children and young people safer. Some staff, such as those working in education were not always attending or being given training. The report praised councils where the training was compulsory for elected members and professionals who work with children and young people, and saw a more coordinated approach to tackling CSE in those areas where this was the case.

Disruption and prosecution

Reports have raised concerns regarding the number of allegations made about CSE and perpetrators and the number of associated prosecutions. There are a number of recommendations for the police, the Crown Prosecution Service and others, but for councils it was made clear that not all areas are making best use of the full range of powers available to them to disrupt offenders.

For example some areas were not issuing abduction notices where they may have been appropriate to safeguard children from sexual exploitation. Multi-agency working and information sharing across partners, including with the police, was seen as a vital approach to improve disruption activity.

Child sexual exploitation: myth vs reality

Recent media attention on specific cases of CSE has led to sector wide concerns that stereotypes and myths about this crime could lead to a narrow focus on one particular form of CSE. The danger of this is that attention can be diverted from crimes which do not appear to match that model, with the risk of victims not receiving the help they need.

There are many myths surrounding CSE and the examples used here are taken from the interim report of the Office of the Children's Commissioner's (OCC) Inquiry into CSE in Gangs and Groups. They are all real, though the names have been changed[5].

10 myths and the reality

Myth #1:
There are very few 'models' of CSE

Reality: The grooming and sexual exploitation of young people can take many different forms. CSE can be carried out by individuals (lone perpetrators), by street gangs or by groups. It can be motivated by money ie commercial sexual exploitation, which involves the exchange of a child (for sexual purposes) for the financial gain of the perpetrator or for non-commercial reasons such as sexual gratification or a belief in entitlement to sex. It can occur in a wide range of settings, but the common theme in all cases is the imbalance of power and the control exerted on young people. The stories below highlight just some of the different models that exist.

Sophie's story

'Sophie's' mum, Linda, has been known to a local violence against women service for a number of years because of the violence she has experienced from multiple partners. Sophie is a white British young woman and she was 13 years old when Linda met Ray. Ray, who was also white British, moved in with Linda and was violent towards both her and her children. Ray began to invite his friends around to the house. They, in turn, were abusive to Linda and her children. Following this, Ray offered Sophie as a sexual commodity to his friends on a regular basis, and threatened Linda and Sophie with violence if Sophie did not comply.

Site visit 4 evidence

5 The myths in this report were put together for a 2013 briefing in conjunction with the NWG Network: Tackling CSE and the Office of the Children's Commissioner. Berelowitz, S. et al (2012) "I Thought I was the Only One. The Only One in the World" The Office of the Children's Commissioner Inquiry into Child Sexual Exploitation In Gangs and Groups Interim Report. http://www.childrenscommissioner.gov.uk/content/publications/content_636

Teegan's story

'Teegan', a white British young woman, was sexually exploited from the age of 12 years old. From the age of 13 Teegan was taken by a Turkish man to a variety of 'parties' across England that she reports were in nice houses and in some cases described as 'mansions'. In these houses Teegan would be raped by several men, from a range of ethnicities, who were paying to use her. Teegan described a book being available with photographs and ages of all of the girls being sexually exploited by this particular group. Men could choose which girls they wanted. Teegan reported men paying those who were exploiting her up to £500 for an hour with her. Groups of men could also request one girl to share between them over a night, where the rape of the girl would be filmed. The operation involved men working the streets to pick up vulnerable girls, forming 'relationships' with them by grooming them and then passing them on to the men who controlled the business. If Teegan ever refused to comply, she would be beaten and her family threatened. Following the abuse, Teegan took several overdoses, was placed in secure accommodation, and self-harmed by cutting and ligaturing sometimes on a daily basis. Teegan described the abuse that she experienced as serious and organised, and is unwilling to make a formal complaint for fear of repercussions from those involved in the operation.

CSEGG interview with a young person

Sahida's story

'Sahida', a 17-year-old British Pakistani young woman, made an allegation of sexual abuse against a family member. As a result she was threatened with a forced marriage. Sahida's family claim they want to remove her from the country to curb her 'wild behaviour'. Following these threats Sahida began spending time with older males, described by professionals as 'Asian', and was moved to multiple locations by them. Sahida is now pregnant as a result of the sexual exploitation she has experienced. Family members have physically assaulted Sahida as a punishment for the pregnancy.

Call for evidence submission

Myth #2:
It only happens in certain ethnic/cultural communities

Reality: Both perpetrators and victims are known to come from a variety of ethnic and cultural backgrounds. CSE is not a crime restricted to British Pakistani Muslim males or white British girls, despite media coverage of high profile cases. Site visits carried out by the OCC inquiry identified perpetrators and victims of CSE from a wide range of ethnic backgrounds. A thematic assessment by the Child Exploitation and Online Protection Centre identified that "Research tells us that the majority of known perpetrators in the UK of this crime are lone white males".

However, it is important that councils and partners do not shy away from confronting the reality of CSE in their area. Through the LSCB, a clear profile of local need should be developed that clearly identifies the prevalence and profile of sexual exploitation taking place. If a particular group or community is disproportionately involved in the abuse of children and young people, this must be acknowledged and tackled.

Myth #3:
It only happens to children in care

Reality: The majority of victims of CSE are living at home. However, looked after children account for a disproportionate number of victims and can be particularly vulnerable. An estimated 20-25 per cent per cent of victims are looked after, compared with 1 per cent per cent of the child population being in care. This does, however, leave around 80 per cent per cent of victims who are not in the care system.

Myth #4:
It only happens to girls and young women

Reality: Boys and young men are also targeted as victims of CSE by perpetrators. However, they may be less likely to disclose offences or seek support, often due to stigma, prejudice or embarrassment or the fear that they will not be believed. They may feel that they are able to protect themselves, but in cases of CSE physical stature is irrelevant due to the coercion and manipulation used.

Randall's story

'Randall' is a 15 year old boy, of mixed ethnic heritage, and described by professionals as 'exploring his sexuality'. He is said to be unaware of safe routes to meeting other gay young people. Professionals report Randall has been seen hanging around at bus stops. He has disclosed to professionals that he has been targeted by groups of men who are grooming him to exchange sex for alcohol, cigarettes and acceptance. Professionals are working with Randall to try to keep him away from areas of risk, but they are aware he continues to go missing and are unable to account for his whereabouts on all occasions.

Site visit 8 evidence

Myth #5:
It is only perpetrated by men

Reality: There is evidence that women can be perpetrators of this crime too. They may use different grooming methods but are known to target both boys and girls. In relation to group and gang related CSE, the OCC inquiry found that the vast majority involved only men and, where women are involved, they are a small minority. Where women or girls were identified as perpetrators, their role was primarily, though not exclusively, to procure victims. Women and girls who were perpetrating were identified during the inquiry's site visits tended to be young, had histories of being sexually exploited themselves and of abusing others in tandem with the group or gang that had previously sexually exploited them. Women and girls directly involved in sexually exploiting children were either in relationships with men who were perpetrators or related to, or friends with, men and boys who were abusers.

Myth #6:
It is adults abusing children

Reality: Peer-on-peer child sexual exploitation happens too and this can take various different forms. For example, young people are sometimes used to 'recruit' others, by inviting them to locations for parties where they will then be introduced to adults or forced to perform sexual acts on adults. Technology can also play a significant role, with young people known to use mobile technology as a way of distributing images of abuse.

Rebecca's story

Rebecca is a 15-year-old black British girl, and has reported she was forced by a group of girls to have sex with a boy in the girls' toilets at their school; otherwise they would beat her up. The group of perpetrators were made up of three 14-year-old girls and one 14-year-old boy, all of whom were black British. One of the girls is described as the 'instigator' of the assault .Another girl filmed the assault on her mobile phone. The assault took place as part of a pattern of ongoing bullying of Rebecca. She was anally raped by the 14-year-old boy. She had never had sex before this assault.

Police Case File Submission

Myth #7:
It only happens in large towns and cities

Reality: Evidence shows that CSE can and does happen in all parts of the country. CSE is not restricted to urban areas such as large towns and cities but does in fact happen in rural areas such as villages and coastal areas. High profile police operations in areas as diverse as Rochdale, Cornwall and Oxfordshire are clear examples of this. Young people can also be transported between towns, cities, villages etc., for the purpose of being sexually exploited and this is known as trafficking within the UK (an offence punishable by up to 14 years imprisonment).

Myth #8:
Children are either victims or perpetrators

Reality: The OCC inquiry found that around 6 per cent per cent of victims reported in their call for evidence were also identified as perpetrators. It is important to keep in mind that, although children may appear to be willing accomplices in the abuse of other children, this should be seen in the context of the controls exerted by the perpetrator.

Mitchell's story

'Mitchell' is a white British 17 year old boy, and has been known to the youth offending service for several years. From the age of 12 Mitchell was seen spending time with white British men, some of whom were believed to be sexually exploiting young women in the local area. Some of these older males bought Mitchell trainers, taught him how to comb his hair in particular ways and how to speak to girls. The older men also introduced Mitchell to some of the girls that they were sexually exploiting. At one point, he was found locked in a garage where one of the older males had brought young female victims of abuse. Mitchell gradually became involved in the sexual exploitation of young women in the local area, and would pass them onto his older peers.

Site visit 2 evidence

Myth #9:
Parents should know what is happening and should be able to stop it

Reality: Parents may be unlikely to be able to identify what is happening: they may suspect that something is not right but may not be in a position to stop it due to the control, threats or fear of the perpetrators. There can be risks to parents when seeking to protect their children and they can need support as well as their children. In some cases, there can be an overlap with abuse within the family and this could be a reason why parents do not intervene.

Myth #10:
Children and young people can consent to their own exploitation

Reality: A child cannot consent to their own abuse. Firstly, the law sets down 16 as the age of consent to any form of sexual activity. Secondly, any child under-18 cannot consent to being trafficked for the purposes of exploitation. Thirdly, regardless of age a person's ability to give may be affected by a range of other issues including influence of drugs, threats of violence, grooming, a power imbalance between victim and perpetrators. This is why a 16- or 17-year-old can be sexually exploited even though they are old enough to consent to sexual activity.

Local case studies

Blackburn with Darwen Council: Engage Team

Background
Operation Engage was a police led operation set up in 2005, focusing on an area of Lancashire where there were a large number of missing children. Operation Engage worked with a total of 30 children, all girls, over a period of three years. The team built up ongoing, trusting and supportive relationships with the young people, who over time disclosed a range of sexual and violent abuse. All of the children (bar one) were looked after, and mostly cared for in children's homes.

The project
In 2008 the Engage Team, a co-located multi-agency response to tackle CSE, was established by Blackburn with Darwen Safeguarding Children Board to continue the work initiated under Project Engage. The team are co-located in one building and key partners are social care, police and health. Voluntary sector service providers are also a key delivery partner. The team consists of: one team manager; six young people's workers (from the council, Barnardo's and Brook); one social worker; one administrator; two nurses; one PACE worker (Parents Against Child Sexual Exploitation, parent support worker); one Princes Trust worker; one detective sergeant; four detective constables and one missing from home coordinator (police). Many external partners are also involved in the work of the team, with virtual support for the wider group of partners who have weekly team meetings eg youth offending, schools, the women's centre, drug and alcohol service and licensing services.

The team has developed over time, becoming more specialised in CSE services from 2009 onwards. Understanding of patterns of abuse, risk factors and warning signs of CSE has developed over time and the team approach reflects this. Since April 2014 the team has additionally been responsible for all interviews when a child returns from a missing episode. The team are independent of the care planning pathway process for 11 -18 year olds, and only involve social workers when there is a clear need, for example where there are cases of neglect at home. CSE demands a non-stigmatising response, so young people's workers are the preferred main point of contact.

The team has access to information on databases from all agencies; the information is shared openly (and legally) in order to protect children. The team reports are always reported up to the LSCB. A work culture where everyone has a genuine voice, where all agencies are equal partners, works well in Blackburn with Darwen; there is no single dominating partner and everyone has ownership of the issues.

Impact
Current key challenges for the team are to ensure that they remain child focussed and non-stigmatising, whilst also aligning processes, such as the recording and evidencing required by social work procedures. Incorporating processes, without letting services be dictated by that process has been a key challenge, avoiding delays in supporting the child or loss of the sensitive approach.

The team has achieved a number of successful prosecutions, resulting in a total of 700 years in custody for perpetrators. This accounts for sexual offences specifically, and does not include other disruption activity such as prosecution for offences such as drugs related charges or abduction order notices. Prosecutions are led by police staff in the Engage Team. The Engage Team worked with the Crown Prosecution Service (CPS) to assess how they could gain convictions using robust evidence, and consequently the team now looks for evidence which supports the young person's story, rather than identifying the gaps and weaknesses. A young person's key worker will prepare the child for the court process, throughout the case, including post-trial; and a PACE worker provides support for parents. The team have a 98 per cent success rate. Over time the team are now predominantly dealing with grooming offences; concentrating on prevention and disruption activity.

The Engage Team Manager, Nick McPartlan, advises that "senior leaders and politicians need to be open, honest and transparent and demonstrate flexibility when addressing the abuse. Political sign-up, resources and capacity are vital."

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Calderdale Council: Co-located specialist CSE team and daily intelligence sharing meetings

Background
In Calderdale, prior to June 2014, children who were identified as being at risk of sexual exploitation were experiencing different levels of service provision across the first response and locality teams. Communication between the key agencies involved in service delivery was sometimes a barrier in ensuring young people received a swift joint approach to address their needs. The agencies delivering relevant services were based in different locations and not always available to respond immediately.

The project
Since June 2014, police officers and social workers have been co-located in a specialist CSE team at the police station. Other key agencies such as The Children's Society's 'Safe Hands', health, youth services and the youth offending team are also part of the virtual team. Daily briefings are held and any intelligence is shared immediately so robust action can take place to ensure children identified at risk of CSE are safeguarded. The roles and responsibilities of the police officers and social workers within the team are clearly set out, as are the responsibilities of the key partner agencies working with the team. The wider operational group of partner agencies now attend a weekly meeting so that all information can be shared in a more timely and effective way.

Impact
The new approach has led to a number of improvements in local work to protect children and young people from CSE:

- all new cases are discussed at the next daily briefing and multi-agency decisions are made regarding the appropriate action to be taken

- fewer transfer points are promoting greater consistency in services for children and young people
- there is improved communication and joint working between social care, the police and the voluntary sector service provider and an increased number of joint visits between the three key agencies
- the continuity of shared intelligence and response delivered by social care staff within the team has improved
- the team provides CSE expertise, support and where required, joint visits to children on the local CSE Matrix who have remained with other social care teams
- there is CSE social care support and guidance in respect of thresholds regarding young people who are on the CSE Matrix
- the team ensures that all operational group recordings and intelligence is shared with other social care staff and recorded on the child's electronic file
- social care staff are now a part of the preventative programme delivered to other agencies.

Many of the actions being taken in Calderdale are recent processes, and results and improvements in processes are already being seen. The council and partners acknowledge that there are still areas for further action including the continual review of team, the processes in place and resources available and needed.

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Essex Safeguarding Children Board: CSE champions

Background
Essex Safeguarding Children Board (ESCB) formed a strategic group with neighbouring local authorities, Southend and Thurrock, to ensure a joint approach to child sexual exploitation (CSE) across the County.

One of the key outcomes from the strategic group was to develop a CSE champion role, and each organisation was subsequently asked to nominate a lead within their agency.

The project
The key features of the CSE champion's role are to:

- keep up to date with developments, policy and procedures in relation to CSE
- act as a point of contact for disseminating information from the ESCB
- provide advice and signposting in relation to individual cases.

The CSE champions are expected to be familiar with the Essex CSE risk assessment toolkit, know how to submit intelligence to Essex Police, cascade the learning from the CSE champions training and provide ongoing updates to their teams.

Impact
There have been about 300 CSE champions trained from various organisations across Essex; some organisations have more than one champion because of their size.

Currently the format of the champions training comprises a full day, with the first half delivered by local practitioners from the Essex Police child sexual exploitation triage team and the Essex County Council CSE lead. The afternoon session is delivered by a psychotherapist who focuses on brain science, understanding perpetrators and making sense of responses of victims.

Going forward, Essex intends to make this a half day training session facilitated by the police and council with input from a voluntary sector organisation. The training will be more focussed on how to apply the tools available in Essex and will be a practical session using case studies.

One of the biggest outstanding challenges is being able to meet the demand for training, particularly as it is being delivered by operational staff and therefore has to fit in with the demands of their day job.

The champion role is an important mechanism for the ESCB, helping to raise awareness about CSE, the Essex risk assessment toolkit, and the importance of submitting the right intelligence to the police. Champions also act as a key communication route through the agencies to staff teams and the community.

As a way of providing ongoing support, the ESCB has recently completed four CSE Champions networking forums in each quadrant area, which have been well attended. This is part of the ongoing commitment to supporting CSE champions in their workplace.

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Greater Manchester: Project Phoenix, It's not okay campaign

Background
Project Phoenix emerged from the Greater Manchester Safeguarding Partnership in April 2012, following a scoping exercise into existing practice in relation to child sexual exploitation. The project was partly a response to high profile cases in Rochdale, Stockport and other parts of the country and recognition from all partners that a more effective joined-up approach was needed to tackle CSE. Project Phoenix was Greater Manchester's single, collaborative approach which aimed to improve the response to CSE strategically, operationally and tactically.

The project
Phoenix is a key priority for the Association of Greater Manchester Authorities' (AGMA) Wider Leadership Team. The Phoenix Executive Board is chaired by the City Director for Salford City Council and the Board feeds directly into the AGMA Wider Leadership Team and the Greater Manchester Leaders' Forum. Tackling CSE is also a priority for the Police and Crime Commissioner and Greater Manchester Police.

The main objectives of Phoenix are to:

- raise standards across all partners in dealing with CSE
- improve cross-border working between local authorities in Greater Manchester

- improve consistency across Greater Manchester
- achieve buy in from all key partners
- raise awareness of CSE with the public, professionals, businesses, young people, etc
- encourage people to report concerns in relation to CSE.

Under Phoenix there are now specialist CSE teams in place in each of the ten districts of Greater Manchester. Each team works with young people being sexually exploited and offers a joined-up, multi-agency response. Prior to Phoenix, there were only two such CSE teams in the region. Phoenix provides advice, support and guidance to these teams to ensure that all professionals are working to a consistent set of standards and procedures to improve services offered to victims and those at risk of CSE.

Impact
One of the main achievements of Phoenix has been to develop and roll out a consistent approach to measuring a young person's risk of CSE. Regardless of where a young person lives in Greater Manchester they will receive the same CSE assessment, meaning that all local authorities and key partners are talking about the same thing when it comes to CSE risk.

The scoring system of the tool allows for professional judgements to be made and is child focussed. The information can be collated and sent to LSCBs in a consistent way and is used to develop a better picture of the scale of CSE across Greater Manchester. The project has also developed local information sharing protocols, education guidance and guidelines around disruption activity.

According to Damian Dallimore, Project Phoenix Manager, "Since its inception in 2012 Phoenix has made great strides in the services we offer to young people affected by CSE and their families. To do this we need the support of the public, professionals, businesses and young people, to contact us with any concerns they may have in relation to young people being targeted and exploited in this way and I would encourage everyone to have a look at our website www.itsnotokay.co.uk where you can find out more about CSE as well as help and advice about where to report it and steps you can take to ensure young people are kept safe."

Further information
The Project Phoenix website, including campaign materials and a range of resources for young people, parents and professionals can be found at: www.itsnotokay.co.uk

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Pan-London Operating Protocol for CSE

Background
The Metropolitan Police Service (MPS) first set up a London wide CSE team in 2012, and the Pan-London Operating Protocol to tackle CSE emerged from the work of this regional team. Detective Superintendent Terry Sharpe chaired a multi-agency group and researched best practice in tackling and disrupting CSE from other areas, and those who had managed successful disruption and prosecution of offenders.

The project

The Pan London Operating Protocol brought together a set of procedures on how to tackle CSE for all 32 London Boroughs, to ensure a consistent approach was being taken across the capital. The Protocol was originally trialled in the summer of 2013 to ensure it was fit for purpose and the final version was launched in February 2014 in London's City Hall. The primary aim of the Protocol is to safeguard children and young people across London from sexual exploitation, and all London boroughs and LSCBs are signed up to the Protocol.

The Protocol is designed to raise awareness, safeguard children and young people and enable identification of perpetrators of CSE and to bring them to prosecution. To do this local interventions and disruptions are being put in place. It can often take a long time to gain the trust of a victim to get them to disclose what has happened to them, so in the meantime creative disruptions are put in place to stop or prevent the abuse from happening. For example a CSE investigation into one perpetrator led to their vehicle registration number being added to the police database. As a result the perpetrator was pulled over and firearms were found in the back of their vehicle. The perpetrator is now in prison, but is not aware that he was stopped as a result of a child sexual exploitation investigation.

The Protocol has established three categories of CSE. The first category, Level 1, is used when there is suspicion of CSE, but no evidence as to what is happening. This is recorded on the police system, so that if there are further suspicions at a later point in time, then there is more evidence to support the case. The information also helps to identify perpetrators and potential 'hotspots.' Level 1 cases are dealt with by local borough police officers or the appropriate statutory agency who is best placed to provide clarity regarding these suspicions. Details of children and young people and with suspected perpetrators are entered onto the Police National Database (PND). Therefore, if a frontline officer finds a young person in a known 'hotspot' area for CSE, or if they stop a car and have concerns, they will be able to take the appropriate action to safeguard the child even when no offences have been disclosed. The level 1 category was not previously recorded by the police in London on a crime recording database, as no crime has been known to be committed at this stage. Level 2 and 3 cases are more serious and dealt with by the centralised MPS CSE Team.

Impact

The Protocol is helping to raise awareness of CSE, particularly amongst frontline police officers. Two videos have been shown to all frontline officers, including telephone staff handling 101 calls. This includes a video outlining the warning signs of CSE. The mnemonic 'SAFEGUARD' has also been created to help officers remember the warning signs along with an app that can be downloaded to assist in remembering the signs. The second film highlights the approach taken by Thames Valley Police in the 'Operation Bullfinch' investigation and shares a victim's perspective of how she was dealt with by the police during her ordeal. This is followed up with a one hour training session, which all frontline Met police officers have attended.

The Protocol has led to improved awareness of CSE amongst the community, particularly with hoteliers and other local businesses such as taxi firms. For example, the London Borough of Waltham Forest has recently launched 'Operation Makesafe,' a partnership initiative with the local business community to identify potential CSE victims and, where necessary, to deploy police officers to intervene before any harm occurs to a child or young person. Operation Makesafe has involved an awareness raising marketing campaign and training for local hoteliers, off licences and taxi firms, to recognise the CSE warning signs and what action should be taken if CSE is suspected. As a result of the training a local firm agreed to donate marketing materials, such as hotel door adverts, posters and car mirror hangers for taxis, for free.

According to Detective Superintendent Terry Sharpe "senior level engagement across partner agencies in delivering the protocol makes a big impact in tackling CSE."

Further information
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The Pan-London Operating Protocol can be found at: http://content.met.police.uk/Article/Launch-of-The-London-Child-Sexual-Exploitation-Operating-Protocol/1400022286691/1400022286691

Portsmouth: CSE strategy and awareness raising campaign

Background
The Portsmouth Safeguarding Children Board set up a CSE subcommittee in 2012 and tasked the council in early 2014 with developing the local CSE strategy. The strategy has been implemented across partners alongside a local CSE action plan and risk assessment tool.

The project/strategy
In conjunction between the Portsmouth LSCB and the Safer Portsmouth Partnership, a marketing campaign was launched in 2013, using a web based approach and traditional billboard and bus adverts to promote 'Is this Love?' The campaign looked at the aspects of a healthy relationship, highlighting the concerns about both domestic abuse and sexual exploitation of young people. The campaign also tied into the Safer Portsmouth Partnership priority of addressing high rates of domestic abuse in the area, particularly amongst young people. It is important to distinguish CSE from other forms of abuse such as domestic violence, however, there may sometimes be links and similar indicators, so all teams in Portsmouth are joined up to ensure appropriate information sharing and plans are in place to safeguard children and young people identified as at risk of abuse.

In addition to the publicity work, a theatre based production for young people, Chelsea's Choice, was run in Portsmouth secondary schools to help young people explore the risks and warning signs of CSE. In early 2014 an awareness campaign was also delivered across local services including GPs and the police, this included a CSE conference for local agencies.

A risk assessment tool was developed as part of the local action plan, based on the Derby Model, and adapted to the local circumstances. This was recently implemented for local agencies to help identify children at risk of CSE. Spot the signs training was also delivered to professionals across the partner agencies. In early 2014 a local CSE strategy was developed; the strategy is a short document, used as a practical tool for front line workers, particularly to give local context to the CSE action plan. The CSE sub-committee of the Portsmouth Safeguarding Children Board has also established a multi-agency operational panel to ensure the coordination of the identification, assessment, and planning for children and young people at risk of or experiencing CSE.

Impact

As a result of the specific local focus and joined up approach to tackling CSE; there have been huge improvements in identification and support for children and young people at risk of CSE.

In Portsmouth a Joint Action Team, with co-located services including social workers, police, health, a domestic abuse worker, targeted youth support worker and Barnardo's, lead on

working with young people identified as being at risk of CSE or trafficking, as well as children and young people who have returned from a missing episode. The work of the team feeds directly into the multi-agency CSE operational group comprising health, police and children's services. The group regularly shares information on the age profiles of victims, gender and ethnicity information, as well as whether children are looked after by the local authority and any professional from any team can raise concerns they have about a specific young person. Details of suspected perpetrators, locations of concern and disruption work are also shared within the group. The meetings give the police the opportunity to share 'soft information' of interest, for example where shops may have been selling legal highs.

The Portsmouth CSE strategy provides direction and filters down to the front line to give focus on CSE, and has influenced changes in practice, for example the risk assessment toolkit is being updated to reflect recent national level developments in CSE. The CSE action plan and strategy is in the process of being refreshed to ensure that it incorporates the wider approach to missing, exploited and trafficked children and young people. Portsmouth Council, the LSCB and the police have also been working on an improved data gathering process for children who go missing. Incidences of children who go missing are currently under-reported, and the council and key partners are working to understand the levels of need of children who have been trafficked.

The refresh of the CSE strategy and action plan is examining in closer detail the impact and outcomes of the local approach, for example, many local indicators are moving in the right direction but the committee is now evaluating impact to establish whether the improvements are a direct result of the local action plan, awareness raising and disruption activities.

Nicola Waterman, Strategy Manager, says that "commitment of all partners is essential in developing a CSE strategy and action plan. Involving all partners from the outset, particularly where there are a number of health agencies, is vital."

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Slough Council: Licensing 'splinter' group

Background
In late 2013, Slough LSCB and Thames Valley Police agreed to work together on a CSE awareness raising campaign for licensed premises. A 'licensing splinter' group was established, linked to the CSE sub- group and consisting of representation from Slough Borough Council licensing team, an Engage worker (CSE specialist team) and a Thames Valley Police Inspector. The group continues to meet on a bi-monthly basis; their work is strongly supported by councillors and forms a key part of the overall communications package on CSE awareness raising.

The project
In late 2013, the licensing group wrote a short article about CSE, which was published in the Slough Taxi & Private Hire Newsletter. CSE has consistently featured in subsequent newsletters to re-enforce awareness, and taxi firms and ranks are a key focus for the 'Licensed Premises' working group. CSE is now mainstreamed into the work of the council licensing team, which has been significant in helping to maintain momentum on issues such as delivery of a CSE

presentation to the Pub Watch Scheme members in December 2013. The three teams involved in the working group set about coordinating premises visits in specific areas, and team members unfamiliar with CSE were trained and briefed on the key messages and action to take. A script with consistent messaging was developed to relay to local businesses. Thames Valley Police and the licensing team have now visited all local hotels and B&B's. The Engage team and police community support officers visited other local businesses and the council's food and safety and trading standards officers are also raising awareness at fast food outlets and other retail outlets during routine inspections.

During visits to local businesses, awareness raising packs were distributed. Hotels and B&Bs received a Say Something If You See Something (SSIYSS) poster, Children's Commissioner CSE indicators, a letter from the Slough LSCB Chair and a Barnardo's leaflet.

Impact
Following each 'wave' of visits, the team completed an evaluation detailing exactly which premises were visited and noting the time it took, who they spoke to and comments about the discussions with businesses and any concerns or questions that were mentioned.

- During 2013 there were 24 joint visits to hotels and B&B's, 44 packs were distributed.
- 261 joint visits were made to local businesses.
- Hotels contacted 101 to share concerns about CSE on three occasions.
- The number of visits in the two years up to December 2014 has now risen to 441.

The SIYSS posters and full awareness raising packs that the team put together, including the letter from the Chair of the LSCB, enabled a professional and credible range of information to be presented to the hotel trade. Over the summer of 2014 the team revisited premises in particular 'hotspot' areas, including hotels. The team took out posters and enquired to find out if they hotels had been displaying them and how staff members were being involved in being alert to CSE.

A multi-agency approach, embedded via the 'splinter group', has delivered enormous benefits, enabling a sharing of resources without placing a large capacity strain on a single agency. By visiting premises and hotels, publishing articles and having a better, wider presence across the town, the licensing working group has increased the degree of conversation within the communities about the issue of CSE in Slough.

In May 2014 the Engage team at Slough Council received an award from the National Working Group: Tackling Sexual Exploitation Network, for their work to address CSE. The council's licensing team was also recognised in early 2014 with a Berkshire Environmental Health Officers Award for Achievement for their work on raising awareness of CSE.

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www.slough.gov.uk/council/strategies-plans-and-policies/awareness-raising-initiatives.aspx

The NWG Network and The Children's Society have developed a campaign pack supporting local safeguarding children boards to work with retail, transport, and leisure and hospitality businesses to protect children in their communities from child sexual exploitation. The resources are available at: www.nwgnetwork.org/resources/resourcespublic?cat=74

Stoke-on-Trent City Council: Commissioning an independent review of CSE and missing children services

Background

Stoke-on-Trent City Council has always taken a proactive approach to analysing the work being done to protect and support vulnerable children and young people and was keen to learn how they could improve their practices and processes in this area.

A third sector organisation, Brighter Futures, is commissioned to deliver services for young people at risk and victims of sexual exploitation in Stoke-on-Trent. The service, known as Base 58, was due to be re-commissioned by March 2015. In February 2014, the decision was made to examine the existing service provision, looking at the strengths and weaknesses of the wider CSE multi-agency system, and assess where there were improvements needed. Brighter Futures was additionally contracted, alongside Base 58, to follow up children who had been reported missing, with workers making contact with young people who had been reported as missing within 48 hours of their return.

The authority commissioned a review of its CSE and missing children service which took place between May and July 2014. In August 2014, 'The Child Sexual Exploitation Service and Missing Children Service for Young People in Stoke-on-Trent; A Review' was published.

The project

The CSE and missing children service review was commissioned by children and young people's commissioners; with the public health team and the Stoke-on-Trent Safeguarding Children Board supporting the review.

The proposal for the review went to the LSCB for their approval and commitment. The process took a total of 8 months from the initial proposal to the final report. The design of the review included an assessment of best practice and benchmarking of the CSE and missing children services. Chanon Consulting in conjunction with the University of Bedfordshire was deemed to be the most appropriate bid, due to the academic rigour and credibility of the proposed approach.

The approach entailed a paper review of policies and procedures, as well as numerous qualitative and quantitative methods. Focus groups were conducted with practitioners, commissioners from the children and young people's service, police, managers, and third sector providers. Children in care were involved, as was the Chair of the LSCB. In addition, case studies of children and young people who had been using the services were also provided.

Outcomes

The report highlighted significant good work and practice, particularly concerning the council's joined-up work with safeguarding partners. In addition, there was praise for the recognition by agencies that CSE continues after 18, with support for young people transitioning to adult services; and mention of the efforts made with schools to raise awareness of the issues.

Recommendations for further work were also noted, with the need to address some minor issues, as well as longer term goals for the CSE and missing children service and suggestions for improved multi-agency working. Quick wins included the creation of a CSE coordinator post. The review has resulted in an action plan which has been put together and is being taken forward. The action plan is owned jointly by all agencies on the LSCB executive. The current CSE and missing children service has been extended for 12 months to enable the council to

ensure that it gets the recommendations of the report right, and to implement any necessary CSE service and wider system re-design.

Amanda Owen, strategic manager for safeguarding and quality assurance at Stoke-on-Trent City Council, says: "We take the issue of child sexual exploitation extremely seriously. That is why, as part of our overall strategy to prevent CSE in the city and to protect our vulnerable young people, we commissioned this independent review. The report has left the city in a very good position to improve services."

To fully benefit from a review of CSE services and strategies, councils and LSCBs should:

- be prepared to take an honest look at the services delivered
- be absolutely honest and transparent about arrangements, for example with the public, the media and all key stakeholders
- consider whether a review is being conducting for the right reasons. Are you willing to redesign and improve your services as an outcome of the review?
- ensure that the review is undertaken by professionals with an understanding of the effect of CSE on children and is undertaken with academic rigour.

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The final report is available at: www.beds.ac.uk/__data/assets/pdf_file/0011/449948/CSE-Missing-Service-Review-Stoke-on-Trent.pdf Christine Christie, July 2014, The Child Sexual Exploitation Service and Missing Children Service for Young People in Stoke on Trent: A Review. Chanon Consulting and The University of Bedfordshire.

West Midlands Region: Regional standards, pathways and self-assessment

Background
The West Midlands region recognised the cross boundary nature of CSE and the need for a robust response, so in 2011 set up a CSE strategic group. The group was established on a metropolitan area regional level involving the seven local councils and the respective police force in the region, as well as voluntary sector and health representatives. The group focussed on the common challenges of tackling CSE and what could be done together. The councils involved included: Birmingham City Council; Coventry City Council; Dudley Metropolitan Borough Council; Sandwell Metropolitan Borough Council; Walsall Council; Wolverhampton City Council and Solihull Metropolitan Borough Council as well as the West Midlands Police. There was recognition of the cross boundary nature of the threat and the need for a robust and consistent regional approach to CSE, to avoid a postcode lottery of service provision across the West Midlands.

The project
In 2013 a task and finish group, chaired by a local authority chief executive, was set up to create a consistent and child centred approach to responding to CSE across the region." The group developed 15 regional standards and pathways for tackling CSE. Guidance was also developed for front line practitioners and managers to support the implementation of the

regional standards and pathways. It is anticipated that the regional standards will be added to each member LSCB's safeguarding procedures manual. (The pathways, standards and self-assessment tool can be found online at www.local.gov.uk/cse)

The aim of the approach was to create a consistent and child centred approach to responding to CSE across West Midlands Police Force area, underpinned by the See Me Hear Me framework developed by the Office of the Children's Commissioner. There are still locally tailored pathways in each council area, dependent on local level circumstances, but a more unified regional level approach is in place, for example through a regional induction pack for the workforce on missing children, trafficking and CSE.

Impact
Implementation of the standards and pathways was managed at the local level, with LSCB Chairs playing a key role in monitoring the progress and impact of the regional standards. A self-assessment framework assisted LSCBs with local implementation, and also enabled the identification of common areas for improvement across the seven LSCB areas; a regional workshop for practitioners and managers was held to support with implementation.

As a result of the common pathways and standards, and self-assessment screening tool, Solihull MBC has found that they are now much better at identifying victims of CSE. There has been a significant increase in the number of young people identified as at risk of harm from CSE since the screening tool was embedded, with an increase of 104 per cent of children identified at risk between May 2013 and October 2014.

Key learning from the regional approach suggests that:

- effective data collection is critical to the delivery of a robust response and to regional problem profiling
- a regional response does not replace the need for robust, coordinated action at a local level
- establishing a regional approach needs a commitment to extra resources and capacity to ensure timeliness and understanding and embedding of the approach
- senior buy in is needed for influence and impact
- sound governance arrangements were crucial to embed the standards and pathways when partners were at different stages of implementation.

Liz Murphy, former Safeguarding Children Business Manager at the Solihull LSCB highlights that "our aim has been to create a consistent response to CSE across the region and, most importantly, to use feedback from children and young people to develop and embed a multi-agency response that recognises and responds to children and young people as victims, and actively involves them in the safeguarding process. In addition we wanted to ensure sufficient emphasis on the disruption and prosecution of offenders."

Further information
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The See Me Hear Me West Midlands campaign website, developed by Dudley MBC as part of the communications plan for the regional framework can be accessed at:
www.seeme-hearme.org.uk/

Key resources and further reading

The online CSE resource for councillors available at: www.local.gov.uk/cse includes many further resources, key links, recommended reports and reading, and more details on our case studies included in this report. Below are a number of key resources:

- Berelowitz, S. et al (2013). "If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner. Rochdale Oxford www.childrenscommissioner.gov.uk/content/publications/content_743
- Alexis Jay (2014).Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013. www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham
- Ann Coffey, (2014). Real Voices: Child Sexual Exploitation in Greater Manchester. An Independent Report by Ann Coffey MP. www.gmpcc.org.uk/wp-content/uploads/2014/02/81461-Coffey-Report_v5_WEB-single-pages.pdf
- Ofsted, (2014). The Sexual Exploitation of Children: It Couldn't Happen Here, Could It? www.ofsted.gov.uk/sites/default/files/documents/surveys-and-good-practice/t/The%20sexual%20exploitation%20of%20children%20it%20couldn%E2%80%99t%20happen%20here,%20could%20it.pdf
- The Communities and Local Government Committee, (2014). Child Sexual Exploitation in Rotherham: Some Issues for Local Government. www.publications.parliament.uk/pa/cm201415/cmselect/cmcomloc/648/648.pdf
- It's not okay: www.itsnotokay.co.uk/ Part of Project Phoenix, Greater Manchester
- See me hear me: www.seeme-hearme.org.uk/ Part of the West Midlands campaign, adapted from the Office of the Children's Commissioner's final report and recommendations.
- Pan London Operating Protocol to Tackle CSE and related resources http://content.met.police.uk/Article/Launch-of-The-London-Child-Sexual-Exploitation-Operating-Protocol/1400022286691/1400022286691
- Office of the Children's Commissioner, CSE Warning Signs and Vulnerabilities Checklist. www.local.gov.uk/c/document_library/get_file?uuid=72f54483-f97b-4f0e-a815-c969509cb27f&groupId=10180
- Barnardo's www.barnardos.org.uk/what_we_do/our_work/sexual_exploitation.htm
- Tackling CSE Helping Local Authorities to Develop Effective Local Responses http://www.barnardos.org.uk/tackling_child_sexual_exploitation.pdf
- The Children's Society http://www.childrenssociety.org.uk/what-we-do/policy-and-lobbying/children-risk/child-sexual-exploitation

- The APPG for Runaway and Missing Children and Adults and the APPG for Looked After Children and Care Leavers (2012). Report from the Joint Inquiry into Children Who Go Missing from Care. www.childrenssociety.org.uk/sites/default/files/tcs/u32/joint_appg_inquiry_-_report...pdf
- National Working Group, Tackling Sexual Exploitation www.nwgnetwork.org/
- NWG Network (2014) Summary of Recommendations: A summary of all recommendations from a series of reports, inquiries, serious case reviews and research. http://www.nwgnetwork.org/resourcefilepublic.php?id=1206&file=1
- Blast – project to support boys and young men http://mesmac.co.uk/blast
- PACE (Parents Against Child Sexual Exploitation) www.paceuk.info/
- University of Bedfordshire: International Centre researching CSE, violence and trafficking www.beds.ac.uk/intcent
- MsUnderstood www.msunderstood.org.uk/

Appendices

Key risk factors and warning signs of child sexual exploitation

CSE is not limited to any particular geography, ethnic or social background, and all councils should assume that CSE is happening in their area and take proactive action to prevent it.

The Office of the Children's Commissioner included in its interim report, a 'key warning signs and vulnerability checklist' to identify those at risk of CSE and for those who may already be victims of abuse.[6] There is no set formula for identifying CSE and therefore the lists should not be seen as exhaustive.

The following are typical **vulnerabilities in children prior to abuse**:

- Living in a chaotic or dysfunctional household (including parental substance use, domestic
- violence, parental mental health issues, parental criminality)
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of honour-based violence, physical and emotional abuse and neglect)
- Recent bereavement or loss
- Gang-association either through relatives, peers or intimate relationships (in cases of gang-associated CSE only)
- Attending school with children and young people who are already sexually exploited
- Learning disabilities
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families
- Friends with young people who are sexually exploited
- Homeless
- Lacking friends from the same age group
- Living in a gang neighbourhood
- Living in residential care
- Living in hostel, bed and breakfast accommodation or a foyer
- Low self-esteem or self-confidence
- Young carer.

6 Berelowitz, S. et al (2013). "If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner. Rochdale Oxford www.childrenscommissioner.gov.uk/content/publications/content_743

The following signs and behaviour are generally seen in children who are **already being sexually exploited**:

- Missing from home or care
- Physical injuries
- Drug or alcohol misuse
- Involvement in offending
- Repeat sexually-transmitted infections, pregnancy and terminations
- Absent from school
- Change in physical appearance
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites
- Estranged from their family
- Receipt of gifts from unknown sources
- Recruiting others into exploitative situations
- Poor mental health.
- Self-harm
- Thoughts of or attempts at suicide.

The Barnardo's 2007 Sexual Exploitation Risk Assessment Framework[7] identifies a range of risk factors for CSE. These should not be seen as an exhaustive list, but include:

- Disrupted family life;
- A history of abuse and disadvantage;
- Problematic parenting;
- Disengagement from education;
- Going missing;
- Exploitative relationships;
- Drug and alcohol misuse;
- Poor health and well-being

7 Barnardo's Pilot Study 'Sexual Exploitation Risk Assessment Framework' (SERAF) (2007). The framework is used as a risk assessment framework by many local agencies. http://www.barnardos.org.uk/barnardo_s_cymru_sexual_exploitation_risk_assessment_framework_report_-_english_version-2.pdf

Overview of key prosecutions

The following list of prosecutions is not exhaustive, but helps to give an overview of the range of towns and locations that have seen high profile CSE cases. The list does not contain all prosecutions, for example cases where perpetrators have been prosecuted for other offences as part of disruption activity e.g. drugs or firearms offences.

Year	Area	Number of convictions
1997	Leeds	2
2003	Keighley	2
2006	Blackpool	2
2007	Oldham	2
2007	Blackburn	2
2008	Sheffield	2
2008	Oldham	2
2008	Manchester	2
2008	Blackburn	2
2009	Sheffield	1
2009	Blackburn	2
2009	Skipton	2
2010	Rochdale	4
2010	Nelson	2
2010	Rochdale	9
2010	Preston	2
2010	Rotherham	5
2010	Derby	9
2010	Cornwall	6
2011	Burnley	4
2011	Blackburn	4
2012	Rochdale	9
2012	Telford	2
2012	Derby	8
2012	Oxford	7
2012	Reading	4

Notes

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Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

For a copy in Braille, larger print or audio, please contact us on 020 7664 3000. We consider requests on an individual basis.

L14-738

Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F

Approved by the OSCB February 26th 2015

Independent Reviewer: Alan Bedford MA (Social Work), Dip.Crim

FOREWORD

i. What happened to the child victims of the sexual exploitation in Oxfordshire was indescribably awful, and a number of perpetrators are serving long periods of imprisonment following the investigation known as 'Operation Bullfinch'. The child victims and their families feel very let down. Their accounts of how they perceived professional work are disturbing and chastening. There is clearly a demand to find out how such extensive abuse could have continued for so long before it was properly identified, and why there was not speedier action. There was a strong public reaction last year and this year to two Rotherham inquiries (which were not Serious Case Reviews) and to similar concerns reported elsewhere, and there have been calls in such cases for individuals to be held to account.

ii. The Serious Case Review (SCR) has seen no evidence of wilful professional neglect or misconduct by organisations, but there was at times a worrying lack of curiosity and follow through, and much work should have been considerably different and better. There is little evidence that the local understanding of child sexual exploitation (CSE), or how to tackle it once identified, was significantly different from many parts of the country.

iii. On the surface, many of the illustrations described in the report can seem like professional ineptitude, unconcern, or inaction. They become more understandable when put in the context of the knowledge and processes at the time, practical difficulties around evidence, and a professional mind-set which could not grasp that the victims' ability to say 'no' had been totally eroded. However, understanding it does not make what happened right. The analysis of 'why', on the surface, there was inexplicable behaviour by organisations is to explain, not excuse. It is in understanding the context in which professional work took place, and what impacted on the thought processes and actions of staff, that there can be learning for individuals and organisations. This is the prime purpose of an SCR. The answers to 'why' cannot be reduced to a few simple sound bites, as there are many complex interlocking issues, which are described in detail in the Review.

iv. The County Council and Police have apologised for not preventing or stopping the exploitation, (and some agency and multidisciplinary arrangements should indeed have been better). The Chief Constable apologised that it took so long to bring the offenders to justice, and said she was "sorry that we did not identify the systematic nature of the abuse sooner, and that we were too reliant on victims supporting criminal proceedings". The Chief Executive for the County Council said that, "we would like to publically apologise for not stopping this abuse sooner and to reassure everybody listening that we have learnt a huge number of lessons in terms of how to tackle this type of abuse and that we are now taking decisive action to stop it happening in Oxfordshire". The attitude seen by the Review is not one of denying the scale of abuse or the errors, but an acceptance of what was missed and a determination to ensure things are better.

v. This SCR is not an 'inquiry', but does identify where there is evidence that things were not good enough. The fact that scores of professionals from numerous disciplines, and tens of organisations or departments, took a long time to recognise CSE, used language that appeared at least in part to blame victims and see them as adults, and had a view that little could be done in the face of 'no cooperation' demonstrates that the failures were common to organisational systems. There have been similar cases to those in Oxfordshire, most notably

in Rochdale, Derby, Bristol and Rotherham. The same patterns of abuse are seen, the same views of victims and parents, and similar long lead-ins before effective intervention. For all this everywhere to be the result of inept, uncaring and weak staff, and leaders who need to go, seems highly improbable. The overall failings were those of a lack of knowledge and understanding around a concept (of CSE) that few understood and where few knew how it could be tackled, but also of organisational weaknesses which prevented the true picture from being seen. It is important this is recognised so organisations can, and can continue to, get it right on CSE, and can respond better when the next new challenge occurs.

vi. There were many errors. Some organisations and some staff should have acted with more sensitivity, rigour, imagination or indeed common sense. Some processes and procedures should have been implemented much better, and the collective agency work around safeguarding before 2011 should have been much stronger. Over a number of years there were many signs of CSE of the type revealed in the Bullfinch trial, and whilst they were not recognised as 'CSE', the extreme nature of those signs required concerns to be escalated to top managers, but this did not happen. Even if what had been happening were unconnected individual cases, the effectiveness of professional work was not good enough. The abuse, as a result, continued for longer than could have been the case.

vii. The issue in Oxfordshire was not very top management and governing bodies knowing about CSE and not acting, but that they didn't know there were cases being dealt with that were showing indications of CSE, even if not defined or recognised as such.

viii. While much should have been better, professionals working with the families concerned, over many years, worked relentlessly (if not always very effectively) to fulfil their professional duties to the victims and their families. Ultimately, it was the efforts of staff on the ground, and their observations and persistence, which was the main driver in the eventual identification of CSE.

ix. Five of the seven convicted perpetrators were of Pakistani heritage. No evidence has been seen of any agency not acting when they should have done because of racial sensitivities. The victims were all white British girls.

x. The vast majority of the information for this SCR has come from the agencies' own internal reviews, so the accounts of any deficits in performance have come from the agencies themselves voluntarily, and reflect a laudable willingness to be open about the past. They were equally forthcoming when the author made additional inquiries. The learning in Oxfordshire has already been significant, with much good practice now in place, and a professional mind-set now attuned to CSE, with children seen as children, however they behave. There is a growing arsenal of tools to identify, prevent, disrupt and prosecute CSE. Operation Bullfinch and subsequent prosecutions have shown concerted and rigorous action.

xi. This Review focuses on what can be concluded and learned for the system overall and about the period leading up to Operation Bullfinch, and includes an overview of progress since. In an associated document, 'CSE in Oxfordshire: agency responses since 2011' the detailed learning identified by each agency is set out, together with key actions taken and points of contact for further learning.

Alan Bedford, Independent Reviewer February 2015

1 SUMMARY AND INTRODUCTION

1.1 **Summary of the findings:** This Review is about the sexual exploitation of children in Oxfordshire, using as background the experiences of six girls who were the victims in the Operation Bullfinch trial. It important to recognise that the time when most of the abuse took place was when there was almost no knowledge of group or gang related CSE nationally, and it is only in hindsight that the full picture is obvious. The Review concludes that many errors were made, and identifies what lay behind the errors (listed fully in section 8).

1.2 Lack of understanding led to insufficient inquiry. That the girls had lost the ability to consent or make their own decisions due to grooming was not realised, and instead they were seen as very difficult girls making bad choices. This, and that most of their families were seen as also having many problems, deflected attention from who was drawing them away from their homes - their own or in Care. The language used by professionals was one which saw the girls as the source not the victims of their extreme behaviour, and they received much less sympathy as a result. They were often in Care for their own protection, and frequent episodes of going missing were again put in the context of them being extremely difficult children.

1.3 The law around consent was not properly understood, and the Review finds confusion related to a national culture where children are sexualised at an ever younger age and deemed able to consent to, say, contraception long before they are able legally to have sex. A professional tolerance to knowing young teenagers were having sex with adults seems to have developed.

1.4 The victims almost never cooperated with investigations (again caused by the grooming) and there was a sense that nothing could be done as evidence was therefore weak. The need for disruption, covert surveillance and comprehensive intelligence gathering, despite no formal evidence from victims, was not understood. In fact, there was limited understanding of guidance related to the exploitation of children, although this has been seen nationwide. The lack of cooperation, and attitudes of the victims, sometimes led to crimes against them not being recorded as such

1.5 Regardless of levels of technical knowledge about CSE, there was a lack of curiosity across agencies about the visible suffering of the children and the information that did emerge from girls, parents, or carers, or some very worried staff. Also, a failure to recognise that the very extreme circumstances around the victims were so bad as to need referral upwards to board/governing body level, and a strategic response. Instead, the cases were seen more in isolation, with the focus mainly on protecting and containing the girls rather than tackling the perpetrators. There was no evidence that the ethnic origin of the perpetrators played a part in the delayed identification of the group CSE. The Review shows that from 2005-10 there was sufficient known about the girls, drugs, prostitution and association with adult men to have generated a more rigorous and strategic response, but this did not happen – and mostly the information did not reach strategic levels.

1.6 In part, the findings above are not new, or unique to Oxfordshire. Much research had shown that few areas were prepared for this type of abuse. However, there were reasons why in Oxfordshire the group abuse was not recognised earlier, when there were opportunities to do so. The predecessor body to the Oxfordshire Safeguarding Children Board (OSCB), and OSCB in its early years, did not show sufficient grip or curiosity when some early signs were presented, and the topic drifted off the agenda. Children's Social Care (CSC) was at the time

of much of the abuse rated as only adequate by Ofsted, and an external review showed the OSCB needed to improve. Social worker numbers were at one point amongst the lowest in the country (leading to high caseloads), and supervision of staff was not strong. Child protection processes were not always robust. Crucially, insufficient value was placed on escalating extreme cases for top consideration, and this must reflect the then management culture. The Police, then, had limited processes in place that pulled together force-wide patterns. The important role of the City District Council in terms of local knowledge and regulation was not understood.

1.7 There are indications that top-level commitment from agencies to the OSCB and its predecessor was variable, and the Board members did not create a Board which rigorously followed things through. Crucial national guidance on 2009 CSE was overlooked, and there was no strategic overview.

1.8 As a result, the discovery of what later emerged in the Bullfinch inquiry and trial was led not by leaders and strategic bodies but by more junior staff working nearer the coalface. A drugs worker for the City Council, a social worker, and a detective inspector, on their own initiative, and in the absence of any strategic work, each led a number of meetings which were unknown to the OSCB or top managers. Their efforts eventually culminated in a shared recognition that there was group-related exploitation of multiple girls. Action from this point became coordinated and successful.

1.9 Since this turning point in early 2011, Oxfordshire has responded comprehensively to the challenge, is rated as 'good', and is held as an exemplar of how CSE should be tackled. There is no denial of either the errors or the scale of abuse, and top-level apologies have been made to the victims and their families.

1.10 The Review identifies around 60 learning points that will help agencies understand why and what needs to happen to be sure CSE continues to be tackled well.

1.11 **The need for a Serious Case Review:** Concerns were identified about children in Oxfordshire being sexually exploited. The collective picture from local agencies, and the intelligence that emerged about those individual children, led to 'Operation Bullfinch'. This complex investigation was led by the Police and involved other OSCB partners. A significant number of children were identified as victims of serious sexual exploitation. Nine men stood trial at The Old Bailey in January 2013, seven of whom were convicted and received substantial custodial sentences. The charges related to six individual girls – four cases of historic abuse and two which were more recent. The abuse was described by the trial Judge as a 'series of sexual crimes of the utmost depravity'.

1.12 A decision was made by the OSCB to convene a Serious Case Review (SCR) on 26 September 2012. The cases of the six victims known as Children A, B, C, D, E, F (referred to in this report as A-F) met the criteria for an SCR as defined in the then national guidance.[1] Children had been seriously harmed and there were concerns about the way agencies had worked together. This guidance was superseded in March 2013 but this would also have justified the decision to conduct an SCR.

[1] *Working Together to Safeguard Children* (DfE 2010), chapter 8 paras 8.9 – 8.12.

1.13 **Terms of reference (TOR):** The 2013 guidance no longer provides core terms of reference for SCRs, but says that final SCR reports should provide a sound analysis of what happened in the case and why, and what needs to happen in order to reduce the risk of recurrence. The TOR are given in Appendix 2. The period covered is mainly 2005-11 (when the multi-agency Operation Bullfinch started), with older history considered where relevant. For four of the girls their abuse by the mainly Pakistani heritage group ended 2-5 years before Operation Bullfinch started in 2011. For the other two, it was still current, but near its end, by the time Bullfinch started. (In all cases the impact of the abuse has continued for them after the abuse itself stopped.)

1.14 This Review, which needs to identify 'why', was asked to look at the following two key questions:

- To what extent was the child sexual exploitation experienced in Oxfordshire preventable?
- What can be learned from the Review's appraisal of the quality of agency work, and the experiences of the victims and their families?

1.15 To answer these questions the review will need to explore:

- What was known about child sexual exploitation and how it could be tackled?
- If it was not identified quickly enough, why not?
- What, including the quality of agency work, contributed to the vulnerability of the victims to abuse?
- How did agencies respond to the growing awareness of child sexual exploitation?
- What have agencies already learned and done as a result of Operation Bullfinch?
- What still needs to be done?

1.16 The Review should identify where agency performance could have been better, but also explain the context in which that performance occurred so that the contributory factors provide learning for OSCB and its member agencies.

1.17 To fulfil these terms of reference the views of the six girls and their families were sought and reported, and they had pre-publication opportunity to hear and discuss the findings.

1.18 **Independent Reviewer:** The original reviewer was David Spicer, a barrister, and formerly Head of Legal Services to Nottingham County Council, who in recent years had undertaken 16 SCRs mainly for Welsh local authorities. When David Spicer stepped down for health reasons, Alan Bedford was appointed by the OSCB from July 2014 and is the author of this report. He has a background in child protection social work with the NSPCC, where he was also National Training Manager. Following this he spent 18 years in the NHS, the majority of the time as a CEO in Trusts and Health Authorities. Through Alan Bedford Consulting he has worked on a range of issues, from infection control to emergency healthcare, and now mainly safeguarding. From 2009-11, he was Director of Safeguarding Improvement for NHS London, leading a London-wide peer review programme, and from 2009-13 was an LSCB Chair. He led on SCRs for the Association of Independent LSCB Chairs 2102-13. He has conducted a number of SCRs, is accredited as a SCIE Systems Reviewer, and has completed the 2010 and 2013 national training for SCR authors.

1.19 **Review process:** A Serious Case Review Panel was set up to oversee the SCR, and met in 15 occasions. It had the following membership

Role/Name	Organisation
Chair	
Paul Kerswell	SCR Independent Chair
Members	
Lucy Butler	Deputy Director, Children's Social Care and Youth Offending Service, Oxfordshire County Council
Hannah Farncombe	Safeguarding Manager, Children's Social Care, Oxfordshire County Council
Peter Clark	Head of Law and Governance, County Solicitor, Oxfordshire County Council
Frances Craven (to Sept 14)	Deputy Director Education and Early Intervention, Oxfordshire County Council
Margaret Dennison (Sept to Oct 14)	Deputy Director Education and Early Intervention, Oxfordshire County Council
Melanie Pearce	Area Service Manager, Adult Social Care, Oxfordshire County Council
Rob Mason	Detective Chief Superintendent, Thames Valley Police
Adrian Roberts (Aug to Oct 2014)	Head of the Complex Casework Unit, CPS Thames and Chiltern
Adrian Foster (from Nov 2014)	Chief Crown Prosecutor, CPS Thames and Chiltern
Jane Bell (to June 2013)	Designated Nurse and Safeguarding Lead, Oxfordshire Clinical Commissioning Group
Alison Chapman (from June 2013)	Designated Nurse and Safeguarding Lead, Oxfordshire Clinical Commissioning Group
Christine Simm (from May 2013)	Chair of the Management Committee, Donnington Doorstep
Clare Robertson	Designated Doctor for Safeguarding, Oxfordshire Clinical Commissioning Group, and Oxfordshire Hospitals NHS Trust
Di Batchelor	Chair, OSCB Education Subgroup
Kate Riddle	Acting Head of Nursing Children and Families Division, Oxford Health NHS Foundation Trust
Kevin Gibbs	Head of Service, South West England & Thames Valley, Cafcass
Tim Sadler (from Sept 14)	Executive Director, Community Services, Oxford City Council
Critical Friend	
Bina Parmar	Specialist Team Member, NWG Network
LSCB Staff	
	OSCB Business Manager
	OSCB Business Officer

1.20 As the SCR started in September 2012, it had to follow a much prescribed methodology under the then statutory guidance, and the Panel decided to continue with that model when in March 2013 successor guidance introduced local flexibility on method. A core part of the traditional methodology was the production of Individual Management Reviews (IMRs), and these were commissioned from the following organisations, several of whom used independent authors.

NHS	Oxford Health NHS FT
	Oxford University Hospitals NHS Trust
	Oxfordshire Clinical Commissioning Group
Health Overview	Oxfordshire Clinical Commissioning Group
Oxfordshire County Council	Early Years/Education
	Children's Social Care
	Adult Social Care
	Public Health – Drugs and Alcohol
	Youth Offending Service
	Legal Services
Oxford City Council	Oxford City
Justice Services	Cafcass
	Thames Valley Police
	Crown Prosecution Service (Briefing Report not IMR)
Voluntary Services	Donnington Doorstep
OSCB	Oxfordshire Safeguarding Children Board

1.21 These IMRs and the combined agency chronologies amounted to around 6,000 pages of information and analysis, and the extent of agency involvement described explains in part the length of time it took for contributory documents to be finalised before the report itself could be started. Each agency IMR made recommendations and organisations have been working on their own action plans. The majority of evidence in this SCR comes from IMRs, but in the narrative it may simply say '(the agency) said' or '(the agency) told the SCR,' etc. This will include information from follow up queries from the SCR author to agencies. The author was given full cooperation with any further inquiries he felt appropriate to supplement that from IMRs.

1.22 The Panel met with the IMR authors for a two-day exploration of the key issues, and the new Independent Reviewer (the author) held a one day workshop with the IMR authors. The original reviewer met five of the six children and several parents, who provided a rich contribution to the SCR. The author met four of the victims and spoke to parents of three. He also met them again, with the OSCB Independent Chair to brief them on findings before publication. The author also interviewed a number of chief officers past and present, the former Lead Member for Children's Services, and a number of staff who had played a significant part in identifying the child sexual exploitation.

1.23 **Anonymity:** When the Review started, the national guidance required reports to be fully anonymised, and it was on this basis that most staff and family contributions were made. *Working Together 2013* no longer requires anonymity but asks the Local Safeguarding Children Board (LSCB) to consider the impact on those involved in determining publication. The OSCB believes it is important to preserve the identity of the children and families. This Review will not therefore describe the families in detail. This is also necessary to comply with the legal requirement not to publish the identity of victims of sexual offences. Members of staff are referred to by job title, and anonymity is also important if maximum learning is to be achieved through staff contribution to SCRs.

1.24 The case illustrations in this report are not associated with a specific victim, even anonymously, but as an account of the sorts of experiences and feelings experienced by the six victims and those working with them. This avoids risking a loss of confidentiality, and

allows mention of some detail which could not be used if there was a risk of linkage with a particular family. The law says that no matter likely to identify a person against whom a sexual offence has been committed shall be published during the victim's lifetime.

1.25 The Review has had to weigh up two risks when referring to the specific experiences. If the initials A-F are used, and in some way identities are revealed, it would be unfair on those involved. On the other hand, if illustrations are reported as typical, common or even 'in one case' then something might be seen to apply to any or all of the victims/families, which might also be or be seen to be indiscriminative. The author has decided, on balance, not to align experiences to victims or families by specific initials.

1.26 **Report structure:** The first Annual Report of the National Panel of Independent Experts on SCRs (which oversees the quality of reviews to ensure appropriate action is taken from the learning) comments on SCRs being produced now. It has expressed concern about undue length. It warns against a level of detail that would make publication difficult (and hence learning limited). It calls for a 'sharp focus' and 'concise accounts'. This SCR therefore uses the case detail to illustrate findings rather than describing all the very significant history, which would lead to a report of such length as to render its aim of being read and learned from impractical and unsuccessful. The SCR uses the six cases to illustrate the findings, but wherever possible findings relate to the whole system not only those cases

1.27 The report describes what happened in the words of the victims and families, and identifies the reasons why agency responses were insufficient for some time to intervene in a protective way. It goes on to look at what guidance was available to organisations and professionals, and then appraises the quality of agency work. It identifies learning points and key recommendations. Early in the report there is an account of how child sexual exploitation is addressed now and the improvements already made.

1.28 **Definition of CSE:** This Review is about child sexual exploitation (CSE) defined by government as follows:
"Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability." [2]
This accurately describes what happened in Oxfordshire.

1.29 **Terminology around ethnicity**: The perpetrators in this case were predominantly of Pakistani heritage. (Five were of Pakistani and one of North African heritage and the other has said he was born in Saudi Arabia.) In this report the word 'Asian' is used more than 'Pakistani'. This is

[2] *Safeguarding Children and Young People from Sexual Exploitation: supplementary guidance to Working Together to Safeguard Children* 9DCSF, 2009).

not to hide any specific ethnic origin, but because this was the description mainly used by the victims and in agency case records. It is believed that when the term 'Asian' was used it did very often refer to those of Pakistani heritage, but 'Asian' seems to be the word used in common professional parlance.

1.30 The victims were white British girls.

1.31 This Report was in final draft stage before the Report of Inspection of Rotherham Metropolitan Borough Council by Louise Casey was published on 4 February 2015.[3]

[3] *Report of Inspection of Rotherham Metropolitan Borough Council*, House of Commons, HC1050 (February 2015).

2 BACKGROUND

2.1 This section is necessarily frank about what the exploitation involved. It is the recognition of just how awful it was that focuses the mind on the suffering and how well agencies acted and reacted. It was so bad that, for a time, it was hard for staff to grasp the reality of what was happening. Concerns were identified about young people in Oxfordshire who were being sexually exploited. The collective picture from local agencies and intelligence that emerged about those individual young people led to 'Operation Bullfinch'. This complex investigation was led by the Police and involved key OSCB partners.

2.2 In Operation Bulfinch over 20 young people were identified as potential victims. Nine men were charged with offences against six children (Children A-F) and committed to trial at the Central Criminal Court in London. As a result, seven of the nine defendants were convicted on 14 May 2013. Five life sentences were given, with minimum terms ranging from 12 to 20 years. The two others were jailed for seven years, with Sexual Offence Prevention Orders. Further investigations and trials continue.

2.3 The six children whose cases illustrate this Review were the victims of between one and 24 of the convicted offences, although the testimony they have given to court, professionals and this Review makes clear that this would only be a very small fraction of the offences likely to have been committed against them. The Prosecution said the charges were *"not intended to reflect each and every act of sexual abuse performed on each of the complainants. Rather, the indictment is intended to reflect the different types of conduct inflicted on the complainants and their ages at the time that conduct was inflicted."* The offences took place between May 2004 and June 2012 when the children were between 12 and 16. For the seven convicted perpetrators, the guilty verdicts related to the following offences:

- 19 convictions for rape
- 10 convictions for conspiracy to rape
- 5 convictions for rape of a child under 13
- 4 convictions for conspiracy to rape a child under 13
- 8 convictions for arranging or facilitating prostitution
- 5 convictions for trafficking for sexual exploitation
- 4 convictions for sexual activity with a child
- 1 conviction for conspiracy to commit a sexual assault of a child
- 1 conviction for sexual assault of a child under 13 by penetration
- 1 conviction for using an instrument to procure a miscarriage
- 1 convictions for supplying a class A drug

2.4 The Prosecution's opening speech at the Operation Bullfinch trial began by saying, "*These defendants, and others not before the court, used and abused the six complainants persistently, over long periods of time, sometimes in groups, for their own sexual gratification and the sexual gratification of others. The depravity of what was done to the complainants was extreme… The facts in the case will make you uncomfortable. Much of what the girls were forced to endure was perverted in the extreme."*

2.5 The Review finds extracts from the remainder of the Prosecution speech a clear summary of the children's experiences. Some acts of abuse in the speech were too graphic to be repeated here.

"… these men, sometimes acting in groups and at other times separately, actively targeted vulnerable young girls from the age of about the ages of 11 or 12. Sometimes the men would come across the girls while the girls were out drinking or playing truant. There is evidence that the men deliberately targeted children who were out of control. They also targeted children who had been sent to live in care homes for precisely that reason. Sometimes girls already being abused by the group(s) were tasked to find other girls for the group(s).

The girls who were chosen generally had troubled upbringings and unsettled home lives which made it less likely that anyone would be exercising any normal parental control over them or looking out for them.

The girls were then groomed in a variety of ways such as being given gifts or simply by being shown the care and attention that they craved. The attention lavished on the girls at the outset was of course entirely insincere as it was merely a device to exploit their vulnerability. Having secured their confidence the men would ply the girls with alcohol and introduce them to drugs such as cannabis, cocaine, 'crack' and sometimes heroin. The girls became addicted to certain of the drugs and felt unable to live without them. This made them even more dependent on the men.

Sometimes the men would also exercise extreme physical and sexual violence on the girls and threaten them that should they ever seek to free themselves from the grasp of the group they and/or their families would suffer serious harm.

In such ways the men came to exercise control over the girls who they knew:

- *Were therefore likely to subject themselves to sexual exploitation and abuse;*
- *Unlikely to ever be able to extract themselves from it let alone complain about it;*
- *And if they were to complain, it is unlikely they would be believed in view of what others would perceive as their delinquent conduct.*

It was a lifestyle described by one of the complainants as a "living hell" from which they could not extricate themselves. The overall period covered on the indictment is from May 2004 to early 2012…

The defendants took the girls to other places, usually hotels / guest houses or empty private dwellings, for other men to have sex with them, again often in groups and often in return for money which was paid to the men and not the girls.

Most of the men were engaged in the sexual abuse of the young girls did so over many years. Each was much older than any of the girls and of an age to know precisely what he was doing; the harm he was inflicting on the girls; the fact of their suffering and that their activity was illegal and in many instances depraved. In short, their conduct was intentional and persistent. Many of the sexual acts committed on the girls were extreme in their depravity. The girls were usually given so many drugs that they were barely aware of what was going on. Indeed, they say that it was the only way they could cope with what was going on.

The sexual abuse included vaginal, anal and oral rape and also involved the use of a variety of objects such as knives, meat cleavers, baseball bats… sex toys … It was often accompanied by humiliating and degrading conduct such as biting, scratching, acts of urinating, being…

suffocated, tied up. They were also beaten and burnt. This sexual activity was often carried out by groups of men; sometimes it would go on for days on end.

The places to which the girls were taken were often private houses and guest houses in Oxford. Some of the private houses appeared to be empty and used solely for the purposes of the abuse. The men who came to pay to have sex with the girls were not always from Oxford; many travelled from far afield, places such as Bradford, Leeds, London and Slough. It seems they came specifically to sexually abuse young girl, often by appointment with the men in Oxford who had dominated the girls.

Between acts of abuse sometimes stretching over a number of days, the Oxford men ensured girls were guarded so that they could not escape. In addition to being abused in various locations in Oxford, some of the girls were taken to other towns and cities such as London and Bournemouth for the same purpose."

2.6 Assessing the scale of CSE is a very difficult task and there is no nationally agreed means of doing this. The Police and CSC were commissioned by the SCR Panel to try to produce robust figure. Adding cases where there was some certainty to those where there was a formal conviction of offences against them, there are grounds for believing that over the last 15 years around 370 girls may have been exploited in the ways covered by this SCR. The total will be a reasonable figure from the collective research of Police and CSC, although not precise because figures, by definition, were not formally collated until the pattern was finally recognised. (See Appendix 3 for methodology.)

Original Bullfinch investigation	39
Ongoing Bullfinch investigation	58
Others from CSC records	21
Children with whom Kingfisher have worked to Dec 2014	255
Total	373

2.7 The author and SCR Panel are conscious that these numbers may seem low given the higher (estimated) figures in Rotherham, but the work was carefully done and was debated and agreed by Panel members. It is not reasonable to extrapolate from the 255 children worked with in 2011-14 back to 1999 because many of these will refer to abuse which took place before 2011.

2.8 There was a commercial aspect to the exploitation, with some of the girls forced to work as prostitutes, hired out for up to hundreds of pounds, and trafficked and sold for sex. The police officer who led Operation Bullfinch characterised the crimes as '*organised*'.

2.9 The Prosecution opening speech refers to the areas men came from to abuse these girls. It says in various statements that the girls were trafficked for sex or being abused in London, Slough, Manchester, Coventry, Torbay, and Wycombe, and accounts of men coming from a range of cities including Leeds and Bradford to have sex with the girls. In February 2014, West Yorkshire Police charged 25 men from Halifax, Bradford, Shipley, Nantwich, Huddersfield, Derby and Newport in relation to sexual exploitation. Together with other high-profile cases of CSE across the country, the spread of places suggests that CSE is a nationwide issue.

3. THE EXPERIENCE OF THE VICTIMS AND THEIR FAMILIES

3.1 **Introduction:** The stories of the children whose cases are covered by this Review are shocking. The accounts here are as told to the original reviewer, the author, or from documents seen by the Review. Little comment is made on the views given in this section as it is important to know what the victims (and families) experienced and how it made them feel, both as a result of perpetrator action and in their dealings with professionals. In later sections, the perspective of staff is described and analysed for learning, and any differences of view discussed. As explained in Section 1, no comment is attributed to a specific victim or family.

3.2 The victims' voices are reflected through this report. The bulleted comments and views in this section are mainly taken from the previous reviewer's detailed notes of discussions with them, from the author's agreed interview notes with victims and parents, and some from other documents seen by the Review.

3.3 This Review will not tell individual stories as they become easily identifiable. The Prosecution speech in Section 2 has given a powerful overview of what happened to the girls. Their views, and parents' views, are given in three sections. Firstly, there is the period when, for most of the girls, a degree of vulnerability made them more susceptible to the attention of older men and the excitement that went with being found attractive, having money spent on them, a sense of drama and of 'living', probably the buzz from doing something on the edge, and alcohol and drugs. The families would be puzzled by the absence of the girls, who they were with, the gifts the girls came home with – and, if there were no problems with school attendance, there soon would be. Some of the children were already in Care or under Social Services care for a variety of reasons. Going missing from home or Care became common , .

3.4 Secondly, there were the results of the grooming. The more extreme behaviour, the longer periods of being missing, the effects of drink and drugs, looking gaunt, non-cooperation with anyone in authority. Longer periods in Care, sometimes being locked up in secure accommodation for their own safety. And despite what any professionals did (and the sum total of their effort was massive, if not too effective), the girls were unable to break away from the men who were by then using them for sex, offering them to others, selling them for sex, and keeping them hooked in by generating dependence on alcohol and drugs, which the girls paid for through sex. They were unable to reveal, in any usable way in court, detail of what was happening to them. During this period, some parents' entire lives would be dominated by searching for the girls, or trying to get agencies to act in a proactive protective way. The more vulnerable parents had less focus on protection.

3.5 The impression given in the history as told to the Review or the Police investigation was one of remorseless drama, chaos, violence, drink, hard drugs, violent and utterly unloving sex, and of not being able to escape – even to the point that the grooming was so successful that there was ambivalence about whether to escape or not.

3.6 Thirdly, there is how the girls and parents viewed the work of staff. Whilst it must be remembered that these cases were amongst the most difficult most staff would ever face, in general, family views were not positive. They saw staff as not taking concerns seriously enough, not believing the girls, not picking up the hints that they were giving about their abuse, and not being inquisitive enough about what was happening to them. The girls saw staff as critical of them and (while all the girls spoken to acknowledged how 'difficult' they were) felt

staff were not able to make a real human connection with them. Understanding the staff perception of this dynamic is an important part of the learning later in this Review. There is more on the parents' experience in 3.12 below.

3.7 The bulleted remarks below are powerful, relevant, and no doubt will be easy headlines which could lead to superficial conclusions. It is important that they are considered in the context of the whole Review. Words in brackets are added by the author to aid clarity.

3.8 **Vulnerability:** These are descriptions by the children after the abuse. Their acknowledgement of their vulnerability does *not* imply they were responsible for what happened to them.

- *It was a bit exciting*
- *They gave us more than my Mum could*
- *Dad was violent to me. I thought it was normal*
- *I had no male love, my father was an alcoholic, he hit me*
- *I was already off the rails before [meeting the men]*
- *Other children have a parent who they can talk to and rely on*
- *My birth father was alcoholic and violent*
- *I have always been aware of my problems, I was a brat*
- *My poor early life made me vulnerable*
- *School was bad for me – I was made fun of as a foster child. So I bunked off*
- *Suddenly the guys were bringing me stuff. They said how lovely I was*
- *They would buy us things*
- *I used to run away before [the grooming]*
- *They made me trust them for months, and I was their friend. I was flattered*
- *It was exciting – Asian boys with flash cars*
- *I wanted an exciting life: after 5-6 months I was involved – it was too late*
- *For a while he was my friend – just the two of us*
- *I used to moan about my home life – I was flattered they listened*
- *I believed they were my friends, nothing was more important*
- *They paid for drinks and gave us drugs*
- *I went missing every week – I thought it was normal*
- *When the grooming started they were so kind and nice. They were a lot older. It was flattering. It was attractive – then things started to change. I was already into drugs*
- *The Asian men felt they ran Oxford. That was exciting. People were afraid of them. I felt protected. People respected them*

3.9 **Experiences after grooming:** There is no need to repeat here some of the very graphic illustrations given by the Prosecutor in 2.4-5 above. Suffice to say, as horrendous as that description is, seeing/hearing about it in the girl's words, for example in statements, is indescribably awful. The victims were describing things happening to them across ages 12-15:

- *It all began when I was about 12 years old*
- *It started with men taking an interest in me*
- *The next thing it isn't nice anymore… they gave us weed and drink to make us feel better*
- *They started nice on the first day, on the second they wanted sex – still being nice. We drank vodka*

- *They took us to a field where there were other men who had come to have sex with us. I tried not to do it. There were five of them*
- *They threatened to blow up my house with my Mum in it*
- *I was expected to do things – if I didn't they said they would come to my house and burn me alive. I had a baby brother*
- *I took so many drugs – it was just a mish-mash*
- *Now I feel I was raped – I didn't have any choice*
- *I wouldn't ever have said no – they'd have beaten the shit out of me*
- *It was always Asian men*
- *I got deeper and deeper into this group*
- *Sometimes I was driven into alleys and woods and men would have sex with me*
- *I wouldn't have done this if I was sober. That's why the men gave us so much to drink*
- *Both men had sex with me lots of times – oral and vaginal*
- *I hate them... all they do is rape you… all they want is sex… it's happened to girls I know, not me before you ask, I not like that*
- *When we were at the flats I knew I was there to have sex which whichever men were brought there.*
- *He urinated on me*
- *I was spit roasted [made to have sex simultaneously with two men]*
- *I didn't want to go to the places to do what I did, but it was my job*
- *I went to London on my own to have sex with men they arranged*
- *The fear is still very real for me – though they are in jail I still check the cars*
- *It wasn't until the trial that I realised the organised nature of the abuse*

3.10 **The victims' experience of professionals:** At the time, the power of the grooming and the fear was so strong that there was an inability to cooperate with caring and justice agencies. Nevertheless, the victims have a great sense that they still gave enough indication verbally and non-verbally of what was happening for agencies to have intervened – even when they would have said they did not want such intervention. Allegations were frequently withdrawn, or details not given. Later in the report this dynamic is analysed in more detail. The comments relate to being missing as well as the absence of intervention.

3.11 Many comments are not attributed to specific agencies, as the learning from what is said applies across all organisations:

- *I was found in the presence of the men constantly. Why were they not pulled in?*
- *Police… didn't find me except once… I didn't hide – I told people where I was*
- *If a perpetrator can spot the vulnerable children, why can't professionals?*
- *Social workers asked me questions which showed they knew*
- *They could have followed us*
- *[On why not more inquiring questions] We wouldn't have told them but it would have showed they cared*
- *Why would a 13-year-old make it up?*
- *They didn't stop to think 'why?'*
- *They did not look on me as a child. In my head I was older, but really truly I wasn't*
- *People were reluctant to see what was clearly in front of them*

- *Social Services knew what was going on – they always asked questions that showed that they knew*
- *The only person who was any good was [the support worker]. She took me to MacDonald's or Costa Coffee to talk. I wasn't confident enough to tell her... but she was taking to me and listening*
- *The support worker was great. She was an adult… she was firm and there for me... she talked about 'we', ie me and her*
- *The social worker just wanted to hear what [the worker] wanted to hear so there was no need to do anything…*
- *[A police officer] tried to get people to listen, but she was banging her head against a brick wall*
- *The same officer was kind, supportive and showed the humanity and respect that so many officers seemed to lack at the time*
- *No one believes me, no one cares*
- *They knew where I was, they didn't care when I came back*
- *I couldn't sleep or eat*
- *The Police never asked me why – they just took me home*
- *They left you in a house with Asian men and didn't even ask my age*
- *I thought if I told the Police what was really happening they would not believe me, and they would not arrest them and then… they did not do anything and that made me think that nothing could be done*
- *I was put in a secure unit because I kept going missing – I thought I was being punished. They did nothing to the men that made me go missing*
- *They should have done something to the men, not me*
- *Staff would see you get picked up by adult males in cars so they knew what you were doing*
- *[On returning from London] No one spoke to me about the men in London. There were hundreds of them – untouched*
- *I never told anyone what I was going through*
- *Taking me away from my Mum was bad*
- *I said, 'I will get burned alive'. She said come round for a coffee*
- *I made a complaint about a man who trafficked me from a children's home. He was arrested, released and trafficked me again*
- *If someone had taken the trouble to ask me I would have told them*
- *Oxford and another council argued about me to try and avoid doing anything. It wasn't my fault I was abused*
- *The old sergeant was great. He has a cigarette with you, and chatted about anything, He didn't make me feel bad about myself and treated me like a person*
- *The social worker didn't understand the extent or seriousness of what was happening. She didn't understand why I wasn't telling them [about the exploitation]*
- *I turned up at the police station at 2/3am, blood all over me, soaked through my trousers to the crotch. They dismissed it as me being naughty, a nuisance. I was bruised and bloody*
- *Social services washed their hands – 'it's your choice' I was told*
- *A WPC found me drunk with men. I said I was ok and she went away and left me with them. I was abused that night*
- *Ms X at the school – she had no idea what to do. She just listened and didn't say do this, do that. She was a rock…*
- *… She did speak to the police. It meant I was whacked around the head with a crowbar*

- *The staff in the Secure Units were good. They knew how to deal with hard cases. If you told them to f-off 20 times, they would still ask if you were ok and wanted a cup of tea*

There were a number of very negative comments from victims about one children's home, Dell Quay in Henley (closed 2008), suggesting poorly trained and inexperienced staff who set a poor example to the girls.

3.12 **The parents' experience:** The SCR Panel decided to approach only those parents where the victims agreed they could be approached. Four parents of three victims agreed to speak to the Review, so the views below do not necessarily reflect those of all parents, but it would be surprising if there were not some similarities. As will be seen later, a number of parents created strong reactions in professionals who might have a different take on some of what is reproduced below. Regardless of how 'difficult' any parents were (either innately, or as a result of the anxieties of caring for exploited children, or their frustrations with agencies), their experiences of having children who, for example, went missing up to hundreds of time, who seemed so distressed and hurt, and who would often act in a self-defeating way was truly exceptional. Any parent whose 12- to 15-year-old has gone missing even once, or had an inappropriate sexual relationship, or been attacked will recall the chaos and upset this caused and have this emblazoned on their mind for ever. These parents dealt with worrying incidents up to daily for years. They were naturally frustrated that agencies did not provide quick solutions to protection, prevention, or discovery. It shows that there was a long period when no one knew exactly what was happening, but the parents knew 'something' serious was awry.

3.13 The bulleted comments are in no special order, but aim to illustrate the range of views. The quotation below seems to sum up what it was like to be a parent of a child caught up in grooming and CSE.

3.14 *"… we... have a situation where [the daughter] is virtually living on the streets and no service or individual has been able to engage with her at all, most have not even tried. She is absolutely alone in the world apart from me and she refuses to allow me to have any influence on her. I have reached the reluctant conclusion that [her] home here is of absolutely no benefit to her and that the toll that trying to preserve it is taking on my physical and mental health and to a lesser extent the well-being of family and friends and neighbours and the police is all for nothing."* Parental comments included:

- *Police wouldn't pursue anyone unless they had a cast iron case*
- *No one thought about us – what it would be like if it was their daughter*
- *She always said she was with friends but would surface, often in A&E, anywhere – usually in London but also Essex Coventry and Gloucester*
- *She would be dirty, hungry, not in her own clothes, very distressed and clearly coming down off some substance*
- *Police wouldn't tell us addresses so we could go and bring her home*
- *She was a minor but we were told it wasn't our business*
- *We thought she was just a rebellious teenager bunking off to smoke and drink in the park – no one said we need to know where she goes*
- *I tried to tell social services about the evidence – but they weren't interested. It was obvious it was something sexual*
- *All this – it has ripped the family apart*

- *I keep emphasising 'she is a minor'. Why would other vulnerable groups be protected from themselves, but she was allowed to make the wrong choices*
- *A big chunk of her life has been taken away – when she should have been at the youth club or skating or the school prom – all that went missing because of them: the perpetrators and the police/social services for not stopping it when they knew*
- *I put window locks on and kept the key... but in the morning found someone had helped her chisel open the sashes*
- *It's in my mind all the time – what happened to my 'baby' and what I did because I didn't understand what was happening to me They knew what was happening to her and didn't tell me*
- *Every day I deal with it – dread the phone ringing in case it's something bad*
- *Why did they let it go on during the long investigation*
- *No one spoke to us about dealing with the people responsible*
- *The social worker was very abrupt, said it was my duty to look after her. I said I was not capable of dealing with it*
- *There were lots of meetings. I got very angry and said it was a load of bull shit - no one was doing anything*
- *The police said she didn't appear in danger, they said she was happy to be there, and refused to tell me where she was*
- *If I had known I would have fetched her out of [named address] – I didn't learn about it till the trial*
- *The Guardian Ad Litem never spoke to me at all, or discussed with me how to protect her*
- *They threatened to kill me and behead my daughter's baby*
- *She was missing for ten days*
- *Because she came home [from missing] they thought she was safe now*
- *Giving her a cuddle and taking her to MacDonald's was the [worker's] solution*
- *One manager said [before the exploitation was understood] 'She's streetwise, and loves it'*
- *[After a theft was investigated where a girl was with older men] The issue for the police was the burglary, not a 13-year-old with older men*
- *At interagency meetings attended no one kept any records/minutes, and there were never agendas*
- *The Children's Home didn't tell me when she went missing*
- *I despaired of ever getting an appropriate response that stood alongside us and didn't try to blame and shame us*

3.15 One parent submitted a written paper to the Review, extracts from which are included above and below:

- *"I don't blame **Social Services** for not understanding exactly what went on- the street grooming by groups was an 'unknown unknown', but I would criticise them for…*
  - *Only working with one model of abuse – intra-familial*
  - *Having no empathy*
  - *Not adequately acknowledging my concerns*
  - *Appearing to have no interest in what was happening when she was placed out of county, and being indifferent to her being trafficked 250 miles from one care home*
  - *Not having the interest and skills to engage an angry troubled child –all bar one excellent down-to-earth support worker*

- *On the whole **the Police** were the only service who tried to get a grip, or which offered interest empathy but…*
  - *Even the police back then didn't see organised abuse as the main reason the girls went missing*
  - *There was a lack of curiosity*
  - *Too many accepted her explanation of being with friends*
  - *I was asked the same questions each time on the scores of occasions I reported her missing, and they would search the house and gardens each time – a waste of everyone's time. The police were always apologetic and sympathetic*

- ***Health***
  - *Wonderful empathetic support from our GP*
  - *In mental health no one really had the skills to engage her as she didn't have a diagnosable illness and she was too challenging*
  - *They did arrange review conferences using the care programme approach*

- ***Education** Although some individuals tried to support her, education as a whole failed her… the response was to exclude her as soon as at 12 she started exhibiting difficult behaviour and truanting… which meant she had nothing else to do except hang around the square where she was first approached and groomed by predatory men. The lack of education also further reduced her self-esteem, isolated her from peers and… made her extra vulnerable to the blandishments of the child groomers.*

- ***Multi-agency meetings** convened by the mental health trust became good at general information sharing, but the elephant in the room for all of us was the fact she was being groomed and exploited. I think we all knew it but no service had the language, understanding and tools to acknowledge it, yet alone deal with it.*

3.16 The parent also described the impact on the daughter – *"now ultra-fearful and cautious and unable to enjoy age appropriate activities. She suffers nightmares, flashbacks and is depressed. She lost her childhood and education…*" The parent described "*hunting the streets of SE England night after night taking its toll on health"*, and "*having to move to escape ongoing threats…*" The parent set out some recommendations which will be referred to later in the report.

3.17 Two parents provided some feedback on staff work through listing their expectations that were not met. They gave the previous reviewer and the author a number of illustrations of these points. They made huge efforts to find their daughter when missing. "*We expected…*
- *To have our concerns listened to and believed… to be taken seriously*
- *Not to be patronised*
- *To have information about our daughter shared with us*
- *Police and Social Workers to work together... not passing the buck to each other while we got more scared and frustrated about what was happening*
- *To be told what was happening to the intelligence we gave them*
- *To get intervention sooner, especially when it as so painful to have to ask for help (as it meant we had failed to keep her safe)*
- *Social Services to listen to recommendations by other professional bodies making sound assessments- they didn't and our daughter's would go back to old ways*

- *We didn’t expect to have to do all the chasing ourselves*

4 IMPROVEMENTS IN OXFORDSHIRE

4.1 The views from families as seen in Section 3, and the analysis in Sections 5 onwards, show that there were indeed missed opportunities to identify CSE and many areas where services could and should have responded better. It is tragic that families had to go through the experiences they described before services made the improvements that are in place now. Since that time (four to ten years ago) there has been much improvement. This does not mean that everything is likely to be perfect, but that the critique later in the Report of what happened in the past can be read with the knowledge that many lessons have already been learned, and that services for children vulnerable to CSE have been improved considerably.

4.2 This will not be a time when known numbers will reduce. Almost certainly the opposite will be the case due to the joined-up rigour with which CSE is now identified and pursued, However, the chances of it being prevented, disrupted or punished are far higher due to the commitment and skill now being shown.

4.3 In light of the strengthened multi-agency work across Oxfordshire to protect children at risk of sexual exploitation, it is likely that children will now experience a persistence and continuity in the services they receive. Those services will be much more coordinated between agencies with staff who are now well trained about the signs of abuse and understand why the victims behave as they do. Perpetrators will now be actively pursued by all available means, regardless of the degree of victim cooperation. That determination, and the persistence of staff who are trained to 'never give up on a child', will give more confidence to victims to disclose and give evidence, and also provide better support for victims and their families.

4.4 This section only gives headline changes. A more complete account is given in the associated document prepared by the OSCB and its members, 'CSE in Oxfordshire: Agency Responses since 2011', which describes the system-wide and agency progress in greater detail so that more learning is available. The source of the information below is agency reports commissioned for the SCR Panel. The improvements are those reported by the OSCB and its member agencies, and confirmed by SCR Panel members. Personally quality assuring these submissions was beyond the author's remit. Recent external inspections have been positive.

4.5 **OSCB overview**: This account of OSCB action may on the surface sound rather bureaucratic, but as will be seen in following sections, the absence of such a framework and focus on CSE played a part in the delayed recognition of CSE. The following arrangements are now in place and monitored by the OSCB:

- The new (2014) OSCB Chair has assured the Review that compliance against the 2009 CSE guidance was last reviewed satisfactorily in November 2014
- There has been a subgroup of the Board focusing on CSE since 2011. It is currently chaired by a Police Superintendent, with membership from the City District Council, County Council, NHS, Police and voluntary sector
- The subgroup scrutinises and challenges prevalence and missing persons reports, oversees the ongoing development of procedures, and acts as steering group over the multi-agency specialist CSE team 'Kingfisher'. (See 4.8-9 and 4.15-17.)
- Progress in addressing CSE in Oxfordshire was last reported in the 2013-14 OSCB Annual Report (July 2014)

- The Board's Annual Conference in 2012 was themed on CSE (before the Bullfinch convictions) and its 2015 conference is to be focused on older children at risk
- The OSCB has comprehensive procedures on CSE as part of the overall Child Protection procedures which are on its website
- There is a 'Tackling CSE: Professional's Handbook: Never Give Up On a Child' covering all aspects of the understanding and management of CSE, including the CSE Screening Tool "to be used by all professionals working with children and young people aged 10 plus" (or younger if necessary). If the tool identifies a certain degree of risk, then referral to CSC is mandatory
- Since 2011 in excess of 7,500 Oxfordshire staff have received training on CSE, including all front line staff and those working with children. Take-up of training is monitored by the OSCB Training subgroup to ensure good compliance
- There is a very extensive multi-agency OSCB Action Plan covering five main themes:
  - Raising awareness
  - Improving statutory responses and provision of services
  - Improving evidence
  - Improving prosecution procedures
  - Improving disruption
- The new OSCB Chair has introduced a Chief Officer Forum on Safeguarding, and has met regularly with the County Council Full Council, Cabinet and Scrutiny Committee
- In the 2014 Ofsted inspection[4] the OCSB's effectiveness was rated as 'good', which means that the OSCB "*coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services."* The Ofsted summary of why Oxfordshire and the LSCB were rated 'good' is in Appendix 4.

4.6 **Leadership commitment:** The SCR will show how top leaders had little influence on what turned out to be CSE by groups of adult males of Pakistani heritage because, for reasons explored below, early concerns were not escalated to them – a pattern that crossed all agencies. It is fair to say that they were shocked by the discoveries, and since Operation Bullfinch there has been an impressive focus, drive and commitment from the top leaders from all agencies – in terms of personal interest, political engagement and resource commitment. In September 2014 the County, City, Thames Valley Police (TVP) and the OSCB co-hosted a major briefing session for all County and District councillors, and equivalent stakeholders. The author attended, and there was a frank assessment of what did not go well together with a positive account of across-the-board improvements. MPs have also been regularly briefed. Both County and TVP Chief Officers have given a number of national presentations on Oxfordshire's learning, and various national leaders/politicians have been to see local progress. Summaries are given for the County, City and TVP.

4.7 *County Council:* In the County Council (which is the local authority for social services and education), the Cabinet receives regular updates on CSE against national expectations, and the CEO describes CSE as her "*number one personal priority".* The OSCB Annual Report is discussed at full Council, Scrutiny Committee, and Cabinet. Children's Services budgets have

[4] *Oxfordshire County Council: Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the LSCB* (Ofsted, 30.6.14).

increased by 80% in real terms between 2007 and 2014, and an estimated £8m was committed to the Bullfinch investigation and the response to CSE, including additional social workers. For example, in 2013-14, £1.4m enabled the recruitment of 21 child protection social workers. Capital resources have been agreed to build new children's homes in-county to allow vulnerable children to be placed nearer home. After the Bullfinch trial in 2013 there was a cross-party Cabinet Advisory Group to consider arrangements for safeguarding assurance. A Cabinet review considered and accepted, in May 2014, 14 recommendations to strengthen the governance and quality assurance of safeguarding.[5] In 2014, Ofsted rated the local authority's services to children as 'good', *"…leading effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted".*

4.8 On CSE specifically, the Ofsted June 2014 inspection (reporting on partnership work, not just the Council) concluded that *"Work done by the Kingfisher service, a specialist team working with young people who have suffered or are at risk of child sexual exploitation (CSE), is of high quality. It focuses both on reducing risks and meeting wider needs for young people, as well as providing good consideration of the young person's holistic needs. Large numbers of professionals have been effectively trained to identify potential indicators of child sexual exploitation. The consistently high use of a child sexual exploitation screening tool by professionals who are concerned about possible CSE is leading to more young people being helped earlier. The Kingfisher team provides good quality consultation and advice to a wide range of professionals on child sexual exploitation. Excellent awareness-raising activity takes place with young people on a continual cycle and is now taking place with parents and carers."*

4.9 And on missing children that "*Good arrangements are in place to respond when children go missing from home and care. The police undertake a 'safe and well' visit when children return home and provide very prompt reports to the local authority. Social workers visit promptly after each missing episode of a child known to the service. They complete a return interview with the young person to understand the reasons for the missing episode. All missing episodes are effectively recorded and risk assessed, with appropriate plans to reduce the risk of future missing episodes. The authority has effective systems for identifying, monitoring and responding to those children who are missing from education and those who are educated at home. Officers provide support and, where necessary, challenge to ensure the quality of the education provided in this way."*

4.10 The Rotherham reports have highlighted the role of Council leaders. The 2014 Ofsted report said, "*Services for children and families are given a high priority by senior leaders and elected members. The local authority knows its strengths and weaknesses well. Strategic priorities are identified and informed by feedback from children, young people, parents, carers and staff. Leadership is strong and effective and services make a demonstrable difference in improving the life chances of some of the most vulnerable children in Oxfordshire. Elected members have high aspirations for looked after children and young people in Oxfordshire and have prioritised continued investment, for example in additional social worker and team manager posts. They hold senior officers to account for the quality of services."*

[5] *Recommendations of the Cabinet Advisory Group on the Strategic Assurance Framework for safeguarding children and young people* (Oxfordshire County Council, 13 May 2014).

4.11 *The Police:* Since 2011, the Police have had a new structure which enables force-wide briefing and identification of new issues. CSE is a strategic priority in the Police and Crime Commissioners Police and Crime Plan and in the TVP Delivery Plan, and a CSE Oversight Group provides strategic oversight to the more significant investigations and intelligence development operations. There has also been significant investment in line with their commitment to prevent, disrupt and prosecute CSE. The Chief Constable's Management Team approved the recruitment of five dedicated CSE officers and, for the Child Abuse and Investigation Unit, 18 detective constables, three detective sergeants, a detective inspector and a detective chief inspector. A DVD of the Chief Constable speaking with one victim and another's parent about their experiences of CSE and feedback on TVP staff has been incorporated in staff training across the force. In 2014 TVP was rated as follows by HMIC *offending, is good at investigating crime and good at tackling anti-social behaviour; the*:[6] *'In terms of its effectiveness, in general, the force is good at reducing crime and preventing offending, is good at investigating crime and good at tackling anti-social behaviour; the efficiency with which the force carries out its responsibilities is good; and the force is acting to achieve fairness and legitimacy in most of the practices that were examined this year'.*

4.12 The OSCB Annual Report is reported formally to the Police and Crime Commissioner, and TVP's Chief Officer team engage regularly with the OSCB Independent Chair.

4.13 The Superintendent, who is the TVP Area Commander for Oxford, said in February 2015,"If you ask any of my staff their number one priority they would say tackling child sexual exploitation."

4.14 *City Council:* The City (in which most of the CSE occurred) is a District Council and does not manage child safeguarding, but provides a range of services and regulatory functions which support vulnerable children and their families. In 2013, the City CEO commissioned an external review which confirmed its self-assessment that it complied with its safeguarding responsibilities under the Children Act. Four service heads act as designated officers to coordinate the Council's approach to safeguarding, within each service area there are named safeguarding officers. A Director now takes the overall lead, and has recently become a member of the OSCB. Investment has included a significant input to the Youth Ambition and Educational Attainment Programme, which aims to boost the resilience and confidence of young people, and a new safeguarding coordinator. City staff wrote the OSCB CSE training materials. Work is ongoing to clarify the interrelationships between the various community safety partnerships and safeguarding through a new community engagement work stream of the OSCB CSE subgroup.

4.15 **Countywide service improvement:** The SCR shows that coordination of work and the sharing of information around the safety of children (so that a wider picture on CSE might emerge) were not optimal in the years before group CSE was identified in Oxfordshire. There have been two major developments. From September 2014 there has been a Multi-agency Safeguarding Hub (MASH), which ensures that referrals about children are considered from the beginning on a multi-agency basis and that information is shared quickly. The Oxfordshire MASH was planned by a multi-agency steering group, chaired by the Assistant Chief Constable of Thames Valley Police. The MASH is based at Cowley Police Station and includes staff from Children's Social Care, Adult Social Care, Early Intervention, the

[6] 'Police effectiveness, efficiency and legitimacy programme (PEEL) assessment of TVP' (HMIC, 2014).

Emergency Duty Team, Thames Valley Police, and safeguarding experts from Oxford Health, Oxford University Hospitals and the Clinical Commissioning Group (CCG). There will also be input from other agencies on a 'virtual basis' such as South Central Ambulance Service, Youth Offending Service, Fire and Rescue Service, Trading Standards and Probation. The hub is a link between universal services such as schools and GPs, and statutory services such as police and social care. Oxford City is piloting MASH links on behalf of other Districts.

4.16 Specifically on CSE, there is the Kingfisher Team, a TVP, Oxford Health and Oxfordshire County Council joint team set up in November 2012 to tackle CSE. The initiative has already won two national awards for its work – for innovative partnership work to protect children at risk of CSE, and for having "successfully linked with different services and partners in innovative and constructive ways and created forward thinking services for children, young people and families". The Team has developed a CSE Screening Tool, which helps build a picture of concerns around the county. Care plans are designed to support and protect those children identified by Kingfisher as being at risk. The team has a strong focus on achieving successful prosecutions as a key way to safeguard and protect children, and also plans disruption activity.

4.17 The Kingfisher Team and the OSCB also coordinated and supported a theatre production (*Chelsea's Choice*) to raise awareness of CSE, which has been shown in numerous secondary schools across the county. Kingfisher also works closely with parents to raise awareness of the grooming process. The team has a full time CSE health nurse who provides one-to-one support for children who are Kingfisher cases. The nurse has specialist training in recognising signs and symptoms of sexual exploitation, and can fast-track referrals to specialist health services.

4.18 The range of services that were provided by Kingfisher can be illustrated by one teenage girl, who was very much like the girls described in Section 3,

Social Worker – regular visits, befriending, family work, building trust, CSE recognition and safeguarding

Specialist Nurse – general health assessment, sexual health screening, contraception, relationships, self-esteem and building trust

Police – gathering intelligence from all aspects surrounding (the girl). Offering support and guidance throughout the ongoing investigation

- Child Protection Plan in place – regular multi-agency meetings and core groups gathering information
- Good communication within the Kingfisher team, sharing information quickly so that there can be a quick response to concerns
- Escalation of concern – (the girl) requested to be taken into care of local authority. Continues to be at risk of CSE
- Further placement found out of county in a therapeutic residential placement
- Statement submitted by (the girl) to the police describing extensive CSE... Police Operation ongoing
- Work continues with same social worker, nurse and police officers

4.19 This shows a level of expertise and coordination that was not present before Bullfinch, and strong multi-agency commitment. Around 255 children have been referred to Kingfisher since it began in late 2012.

4.20 **Investigation, disruption and prosecution:** Among the problems before the Bullfinch case, and the expertise gained through it, were insufficient disruption activity, insufficient focus on potential abusers, and difficulties in getting to prosecution given the evidential difficulties these cases threw up. The Bullfinch operation itself was a major exercise with the Police and CSC working together on intelligence gathering and to support the victims through the most challenging process of agreeing to give evidence and them maintaining that commitment through court. The Police used innovative covert investigative tactics. Seven men were found guilty and imprisoned for 60 offences. There were three further, related convictions in June 2014. In February 2015, a man was convicted of five offences related to sexual exploitation of two girls. Further trials are imminent.

4.21 In the autumn of 2014 the Chief Constable reported 16 live CSE operations across the TVP area, with 35 arrested as a result of current operations and a total of 78 charges made. For example, in June 2014, seven men were arrested with 25 charges against girls of 13-16 in Banbury. It took over 12 months of intensive work by Kingfisher with a number of girls to get to the point where they felt sufficiently safe and trusting to make disclosures. This included two seeking reception into Local Authority care as they did not feel safe disclosing from home. In September, eight men were charged for offences linked to CSE in Aylesbury.

4.22 There is also a wide use of disruption process such as Abduction Notices and work with other regulatory bodies such as District Councils on matters such as housing, nuisance, licensing of premises and taxis to provide concerted action to disrupt.

4.23 There is now updated guidance on prosecuting cases,[7] which used some of the Bullfinch learning. This introduces a range of approaches which make it more possible to use the sort of evidence that girls subject to grooming may be able to give, and make it easier for such evidence to be given. For example, changing evidence or matters which might be seen to undermine a girl's credibility are now put forward as possible confirmation of exploitation.

4.24 The collective approach to prosecution and protection can be seen in one recent exploitation case where a long jail term was given. The victims were looked after children (LAC)**.** Carers concerned about one girl followed her and immediately called the Police when an adult male was involved. The man was arrested immediately and served with an Abduction Warning Notice. The victim soon disclosed a range of abuse and other victims identified.

4.25 **Community relations:** With the known perpetrators of group CSE being significantly of Pakistani heritage, there is considerable work to build relationships with these communities (and others), increase their understanding of CSE and help build a preventative approach. Some examples:

- The Children's Society runs 12-week induction programmes for young unaccompanied asylum seekers, on which CSC and the Police provide input on CSE and age of consent issues

[7] *Guidance on Prosecuting Case of Child Sexual Abuse* (Crown Prosecution Service, 2013).

- The City Council is appointing a Pakistani Father Support project worker, and has developed a new mentoring programme to prevent CSE amongst at risk BME/South Asian males
- The Superintendent in charge of the Oxford Police (who also chairs the OSCB CSE subgroup) meets Mosque leaders every two months, with for example discussions on CSE warning signs. In 2015 it is planned to extend this to include the City and County Councils
- The Superintendent also has a bi-monthly Independent Advisory Group which includes all faiths. CSE is always on the agenda, and the Group is briefed for example on disruption operations
- Police officers attend the Mosque Friday Prayers weekly
- The OSCB's revised CSE Strategy will have a major new section on community engagement
- The Local Authority Designated Officer (LADO) has led work with the Oxfordshire Mosques and their linked Madrassas on safeguarding children and has worked to ensure safeguarding arrangements are in place including DBS checks, basic training and a safeguarding policy
- Seven faith leaders attended a top-level briefing on CSE progress in September 2014
- In October 2014, Muslim representatives attended a CSC/TVP meeting, discussing trafficking and CSE with other religious leaders
- A meeting was held in February 2015 between Police, City and County representatives and the OSCB Chair with Muslim community leaders

4.26 **Involved agency progress:** Full details on progress can be found in the associated 'CSE in Oxfordshire: Agency Responses since 2011' but brief extracts are given here to show developments in agencies (on top of the progress described above).

4.27 ***Oxford City Council***

- All staff audited for safeguarding training needs
- Internal safeguarding expectations now explicit
- The Community Safety Team (with Public Health funding support) has commissioned a range of CSE-related activities in Oxfordshire including:
  - A human trafficking conference for front line professionals and members of the BME community
  - A scoping exercise on 'at risk' communities
  - A CSE awareness conference for hotels and B&Bs
  - Revision of guidance for new taxi drivers to include trafficking
- Joint operations targeting premises involved in CSE
- Landlords used to place vulnerable persons subject to fit and proper persons tests and intelligence sharing with TVP
- The City Council's taxi licencing policies on 'warnings, offences, cautions and convictions', and its application pack for licencing are published by the National Working Group on CSE as exemplars, as is their training materials. The City has a website on 'Taxi and Private Hire – Safeguarding children and vulnerable people'
- There is an information-sharing arrangement with Oxfordshire County Council's School and Social Care Transport team who will provide details to us of any concerns they have regarding a driver licensed by Oxford City Council

4.28 ***Oxfordshire County Council:***

Adult Social Care

- Joining the MASH from April 2015
- Reinforcement of escalation procedures for CSE identified by staff working with adults
- Focus on work with parents with disabilities and young carers (issues in this review)
- Adult Social Care now represented on the Community Safety Partnerships

Children's Social Care

- Commitment to funding the ten staff in Kingfisher
- Use of Troubled Families funding to support, with the voluntary sector, work with parents of children at risk of CSE
- Jointly funding a new Kingfisher post to engage South Asian communities' girls and women
- Joint work with Police and NHS on coordinating responses to girls with serious injuries
- Taking part in a national trafficking pilot about identifying and supporting CSE victims
- Monthly extended team meetings now operating across the county, led by Kingfisher and involving a wide range of partners including schools and the voluntary sector. These are proving effective in implementing the CSE Screening Tool in the early identification of children at risk and enable targeting of new 'hot spot' areas
- Independent Reviewing Officers and Independent Chairs of Child Protection conferences have worked through a programme of quality assurance audits, observations of chairing practice and team development focused on improving the quality of children's Care and Protection Plans and raising the standard of their scrutiny role. Challenges made by independent Reviewing Officers/Independent Chairs to social workers are recorded on children's files and entered on a tracking system that ensures challenges have impact on social work practice
- CSC used its IMR's critical analysis to run challenging practice development sessions with 360-plus staff and managers

Education and Early Intervention Service (EIS)

- EIS organises or conducts return from missing interviews for children not open cases
- Safeguarding on the agenda of the termly Heads/Chair of Governors meetings with the Director of Children's Services, eg dynamics of grooming, impact of absence
- Bespoke training for 250-plus staff in schools and FE colleges
- All state school year 8 and 9 shown the play *Chelsea's Choice*, a powerful drama about grooming, and year 10s will be shown *Somebody's Sister, Somebody's Daughter*
- Senior EIS managers are involved with the OSCB, and its CSE and Quality Assurance/Audit groups, the Missing Persons Panel, and three staff are seconded to Kingfisher
- Centralised easy access list of children missing from education
- Transfer of records, including safeguarding concerns, between schools to be audited
- Greater information sharing about exclusions from school
- Directory of alternative quality provision completed

Youth Offending Service

- All staff have received CSE training
- CSE Screening Tool core part of YOS assessment files
- Safeguarding a standard item for all team meetings
- Any significant risks for a child are escalated to the Chair of the YOS Management Board

Legal Services

- Improved process for monitoring the completion of actions following decisions
- Legal advisers more aware of the wider powers, beyond the Children Act, that can be used to protect children

Public Health

- School health nurse provision enhanced to be available for all secondary schools
- CSE expectation of providers more explicit, including school nurse joint work with CAMHS and sexual health services
- New drug and alcohol education programmes for year 8/9 in all secondary schools
- Permanent drug and alcohol worker seconded to MASH
- Safeguarding audit of adult case files on parental drug/alcohol use, with findings fed back to the OSCB to improve joint planning of services

4.29 ***NHS:***

Clinical Commissioning Group/NHS England

- Providers are now contractually required to use the CSE Screening Tool, provide CSE training and have agreed referral pathways. This is monitored through contract meetings for relevant services
- Providers are required to have clear internal escalation processes that link to OSCB escalation procedures.
- A specialist practitioner has been commissioned for Kingfisher to enable health assessments and referrals to be made in a timely way. This service is provided by Oxford Health
- The Designated Nurse and Doctor delivered CSE training to all GP localities as soon as the learning emerged of the extent of CSE in Oxfordshire. This is being sustained through a rolling training programme. As a result, GPs are increasingly requesting support and advice on CSE from the CCG Safeguarding team
- A review of healthcare provision in the LAC (looked after children) system has been undertaken. The intention is to identify where improvements can be made

Oxford University Hospitals NHS Trust

- CSE is included in all child safeguarding delivered to Trust staff. Targeted Level 3 CSE training has been provided for genito-urinary medicine (GUM), paediatrics, emergency department, psychology, obstetrics and midwifery. As a result of training, the Safeguarding team is now receiving regular enquiries from a wide variety of professionals for advice on possible cases of CSE
- Teenage pregnancy pathways have been updated to include the CSE Screening Tool.
- Sexual health services have a new pro-forma for assessment of CSE and use the CSE toolkit. They have weekly multidisciplinary team meetings to review notes of all under 16s seen, and flag records of potentially vulnerable young people. They have regular meetings with the specialist nurse from the Kingfisher team and where relevant share information with her, the OUH Safeguarding team, school health nurses and make referrals to the MASH

- Professionals are better at considering CSE as a possibility in young people who are admitted with self-harm and/or challenging behaviour. Where there are concerns, an MDT meeting is held before the young person is discharged
- The criteria for referring concerns to CSC have been reinforced, and professionals have been made aware of how to escalate concerns

Oxford Health NHS Foundation Trust

- The Trust provides the specialist Kingfisher nurse. The nurse undertakes health assessments and facilitates information sharing across health providers to ensure that health needs are met and attends the Missing Children's Panel
- Since 2010 the Trust has provided a specialist nurse for looked after children who works with children in residential settings and harder to reach young people, and will attend LAC reviews
- All Looked After Children have full access to CAMHS, including access to 24/7 outreach service for crisis support. The CAMHs service is now routinely considering Dialectical Behavioural Theory (DBT) for children who are looked after and who are open to the Kingfisher team
- Looked After Children's Initial Health Assessments are now completed by dedicated doctors. This results in an improved assessment which is informed by social care histories and the GP records, leading to better healthcare plans
- All young people under 16 (or older if at risk) accessing contraceptive or sexual health advice from the school nursing service have a risk assessment for sexual abuse/exploitation
- CSE is embedded in the Trust safeguarding training. Health visitors, school health nurses, college nurses, CAMHS and inpatient adolescent mental health unit have been trained in the use of the CSE Screening Tool
- New Trust escalation guidance is in place and compliance is audited

4.30 ***Thames Valley Police (TVP):***

- TVP has six dedicated CSE officers in the Kingfisher Team (based at Cowley Police station), including the Detective Inspector, who leads the team, and a Missing Persons Coordinator
- One office of the Major Crime Unit is dedicated to ongoing CSE investigations in Oxfordshire with 24 police officers, including a Detective Chief Inspector lead and five Police staff
- Each of the remaining three Major Crime Offices is conducting CSE investigations across the Force with officers and staff seconded to these investigations
- The Force has ensured clarity around the ownership of CSE investigations through allocation to the Child Abuse Investigation Unit (CAIU), Crime Investigation Department (CID) or Major Crime teams based on complexity
- All front line officers and staff, including constables, PCSOs and sergeants, have been attending bespoke CSE training since 2013, and control room staff are now trained in recognition of CSE signs; all officers have a CSE 'aide memoire'
- Bespoke guidance, 'Be confident in your powers to protect children – you may be the last chance that child has', about powers of entry and reasonable force, has been developed

- Bespoke missing persons (CSE) training for all inspectors, detective inspectors and chief inspectors since 2013, and all staff have also completed the College of Policing e-learning package, which further reinforces the link between missing children and CSE
- All officers had a laminated card with guidance on 'safe and well' checks for missing persons
- Full array of disruption tools used including, for example, Abduction Warning Notices
- Covert investigation guidance as a core tool in building cases against perpetrators (adopted as national good practice)
- Numerous actions to improve the recording and management of crime
- Four flags have been added to the Police National Computer System to ensure alerts on potential victims of CSE, repeat missing persons, the presence of Child Abduction Warning Notices (and the associated children)

4.31 ***The Children and Family Court Advisory and Support Service (Cafcass):***

- Managerial oversight within Cafcass was assessed by Ofsted as 'good' in 2014
- Cafcass now has a CSE strategy
- In response to the SCR Cafcass has significantly increased training on CSE, including for self-employed assessors who are contracted in
- Cafcass will be able to collate information about cases from its national caseload with connections to CSE from March 2015

4.32 ***Crown Prosecution Service:***

- A dedicated CSE specialist lawyer within the Complex Casework Unit, who is part of a national network of specialists
- A dedicated Rape and Serious Sexual Offences (RASSO) team of lawyers and paralegals has been established working across the area, handling early investigative advice to the Police, decisions on charging and prosecutions of rape, serious sexual offences and child abuse
- New guidance on the handling of child sexual abuse cases was issued to all lawyers in 2013
- A real focus on the credibility of the allegation rather than that of the victim

4.33 ***Donnington Doorstep:*** (voluntary organisation)

- Supervision arrangements for staff have been substantially improved
- Recording systems have been improved
- Runs (since 2011) the Step Out project providing casework support for girls and young women at risk of CSE; a staff member is part of the Missing Persons Panel
- Funding from local agencies has extended casework from the City to the County, to include boys and parents
- Donnington Doorstep's Board regularly monitors its work with CSE

4.34 **The views of girls currently at risk:** Some girls working with the Kingfisher team helped make a DVD which was shared in September 2014 at a major event hosted by the County and TVP with County councillors, City councillors, Oxfordshire MPs, Oxfordshire CCG, Oxford Health, Oxford University Hospitals Trust, the Deputy Police and Crime Commissioner, nine Chairs of Neighbourhood Action Groups, seven local religious leaders including from three mosques, eight Chairs of Independent Advisory Groups, three head teachers of local schools, and members of the OSCB. Some extracts are given.

4.35 On proactivity and support: "*Someone was involved with CSE and she mentioned my name to them. So Kingfisher came and found me, they came and spoke to me and asked me some questions about certain people."*

On building trust to get special help, three views: *"I started talking to my social worker more, started having 1-1 time with her and then I went on the Kingfisher team"* … "*'I got put in foster care and I quickly got close to my foster carer. Then I got closer to my social worker and I started telling her more on a 1-1 sort of thing" … "I feel like they [Kingfisher] are my family and they like me for me. I just get on with everyone, it's a nice environment and everyone is nice and stuff."*

On the skill needed to engage potential victims: "*I got told it [the Kingfisher team] was for girls who were being exploited. I didn't think I was being exploited. I thought I was in trouble for things I hadn't done or anything and then the more they talked about things the more I realised I was in a wrong situation. The more they talked about it [exploitation] happening to other people the more I wanted to let them know that things were actually happening to me."*

On advice for social workers: *"Just wait. Different people trust people quickly and others take long to trust people. Just wait until they get used to you. You shouldn't just assume stuff."*
And from another girl:
"This woman [a social worker] came to my house and talked to me for about ten minutes and asked lots of questions, then they talked to my parents a lot. The social worker came to see me at school. She kept asking me questions and trying to talk to me but at first I didn't talk back. It was like she was talking to a brick wall at first. It was very hard because I wouldn't give out any information about my friends." The girl went on to say, *"It was nice to have the company of the social worker, to have someone come and see me, to talk to me and be interested in what I was doing on a daily basis."*

On the balance between caring and controlling: *"I just felt she [the social worker] was really there for me, as if she was a friend. It was like having a mum, a mum who cared… but someone who would leave you alone at the same time, someone that wasn't in your face but was there."* (See 5.114 on Professionalism.)

4.36 And Kingfisher social workers also noted these comments about a departing Police case investigator and a PC attached to the team, showing the contrast from victims in the past"

A girl: *"I'm sorry he is going, he is really good and I liked speaking to him… he is really approachable and easy to talk to."*

And a social worker said : *"He took one of the statements from [a name] and she really liked him and felt comfortable with him, she was happy to see him as he made her feel safe... all the girls liked him and they remembered him."*

On the PC: *"[She] made me feel really comfortable during the trial."*

4.37 The remainder of this Review will show that it was not always like this across the County, and that opportunities to identify and act on exploitation were missed, although Oxfordshire was not alone. The progress described above has come from a willingness in organisations working with children to learn and change – which should be acknowledged.

4.38 **Moving on – an apology:** One of the children, now an adult, takes part in regular training for a range of Police staff on CSE. She told the Review that after one session an officer approached her and said, “I feel I need to apologise to you for all the girls I treated wrongly.” This was hugely appreciated by the victim concerned.

5 WHY THE DELAYED IDENTIFICATION AND ACTION ON CSE?

5.1 **Introduction:** The identification of CSE and robust action to intervene was delayed in the sense that it was going on for some years before it was truly recognised, and before concerted action was taken. This section looks in the context of the time at what will seem, in hindsight, to be glaringly missed opportunities, and offers some explanation. It also identifies underlying issues of practice that did not relate specifically to CSE, but which hampered progress. The explanations that follow do not excuse the inexcusable, but describe the complexities of work in this area. The section does not go into all the detail (which would take hundreds of pages), but describes the general reasons for the late response. This section is for describing 'why', rather than giving judgement. It describes the period before the very successful investigation that was Operation Bullfinch and the improvements described earlier in Section 4.

5.2 The explorations of 'why' given below do not imply that this Review finds what is described as acceptable. Section 8 gives an appraisal of the work. The points discussed are often not discrete and feed off, or into, other points. Most of what is described below has been addressed by agencies.

5.3 To prevent this report becoming unreadably long, the causes of the delays are rarely specifically dated, and some will have varied in strength or even presence over the pre-Bullfinch period. This SCR is not saying it was like this everywhere all the time, but is describing the 'sorts of things' that conspired to create the delays in action. It also needs to be said that most of what is described occurred before there was a real national understanding of 'group-related CSE' as we now understand it.

5.4 **Why the delays**: What follows are summaries of the main findings from the agency Individual Management Reviews (IMRs) which, in the opinion of the author, have described performance in very honest detail. The Police and CSC IMRs (which, for example, are 1,000 pages between them) describe and explain what happened frankly in a way that has allowed the SCR Panel and author to draw conclusions, and they do not shy from drawing robust conclusions of their own. The issues described may be focused on one agency more than another, but in most cases are not described under an agency heading as there is so much overlap.

5.5 In the most simplified of summaries, a combination of not grasping the extent of exploitation, the focus on the girls and their families as the source of the problems, the corresponding lack of focus on perpetrators, and a host of administrative and management issues all worked together to lead to CSE being identified later than it might have been.

5.6 ***Knowledge:*** Although there was an increasing literature from the 1990s about what we might know now as CSE, and patterns of abuse through control, the phrase 'child sexual exploitation' did not appear in the core national guidance of safeguarding management 'Working Together to Safeguard Children' 2006 (HM Govt). However, it did say: *"The identification of a child involved in prostitution, or at risk of being drawn into prostitution, should always trigger the agreed local procedures to ensure the child's safety and welfare, and to enable the police to gather evidence about abusers and coercers. The strong links that have been identified between prostitution, running away from home, human trafficking and substance misuse should be borne in mind in the development of protocols."* But the language was mainly about prostitution. The government did produce, in 2009, supplementary guidance to *Working*

Together called *Safeguarding Children and Young People from Sexual Exploitation*,[8] which set out the framework for what is now understood to be a more modern approach to concerted action. Several national reports have shown that this guidance did not catch on uniformly across the country.

5.7 The House of Commons Home Affairs Committee report, 'CSE and the response to localised grooming' (June 2013), said that *"The failure of these cases has been both systemic and cultural. Rules and guidelines existed which were not followed. People employed as public servants appeared to lack human compassion when dealing with victims. Children have only one chance at childhood. For too long, victims of child sexual exploitation have been deprived of that childhood without society challenging their abusers. Such a situation must never happen again."* (This was, of course, written after Operation Bullfinch had indeed 'challenged the abusers' and gained numerous convictions, which was only possible because of highly skilled, determined and rigorous local work.) The key to understanding 'why' therefore rests in an earlier period, which in Oxfordshire would be around 2005-10, when there were indeed indications of children suffering, but limited understanding and little intervention that could have inhibited the abuse.

5.8 It cannot be denied that there was much existing guidance (and there were some reports about the growing awareness of exploitation) but that is not the same as front line staff or even their immediate managers knowing it, absorbing it, understanding it, or feeling confidant to use it – especially when it cuts across traditional ways of interpreting or doing things. As one parent said, *"no service had the language, understanding and tools to acknowledge it, yet alone deal with it".*

5.9 The overall problem was not grasping the nature of the abuse – the grooming, the 'pull' from home, the erosion of consent, the inability to escape and the sheer horror of what the girls were going through – but of seeing it as something done more voluntarily. Something that the girls *did* as opposed to something *done to them*.

5.10 This lack of knowledge crossed all organisations and professions. The Education IMR put it well*. "It was clear to… through conversations with a range of professionals for this review, including a focus group with head-teachers and designated school safeguarding leads, that there was little understanding of child sexual exploitation and any indicators to suggest that any of the girls might be subject to or at risk of it, at the time. Certainly there was significant anxiety about their safety and well-being, but this tended to be focused on their home situation, the domestic violence they were living with and the lifestyles of their parents. The girls were labelled as promiscuous, at risk of prostitution, out of control and certainly not viewed as victims of CSE."*

5.11 The lack of knowledge also, for example, affected the therapeutic care given to the girls as risks were not identified, clues not picked up, and the presenting issue was the focus. "*Primary care* [and a listed range of sexual health and pregnancy services] *failed to recognise that these girls were at 'high on-going risk' and failed to protect them from pregnancy and sexually transmitted diseases (STDs) and failed to work together to safeguard them."*

[8] *Children and Young People from Sexual Exploitation: Supplementary Guidance to Working Together* (HM Govt, 2009).

5.12 One social worker, who played an important role in identifying the CSE in the lead up to Operation Bullfinch said in 2014, "*Even now I still can hardly believe that adult males would do what they did to children – too awful to believe it could happen in the city I live in."*

5.13 ***Language:*** The language used demonstrated the lack of full understanding of CSE at the time. It described the girls getting themselves '*into trouble'*. Other examples quoted by the Police as from the Missing Persons database (two of which were recording referrals from a parent) included

"[The missing person] is believed to be prostituting herself… to pay for drugs', '*putting themselves at risk"*

"She is a streetwise girl who is wilful…"

"She associates with adults who have warnings for firearms and drugs. It is possible she is prostituting herself"

"... Deliberately puts herself as risk as she goes off with older men that are strangers"

5.14 In some senses, parts of these examples were literally true. There was seldom from the victims an overt sense of helping agencies to affect change, but the language had a consequence which delayed the protection which the girls covertly wanted, and the parents very clearly wanted. This was because the words were judgemental and focused on the victim and their contribution, and deflected from the more proper perpetrator focus.

5.15 As the CSC Review says, *"This labelling followed the child and became a barrier to understanding their situation."* This Review does not believe that this indicated a general callous disregard of the needs of young teenagers, more that this was the longstanding way for describing children of that age who led a wild, risky life of premature sex and early excesses of drink and drugs. The problem was that the prevailing understanding of it being wayward youth tended to blind staff to something serious when it happened, and continue to see the victim as the author of their own downfall. Some of the examples quoted in the Police IMR of events that were not investigated make the point powerfully.

5.16 The IMR for the NHS Trust which provides community and mental health services describes how partner agencies reported a girl 'hanging out' with older men, and a social worker described to the school nurse men in their 20s as 'lads'. School health records used the words "*prostituting herself"*. The IMR said, *"The word 'lad' may have influenced practitioners to minimise the potential seriousness of the situation because the term is suggestive of someone who is much younger. The School Health Nurse records also state that there is a concern that (the child) was 'prostituting herself'. This raises a concern that [the child] may have been viewed as active perpetrator of criminal offences such as prostitution and as a challenging young person who creates risk and rather than being seen as a victim of abuse. These views will/may have affected how she was supported by professionals."*

5.17 There were other ways the use of words had a counter-productive impact. In particular, the use of the word 'boyfriend' deflected from the awfulness of what was happening by implying a benign or acceptable relationship. This compounded the girls' use of the word, which, as it usually applied to a much older (sometimes very much older) man, was more a sign of the grooming than fond acquaintance. 'Boyfriend' was used even when referring to a 13- to 15-year-old and males in their late teens, even to their thirties. This is not to say that 'boyfriend' was used to deliberately condone illegal relationships, but that its use did not help and at times hindered. It also conveyed confusion about what was and was not consensual and lawful.

5.18 The use of the word 'prostitution' also had the effect of deflecting from the extreme youth of the victims and the phrase sometimes heard of 'prostituting themselves' deflected attention from their groomers. Referrals to the Police from say social care settings also used language which, in the positive interests of information sharing, compounded the impression that the victim lacked credibility by detailing their difficult behaviour.

5.19 ***Consent and age:*** Related to the language of wilfully participating was the understanding of consent to sexual activity, and the relevance of age. In law, no one under 16 can consent to sexual activity, although, if the child is aged between 13 and 16, no offence is committed if the adult reasonably believed the child to be 16 or over.[9] There is no such defence if the child is under 13. The Police IMR found a number of occasions where 'unlawful sexual activity' offences were brought to Police attention, recorded and subject to initial investigations, adding that *"it was evident [to the IMR] that investigators were repeatedly wrestling with the challenge of age"*, and for example described where, in an allegation of sex with a 13-year-old, the detective said, "*she is a 13 year old girl who could easily be mistaken for being 16 years old".* The Crown Prosecution Service (CPS) reviewed the evidence and decided against a prosecution for sex with a 13-year-old girl, as her appearance, actions and saying she was 16 would, in their view, have meant there was no realistic prospect of conviction.

5.20 A CID sergeant reported that one 14-year-old appeared 18 or 19, and "*by her own admission initiated the sexual intercourse with both named males… and said she told then she was 19".* The victim refused to cooperate with any means of investigation, so a combination of issues relating to cooperation, consent, and age came together to hamper any protective action. The Police review suggested that *"… decisions being made throughout … were often tainted with the perception of these children having consented to the sexual activity. This was evidently an opinion shared amongst professionals that was only reinforced further by the way the children were presenting to them. As can be seen throughout this [IMR] the national awareness of CSE and the impact on the victims ability to consent at this time was, at best, described as 'patchy' and certainly does not appear to have been embedded amongst agencies within Oxfordshire. As such these views… had a significant impact on many of the investigations undertaken during this time.*" One of the victims found with several Asian adult males told the author that the Police did not even ask her age.

5.21 This was not just an issue for Police. CSC concluded that, *"throughout this [IMR], there are recorded instances of young girls having sexual relationships with older males. There appears to have been a tolerance of underage sexual activity and no recognition of factors such as abuse of power and coercion and the fact that this was against the law. At interview most members of staff disputed they tolerated underage sex and they did try to talk to the girls about this but that often the most they felt they could do was to stress that it was inappropriate, to ask the girls why they thought older men would be interested in young girls and to talk about safe sex."* This brief but powerful summary shows the debilitating uncertainty about the ability to take action, and the sense of powerlessness. While there is usually some understanding of sex between underage children and peers a little older, what CSC called 'tolerance' also seemed to apply to relationships with those much older. The CSC IMR was concerned to find in one record on a 13-year-old the phrase, *"an age*

[9] Sexual Offences Act 2003, section 5-15.

appropriate sexual relationship… [which]... evidenced a lack of understanding the law and/or an unsafe acceptance of young teenagers being sexually active".

5.22 The Health Overview points out: *"Skilled questioning is required to establish whether a relationship is consensual, when victims do not see themselves as victims and perceive that they are consenting to a relationship, to explore potential power imbalances. Whilst Contraception and Sexual Health (CASH) clinics established that these young people were able to give consent to sexual activity it was not specifically considered within an exploitative relationship. The Genito-urinary Medicine (GUM) service did explore potential power imbalances but from the answers given did not detect potential vulnerabilities or exploitation at the time, although in retrospect and with current knowledge can see that in some cases indicators were present."*

5.23 The IMRs which contributed to this SCR very openly describe illustrations or suggestions of terrible abuse to children, where reading them generates the immediate question of "why wasn't something done?" The author's conclusion is that there was, beyond any lack of knowledge or clarity, an acceptance of a degree of underage sexual activity that reflects a wider societal reluctance to consider something 'wrong'. This involves ascribing to young teenagers a degree of self-determining choice which should be respected. This is not altogether surprising when in Health (looked at more below) the national guidance involves an assessment of the child's ability to give true consent to receiving contraceptive advice or treatment without the involvement of parents. In a nutshell, a child may be judged mature enough to get contraceptives to have sex with an adult at an age when they are deemed in law unable to give consent to the sex itself. It is no wonder there was confusion and a lack of confidence in taking action.

5.24 What all this was not grasping was that the ability to consent had been eroded. The CPS's submission on consent in the Bullfinch trial pointed out that, regardless of perceived or stated age, there was no exercise in free choice.[10] It described the orchestrated 'incremental steps' by which any wish of the girls was squashed by the men through a progression of gifts and attention, getting physical for sex, pestering, threats, orders and "*doing by force despite protestation – despite physically being incapable through drink, drugs, or despite an unwilling body and fatigued beyond endurance"*. The Crown argued that the lack of true consent was clear, or why would the groups escalate their tactics to ever more controlling, threatening methods?

5.25 The judgemental language about the girls/families, the confusion over consent and age and the lack of knowledge led to a lack of focus on what was being done *to* the girls, and to the lack of the mental leap to focus instead on the perpetrators. The more determinedly self-assertive, disruptive or extreme the child's behaviour, the more self-determination they were assumed to have. In fact, the opposite was true.

5.26 ***The nature of the families*****:** This is a very hard section to write without risking being misleading or unfair. It describes the nature of the families with which numerous professionals from numerous agencies worked. It runs the risk of being seen as deflecting blame from professional weaknesses, but this is not the intention. The reason is that if the statutory

[10] Section 74 of the Sexual Offences Act 2003 defines consent in the following terms: *"For the purposes of this Part, a person consents if he agrees by choice, and has the freedom and capacity to make that choice".*

requirement of SCRs is to understand 'why', it is important to describe what professionals saw in front of them, and whether it was understood properly or not. Describing this is *not* blaming the victims or their families. Indeed, this report is critical of how parents were sometimes treated. It is important to put professional work in context where its quality is being reviewed if learning is to be obtained. It is also important in terms of allocating professional effort to be clear that most victims will be those with most vulnerability.

5.27 Managing the cases concerned was not at all easy. Most (but not all) of the children and parents concerned did have a predisposition to difficulties or challenges in childcare and growing up. This does not mean that family members were responsible for the CSE; they were not. The perpetrators (or at least a number of them) who *were* responsible are in jail. It does mean that the children were vulnerable to grooming, and that many parents (just like many professionals) did not have the knowledge and understanding, skills or strength to intervene and protect. Some families had had involvement with the statutory agencies for many years before CSE happened. The Review summarises some of this below – but only in broad terms in order to protect victims and their families from unintended identification.

5.28 The offences against the children were not of a lesser magnitude because they may have been 'troublesome' and/or may have experienced abuse before. In some senses it makes it worse as it added, in a most horrible way, to any experiences they may have already been through.

5.29 Most of the victims had experienced parental domestic violence at home or in their birth families. Police attended one family for domestic abuse 74 times in one two-year period. There was considerable experience of family instability. Two children were removed from their homes for their own protection long before the CSE. One of these had experienced three different LAC placements and a broken-down adoption placement in another part of the country before the age of ten.

5.30 CSC says that there is information suggesting that three of the victims had experience of sexual abuse in their families of origin. One was sexually abused when looked after (not related to Oxfordshire). One parent was an "offender who has been identified as posing a risk, or potential risk, to children",[11] and three children were exposed to such offenders in their home environment. For a number of the six there was wide experience of drug/and or alcohol problems in their birth or subsequent families, and drug/alcohol services had dealings with three of the families. One parent died of drug-related illnesses. Two had parents with criminal records, and in one of those families the parents had nearly 150 convictions. Statutory agencies had been involved with several of the families for the whole life of the girls concerned. Parental ill health or disability was prominent in two families, and in one the child was regarded as carer from a young age.

5.31 The CSC Individual Management Review (IMR) summarised: *"… girls experienced home lives which contributed to their vulnerability to abuse [and] sexual exploitation. With the… exception of [one girl] the girls experienced varying levels of neglect linked to their parents' own issues taking precedence over the needs of the child. These are 'Push Factors' which contribute to*

[11] Formerly known as 'schedule 1 offenders' under Schedule 1 to the Children and Young Persons Act 1933 (CYPA), which lists a wide range of offences against children and young persons under the age of 18, from murder to cruelty or neglect, and offences resulting in bodily injury to the victim.

pushing the child away from where they should be safe and protected from harm." It also made them very vulnerable to the 'pull' of grooming and their inability to escape once groomed. *"It is likely that their low self-esteem and experience of domestic abuse, parental drugs and alcohol use and physical and sexual abuse will have desensitised the girls to the grooming and CSE model making them very vulnerable victims…*"

5.32 There were, in addition to the above, challenges created or partially by the CSE itself. The six girls were reported missing between one and 193 times in their early teenage years. Five of the six girls had from one to 18 periods of being Looked After including spells in secure units for their own protection. The majority of 'missing' reports for the girls who had spells in care were while the children were accommodated in care.

5.33 The majority of the girls were investigated for offences ranging from acquisitive crime, drugs offences to damage and violence – including some against parents. Four were known to the YOS. These offences should be seen in the context of what they were required to do by the perpetrators, the chaotic and violent environment in which the exploitation took place, and reacting to those wanting to stop their behaviour before they themselves were able or ready to.

5.34 As an example of the crossover between underlying vulnerability and signs of the exploitation, CSC reported that*, "The six girls lived within a culture of acceptance of very early sexual activity and in some of the cases this was accepted and condoned by their parents and in others it was tolerated… The girls were attending sexual health clinics for tests and treatment and were being prescribed contraception from an early age, in most cases with their parent's knowledge."*

5.35 There was also health involvement through mental health services for four of the children. And of course the girls were in education. This extract from the Education submission to this Review shows both the challenges, but also the lost opportunities to take advantage of innate ability. *"From the educational settings' point of view… the persistent disruptive behaviour of the girls and the challenges that they posed were not easy for any setting to manage and, at times, they were at a loss to know what to do. These were girls that staff told the [IMR] author they had remembered for years, they stuck in their minds and had a significant impact on them. They were also girls that, even with all the challenges they posed, had academic ability. Staff spoke with affection about them and it should be noted that some tried really hard to support them when at school, and now feel a huge sadness at now knowing more about the reality of what was actually happening to them at the time."*

5.36 The scale of professional involvement with the families, going back many years was vast. The chronologies from agencies of their involvement provided for the Review amount to 3,900 pages. The Police had 1,561 recorded contacts with the girls during the Review period. The sheer scale of agency involvement in itself demonstrates the complexity of the task of inter-agency collaboration, and that if it were easy and obvious to identify CSE or effect change at the time, given the cumulated brainpower being applied, it would have been done earlier.

5.37 This section is not emphasising the difficulties emanating from the nature of those who needed help to deflect attention from agency performance, nor is it suggesting anything unique about A-F. The challenge remains the same now even for those with real expertise. At a conference in 2014 attended by the author, the Kingfisher team of CSE experts (with the most up-to-date knowledge of CSE and how to approach it) said of today's potential victims: *"They are the*

most difficult children to deal with", and illustrated with a case example: *"Poor school attendance, behavioural concerns dysfunctional family relationships… difficult to engage, missing episodes, attendance at sexual health clinics and third party information regarding X being seen at parties and parks with older males."* This statement was not blaming the children but simply describing the reality of trying to help exploited children, which is incredibly difficult.

5.38 ***Levels of cooperation*:** The victims were not able to cooperate with the authorities for three main reasons. Firstly, for a while, they felt they were getting something of what they wanted from the perpetrators. Secondly, they were groomed into a misplaced sense of loyalty to their abusers. Thirdly, they were trapped by fear of punishment by the perpetrators, and by the cycle of having to repay, through sex, the cost of drink, drugs and so on into which they had been skilfully led.

5.39 A senior Police officer in Operation Bullfinch said that *"The girls were 'the most difficult victims [that officer] had ever had to deal with… as a direct result of their grooming/conditioning. They were isolated so much by their abusers they trusted no one except them – so 'helping' agencies or any adult were not to be trusted or cooperated with."* An illustration was given which illustrated the hold over the victims by the perpetrators. The officer described how one girl was punished by being taken to a wood and humiliated and raped in different ways by seven men. Left alone, hurt, crying, naked and covered with semen, the person she called for help was not the parents, social worker, police or ambulance but one of the abusers who had just raped her.

5.40 The case illustrations from IMRs are full of examples of the victims, we know now because of the grooming, refusing to be interviewed or make statements, refusing to identify perpetrators, demanding that no action be taken on their behalf, and sometimes criticising any action that was taken. They did from time to time make specific allegations, and were often found in a condition when it was obvious 'something' had happened. But whilst it is the case that police investigations were not adequate by current methods, it is also the case that victims seldom assisted seeing anything through because of what we now know was fear, intimidation or misguided loyalty to the abusers.

5.41 This was compounded by the experience of one child who was prepared to give evidence in a 2006 trial but who withdrew from the case (leading to its collapse) in the face of what was to her a brutal and humiliating defence cross-examination. Also, by the victims' sense that the police were powerless to control/contain the perpetrators thus making it very risky to reveal anything in case it led to their ordeal at the hands of the offenders getting worse. While the reasons for no action against the perpetrators were extremely complex, understanding that would not have prevented the victims feeling exceedingly vulnerable.

5.42 As seen in Section 3, the parents went through the most worrying of times, could be exasperated with the inability to tackle their children's vulnerability, and felt that professionals showed insufficient tenacity or concern. But to some agencies, some parents were seen as uncooperative, collusive and even obstructive. CSC, which worked with the families on child protection processes, care proceedings, investigations and so on, reported to the Review that one parent was aggressive and difficult with the social worker, another was convicted for threatening a worker, another 'manhandled' the social worker, another was 'verbally aggressive and abusive'. Five of the six parents, CSC said, did not at times report their

children missing. There was evidence of some of the girls having sex with adult males in their family homes, seemingly with parental knowledge.

5.43 Some of the parental hostility to social work staff may have reflected the extreme frustration with 'inaction', or feeling overwhelmed by the challenges posed by their children. Some lack of cooperation by, for example, removing children against advice from children's homes may indeed have reflected their deep ambivalence about the need for care or, as the CSC IMR acknowledges, the lack of safety that care provided.

5.44 But whatever its cause, the antagonism to professionals added to the complexity of managing these cases. But, to repeat, it was not the families who committed the CSE.

5.45 The author consulted the girls he interviewed about his intention to describe their background and the four he met were all in agreement. They were all very open about how difficult anyone would have found them at that time.

5.46 ***Crime/No crime and evidence:*** Whereas now good practice is followed and perpetrators are investigated through a variety of means, regardless of victim cooperation, and CSE is well understood, during the period before the Bullfinch convictions, the Police IMR identified how only a proportion of what was reported became logged officially as a crime. The Police had only 26 recorded offences related to the six girls on the main database of 'crimes', but the Bullfinch inquiry and the IMR identified many more recorded in other ways which, in the Police view now, should have been responded to as 'crimes'. This was for a variety of reasons, which did not seem to be for reasons of deliberate disregard but because of confusing processes and many of the other issues described in this section.

5.47 There is evidence that not recording crimes as crimes, or declassifying an event as no crime inappropriately, is a national issue. Her Majesty's Inspectorate of Constabularies (HMIC)[12] in 2014 reported that its national inspection on crime data found that over 800,000 crimes reported to the police had gone unrecorded each year, *"representing a national average under-recording of 19 percent".* Also, in 20% of the cases studied, where something was reclassified from crime to no crime, that the change was inappropriate. The examples given here of Oxfordshire cases up to a decade ago, whilst regrettable, were almost certainly not unique to the County. (A 2014 review[13] of TVP's crime recording says that "*the force's approach to 'no-criming' is generally acceptable… and found that frontline officers saw the no-crime process as rigorous"*.)

5.48 One example was when a mother reported her daughter being persuaded to deal drugs. The child did not want police to visit in case the men *"f…..g kill me".* Later, the mother said the girl was out armed with a knife for protection dealing drugs in a named place, and later still said that the Police should not miss this chance to get information from the girl. This was not investigated, nor any attempt made to speak to the (unwilling) child. It is unlikely that CSC was told. In another case, at a 'safe and well' check after a child returned from being missing, a PC heard that she had been overnight with older men, drinking all night and taking heroin. The child was described as uncooperative, regarding it all as funny. Nothing

[12] *State of Policing: The Annual Assessment of Policing in England and Wales 2013/2014* (HMIC, 2014).
[13] *Crime Data Integrity: Inspection of Thames Valley Police* (HMIC, 2014).

was investigated and the officer submitted an intelligence report *"in the hope another department who knew more about her could have taken more action".* On another occasion, after another child returned home, the flat where a girl had stayed with an adult was visited, and the man (who denied sex had taken place) was warned she was under 16 and "*told he was lucky not to be arrested".* Another officer noted on an intelligence report, rather than formally as a crime, a named man attempting to prostitute two of the girls (aged 14 and 15), plying them with alcohol to get sex, the fear of the girls who could not resist the man's demands that they run off from their children's home, and how the man was attracted to their extreme youth. That officer is clear that now a crime report would be created.

5.49 There were other examples, including when Police were told of an old rape allegedly committed by a (partially) named man. When a parent reported a 'rape' and the child confirmed then denied it, the case was closed without full investigation due to a view that the original claim was manipulative, the parent agreeing the story was made up, and verbal abuse of officers by the child. This was before the current understanding that the story and denial may in themselves actually indicate CSE, which needs thorough inquiry, and at the time no 'crime' was logged. The Police IMR said that *"by not treating the reports they received as crimes, it is evident that TVP staff did not bring the necessary investigative mindset to what they were being told".* The officer then in charge of Oxford CID says cases would have been investigated if referred (within the practice of the day) and was very frustrated to find from the IMR that there were many incidents not treated as crimes, so not passed to CID.

5.50 The Police review for this SCR also identified that even if there was a 'crime' there was, at the time, lack of clarity about which branch led the investigation – from the attending officer through to CID and the Child Abuse Investigation Unit (CAIU). This meant sometimes that the necessary understanding or skills for such complex work might not be there.

5.51 In addition to the 'no crime' issue, there was a difficulty in proceeding without victim disclosure. A national CEOP report[14] said: *"Overall, victims are unlikely to disclose exploitation voluntarily as a result of fear of exploiters, loyalty to perpetrators, a failure to recognise that they have been exploited and a negative perception or fear of authorities."* Of the 26 reports the Police had of offences against the six girls, evidential statements were made in seven. Of the other 19, six were made by third parties, so the police had 'only' 13 disclosures. In no case where the report was from a third party did the victim support the police investigation.

5.52 The Police describe one process in relation to underage sex with three men encouraged by money, and reported by a children's home after one of the children returned from several periods of being missing. It was not originally recorded as a crime. The IMR identified over 24 recorded investigative actions over four months (mostly related to multi-agency liaison including several meetings). At an early stage the officer in charge said that "*there is no victim as such as she is not willing to give police a statement".* Later an Inspector recorded that *"the aggrieved is indicating that she does not wish to speak with the police and so this matter may not be progressed as a criminal investigation".* Sometimes opportunities were lost as evidence gathering was delayed for the outcome of multi-agency meetings, when it is clearer these days that there are occasions when 'now' is the only time something might be disclosed.

[14] *Out of Mind, Out of Sight: Breaking Down the Barriers to Understanding CSE* (CEOP, 2011).

5.53 Even where there was some disclosure, getting anything to a successful prosecution was far from easy. The updated CPS guidance,[15] which takes a helpful approach about using the weaknesses or contradictions in evidence as signs that courts could consider as demonstrating sexual abuse, was not published until 2013. In a speech used in many settings, including to the Home Secretary, the Detective Chief Superintendent currently overseeing CSE work in Oxfordshire said: *"The picture is not as simple as these children were completely ignored. They were not. There were attempts at investigation throughout the period but they were not sustained or coordinated or prioritised and each attempt faced almost insurmountable odds in a criminal justice system that had no real idea how to present evidence from difficult young victims (with) a whole baggage load of complex disclosure issues and problems."*

5.54 The Police also identified what was described as 'tunnel vision', whereby investigations before Bullfinch tended to look at the presenting issue only, and not 'join the dots' to other reports to the Police. They re-assembled over 40 pieces of information available about two 14-year-old girls in 2006 from the Missing Persons database, interview statements, crime and intelligence records, etc. This included information from third parties as well as from the girls. It included information about being held against their will, hard drug use, 'consenting' sex with a number of males, several accounts of sex with up to seven men, sex with a named man at 13, and a number of named men. Whilst there were a number of arrests for offences up to rape, there were no prosecutions (for the sorts of reasons given earlier, including lack of victim support). The IMR concluded that there was a lot of potential evidence that was not pursued beyond intelligence or missing persons reports, and that investigators did not make the connection – such as one girl being found at the same address where another had been the previous week, or linking names. Saying this does not necessarily imply that making the connections could, at that time, have led to successful prosecutions in the light of, say, the absence of victim evidence, but the chances would have been higher, and disruption could have been undertaken.

5.55 The Police IMR also identified that there was a risk that information recorded on intelligence systems might not get to the relevant safeguarding teams. It illustrated this with a 2007 account of a 13-year-old girl found hiding in a car with an adult Asian male, with condoms in the car. The officer also suspected drugs. Their account of being 'friends', and him not knowing she was 13 seems to have deflected focus on the risks. The man was advised and *'sent on his way'*, and the girl taken home. Only an intelligence report was submitted. The officer's open comments many years later to the IMR are repeated here as they are a useful indication of front line mind-set and how hard it was to grasp the extent of what might be happening. *"That was probably the first time I thought – what is going on here, this is a bit odd. At the time from a beat officer's point of view you don't have the knowledge and the know how to know what to do. I had 25 years' service but didn't have the experience to deal with it... my mind was that would go to a department or someone that would be more suitable to deal with it… a department or someone that would be more suitable to deal with it."* The IMR could not trace that any action was picked up. It was assessed as a 'non-crime incident', which means, says the IMR, it may not have been passed on to CSC. (However, the police officer concerned attended a professionals' meeting two days after the incident where it was discussed, so CSC was informed.). The combined agency chronology about

[15] *Guidance on Prosecuting Case of Child Sexual Abuse* (CPS, 2013).

this child shows over 80 entries during the month of this event, including major legal and multi-agency considerations, and the City Council was expressing serious concerns about the girl's wellbeing.

5.56 The CSC IMR describes how at times social work or residential staff might report concerns to locally based front line police officers who might make some preliminary inquiries but not forward to the Police CAIU, thus preventing the safeguarding team considering more formal steps. It is possible that the informal conversations were not seen as 'referrals' but might have been meant as such.

5.57 There were some unsuccessful early attempts at prosecuting or convicting men who may well have been involved in activities akin to the Bullfinch offences. Four allegations were referred to the CPS for charging advice. One case of rape against three men did get to court in 2006, but was discontinued when the victim refused to give further evidence, distressed by the cross-examination. The CPS explained to the SCR the reasons why other potential cases involving these children (not necessarily all with Pakistani group members) did not get even this far. In some respects, there is overlap with the issues around knowledge, language and consent discussed earlier. In one case, where one of the victims was 12, there were concerns about voluntary actions by the girls, a refused medical examination, and the credibility of the victims in light of their behaviour. (The CPS describes the police investigation as 'thorough'.) In another, the problems were given as poor credibility as the victim was *'out of control'*, no corroborating forensics, and that the police officer in charge was *'shocked'* the girl was only 13 (so there might be a defence on perceived age). This shows that the way of thinking about these victims was, in the mid-2000s, similar across agencies including courts. There was, at that time, a failure to focus on the actions of the perpetrators.

5.58 The author has seen CPS correspondence about a number of cases involving children from A-F and the reasons given for not taking court action. Whilst the wording may indicate that the girls' behaviour was a relevant factor, and there was no more understanding than anywhere else about how consent was eroded, the CPS arguments were in the author's view merely reflecting accurately how the defence and juries at the time would see the weaknesses in any prosecution.

5.59 It is important to show that there was indeed effort to obtain convictions for offences against the girls during 2005-8, so this was not a period of doing 'nothing,' although the hoped-for outcome was usually thwarted. The children are not identified by A-F to avoid inadvertent identification. The first chart includes any alleged perpetrator, not necessarily the group later convicted in Bullfinch. Only three investigations resulted in a conviction (italics) for the reasons given.

CHILD	**OFFENCE**	**OUTCOME**
1	Sexual activity/child under 16	CPS decided insufficient evidence/cooperation
	Sexual assault on a female 13+	4 arrested (2 later Bullfinch suspects), but victim denied assault. Men released
2	Rape of female under 13	Case discontinued by CPS on evidential grounds, although child was believed
	Rape of female under 16	2 men arrested but not charged as no cooperation with medical or statement
	Sexual activity/child under 16	No statement from victim – case filed

	Sexual activity/child under 16	*Man in 30s convicted and jailed*
	Rape of female over 16	Victim made statements but then withdrew them. Not pursued as a crime
3	Sexual activity/child under 16	*Man guilty on 3 counts and jailed*
4	Rape of female under 16	Victim would not support proceedings or have medical. CPS advised no further action
	Rape of female under 16	3 men charged, but acquitted when victim withdrew in face of cross-examination
	Rape of female under 16	Cooperation with medical and video but DNA evidence led to no further action against later Bullfinch suspect
4 and 1	Sexual activity/child under 16	Victims withdraw cooperation, and CPS decide no public interest in proceeding (a young alleged perpetrator)

The second chart records arrests of Bullfinch suspects against girls other than A-F in the period 2007-10.

Offender	**OFFENCE**	**OUTCOME**
1	Insulting words causing harassment/alarm/distress (encouraging 11- to 12-year-olds into his car)	*Fined*
	Rape of adult	Arrested but inconsistent victim evidence
2	Sexual assault of adult	Case dismissed at court
3	Rape of adult	Case filed as inconsistencies in victim account
4 plus 1	Rape of two 17-year-olds	Two men arrested – no further action due to consent and evidential issues

5.60 ***Lack of curiosity and rigour:*** CSC staff at times did not follow through some information that in hindsight needed investigation. The CSC IMR says that four of the six children alleged they were hit by their parents but, whether the allegations were true or not, none led to formal investigations*. "The girls learned that adults could hit them and nothing would happen and this added to their de-sensitisation and vulnerability, with managers signing off assessments without ensuring the allegations had been addressed."*

5.61 In another illustration, in a CSC Initial Assessment, *"an opportunity to pick up on the concerns about a thirteen year old child associating with older males and being sexually active was missed. It also failed to take full account of the information that her father was a Schedule 1 offender [now known as an 'offender who has been identified as posing a risk, or potential risk, to children]. The Team Manager should not have signed off the assessment as – no further action as a 'team around the child' in place – given this information."* There were other references to two partners of parents who were such offenders who were not assessed.

5.62 A lack of professional curiosity was described as *'a theme'* which ran through the CSC internal management review. *"There [were] unanswered questions in relation to several of the girls, for example, them associating with unknown adults… Team Managers needed to be challenging this in supervision but rarely did so."* It gave examples, asking why there seemed to be no exploration of why a girl in a deeply troubled family was using contraceptives at 12. The IMR concluded that *"what was lacking was a real sense of*

professional curiosity and the wish to really get underneath the behaviours and identify the issues. The fact that assessments were not routinely reviewed and updated compounded this issue. Team Managers should also have been picking this up and helping the case holding social workers manage the complex cases and ensure appropriate plans were in place to address all the identified issues." This is a good example of how issues described in this section relate to each other.

5.63 The lack of curiosity was not restricted to certain agencies. A senior social work manager said the Police were similarly uncurious. *"The police response lacked curiosity – they would pick the child up, give them a telling off and drop them back at the children's home",* and the Police IMR confirms this with its own illustrations. In Health, children accessing Sexual Health Services were also subject to a lack of curiosity. The Oxford University Hospitals (OUH) IMR gives a good example about an admission for excess alcohol. *"… the team did not review (the child's) sexual history other than at first presentation at a time when she was still intoxicated, when she told the admitting junior doctor that she 'regularly has sex for alcohol and drugs' – but describes those she has intercourse with as 'friends'. This information was taken at face value: at that time there was limited knowledge of potential Child Sexual Exploitation amongst clinical staff."*

5.64 *"The fact that she described those with whom she had sex as 'friends' gave the impression that she was talking of young people of a similar age. However, at a different point in the history she had explained (to the medical student who was the first person to see her) that she had run away and was staying with 'people she knows in Cowley' who she describes as much older – and uncertain of their ages. This comment is completely separate from the one about having sex with 'friends' and further questions should have been asked when the effects of the alcohol had worn off. This subject was not revisited in detail when she was sober."*

5.65 Sometimes the lack of curiosity was tactical. OUH described the concerns of staff in sensitive areas such as GUM clinics: *"If they are seen to pry too much the children might not stay, or fail to re-attend: this compromises staff's ability to give best medical treatment so there is a fine line between what staff perceive as an appropriate degree of professional curiosity and what a young person perceives as simply too nosey or intrusive."* Oxford Health also found a lack of curiosity in substance misuse services and health visiting about what was really going on behind the presenting issues. *"Although staff had significant concerns about the behaviour and disclosures of Children A-F there was a lack of professional curiosity in establishing the nature of these relationships and the identity of the individuals they were associating with…"*

5.66 The lack of follow up of concerns was also related to assumptions. Oxford Health describes how, with all the children being Looked After Children (LAC) or having a social worker, Health staff assumed that they knew about and were managing ongoing concerns. Oxford University Hospitals also said its clinical staff would assume that statutory agencies already knew about what they were hearing from their patients.

5.67 The apparent lack of rigour also related to uncertainties about Police powers – for example the right to enter property to search for a child, or the appropriateness of following children covertly to try to identify possible perpetrators. The Police look-back at the cases said that

while covert operations were used in 2007, they were not then used again until 2011. (From Operation Bullfinch onwards there was much greater clarity on this.)

5.68 ***Disruption:*** Whilst the idea of disrupting the activity of individuals and groups that are exploiting children is now a core part of practice, during the years leading up to the Bullfinch investigation and trial it was uncommon and the Police have concluded it was indeed under-used. This included not using various legal orders which had been available for many years. Disruption runs alongside safeguarding and investigation, and may protect children but also build evidence of a propensity to behave in a particular way that can be used in later proceedings. For example, Child Abduction Notices, which do not need a complaint from a victim, have been available since 1984 for under-16s, and since 1989 for under-18s. It is an offence to take a child away without legal authority. Such a notice might warn a suspect that a child was less than 16 years old, so removing belief of being older if eventually charged. The person can be arrested if the warning is breached.

5.69 The Police review showed many records of the consideration or decision to use such notices. *"However whilst this [IMR] found numerous directions to make use of these notices, there is very little evidence of them actually being served on people,"* and found only three in relation to A-F. The Police did note that it was not easy to ascertain from records if such notices had been issued, but concluded *"this may have been down to a lack of knowledge amongst the front-line staff",* quoting interviews with staff who were working on cases at the time, and there was no specific training on the use of these orders in the mid/late 2000s. It is also likely that the views discussed above about the girls being seen as voluntarily getting involved would lessen the sense of there being an 'abduction'.

5.70 Risk of Sexual Harm Orders were also available from 2003. They can be imposed on an offender who has demonstrated behaviour that suggests he may be at risk of committing a sexual offence against children, where the court is satisfied that the order is necessary to protect children from harm from the defendant. There have to be at least two specified incidents of concern but there does not need to be a previous conviction. There is no record of such orders being used.

5.71 Disruption can also include targeted surveillance, gathering of information about, say, the use of specific taxi firms, stop-checks and so on. There was an increasing use of these tactics over the years of this Review, but the Police conclude that they were uncoordinated. Looking back, the Police say they should have involved other agencies more in Police 'tactical' meetings around these cases *"to have ensured all of the information they held was made available to support the development of robust investigation and disruption plans. As it was, the professionals involved seem to have repeatedly fallen in to the same trap... relying on an approach that was doomed to fail as the children were unable to support the criminal prosecutions."*

5.72 ***Escalation****:* The CSC IMR found that, whilst casework decisions on these girls (and others like them) were escalated from the front line, both in social work and residential care, to their managers, this was not always shared with more senior managers. This meant that concerns about what might be happening (before CSE was properly recognised) were not discussed in the higher reaches of the Council (or Police), but it also affected the front line staff. CSC told the SCR that the non-escalation *"became part of the culture of the service and meant senior managers were not providing challenge and support on these complex cases'.* The extent to

which the top of agencies was aware, or should have been aware, of the exploitation of girls in the County is explored in Sections 7 and 8. Here the focus is more on those involved in operational work.

5.73 In the middle of the first decade of the 2000s, despite the formal existence of processes which would allow reports of concerns to reach high-level managers, middle managers told the CSC Review that *"staff and managers have described children's social care as being 'extraordinarily self-sufficient'. In addition middle managers said that their experience was if they took issues to senior managers it would result in criticism and blame and so they learned not to escalate but to try and manage things themselves."* The IMR says: *"One example which some managers have cited is that asking for a placement for a child to become looked after was seen as a failure on the part of the social work team, asking for an out-of-county placement was seen as a failure and an unacceptable demand on budgets... The panels were also seen as very challenging and distressing for some social workers and so they began to avoid them until absolutely necessary."* The IMR also recorded middle management concerns about an oppressive culture around 2010,[16] "*which led to them retrenching and avoiding raising concerns because to do so led to blame".* Whilst, if correct, the atmosphere at certain points would not be conducive to the maximum management of the most difficult cases, caution needs to be exercised in assuming a connection between this and specific issues about CSE, especially as middle managers may not have grasped its magnitude anyway. All that can be said is that, to find an understanding of CSE, a means to protect from it and a solution for it, systems needed to be working very smoothly indeed.

5.74 Escalation also did not happen across agencies. For example, the Drugs and Alcohol IMR says that a drugs service, hearing very worrying things from a 14-year-old, should have escalated to CSC management when there was sustained non-response to calls made to a front line CSC worker.

5.75 In the Police, there were some illustrations of more junior staff formally informing senior officers about their concerns. In 2006, the then Missing Persons Coordinator (a constable) wrote to the Detective Chief Inspector, copying in the Oxford and Oxfordshire Commanders, about a lack of inquiry into where two girls were or giving them due priority. The Police said this led to better multi-agency planning and a Police visit to Lancashire where there was more experience of sexual exploitation. In 2010, a sergeant wrote to the CAIU Detective Inspector in charge of Missing Persons describing many of the features now known as CSE, and this was fed into subsequent meetings of the Missing Persons Panel.

5.76 There is also an example where a City Crime and Neighbourhood Nuisance Officer was hugely concerned about a particular child and escalated to senior staff in other agencies, but not within his own. His Chief Executive was unaware of it until this SCR, despite the work being subject to a director-level complaint from the County Council. The Nuisance Officer was a former Detective Sergeant and acting Detective Inspector with experience in child protection sections of the Police. In 2007-8, he repeatedly raised concerns with senior CSC and Police staff (including the then Director of Children's Services, but not above his own

[16] The DCS at the time says she and the Interim Deputy, not long after their arrival, had drawn safeguarding shortfalls to the attention of County CEO and Lead Members for Children and Education and "had to lead rapid improvements in safeguarding arrangements that required constructive challenge, challenge which I considered some managers were unused to".

City team leader) about a particular family and child (one of A-F who was at times looked after), describing her behaviour and associates which today would lead to a speedy recognition that something bigger might be happening, but which at the time led to rather harsh disregard and criticism. For example, in February 2007, he reported *"men going into the flat every night and leaving in the early hours of morning"* and seeing the 13-year-old lying under a cover with an adult male (which led to a Police Protection Order). He also sought a child protection case conference after a rape allegation but this was turned down. He and a colleague told the OSCB City subgroup about the risks to children from massage parlours and reminded the meeting that his team was continuing to pass to the Police information about 14 and 15 year olds being seen in cars with older men.

5.77 This episode is one that agencies must learn from. The Nuisance Officer concerned was helping manage a situation with a very difficult challenging family where the behaviour of adults was the prime focus, but where the behaviour of one child in this review was also a serious issue. The officer gathered very significant information about the girl, her association with much older adults, and her general access to risky situations – having argued in 2007 against her coming off the Child Protection Register, as she was going missing so often.[17] He resorted to sending emails to many senior Police and CSC staff such was his concern (which seem from what is known about the child and exploitation quite justified). The SCR has seen correspondence with Police and Social Services about the girl with adult males late at night in January, February, March, June 2007 and February March and May 2008 (when she was 13 or 14 and was under Council supervision or formally in Care)

5.78 Whilst Police responses were calm and aimed at reassuring him (and implicitly supported the officer's intentions, once encouraging him to continue his communications with the County Council), responses from a CSC senior manager were, in the author's opinion, rather hostile and demeaning. The Nuisance Officer's emails included phrases like *"can we all live with risk that this young girl is exposed to in view of the intelligence we have of her association with Males".* He referred to both *'Asian'* and *'black'* males on several occasions. The child was subject to a Care Order and the risks being described were at times when resident in Council care. One CSC response to concerns about sexual association with adults said: *"The innuendo relating to her alleged associates I find a little presumptive and unsavoury, and does not in my view indicate a significant prima facie risk of harm…"* Another email said that *"the evidence beyond innuendo remains thin".* (By this point there were numerous reports collated by the Nuisance Officer of association by the then 14-year-old, late at night, with adult men.) The writer of those messages accepts that their tone was wrong, but at the time believed the course of action the Police and CSC were taking to focus on reducing missing episodes was right.

5.79 CSC, who knew the Nuisance Officer had good connections with the Police, thought the officer had unreasonable access to confidential police information about the case, but the Police IMR saw this more as good liaison between agencies. A police officer was embedded in CANACT (Crime and Nuisance Action Team), so close liaison was the norm. The County's Head of Adult Social Services was asked by the CSC Head of Service, through his contacts

[17] A view was put to the SCR that, if the child was Looked After, a Child Protection Plan was not needed, but there is nothing to this effect in the 2006 *Working Together*, which actually described the process when both were in effect. The criterion for being on a Plan was 'if the child is at continuing risk of significant harm', and is hard to argue this was not the case given what was known about her and adult males, whether the child was at home or placed with a relative or in a children's home.

with the City, to complain about the Nuisance Officer's emails and style, and the City senior manager apologised for *"the attitude of the staff member and for the unprofessional way he has acted. I am most upset that an officer under my control could act in this matter, and apologise to your staff unreservedly. Please be assured I have taken strong action to ensure this does not happen again*." The author understands that the worker was asked to stop emailing, but not told that his concerns were inappropriate. It is likely though that his managers assumed that the Police and CSC would be doing the right thing as it was their responsibility, and so did not take up the issues themselves. Only his team leader, and no one more senior, spoke to the Nuisance Officer, who said that he was told the County did not like senior staff being criticised by a junior person.

5.80 Whatever the style of the Nuisance Officer concerned, he was trying to get a child protected, and responses received (including turning down a case conference request) show one reason why the full picture of CSE was delayed. There is no evidence that the very top managers in the City knew about this disagreement but, according to CSC, *"At one stage in this correspondence the Directors of Social Services[18] and Education were copied in to the City Council employee's correspondence – the Director of Education because (the Child) was not in school. Both asked their direct reports to respond."* He also describes being so frustrated he went to the County Council and demanded to see a senior manager, and was seen, he says, by the Head of Adult Social Services[19] to whom, he says, he relayed all his concerns.

5.81 In 2008, the then Lead Member for Children's Services was copied into some of the correspondence and asked the CSC senior manager with whom the City officer was corresponding to draft a reply. The Nuisance Officer also says he spoke to the Lead Member and briefed her on the whole picture, including the association with adult black males. The Lead Member for Children made personal inquiries. *"She also met with the staff at the residential children's home, without a senior manager present, to ask them herself about the child and she was also assured that the males [the child] was being seen with were young asylum seeking males. She accepted this explanation."*

5.82 The correspondence was concerning (or the Lead Member would not have made personal inquiries) but it must be noted that was no indication of group-related CSE, but rather concerns about one child/family. However, the Lead Member also told the CSC IMR about a meeting with the CSC Head of Service, other senior managers and staff from two Homes. No minutes have been found but it seems probable the Lead Member had two meetings. The Lead Member recalls her prime concern being girls in care being out late at night and the risks that must follow that from men, rather than specific examples, and says she was unaware of abuse by Pakistani heritage men of multiple girls until 2011. She says that the County Corporate Parenting Panel saw that the missing statistics had recurring names and was concerned about the risks, but says the Panel would not have known what was happening to them when away.

5.83 The former CSC manager who had some of the correspondence with the Nuisance Officer now accepts that the strategy of trying to support the girl to learn how to cope with her

[18] The emails into which the then DCS or the Director of Adult Social Care were copied did not mention anything specific about adult males or sexual activity.
[19] It may well have been another senior manager who reported to the Head of Adult Services.

complex family situation rather than removing her from the risks was wrong, but believes it was followed with good intentions.

5.84 The Bullfinch perpetrators were found guilty of 25 offences against this child. The girl was reported missing from Council Care 69 times in 2007 and 79 times in 2008.

5.85 ***'Nothing can be done':*** The perceived difficulty in prosecuting and the lack of investigation on occasions led to a vicious circle whereby victims would either not disclose, or make only a partial disclosure, or withdraw support for the Police, because they could see that there was no guarantee of sufficient action to be safe from perpetrators if they did support the Police. Victims can describe circumstances, some quite dreadful, when they made allegations or were found in dire straits after abuse yet 'nothing happened'. Although there might be understanding now about why nothing (much) happened to end the abuse, for victims who were scared, hurt and trapped, this must have merely reinforced their sense of isolation and lack of choices. Exasperation might then reduce further cooperation or lead to withdrawal of cooperation, which would then enhance the sense amongst police and others that this was all too hard. One detective said of the pre-Bullfinch period that *"if a child did not disclose it was a matter for social services as we needed to move on to the next job".* This showed the then absence of other measures such as disruption and covert surveillance.

5.86 The limitation to investigation was reflected on by a very senior police officer looking back at that period. He told the SCR that at the time of the illustration above there was real pessimism about whether cases could successfully get to court due to evidential constraints and lack of evidence from victims, and that was a disincentive to further investigation without victim support. Attention was instead focused on a strategic approach to managing 'missing persons' and multi-agency safeguarding plans, rather than what were expected to be fruitless investigations. This was acknowledged, in hindsight, as clearly being the wrong approach with this form of CSE.

5.87 CSC/residential homes staff, felt frustrated that 'nothing was done' with information they provided. CSC say that *"the prevailing culture became, if the police can't do anything there is nothing we can do, and this became a source of frustration and anxiety for some social care professionals".* But there is also evidence in IMRs of Social Care and Health staff at times being reluctant to tell police all they knew or heard in case it undermined their relationship with the girls. Police were also frustrated by the sorts of issue described earlier, such as evidential issues and cooperation. As will be seen below, there was a growing level of shared concern at the end of the 2000s and which culminated in the excellent Bullfinch initiative, but for a period (despite vast public sector involvement) the understanding and skills were insufficient to solve that frustration.

5.88 ***Missing persons management:*** 'Missing persons' was a powerful and complex issue running through these cases and the developing understanding of CSE. The Police IMR alone took 176 pages to describe, analyse and pull out the learning from the management of those who went missing. There are 450 Police Missing Reports held on the six children in this SCR, and there were further episodes not reported. The 450 represented only 4% of the 10,600 total under-18 missing episodes in the County in 2005-13. And the 10,600 Missing Children reports were only just over half of all Missing reports, which averaged 2,450 per year. Oxfordshire figures were around a third of the TVP area overall. However, for children missing from being Looked After, Oxfordshire had a much higher proportion in 2006-9, which

may reflect the pernicious effect of the exploitation, and a reducing proportion thereafter, reflecting the increased local focus and awareness and improved joint agency systems. For the six children concerned, the episodes increased from ages 12-14 and decreased to almost none at 16, which was associated with the perpetrators losing interest as the girls got older. Five of the six girls started going missing from home, so this was an established pattern before spells as Looked After Children.

5.89 The obvious questions are – was it not obvious that these girls were being exploited in a major way, and why were they not stopped from running away to danger? An extract from the Oxford University Hospitals IMR shows one of the main causes, but also the link with other issues in this section. A 14-year-old girl was admitted with excess alcohol and there was a lot of interagency liaison. *"OUH staff accepted the view of those professionals in police, the Care Home and CAMHS that this was simply another episode in the life of a girl with significant behavioural difficulties rather than exercising a higher level of professional curiosity about what was causing this. Specifically, her comment while intoxicated about having sex with friends for drugs and alcohol was taken at face value: mainly because of an assumption that this was simply part of the 'bad behaviour' but also because of lack of knowledge amongst health professionals about grooming, and the significance of missing episodes as one possible indicator of Child Sexual Exploitation as this was not a widely publicised factor at that time."*

5.90 There was a sense of exasperation about so many missing episodes, and for too long staff found it easier to try to control those episodes rather than work on the perpetrators to weaken the 'pull' factors. One senior social worker said, *"We would get missing reports most days. I guess the view [then] was that the children were just playing up. It was always the same children."* There was also the traditional view of those who run away as running 'from' something (e.g. abuse at home or the control of a children's home). With some of the families this could be a tempting thought, and it took some time before the enormity and power of the *pull* from grooming was grasped.

5.91 There was also an assumption that the children were better off in Care, and even safer in secure accommodation. This proved not to be the case as the very numerous missing episodes from Care showed. Only official secure accommodation is allowed to lock doors or windows, and even when one girl had round-the-clock 2:1 staffing in a residential care home, windows were used to get away. More distant homes proved no barrier, as some girls would find their way back to Oxford. Whilst the girls could not get away from secure accommodation and were safe for that time, the fact that their perpetrators were untouched by such a placement meant that the abuse resumed on their discharge (unless they had become too old to be attractive to the men in the meantime). The CSC IMR was concerned about one child in the mid-2000s who was in a local children's home after two spells in secure accommodation. It said it was well known that she was being hurt when missing from the (not secure) home, and that it was *"a serious error of judgement*" when senior managers indicated that a third spell in secure would not be agreed. (Although it must be said that secure was a respite from abuse and not a solution.)

5.92 Physical restraint can be authorised, but it was virtually never granted as the social work managers who had to deal with such a request apparently regarded restraint as a sign of failure, and it could not in any case have been a continuous action. (Every parent knows there is a point beyond which it becomes impractical or unreasonable to physically control teenagers.) Removing or disrupting the perpetrators is now the solution. It was some time after Children's Homes began reporting names they knew or had heard, car registration

plates, visits by perpetrators, etc before such action against perpetrators was consistently and successfully taken by the Police.

5.93 There were a number of procedural issues that fed into the pattern of insufficient action to make a difference. A sample of those is described below. The Police told the SCR that whilst most missing reports were correctly graded for an 'urgent' response, there were some that should have been 'immediate', where for example the operator noted that the caller (a parent) "*thinks [the daughter] is being held against her will by Asian males"* or *"at risk of sexual exploitation, harassed by a group of Asian males".* The Police tried to establish why staff were not recognising vulnerability issues, and identified some confusing wording in the risk assessment questionnaire, but concluded that overall the cause of misclassification was: *"It is evident throughout this review that TVP staff did not have a sufficient understanding of CSE to be able to readily identify this as a form of child abuse and a factor that increased the young person's vulnerability. This was not surprising given the national awareness of CSE at this time, with both national guidance and TVP policy regarding missing persons not overtly recognising this link and its impact on risk. It certainly did not feature in TVP staff training nor within the force policies that….staff were following."*

5.94 Such were the numbers of missing episodes, of which A-F were a small proportion, that processes were agreed that allowed a differential approach, and the IMR found that some officers read the lack of *requirement* to attend as meaning they should *not* attend rather than use case-by-case judgement. This had the impact of lessening the impact of oft repeated (and oft returned from) spells of being missing and the Police quoted one duty sergeant: *"I do not agree that she is high risk. She has many friends who she stays with. She regularly goes missing to return in the following day. Due to her age she is of concern due to her choice of people that she associates with. This is not something that we can control. Neither can we prevent her choice of boyfriend."* The IMR commented that *"this entry highlights the impact the frequent missing person reports made by staff at the home had had on this supervisor's perception of [the 14-year-old and 21-year-old male), to the point that potential risk factors and child protection concerns appear to have gone un-noticed."* This view is enhanced by illustrations that the more a child went and came back, the lower the level of risk perceived, while it is realised now that the opposite is the case and risk of CSE is very high with more episodes. One Inspector updated a report on a frequently missing child by writing: *"Risk category changed from high to medium. Regular misper who is streetwise."*

5.95 Although Association of Chief Police officers' guidance emphasised the need to 'investigate' missing persons, and that failure to do so may leave an individual at risk, the Police identified many situations where the Missing Persons report was seen as a process, not a need to investigate. This should not be read to indicate that police officers were not in most cases attending the place from where the child was missing, checking the children were safe on their return, and so on. One mother told the SCR about their politeness and apologies for asking the same questions and searching the house yet again. She also gave fulsome praise for the Police Missing Persons Coordinator. However, the volume of reports – not just for A-F – desensitised people to the risks involved. Also, resources would have been overwhelmed by actively investigating every episode. As a result of the learning from the experience in Oxfordshire, there are significant increases in staffing, which were not there in the time of this Review. Whilst it is not hard to understand the impact of complex processes, that 'CSE' was a barely understood concept, and that the hundreds of missing episodes could have had a

wearying and desensitising effect, it is also true that there were very serious descriptions of harm or potential harm to the children, which were not investigated.

5.96 All missing children were supposed to have a 'safe and well' check by the police and also an independent 'return interview'. In the middle of the previous decade there was an agreement between the Police and the County Council that, to avoid duplication and so that the 'right person' spoke to a child, Care Homes would do many of the checks and interviews. The Police concluded in hindsight that, whilst this plan was understood, it reduced the opportunity for the Police to identify the possibility of a crime against the girls and lessened the potential linking of incidents. It also lessened the chance of another possible decision – that the Police should do all return interviews for a specific child owing to the risks involved. An example was given where there was an apparent risk to a child from a member of the children's home staff. In another case, a Missing Persons staff member saw on a child's return to a Children's Home that the 14-year-old girl had a pashmina and silver ring from a named Asian man, and had mentioned that her abuse started at 13. This never moved from an intelligence report to any investigation or inquiry.

5.97 Paragraph 5.75 described how the Missing Persons Coordinator wrote in 2006 to a number of senior officers, including her DCI and some Superintendents, seeking more action on missing children, including the following: *"The sad thing is, is that I'm not at all shocked or surprised at this lack of response as both girls appear to be labelled – repeat Mispers, Streetwise, too much trouble, not worth the effort of finding them as they will run off again... The staff at [the children's home] give plenty of information as to the vulnerability of these girls and I don't know what more can be done to ensure that these vulnerable Mispers are treated as a priority enquiry until one of them is found dead!... I know that you share my concern about these girls and I apologise for sounding off but I would like some help in both raising awareness and to try to track the people responsible for abusing these girls on a regular basis. Thanks for your time."* This did lead to some improvements, but more about Missing Persons organisation than seeing the wider picture the coordinator was trying to get across and the need for more investigatory action.

5.98 The DCI in charge of the Missing Persons Coordinator asked her and her Inspector to visit Lancashire as it was known that it was more advanced on missing persons. The report brought back to the DCI led to discussions with many agencies and to the creation of the multi-agency Missing Children and Families Panel, which went live in 2007.

5.99 At these Panels up to 38 children (August 2010) were discussed at such meetings. This was positive process but, as concerns in various agencies grew about CSE, other multi-agency meetings began and decision-making processes became unclear – who was 'doing' what and where authority lay. The YOS IMR says the meetings appeared *"to be unclear about purpose and function: was it there to agree action plans, just report, or look for patterns of behaviour for individuals and or groups?"* Oxford Health made a similar point: *"During the time frame of the review there is no evidence in the clinical records that any liaison took place with staff regarding any missing episodes a child or young person had or that relevant information was entered on to the clinical record to alert staff. Interview with the Designated Nurse for LAC (who was a member of the Missing Persons Panel) clarified the focus of the meeting was to share information with partner agencies rather than individual practitioners."* This suggests that front line staff in health may not have been in the loop on missing children.

5.100 If anything, the duplication was a 'good fault', as it represented a drive from involved staff to finally understand and act on CSE, but the Police say it led to inactivity through assumptions that others were acting. The Police looked back at the membership, and while the Police and CSC attended nearly all meetings and the key children's home (Home A) 88%, the PCT (which at the time provided the LAC health service) attended a third, and Education 6%. There was no attendance from the City Council and it is unlikely they were asked, nor from the voluntary sector. From November 2010 the Police provided CSC with daily lists of all children reported missing in the last 24 hours, up from weekly, in accordance with government direction.

5.101 The Detective Chief Superintendent now in charge of crime investigation says: *"In retrospect it wasn't 'our' problem. It was up to our local authority partners in CSC to solve it. So we set up the Panel in the hope we could find a solution down the safeguarding route... 'control your children!'… but now we know that even when our partners pressed their 'nuclear' option... secure accommodation... even that failed to make the children safe as they often returned to the same areas and continued to be abused."* While this doesn't do justice to the efforts of Police Missing Persons staff, it does show a frank recognition that there was insufficient understanding at the time.

5.102 The TVP Prostitution Strategy of 2008-11 was very clear. *"The possibility of grooming must always be considered as part of the missing person risk assessment and investigation, particularly in cases of frequently missing young persons from care settings. Regardless of the background to the grooming process, and any apparent willingness to participate on the part of the child, any young person involved in, or at risk of becoming involved in prostitution must be regarded as a victim."* The associated standard and policing guidance document was equally clear: *"Any missing person enquiry involving a young person, particularly those from care settings, should consider the possibility that the individual is being groomed or becoming involved in prostitution as part of the risk assessment and investigation procedure."*

5.103 ***Pressures in Children's Social Care:*** The issues which follow relate more to CSC. Some are related to CSE itself and some to general performance which might have an undue impact on the very complex cases around CSE. This SCR makes a number of references to management arrangements around CSC, and acknowledges that most of the information has come from the way in which CSC has contributed frankly to the SCR. In some respects, it would not be surprising if there were some problems in the way services operated as reviews, including a Joint Area Review (JAR)[20] (a multi-agency external review), reported some concerns in public reports. The author's summaries below are aimed at explaining any problems identified, not the whole report.

2005: Children's Services were 'good', although one team was struggling, with assessments behind time, and there needed to be more local placement choice of looked after children (LAC).

2006: Adequate. Too many children placed too far from home; reviews for children who are looked after need to be done on time; and the lack of placement choice on occasions puts children and young people in less appropriate placements.

[20] *Joint Area Review – Oxfordshire* (Ofsted, April 2008).

2007: Adequate. Weaknesses with the referral, assessment and child protection systems. Increases in children being de-registered and re-registered (suggesting hasty de-registration). A need to improve the timeliness of LAC reviews.

2008: Adequate. Management of referrals and assessment raised for third time. Re-arranging processes had led to 'referrals' doubling. The JAR (Ofsted plus Police and the Healthcare Commission among others) also judged Children's Services as adequate and had concerns about the public sector partnership overall, with QA underdeveloped and the LSCB needing to improve monitoring: *"Insufficiently rigorous management structures and procedures within the partnership to ensure comprehensive management oversight of processes and outcomes."*

2009: The Annual Statement said, 'Performs well'. There remained concerns about the timeliness of child protection inquiries, poor timeliness for assessments, and problems with prompt allocation to the long-term team.

2009: The unannounced inspection, which was reported after the 2009 Annual Statement, described 11 areas of satisfactory performance in the contact assessment and referral service, and five 'strengths' including the management oversight of complex cases. There were six areas for development including that some child protection inquiries had insufficient management oversight. There was one area for priority action: *"Staff turnover within one of the contact, referral and assessment teams has had a recent but marked adverse impact on its performance, particularly on the timeliness and quality of assessments and management oversight of contacts held on duty."*

2010: Performs well over the year. The unannounced inspection had some concern about supervision and support for staff, and about overly optimistic assessments that needed more attention to the background circumstances.

2011: Good overall. Ofsted asked for more involvement from Adult Services in Child Protection Case Conferences, for Child Protection Plans to be improved, and all children to be interviewed after going missing.

2014: Child Protection, LAC services, and Management were all rated 'good', as was the LSCB.

5.104 Although the external assessments improved over time, the Director of Children's Services (DCS) from 2010-11 identified issues with safeguarding, organisational structure and culture, capacity and quality of management, policy, performance management, business processes and systems and practice. The Director told the CSC IMR that there was a lack of performance information on which to judge services, and lack of compliance, for example with missing procedures. Her concerns were shared with the County CEO and Lead Members.

5.105 The years before the Bullfinch investigation had been one of considerable leadership change at the top of CSC, which had been merged with Education in 2006. From 2004-11 there were five substantive Directors, and three periods of interim directorship. Under the Director, the operational management of CSC was under a Head of Service. From a similar period (to 2012) there were four Heads of Service and at least seven spells of interim leadership. However hard anyone tried, this degree of change would have an impact on consistency and

clarity of direction.[21] This also applied to the Safeguarding Board. For example, between June 2006 and March 2008, before the first Independent Chair was appointed, six different Council officers chaired meetings of that Board. As seen at the end of that period, the external JAR inspection said there were "*insufficiently rigorous management structures and procedures within the partnership to ensure comprehensive management oversight of processes and outcomes"* (a responsibility of course shared with its members from all other agencies).

5.106 Three former Directors, speaking with CSC for this SCR, found (to one degree or another) Oxfordshire CSC to be insufficiently well organised, weak at performance management, inclined to overrate its own performance and resistant to change. It was also commented that if CSC did not do well on any national performance indicators, the view was always that the indicators were inappropriate. One *"felt the culture… was really trying to avoid the issues and pretend they weren't there and no sense of urgency, that people were not open with me…"* Directors felt the need to address some of these issues vigorously and this was at times seen as unsympathetic or over-firm leadership. The merger with Education also had an impact, with interviewees saying that CSC was the poor relation in terms of resources, and some staff saying that having no Director until 2010 with a social work background was not helpful. (Education interviewees also found this period difficult.) One CSC Head of Service said that not having a social work professional as line manager meant that one did not get professional supervision, or professional challenge. If this contributed to the lack of escalation to the top described earlier, that would not have been appropriate.

5.107 There were recurrent financial challenges impacting on, say, placement budgets but that is far from uncommon in local government, and new resources were successfully sought by the CSC Head of Service in the process described in the Cabinet paper below.

5.108 The SCR is not suggesting a direct connection between the delayed identification of CSE and the tensions and changes within CSC, but that it must have been harder for such a difficult topic to get the right attention with so much else happening.

5.109 Another issue may have been a new 2006 CSC strategy, which seems laudable but may have had unintended consequences. The model is not ideal for dealing with CSE where consent in the victims is eroded, and CSC and others need to take tough decisions to protect the children regardless of a child's, or at times their family's, wishes. For children tied up by CSE, the concept of 'choice' is not a real one. It also, in a quite unintended way, kept focus away from the non-family perpetrators by its (otherwise praiseworthy) focus on the family. A 2006 Council Cabinet paper[22] said: "*A key recommendation concerns the establishment of services and decision-making structures that replace the existing, professionally-dominated models, with mechanisms that enable and empower families and kinship networks to find solutions for, and meet the needs of, their children: the role of the public services becomes that of supporting families to take decisions and make plans for their children, ensuring that through such an approach children are better safeguarded and enjoy better outcomes as a consequence... Such an approach has a strong research and evidence base to support that outcomes improve, that families can and do make safe and secure arrangements for their*

[21] The Association of Directors of Children's Services in its *DCS analysis March 2007 – March 2014* reported that, in that seven-year period, 63% of authorities had the three DCSs that Oxfordshire had. The average tenure of a substantive DCS nationally was only 32 months.

[22] *External Review: Children's Social Care Service and Strategy Action Plan* (Oxfordshire County Council Cabinet, 11 November 2006).

children, and that numbers in the Public Care and formal child protection systems fall as a consequence of child-focused, family-centred practice and management models." This may also give context to the philosophical approach to decisions about accommodating teenagers.

5.110 The same Cabinet paper, describing the position from which improvements were to be made, said that Oxfordshire was a low spender on CSC services, in the bottom quarter nationally although overspent, (i.e. underfunded). It was 132nd lowest of 150 authorities nationally, and the number of social workers was the tenth lowest in the country, with 14.7 per 10,000 population compared to 27.2 nationally and 19.1 in the most comparable authorities.

5.111 ***Supervision:*** Anyone working on abuse needs to be supervised so their work is supported, reviewed, and challenged. This is because working in such an emotive and at times scary way increases the chance of objectivity being weakened, or finding judgement is affected. One learning point from CSC said: *"In most cases supervision took place at reasonable frequency although one manager did not provide supervision. The quality of supervision was generally poor with the focus being on updating the manager and checking that processes such as reviews were being completed in timescale. There is insufficient evidence of managerial decision making and little if anything to show that supervision was focused on reflective practice."* These cases were so hard that they needed the very best supervision. The Police IMR also points out that their supervisory processes were not always robust around cases like those in this Review.

5.112 ***Working with the parents****:* Social workers (and other professionals) found dealing with the parents very hard. This is not unique and is challenging everywhere. This took a variety of forms which CSC has identified in its own review. In two cases it appears that decisions were made to reduce the risk status around Child Protection planning because of strong parental opposition, when retaining the higher status may have been in the child's best interests. With another child, a case was (in the current opinion of CSC) wrongly closed as a mother would not cooperate. One parent was not allowed to attend LAC reviews *"as a result of... abusive and threatening behaviour".* In another case, workers could not visit alone owing to aggression. CSC concludes that this did impact on professionals' ability to work with and plan for the child. Not gaining cooperation limited the ability to conduct assessments that would illuminate the situation.

5.113 The SCR author, from the family interviews and detailed IMRs, wonders whether the dynamic was more subtle than this and, just as language suggested that the children were the author of their own downfall, workers came to see some parents too as partly responsible for the mayhem actually created by the abusers. In a multi-agency meeting in 2006 discussing two children, a CSC worker is recorded as saying that the father of one *"is obsessed with finding her when she goes missing".* The author would be worried if any parent was *not* obsessed with finding a 13-year-old girl who has been subject to rapes, excessive drug taking and alcohol, or who was running from Council Care. Later the minutes say that *"there was a discussion about the parents who moan about social services and police and that (the child) does this as well… her behaviour is a reflection of her parents".* The parents' 'moans' were about the public services not seeming able to assure the safety of their daughter. The child had gone missing from Council Care 12 times in the 10 weeks before the meeting for a total of more than 26 days.

5.114 ***'Professionalism':*** The girls to whom the author spoke acknowledged just how difficult they were with professionals and did not think the author should disguise this. They would not deny that they gave staff (they were talking mainly about social workers, but also the Police) a very hard time, but they said the more someone acted like a 'professional' the more they found it difficult to relate, and the less likely they were to disclose. They talked of staff coolness, a dispassionate approach, or not being prepared to talk about themselves, and about a sense that they did not feel they were being related to as people. In contrast, they said that unqualified staff were more down to earth, prepared to act as if they were on an equal footing, and would share something of themselves. Of course, being objective, measured and preserving professional boundaries is the basis of being professional, but it seems that with these girls (who had more dealings with adults than most, even if inappropriately) needed someone more 'ordinary' to stick with them. The professional approach, which cannot in itself be criticised, may have inadvertently acted as a barrier. (This seems to be different now, see current quotes in 4.34 onwards.)

5.115 Some staff understandably found it hard to stay dispassionate in face of behaviour that they saw as at least partly self-determined, frustrating and self-defeating. Some girls told the author of demeaning comments by some police officers (*'snide'* said one victim) and these again acted to prevent trust. It was interesting that secure accommodation staff (who almost by definition are used to the most difficult children) were praised by the girls for remaining polite and nice however they behaved

5.116 It is important when reading the above to consider the girls' views in the context of most staff members investing a huge amount of attention and care into what they did, in very difficult circumstances – even if those efforts were not always effective.

5.117 ***Looked After Children processes:*** Five of the girls were accommodated in the Looked After system at varying points. After 2005, Oxfordshire had an increasingly lower proportion of children in care. In some respects this might be a good achievement but CSC has identified that, in the mid to late 2000s, there was a prevailing culture at senior operational manager level described by staff as contributing to the IMR. Various panels were put in place to gate-keep entry to LAC status, and many staff told the IMR that when seeking such a placement they felt 'attacked' or they were told there were no placements with nothing else being offered. One manager said, *"I started to go with social workers to protect them.*" The figures do show a small reduction in children looked after in 2007 and 2008, but a big rise in 2009, so there is little evidence of policy induced drops in placements. (By 2011 Ofsted was praising the decision-making process around placements.)

5.118 In relation to the reported discouragement of placements, the County Council Legal IMR said that whilst to that point social workers had unfettered access to in-house solicitors to discuss risks and justification for statutory action, the clamp down on placements led to social work being stopped from direct access as legal services was seen as a source of encouraging care proceedings leading to additional requirements for accommodation/placements. A Panel was instituted and, although Legal say that in most cases social work managers and lawyers agreed, "*… such formality… may well have meant that legal advice was sought late on in the working of a case when earlier advice might have led to less delay and a more informed decision".* This IMR, and CSC's, also said that the use of voluntary receptions into care, as opposed to Care Proceedings (particularly when the focus was trying to maintain parental cooperation and engagement), "*resulted in a weakening of robust long term planning".* The

CSC IMR identified that at the time there was no process of performance managing decisions made in legal planning meetings, so if a conclusion to take certain action was not implemented it might not be picked up.

5.119 A senior manager at the time says that the stance on placements (which he saw as getting the *right* placement for a child) was not only to address serious financial issues, but also because being accommodated did not seem to benefit all teenagers, and there needed to be a rigorous decision-making process that examined all alternatives to residential care. The manager told the SCR he was committed to finding creative alternatives to residential care and implemented an innovative scheme to help teenagers. To some extent the manager may have been right as the victims in this case were not protected as a result of being in Care, but the CSC IMR concluded that the "*unintended consequences of attempts to manage pressure on budgets and to reduce the numbers of teenagers in care and the culture brought by senior managers meant that some of these very vulnerable girls were left in unacceptable family situations for too long".* There is some evidence to support this, but more from trying to follow good principles about supporting families and trying to avoid residential care if possible than any thoughtless approach. However, it is clear from the IMR that there was some tension with the management approach, tension between social workers and those managing placements, and limited choice of where a troubled teenager could be placed (including inappropriate co-placements with other girls who might influence each other and increase risk). CSC told the SCR, "*There was a lack of effective strategic planning as to how the local authority would meet its sufficiency duty and place looked after children close to home. This resulted in ad hoc placements which were not always matched to the child's needs and where the quality was uncertain."* Several of the girls were placed in distant homes, for example in Devon, Cheshire and East Anglia, and it appears they were not safe there either. One girl was trafficked several times from a Devon home, and according to a parent had the same staff attitudes from residential staff and Police, which suggests again that Oxfordshire was far from unique.

5.120 Caution needs to be exercised when considering the above. The girls appeared to be just as vulnerable to the abusers when in residential care, and at least one parent thought that, for all the struggles, the daughter was safer at home than in residential care. It is also, sadly, the case that three of the five girls who were looked after made allegations of sexual abuse by carers whilst in care (one was before she was living in the County). One of the children may have been the victim of two different men within Care. As CSC says, *"All three of these girls had been or are suspected to have been sexually abused within their birth family before becoming looked after and it is very worrying that they then suffered abuse when they should have been safe in care".* It is interesting that investigations into these concerns showed similar patterns to allegations against the exploiters: allegations made and withdrawn, sometimes made several times over years, sometimes the investigation was poor. With a recent concern the author has seen evidence of a very thorough assessment of risk by the Council.

5.121 There was also concern about one private children's home (long since closed) where it appears there were serious problems concerning the quality and training of staff, poor boundaries between staff and children, and a recorded instruction to staff not to share information about the girls with social worker or parents. Ofsted has confirmed to the County Council that appropriate safeguards have been put in place to identify any inappropriate future applications to lead care establishments. Despite the very high levels of going missing

from Home A, this in-county home was generally praised by the IMR for its care, effort and collation of information about predatory males.

5.122 Another issue was the review/plan for Looked After children. CSC says that LAC reviews tended to be planning forward, and missed the opportunity to re-assess risk by piecing together prior patterns of behaviour or harm. *"The overall quality of reviews was variable. Sometimes there was a failure to consider the presenting concerns, including absconding, allegations of rape and sexual assault, inappropriate calls to the homes etc. The Independent Reviewing Officers interviewed as part of this review have explained that the LAC review is seen as 'looking forwards' not backwards and this results in a failure to undertake a meaningful review of the child's placement and whether and how their assessed needs are being met."* Oxford Health said that Health staff contributing to LAC reviews were not invited to review meetings, so limiting the interchange of information between professionals, and that Health staff might do assessments with little knowledge of preceding history.

5.123 The Council Legal Department submission to the SCR points out that the legislative framework with regards to secure placements (under Section 25 of the Children Act 1989) creates significant practical difficulties for those responsible for the children. One of the main grounds for such secure accommodation is that the young person has a history of absconding and a likelihood of absconding and that when absconding they are likely to cause significant harm to themselves or to others. However, once a person is securely accommodated, the immediate risk of absconding goes and through a good response to any therapeutic input they may be able to evidence a reduced risk of significant harm. These restrictions on liberties are subject to stringent review with a strong independent element, and if the grounds are no longer met the young person must be immediately released. The focus, says Legal, is therefore on the child's current behaviour but, of course, that creates difficulties in relation to assessing the risk and likelihood of absconding from other types of placements. Cooperation and becoming more settled might be seen as a positive development of the therapy but might actually lead to the risk of premature discharge. Frequent returns to Court can also cause destabilisation within the placement.

5.124 The SCR heard that reviews of children in secure accommodation did not include wider plans for disrupting or stopping the exploitation from which they were locked up for their own safety, so nothing changed on discharge. The absence of any clear purpose and outcome of such a serious placement was not set out, so it became hard to justify its continuance.

5.125 One of the children was adopted in Oxfordshire after being placed by another authority. When there were issues (ten years ago) that needed dealing with about that child and family, there was a long debate between the authorities as to whose job it was to respond or to fund care. There was an incident where the child was found by a parent dishevelled, partially clothed, drunk in a room with seven adults, and later, after a brief spell in a police station until sober, taken by the mother to hospital (and admitted) with after-effects and injuries. The chronology suggests that debating which authority should be doing what took energy that might better have been used inquiring into what happened to her. This was distressing for the family concerned and did not get relationships within Oxfordshire off to a good start. Interestingly, the police made no inquiries as to what had happened, and when the child was admitted to A&E two weeks later complaining of assault, no link was made to the recent inpatient spell and no referral was made to Social Services. The County Council told the Review they accepted the case, so that the child's needs were met.

5.126 The Children and Families Court Advisory and Support Service (Cafcass), which provides independent support to children going through various Family Court proceedings, also found in its own review that its staff had a similar lack of knowledge about CSE and the erosion of consent. Signs that would now be seen as evidence of likely abuse were not seen as such and there was insufficient discussion of child protection issues with supervisors.

5.127 General Practices involved had little knowledge about their patients in the LAC system. The CCG IMR said, *"For all the girls in care, except (one), the registered GPs never knew anything about them. They had no background information about why they were in care, who had parental responsibility, no information about their needs and no important contact details, like the name and phone number of their social worker. This could lead to less than ideal care."* The Health Overview noted the following having looked at all the Health IMRs: *"Whilst the statutory assessments were happening, the health review has identified them occurring as single episodes and there being a lack of continuity of care following these assessments. There was no identified health professional that knew the child in a holistic way and co-ordinated health care or followed up on needs identified within the assessments. There also seemed to be a lack of multi-agency working at reviews with school health nurses not being involved in LAC meetings. There was some involvement of CAMHS with LAC reviews, when they were involved but many reviews were found to involve no health professionals."*

5.128 ***Assessments:*** As well as assessments whilst Looked After, there were of course many assessments and plans for children living at home. The CSC IMR has looked at them all and, bearing in mind some are a decade old, found that, linked to weaknesses in supervision and management decision-making, they did not make effective use of Child Protection planning or legal proceedings to bring about improved safety for the children. Social workers showed commitment and care in their dealings with young people, but plans were of limited quality, with drift, not changing direction with information about risks that were external to the family, nor leading to wider inquiries or the coordinated engagement of police.

5.129 The County's Adult Social Care service was also involved with one family which has a wide range of problems. Details are not given to preserve the identity of the family concerned. Although in the same organisation, its IMR described how at the time (many years ago) paper files in CSC meant that progress on a child could only be tracked through personal contact with other professionals, and that case conference minutes would be too late to serve an updating purpose. It also recommended a single 'case coordinator' when a case involved two or more County departments.

5.130 ***Use of Child Protection procedures:*** Throughout the pre-Bullfinch period, IMRs identify that there was a patchy use of Child Protection procedures. There was a period when, even within the Police CAIU, what the girls were experiencing (before the full situation was known) was seen as not really for 'Child Protection' as it was occurring outside the family. The lack of Section 47 inquiries into the potential offences against children as a result of 'crime' not being properly identified, or a sort of tolerance developing to what was happening, or the notion that the girls were the initiator of their abuse led to relatively few case conferences, and indeed not many 'strategy meetings'. These statutorily backed meetings are supposed to be held (to use words in 2006 guidance) *"Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, there should be a strategy*

discussion involving LA children's social care and the police, and other bodies as appropriate (e.g. children's centre/school and health), in particular any referring agency. The strategy discussion should be convened by LA children's social care, and those participating should be sufficiently senior and able, therefore, to contribute to the discussion of available information and to make decisions on behalf of their agencies."

5.131 Its purpose included *"to share available information, agree the conduct and timing of any criminal investigation, decide whether a core assessment under s47 of the Children Act 1989 (s47 inquiries) should be initiated, or continued if it has already begun to plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose, agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support. If the child is in hospital, decisions should also be made about how to secure the safe discharge of the child".*

5.132 The Police can only identify around 20 such discussions across all six children over many years, ranging from none to eight per child. None made any direct reference to CSE for reasons discussed at length above. It is clear now, although not always recognised at the time, that there were many more occasions when there was reasonable cause to suspect the presence or likelihood of serious harm. The Police give several examples where there was no strategy discussion (eg after S46 Police Protection Powers were used) and no Section 47 joint inquiry with CSC, including an extreme example, ten years ago, when a child of 15 said she was raped (by a man later convicted in Bullfinch). There was a criminal investigation, but one can see from the previous paragraph that without the strategy meeting the degree of joint-ness, information sharing, and obtaining or a joint plan of action is severely limited. There were a several 'professionals' meetings' which discussed a number of children together. These were held for the best of reasons, and were part of the movement that eventually led to the true picture of local CSE being recognised, but although they were sometimes called strategy meetings they were not. They were often not minuted. They often led to confusion about what was decided and who was responsible for actions, and confusions with other meetings discussing multiple children, such as the Missing Persons Panel. CSC has found that even when there were minutes they were not placed on each child's records – showing a blurring of meetings about an emerging pattern of abuse and decision-making meetings.

5.133 Only half of the six children were made subject to a Child Protection Plan (formerly known as 'on the register'), and CSC believes that on two occasions *"child protection processes were not used because of the hostility of the parents",* which does not seem to be child-focused decision-making, but does illustrate the challenges faced by staff. CSC says that *"professionals became aware that the parents were failing to report the child missing but this did not trigger a strategy meeting to consider the risk and implications and how these should be addressed with the parents. This failure to report should have been seen as a safeguarding issue and the appropriate child protection processes should have been triggered."* Those who were on a plan were so for reasons other than the CSE, but when events happened that were typical of what is now understood to be grooming and exploitation, plans were not changed. *"Child protection processes were ineffective in protecting the girls from CSE because CSE was not recognised as a safeguarding issue and so not included in their child protection plans. Since 2013 there has been a child protection plan category 'at risk of CSE' which was not available to workers during the timescale for this review."*

5.134 One of the benefits of being on a Child Protection Plan is that details are usually kept in A&E departments, and attendance can trigger more rigorous scrutiny or interagency checks. Lists of Looked After children are not kept by hospitals (although a call to CSC would discover LAC status).

5.135 ***Minutes and meetings:*** For both IMRs and this SCR the collation of minutes (a key record of decisions) has been a hard task. The SCR has looked in particular at those meetings called about multiple girls or to get more strategic interest. A number of meetings were not minuted or, if minuted, noted in a rather informal way. It was hard to work out where such meetings fitted into decision-making structures. Some meetings changed titles, and others were assumed to be 'strategy meetings' when they were really something else. There were indications of delays in circulating minutes, and the Police referred to a recent inspection where their files could not be updated promptly for decisions as minutes were late arriving – so it may still be an issue. The lack of clarity around minutes did not help the shared understanding of growing concerns.

5.136 ***Donnington Doorstep (DD)***: This is a voluntary organisation that worked with several of the girls and with others who have been exploited or at risk of exploitation. It has provided a wide range of support services for children, young people and families since the 1980s. It started to identify CSE in 2009 and more recently has provided specific services in support of children vulnerable to CSE. It worked with two of the six girls (not specifically for 'CSE') whose experiences illustrate this SCR, and had second-hand knowledge of a third through a parent who assisted the organisation. It played a significant part in raising concerns about the emerging picture that was finally recognised in Bullfinch. One of the features of a voluntary organisation is that it is *not* an organisation with statutory powers or duties, and so has a different relationship with its clients. This throws up issues of confidentiality, what to report, and what it should be told by other agencies.

5.137 An example is that on a number of occasions DD discussed very worrying concerns with CSC on a 'no names consultation' basis, as was allowed by multi-agency procedures, to enable a discussion without having to make a 'referral'. On one occasion it was recorded that this was due to the relationship between one child and DD being the only protective factor. The author agrees with the CSC IMR that such a process is risky and inappropriate. In this case, although very well intentioned, it meant that the statutory agencies could not either add the information to what else they held, or intervene. To some extent, the hesitation about being open is the same as seen in the girls themselves – being open is very risky without a guarantee of protection and abusers being halted.

5.138 DD did pass on much information to Police community support officers and social workers, and participated in many meetings. It experienced difficulties in tracking through decisions made, and frequently received no minutes of meetings about children. (It is not clear if this reflected a general weakness in minuting or something specific to DD.) It also found different meetings uncoordinated or not linked, which was also mentioned by the Police.

5.139 ***School-related issues:*** Education reported to the SCR that*, "The reality is that the secondary educational experiences of the six girls were in the main poor. They appear to have been responded to either through detention or exclusion and had long periods of absence from school. Alternative provision was limited, with little evidence of cross-checking against alternative provision registers and school registers, leaving young people vulnerable as*

schools were not aware as to whether they were actually attending alternative provision." It also said that many staff saw the period after 2005, when Education and CSC were theoretically merged but in their view operating separately, as one of low morale and 'chaotic reorganisations'. The IMR said that before 2008 there was view that the *"educational needs of Looked After Children (LAC) were just not seen as important as there was so much structural and leadership change",* and that *"from 2008–2010 children's homes' response to home tuition was not consist*ent*".* This may not be directly related to CSE but if it had been better could have contributed to the alternative to the groups being a little more attractive.

5.140 As with other agencies, Education says that its staff, including its Social Inclusion Officers who advised on children likely to be excluded, had no real understanding of CSE. Exclusion decisions were based on children's behaviour and attainment issues rather than wellbeing, and Heads who contributed to the Education IMR said they still see this as the national agenda. It is not surprising, given how all the other professions were seeing the girls' behaviour, that education professionals also saw the solutions as lying with the children (or excluding them), or pressing the parents to improve their children's attendance, rather than seeing the girls as victims.

5.141 The Education IMR described how a panel determined alternative arrangements after exclusion, but if the exclusion happened a day after a panel, nothing was done until the next panel. Now alternatives for Looked After children are planned promptly but, in the past (and all of A-F required alternative education provision), they *"often had to wait some time before it was provided. Some of the parents or carers of the girls were at times left trying to negotiate provision and appeared to get caught up in the administrative processes and bureaucracy of meeting thresholds and choosing from the limited range of provision on offer. This was particularly evident for [three of the girls] when they were returning from residential or secure placements to mainstream school."*

5.142 Education says that, at the time (but now improved), the transfer of education records between schools was poor, which would have affected these children more than most because of the moves and exclusions. In another administrative issue, children could be recorded as present if they were known to be receiving alternative education elsewhere, but reported that there was no real system to be sure of actual attendance elsewhere, so absences could be missed when considering a child's progress. Like Donnington Doorstep, schools used the no names consultation process, and the Education IMR says that staff found this confusing, and actual referrals were 'low'.

5.143 It summarised the position before Bullfinch: *"At no time did it appear that professionals were really aware of the increased risk and vulnerability to CSE that being out of school posed or the implications of delay in finding alterative provision. At the same time, it has highlighted that the level of disruptive behaviour that the girls mostly displayed was something that the schools were at a loss to deal with and the support available to them was minimal."*

5.144 ***Drug and alcohol issues****:* Drug and alcohol services were provided by a range of NHS and voluntary organisations. Specialist services were provided to a relative/s of three of the children. The use of alcohol and drugs, initially as a gift, then to weaken the resistance of children, and probably taken thereafter to anaesthetise their trauma, was a common feature of the exploitation. One girl who was being helped at 14 by a specialist service told of daily cannabis use, cocaine at parties, and drinking up to forty five (45) units of alcohol in one night.

She also talked about her 19-year-old 'boyfriend'. Workers tried to speak to the CSC family support worker (who had referred the girl with reference to CSE) a number of times without an answer or call back. The IMR said that the drugs worker should also have found out more about the CSE before seeing the girl to aid the forthcoming conversations.

5.145 The Drug and Alcohol IMR author, from scrutinising the combined chronology, points to the lack of referral to specialist services despite drug and alcohol use/misuse being so frequently referred to. *"Even when a social care or health record talks about excessive alcohol use, or worrying use, it is not followed up with an action to make a referral to drug and alcohol services or to work with the young person around their use. This suggests many missed opportunities to support and advice the girls about the risk associated with it, and to get them support from appropriate services."* The Oxford Health IMR says that Child Mental Health Services should have taken more initiative about drug and alcohol use revealed by the girls, with referrals to specialist services and been more curious about the source of access to it given the girls' young age.

5.146 ***Summary of health issues:*** A summary overview of health-related issues has been provided to the SCR by the Designated Nurse and Designated Doctor for Safeguarding. The issues of knowledge, language, lack of curiosity and so on are seen in health as in other sectors. There have been a number of references to Health IMRs above. The Health Overview identified that the degree to which patients were assessed to check vulnerability varied. For example, Genitourinary Medicine (GUM) used the Vulnerable Persons Questionnaire, but the Contraceptive and Sexual Health Clinic (CASH) did not (although they followed Fraser guidelines and service protocols). Records show that whilst the particular pattern of abuse in this Review was not known, there are many entries describing elements of such abuse. The Overview also pointed out that there a multiple of access points for confidential Sexual Health Services, so accessing one of them might remain unknown to others or mainstream health services.

5.147 Health notes recorded being told by girls of pregnancy terminations, but none had a termination performed by services commissioned by the Oxfordshire NHS (unless with false names). The complexities of information sharing across multiple health services was described in the Health Overview*. "The review of health information demonstrated that the GP record was not a repository of all health information and emphasised the need for dialogue and better sharing of information by all involved in a child's care to ensure understanding. Services did not consistently inform or involve the GP, often the information was incomplete or provided to them retrospectively. There were services such as sexual health services who only notified the GP when patients gave consent, resulting in gaps within the records. Communications from other professionals was generally only summarised and although added to records and reviewed by the GP who assumed that the professional sending the information was acting appropriately on it."* When other agencies are added into the matrix one can see the difficulty in getting an overall picture on one child.

5.148 The Health Overview summarised well a pattern seen everywhere else about not recognising the patterns of abuse, and added how symptoms rather than causes were the focus. *"Health care staff recognised unusual and challenging behaviours that were beyond normal parameters but did not see them as indicators that raised concern about CSE. Managing behaviour changes when identified was found to be an area of challenge for health care staff. In some situations the behaviours were treated as the diagnosis rather than as a symptom*

e.g. PTSD. Interventions and treatment often related to resolving the behaviour not asking why the behaviours were occurring."

5.149 **Taxis:** Oxford City Council is the licensing authority (although national rules allow someone licensed elsewhere to operate anywhere). The Review understands that one of the Bullfinch defendants held a licence for a year, but not at the time of Bullfinch. No drivers licensed elsewhere have been implicated. There have been concerns about links between the perpetrators and certain firms, but no evidence about this was presented at the trial. If a licence holder is arrested for a sexual offence there is Police-City liaison and the driver suspended. The City says that to date there has been no conviction of a named licensed driver. From June 2010 to April 2014 there were nine complaints about sexual assault, all but one by adults. In four cases, the driver has not had the licence re-issued, but in five cases the licence has been reinstated after no prosecution or acquittal. The City's well-regarded practices on taxis were described in 4.27. The Police told the Review that recently a taxi driver drove a girl to a Police station, worried that she was being sexually exploited, which they said suggested the training was effective.

5.150 ***The whole multi-agency team:*** Many illustrations in this section describe issues which are within one agency or profession, but in practice success with such complex cases comes from the whole group of professionals or other staff, each doing their bit. The girls might be involved with social workers, police, doctors, sexual health clinics, voluntary organisations, mental health services, schools, and so on. There is much focus on Police and CSC in this Review, but for cases of this complexity, unless every agency plays its part sharing a similar approach to and understanding about children at risk of CSE, the work of those agencies with the statutory powers to intervene will not be effective. As the 2009 statutory CSE guidance says, *"Safeguarding and promoting the welfare of children and young people in this context, like safeguarding children more generally, depends on effective joint working between different agencies and professionals that work with children and young people... Their full involvement is vital if children and young people are to be effectively supported and action is to be taken against perpetrators of sexual exploitation. All agencies should be alert to the risks of sexual exploitation and be able to take action and work together when an issue is identified."*

5.151 ***Ethnicity*****:** Only one reference was made, either in family interviews or in agency evidence, to the SCR that suggested any reticence related to ethnicity. A parent told a police station about information provided by the daughter and queried why no immediate arrests were being made. The parent says the desk officer responded by saying that such arrests could not simply be made on such information and that the Police were also under pressure not to appear institutionally racist. (The incident is likely to have been around nine years ago.) No other information has come to this SCR to suggest that any processes of identifying CSE or taking action against it was delayed due to the ethnicity of the perpetrators. In 2,000 pages of IMRs, there is barely a mention of ethnic issues.

5.152 The frankness of the IMRs suggests that, had there been indication of any 'go easy' to avoid an appearance of racism, it would have been uncovered and reported. The SCR Panel (representing all involved agencies), when considering the draft SCR and this section, confirmed no knowledge of indications of perpetrator ethnicity dampening concerns about children. In subsequent similar operations to Bullfinch, both in terms of prosecution and

disruption, the perpetrators or alleged perpetrators have mainly been from BME groups, which would again suggest no holding back on grounds of ethnicity.

5.153 The Police IMR (in 550 pages), when referring to official records and family/staff quotes, does not use 'Pakistani' and, in a similar size IMR, CSC uses it nine times. This compares to 54 and 126 uses respectively of 'Asian'. When referring to possible perpetrators, the Police IMR uses 'black' twice and CSC uses 'black' about 15 times. The Police say they would not use 'Pakistani', a nationality, in their reports, as the perpetrators of Pakistani heritage were of British nationality. It would seem that 'Asian' is the phrase predominantly used by professionals and victims in documents and interviews. The offenders of Pakistani heritage gave their ethnicity to Court and the prison as 'Asian'. One of the others, who says he came from Saudi Arabia, described himself as 'British Asian'. Whilst the terminology used is interesting, the author can find no evidence of 'Asian' being used to hide the predominance of Pakistani heritage involvement.

5.154 **Summary:** This section has described a multiplicity of reasons why CSE as in Bullfinch was not recognised for a long time after it had started to occur. An explanation does not, of course, make it 'all right'. Agency work is appraised in Section 8. The issue is not only about how much agencies and professionals knew/understood about the Bullfinch type of organised exploitation by groups. The question is also whether they did well enough with what they *did* know was happening.

6 WHAT MIGHT HAVE BEEN KNOWN ABOUT CSE?

6.1 **Introduction:** This section looks at what organisations might have known about child sexual exploitation from guidance in the years before the Bullfinch investigation in order to help assess organisational action. There was much published from the late 1990s that might be deemed relevant to CSE. However, it was not specifically about the Bullfinch type of abuse, and was generally couched around 'prostitution'. If 'trafficking' was used, it meant trafficking from abroad. The notion of sexual exploitation of young teenagers by groups in local towns was not something many people saw, or something of which they were even aware. However, although the labels were different, the signs of it were indeed covered by guidance over many years – but it was not to the forefront of thought in the public sector. This section also looks at how guidance was received nationally.

6.2 **Guidance:** The 1999 version of the statutory Child Protection guidance *Working Together*[23] had only half a page amid its 128 pages on prostitution, other forms of commercial exploitation and pornography/internet grooming, but it did list some of the cornerstones of today's management of CSE:

- *treat the child primarily as a victim of abuse;*
- *safeguard the children involved and promote their welfare;*
- *provide children with strategies to leave prostitution; and*
- *investigate and prosecute those who coerce, exploit and abuse children*.

6.3 In 2000, the government published, *Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children*.[24] It repeated the above bullets and again identified key ways of thinking which were missing in Oxfordshire before Operation Bullfinch a decade later. For example, *"Although not always prominent or visible, children are involved in prostitution… It is a tragedy for any child to become involved... It exposes them to abuse and assault, and may even threaten their lives. It deprives them of their childhood, self-esteem and opportunities for good health, education and training. It results in their social exclusion. Children involved in prostitution should be treated primarily as the victims of abuse, and their needs require careful assessment. They are likely to require…in many cases, protection under the Children Act 1989… the vast majority of children do not voluntarily enter prostitution: they are coerced, enticed or are utterly desperate. We need to ensure that local agencies act quickly and sensitively in the best interests of the children concerned. It is important that proper prevention, protection and re-integration strategies are put in place to ensure good outcomes for these children. All services… should treat such children as children in need, who may be suffering, or may be likely to suffer, significant harm*." What the Oxfordshire girls were involved in was very akin to this; some were literally involved in prostitution and some were trafficked for sex.

6.4 In 2001, the government published a *National Plan for Safeguarding Children from Commercial Sexual Exploitation*.[25] Again, it had many echoes of the current form of CSE. *"The causes of children's involvement in commercial sexual exploitation… cannot easily be*

[23] *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children* (Department of Health, Home Office, Department for Education and Employment, 1999).
[24] Department of Health (2000).
[25] Department of Health (2001), but jointly with the Home Office.

disentangled from the wider problems of poverty, family conflict and breakdown, child abuse, domestic violence and homelessness. All commercial sexual exploitation of children is utterly unacceptable. It takes away children's self-respect and dignity. It exposes them to great danger and it takes away their childhood. Tackling this evil trade needs determination, clarity of purpose and an ongoing partnership between a wide variety of organisations in the public, private and voluntary sectors… The term commercial sexual exploitation is interpreted widely in this document to include the prostitution of children and young people; the production, sale, marketing and possession of pornographic material involving children; the distribution of pornographic pictures of children over the internet; trafficking in children; and sex tourism involving children."

6.8 It also had guidance for ACPCs[26] (the predecessors of today's LSCBs): "*… It also falls within [ACPC's] remit to ensure that appropriate protective services exist to support children caught up in such exploitation or who have been abused… there is a need for the ACPC to raise awareness of the nature and scale of harm with agencies before taking action. Action is then best targeted simultaneously on the investigation and prosecution of abusers and the support of the children involved."* Note the emphasis on investigating the abusers, which was missing for too long.

6.9 The 2006 'Working Together', in a document twice as long as its 1999 predecessor, again still had half a page on 'children abused through prostitution', but it did have a larger section on trafficking – largely about trafficking from abroad. In 2006, after 'Working Together' 2006 was published, the OSCB agreed 'Guidance for Professionals Working with Sexually Active Young People under the Age of 18 in Oxfordshire'. This gave clear guidance on consent, and how to assess the risk to the young person, and included the following pointers which describe the process later identified on Bullfinch:

- *The nature of the relationship between those involved, particularly if there are age or power imbalances…*
- *Whether overt aggression, coercion or bribery was involved including misuse of substances/alcohol as a disinhibitor*
- *Whether the young person's own behaviour, for example through misuse of substances, including alcohol, places them in a position where they are unable to make an informed choice about the activity*
- *Any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship*
- *Whether sex has been used to gain favours (e.g. swap sex for cigarettes, clothes, CDs, trainers, alcohol, drugs etc.)*
- *The young person has a lot of money or other valuable things, which cannot be accounted for*
- *Whether methods used to secure compliance and/or secrecy by the sexual partner are consistent with behaviours considered to be 'grooming'*

6.10 If a young child *"may be at risk of sexual exploitation through prostitution, a referral should be made to CSC* (and if an emergency) *the Police should be contacted immediately".* Oddly, this guidance, whilst having a 'presumption' of referral, allowed for a referral not to be made even if an under 13-year-old was having sex, but this is no longer in current guidance. Whilst the reference is to exploitation 'through prostitution', the bullets above describe exploitation in general. This 2006 OSCB guidance was very appropriate, and relevant to what the girls were

[26] Area Child Protection Committee.

going through, but the links between the cases and what the guidance was describing were not made.

6.11 In 2008, the University of Bedfordshire published a government-commissioned paper, 'Gathering evidence of the sexual exploitation of children and young people: a scoping exercise'. This could not have been clearer about the key principles of preventing, disrupting and prosecuting CSE which would be advocated today. It is unlikely that it was seen widely.

6.12 In 2009, there was major supplementary guidance to *Working Together 2006* on child sexual exploitation – *Safeguarding Children and Young People from Sexual Exploitation*.[27] This was the first guidance to use the phrase 'child sexual exploitation' and, like others in this section, described the sorts of abuse experienced by the six children in this SCR- other than the ethnic origin of the perpetrators.

6.13 There is very little missing in it from what guidance written today would say. It uses the definition of CSE still used (see 1.28 above). It refers to criminal groups. It emphasises the child-centred approach required of professionals and warns that professionals *"should be aware that children and young people do not always acknowledge what may be an exploitative and abusive situation"* and that *"Sexual exploitation of children and young people should not be regarded as criminal behaviour on the part of the child or young person, but as child sexual abuse".* It describes how to manage individual cases, the roles and responsibilities of the LSCB and agencies (requiring an LSCB CSE subgroup and a lead professional in each agency),[28] and has a detailed chapter on 'Identifying and prosecuting perpetrators'. This described most of the techniques which came to be used in Bullfinch around disruption, evidence gathering, and so on. It is all there.

6.14 The 2010 edition of *Working Together*, the last before the Bullfinch convictions, required LSCBs to include in their annual reports (a statutory requirement) *"progress on priority issues (for example, child trafficking, sexual exploitation and domestic violence)".* It also said: *"Every Local Safeguarding Children Board (LSCB) should assume that sexual exploitation occurs within its area unless there is clear evidence to the contrary, and should put in place systems to monitor prevalence and responses."*

6.15 It also left little doubt that it was talking about the sort of abuse that came to be understood in Oxfordshire. *"The guidance states that LSCBs should ensure that specific local procedures are in place covering the sexual exploitation of children and young people. The procedures should be a subset of the LSCB procedures for safeguarding and promoting the welfare of children, and be consistent with local youth offending protocols. The identification of a child who is being sexually exploited, or at risk of being sexually exploited, should always trigger the agreed local procedures to ensure the child's safety and welfare and to enable the police to gather evidence about abusers and coercers… The strong links that have been identified between different forms of sexual exploitation, running away from home, group activity, child trafficking and substance misuse should be borne in mind in the development of procedures. These should include identifying signs of sexual exploitation, routes for referring concerns,*

[27] HM Govt, 2009.
[28] It is an interesting illustration of the vagaries of national guidance that only two years later this statutory guidance *'should'* had been downgraded by a new government to *"the DoE can help LSCBs to consider if it is appropriate to…". Tackling Child Exploitation: Action Plan* (DfE, 2011).

advice on working with other professionals to disrupt sexual exploitation and support victims, gathering and preserving evidence about perpetrators, as well as how to deal with more complex issues such as those relating to the increasing use of the internet in sexual exploitation."

6.16 On complex case management and trafficking it said, *"Children do not have to be trafficked across international borders to be exploited in this way. There is evidence that some UK resident children, mainly young girls, are being groomed, coerced and moved around between towns and cities within the UK for the purposes of sexual exploitation."* (This was happening to some of the girls.) "*Relevant agencies should remain alert to the possibility that this can happen, and work together to address it."*

6.17 The Police have identified eleven items of guidance on missing children from 1997-2010. In 2009, there was 'Statutory guidance on children who run away and go missing from home or care',[29] which very accurately describes what was found in Bullfinch. *"Grooming for potential sexual exploitation: In some cases, young people may run away or go missing following grooming by adults who will seek to exploit them sexually. Evidence suggests that 90 per cent of children subjected to sexual grooming go missing at some point. The supply of drugs and alcohol or the offering of gifts may be used to entice and coerce young people into associations with inappropriate adults. Both girls and boys are at risk of sexual exploitation. Looked-after children may also be targeted by those wishing to abuse and sexually exploit them, and encouraging these children to run in order to disrupt their placement is often part of this abuse. Young people living within residential care units are particularly vulnerable to being directly targeted in this way."*

6.18 In November 2010, there was some publicity (but not to the later Rochdale or Rotherham level) about the convictions of a number of Asian men in Derby and the associated SCR. The circumstances of the cases were very similar to what was happening in Oxfordshire. In early January 2011, *The Times* published a series of articles, which promoted significant media and top-level political comment, about the sequence of convictions in recent years, the overwhelming predominance of Pakistani heritage men as convicted perpetrators, and suggesting blind eyes were being turned.

6.19 In November 2011, there was a further government publication, *Tackling Child Sexual Exploitation – Action Plan*,[30] which had strong ministerial backing. Although it mentioned nowhere that group CSE had actually been identified, there can be little doubt it was talking about the sort of abuse discovered in Oxfordshire, with strong messages for LSCBs: *"LSCBs… have a central role in overseeing much of the work set out in this action plan. The University of Bedfordshire research, however, found that many LSCBs have not identified child sexual exploitation as a priority issue in their area… The Government believes that LSCBs will want to assure themselves that local services are based on a robust assessment of need in the locality, taking account of the statement in the statutory guidance that every LSCB 'should assume that sexual exploitation occurs within its area unless there is clear evidence to the contrary'. They will also want to assure themselves that local services are designed and delivered effectively to tackle the issue where it arises."* The Oxfordshire LSCB had already set

[29] Department of Children Schools and Families, July 2009.
[30] *Tackling CSE – Action Plan* (Department of Education, 2011).

up its CSE subgroup, and Operation Bullfinch had already been underway many months when this came out.

6.20 In November 2012 the Office of the Children's Commissioner produced *"I thought I was the only one the only one in the world": the Interim Inquiry into Child Sexual Exploitation in Groups and Groups*, which LSCBs would have wanted to see as they contributed to the research.

6.21 Looked at now, there is little doubt that national guidance and reports across the early years of the 2000s, and especially around the end of the decade, were giving clear indications of the approach to exploitation, describing it well (even if in different words) and requiring action. The problem was that the guidance, especially that published more than two or three years ago, just did not have the required impact across the country – whether in towns that had a major challenge from CSE or other places. Subsequent inquiries by the University of Bedfordshire[31] and the Children's Commissioner found that only a minority of LSCBs had introduced key elements of the guidance. In 2013 (after Oxfordshire had successfully implemented Bullfinch), the Office of the Children's Commissioner[32] reported very patchy take up of the guidance. That suggests a problem across systems nationwide in grasping what was happening and needed, rather than individual failings – something about the process of issuing and responding to the guidance, and how guidance may not be absorbed if one thinks the problem described is rare and is occurring somewhere else. The notion that such widespread organisational poor response is down to most professionals or responsible organisations deliberately disregarding a known problem is not one the author finds credible. It seems mostly to be connected to organisations thinking such abuse happened somewhere else.

6.22 Even in November 2014, Ofsted[33] was still finding that *"Until very recently, child sexual exploitation has not been treated as the priority that events in Rotherham and elsewhere strongly suggest it should have been. As a result, local arrangements to tackle the problem are often insufficiently developed and the leadership required in this crucial area of child protection work is frequently lacking…"* In Oxfordshire, there has been a very robust response since 2011 – see Section 4.

6.23 In addition to guidance, there were also prosecutions on CSE. Before the main Rochdale convictions brought CSE to un-missable attention in 2012, there had been some convictions in Bradford, Blackpool, Oldham, Sheffield, Blackburn, Rochdale, Manchester, Skipton and Nelson. None of these registered CSE in the national consciousness until, to some extent, the convictions in Derby in late 2010 and then very significantly with the main Rochdale convictions, which were in 2012. If anyone was aware of any of the convictions before the very end of 2010, they would have had the impression this was a 'northern problem'.

6.24 The author recalls a common reaction to the 2009 guidance and requirements for CSE, which was outside most people's area of knowledge: 'who can we find to lead a CSE subgroup, who knows anything about it; group-related CSE doesn't happen here, does it?', etc. Any new large-scale requirement can be difficult for LSCBs, with actions having to rely on agencies volunteering time when they have numerous competing requirements. Independent Chairs

[31] 'What's going on to safeguard children and young people from sexual exploitation?' (University of Bedfordshire, November 2011).
[32] *If Only They had Listened: Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Groups and Groups. Final report* (November 2013).
[33] *The Sexual Exploitation of Children: It Couldn't Happen Here, Could It?* (Ofsted, November 2014).

may only have half a day a week. It is likely that, in many areas, the assumption that group-related CSE was something others had led to insufficient attention being given. This assumption and reaction, while regrettable and wrong, is not the same as knowing about local CSE and not acting. This SCR tells of a small number of relatively junior staff in two or three agencies who began to see the risks and increasingly knew about CSE; the learning came from the bottom up and not down from leaders. It was the grassroots knowledge of vulnerable children by a small number of determined staff which eventually led to system-changing action.

6.25 In summary, two factors seemed to prevent the guidance being used in recognising and dealing with CSE before 2011. For many years, guidance, whilst describing the signs of CSE, did so in the context of prostitution and trafficking rather than the language of the group CSE later identified. But, anyway, the prostitution was not recognised either. Secondly, even when the guidance became more explicit, group CSE was thought of as something that happened somewhere else. Nevertheless, there was a lot in the guidance that would have been very helpful, and much of it remains very apt.

7 ORGANISATIONAL AND LEADERSHIP AWARENESS

7.1 **Introduction:** When there is a period when performance across agencies does not have the required outcome, it is appropriate to ask whether the leadership of the agencies was doing all it could, or whether it had knowingly not responded to CSE issues. This section will describe the level of knowledge organisations and top leaders had and, if they had little or no knowledge, why this was the case. There is no evidence of governing bodies in the major agencies being aware of the CSE in terms of organised grooming and exploitation by groups of Asian males until at least early 2011 (the year in which Operation Bullfinch was formed) and reasons for this are examined. This is different, therefore, from Rotherham, where the inquiries concluded that warnings had been disregarded at the top. The SCR benefited from detailed reviews of the national context in the Police and CSC IMRs, and the author also commissioned additional reports from each agency analysing what was known at their higher levels in the period under review, to which all responded. SCRs, especially those commissioned under *Working Together 2010*, are not 'inquiries', so rely largely on self-report, but the author's own inquiries (which were responded to openly) have found no reason to challenge agency submissions.

7.1 Parts of this section may seem in places to be rather dense and bureaucratic, but the detail will aid professional readers who can see the impact of structures and processes on outcomes for children. However, it also sets out what was known about the children's suffering. The section is structured as follows:

- The headline priorities for the Police and CSC
- Oxfordshire's journey towards identifying CSE
    - The OSCB
    - The growing awareness in the County
    - The knowledge at the top of organisations
    - Operation Bullfinch
- Overarching comment

7.2 **Priorities:** Whilst the protection of children can always be said to be a 'priority', and there has been a major focus on child protection activities since Maria Colwell in the 1970s, that is different from saying the protection of vulnerable people was always in formal priorities set by government, and on which organisations and their leaders are performance managed. If an organisation does not meet those formal priorities (often known as targets), there are serious penalties to be paid. This point should not be exaggerated, as a hurt child is a hurt child whatever the target of the day, but as far as the Police and Social Services are concerned it is interesting to consider the issues for which they were under pressure. The author has looked at all Ofsted reports on Oxfordshire Children's Services from 2004 to 2014 and the words 'sexual exploitation' do not appear until after the Bullfinch case. There is no evidence therefore that Ofsted was looking to see how the County was dealing with CSE, even after statutory guidance was issued in 2009. This suggests that the notion that it could happen anywhere so everyone needed to be well prepared was not one that was inspected in practice; rather, it was something that only happened in particular places.

7.3 The Police IMR does not hide behind the fact that sexual exploitation, or even protecting vulnerable people, was not a national priority during the pre-Bullfinch years and

acknowledges openly that many mistakes were made. Nevertheless, it does point out that the key aspects of performance on which TVP was being judged did not include an emphasis on vulnerable people. It describes how the statutory performance indicators in the National Delivery Plan 2006-9 were mainly about rates of acquisitive and life-threatening crime, gun crime and violent offences per 1,000 population. There was no mention of child abuse in the Delivery Plan. The IMR says: *"The Home Secretary's 'National Policing Plan 2006-2009' guided local priorities particularly in relation to their performance target"* and described some local plans. *"It is also notable that like the National Policing Plan neither child protection nor missing persons featured in the performance data produced for this document, suggesting at this time neither were seen as a specific [local] priority, something reflected across the Force."*

7.4 This does not mean that staff who were working on, for example, missing persons did not work extremely hard at what they were doing, but does indicate the challenge to devote priority time to activity that might prove lengthy – and often fruitless as investigations were unlikely to lead to convictions. There was, however, no evidence of a knowing decision *not* to pay attention to potentially exploited or otherwise vulnerable children because of priorities. Again, not using this as an excuse but to illustrate the context, the County Council showed the SCR how intensive the external performance management culture was with, say, in 2008-9, 115 different targets for children and young people that had to be accounted for – none specifically related to sexual exploitation and one for missing children.

7.5 **Oxfordshire's journey:** This section goes into detail, as local agencies will learn from seeing how the knowledge developed in the uncoordinated way it did. There is no evidence that the overall position of readiness in Oxfordshire differed substantially from that in many other areas, but it is the case that from the mid-2000s there were girls (and more than A-F) who were sexually active with much older men, getting involved with drink and drugs and some associated crime, sometimes hurt, and often missing for substantial periods – so Oxfordshire may have had a greater chance than some areas to identify CSE. As will be seen, what is hard to explain is that, with many professionals very worried about the girls, with considerable resources being used to keep them safe (for example, in distant secure facilities) and 'missing' statistics which were unusually high, why the full picture did not emerge and the issue never percolated through to governing body level such as CEOs, Boards, or Committees. The 'journey' is described firstly by looking at the OSCB, which had a statutory oversight of child protection work, and secondly how things unfolded across the County over time.

7.6 ***The Oxfordshire Safeguarding Children Board (OSCB):*** The 2002 Oxfordshire ACPC (the predecessor body of the OSCB) procedures echoed recent national guidance and included *"Entry into prostitution usually involves a complex set of factors often including a strongly dependent relationship with a coercer or an abuser. Helping a young person to leave prostitution will therefore be complex, involving winning trust and overcoming fear, and may therefore take time… Children and young people living in and leaving care, especially residential care, are particularly vulnerable and those who run away even more so. Joint local authority/police procedures must be followed when young people go missing and when they return."*

7.7 The first reference to young people involved in prostitution in ACPC minutes was in 2005, where it was agreed that police and CSC would work on 'a piece of action research'. At the next meeting, it said that *"a member of the CSC's City team was working with the Police Child*

Protection Unit to identify incidents of 'sexual exploitation' with a view to further analysis", with the action allocated to the interim Head of CSC. The OSCB says there are no subsequent references to this.

7.8 In 2007, there were several mentions at the Board or its subgroups. In March 2007, the minutes of the OSCB (chaired by the CSC Head of Service) referring to its City sub-group noted '*... concerns about 14-15 year old girls in relation to drugs/prostitution/going missing, a problem which seems to be increasing. It was agreed that the Board needs to address this. Action is in hand locally".* (At interview, the then City subgroup chair said that local action meant "*We were dealing with the individual children's cases and managing the risk".*) In May 2007, the OSCB Core Group (a subgroup which monitored OSCB business), chaired by the Head of Service for CSC, agreed to a future agenda item, the "*role of child protection process in protecting young people exhibiting risky behaviour (drug abuse, prostitution etc) for July agenda". (*At the next two meetings of the OSCB Core Group, discussion was postponed twice due to the absence of the Police member, with any references then stopping after August 2007).

7.9 Parallel to this, the OSCB City subgroup met in June 2007 and recorded *"continued concern regarding cases of 14-15 year old girls exhibiting out of control behaviour and possible involvement in prostitution and drug use within Oxford"*. There was a case discussion about two girls, one of whom from initials used was one of A-F. *"… Police are feeling equally as 'stuck' as any other agency in how the negative influences for these cases can be addressed (i.e. Drug Dealing, Possible Prostitution, Missing Persons and high risk out of control behavior). Subgroup members agreed, at last meeting, that this required a wider/ joint response, but issues still appear to be being considered on a case by case basis. There is a serious concern that there is an organised abuse ring within Oxford and that a Complex (organised or multiple) abuse investigation should be considered".*

7.10 The action was for the subgroup chair, a CSC officer, to brief his two senior CSC safeguarding and quality assurance colleagues. There was no mention of this item at the next City subgroup meeting. There is no indication that a *"complex abuse investigation"* was held or actively considered. The Review understands that the County Head of Safeguarding wrote to social workers to try to obtain more evidence about CSE, but had a *"poor response"*, and it was not thought that complex abuse procedures should be implemented. There should have been follow-through to a formal conclusion. The point the subgroup minute made about things being looked at on a case-by-case basis, and it needing a wider, joint response, was exactly right and stayed the position until early 2011.

7.11 The OSCB, a week later in mid-June, had a verbal report of the City subgroup and minuted *'There are concerns about a number of young women coming into contact with statutory agencies who may be victims of organised prostitution. (A CSC service manager) is pulling together what information is known with a view to making a judgment about likely connections and the need for these cases to be addressed other than on a case-by-case basis."* The minutes made no reference to its City subgroup's view that *"there is a serious concern that there is an organised abuse ring within Oxford and that a Complex (organised or multiple) abuse investigation should be considered".* There is nothing in subsequent minutes. The OSCB IMR says that, at the time, there was no process in place to pick up items that dropped off the agenda.

7.12 In September 2007, the OSCB City subgroup met again and, as mentioned earlier, the City Nuisance Officer and a colleague warned about the risks to children from massage parlours and reminded the meeting that his team was continuing to pass to the Police information about 14 and 15 year olds being seen in cars with older men.

7.13 No further reference to the mix of drugs/prostitution/young teenagers has been identified in OSCB and subgroup minutes until the Bullfinch investigation.

7.14 In September 2008, the OSCB's Monitoring and Evaluation subgroup noted the increase in children going missing, and at its March 2009 meeting a member of the Missing Persons Panel said there were *"no specific concerns"*. That year, following a Joint Area Review[34] (a multi-agency external review), an OSCB Business Manager was appointed full-time for the first time to address the deficiencies in business administration. The OSCB says there are several recorded minute entries about insufficiently regular or senior attendance leading to insufficient *"promotion of child protection issues and disseminating information within their agencies".* (The March 2009 review[35] of progress after the Joint Area Review rated the OSCB as good, as has Ofsted since then.)

7.15 The 2009 statutory guidance was not picked up in any meaningful way. The OSCB explained to the SCR, "*From 2008 to 2010 there is an increase in the number of guidance documents raised at Board level, as evidenced by the Board minutes and associated papers. At the time the role of Business Manager… included producing an overview of recently published guidance and proposing recommendations to the Board for further action… this appears to have been left for the Business Manager to assign follow-up actions. There is no evidence these actions were arrived at in conjunction with the Chair… or any Board Member. This reliance on the Business Manager appears to have led to complacency amongst the members in challenging whether these decisions were the most appropriate ones."*

7.16 The Board members were not sent a copy of the guidance but alerted to its existence in a September 2009 agenda paper, which listed another 11 items of guidance from the previous six months. The recommended action in the paper was *"OSCB procedures to be reviewed against guidance. Put on website".* The minutes make no reference to it, so one presumes the fact that it contained much beyond simply 'procedures' was not noticed by members or Board officers. In fact, nothing happened until the January 2010 OSCB meeting, when a 'Sexual Abuse Mapping' paper went to the Board. It said that the Oxfordshire Safer Communities Partnership had set up a Sexual Violence and Abuse Group to *"drive forward the agenda".* Noting that a senior CSC manager had not been able to attend, the paper (which made no reference to CSE in the narrative) recommended that the OSCB *"require that a senior manager from Children's Social Care become an active part of the sexual abuse strategy group to ensure the needs of children are included in this strategy… This member to feedback to the OSCB on a 6 monthly basis the progress to date… ensure this member also pick up the work from the Government's Guidance on Children who are Sexually Exploited…"* A strategy was delivered for July 2010, but did not cover most requirements of the statutory guidance.

7.17 A senior safeguarding nurse on the OSCB told the Review that it was not that there was no consideration of CSE, but that it was *"simply not believed to be a local issue".*

[34] *Joint Area Review – Oxfordshire* (Ofsted, April 2008).
[35] *Final Evaluation of OSCB* (DCSF, March 2009).

7.18 The Sexual Violence and Abuse Group to which the OSCB passed the statutory guidance was not actually part of the OSCB, but was under the Oxfordshire Safer Communities Partnership, another multi-agency partnership, facilitated by the County Council. This was not or not wholly appropriate as the guidance contained statutory requirements for the OSCB itself.

7.19 In January 2011, the OSCB Chair and Business Manager received from the chair of the Board's City subgroup a City Council report on CSE. It was referred on to the Sexual Abuse Strategy Group (see previous paragraph) and seems never to have been put to the Board. The City report, which had been drawn up after surveying agencies' knowledge of the signs of CSE in their work, summarised national guidance, gave the results of the survey, highlighted the shortcomings in local services, referred to the recent major CSE case and SCR in Derby (Operation Retriever), and made many recommendations.

7.20 It came from the City's Drug Strategy Coordinator, but was the sort of report that should (under national guidance) have been prepared by Safeguarding Boards, or certainly given higher-level consideration. It was done because "*In late 2009 concerns were raised in Oxford by a professional that young school girls had disclosed that they were in receipt of high priced gifts in exchange* for *sexual favours",* and it identified that *"No data collection of children & young people who are 'at risk' or who are affected by sexual exploitation, No specific child sexual exploitation training for professionals, care pathways are generic and do not address specific concerns for children & young people who are being sexual exploited, and no specialist service who can offer support to those at risk, victims and/or parents/carer."* It was a useful review of national knowledge, organisational and training needs locally, staff perceptions of local risk from CSE, etc, but it did *not* identify the CSE as it was later understood. At the end of January 2011, the Drug Strategy Coordinator asked the OSCB City Safeguarding subgroup Chair if the report had gone to the OSCB Executive. The response was that it was understood the matter was to be put to an existing sexual violence group and asked whether the Drug Strategy worker knew the Chair of that group. *"I will discuss with [the Business Manager] as you must be linked in!"*

7.21 It was June 2011 before that report's author joined the Sexual Abuse Strategy Group and the minute does not indicate that her report was received. In any case, this was not an OSCB subgroup. By this time, Operation Bullfinch had started, although few people, for reasons of operational secrecy, knew the details. In the summer, as a result of some knowing what was being investigated, the Sexual Abuse Strategy Group was disbanded and replaced by the CSE Task and Finish Group, which, this time, was a subgroup of the OSCB. Invitations were issued in August 2011 and it had met before it was formally approved by the OSCB. The City Drug Strategy Coordinator was a member.

7.22 It is clear that failing to follow or to follow fully the 2009 national guidance was initially widespread in England, and the OSCB did go through a period when it was less than thorough on CSE, with no strategic oversight of the topic. It was not that it was ignoring messages about local concerns, but that, other than in 2007, such messages did not get to the Safeguarding Board itself until 2011.

7.23 Some former top CSC managers were critical of OSCB organisation/proactivity in their interviews with CSC. Before 2008 there was no Independent Chair. Other than the very part-time Independent Chair from 2008, all LSCBs consisted only of the senior representatives

from each agency, and the critics were some of the most senior and influential members. This raises questions about how much members of the OSCB fulfilled their statutory duties as members.

7.24 Safeguarding Board Annual Reports were statutorily required from 2010-11. The first contained no reference to CSE, but did include an article about missing children by the Detective Inspector in charge of the Police CAIU. It did not refer to CSE being a possible cause. This may have been because Operation Bullfinch had just started and great discretion was being used until arrests were made. In contrast, the 2011-12 report has tackling CSE as a priority. There is a CSE subgroup. It identifies there is CSE in the County, reports a July 2011 OSCB conference on CSE, and announces the forthcoming CSE strategy and the introduction on the Kingfisher specialist multiagency CSE team. The then Chair said that *"CSE has become a key focus for the Board…"*

7.25 ***The growing awareness in Oxfordshire:*** This part looks at how awareness grew across the agencies working with the families. The detail here highlights not only great effort in some quarters, but also who knew what, and learning about inter-agency connections. The awareness in the County came from those who worked with these children and families or in their communities and who had a growing sense, despite the girls' frequent denials and lack of cooperation, that there was something really awful happening. Many signs could have been seen, and the girls and families would at times give sufficient information for conclusions to be drawn. The headline milestones in the journey should not be taken to mean that nothing else was happening, as the 3,900 pages of agency chronologies testify. Many entries are the same event described by different agencies, but there would probably be up to 10,000 contacts and events. The momentum grew strongly in 2010 as various groups took the initiative, although not in a coordinated way, and staff who led those strands of discovery should be applauded for their determination and concern.

7.26 The paragraphs above on the OSCB describe some mentions of child prostitution from 2005, with nothing further on this or exploitation until 2007. However, there was growing awareness in 2005-6 of very serious cases and extreme behaviour associated with going missing, drugs, older men and prostitution that do not seem to have been addressed by the OSCB, its local subgroups or top managers – or, more accurately, not brought to their attention. With one of A-F, the following references could be found in her chronology of agency records in one period of less than three weeks in 2005.

- 13 years old
- Drug use – crack
- Symptoms of cannabis dependence
- Delivering cocaine/admits drug dealing
- 'They sprinkle coke on weed'
- Associating with 'older inappropriate males'
- Not eating when missing
- Frequently missing
- Returns home dehydrated and in neglected state
- Emaciated in police station
- Mother complains over 3 weeks is too long to wait for a multi-agency meeting
- Child left a note about 2 rapes – charges followed
- Blood soaked jeans and underwear

- May have been 'prostituting herself'
- Says she will be dead by 20
- Receives phone call with accented black man – she is in debt to men. Number given to police
- Being driven in and driving cars
- At risk of sexual exploitation
- Sexually assaulted by 2 males

7.27 There was very considerable agency activity in this period, but one wonders if this case was typical of many and did not stand out, or was so extreme that it should have warranted very top attention. In the same year, there were concerns about at least three of the other girls around going missing, adult men, drugs, coming back from missing with money, etc. One girl was branded. Despite this, there was no recognition of a Bulfinch-type coordinated and wide-scale abuse.

7.28 In 2006, there was the abandoned trial when a child refused to give further evidence under tough cross-examination. There was also concern about the management of missing children, especially from Care, as seen in the plea from the Police Missing Persons Coordinator to her superiors up to head of Oxfordshire level in September 2006, and there were meetings about individual children with good level multi-agency involvement. This included a Police DCI-led 'Tactical Meeting' (which may in part have been a response to the coordinator's email) with County and City staff present, as well as the private home where the girls were placed. It discussed multiple offenders described as a *"paedophile ring"* being arrested for offences against one of A-F. It was agreed that TVP would consult other forces about the subject in general and the child concerned (which led to the creation of the Missing Persons Panel).

7.29 The minutes show that, as well intentioned as the meeting was, much of what the child was saying was disbelieved, even though the notes showed that many signs of being abused were known. There was a discussion on using ASBOs and other control measures with *"the males".* This indicates an awareness of the possibility of group exploitation in 2006. There was also a very high level of concern for several of the girls across 2006. This is discussed further under 'Missed opportunities' in Section 8.

7.30 In 2007 the OSCB, as described earlier, twice recorded concerns by its City subgroup. In June 2007, after concerns were raised about a possible 'organised abuse ring', the County Head of Safeguarding tried to find supporting evidence and decided not to introduce complex abuse procedures, it is understood because he thought there was insufficient evidence. At the end of 2007 a strategy meeting was held about one child and her involvement with an adult Asian male (referring to violence from a man later convicted in Bullfinch). A few days later, cross-references to other children began to emerge when, at a strategy meeting with at least CSC middle managers present (but no police), others in A-F were mentioned. The notes say: *"Concerns regarding the association between a number of girls LAC/leaving care and adult men from the Asian Community".* Three from A-F were listed. The content of the meeting, although relating to different girls, was very similar to the meeting almost three years to the day later, which led to the first complex abuse meeting being called. It told of groups of men, sex with adults, drugs, drink, named men, and disclosures from a child.

7.31 A CSC chronology comment wondered whether this was the first strategy meeting where multiple victims were discussed. It may have been for three or more girls, but the September

2006 Tactical Meeting was about two girls and multiple men. However, earlier in 2007, the City Drug Strategy Coordinator, part of the City's Community Safety Team, attended the daily morning briefing of the Oxford Police as usual and heard about two of A-F absconding from Care and being with two adult males (later convicted in Bullfinch). She corresponded with a Police managerial colleague: saying "*There are a number of females in social services care and the missing persons who are going missing on a regular basis. Care Plans are in place for some but there seems to be little done about the males involved."* She asked if the care homes could stop the children or test for drugs on return. *"If all else fails note the details of the car, occupants and pass them onto the Police. Letters can be sent to the registered owner advising if found with the females again or in the area of the Home legal proceedings will be considered..."* The Police colleague replied saying she had told a senior officer about "*possible tactics that could be used against perpetrators"* in order to tell more senior staff.

7.32 The City worker forwarded the correspondence to the Missing Persons Coordinator who, in response, reported positive links with residential homes. *"I have spent many an hour with social services at the children's homes with reference to keeping their children safe. They are powerless to prevent them from leaving and are VERY well aware of the risks the children are exposing themselves to. I've a fairly good relationship with the staff and have been given some info re males, vehicles etc, which has all been submitted on 72s."*[36] This suggests that, by spring 2007, there was a degree of knowledge about multiple victims and perpetrators at least amongst those involved in the management of missing persons. This adds to the similar conclusion about 2006.

7.33 Across 2007 and 2008, the City Crime and Nuisance Action Team's (Canact) Nuisance Officer was repeatedly trying to alert CSC (and the Police) to concerns about the vulnerability of one Bulfinch victim. In March 2008, he alerted the senior Police officer in charge of Oxford, copying in a CSC social worker and the safeguarding manager concerned that a 13-year-old was connected to prostitution, was associating with adult Asian males, and was unprotected. (There was indeed very considerable Police and CSC activity around this child, but the gist of his concerns was that protection was not nearly robust enough and specific risks were being tolerated.) The records show he submitted personal sightings of the child in compromising situations with adults, and numerous intelligence reports gathered through his work about her late night contact with adult men despite being in Care.

7.34 In January 2008, a CSC manager told the Missing Persons Panel that one of A-F "*had been disclosing to her social worker her involvement in the past with groups of young Asian males from the [named] area and named other girls involved. [The social worker] described how [the girl] would provide information up to a point but was afraid to stand alone."* CSC says that a *"strategy meeting was to be held on February 5th at Oxfordshire County Council to look at girls with common stories/males for mapping. Details/minutes of meeting not located"*. A few days after that, the County Council Safeguarding Panel (which looked at complaints raised by Looked After children) discussed three of girls A-F. In two cases, the 'complaint against' was logged as *"Asian men' including X"* (a well-known Asian who had allegedly raped one of the girls at 11). The 'Concern' was listed as *"sexual exploitation".* The action was logged as *"strategy meeting held... intelligence being collated… names of other girls… registration of numbers of cars".* At interview for the CSC IMR, the Director of Children's Services at the time had no recollection of this and the Head of Safeguarding was *"not aware"*. The Head of

[36] An internal Police intelligence document on which information is shared and assessed.

Looked After Children services was aware, as was the CSC QA manager for safeguarding who was keeping a list of girls to be followed up at the monthly meetings.

7.35 In 2008, the Police Prostitution Strategy 2008-11 (which had been contributed to by the Drug Strategy and Domestic and Sexual Abuse Coordinators from the City Council) was produced, with good guidance on missing persons, grooming and so on – but it is clear at that point that there was no awareness of abuse on the scale later revealed, as it refers to only *"small pockets"* of prostitution.

7.36 The City Drug Strategy Coordinator chaired the multi-agency Sex Workers Intervention Panel, which began to hear about much younger females being involved. The Detective Inspector who later led the Bullfinch inquiry, on the back of a successful trafficking trial, and was keen to understand more about CSE, also encouraged her to explore further. She decided, in consultation with her manager, to set up a youth version of that Panel and in March 2010 the Prostitution Strategy Youth Group met with representation from 12 staff from the City, County and Health, with apologies from a Police schools officer. The minutes said that *"anecdotal evidence had come to light of young girls who were being groomed by much older men in Oxford. The men were buying expensive gifts for the girls who believed them to be their 'boyfriend'. This has raised concern and this scoping meeting has been set up to determine if other agencies are aware of young people, boys and girls, who are being sexually exploited. If they are then how prevalent is it and how are they responding. If it is agreed that there is an issue then how do we tackle it?"*

7.37 Interestingly, it said that *"all agencies reported cases of young people engaged in some form of exploitation".* (By 'all agencies', it meant the relatively junior staff with whom inquiries had been made.) The minutes say the form of the abuse included the following – a near perfect description of what was described three years later in the Bullfinch trial:

- *Older 'boyfriends' who buy expensive gifts for girls under the age of 16*
- *Girls granting sexual favours in return for somewhere to sleep for the night*
- *Girls selling their bodies to pay for a drug habit*
- *Girls being collected and taken to London*
- *Family member actively facilitating sex with their child*
- *Grooming solely to sexually exploit*
- *Abusive same age relationships, where the females believe that they cannot say no*
- *Young girls actively targeting older men to establish a 'father figure' relationship that is missing from their lives*
- *Young people going through the care system increasing the likelihood of being sexually exploited*
- *Young girls proactively engaging in sexual activity with older men for complex reasons*
- *Rape being used as a punishment within groups*

"In all of the cases reported there is professional involvement but the majority of the females do not see themselves as victims at this point and are not ready to listen to advice… It was agreed that there does appear to be a problem in this area but as there is no formal monitoring the number of girls being sexually exploited is impossible to quantify." The minutes say they needed to continue to develop a strategy to tackle CSE and bring the Police and some other agencies into the group. The pooled information at this meeting suggests considerable awareness of sexual exploitation a year before the Bullfinch investigation started, but the

minutes were not seen in any senior setting.

7.38 The day before this meeting, the Missing Children Panel, with no overlapping membership, had met and noted the 57 missing episodes from Home A in the previous three months. A month later, the OSCB (also with no overlap with those who were working on identifying the problem) appears from its minutes not to have a related item on the agenda.

7.39 The next meeting of the Prostitution group was at the end of April 2010 – this time described as the Youth Sexual Exploitation (YSE) Group, with senior police attendance. The group was working hard on a terms of reference and clearly, and to their personal credit, saw it as *the* setting in which the problem was to be tackled on a strategic basis. A subgroup of the YSE group met in May to map out all the tasks that needed doing, and was concerned how they could demonstrate there really was a problem so they could argue for funding support. A *"risk"* noted gave a view that senior management was *"reluctant"* and was nervous of funding issues – but about what request and which management was not specified. It was from this work that the City Drug Strategy Coordinator did the research and produced the December 2010 CSE Scoping Report, which is discussed above in relation to the OSCB.

7.40 While this was happening, concern was growing in the Police. In February 2010, a CAIU Sergeant was raising concerns about three girls who had gone missing 53 times from Home A in three months and a request was made for this to be discussed at the Missing Children Panel in March. In May, a PC in the East Oxford Neighbourhood Policing Team became aware of several girls being involved with older Asian males regarding prostitution and underage sex, and another PC logged 31 intelligence reports about the same thing. In June, a DC in the CAIU reported attending a meeting about seven girls (two from A-F) called by CSC. No minutes have been located but notes suggest useful exchange about involved places and names of adults. Donnington Doorstep also attended. This was one of three such meetings that were key in piecing the scale of the abuse together

7.41 The meeting above was called and chaired by a CSC specialist practitioner (senior front line worker) who worked in the CSC referral/assessment team, where she was *"seeing all new referrals at the assessment team, talking to colleagues at the office, and especially with the ex Home A colleague... the same names kept cropping up. I also picked up more as locality senior for East Oxford which included Donnington Doorstep, relevant schools and children's centres… There were three girls [two of girls A-F and another]. There was something else – we didn't understand what."*

7.42 Although often referred to in records as strategy meetings (statutory meetings to determine investigative steps on a child), they were not. Rather, they were 'professionals meetings', which are informal information exchange meetings. The chair's team leader was aware of the first and the area manager from the second. Minutes have only been located for one of the first three meetings, although one attendee kept personal notes seen by the Review

7.43 After that first meeting, the CSC Service Manager for Strategy, Performance and Development contacted the Youth Exploitation chair (the City Drug Strategy Coordinator) to ask whether she had any figures on child exploitation to assist with the sexual violence and abuse strategy she was working on with a colleague, also from the City. In a long response, she explained about the Youth Exploitation Group, the impending survey, youth workers' concerns about girls and older men, how youth workers felt they needed more

training, and her thoughts on how she could go about making links to take the work forward. The reply was that the Service Manager would raise this with the Service Manager for Safeguarding and the Chair of the Sexual Violence and Abuse Group: *"However, I agree if this is a growing concern, more strategic action will be needed."* (The CSC head of safeguarding told the CSC IMR he was unaware of concerns until 2011.) The same month, the City ran a conference on human trafficking *"especially women and girls into prostitution"* attended by 100 people.

7.44 The OSCB met at the beginning of July 2010 and approved the Sexual Violence and Abuse Strategy, which had some reference to CSE but was not a CSE strategy. Also in July, whilst conducting inquiries on one of the girls, officers were told by her social worker about four men she was believed to be associated with. Two days later there was a *"child protection (non-crime incident) report"* which said confusingly, *"This crime report has been created to collate information/intelligence/referrals etc in relation to a number of young females [including two of A-F] in the Oxford area who are suspected of being involved in the sex trade. To date there is a number of crime reports in existence. A number of the females concerned are also regular missing persons."*

7.45 A few days later two neighbourhood PCs attended the second professionals meeting chaired by the CSC Senior Practitioner about nine girls who were or might be involved with sexual exploitation, including the same two from A-F. Again, a number of males were named, with at least one later convicted in Bullfinch. The Drug Strategy Coordinator who chaired the youth exploitation meetings was there and recalls feeling concerned that the group was not meeting again until after the holidays and there appeared to be no plan in place to address what was being discussed about the girls. (The concern was not escalated.)

7.46 The Sexual Violence and Abuse Group to which was referred the City CSE report was another stream of meetings, in addition to those led by the City/Youth Exploitation and CSC, and the developing thinking by the Police. In October 2009, a multi-agency meeting of the Sexual Violence and Abuse Strategy Group (SCASG), occurred *"under the auspices"* of the Oxfordshire Domestic Abuse Steering Group (ODASG), itself a subset of the Crime and Disorder Reduction Partnership (CDRP). It said that *"reports will go to the Oxfordshire Safer Communities Partnership and CDRPs via OSDAG".* (The SCR understands that, while Community Safety Partnerships sit statutorily under Districts, the Oxfordshire Safer Communities Partnership sits under the County Council.) One of the Strategy Group's functions was to "*drive the Sexual Violence and Abuse Strategy".* Its place in the structure of meetings was unclear as the minutes say that "*SVASG would be a stand-alone strategic group but will be reviewed in future to determine if it would be better placed in ODASG".* It met again in early 2010 with an OSCB officer present and began to refer to children, noting that the OSCB had no sexual abuse strategy.

7.47 Despite this rather vague positioning, the group did do important work and created the Sexual Violence and Abuse Strategy that was presented to the OSCB on 1 July 2010 by a County Council Strategy Manager who had been part of the process. The strategy did have a children's section. The lack of clarity about structure was shown in the City IMR, which said the SVASG belonged to the Safeguarding Board, while also saying that when the Drug Strategy Manager went to her first meeting of the group in April 2011 it was *"convened as a development group rather than established partnership and will look for a longer strategic 'home' for this work".* This demonstrates that the process was not clearly 'owned'.

7.48 In August 2010, an intelligence PC prepared a report about children running away from care. "*Most were regular missing persons and intelligence suggested that they were being collected from the Oxford area and taken to addresses in the West London/Slough/Reading areas where they were supplied with alcohol and drugs and were then used for sex with groups of older Asian males. This report raises concerns that the males had returned and a 'new generation' of young girls were being involved in the same activity."* In another report, a CAIU Detective Constable told the Detective Inspector that she had visited all four girls (two from A-F) some several times, including *"one last time with their social worker".* Three of them denied any involvement in prostitution, and the fourth subsequently denied it. The Police had been conducting *"high visibility patrols/stop checks",* the PC had researched Facebook, mobile phone records were being examined. It concluded: *"I do not believe we are in a position to progress this investigation further at this time In my opinion, the only way… would be to conduct a covert operation in order to identity possible offenders and gather intelligence".* This shows much work by the Police in association with CSC, even if it concluded they could not act against offenders then.

7.49 In September 2010, the third of the CSC professionals meetings chaired by the Senior Practitioner (now an Assistant Team Manager) was held. The Police reported that all the relevant girls had been seen but there had been no disclosures. Six days later, the fourth youth sexual exploitation meeting took place with a range of City, County and Health staff, and the Detective Inspector for the CAIU. Like the previous meetings, it was chaired by the Drug Strategy Coordinator. Only a City Community Partnership Manager was at both meetings. It discussed the results of the survey the City worker had done. The numbers of cases reported by the respondents was more than had been referred to CSC. It was wondered whether they were referred without use of the word 'exploitation'. It was suggested the group contact the Chair of the OSCB. The Inspector suggested a presentation at the OSCB to include gaps in return interviews of missing children

7.50 In October 2010, at an Oxford City Police meeting, another Detective Inspector discussed one of the children who was missing being involved in prostitution, and the CAIU met with the Children and Families Assessment Team regarding a number of girls. The Police note that there was a *"joint decision that without further actionable intelligence or disclosures this could not be progressed any further".* Later in the month, a CAIU report showed that there had been 204 missing episodes from Home A in the first ten months of 2010.

7.51 In the autumn the Youth Exploitation Chair (and two other City colleagues) joined the National Working Group (NWG) on Child Sexual Exploitation – a network of projects, practitioners and policymakers. *"It gave me a huge amount of knowledge, contacts, resources – and access to the lead of the NWG."* She informed the Oxford DCI of the Leicestershire Police model and *"obtained copies at his request including the policy which was currently being reviewed by the National Police Improvement Agency (NPIA) for adoption of good practice nationally".*

7.52 In November 2010, the CID Detective Inspector who later initiated the Bullfinch plan first *"recognised the potential for wide scale abuse and began work to identify the full details of the offending"*, a view which he further confirmed in January 2011. Also in November, there was a Child Exploitation Project meeting chaired by the City's Drug Strategy Coordinator to discuss how to take forward the findings of the survey and resulting report. This had more senior presence, with the Chair of the OSCB's City subgroup and the Designated Nurse for

Safeguarding (who was to forward the report to the OSCB), the District Council's representative on the OSCB, as well as the County lead on teenage pregnancy. In December 2010, the City CSE report described above was sent to the OSCB, although with little apparent response.

7.53 In December 2010, concerns were mounting, on top of considerable ongoing casework by CSC. Mid-month, the City Drug Strategy Coordinator wrote to CSC, the Police and Donnington Doorstep: *"I have been informed that the two girls are linked to a well-known sex worker… maybe introducing them into the ways of working. It is believed that the girls have been in her company whilst getting into a vehicle. They have also been seen at hanging around a known sex worker's address on the X Road… is believed to be out all night staying at her boyfriend's who is believed to be 21 years old [later found guilty of nine offences at the Bullfinch trial]. Mum seems to know where he lives and the relationship that [the child] has with him, may have been in this relationship for a number of years… You may already have this information but I am very worried about what is happening to these girls. The girls refer to themselves as prostitutes but in reality they are abused children as they cannot give consent. Is there any way that the girls can be removed from Oxford and found a place of safety? I am really scared that something serious will happen to these girls.*

I am trying not to be too dramatic but I really do have concerns and would recommend a case conference with all the agencies who have any contact with the girls to talk, with the girls present and their parents and explain what could, would, will happen if this continues… It would be helpful if the police could, where-ever possible, engage with the girls and give warnings to adults present about their involvement with these children. It maybe that the police consider issuing warning/harbouring notices to these adults."

7.54 It appears that, in response to this, CSC called a strategy meeting for the following day which included City, County, Police and Donnington Doorstep staff. Again, names of victims, perpetrators and addresses were pooled. The chair was the senior practitioner's team manager, and included Police and the CSC area manager who invited her Assistant Director. The notes, discussing one of A-F, said: *"…sex exploitation – discuss with (CSC head of safeguarding) we need to focus on this".* And also, *"Report being prepared for [the Chair of the City OSCB subgroup] to take to the OSCB".*

7.55 As a result of that meeting, and the worrying information being mapped about a number of girls, the CSC Assistant Director immediately wrote a briefing note to the then Deputy DCS (and Head of Service for CSC) referring to the information pulled together by City, County, Police and other professionals saying, *"… there are at least [five] girls known to social care who would appear to sexually expolited by much older men, a network of girls… (some are care leavers) linked to both adult sex workers schedule 1 offenders and half way houses for offenders… This was eye opening and as you can imagine extremely concerning."* It referred to three of the girls associating with Asian/Afghani men. A response is not in the documents provided, and there is no record of a follow-up meeting (given the level of concern) for six weeks, when CSC invited, at the end of January, a large multi-agency group to a 'highly confidential' Complex Abuse meeting on 9 February 2011. (There had been work in CSC on mapping information which had led to calling this meeting.)

7.56 Also in December 2010, the Greater Manchester Police (GMP) came across an Oxford girl in their Rochdale inquiries. She indicated a similar pattern in Oxford. There was communication

between GMP and TVP and the girl's Oxford social worker and the Police. The social worker's notes stated that a GMP email had said there had been *"an email from police in Oxford to say that there is a similar enquiry happening in Oxford… regarding child sexual exploitation".*

7.57 The CSC Assistant Team Manager called a 'planning meeting' around two of the girls for 17 January 2011. No minutes or attendance have been identified, other than a brief note by one attendee. The following day a decision was taken to call a Complex Abuse Strategy meeting.

7.58 On 20 January 2011 the OSCB Executive discussed the annual Missing Children Report. The Chair of the OSCB City subgroup, and the senior manager who had alerted the Deputy DCS in December to the sexual exploitation were there. *"Missing Children – There is more work to do in this area. There appears to be an issue with regard to the approach taken when dealing with frequent runaways. Each instance needs to be as thoroughly looked at as the first. Why they went, where they went and who they were with should be fully explored through return interviews as we need to know more about who they are with when they're gone. Within Oxfordshire most of the missing children reports come from the same few children.The Missing Children Panel is a case discussion panel and does not have sufficient strategic oversight of Missing Children. There needs to be a formal strategy... The Terms of Reference for the Missing Children Panel need to be checked to see if this is a function they could also pick up and if it would be suitable for that group. The Thames Valley guidance on Missing Children has yet to be signed off by all authorities. When it has been Oxfordshire need to ensure they are compliant."* There was no reference at that OSCB Executive to any of the concerns about CSE discussed at professional, strategy, Police or youth expoloitation meetings held over the previous year.

7.59 The same day the local CID Detective Inspector chaired a CSE scoping meeting, which included seven Police staff and the author of the City CSE Report, although the minutes incorrectly say she was from the County Council. This was essentially an operational meeting about tactics and information gathering – largely around girls missing from Home A. The meeting Chair told the Review that this was the point at which he decided that real action now had to be taken.

7.60 As a result of this meeting, the DCI for Intelligence and Protecting Vulnerable People wrote to the Deputy Director of Children's Services at the beginning of February 2011 to say "*There is significant intelligence to suggest that the national trend of local Asian males targeting our most vulnerable girls is occurring in the city. A number of these girls are housed within your institutions and we have particular intelligence relating to (Home A)... There are a number of options and tactics available to (the Oxford DCI) when considering long and short term solutions all of which need careful consideration. As some of these tactics are quite sensitive it is important we consider the appropriate engagement with yourselves as a starting point. This is particularly prudent in light of (the service manager for safeguarding's) work around grooming, prostitution and exploitation… What would be a good start is for the 5 of us to get together to discuss the situation and agree a way forward."* The Vulnerable Persons DCI was informed of the impending Complex Abuse meeting and asked the senior officer who had led the 20 January scoping meeting to attend.

7.61 Eight days later, on 9 February 2011, there was the first strategy meeting held under the 'Potential Complex Abuse Case' heading with a large attendance from CSC, health (the designated nurse) , the City, the voluntary sector and the Police (both the Oxford DCI and

CAIU DIs). The 28 January email invitation from CSC said that *"Family Support Teams in Oxford City have identified some potential links between children… that may indicate a grooming network for CSC."* The meeting discussed a number of girls, including three from A-F. It was chaired by the CSC Service Manager for Safeguarding. The Chair's pre-minutes note of the meeting said, *"During December and Jan 2011 social workers in the family support teams in the city noted continuing concerns relating to [five girls]. On January 18th the area service manager for the city and service manager for safeguarding met, a complex abuse strategy meeting was arranged to continue mapping out the concerns and inform the need for complex abuse investigation."* There was no mention of the 1 February top-level approach from the Police about group CSE being identified in the City, but three of the recipients of the 1 February email were there. It was a very detailed meeting sharing information, including 26 suspect addresses and health concerns.

7.62 The meeting concluded that there were *"some very worrying concerns…* and… *several participants remarked on the worry that this had been going on for some time".* It was also recorded that the police investigation so far had *"met a wall of silence".* The meeting concluded the need for *"absolute confidentiality"* to ensure no possible offenders were alerted. A large range of operational actions were agreed, and the Head of Safeguarding for CSC agreed to brief the DCS, with the intention of setting up a senior management group by 18 February 2011 *"to drive the investigations forward*" as per the Complex Abuse Protocol.

7.63 The Police have described the 9 February meeting as *"a critical meeting where for the first time all agencies involved acknowledged the extent of the potential abuse and in effect identified that child sexual exploitation was occurring".* After this meeting, the CSC Head of Safeguarding discussed it with the Interim Deputy Director who briefed the then DCS. The DCS informed the CEO and Lead Member for Children, and the CEO briefed the Council Leader. The next day, the City IMR says, *"the [Chair of the Youth Exploitation meetings] met with police to discuss issues and allocate tasks".*

7.64 The SCR has seen a helpful briefing note about the analysis and proposed investigatory work from the Interim Deputy DCS (who became DCS in November 2011), which it is believed was sent to the OSCB Chair (and top County officials), again urging confidentiality. For reasons which are not fully understood, the City Council CEO was not briefed for a further year, in March 2012, by either the Police or CSC.

7.65 In March 2011, the CID DI communicated with Oxford staff about the Home A girls being targeted, directed staff to pay particular attention to the males they were with, and provided guidance on Abduction and Harbouring Notices. The Assistant Chief Constable and then the Chief Constable were briefed in April.

7.66 ***Top of the office knowledge:*** A key issue in this Review is how long it took for concerns across the field to be coordinated and then reach the highest reaches of organisations. In the NHS there is no evidence that anything went to a board-level manager until after Operation Bullfinch had started. (One parent in 2004-6 did copy the Social Services Director into several letters to an MP, worried about the care and management of the daughter. One of the six letters did refer to the child being trafficked to London from another area where she was Looked After. The traffickers were not connected to Oxfordshire). At Donnington Doorstep the management was aware of individual cases from 2007, and was part of the meetings across 2010 which began to build the collective picture which Doorstep was itself seeing.

7.67 In the City Council, the Chair of the Community Safety Partnership (a Director, not a member) and the Partnership were aware of the national cases of CSE. It was from the Community Partnership arena that the work done leading to the City's December 2010 CSE Report emanated. The City CEO was not briefed on this work, but was briefed by the County DCS in March 2012 about Operation Bullfinch and recalls that he was shocked to hear what was happening, as was the City Council Leader who the CEO immediately briefed. The City says that *"was [the CEOs] first knowledge of the cases involving the children and also to the prevalence of Child Sexual Exploitation in the city".* This raises issues about inter-agency communication and internal escalation, as City staff were aware of at least the generality of Bullfinch. It is possible that those staff followed the Police request for complete confidentiality and did not even have discussions internally, but the Police, the SCR was told, assumed staff in the know would tell their seniors! The author is surprised that the City CEO was not taken into the inner fold of Bullfinch at the beginning, given that the offences were mainly in the City, its community safety role, and the role played by his staff in raising awareness of CSE.

7.68 At the County Council, there were long periods when concerns did not seem to be escalated above Head of Service level, or even at times to that level. The CEO said that she was first formally informed in writing about CSE in February 2011. She says: *"I was immediately alerted by the then DCS as soon as she herself had been briefed by her Interim Deputy Director... I also have a clear recollection of the deputy... [giving] me a heads up and saying words to the effect that he thought we might have a group operating similar to one of those in the north... Prior to this I had no knowledge of the concerns about CSE in Oxfordshire... I was subsequently made aware of concerns about a number of girls, some of whom were looked after but others who were living at home, who were suspected of being abused by adult Asian males. I was also made aware that there were concerns of historical abuse of a similar nature. At that stage we did not know the extent of the alleged abuse but obviously we quickly began work to identify this and thereafter I was regularly kept informed of progress... No previous Director had ever raised concerns about this issue with me. I had therefore not raised the issue previously with the Leader of the Council, the Lead Member or any other Elected Member."*

7.69 As the Deputy Director overseeing CSC was aware of pretty serious concerns from at least mid-December, it is surprising that neither the DCS nor CEO and Lead Member were briefed until after the Complex Abuse meeting nearly two months later. Escalation also did not happen to very top Police officers for some time after the pattern began to be recognised, which is also surprising.

7.70 The Chief Constable summarised the position for the SCR. *"The first time the issues, that were to become Bullfinch, were taken beyond the Police area occurred was when (the CID DI) highlighted his concerns to the Head of Crime, Detective Chief Superintendent… early 2011. Initial inquiries continued until the matter was taken to the appropriate Assistant Chief Constable who was responsible for both Oxfordshire and Force Crime... who then briefed me on Operation Bullfinch in April 2011."*

7.71 ***Operation Bullfinch***: In May 2011 Operation Bullfinch formally commenced following preparatory work and resource commitment by both the Police and Children's Social Care from Oxfordshire County Council. The joint Police and County investigation team comprised Police officers and staff and two senior social work managers seconded from CSC. This

ensured an aligned approach to the management of victims and eased the ability to share information. The investigation progressed identifying suspects and liaising with potential victims to obtain disclosures of sexual abuse. It proved very challenging to obtain disclosures from the victims as most were, understandably, mistrusting of any form of authority and the relationships were particularly difficult to maintain. Innovative but challenging tactics were used to secure forensic evidence which would prove critical at Court.

7.72 In April 2012, over twenty males were arrested in connection with the disclosures made by the victims and forensic evidence. Nine men were charged with various serious offences. Throughout this period the most challenging part of the investigation remained the ongoing management and support of the victims. Extensive work was undertaken with the CPS to overcome significant legal disclosure issues. The scale of this task required the CPS to employ two dedicated 'disclosure barristers' in addition to the prosecution barristers. The trial began in early 2013 and after several weeks the jury found the majority of the defendants guilty.

7.73 **Comment:** In many respects, organisational knowledge and reaction to guidance in Oxfordshire was similar to elsewhere, as national surveys have shown. There was the same slowness to grasp what was happening, and similar limitations in skill in how to tackle group-related CSE, as has been seen elsewhere – and not just in places with notable trials. What was to some extent different was that in the County, and mainly the City within it, there were more signs pointing in the direction of exploitation than would have been seen somewhere where there was no group-related CSE. In other words, there was an opportunity. In each year from 2005-10, there were discussions in one setting or another in Oxfordshire about sexual exploitation, but hardly any of this was at a level that could have made a strategic difference.

7.74 The author is not sure that the fact that seeing what was happening as prostitution, out-of-control teenagers, the result of home problems or whatever is sufficient to explain how it was so many years before there was concerted action and top leaders became involved. It might not have been understood as CSE, but there was little doubt the girls were suffering badly – even if it was thought to be self-induced. Not knowing the full picture does not explain some of the individual case management. The girls were only 12-15 years old.

7.75 It must raise a question about the culture of escalation in Oxfordshire, where top leaders seem never to have been briefed or consulted about what many of their staff were struggling with, or even interagency disputes. Also, about the effectiveness of the OSCB which appeared fairly peripheral at the time to the growing awareness of CSE. The report about CSE from the City was not put to the Board. It also raises questions about the working relationship between the County Council and the City Council, especially given that most of the abuse was in the City.

7.76 If important information does not reach the very top, it must be a combination of issues which relate to both escalating and receiving escalation. The OSCB and its member agencies will need to be assured that there are, now, more effective systems of escalation for concerns about abuse (both within and between agencies), that the OSCB is managed so it effectively implements national requirements and indeed holds the safeguarding ring in the County, and that there are open effective relationships around safeguarding, especially sexual exploitation between major agencies.

8 APPRAISAL AND LEARNING

8.1 Introduction: This section makes an appraisal of how agencies worked in Oxfordshire, looking at the context and explanations from previous sections, and forms a view on their performance back to 2005. Professional responsibilities for keeping children safe are both agency and collective. It is important to acknowledge the vast amount of work by professionals in all agencies with the girls and their families. Reference has already been made to the nearly 4,000 pages of chronology itemising agency dealings with the six girls, and the author could see evidence of daily work over long periods of time of a very challenging nature. This is not a story about not trying, but the degree to which the effort was effective in preventing or intervening to stop exploitation. Looking back now, even if there was enough information to indicate something very bad was happening, the CSC IMR author, referring to the full horrors of what emerged in Bullfinch, commented that *"It was striking at interview that all the social workers and managers had been shocked when they found out via internal briefings and external media reporting what had actually happened to the girls with whom they worked."*

8.1 As far as CSE is concerned, Oxfordshire has made very significant progress from the time in 2011 it was finally realised there was a pattern of organised CSE and multiple victims (see Section 4). It now uses modern methods of perpetrator-focused intelligence gathering, disruption and prosecution. The old attitude of the victims being responsible for their own plight has gone. Top leaders have shown high levels of personal commitment to tackling CSE, as well as the commitment of their agencies. People now visit Oxfordshire to see how things should be done. Nevertheless, it is right to see what can be learned from the period where arrangements were not nearly as good as they are now.

8.2 Learning points: Some 'learning points' from the SCR are itemised under each heading. Asking in these points for something to be checked against current practice does not be mean that it is necessarily not now in place, but emphasises the importance of agencies assuring themselves that it is. Some learning points may seem bland when compared to the dramatic stories in this Review, but they are about creating the environment within which front line work with the most difficult cases can be nurtured. This Review is being written up to four years after the corner was turned in Oxfordshire, and many learning points itemised below are already subject to work, for example in the OSCB CSE Action Plan. Where that is the case, these points act as further confirmation of their priority. A much more detailed description of the rich learning points for each agency can be seen in the *CSE in Oxfordshire: Agency Responses since 2011* report published alongside this SCR.

8.3 Were mistakes made? This SCR tries to understand why agencies responded as they did in order to learn from it. Although much of the response is understandable in the context of the time, it is clear that mistakes were made. There has been no attempt to deny this and the two most involved agencies have issued clear apologies. The Chief Constable apologised that it took so long to bring the offenders to justice and was sorry that "*we did not identify the systematic nature of the abuse sooner and that we were too reliant on victims supporting criminal proceeding"*. At the time, she wrote to all six victims and apologised, and met with three of the girls to make the apology in person. The County Council CEO was *"deeply sorry we were not able to stop the abuse sooner"* and said, *'We would like to publically apologise for not stopping this abuse sooner."* The DCS met four of the victims personally. It is clear to the author how shocking agencies and professionals have found the full revelation of the abuse,

and that opportunities to intervene were missed or belated. The author has encountered no efforts to deny the scale of abuse or that there were errors. The County Council offered and provided the children with (where accepted) a range of practical and material support in relation to post-trial normalisation of their lives. This recognised that victims lost a lot of normal opportunities earlier during their abuse, for example by not being able to complete their education.

8.4 Section 5 described in some detail the agency-based delays, and a summary of errors is as follows. Some were agency specific, some system wide. Many of the issues have been seen wherever else CSE has come to light, but some were more Oxford specific.

Lack of understanding led to insufficient inquiry

- National guidance was not widely understood or followed
- The behaviour of the girls was interpreted through eyes, and a language, which saw them as young adults rather than children, and therefore assumed they had control of their actions
- At times, their accounts were disbelieved or thought to be exaggerated
- What happened to the girls was not recognised as being as terrible as it was because of the view that saw them as consenting, or bringing problems upon themselves, and the victims were often hostile to and dismissive of staff
- As a result, the girls were sometimes treated without common courtesies, and as one victim described it by *"snide remarks"*
- There was insufficient understanding of the law around consent, and an apparent tolerance of (or failure to be alarmed by) unlawful sexual activity
- There was insufficient understanding of parental reaction to their children's behaviour and going missing, so distraught, desperate and terrified parents were sometimes seen as part of the problem
- There was insufficient curiosity about what was happening to the girls, or to investigate further incidents or concerns which on review now appear to be crimes or something for formal child protection investigation
- Although there were very few formal disclosures, there were many, often stark, indications that what was happening to them was extreme and out of the ordinary
- There was insufficient attention to investigating and disrupting the activities of the alleged perpetrators (compared to the effort to contain the girls behaviour), and various available legal tools were not used
- There was insufficient understanding of how the City Council's community safety function could contribute to the prevention and management of CSE

Day-to-day processes were not strong enough

- Insufficient use was made of Child Protection processes, and staff sometimes allowed parental reaction to prevent Child Protection processes being used
- Processes in CSC, such as supervision and the quality of reviews, were not strong, especially in 2006-9
- Minutes of multi-agency meetings and review were largely of low quality or missing, which weakened planning and information sharing
- Recording of 'crimes' was inconsistent
- Transfer of educational records between schools was poor

- The provision of alternative education after exclusion, or of post-secure placement education, was slow
- In Health, there was insufficient sharing of information heard from or about the girls (often for 'confidentiality') and LAC medicals were often done without full knowledge of history and context

The organisational response in Oxfordshire was weak and lacked overview

- Escalation about serious concerns about looked after children and emerging patterns did not reach governing body level or chief officers for several years after they had begun to emerge in 2005, and again 2006-10
- When some signs reached the ACPC and OSCB in 2005 and 2007 respectively there was insufficient curiosity and no follow through
- The OSCB, before late 2011, did not lead the scoping, understanding and prevention of CSE after the 2009 statutory guidance, and member agencies comprising the OSCB share that responsibility
- Whilst before 2010 there was much less recognition of the connectedness of cases, or the organised nature of perpetrators, both within and across agencies the growing awareness in 2010 still did not reach top management or the OSCB
- Before 2011, there were fewer processes in place to help form a force-wide Police view of developing problems
- There was a gap of one to two months between senior managers being aware of the bigger picture, or at least the strong likelihood of a bigger picture, in late 2010 and very top management being informed

8.5 **Could CSE have been identified or prevented earlier?** The simple answer is yes. In practice, identifying CSE has proved difficult in many parts of the country, and it is likely that there will be more discovered elsewhere. Wherever it has appeared and led to convictions, there seem to have been warning signs not picked up earlier, a difficulty in believing such things could happen, and an attitude that looked more at victims than perpetrators as the source of the problem. This has been regardless of guidance, which has (even if using different terminology) for many years described the signs of child sexual exploitation and offered guidance on action. The issues contributing to the delay are appraised below.

8.6 ***Missed opportunities***: There was a window within which a number opportunities to recognise what was happening were lost. Given the general level of knowledge at the time, the then evidential requirements and the then lack of experience elsewhere, it would be wrong to conclude that Operation Bullfinch would definitely have happened earlier, but it might have done. In 2005-8, there were some significant concerns about multiple victims and abusers to a level very similar to that which, in 2010-11, led to Operation Bullfinch.

8.7 In 2005, there was considerable concern about some girls who we now know were being exploited. A detailed illustration is given in 7.23 above. There was similar knowledge in 2006 with the plea from the Police Missing Persons Coordinator, only a constable, to quite senior colleagues about the need for more action in relation to two girls, the need to go after the perpetrators, and expressing a fear that even death might occur. The same month (September) the police-led, multi-agency 'tactical meeting' discussed multiple offenders using the phrase *"paedophile ring"* and hearing allegations of rape by multiple men.

8.8 The coordinator's concern and the focus of the meeting were two girls in particular, one of from the 2005 example. The purpose of the table below is not to criticise action by front line staff – their work was dominated by these girls daily, and there were investigations, arrests of six men for offences against one child, residential staff out searching, medical care provided, Police visiting other areas to learn more, and very little consistent evidence was given. The purpose is to argue that what was happening was so extreme that it required attention by the highest levels of management, who, with their greater distance, may have been able to bring a more strategic approach to the problem and may have been able to identify patterns. It is also to query why these concerns were not reported to governing level.

8.9 The table shows extracts from agency chronologies of two girls in a period of around six weeks around the time of the tactical meeting, so both Police and CSC staff were aware of the detail (and doing a lot of work around these children). It would be hard not to conclude by this point that there was an organised element to the abuse. However, to put this in context, in 2006 there was little experience anywhere in the country of identifying, let alone getting convictions for, CSE and cases were still being seen as relatively isolated, with little chance of successful prosecution.

First girl, age 14/15	**Second girl, age 14**
Frequently missing from care home	Frequently missing from care home
Gave addresses where abuse happened	Gave same addresses as first girl
Admitted 'underage sex' with a group of Asian males	Advised police that she and the first girl had stayed the previous night in a multi-occupancy dwelling where there was drug taking. She showed police several addresses … described that the occupants at one address had two firearms
Drank a bottle of Jack Daniels	Said she had sex with four men one night, two the next and one the night after – in their 20s and 30s
Admitted to hospital, alcohol poisoning	Reported an oral rape
Tells hospital her friends have sex with her	Found by police with several Asian men who she said she had had sex with. Men later convicted in Bullfinch also arrived
Describes rape by two men convicted in Bullfinch six years later	Multiple arrests of Asian men
Told residential home staff she had sex with at least seven Asian men aged 17-33, with two older	
Told police she had oral sex with eight men in return for alcohol	
'These men are my protectors'	
In a crack den with Asian males	
Strategy meeting planned but did not happen	
Eventual meeting talks of 'paedophile ring'	
Thought to be having sex for drink drugs, lifts	
Tells police she has had sex with several Asian men	
Twice stopped by Police with an Asian male later convicted in Bullfinch. Told Police she was afraid of him, and that he and her friends knew her age	

Found with same man a week later and alleged rape	

8.10 There was a recognition that the management of missing children needed to be better, advice was taken, and the Missing Persons Panel introduced. But it was still not recognised that the prime focus on managing the girls was not the right approach.

8.11 In 2007 the OSCB was twice alerted to concerns from its City subgroup. The Board minutes in March noted, concern about an 'increasing' problem of 14-15 year olds going missing, agreeing the Board needed to deal with it, and action was 'in hand locally. In June, the Board noted its City group's concern that girls could be victims of 'organised prostitution' (the subgroup minutes called it an 'organised abuse ring'). The Board minute did not refer to the subgroup's view that a "*complex abuse investigation"* may be needed, or the "*need for a wider/joint response"* (rather than just tackling it on a case by case basis). The subgroup had agreed these views would be passed to County safeguarding managers. There is no evidence of significant action as a result of these concerns.

8.12 In 2007, the minutes of six OSCB and subgroup meetings refer to risks to young teenagers including from drugs, prostitution, and associated risky behaviour with men. Either attending, or seeing, minutes would be a range of senior managers and safeguarding staff (below director level). However, concerns were never revisited, and did not reappear in minutes for four years. The SCR has seen no evidence of this being in anyway a deliberate suppression, but it is clear that the OSCB and its member agencies should have taken it more seriously and reached minuted conclusions on any necessary action. For context, CSE by Asian groups as it later emerged was an unknown issue in 2007.

8.13 Also in 2007 (and 2008), there was the concern expressed by the City Nuisance Worker around one child aged 13-14, with numerous reports of association whilst in care with adult males late at night. In December 2007 there was a strategy meeting about one child about a missing girl marked by a man later convicted in Bullfinch, and threats from this man's family members. Eight days later, there was a very significant strategy meeting, which noted: *"Concerns regarding the association between a number of girls LAC/leaving care and adult men from the Asian community".* The meeting discussed groups of men, sex with adults, drugs, drink, named men, and disclosures from a child. It also discussed an incident for which there were convictions six years later in the Bullfinch trial.

8.14 The statistics on 'missing' in this period were also worrying. From 2005 to 2007, three of the girls went missing a total of 359 times, with 161 of those occasions being from Council care. In 2006 and 2007, Oxfordshire had almost half the missing from care episodes in the TVP area with only a third of the population. Half of all Oxfordshire missing from Care episodes in 2006 and 2007 were for two girls from A-F, so it is hard to argue that these were not exceptional cases. (The missing from care episodes in Oxfordshire continued to grow in 2007-8 and 2007-9, although the contribution from A-F was much smaller, which suggests the possibility of more girls being trapped by groomers.)

8.15 In 2008 the Missing Persons Panel, the County Safeguarding Panel and the Nuisance Officer's referrals all discussed exploitation by adult Asian males. In 2009, Donnington Doorstep was sharing concerns about girls and adult men. Early in 2010, the junior respondents from 'all agencies' reported to the Youth Exploitation Group a full range of signs

of CSE, and professionals meetings began to put the picture together around specific girls. The first any of this got to Director level was December 2010. The OSCB and agencies must make sure that there are processes in place so this could not happen again

8.16 There were also in 2005-8, for just four of A-F, 12 reported sexual assaults by some of the men later convicted in Bullfinch. Only two led to convictions, mainly due to evidential weaknesses, but this only led to a sense that little could be done, and the sequence did not seem to be discussed in any forum where the pattern could be recognised.

8.17 From what was recorded over these years, at least a partial picture of a group of girls, links with being LAC, multiple Asian abusers and real harm to those girls could have been formed. The component parts of that picture were seen to some extent by operational staff and some more senior staff in the CSC and the Police, but they did not trigger, in their un-joined-up state, a collective high-level managerial and strategic response, as occurred in early 2011. In the author's view, the level of information known by 2007 was not dissimilar to that which was sufficient in 2011 to trigger the discussions that led to Bullfinch, so opportunities were indeed missed.

8.18 The CSC IMR came to a similar conclusion about the depth of knowledge from 2005. It said: *"There can be no doubt that from 2005 onwards there was knowledge of these and other young girls being involved with older Asian males."* It gave many examples of girls being found with men convicted years later in Bullfinch, of events which were not fully investigated, for which there were convictions later in Bullfinch, and of where it would have be possible for staff to make connections. It said that the four older girls being managed in separate CSC area teams *"did not aid social workers to make connections"*.

8.19 It is not just that the bigger picture was not grasped but that the individual cases, which by and large were not linked, were so extreme in their circumstances that greater protection should have been given – regardless of whether there was an abusing group or not. It is important that this is not overlooked by just focusing on the missed bigger picture.

8.20 Ofsted rated CSC only as adequate in 2006, 2007 and 2008, raising issues including too many children placed too far from home, reviews for children that are Looked After need to be done on time, and the lack of placement choice on occasions putting children and young people in less appropriate placements (2006); Weaknesses with the referral, assessment and child protection systems. Increases in children being de-registered and re-register (suggesting hasty de-registration) and a need to improve the timeliness of LAC reviews; and the management of referrals and assessment raised for third time (2007); Rearranging processes had led to 'referrals' doubling (2008). The JAR in early 2008 described Council services saying, *"Oxfordshire's performance is often below that in similar authorities and the track record of improvement in services has been variable."*

8.21 A former DCS in post in 2006 and 2007 said: *"My perception of children's social care was of a service under very considerable pressure, high demand, significant overspends and I suppose in response to that it seemed like it had been constantly reviewed and there was a view that things needed to be different. Pressure points appeared to me to be: – entering care/LAC/Assessments …"* The CSC IMR described supervision as generally poor in these cases. Such cases, which are so hard, create powerful feelings and emotions in staff, and

good case supervision is essential so staff can be as insightful, objective and effective as possible.

8.22 Many authorities were 'adequate' at the time, so there is no necessarily direct correlation between this and CSE-related weaknesses. However, the key weaknesses listed by Ofsted and the JAR are those which may well have made it less likely that trends would be picked up, that risks that needed escalating would be identified, that children's progress would be reviewed well, and that children in Care would have been placed optimally. The tensions (not restricted to Oxfordshire) described above where DCSs did not have a social work background may have contributed (wrongly) to attitudes to escalation in CSC.

8.23 ***What was missing organisationally in Oxfordshire?*** Whilst there was much, looking back, which was not helpful, was ill-informed or even seemed uncaring, the general patterns seen in this Review were not unique, and there is no evidence of top managers or governing bodies failing to respond to what was later subject to many convictions at the Bullfinch trial – they did not know about it. What needs to be learned from locally is the picture (that did not fully emerge until the SCR) of parallel streams of work on what is called, in Section 7, 'Oxfordshire's journey' of discovery about CSE. The local consensus is that there are now substantially better inter-agency connections, joint working arrangements, a well-functioning OSCB, and Bullfinch itself is said to have drawn professions and organisations together in an unprecedented way. But this SCR offers the opportunity to take steps to be sure that what is described under this heading has indeed been addressed or will be.

8.24 What was seen in Oxfordshire was a range of concerns, some very high, about the risks to which a number of girls, mainly LAC, were exposed by their association with much older men, drink/drugs and generally 'difficult' behaviour. For a whole host of reasons described earlier, responses were not what they would be now, the signs of CSE were not recognised or, even if suspected, were not drawn together in a way that led to collective top-level action.

8.25 In 2010 the several parallel strands of discovery began in earnest: the more strategic approach by City staff, the case-focused approach by County staff, and the growing concerns by City Police. And, across the whole period, the most intense work by CSC staff to manage the most difficult of cases. The key question is, why it was not pulled together earlier?

8.26 There are the simple answers about lacking knowledge, the inability to grasp that something so dreadful could be happening in Oxford or the County, and the nationwide attitudes which failed to see such difficult children as victims, and so on. However, there seemed to have been weaknesses in the collective work across the child protection partnership. The author would not want to imply that this was all unique to Oxfordshire, but it is what the OSCB and other strategic partnerships must make really sure has been addressed now.

8.27 The OSCB, although seen as good for some years, was not well developed by the time of the JAR in 2008: *"Underdeveloped operational and monitoring arrangements for the OSCB".* And although improvements were put in place with a new Independent Chair that year, it is clear that reaching a good level of functioning took some time, as evidenced by the non-response to the 2009 statutory guidance or not utilising the 2010 City report on CSE. That new and first Independent Chair reported that she found it hard to get deadlines met and to improve the performance management rigour found wanting earlier. She also felt that

meetings with senior council officers only happened at her instigation. (It would be fair to say that many councils found it hard to adapt to their first Independent Chair.) That Chair says her first priority was to improve the level and commitment of agency membership and develop the governance arrangements of the Board. The DCS appointed in 2010 says she instituted regular meetings with the OSCB Chair, and between the OSCB Chair and the County CEO.

8.28 Also, it has often proved hard for agencies, even senior staff, to appreciate that, other than the Independent Chair, who then would have worked maybe half a day a week, the LSCB does not exist other than as a collective of members. The only 'independent' professional on any Board is that very part-time Chair. This means that, largely, challenge and scrutiny of performance has to be on a peer basis. Indeed, at the time of Bullfinch, national guidance[37] required members to act independently of their agencies. *"The individual members of LSCBs have a duty as members to contribute to the effective work of the LSCB, for example, in making the LSCB's assessment of performance as objective as possible, and in recommending or deciding upon the necessary steps to put right any problems. This should take precedence, if necessary, over their role as a representative of their organisation."* (This was removed from national guidance in 2013, and it is unclear whether government still expects the spirit to be adhered to.) Before Bullfinch, the OSCB was not as proactive as it should have been. Certainly the work the City Drug Strategy Coordinator and colleagues did in 2010 to try to scope CSE and join agencies together to address growing concerns was what the OSCB should have been doing following the 2009 guidance, and doing more thoroughly in a CSE strategy.

8.29 There are indications that, before Bullfinch, the influence on the OSCB from top managers varied. This contributed to the OSCB not operating in a way that was picking up growing levels of concern, or exercising its statutory duty to have led collectively on CSE from 2009. National research would suggest this was not an uncommon picture. This, and the fact that concerns across all agencies never reached the most influential decision-makers, meant that those leaders were not driving a strategic approach and this contributed to the delay in identifying the CSR. The OSCB has been working well on CSE since 2011.

8.30 Secondly, there were also issues across agency boundaries. Oxfordshire has a two-tier local authority arrangement. Districts have community safety responsibilities, whilst the County have the statutory child protection role. It has taken Bullfinch for there to be a realisation of just how related are these two service areas. Without that understanding, the connections between the two in the City (the only District specifically looked at) were not close enough at middle management tier, whilst there is evidence of much closer working at field level. Although there is a much better mutual understanding now, pre-Bullfinch there was a degree to which it appears that in some quarters the City was seen as a rather small player. The correspondence about the Nuisance Officer's concerns did not show due respect for the views being put forward; not taking the City CEO into full confidence about Operation Bullfinch for a year seems remarkable. The only involved major agency not invited to join the overseeing Panel for this SCR when formed in 2012 was the City. City staff did as much as if not more than any to understand and identify responses to CSE when this was actually a collective duty, but this good contribution was not generally known until it emerged during this SCR – which makes the point.

[37] *Working Together to Safeguard Children* (HM Govt, 2010).

8.31 It is clear now that, within the County, CSE is not just in the City. One district used to represent all five on the OSCB. (The previous OSCB Chair told the Review that this was their choice). This has been addressed by the new Independent Chair, who has secured both resource and senior management commitment to the OSCB from all the districts. All districts understand the importance of membership. The need for greater understanding and clarity about the link between various strategic partnerships was confirmed in a 2013 external review[38] of OSCB effectiveness, commissioned by the OSCB, which listed as an area for development: *"Specifically clarify the respective roles and inter-relationships between the OSCB and the Health and Well-Being Board, the Children and Young People's Partnership Board, the Community Safety Partnership and the Safeguarding Vulnerable Adults Group".*

8.32 Thirdly, there is an issue for agency governing bodies. In the evidence received for the SCR, there was almost no reference to governing bodies such as Boards or Council Committees (which in all cases involve lay people). The absence of concerns getting to directors would be the main reason for governing bodies not addressing CSE before Bullfinch. It would be a good exercise for governing bodies to consider whether, in hindsight, there is information, which, looking back, should have got to member/non-executive level – and if so to make such expectations clear now. Related to this, they should consider whether existing performance management processes are identifying significant causes for concern at an early enough stage: for example, the very worrying missing from care figures and what was happening to the young people concerned. If this was a new issue today, are there processes which would ensure governing bodies have the opportunity to contribute to a robust response and determine priority?

8.33 Fourthly (and great credit should go to the mainly junior and middle ranking staff who pursued the implications of what they saw and heard until eventually there was some joined up action), there was something that prevented those concerns being either passed upwards or put into a more strategic arena by those who were aware. It is hard now, many years later, to be clear what that 'something' was. It is known, for example, that in CSC there was a climate of trying to deal with things at a senior operational level rather than at a more corporate County level. TVP is a very large organisation, which, before 2011, had fewer processes in place than it has now to see things on a force-wide basis.

8.34 The minutes of meetings seen by the SCR seem to support the notion of a lack of grip. Most were multi-agency, although 'owned' by one agency. IMR authors and this author found it difficult to find minutes of many meetings (for 2011 and earlier) referred to in the SCR. All except OSCB minutes were devoid of logos or other headings to distinguish the agency responsible for them. A number did not indicate who chaired them. In many, it was hard to follow what happened, and as many of these meetings were subgroups it was hard to see to whom they were accountable. The impression was of informality and a lack of either clarity about or understanding of the importance of 'governance'. This is not to say that the meetings were not doing good work, but that minuting during that period needed to be a much more valued exercise. This comment applies both to agencies preparing them and agencies receiving them.

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[38] *Independent Review of the Effectiveness of the OSCB* (Paul Burnett, August 2013). Note: the current OSCB Chair told the Review she was 'comfortable' that all the recommendations in this report had been achieved.

8.35 *Learning points:* Rather than trying to be definitive about why inter-agency arrangements did not lead to greater awareness at the top, and why it was left (not consciously) to junior staff to scope and identify the CSE when there were requirements for this be done at a higher level, the relevant learning points below can be used as a guide against which current ways of working can be assessed:

- The risks an OSCB runs if it does not have robust processes for:
  - acting on new guidance
  - performance monitoring to ensure actions are seen through
  - ensuring there are routes in for fieldwork concerns to be heard
  - its role being widely understood by staff at all levels
- The OSCB, other than the part-time presence of an Independent Chair, has no existence other than as a collective unit. This means that governing bodies must be sure their organisations and leaders actively share in leadership and shaping the Board
- The importance of the District Council community safety role being proactively understood by partners, and appropriate links with County Children's Services being strong at operational and more strategic level
- The need to be sure that all Districts continue to be represented on the OSCB
- Governing bodies need to be sure they are clear on what they expect reported to them by way of early warning, so they have an opportunity to reflect on an issue as early as is useful
- Governing bodies need to be sure that performance management arrangements identify key measures of child safety, including those around looked after children
- The benefits of relatively junior staff using their initiative to take forward discussions and explorations about concerns on child safety, but…
- ... there is also a need for their managers to ensure such important work makes the right links inside and across agencies, and also what is the governance framework for the work

8.36 ***Knowledge:*** In general terms, Oxfordshire would not stand out from many other parts of the country in its amount of accumulated knowledge about the concept of CSE, or in terms of implementing guidance. The Review has described national research in 2011, and even in 2013 (by which time Oxfordshire was doing well), which showed low uptake of national guidance. On the other hand, the OSCB at the time of the major national statutory guidance in 2009 did not have a very robust process in place to ensure that new guidance was always dealt with at the right level. Also, many OSCB member agencies would have known of the guidance but did not raise it with the Board as a shortcoming, so responsibility must be shared. Although there were some concerns over the years, the evidence for the SCR shows only some City staff making determined efforts to learn more about CSE – notably through the Community Safety Team which should be applauded for its efforts – and, associated with this, the Police also began making inquiries elsewhere.

8.37 The Oxfordshire experience (and that of others) shows how long inappropriate views can remain entrenched if there are not good processes of learning from national good practice guidance and robust multi-agency oversight

8.38 *Learning points:*

- OSCB member agencies also receive such guidance and need to share responsibility for it being considered both internally and collectively by the Board

- The value of more widely and proactively seeking out learning and good practice, as shown by the City and the Police
- There may be an assumption that the focus on CSE is so high now that the old, less unhelpful attitudes to the victims have gone. This needs ongoing monitoring

8.39 ***Escalation*****:** In this Review, the evidence was of very limited escalation to top decision-makers, so no Directors/Chief Officers or governing bodies were aware of anything akin to organised Asian groups and multiple young victims until very late 2010, 2011 or even 2012. The reasons varied. Some organisations like the Police and County are so large or have such a range of services that the individual cases (as they were seen) might not reach the very top. In other cases, staff were trying to be sure there was something especially unusual before pushing it up the line.

8.40 Whether they should have realised it or not, there is little evidence of anyone having a *clear* picture of group-related CSE and not escalating it, although the IMRs have identified evidence that might have supported such a picture in 2005-8. It took from mid-December 2010, when the Deputy DCS was briefed in writing about growing concerns, to mid-February 2011 before the DCS and then CEO/Lead Member were briefed, a point two weeks after the Police identified to CSC concerns about the group sexual exploitation of children in care of a very significant nature. This should have been done quicker. It was April 2011 before the Assistant Chief Constable, and then Chief Constable, were briefed about awareness of local group CSE. Again this should have been quicker.

8.41 Given how long, due to the complexity, it took Operation Bullfinch to get even to the point of arrest (a year), it is unlikely these delays made much difference but the speedier upward briefings would have been appropriate. By this point, there was some national awareness about Asian-led group abuse of multiple children, and the Directors/Chief Officers should have been given the opportunity to consider the implications both practically and politically and be sure action was at the appropriate level. It is important to emphasise that this was in no sense 'hiding' the issue but staff not seeing the need to brief chief officers (wrongly in the author's opinion).

8.42 It is also important to avoid hindsight when assessing how soon the chief officers needed to know. The Rochdale and Rotherham publicity is now etched on the public consciousness, but the beginning of 2011, when it was realised Oxfordshire had a pattern locally, was over a year before the main Rochdale trial concluded and over three years before Rotherham became news. Only the far less publicised Derby case might have been known by then.

8.43 Over the years, the issue is whether concerns should have been escalated and, had they done so, would there have been more strategic and concerted action. (See also 'Tolerance' below). The Chief Constable, talking to the SCR, was asked about expectations of escalation, and illustrated the above point about hindsight: *"Knowing what I know now about the significance of the operation and the court case for Thames Valley Police I would have wanted to know sooner. However I do not think that my knowing would have affected the outcome of the investigation. The question is whether it is reasonable for the officers involved, knowing what they did at the time, to have begun to deal with the case without escalating it to chief officers. In early 2011 they were establishing the team in partnership with Social Services from within resources they controlled and had no need at that time to seek additional help or permission to begin to develop the intelligence and gather evidence."*

8.44 What is clear is that the pattern of limited escalation of whatever was known at the time was more or less the same across all agencies, despite leaders feeling they were open to hearing staff concerns. To some extent, this was because staff did not know that something uniquely awful was happening, or could not believe it, so thought they were dealing with the difficult end of the spectrum of cases which they were expected to get on with. On the other hand, this Review has shown that there was enough information about the signs (as a opposed to the recognition of the overall pattern) of abuse of linked children by multiple men of mainly Pakistani heritage for many years before Bullfinch began, which would have benefited from the consideration of top managers and governing bodies.

8.45 Chief officers were never told of any of the concerns during 2005-10, neither were Directors of Children's Services. (CSC had its first Escalation Policy in 2010.) Even the City Council did not agenda its own December 2010 CSE scoping report at any internal meeting or even at the Community Safety Partnership where it was lead agency. One former DCS said: *"In previous jobs if a social worker had concerns they would want it to get to the top of it asap and get it dealt with…"* That DCS said that in OCC (Social Work and Education), there was a sense of *"people not wanting to deal with things"* and "*letting it go"* if the manager above was perceived as not being interested.

8.46 The author, in discussions with senior staff and the new independent OSCB Chair about draft findings, has found there is still a degree to which the value of top managers/governing bodies being briefed is not grasped. This suggests a public sector culture within Oxfordshire where middle or even senior management feel a need to solve problems themselves, rather than considering the wider corporate governance issues, and in doing so deny the top the opportunity to have influence. This means that top management/governing bodies must consider how open and welcoming they are to early warning, and indicate their need to know about extreme matters being handled by their staff. Those with whom the author has spoken believe they have always been open, so the cause of the non-escalation will need to be understood, and current improvements tested.

8.47 Agencies and the OSCB need to consider whether, should another 'new' topic emerge now, it *would* find its way up the line more easily and more quickly, so there could be a more corporate response. Agencies should review how clear it is what their staff and junior managers are expected to escalate, and the OSCB should review its committee and other arrangements so that it gets to hear of worrying concerns early enough to use its collective influence well. Many local agencies will have looked at this in recent years as a result of Bullfinch (and CSC has an updated 'Need to Know' policy on escalation) so the task will be to test out new arrangements to make sure they are robust, that the 'top of the office' is indeed told what it would expect to hear, and that staff are quite clear what they need to share.

8.48 Disputes between agencies about case handling may at the time seem unnecessary, but they may well contain issues of real concern that can be submerged in irritation across agencies or professions. The 2007-8 tension described around one child and family, given the nature of concerns expressed, could have been handled much better, and would have benefited from, in both City and County, higher managers considering the childcare implications. In this case, the resolution at the time seemed more tactical than child focused.

When there were concerns about child protection processes (eg case conferences) not being used, there was no sign of disputes processes being used.

8.49 *Learning points:*

- OSCBs are strategic, but must also be sure that they have processes that allow them to hear of operational concerns at an early stage, so there can be a decision as to whether the Board needs a collective response/action
- Agencies should satisfy themselves that formal escalation processes work in practice, from the perspective of both front line staff and top managers
- Also, that there is a culture which promotes the sharing of concerns and reacts positively rather than negatively to service concerns
- There need to be clear processes that are understood and followed regarding resolving differences of opinion about cases or groups of cases both internally and across agencies

8.50 ***Tolerance:*** Other reviews have found it hard to get over to the public how incidents in which children have been hurt or exposed to major risk have not always led to 'something being done' and the whole pattern not recognised. One does not need training in CSE to know that a 12-year-old sleeping with a 25-year-old is not right, or that you don't come back drunk bruised, half naked and bleeding from seeing your 'friends', etc.

8.51 It is not the role of the SCR to examine each individual incident and judge whether a professional acted in a culpable way (that lies with agency processes separate from SCRs), but it can summarise some of the reasons and suggest the impact of national culture. The Police are clear that, where a specific allegation reached investigators, cases were indeed investigated – although success was mostly limited for evidential reasons and insufficient focus on perpetrators. However, the Police review also identified reports of many incidents that were crimes but not regarded as such, and where judgements on future action were coloured by attitudes which saw action as futile due to non-cooperation or self-induced harm. The SCR has also described CSC's reports of incidents that merited, at the least, further thought and at times statutory inquiry, which received neither. There were also times where it seems that confidentiality was put before protection (with the intention of maintaining relationships with staff who could offer ongoing help).

8.52 The result was that inappropriate or illegal sexual activity by children who were clients, patients or looked after children was subject to a higher tolerance threshold than would be the case than, say, the average parent. This may have been because professionals could not find a way to stop the girls going where they were at risk; it may have been from trying to avoid being too 'controlling' and risking more alienation, and from the wide sense that 'nothing could be done'. However, for some, it may also relate to a reluctance to take a moral stance on right and wrong, and seeing being non-judgemental as the overriding principle. What is right and wrong about youthful sexuality is anyway a rather blurred issue. Paragraph 5.43 referred to health guidance which determines a child's ability to consent to sexual health advice and get contraception for an act which the child might be legally unable to consent to. The law regards underage sex between peers over 13 as not something that should have any intervention, and it is not much more of a step to see sex between say a 14-year-old and a young adult as 'one of those things'. And, in this Review, sex with older adults did not always lead to what might colloquially be called bringing in the cavalry to intervene come what may. The benign word 'boyfriend' disguised age-inappropriate relationships.

8.53 This is more than a policy debate. It affected practical steps. Missing children in care were in the main reported missing, but it was some of the parents who scoured the streets trying to find them, not generally the corporate parent (the Council), although there were some notable exceptions of residential staff doing just that. The logistical difficulty in council staff doing what a parent beside themselves with terror about a child might do is understood, but it is interesting to consider the comparison.

8.54 There can be little doubt that the earlier sexualisation of children, the age of perceived self-determination and ability to consent creeping lower, and the reluctance in many places, both political and professional, to have any firm statements about something being 'wrong', creates an environment where it is easier for vulnerable young people/children to be exploited. It also makes it harder for professionals to have the confidence and bravery to be more proactive on prevention and intervention. This is an issue reaching way beyond Oxfordshire and requires a national debate.

8.55 There is also the tolerance that comes from dealing with the extreme ends of human activity, which can happen to any professional. The author has an impression from reading the evidence that because the girls faced so many problems, were missing so often, caused concern so often, that any one incident would be regarded less seriously than a single incident would if it were the only occurrence. This is a natural reaction, but one which can have serious consequences if it results in downplaying the level of harm a child is experiencing. Reading the chronology of events around the child subject to the longstanding concern of the City Nuisance Officer, described earlier, it is disturbing to see how, despite very clear accounts of her late-night lifestyle at 13 with adult men, she was 'protected' by being placed with a relative from where the activity continued, as it did when in residential care.

8.56 Whatever the reasons for the higher professional tolerance levels for these children, it was one of the factors that prevented sufficient weight being given to the key task of stopping the abuse.

8.57 *Learning points:*

- Staff at all levels need to be clear about the law of consent (to sex and healthcare)
- Verbal consent does not mean it is free consent, or sensible consent
- Across agencies, supervisors should test out with staff making decisions about how they see the threshold for action with sexually active children
- Supervisors (and their managers) need to be aware of the tendency for the impact of an incidence of abuse or risk to lessen when such incidents happen frequently
- In the tension between action to be non-judgemental and action to prevent harm because an activity is wrong or inappropriate, the latter should be the overriding principle with children
- Agencies which act as parent or share parental care should, when determining what is appropriate action in the face of risky behaviour, consider what a good parent caring for a child at home would do
- There needs to be a rethink of the national guidance regarding sexually active children, to ensure that well-intentioned policies to support the vulnerable young do not inadvertently add to a climate that facilitates exploitation

8.58 ***Staff attitudes and rigour:*** Although the impact of staff attitudes on the handling of CSE has been written about in guidance and several other SCRs or similar, it is worth repeating here as this is at the heart of messages from victims and their families. A number of illustrations were given in their own words in Section 3. While there is no doubt that the grooming, threats and abuse made the victims unable to support investigations, and unable on most occasions to give what would be good evidence, it is also the case that there were plenty of signs that something serious was wrong. One victim, in a Police training video, has described very lucidly signs that she thought were visible and should have meant more to staff. Extreme stories of sex or violence that 12- or 13-year-olds *"could surely not make up"*, about marks on her that were not pursued, about the ravaging by drugs at such a young age, about being dishevelled and bleeding and not feeling cared for, about no one asking if she was ok, about leaving disturbed pictures around for people to see, and of not being believed. She talked of 'snide comments' and an attitude that it was her fault. She would admit she was very difficult to deal with, but thought there were enough clues. (The context of these remarks was about the police, but the CSC IMR details a number of illustrations where CSC did not pursue signs of harm, and Health staff also heard worrying stories and assumed others were dealing with it.)

8.59 These reactions often stemmed from the belief that the girls were being difficult, badly behaved and putting themselves in harm's way. This in turn made it easier for staff not to be inquisitive, not to pursue every allegation or sign of harm, not to deal with the girls in a way likely to encourage them to be more open, and not to pick up the hints and signs that were there. Whilst in the absence of understanding the grooming process the reactions might be understood, they were not right, fed into the delays, and unintentionally added to the girls' isolation and sense of vulnerability to the abusers

8.60 Although some of the parents were far from easy to deal with, there was insufficient recognition of how *they* were affected by their child's grooming inspired behaviour. Illustrations were given in 5.112. One can see that, in some cases, social work staff became quite exasperated by parents and in these situations staff need the highest level of support and supervision to help tease out what might be an inherent parental reaction, what might be from dealing with the nightmare scenario of a child as a victim of CSE, and what might be a reaction to how they are being treated by staff. Some parents also found the Police at times insufficiently sensitive to their desperation.

8.61 The girls' comments about how they trusted and felt most at ease with unqualified staff (see section 3 and 5.113), finding some professionals hard to relate to and cool/distant/boundaried, is food for thought for those involved with professional training and practitioners. Professionals were no doubt, by and large, acting as they had been trained, and the depth of dysfunction, the risks, and statutory roles all need professionals' skills, but the victims are saying that they would have shown more trust and be more likely to disclose (after some time) if some key staff had been more ordinary. They did not use this word, but it sounded like they meant more like 'friends'. It would seem that to be successful with girls at risk of or suffering CSE that at least one person in the team needs to be like this.

8.62 *Learning points:* Some of the learning points have used words given by victims and parents

- However difficult they may appear, children need to be treated as children
- Ask if they are ok

- Use the basic niceties
- Start with the basic assumption that what the child says is to be believed
- Don't make snide remarks to possible victims (however they behave) which undermine them more
- It is important that, just as the victims are not blamed for their exploitation, parents are not blamed for their children's exploitation
- Signs of drug and alcohol use at a very young age are not normal and need real inquiry
- Signs of physical harm must always be investigated
- If you have any suspicions that a child may be being abused, do not be frightened to ask them about it … and keep asking
- Go with your instincts if something seems wrong
- Children do not go missing on numerous occasions without there being a reason. That reason must be explored rigorously
- Beware in case being more 'professional' makes it less likely that the victims will engage

8.63 ***Investigations:*** The Police have been very open in their review for this SCR that, on many occasions and for a host of reasons, incidents which needed to be logged as crimes and investigated as such were not, or that incidents initially classified as crimes were reclassified. The HMIC 2014 report shows that this is still a national issue, and the findings in this SCR may well reflect a national position rather than just local. Also, many of the mistaken classifications reflected the level of understanding and the attitudes about CSE prevalent at the time. Nevertheless, the decisions now seen in retrospect to be wrong did mean that victims were sometimes denied their right to a full investigation of crimes against them (even if they might not have been helpful to that investigation). It also meant that it was less likely that patterns and links would be identified. The Police also identified issues about a lack of clarity around the 'ownership' of investigations, and confusion around consent. The cases were hard enough and any lack of clarity could not have helped.

8.64 It was not only in the Police that processes led to no or inadequate investigations. CSC's own review showed alleged assaults by parents not being investigated, information revealed in strategy meetings not looked at quickly, strategy meetings not being called when Police *were* investigating, and the presence of known offenders with a risk to children in children's lives not being explored. There were also illustrations of multi-agency investigations delayed to await meetings, and the 'moment' when disclosure may have happened was lost.

8.65 In their work for the SCR, both the Police and CSC have emphasised the importance of supervision and review processes in being assured that proper decisions and appropriate action are being taken. In both organisations, there was the involvement, at least at some point, of more senior managers/officers in most of the examples where it is now deemed that an inappropriate decision was taken. This emphasises the importance of a corporate understanding about how processes are working in practice, and of how CSE should be managed.

8.66 Alongside the lack of evidence gathering around offenders until late 2010 and 2011, there was also a lack of disruption activity – which is now a central part of the armoury in tackling CSE. The tools (such as Child Abduction Notices) were available throughout the period under review, and in guidance, but TVP, alongside most other forces, made little to no use of them. The impact was that when the victims were not protected through

prosecution/conviction, they were also not protected through the disruption of offender lifestyles in the way one would be today. As an indication of the newness of disruption techniques, Birmingham City Council gained significant national publicity in November 2014 for using civil injunctions to restrict risky men when prosecutions seemed not possible, even though orders with similar powers have been available since the 1980s.

8.67 There was also the focus on the abused and their evidence, rather than getting evidence about the abusers. Although guidance pointed to the necessary focus on the alleged perpetrators, the need to put in major effort was not grasped, and many offences could not be pursued due to weak victim evidence. Not using this approach delayed both the full identification of this sort of CSE and successful prosecutions. But relying almost solely on victim evidence was not unique to the County, and it is only in the most recent years that more offender-focused approach has been accepted as national good practice. The Police IMR has two summary learning points which make the point well: *"Moving away from victim disclosure led investigations towards the evidence based approach taken in domestic abuse cases. Building the case without the victim generates disruption/enforcement opportunities and ultimately creates a better environment for them to provide their evidence (Example -The investigation may identify other victims, forensic and/or CCTV evidence that corroborates the victim's account and reduces the reliance/pressure on them). Recognising that unlike interfamilial abuse the safeguarding of CSE victims relies more heavily on the police led criminal justice interventions as opposed to the social care led 'Working Together' processes. This is because these traditional safeguarding approaches cannot protect against offenders outside the family setting, particularly as these will often be unidentified."*

8.68 This was echoed by the CPS: *"At the heart of any investigation into child sex or grooming must be a 'what is happening' or 'what happened' to the victim as opposed to simple evaluation of the quality of victim and his/her account as a witness. The CPS has adopted this approach so that the focus rest on the credibility of the allegation rather than the credibility of the complainant… What is required is an investigation both with the co-operation of the victim if the victim is prepared to co-operate and also an investigation independent of the victim, whether or not the victim is prepared to co-operate."* It gives as an example the Oxford Police obtaining forensic evidence from victim's clothing without their knowledge. Also the use of phone evidence, care homes and families keeping contemporaneous records of victims' comings and goings, their appearance, descriptions of those they meet, and vehicle details. The combined effort in Oxfordshire to do all this in the Bullfinch investigation and since is to be applauded, although some family members and care staff did provide information like this years before Bullfinch.

8.69 The CPS also said, *"The investigation team did a remarkably good job in encouraging the victims to give evidence and thereafter, keeping in contact with them in the run up to the trial. That is a lesson well learned and should be repeated. The idea of having a dedicated flat for the use of each victim as she gave her evidence was extremely sensible and worked extremely well."* (This involved Police and CSC working together.)

8.70 The Police think greater emphasis on the wider investigative aspects of CSE could be given in the statutory 'Working Together' guidance. For example, the section beginning *"Professionals should, in particular, be alert to the potential need for early help for a child who…"* does not refer to sexual exploitation (which is not mentioned in the core text of the

guidance). The guidance on assessment is all about the child and their family, when it might be better also to include the key points of dealing with abuse from outside the family.

8.71 In Oxfordshire, it has been clear since 2011 that it is only the combination of disruption, investigation, intelligence gathering, prosecution and safeguarding the children which leads to successful prevention or intervention, and these method have been or are being used since Bullfinch across the whole Thames Valley area.

8.72 *Learning points:*

- How attitudes and understanding of CSE, or indeed 'difficult' teenagers and families can impact on what is recorded as and acted upon as a crime
- How attitudes and understanding of CSE, or indeed 'difficult' teenagers and families, can impact on decisions about fulfilling statutory duties in CSC
- Any allegation of abuse must be investigated formally, even if it does seem to be part of teenager/parent disputes
- Strategy meetings must always be used to agree the multi-agency roles on inquiries when the criteria are met.
- The crucial importance of supervisory and review processes to ensure that staff near the front line are making sound and objective decisions
- The need to recognise that evidence around the 'bad character' of offenders can back up vulnerable evidence by victims, and the presence of such evidence can give victims more confidence to give and stick to evidence themselves
- The need to investigate regardless of the cooperation of the child
- The need to ensure that there are robust processes in place to make links between victims and between perpetrators – including the use of covert actions and intelligence gathering
- Disruption of abuser activity is an essential protective process, regardless of whether a criminal case can be brought

8.73 ***Going missing:*** The scale of missing episodes was vast. From 2005-10 the six girls were reported missing around 500 times, with around half of the episodes being from Council care. Bearing in mind that no one child was went missing in more than three of those years, one was never in care and several were unable to be missing for long periods as they were in secure accommodation, the intensity of these episodes was high. There was a multi-agency Missing Persons Panel in place from 2007 and the Police's Missing Persons Coordinator is widely seen (by staff and families) as one of those who should be strongly praised for the personal commitment shown. Paragraphs 5.88 onwards describe a number of weaknesses in the overall process and, despite the coordinator escalating concerns upwards, a focus on managing the girls rather than blocking whatever was being done to them.

8.74 Many of the things that should have been done better are covered above – about crime/no crime, not being sufficiently curious, seeing the girls as at fault, and so on. What is striking to this Review is the scale of going missing and the scale for individuals about whom there was particular concern about health and well-being and sexual activity with older men. This is another confirmation that, over a period of years, processes were not in place which might have brought such issues to the highest attention (managerial or political leaders) so that a major, system-wide response or inquiry could be made to address it.

8.75 Care must be taken in making this point. From April 2006 to March 2010 (when the journey of discovery was just beginning to gather pace), there were over 17,000 episodes of being missing in the TVP area, and over 5,800 of these were from Oxfordshire, so going missing was not an unusual occurrence. However, had it been known at the time by higher management or the OSCB that Oxfordshire's missing from Care figures in 2006-9 were disproportionately large in the Thames Valley, or that half their missing from care episodes related to girls with many recorded concerns about adult males, etc, there *may* have been a quicker, higher-level response. For example, the OSCB Monitoring and Evaluation Subgroup received missing statistics twice yearly, with a one-line minute in September 2008 and March 2009 saying, *"Group to note numbers, with significant numbers of episodes and trends and review over time"*, and then *"No specific concerns from [Missing Persons] Panel. Very positive re work of Panel."* In the year ending March 2009, the Police recorded the highest numbers missing in Oxfordshire under 18 years, both overall and from Care. There should have been more challenge at this point. Indeed, the CSCs IMR concluded that their own *"Performance management systems should have picked up the issue of large numbers of incidents of children missing from care and triggered further challenge about what was happening and why".*

8.76 *Learning points:* This Review does not intend to go into detail about how managing missing children is best managed. Recent government statutory guidance covers this well,[39] and more detailed local agency learning is in the associated publication, 'Agency Responses since 2011'.

- Going missing does not always but may well indicate the child concerned is being exploited and therefore has eroded consent
- Going missing from residential care is an even bigger indicator, as there may well be an inherent vulnerability that can attract perpetrators
- Because of this vulnerability it can be easy to see the children as running *from* somewhere, so inquiries must be made as to what they are running *to*
- There is now a statutorily required for local authorities to ensure a discussion with the child, the family or both after two or more episodes, and also a requirement to ensure that previous episodes and actions are always taken into account
- The OSCB, relevant Council committees (or equivalent), including the lead member for Children's Services, and senior police performance management meetings need not only receive the Missing Persons information regularly, but actively consider and interrogate it to make sure that high volumes are seen as significant rather than downplayed by their commonality
- Secure accommodation may solve the problem temporarily, but is ineffective beyond the period in secure unless the groomers are disrupted or removed from the scene through conviction

8.77 **The impact of ethnicity:** As noted above, the material submitted to this SCR makes little reference to ethnicity. This Review has considered whether this reflects the deliberate ignoring of the ethnic aspect to protect sensitivities (which has been suggested elsewhere in the country), or any failure to consider it when to do so would be helpful. The answer, within the limits of time and methodology, is that the author has identified neither, and reports and

[39] *Statutory guidance on children who run away or go missing from home or care* and *Flowchart showing roles and responsibilities when a child goes missing from care* (DFE, January 2014).

interviews suggest that the perpetrators were seen as just that, and not treated differently because of their background. The members of the SCR Panel also specifically discussed this in December 2014, and assured the author that no one was aware of evidence of any holding back due to ethnicity.

8.78 This does not mean that investigators might not have found working with tight-knit groups of a different culture, and at times language, hard. But that does not imply any 'going easy' to avoid offending cultural sensitivities or seeming politically incorrect. However, as has been found wherever this type of organised group abuse has been uncovered, the perpetrators have been mainly from an Asian heritage, with some from Africa or south east European countries, and with a mainly Muslim culture. This has continued with the Thames Valley cases post-Bullfinch, and in the very recent convictions in Bristol.

8.79 This SCR, in one county, is not the place to attempt a definitive analysis of why this is, and this needs to be researched and understood at a national level given both its importance and the sensitivities of any conclusions. It cannot be parked as too potentially sensitive or inflammatory to pursue openly at that level.

8.80 The association (not of all CSE, but group-based CSE) with mainly Pakistan heritage is undeniable, and prevention will need both national understanding, communication and debate, and also work with faith groups at a local level. A national recommendation is made below. Section 4 described some of the work around developing community relationships and resilience in Oxfordshire.

8.81 *Learning points:*

- The importance of agencies individually and collectively developing strong links with faith groups to share understanding about CSE and to assist with each community's own efforts to protect children and prevent CSE

9 CONCLUDING SUMMMARY AND RECOMMENDATIONS

9.1 This conclusion summarises the facts and findings of the Serous Case Review and makes some recommendations. These recommendations do not aim to repeat the agency-specific recommendations contained in IMRs and being worked on by agencies, nor the OSCB's collated Action Plan. These can be seen in the associated 'Agency Responses since 2011'. Rather this Review focuses on overarching, system-wide issues, or those for national consideration.

9.2 A group of approximately 370 girls and young women have been identified as possible victims of sexual exploitation within the last 16 years. Since 2011, there have been a large number of investigations and convictions, the most significant of which was Operation Bullfinch, which culminated in seven men being convicted of around 60 offences against six children. This investigation used a multi-agency approach and innovative tactics to bring together victim statements and intelligence about the lifestyle of the offenders. The core of this SCR is whether this point could have been reached earlier, and if so why.

9.3 The agencies involved have made comprehensive reviews of their own services, and have openly identified many things that could have gone better. The author has been impressed by the candour of agencies (as well as their huge commitment to make things better now). However, there were clearly many things done which are clearly seen now as mistakes or mistaken approaches. The author has seen little that has not been replicated in other SCRs on CSE, or in national reviews which have identified over and again the slow progress in responding to guidance, and a poor understanding of CSE and its wide geographical spread. That slow progress was often related to three things – thinking group based CSE happened somewhere else, an inability to grasp that something as horrible could really be happening, and seeing the victims as placing themselves at risk rather than understanding the grooming process.

9.4 The fact that the most of the patterns of agency and professional response seen in Oxfordshire were not unusual is both true and sad. But the fact that the lack of knowledge and understanding of CSE and attitudes to the most difficult teenagers were common nationally does not mean no one was responsible: all agencies and professionals in the country share the responsibility of protecting children. This is why this Review has gone to some length in describing what happened and the long process to discovery. As most information about what happened has diligently and openly come from agencies, it is also to show that Oxfordshire has recognised what could and should have been different, and is not hiding its own mistakes.

9.5 There were three other attitudes which also lay behind the failure to recognise more quickly that group CSE was occurring to multiple girls. Firstly, the girls' precocious and difficult behaviour was seen to be something that they decided to adopt, with harm coming because of their decisions to place themselves in situations of great risk. The fact that most of the children came from families with other problems enhanced the belief that the problem and the solution lay with the family or the girl concerned. Secondly, there was a failure to recognise that the girls' ability to consent had been eroded by a process of grooming escalating to violent control. These two issues sometimes resulted in responses to the girls or parents which compounded the lack of trust in agencies instilled by the grooming. Thirdly,

there was pessimism about the prospect of criminal investigations being successful. Very strong evidence was needed and, through the impact of the grooming and fear, hardly any evidence was obtained that was not withdrawn or later denied.

9.6 Overlaying this, and partly related to the attitudes in the previous paragraph, were confusions about what should be recorded as a crime and investigated, a lack of curiosity, and a failure to look into worrying events, was seen in several agencies. This in turn was enhanced by weaknesses in supervision. There was also an apparent tolerance of inappropriate sexual activity, which was partly created and partly fuelled by societal ambivalence (and lack of understanding) around consent.

9.7 There was very little use of disruption tactics before Bullfinch; although several such tactics were known and available, these were also not widely used elsewhere. Neither were the covert surveillance and rigorous intelligence gathering now seen to be essential. This meant that taking something forward rested almost wholly on victim evidence – which in CSE can rarely be expected to be forthcoming or maintained. Whilst Oxfordshire now has a nationally renowned level of expertise in how to approach the multi-agency investigation of CSE, the approaches it uses now were not widely known and understood before 2011.

9.8 The patterns seen above are likely to have been seen anywhere where CSE has been a challenge, but there were in addition issues that seemed to be more local to Oxfordshire. Whilst the fact that the OSCB regrettably did not respond adequately to the 2009 statutory guidance on CSE was not uncommon amongst LSCBs, it did seem to reflect a pattern in Oxfordshire in the years leading up to Bullfinch of weaknesses in the way agencies collectively worked together around safeguarding. External inspection showed the OSCB to need improvement in 2008, and the fact that it did not get a grip of CSE until 2011 suggests it took some time to work well, although it was externally rated as good from 2010 so must have been making improvements. The Safeguarding Board consists almost entirely of Oxfordshire agencies. There is no indication that any of them challenged the delay in responding to the statutory guidance, or indeed the earlier dropping off the agenda of concerns expressed in 2007 about girls and 'organised prostitution'.

9.9 Despite there being very worrying case illustrations over a number of years involving more than one girl, multiple alleged perpetrators, usually Pakistani, with a very strong association with children in care, the highest levels of management were not briefed until 2011. This included Directors of Children's Services. Whilst it must be pointed out that, until the end of 2010, there was little knowledge of the CSE that had happened elsewhere in the country, this Review concludes that the circumstances described, regardless of the name given to them, were so extreme that top management and indeed governing bodies should have been given the opportunity to bring their unique perspective to the issue earlier.

9.10 There are, of course, differing cultures of escalation in different agencies, but the fact that there was no exception to this pattern of non-escalation suggests something that leaders in Oxfordshire must make sure is not present now. It is true that the way this Review has tabulated series of events over short periods to illustrate what was known is a type of collation not done until late 2010, so staff never saw the picture as starkly. That in itself provides a learning point about continually taking history into account.

9.11 This lack of overview is regrettable, as the information, for example across 2005-8, was very similar to that which triggered Bullfinch in 2011. The position in Oxfordshire was not therefore of clear warnings to top decision-makers but the absence of such warnings.

9.12 The various strands of thinking about CSE which eventually culminated in the Bullfinch investigation were led by dedicated and enthusiastic staff, some quite junior, in the City and County Councils and the Police (with support from other agencies), and their work must be applauded. It was the combined impact of their work which in the end led to the investigation, convictions and modern ways of tackling CSE. However, the fact that this work was essentially done in a governance vacuum, without strategic oversight, provides a clear lesson for agencies about what was missing, and about what they must be sure is in place now.

9.13 The contribution to the Review by victims and parents has been extensive and hugely valuable. Their perspectives about the grooming process, their interaction with staff, and what they think would have made things better have had a big impact on this Review, for which the author and the OSCB is most grateful.

9.14 **Recommendations:** The recommendations from this Review are aimed at the system. The learning points, set out in collated form in Appendix 1, provide a more detailed set of points for OSCB and agency consideration – for use as a checklist against which to assess current practice. There are three recommendations for national consideration. The local recommendations below are set out for OSCB consideration, either for direct action or to oversee in its assurance role. Such assurance needs to be ongoing. They are worded that the OSCB has flexibility in how it achieves them. Where there is reference to 'member agencies', this should be deemed to include educational establishments that are not actual members, nor under OCC management, and the OSCB will need to be sure how it seeks assurances from them

For national consideration

i. The DfE should review 'Working Together' 2013 to ensure it gives sufficient weight to investigation and disruption aspect of safeguarding children at risk from CSE
ii. Relevant government departments should consider the impact of current guidance on consent to ensure what seems to be the ever-lower age at which a child can be deemed to consent (for example to treatment) and attitudes to underage sex are not making it easier for perpetrators to succeed
iii. With a significant proportion of those found guilty nationally of group CSE being from a Pakistani and/or Muslim heritage, relevant government departments should research why this is the case, in order to guide prevention strategies.

For the Oxfordshire Safeguarding Children Board

The Board should (if it has not done so already):

i. Ask each member agency to review its escalation procedures, and provide assurance to the Board that they are understood and complied with

ii. Review the interrelationships with other multi-agency partnerships, such as District Community Safety Partnerships and the County Safer Community Partnership, to ensure there is mutual clarity about each other's roles and appropriate cross-representation
iii. Ask each agency to provide evidence of its supervision policies and how the agencies ensure they are effective
iv. Be assured that the lessons from this Review and IMRs are embedded in OSCB and single agency training
v. Ensure that the messages from victims and their families given to this review are embedded in training
vi. Seek evidence that minutes of multi-agency meetings are clear about ownership, have consistent titles, and can be seen by their content and appearance to be of high value
vii. Seek assurance from TVP about progress on recording crime relating to sexual offences
viii. Seek assurance from OCC that there is appropriate access to the necessary range of LAC placements
ix. Ensure that reports on missing children statistics for the Board are fully interrogated to identify any emerging patterns
x. Seek assurance from Oxfordshire County Council that there are good arrangements for the transfer of information between schools about child vulnerability, and that decisions around exclusion from school and its management (risk assessments and plans) take into account that the behaviour is or may be related to exploitation
xi. Seek assurance from NHS bodies, including general practice, that staff include the consideration that consent has been eroded through exploitation when assessing a child's ability to consent to treatment and that referrals to statutory agencies will be made appropriately
xii. Seek assurance from all member agencies that staff are aware of the guidance around consent to sexual activity, and relationships
xiii. Continue to undertake rigorous multi-agency case audits where CSE is suspected

APPENDIX 1: COLLATED SCR LEARNING POINTS

From 'Were mistakes made?'

Lack of understanding led to insufficient inquiry

- National guidance was not widely understood or followed
- The behaviour of the girls was interpreted through eyes, and a language, which saw them as young adults rather than children, and therefore assumed they had control of their actions
- At times, their accounts were disbelieved or thought to be exaggerated
- What happened to the girls was not recognised as being as terrible as it was because of the view that saw them as consenting, or bringing problems upon themselves, and the victims were often hostile to and dismissive of staff
- As a result the girls were sometimes treated without common courtesies, and as one victim described it by '*snide remarks'*
- There was insufficient understanding of the law around consent, and an apparent tolerance of (or failure to be alarmed by) unlawful sexual activity
- There was insufficient understanding of parental reaction to their children's behaviour and missing, so distraught, desperate and terrified parents were sometimes seen as part of the problem
- There was insufficient curiosity about what was happening to the girls, or to investigate further incidents or concerns which, on review, now appear to be crimes or something for formal child protection investigation
- Although there were very few formal disclosures, there were many, often stark, indications that what was happening to them was extreme and out of the ordinary
- There was insufficient attention to investigating and disrupting the activities of the alleged perpetrators (compared to the effort to contain the girls behaviour), and various available legal tools were not used.
- There was insufficient understanding of how the City Council's community safety function could contribute to the prevention and management of CSE

Day-to-day processes were not strong enough

- Insufficient use was made of Child Protection processes, and staff sometimes allowed parental reaction to prevent Child Protection processes being used
- Processes in CSC, such as supervision and the quality of reviews, were not strong, especially 2006-9
- Minutes of multi-agency meetings and review were largely of low quality or missing, which weakened planning and information sharing
- Recording of 'crimes' was inconsistent
- Transfer of educational records between schools was poor
- The provision of alternative education after exclusion, or of post-secure placement education, was slow
- In health, there was insufficient sharing of information heard from or about the girls (often for 'confidentiality') and LAC medicals were often done without full knowledge of history and context

The organisational response in Oxfordshire was weak and lacked overview

- Escalation about serious concerns about looked after children and emerging patterns did not reach governing body level or Chief Officers for several years after they had begun to emerge in 2005, and again 2006-10
- When some signs reached the ACPC and OSCB in 2005 and 2007 respectively there was insufficient curiosity and no follow through
- The OSCB, before late 2011, did not lead the scoping, understanding and prevention of CSE after the 2009 statutory guidance, and member agencies who comprise the OSCB share that responsibility
- Whilst before 2010 there was much less recognition of the connectedness of cases, or the organised nature of perpetrators, both within and across agencies, the growing awareness in 2010 still did not reach top management or the OSCB
- Before 2011 there were fewer processes in place to help form a force-wide Police view of developing problems
- There was a gap of one to two months between senior managers being aware of the bigger picture, or at least the strong likelihood of a bigger picture in late 2010, and very top management being informed

From 'What was missing organisationally in Oxfordshire'

- The risks an OSCB runs if it does not have robust processes for
  - acting on new guidance
  - performance monitoring to ensure actions are seen through
  - ensuring there are routes in for fieldwork concerns to be heard
  - its role being widely understood by staff at all levels
- The OSCB, other than the part-time presence of an Independent Chair, has no existence other than as a collective unit. This means governing bodies must be sure their organisations and leaders actively share in leadership and shaping the Board
- The importance of the District Council community safety role being proactively understood by partners, and appropriate links with County children's services being strong at operational and more strategic level
- The need to reconsider how Districts are represented on the OSCB
- Governing bodies need to be sure they are clear on what they expect to be reported to them by way of early warning, so they have an opportunity to reflect on an issue as early as is useful
- Governing bodies need to be sure that performance management arrangements identify key measures of child safety, including those around looked after children
- The benefits of relatively junior staff using their initiative to take forward discussions and explorations about concerns on child safety, but…
- … there is also a need for their managers to ensure such important work makes the right links inside and across agencies, and also what the governance framework is for the work

From 'Knowledge'

- OSCB member agencies also receive such guidance and need to share responsibility for it being considered both internally and collectively by the Board

- The value of more widely and proactively seeking out learning and good practice, as shown by the City and the Police
- There may be an assumption that the focus on CSE is so high now that the old, less unhelpful attitudes to the victims have gone. This needs ongoing monitoring

From 'Escalation'

- LSCBs are strategic, but must also be sure that they have processes that allow them to hear of operational concerns at an early stage, so there can be a decision as to whether the Board needs a collective response/action
- Agencies should satisfy themselves that formal escalation processes work in practice, from the perspective of both front line staff and top managers
- Also, that there is a culture which promotes the sharing of concerns and reacts positively rather than negatively to service concerns
- There need to be clear processes that are understood and followed about resolving differences of opinion about cases or groups of cases, both internally and across agencies

From 'Tolerance'

- Staff at all levels need to be clear about the law of consent (to sex and healthcare)
- Verbal consent does not mean it is free consent, or sensible consent
- Across agencies, supervisors should test out with staff making decisions how they see the threshold for action with sexually active children
- Supervisors (and their managers) need to be aware of the tendency for the impact of an incidence of abuse or risk to lessen when such incidents happen frequently
- In the tension between inaction to be non-judgemental and action to prevent harm because an activity is wrong or inappropriate, the latter should be the overriding principle with children
- Agencies which act as parent or share parental care should, when determining what is appropriate action in the face of risky behaviour, consider what a good parent caring for a child at home would do.
- There needs to be a rethink of the national guidance regarding sexually active children, to ensure that well-intentioned policies to support the vulnerable young do not inadvertently add to a climate that facilitates exploitation

From 'Staff attitudes and rigour'

- However difficult they may appear, children need to be treated as children
- Ask if they are ok
- Use the basic niceties
- Start with the basic assumption that what the child says is to be believed
- Don't make snide remarks to possible victims (however they behave) which undermine them more
- It is important that, just as the victims are not blamed for their exploitation, parents are not blamed for their children's exploitation
- Signs of drug and alcohol use at a very young age are not normal and need real inquiry
- Signs of physical harm must always be investigated
- If you have any suspicions that a child may be being abused, do not be frightened to ask them about it… and keep asking
- Go with your instincts if something seems wrong

- Children do not go missing on numerous occasions without there being a reason. That reason must be explored rigorously
- Beware in case being more 'professional' makes it less likely that the victims will engage

From 'Investigation'

- How attitudes and understanding of CSE, or indeed 'difficult' teenagers and families, can impact on what is recorded as and acted upon as a crime
- How attitudes and understanding of CSE, or indeed 'difficult' teenagers and families, can impact on decisions about fulfilling statutory duties in CSC
- Any allegation of abuse must be investigated formally, even if it does seem to be part of teenager/parent disputes
- Strategy meetings must always be used to agree the multi-agency roles on inquiries when the criteria are met.
- The crucial importance of supervisory and review processes to ensure that staff near the front line are making sound and objective decisions
- The need to recognise that evidence around the 'bad character' of offenders can back up evidence by victims, and the presence of such evidence can give victims more confidence to give and stick to evidence themselves
- The need to investigate regardless of the cooperation of the child
- The need to ensure that there are robust processes in place to make links between victims and between perpetrators – including the use of covert actions and intelligence gathering
- Disruption of abuser activity is an essential protective process, regardless of whether a criminal case can be brought

From 'Going missing'

- Going missing does not always but may well indicate the child concerned is being exploited and therefore has eroded consent
- Going missing from residential care is an even bigger indicator as there may well be an inherent vulnerability that can attract perpetrators
- Because of this vulnerability it can be easy to see the children as running *from* somewhere, so inquiries must be made as to what they are running *to*
- There is now a statutorily requirement for local authorities to ensure a discussion with the child family or both after two or more episodes, and also a requirement to ensure previous episodes and actions are always taken into account
- The OSCB, relevant Council committees (or equivalent), including the lead member for Children's Services, and senior police performance management meetings need to not only receive the Missing Persons information regularly, but to actively consider and interrogate it to make sure that high volumes are seen as significant rather than downplayed by their commonality
- Secure accommodation may solve the problem temporarily, but is ineffective beyond the period in secure unless the groomers are disrupted or removed from the scene through conviction

From the Impact of ethnicity

- The importance of agencies individually and collectively to develop strong links with faith groups, to share understanding about CSE and to assist with each community's own efforts to protect children and prevent CSE

APPENDIX 2: SCR TERMS OF REFERENCE

Note: The Terms of Reference are those agreed by the SCR Panel on 11.9.14 to update them for revised national expectations following new guidelines published in March 2013, and to guide the production of the final report. They were originally prepared in November 2012.

TERMS OF REFERENCE FOR THE SERIOUS CASE REVIEW OF CHILD SEXUAL EXPLOITATION IN OXFORDSHIRE (CHILDREN A-F)

1. Decision to hold the Serious Case Review

Following the review of circumstances relating to the cases of Children A,B,C,D,E,F from Operation Bulfinch, a decision was made by Oxfordshire Safeguarding Board to convene a Serious Case Review (SCR) on 26 September 2012. The cases met the criteria for a SCR as defined in chapter 8 paragraphs 8.9–8.12 of 'Working Together 2010'.

This draft of the Terms of Reference is a **working document** and will be subject to amendment by the SCR Panel.

2. Background and scope of the review

Background: Concerns were identified about young people in Oxfordshire who were being sexually exploited. The collective picture from local agencies and the intelligence that emerged about those individual young people led to 'Operation Bullfinch'. This complex investigation was led by the Police and involved other OSCB partners. Over 20 young people were identified as victims of serious sexual exploitation. Nine men stood trial at The Old Bailey in January 2013, seven of whom received substantial custodial sentences. The charges related to six individual girls: four cases of historic abuse and two which were current. The abuse was described by Judge Rook as a "series of sexual crimes of the utmost depravity".

Scope: This review is on child sexual exploitation in Oxfordshire and using the cases of the six victims, reviews the work of agencies, the extent to which they were aware of the abuse, and how they responded to it.

The six had suffered abuse over a long period of time and they were a representative group of a wider cohort of known young people. The complexities of their circumstances led to a thematic review in order to build on what was already understood by 2012 and to maximise learning.

The report will describe the background to and experiences of the girls' journey through exploitation. This process will draw out the themes that show the strengths and weaknesses of the safeguarding system and aims to understand not only 'what' happened but 'why'.

The first annual report of the National Panel of Independent Experts on SCRs (which oversees the quality of reviews and that appropriate action is being taken from the learning) comments on SCRs being produced now. It has expressed concern about undue length. It warns against a level of detail that would make publication difficult (and hence learning is limited). It calls for a 'sharp focus' and 'concise accounts'. This SCR will take this into

account by using the case detail to illustrate findings rather than attempt to describe all the very significant history.

3. Key themes for study

Although this review was commence under the national guidance, 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2010', these terms of reference are now also guided by the successor guidance, 'Working Together, 2013'. This guidance captures the purpose: *when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm…*

These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

'Working Together, 2013' goes on to say:

- *reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;*
- *action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and*
- *there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public.*

SCRs... should be conducted in a way which:

- *recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings.*

This Review will explore any avenue necessary to fulfil these statutory requirements, and will look at the following two key questions:

- To what extent was the child sexual exploitation experienced in Oxfordshire preventable?
- What can be learned from the reviews appraisal of the quality of agency work, and the experiences of the victims and their families?

To answer these questions the review will need to explore:

- What was known about child sexual exploitation and how it could be tackled
- If it was not identified quickly enough, why not?
- What, including the quality of agency work, contributed to the vulnerability if the victims to abuse?

- How did agencies respond to the growing awareness of child sexual exploitation?
- What have agencies already learned and done as a result of Operation Bullfinch?
- What still needs to be done?

The Review should identify where agency performance could have been better, but also explain the context in which that performance occurred, so that the contributory factors provide learning for OSCB and its member agencies.

To fulfil these Terms of Reference, the views of the six girls and their families must be sought and reported, and they should have an early opportunity to hear and discuss the findings.

SCR Panel 11.9.14

Report author: The Report author from July 2014 is Alan Bedford, who has a background in child protection social work, senior leadership of NHS Trusts and Health Authorities (13 years as a CEO), as an LSCB Chair and is the author of many SCRs.

APPENDIX 3: CSE NUMBERS – METHODOLOGY

'A group of approximately 370 girls and young women have been identified as possible victims of sexual exploitation within the last 15 years'

This is the method used in reaching the figures as assessed by Children's Social Care and Thames Valley Police

These figures have been derived from TV Police and OCC records. Individual children have been cross-matched to avoid duplication and to ensure that both agencies are agreed as to the appropriate category for the child. Children's Social Care records cover the period 1999-2012. TVP records cover the period from the period subject to the Operation Bullfinch investigation (2005) to date. Kingfisher figures (joint CSC and TVP) cover its referrals since it started November 2012 to December 2014.

From a Children's Social Care perspective, the figures were arrived at following work during Operation Bullfinch. All the girls of interest to Bullfinch were identified with the police team and a search done to identify those with whom CSC had had any contact. A file review was then undertaken looking at each of those girls to identify any issues and concerns which may have been an indicator of CSE, including missing episodes, allegations, and information such as having an older boyfriend or associating with other girls at risk. Some of the girls were active Bullfinch cases and information from the police team was used to prioritise the review work.

That information was collated on a simple pro-forma and then analysed and the girls categorised into the following groups:

- Disclosed to the police, either before or as part of Operation Bullfinch, or possibly a clear disclosure to a social worker or other professional, even where that did not result in a formal statement or charges
- Evidence but no disclosure = strong evidence of grooming/CSE noted by either the Bullfinch investigation or in CSC records, which includes a 'third party' disclosure by a friend or family member but where the girl herself (at the time of writing) had declined to make a disclosure
- Probable = examination of these cases show clear indications of grooming or CSE as would currently be identified in the CSE Screening Tool, including information that the child had been with other victims and/or at addresses where other victims were believed to have been abused
- Possible = less clear than the previous group, but case records indicate some of the signs of CSE/grooming which would currently be identified in the Screening Tool
- No Evidence = these girls names were raised through Bullfinch but analysis of records does not give any clear indications of grooming/CSE
- Girls specifically linked to a (named) case which has since been dropped

An additional four girls were added to the list following a review of a children's residential unit which identified them as likely victims, ie they would have fallen into group two.

In 2013, the police in the Bullfinch Team were provided by CSC's reviewer with a full report setting out details of all the girls where concerns had been identified. A meeting was held with the senior officer within the team, a second police officer, the CSC reviewer, the manager of Kingfisher and the Area Social Care Manager to discuss the report. It is understood that the Bullfinch Team would consider those cases as part of their ongoing investigations.

APPENDIX 4: OFSTED INSPECTION 2014: KEY FINDINGS

Section 1: The local authority

Summary of key findings

This local authority is good because:

1. When agencies are concerned about children, they know how to get the right level of help for them. Thresholds for the different levels of help, including social care, are clear and understood by professionals.

2. Agencies work well together. Early help services are well coordinated and have clear thresholds for support. The Troubled Families programme, Thriving Families, is well targeted and responsive, with good take-up by those families in most need. When children are referred to children's social care they almost always receive a prompt response and the right help. The large majority of social work assessments are good. Children are always seen and asked about their life and what they need to improve it. Assessments analyse risk carefully and what needs to be done to reduce it. Hospital-based social workers complete good assessments that result in effective planning and discharge arrangements for newborn babies who may be in need of help or protection.

3. The large majority of child protection enquiries are carefully planned by children's social care with the police and other agencies and investigated thoroughly. Social work action to protect children when they need it is decisive and proportionate.

4. Consultation and advice are readily available to professionals who are concerned about possible child sexual exploitation. The Kingfisher team provides a consistent service for children identified as at risk of sexual exploitation. Their work is clearly focused on reducing risks as well as on meeting children's and young people's wider needs.

5. A stable workforce in children's social care means that most children experience consistency of social worker and say they have a significant, sustained relationship with them.

6. Decisions about whether children should become or remain looked after are timely and based on evidence about the child's needs. When necessary, care proceedings are initiated quickly to ensure that children are not exposed to harm for extended periods.

7. The Family Placement Support Service is a particular strength. It works effectively with families to prevent the need for children to become looked after. It also supports families when a child returns home after being looked after.

8. Long-term planning to secure stable futures for children is given a high priority. The search for suitable alternative families starts at the earliest possible stage. The contribution made by the adoption service is good. The number of children placed for adoption has increased over the last two years and includes improved adoption rates for older children.

9. Young people are well supported when they leave care. The quality of most pathway plans is good and, whilst some lack detail, most reflect clear and timely actions to help young people make the transition to independence. Most care leavers feel well supported by their

social workers and describe effective and consistent relationships that enable them to develop trusting relationships.

10. A ‘Staying Put’ scheme has enabled a growing number of care leavers to remain with their carers beyond the age of 18. This is bringing demonstrable improvements to the life chances of most care leavers, for example in increased emotional stability as well as a secure base while in education.

11. Services for children and families are given a high priority by senior leaders and elected members. The local authority knows its strengths and weaknesses well. Strategic priorities are identified and informed by feedback from children, young people, parents, carers and staff. Leadership is strong and effective and services make a demonstrable difference in improving the life chances of some of the most vulnerable children in Oxfordshire.

12. Elected members have high aspirations for looked after children and young people in Oxfordshire and have prioritised continued investment, for example in additional social worker and team manager posts. They hold senior officers to account for the quality of services.

13. Management oversight of practice is good. Performance data are used effectively to inform change and drive improvement. This learning culture is further supported by the effective identification and dissemination of lessons from audits and serious case reviews.

APPENDIX 5 ACRONYMS

ACPC	Area Child Protection Committee
ASBO	Anti Social Behaviour Order
BME	Black and Minority Ethnic
CAIU	Child Abuse Investigation Unit
CEOP	Child Exploitation and Online Protection Centre
CID	Criminal Investigation Department
CSC	Children's Social Care
CSE	Child Sexual Exploitation
DC	Detective Constable
DCS	Director of Children's Services
DfE	Department for Education
DI/DCI	Detective Inspector/Detective Chief Inspector
FT	NHS Foundation Trust
GP	General Practitioner
IMR	Individual Management Review
JAR	Joint Area Review
LAC	Looked After Child/ren, ie in Council Care
LSCB	Local Safeguarding Children Board
MP	Member of Parliament
NWG	National Working Group on CSE
OCC	Oxfordshire County Council
OCyC	Oxford City Council
OH	Oxford Health NHS FT
OUH	Oxford University Hospitals NHS Trust
OSCB	Oxfordshire Safeguarding Children Board
PC	Police Constable
PCT	NHS Primary Care Trust
SCR	Serious Case Review

APPENDIX 6: OXFORDSHIRE SAFEGUARDING CHILDREN BOARD MEMBERS

As of 26.2.15 when it accepted this SCR and approved it for publication

Name	Job title	Organisation
Maggie Blyth	Independent Chair	Independent
Jim Leivers	Director for Children's Services	Children Education and Families Oxfordshire County Council
Christian Bunt	Superintendent	Thames Valley Police
Stephen Czajewski	Director	Thames Valley Community Rehabilitation Company
Katy Barrow-Grint	Detective Chief Inspector	Thames Valley Police - Protecting Vulnerable People Unit
Peter Clark	Monitoring Officer and Head of Law & Governance	Legal, Oxfordshire County Council
Clare Robertson	Designated Doctor Safeguarding	Oxfordshire Clinical Commissioning Group
Sula Wiltshire	Director of Quality and Innovation	Oxfordshire Clinical Commissioning Group
Pauline Scully	Director of Children and Families Division	Oxford Health NHS Foundation Trust
Ros Alstead	Director of Nursing and Clinical Standards	Oxford Health NHS Foundation Trust
Lucy Butler	Deputy Director	Children's Social Care & Youth Offending Service Oxfordshire County Council
Rebecca Matthews	Interim Deputy Director for Education and Early Intervention	Children Education and Families Oxfordshire County Council
Seona Douglas	Deputy Director for Social & Community Services (adults)	Social & Community Services Oxfordshire County Council
Clare Edwards	Lay member	
Modupe Adefala	Lay member	
Alison Chapman	Designated Child Protection Nurse Safeguarding	Oxfordshire Clinical Commissioning Group
Julia Grant	Acting Lead Nurse, Safeguarding Children Services	Oxford Health NHS Foundation Trust
Tracy Toohey	Safeguarding Children Lead and Patient Experience	Oxford University Hospitals NHS Trust
Debra White	Senior Probation Officer	Oxford Probation Service
Gareth Davies	Brigade Welfare Support Officer	Army Welfare Service 11Bde

Hannah Farncombe	Safeguarding Manager	Children Education and Families Oxfordshire County Council
Penny Browne	Area Social Care Manager Central Area	Children Education and Families Oxfordshire County Council
Tan Lea	Early Intervention Manager	Children Education and Families Oxfordshire County Council
David Heycock	GM Home and Community Safety Manager	Fire and Rescue – Oxfordshire County Council
Catherine Stoddart	Deputy Chief Nurse	Oxford University Hospitals NHS Trust
Julie Kerry	Thames Valley Area Team Manager	NHS England
Tony McDonald	Divisional General Manager – Children & Women's Division	Oxford University Hospitals Trust
Gerry Stevens	Social Work Team Manager	SSAFA Personal Support and Social Work Service RAF
Amrik Panaser	County Manager Youth Offending Service	Children Education and Families Oxfordshire County Council
Sally Thomas	Service Manager Oxford	CAFCASS
Sally Truman	Shared Policy and Partnerships Manager	South and Vale District Council
Tim Sadler	Executive Director, Community Safety	Oxford City Council
Val Johnson	Partnership Development Manager	Oxford City Council
Nicola Riley	Shared Interim Community, Partnerships and Recreation Manager	Cherwell and Northants District Council
Diana Shelton	Head of Leisure and Tourism	West Oxfordshire District Council
Jo Melling	Head of Commissioning - Drugs & Alcohol Team (DAAT)	Public Health – Oxfordshire County Council
Romy Briant	Voluntary rep	Reducing the Risk of Domestic Abuse
Emma Lawley	Head teacher	Springfield School
Annabel Kay	Head teacher	Warriner School
Lynn Knapp	Head teacher	Windmill School
Melinda Tilley	Councillor and Lead Member for Children	Oxfordshire County Council

CHILD SEXUAL EXPLOITATION 'MAKING A DIFFERENCE'

The impact of the multi-agency approach to tackling CSE in Oxfordshire

MAGGIE BLYTH

June 2015

OXFORDSHIRE SAFEGUARDING CHILDREN BOARD

CONTENTS

FOREWORD

This report pulls together collective work by Oxfordshire agencies to tackle the perpetrators of child sexual exploitation (CSE) and protect children. It headlines the progress that has been made since 2011 when Operation Bullfinch commenced, in the identification and analysis of CSE and in the provision of clear pathways for children at risk through the Kingfisher team and the work of the CSE sub-group of the Oxfordshire Safeguarding Children Board (OSCB). The report concludes that services and interventions across all agencies in Oxfordshire are making a difference to children because of changes made since 2011. The overall conclusion is that there has been good progress in setting up specialist interventions for children at risk of CSE and robust measures used to identify perpetrators and bring them to justice. A parent of a child victim of Operation Bullfinch told me in April 2015;

> ***'I have no doubt the Kingfisher team would have been very helpful to us if they had existed 12 years ago.'***

The partnership in Oxfordshire has moved a long way together to address the problem of CSE, identify collective solutions and produce some tangible evidence of impact. This has led to other improvements to help children, such as tackling self-harm, neglect within families, and Female Genital Mutilation (FGM). There is much stronger engagement from NHS organisations, schools and the faith, community and voluntary sectors working with parents and children and with district authorities and the county council to provide solutions. This report outlines the impact of these changes and describes a professional culture that has adapted and is changing.

While this is positive the findings also show the continuing need for *strategic co-ordination* of activity across organisations. It is vital that the county council's children's services department, the body tasked with lead statutory oversight responds to safeguarding concerns swiftly, and is also perceived by all to be in that leadership role for safeguarding. Changing the culture of how all professionals work together takes time and this report concludes that while agencies know where the gaps remain, there can be no room for complacency. There are two areas in particular that require further work involving the regulation and use of taxi drivers and the commissioning of services to provide help and

therapy for children into adulthood. Oxfordshire county council has set a high bar for ensuring the children it is responsible for are transported safely, but maintaining such standards requires robust *strategic co-ordination* across different departments within the county council. Oxfordshire licensing authorities (district councils) need to improve how they share information about drivers, delegate enforcement powers and require taxi drivers to complete safeguarding training as part of any knowledge test.

Overall this report demonstrates that while positive progress has been made in Oxfordshire since Operation Bullfinch, strategic drive is required in the areas outlined below. The partnership must also remain vigilant about where the next pressure points could appear. The role of the Director of Children's Services (DCS), the statutory position empowered with operational lead responsibility for education and children's social care, continues to be vital in this regard. Safeguarding concerns must be routinely escalated to the OSCB to provide challenge and solution. Organisations have to work together to keep children safe not just from CSE but from all forms of abuse and neglect.

The report makes five important observations about where Oxfordshire agencies must focus:

A) Tackling CSE means getting the basics of frontline child protection right and relies on strong and persistent leadership that can change culture and attitudes towards the most vulnerable children. Chief officers, with an example set by the DCS, must take responsibility to ensure that all serious safeguarding matters are escalated to the Board for challenge by the partnership.

B) The perpetrators of CSE in all its forms, like other forms of child abuse are very clever at targeting vulnerable children and in disguising their activity. More understanding is needed of perpetrator profiles.

C) The success of Oxfordshire's work with CSE has been the impact of specialist services for child victims of CSE through its Kingfisher team. Similar specialist interventions are needed for those adults who may only disclose the abuse they experienced as children some years later.

D) The regulation of the contracts to transport vulnerable children across Oxfordshire and the licensing of taxi drivers should be more robust.

E) Working with and engaging communities is key to effectively tackling CSE. The CSE sub-group of the OSCB must hold to account the co-ordination of district council community safety partnerships in this area.

To conclude, Oxfordshire organisations have identified what is working well and where more needs to be done there is a clear and coherent strategy in place. In keeping up the pace of change required, the OSCB will continue to hold services to account to make sure that the impact of the investment over the last three years continues to lead to positive outcomes for children.

Maggie Blyth
Independent Chair
Oxfordshire Safeguarding Children Board

BACKGROUND AND METHODOLOGY

On the 3rd March 2015 the Independent Chair of the Oxfordshire Safeguarding Children Board (OSCB) received a letter from the Parliamentary Under Secretary of State for Children and Families, the Minister of State for Crime and Prevention and the Parliamentary Under Secretary of State for Health. This was in response to the publication of the Serious Case Review into Child Sexual Exploitation in Oxfordshire (Children A-F).

The OSCB agreed to lead on a specific piece of work into the impact of the multi-agency approach to tackling CSE in Oxfordshire. Sophie Humphreys was appointed by the Children's Minister to work alongside and support the OSCB to gather evidence of the impact of the reforms to frontline practice. This stocktake offers Government and the public in Oxfordshire additional assurance, and should be a valuable contribution to the establishment of a national centre of professional expertise on what works in effectively tackling CSE.

The OSCB and its partners have looked at services as they are now and has considered how they may be further improved in the future. It examines the root causes of earlier failings and whether they have been addressed in current arrangements. Most importantly the report identifies the impact that the new way of working in Oxfordshire is having on improving outcomes for children and families.

In answering five key questions agencies have not shied away from identifying where further improvements may be needed. Facts, data and qualitative and quantitative information have been gathered and at the heart of this has been the experiences of children and their families alongside the wider community of Oxfordshire affected by the abuse inflicted on their area's most vulnerable children. Oxfordshire has asked itself:

1. Has our **culture** changed?
2. Has our **attitude** to vulnerable children and parents changed?
3. Has our **response** changed and are we keeping vulnerable children safe?
4. Are **strategic leaders** working to safeguard children from CSE?
5. What are our **risks and gaps** and are plans in place to address them?

The information that follows describes what Oxfordshire was previously like for children and their families, how services respond now and what difference this is making to their lives presently and in the future.

All organisations and individuals have responded openly and candidly and acknowledged that they are on a journey of improvement. The techniques used throughout this stocktake have drawn on 'real time' information from children's social care, adult services, district authorities, NHS organisations, schools, police, probation, courts and community and voluntary sector activity supplied through 'business as usual' meetings, deep dives and evaluations, as well as on-the spot audits, interviews and focus groups to check the validity and robustness of service responses and user experiences.

A multi-agency audit examining 13 randomly selected cases was specifically used to identify findings for this stocktake report. Quotes from the case audit are used to support evidence. Interviews were carried out with 6 children and 7 parents from the audit sample and information from those interviews is used throughout the report. A full list of evidence is available at Appendix 1.

This information was analysed by a project team of staff from all agencies represented on the OSCB and provided to the Independent Chair, supported by an independent Safeguarding Board Manager from outside Oxfordshire, Julie Davies. That is a strong audit approach but inevitably less evidentially robust than a full inspection. The report was written by Maggie Blyth with support from Julie Davies.

We are grateful to all the frontline staff, managers, families and children who have provided us with their observations between March and June 2015.

WHAT HAPPENED IN OXFORDSHIRE

The serious case review (SCR) published by OSCB in March 2015 describes in graphic detail the experiences of six girls who were the victims of child sexual exploitation between 2004 and 2012. The girls were aged between 12 and 16 years at the time of their abuse. Nine men were convicted in May 2013. Work is on-going to identify other victims and perpetrators. There have been further arrests and convictions through Operation Reportage, March 2015 and Operation Sabaton, June 2015.

The language used by professionals saw them as the source not the victims of their extreme behaviour, and this profoundly affected the response from all professionals who encountered them. They were seen as troublesome and making bad choices of their own volition. Many of their families had complex problems, which deflected attention from who was drawing the girls away from their homes.

The girls lost the ability to consent or make their own decisions due to grooming. The law around consent was not properly understood, and this was compounded by contraception being prescribed (albeit legally) long before the law states children are legally able to have sex. There was a professional tolerance to knowing young teenagers were having sex with adults.

The victims almost never co-operated with investigations and this led to a sense that nothing could be done as evidence was weak. The need for disruption, covert surveillance and comprehensive intelligence gathering, despite no formal evidence from victims, was not understood.

There was a lack of curiosity across agencies about the visible suffering of the children and the information that emerged from girls, parents, or carers, or staff. There was also a failure to recognise the extreme circumstances around the victims were of such concern that information should be escalated and a strategic response be developed. Instead, the cases were seen in isolation, with the focus mainly on protecting and containing the girls rather than tackling the perpetrators.

It is clear, unlike Rotherham, that the ethnic origin of the perpetrators did not delay the identification of the group CSE.

The endeavours of frontline staff using their own initiative eventually led to a shared recognition that there was group-related exploitation of multiple girls in Oxfordshire. Action then became co-ordinated and successfully led to the Bullfinch inquiry and trial 2011-2013. This could and should have happened much sooner. Information had been known but not appropriately acted on in the period 2005-2010.

This stocktake report provides evidence that the root causes of failings in Oxfordshire are being remedied and that there are now in place effective multi-agency systems to identify early and address all child protection issues as they arise, with clear strategic management and oversight so that children are confident they will be heard and communities are assured that swift action will always be taken. The agencies have an understanding of where further improvement is needed and demonstrate a strong commitment to continue to address those areas.

HOW OXFORDSHIRE RESPONDED

1. Has our culture changed?

Oxfordshire then

Many professionals from numerous disciplines, and several organisations took a long time to recognise CSE. They used language that appeared to blame victims and see them as adults, and had a view that little could be done in the face of 'no co-operation'. The language used contributed to delaying the protection needed by the girls and asked for by their parents. It had the effect of judging the behaviour of the victims and deflected away from the groomers. There was a perception of children consenting to sexual activity and a very unreasonable excuse of uncertainty about age as the reason for not taking further action.

The patterns of abuse uncovered in Oxfordshire mirrored those seen in other places such as Rochdale, Derby, Bristol and Rotherham. Organisational weaknesses prevented the true picture from being seen.

Staff did not act with appropriate sensitivity, rigour, imagination or common sense. Processes and procedures were not implemented correctly, and the multi-agency work around safeguarding was not strong enough or apparently evident. Concerns were not escalated to senior managers, and the work done was not good enough. This meant the abuse continued for longer than it should have.

The value of top managers and governing bodies needing to know and be involved was not grasped. The culture within Oxfordshire was for middle managers and practitioners to solve problems themselves rather than considering the wider corporate governance issues. This denied those at the top of the office any influence over what was happening and created a culture of them not being open to early warning and wanting to know about the most challenging and risky issues being handled by their staff.

Oxfordshire now and the difference this is making for children and their families

The creation of the ground-breaking multi-agency Kingfisher team in 2012 introduced real-time sharing of 'soft' and 'hard' information from a wide variety of sources including police intelligence. This creates opportunities to identify county-wide patterns of children at risk of CSE very quickly and enables the team to see links between individual children and potential perpetrators and this has been instrumental in recent and current investigations. The team gathers intelligence and information about children and suspects of concern. As of 1st April 2015 they were working intensively with 70 children and identified over 100 potential offenders. 373 children have been identified at risk in total[1],[2],[3].

The recent Operation Reportage (March 2015) is an example of using experience from Operation Bullfinch to inform new investigations. Action was taken following concerns raised by family members even though the child was not making disclosures to the professionals. Small pieces of information about one child led to talking to other children and linking them with the perpetrators. The police investigation team and the Kingfisher team understood that some victims were unlikely to feel safe to disclose until the perpetrators had been arrested and that the victims will tell their story in small installments as they 'test out' the police and social workers and look to see whether they will really be helped. The ability to stick with the child, even when they were non co-operative and abusive was a critical factor in gaining their trust. At the conclusion of the trial guilty verdicts were returned on 23 out of 26 indictments and the perpetrators received custodial sentences.

The Kingfisher Team also provides consultancy and support to other professionals working with children at risk of CSE and co-ordinates locality based information sharing through 'extended team meetings'. They have supported the roll out of Chelsea's Choice, attending sessions in schools and have taken disclosures from children as a result.

The implementation of the CSE screening tool across all agencies has raised awareness and ensured that key partners take responsibility for early identification. A recent report highlights the range of partners completing the screening tool. There has been a 104%

[1] Summary of Kingfisher work and outcomes
[2] Kingfisher Intelligence
[3] Letter from Louise Casey following a visit to the Kingfisher Team

increase in the number of tools completed in January to March 2015 compared to the same period in 2014. The multi-agency case audit for this stocktake indicated that they were completed to a high standard and in cases where there were concerns, but not evidence of grooming or CSE, support was in place through schools, School Nurses and early intervention workers, including voluntary sector providers to work with children. Where appropriate, the screening tools had been updated as new information came to light[4].

Evidence provided for this report demonstrates that agencies across Oxfordshire have increased awareness of the risk and indicators of CSE. There were examples of CSE screening tools being completed by schools, health services, the youth offending service, early intervention service and social care. They were completed in a timely and thorough way to enable the Kingfisher Team to consider risk and create a full picture of the situation the child was in.

Children's social care has employed an Analyst who is working within the Multi-Agency Safeguarding Hub (MASH), the first point of contact for most CSE referrals. The Analyst is developing a Social Network Analysis approach at this first point of contact considering multi-agency data including missing children data and CSE screening tools to enhance understanding and early identification of children at risk and their links with other children and potential perpetrators.

Anyone under 18 is now referred to as a child and not as a young person so their status as a vulnerable child is never overlooked or misunderstood. The Senior Investigating Officer in Operation Reportage reinforced the importance of this in presenting the case to the court and in enabling the Jury to see that the victim was a vulnerable child. He commented that prosecution barristers needed to be reminded of the importance of this in presenting the case. Children understand that police, social care and health work together and share information. This enables openness and reduces the need to repeat their story which children and parents find frustrating.

Parents and carers are recognised as pivotal players in keeping children safe. This is shown in the case records audited[5] for this stocktake, and the pledges published in the

[4] Analysis of completed CSE screening tools from January 2013 - March 2015
[5] Multi-agency case file audit, May 2015

Oxfordshire CSE [6] promise following Operation Bullfinch. Social workers and other professionals work closely with them to support and protect their child and provide appropriate challenge and intervention when parents are not protective. Almost all the children and parents spoke positively about being involved in planning for the child although some felt that some agencies could do better[7].

Many parents interviewed for the case audits spoke positively about the support they had received and commented on how this had improved in recent years –
'They've got better – the professionals'

Foster carers (some of whom had previously cared for a few of the A-F children) told us that it is like **'*being in a different world now'*** and that when they **'talk *to social workers about concerns now they jump'*.**

Some parents still felt that the professionals could share information with them earlier or that sometimes the professionals could work together with schools better.

'It mattered that she stuck with it. I had 4 social workers before I got my social worker, I was a pain and just told them all to f off, but my social worker wouldn't f*** off!'***

Children's social care 'Need to Know' policy sets out the types of situations that need to be escalated to senior managers. Following the findings of the SCR A-F a workshop was held for senior and middle managers to reinforce the policy and expectations. Analysis of the use of this policy shows that cases are being escalated from social care teams across the County and directors are confident middle managers are contacting them appropriately about cases causing concern.

This is supported by the multi-agency audit where cases were swiftly followed up when one agency failed to act on a concern or pursue it in a timely way. One practitioner told us

[6] Oxfordshire CSE promise
[7] Engagement Report

during a frontline visit that she is confident that 'it feels there is enough people to take an issue forward to if we were not happy with an initial response'.

Escalation in social care in the 12 months up to March 2015[8] identified themes around teenage self-harm incidents, an emerging gang culture in one area and a growing awareness of perpetrator profiles linked to asylum seekers. This change in culture has resulted in the review of historic records and cases re-referred for further investigation as well as the setting up of specific groups to tackle new and emerging themes.

Peer violence amongst older children has been identified as a priority for the OSCB in 2015/16 through feedback from cases. A visit to the team working with children in care and those leaving care showed us the importance of continuing support beyond 18 for some children at risk of CSE. Training is extended to housing providers and personal advisers working with care leavers.

Children's social care has secured funding for children in care, to increase children's residential units increase from 12 to 32[9]. A core aspect of the strategy is to keep the most vulnerable children closest to home and reduce the use of out-of-county placements[10]. This case study below shows why this is important:

A child was admitted into care in crisis. She was known to be engaging in sexual relationships with older teenage males and males up to the age of 26 years. A multi-agency risk management action plan (MARAMP) allowed the home to provide high level safeguarding responses. For example tracking the child's movements on the buses to provide the Kingfisher team and police with addresses and areas frequented. This resulted in the older teenage males being remanded on police bail under the abduction act and drug offences and other abduction notices being served to disrupt unsafe behaviours. The child is beginning to form trusting relationships with her social worker and the team at the home.

Thames Valley Police (TVP) have robust systems in place[11] to ensure senior officers are aware of emerging issues and concerns including daily management meetings and weekly

[8] Evidence of escalation in Children's Services
[9] Oxfordshire's Placement Strategy for children in and on the edge of care, July 2013
[10] Update on progress of Placement Strategy April 2015
[11] Evidence of escalation in Thames Valley Police

tasking and co-ordination meetings. These enable senior officers in leadership roles to quickly respond to changing needs and to deploy resources accordingly.

For CSE, TVP have a force-wide CSE oversight group that meets monthly and is chaired by a Superintendent who holds the CSE strategic lead. This tends to cover larger CSE investigations and themes across the force. For example, an issue of "trap parties" was raised recently in this forum but subsequently found to be involving over 18s.

A force CSE Gold group is the final overview and escalation process. This is chaired by the Assistant Chief Constable for crime and provides chief officer oversight on all CSE issues and concerns.

The Superintendent briefs all district Chief Executives quarterly and local Commanders extend these briefings where there are serious issues and investigations. Reports are added to tactical assessments and joint work with taxi licensing is identifying potential suspects.

In 2014 the early intervention service, police, social care and the missing person's panel were sufficiently curious to share concerns they had about a group of children in the south of the County. They were worried about the risk of CSE because of the children's substance misuse, sexually risky behaviour and the number of times they were going missing. Agencies mapped the connections between these children and the services they were known to. This confirmed there was no organised or prevalent CSE issue. They continue to share information to monitor the situation and keep the children safe[12]

Our observations are that escalation from the frontline to management is more robust and this is reported through section 11 returns to the OSCB[13]. This is supported by the proactive approach taken by district councils through their youth engagement activities and training their staff on the ground to be the 'eyes and ears' of safeguarding. Moving forward, the partnership, through OSCB, must collectively evidence that it is sufficiently equipped through its membership to highlight any new pressure points emerging within child protection.

[12] Practice example
[13] OSCB Section 11 report and peer review

A school Nurse at one Oxford city secondary school told us that any child missing from school was immediately sought out and found by a bespoke minibus service operating from the school. This stocktake has shown that schools are compliant with reporting missing children swiftly and robustly and this is reported to the OSCB. A focus group of foster carers who were contributing to the refresh of the OSCB CSE strategy gave very positive feedback about schools engagement with missing children and those at risk through CSE and analysis of the missing children data confirms that schools are now very proactive[14].

'We tested them, the social workers and everybody; we didn't know who we could trust it was important that they kept coming back.'

Extensive awareness raising activity and training, and reviewing and re-writing of operational and strategic policies has resulted in an increase in the completion of screening tools and referrals to the Kingfisher Team 2012-14. The pervading acceptances of the risks that CSE presents to children has permeated the language and tone of the conversations between professionals and their confidence to challenge through escalation if they are not happy with, or are unsure about, the action being taken. This is matched by the senior management response to confronting the nature of CSE and taking action against it by working in partnership, hearing the safeguarding issues and never giving up.

CSE is now evidently seen as child abuse and responded to as a crime. It is a community safety issue and the district community safety partnerships are well embedded into the county-wide approach to tackling CSE[15]. Local police commanders are expected to keep district council chief executives apprised of risks and threats in their area and they in turn are expected to work in partnership with the OSCB to tackle and disrupt perpetrators[16], [17].

[14] Foster carer focus group
[15] Minutes of meetings with district councils
[16] Local Police Area disruption plans
[17] Thames Valley Police Prevalence Report

'It wasn't good before Kingfisher. People did not know about CSE and grooming.'

'We are going to university and train to be social workers and then we are going to work in Kingfisher and help girls like us.'

2. Has our attitude changed towards vulnerable children and parents?

Oxfordshire then

The views of families about police and social care were not positive. They saw staff as not taking their concerns seriously enough, not believing the girls, and not picking up the hints that they were giving about their abuse. As one parent put it;

> ***"no service or individual has been able to engage with her at all, most have not even tried. She is absolutely alone in the world apart from me and she refuses to allow me to have any influence on her".***

To some agencies, certain parents were seen as unco-operative, collusive and even obstructive. The girls held similar views about police and children's social care. They said people were not being inquisitive enough about what was happening to them. They saw staff as critical and unable to make a meaningful connection with them. Their bewilderment at not being seen as a child and never being asked 'why' is graphically expressed in the SCR.

The girls were not always seen as children nor were they seen as victims. Their verbal and non-verbal actions were ignored and professionals did not understand these as signs of grooming and CSE and so agencies did not intervene. Agencies did not respond robustly to their resistance to support and were unable to handle the frequent withdrawal of allegations or refusal to give details of what happened.

The language used by professionals demonstrated the lack of full understanding of CSE at the time. It described the girls getting themselves 'into trouble'. Other examples were a child missing being recorded as:

> ***'Believed to be prostituting herself... to pay for drugs', 'putting themselves at risk"***

This unsuitable language had the consequence of delaying the protection needed that the

"She is a streetwise girl who is wilful..."

girls secretly wanted, and the parents very clearly desired. This was because the words were judgemental and created a sense of the child as a criminal rather than a victim, and deflected attention away from the perpetrator and the role they were playing.

There was a poor relationship with the sexual health clinics as they focused on maintaining confidential relationships rather than considering if children were safe. This heightened the dearth of professional curiosity. Information sharing was poor and the issue of consent in a sexual relationship under the age of 16 was not widely understood or consistently recognised.

Police investigations looked at the presenting issue and did not progress unless the girls were prepared to make a statement or provide a Video Recorded Interview. Potential evidence was not pursued beyond intelligence or missing persons reports, and investigators did not make the connection. This meant the chances of a successful prosecution were much lower and little disruption activity was undertaken.

Oxfordshire now and the difference this is making for children and their families

Proactive work has been instigated around the issue of consent. This started in 2013 and was repeated in 2015. A dedicated website has been developed (www.checkconsent.com) alongside campaign materials[18]. Posters were distributed to Pub Watch Co-ordinators across the Thames Valley area and to every secondary school and university. The OSCB has re-commissioned its training on working with vulnerable children and risky behaviours to include more information on consent.

Thames valley police collate and store evidence and information regardless of the child's current attitude towards progressing the investigation[2]. This means it can be retrieved and is valid should the child decide to make a statement at a later stage or other evidence comes to light which could lead to a prosecution.

'Before Kingfisher the police just used to find me, take me home and push me through the door saying there you are she's home.'

The Crown Court Trial of Operation Bullfinch made consistent and important decisions about how vulnerable victims should be treated when giving evidence. Operation Reportage 2015 benefitted from this approach and Oxfordshire has put together detailed support packages for all victims giving evidence, working closely with family members.

'The police since Kingfisher are different. They understand it and they tell you like it is'.

A more understanding and robust attitude towards children involved with CSE is clearly evident not just in the courts but within policing and in particular with the officers working within Kingfisher. Comments made by parents and children during the audit interviews confirmed that professionals in the key agencies were alert to the signs of CSE and that they were 'curious'. Several children and some parents described professionals as 'being nosey' and one child spoke about a police officer not giving up when worried about her[7]:

'They kept on asking what it was all about and in the end I had to tell them'

Additionally the review heard of some noteworthy practice in understanding the child's needs from those who led Operation Reportage. The approach is child-centred, welfare issues are considered and the pace of the work is matched to the child's needs[5].

The social worker spent time talking to a child and listening to them. They also spoke to the child's parents and extended family, and the school. This led the child to quickly disclose he was gay and to explore his gender identity issues with the social worker and later with a nurse. Discussions unpicked issues such as the child saying he was looking for a father figure when searching for males on line.

The child was unco-operative throughout the prosecution because of the feelings he had towards his abuser. The social worker, police, nurse, and placement maintained a very clear approach with him that he had been abused. They worked with him to develop his understanding about this and to address the on-going risks he faced when attempting to contact his abuser and possibly other adult males.

As a result of this work the child is now safer. He gradually understood the risks of meeting males on-line and has stopped doing this.[5]

Operation Reportage, March 2015 and Operation Sabaton, June 2015, show on-going commitment to never giving up on children, allowing the time they need to build trusting relationships and to disclose their abuse and a determination to hold perpetrators to account for their actions. Following publication of the SCR two of the Bullfinch victims spoke to over 450 frontline staff and managers in March and May 2015 about their experiences and this had a significant impact on those who heard their input.

Police and social workers jointly visit and patrol locations where CSE is suspected to ensure that welfare issues are incorporated into any police-led activity[19]. Hotspot locations are identified through surveillance reports and disruption actions identified in each local command area CSE disruption plan[20]. The case audit illustrated how children are given time to tell their stories and be believed. Children spoke positively about those professionals who gave them time and who understood they needed to build trust. They were less positive about those they saw as asking too many personal questions too soon. Sexual health services work with children, explore the issues of consent and are inquisitive about their home life and support they are receiving.[7]

Social workers openly discuss issues, such as religious beliefs and sex, with parents and their children. Honesty about the impact of individual actions is at the forefront of these conversations. Parents and children spoke about the importance of social workers setting boundaries and of the professionals being friendly and welcoming. Parental behaviour is challenged and change supported so they are better able to support and protect their child. This example was included in the case audit[5].

A teenage boy told his social worker he wanted to be called by a girl's name to wear girl's clothes. The social worker accepted what the child was saying. In discussing what had changed for them the child said – 'I now feel safe'.

The social worker was uncertain whether the gender identity issues were a reaction to the sexual abuse the child had experienced or something that would have happened anyway.

[19] Case example of disruption work
[20] Multi-agency disruption examples

They recognised the need for specialist advice and support for the child and for themself in working with them on this.

The child was supported by the social worker to talk to his parents about his sexuality and work was undertaken to help them understand and accept this.

Children are no longer considered in isolation. The involvement and impact of other children is considered. For example, the behaviour patterns of children in one part of Oxfordshire were linked through the sharing of information at the district community safety partnerships and the problem profiling report compiled for the safeguarding board CSE sub-group[17].

A 13 year old girl's friends raised concerns with school about her being sexually exploited by a relative. The children were believed and a strategy meeting was held with the Kingfisher team in June 2014. The child and her mother initially lied about her contact with the relative. The child insisted their relationship was not sexual and she denied their relationship and tried to stop professionals talking about what had happened with the adult concerned. The social worker saw how well the child responded to the child abuse investigation officer and it was agreed the police would take the lead role with the girl.

Agencies are working with children on protective behaviours, which has led to the development of a consent checklist for sexual relationships used by School Nurses. All secondary schools have a School Nurse. Children can self-refer to this service. Some School Nurses are available all year round and not just in term time.

Each year School Nurses compile school health improvement plans with input from head teachers. These provide an opportunity to highlight the strategic safeguarding needs of the school. The specialist nurse working in Kingfisher has provided CSE training for School Nurses and offers support and advice on cases where early concerns have been identified. One city school reported that emotional wellbeing, self-harm and sexual health were priorities, triggering questions around CSE[21].

Oxfordshire has an effective response to CSE, which has been in place for 3 years. However, this should not and cannot distort the single- and multi-agency response to other

[21] Good practice examples from School Nursing Service

known pressures in the child protection system such as the impact of domestic abuse, substance misuse, and neglect. There is good evidence of this wider safeguarding work being prioritised, for example though a 'neglect pilot', a multi-agency project for schools and colleges in responding to and reducing self-harm in the north of the county and a new pathway to tackle FGM[22], [23], [24], [25]. It is essential that children's social care continues to evidence to itself and the OSCB that the top of the office is aware of safeguarding pressures.

It is recognised that these factors can be linked to an increased vulnerability to grooming and CSE and a reduced resilience. This understanding is being used to target interventions, particularly in the faith, community and voluntary sectors and often in partnership with schools, the police, social care and early intervention services. There is evidence through this review of good practice with work being done with children on raising their self-esteem, recognising unsafe and safe relationships and encouraging children to provide positive support to each other[26], [27], [28], [29], [30], [31]. The district councils have used funding via their community safety partnerships to support local projects undertaking this work.

'It's like a different world now – nothing like it was when I cared for my girl in 2009/10'

'The police response has definitely changed. They now respond to all missing children and take it seriously – even if the child is over 16. Before they would tell us the child was making their own decisions, now they look for them and bring them home'

'Schools are better at sharing information now and they come to the strategy meetings which is good'.

[22] Complex case planning report
[23] FGM training GP impact quotes
[24] Development of the MASH
[25] Impact of work on FGM
[26] Practice example
[27] Early Intervention Service feedback fortnight
[28] Values verses violence evaluation
[29] Residential care case example
[30] Oxford Pastors Forum October and December 2014
[31] Early Intervention Hub case example

3. Has our response changed and are we keeping vulnerable children safe?

Oxfordshire then

There was little co-ordination of the services being offered to the girls and their families, professionals struggled when they met with resistance and staff were not adequately trained about the signs of CSE and in understanding why the victims and their families behaved as they did. This lack of knowledge also affected the therapeutic care given to the girls as risks were not identified, clues not picked up, and the presenting issue was the only focus.

Disrupting the activity of individuals and groups that were exploiting the girls was not a core part of practice. The police did not use the range of legal orders that had been available since the mid-1980s (child abduction warning notices introduced in 1984 for under-16s, and in 1989 for under-18s and risk of sexual harm orders introduced in 2003). Also, the police did not involve other agencies in tactical meetings, such as the district councils who issue licences for taxis or the county council who have a range of other regulatory powers.

In some cases there was a lack of determination and persistence from staff, which meant there was little chance of the girls building trust with a dedicated worker. Victims were not confident to disclose and give evidence, and there was little or no support for victims and their families.

Prosecution was perceived as difficult and investigations did not always occur. The girls therefore did not disclose, or they made a partial disclosure, because they could not see how the police would keep them safe from their perpetrators. In their eyes nothing happened as a result and this reinforced their sense of isolation and lack of choice.

There was pessimism about whether cases could successfully get to court due to the lack of evidence from victims, and this was a disincentive to further investigation without victim support. Attention was focused on a strategic approach to *managing* missing children rather than bringing adult perpetrators to justice.

Children's social care tried to manage the times the girls went missing rather than focussing on understanding why they were going missing and so did not understand the need to

weaken the perpetrators 'pull' on these very vulnerable children. Added to this, there was a total disconnect between the missing children's panel and specific CSE issues.

Overall the co-ordination of work and sharing of information around the safety of these children was poor. This meant that a wider picture on CSE could not be gained to enable effective multi- and single-agency interventions to be deployed to safeguard children who were incapable of protecting themselves.

Oxfordshire now and the difference this is making for children and their families

At the heart of the change in structures and culture is the Kingfisher team formed in autumn 2012. It is a joint team comprising of social care, police and health professionals working solely on child sexual exploitation issues in a single office. Those children whose cases were audited, and their parents, were all positive about the Kingfisher team[7] valuing their skilled approach and that the workers had the time to build relationships. Parents appreciated social workers who were responsive and being able to call and text if they were worried.

Kingfisher's remit is to help and protect children who have been or who it is thought may have been subject to child sexual exploitation, and to disrupt criminal activity with the aim of bringing court proceedings against perpetrators[32].

The team has been fundamental to supporting Operation Bullfinch, bringing forward other prosecutions, including the convictions in March 2015 of six individuals in Banbury. In addition to the group-based convictions in the period to March 2015, a further six lone offenders and another group of three offenders have been convicted of offences including on-line grooming and abuse of both boys and girls. Convictions have been secured in relation to offences against 35 children in total. The most recent arrests took place on 2nd June 2015 and at the time of writing a number of males have been charged.

Every child that is referred to the specialist nurse in Kingfisher is offered a health assessment. There has been a 60% uptake of these[33]. The other children have chosen to receive this support from someone they are already working with. A small number choose

[32] Independent Reviewing Officers Report May 2015
[33] Report from specialist nurse in Kingfisher

not to engage with health.The Kingfisher nurse offers emergency contraception, pregnancy testing and chlamydia screening. They work closely with the School Nurses and can refer to sexual health clinics.

Engagement with schools and education was an area where further improvements were needed and it is evident attending school is seen as a significant safeguarding indicator. Some parents and children still spoke about school not understanding their particular issues.

The case audit highlighted how this is now being addressed through partnership work and engaging with the child and family[5].

Initially supported in her local secondary school, it was quickly noted that one girl's unsafe behaviour led to the need for an individual educational package, mostly away from the school site.

Assessing her needs and listening to the child's views, the child was placed in an appropriate full-time school provision. This took account of her wishes for the future and was mindful of the risks regarding placement highlighted by multi- agency work.

She has been able to re-take one academic year and is on track to attain her GCSEs. She is happy and feels that she belongs in her new school.

Refresher training has been provided on the use of the multi-agency risk assessment and management plan (MARAMP) tool[34]. This tool has improved the approach to evidence-based and outcome-focused multi-agency working with high-risk children. Professionals are identifying risk factors and thinking about how to build children's resilience. They ask 'why' and focus on what is triggering the risky behaviour. The children and their families work with services and take responsibility for some of the agreed actions. One parent commented positively on the use of a child protection plan and how it served to bring all the professionals together, although she had found the conference itself quite intimidating.

The youth offending service is contributing towards the emerging proactive approach and early intervention work around CSE. The Oxford Child on Parent Violence Project started

[34] Audit of Multi-agency risk assessment and management plan (MARAMP)

in April 2015 and a pilot called 'Building Respectful Families[35]'. These projects are for teenagers and families experiencing child-on-parent violence and are being delivered through partnership with the voluntary sector using funding from the Police and Crime Commissioner. This potential indicator of child abuse was a feature in several of the A-F girls and shows the significance services place on supporting parents and children together.

We found evidence that services recognise the vulnerabilities of older children and there is consideration of their housing and accommodation needs. It is the norm in Oxfordshire for looked after children to remain looked after and in placement until at least they reach 18 years old. In all cases the Deputy Director or Director have to agree a discharge from care before 18 and no cases have been put to them for agreement in the last year.

Prior to the Staying Put legislation (2013/14) the county council had a policy which allowed young people to remain in foster care post-18 for the remainder of the academic year in which they turned 18 providing they remained in full time education. Between 2009 and 2013 sixty children aged 18 remained with their carers to complete education. Since the Staying Put legislation was implemented Oxfordshire has actively promoted the scheme although the transition to financial support through housing benefit as opposed to fostering allowances has not been without difficulty for some carers. Since the Staying Put scheme was introduced 24 young people have remained with their foster carers.

Young people who are Looked After or Leaving Care aged 16 and 17 are able to access the full range of LAC accommodation provision. Those not looked after but in need of supported accommodation can access the Supported Housing Pathway. The Pathway is an intervention based on multi-agency needs and risk assessment through the MARAMP (multi-agency risk assessment and management plan). All supported housing providers, as well as children's social care teams, have received training in the function of this framework and its implementation. Every supported housing provider within the Pathway has adopted this framework as their primary risk management tool and have given very positive feedback around its impact on improving accurate risk information and shared management strategies.

The Early Intervention Hubs play a key role in supporting teenagers in the community and their role includes return interviews with some children who have been missing from home.

[35] Building Respectful Families Project

Providing long term support for young people abused through CSE is placing additional demands on services and the county council has commissioned a review of the needs of vulnerable young people aged 16 to 25 years to consider best practice and recommend future servcie models. Other partners, including health, are also reviewing their transition services.

The Missing Person's Co-ordinator is part of the Kingfisher team. They share information immediately with the team. This has increased knowledge on potential perpetrators or venues where CSE may be taking place. It has also strengthened the approach to gathering evidence used for arrests and prosecution. The OSCB CSE sub-group has responsibility for monitoring practice in relation to missing children and has recently followed up concerns about the timeliness of return interviews in some cases. Many parents spoke positively about police and social work responses when their child was missing[36].

The role of community safety alongside the civil remedies available to the police has led to a number of successful disruptions and new operations to bring perpetrators to justice[20]. Over the previous 15 months 29 child abduction notices have been issued by the police and 6 sexual harm prevention orders have been issued by the courts at the request of the crown prosecution service and the police. To date no civil orders have been used but the county council legal team has been in contact with Birmingham to consider how they have been used there and the childcare team is briefed to advise social workers should there be a case where such an order would be appropriate. Local police teams carry out joint disruption patrols with the Kingfisher team using data and intelligence that identifies CSE hot spots where young people are congregating or it is known have been approached.

The district councils and the county council have been involved in joint intelligence sharing and joint operations which have served to safeguard children, including a case where intelligence suggested that girls were being given free alcohol from an off-license in exchange to then performing sexual acts on staff members. Test purchasing operations were organised, together with licensing officers from the local council, but no further concerns were evidenced. This was accompanied by a covert police operation which again raised no further concerns in terms of the location, but additional intelligence work is being completed regarding the males.

[36] Report on Missing Children

In another case a number of individuals had been frequenting a public house and conducting their business of dealing controlled substances and engaging in CSE offences. A large-scale operation involving fire, licensing, council, health and safety resulted in the premises being closed down. The closure of the public house has shown the community that the activity was unacceptable. It was well known that young girls were being groomed by males, who believed they were in a relationship with some of these men. The management of the establishment was telling staff not to report outbreaks of violence.

In 2013 a number of multi-agency warrants were executed at a guest house in Oxford which was historically linked and frequented by perpetrators of CSE. Police co-ordinated the warrants working with Fire and Rescue, Health and Safety, Licensing and HMRC. As a result of these warrants two of properties were closed.

In 2014 a warrant was executed at a guest house believed to be linked to CSE and trafficking. This was an extended multi-agency warrant involving the National Crime Agency, City Council, County Council, Police, Operation Bullfinch, and the Police lead for human trafficking. Two suspects were arrested. Prosecutions are on-going by the council for numerous environmental breaches. Two females were removed from the property and have been assisted to return to their home country.

The district councils are committed to sharing information to improve the regulation of taxi licensing across Oxfordshire and deal with safeguarding issues in a pro-active way[37]. However, collaboration across all the district councils is needed, with monitoring of this, to overcome the challenge presented by licensing rules that make it increasingly common for a driver to be licensed in one area but drive a private hire vehicle in another area. This has the effect of cancelling out any council's attempt to protect the public by raising the bar for its licensing criteria. Information exchange between licensing authorities needs to be set on a formal footing to enable the effective assessment of whether a driver passes the 'Fit and Proper Person' test. This determines whether a license is refused or revoked due to conduct.

Oxfordshire county council's changed its procurement arrangements in 2015, meaning that it will only issue contracts to providers who meet a new higher standard. However,

[37] Taxi licensing information from City and district councils

challenges remain in regulating drivers of vulnerable children and adults and during this stocktake it has become apparent that the system requires robust overview. Remedial action has been taken and new face-to-face vetting procedures will be introduced from June 2015[38],[39].

The county council has set high standards relating to the regulation and transporting of vulnerable children but information provided to us showed there have been on-going challenges to monitoring these across different county council departments and between county and district authorities. An internal audit was undertaken in early 2015 as children's social care recognised that progress had been too slow in completing risk assessments on providers. The county council acknowledges the need to connect their assurance mechanisms around transport to the wider issue of risks to CSE in partnership with the district councils and that concerns like this must be escalated to the OSCB more swiftly in future as part of the drive for continuing improvement. Safeguarding children in transport was identified as a priority for the OSCB at its extended meeting in April 2015 and the OSCB is monitoring progress both within the county council and across the districts. The OSCB section 11 requirement has been extended to the county council department with oversight of transport contracts for its 2015 return as it is clear that reporting from children's social care alone was insufficient.

A huge amount of training and awareness-raising has been and continues to be delivered to a wide range of professionals across the county[40]. This includes staff in schools and GPs. In 2014 over 7,500 practitioners who have contact with children received training on CSE. The impact from this can be seen in the significant increase in the number of CSE screening tools completed and the range of agencies referring into the Kingfisher team. However, in this report we noted the difficulty in mandating safeguarding training to wider sectors of the community. Although training has been provided to hoteliers, for example, only 12 out of 800 Oxford city licensed drivers took up the offer of training from Oxford city council in the last 12 months and no safeguarding training is offered in the other districts. We recommend that licensing of taxi drivers should be linked to mandatory safeguarding training across Oxfordshire and the rest of the country. Work has begun to co-ordinate practice across the district council areas and local police area command areas on the roll

[38] Allegations management - taxi providers
[39] Action plan, safeguarding in transport
[40] Partnership training information

out of ‘Say Something If You See Something’[41] training to hotels, guest houses, door staff, parks and street scene staff and others who can act as ‘eyes and ears’ on the ground.

Following a visit to Kingfisher, one of the A-F girls is quoted in a BBC news article as saying she believes the police are **"*well on their way*"** to improving their methods in dealing with child sex exploitation. "*They're more vigilant*," she said. **"*There's more police out looking for older men with younger girls, or young girls looking distressed*."**

This view was expressed by practitioners at a learning lessons event run by the safeguarding board in March 2015. In 2014 the Kingfisher team secured support from BLAST, an organisation with specialist expertise in work with boys based in the north of England who provided training and support to the team. Two cases audited for the stock take were boys and both demonstrated evidence of practice to a high standard and sensitivity to their needs. The boys were involved in on-line grooming and had met adult males who abused them. The proportion of males in the Kingfisher caseload has gradually increased over the life of the team and by March 2015, made up 17% (1 in 6) of the open caseload.

[41] Say something if you see something update

4. Are strategic leaders working to safeguard children from CSE?

Oxfordshire then

Top-level commitment from agencies to the OSCB was variable, and board members did not follow things through. Crucial national guidance in 2009 on CSE was overlooked, and there was no strategic overview.

Before Bullfinch, the influence on the OSCB from top managers varied. This contributed to the OSCB not operating in a way that was picking up growing levels of concern, or exercising its statutory duty to collectively lead on CSE from 2009. Concerns across all agencies never reached the most influential decision-makers, and therefore those leaders were not driving a strategic approach.

There were issues across agency boundaries. There was limited understanding of the relationship between the community safety responsibilities held by the districts and the statutory child protection role of the county. Performance management processes did not identify significant causes for concern at an early enough stage. Governing bodies therefore did not have the opportunity to contribute to a robust response and determine priorities.

It took a long time for concerns to be co-ordinated and reach the highest level of organisations. In each year from 2005-10, there were discussions in one setting or another in Oxfordshire about sexual exploitation, but hardly any of this was at a level that could have made a strategic difference.

Oxfordshire now and the difference this is making for children and their families

Following an internal review in August 2013 the OSCB has recognised it must have a strong strategic profile of child protection across Oxfordshire and all organisations are now properly represented at the right level on the safeguarding board with regular formal meetings.

The Oxfordshire Safeguarding Children Board has had a CSE sub-group in place since 2011 and produced a CSE strategy and action plan, a CSE Screening Tool and

Professionals Handbook in 2012. The strategy and action plan is currently being refreshed and includes input from children, parents and carers. The refreshed strategy is written to reflect Oxfordshire's involvement as one of three national pilot sites for the office of the children's commissioner 'See Me, Hear Me' framework. The CSE sub-group brings together all key partners, including the district councils and voluntary sector, and is driving forward the local response to CSE. The sub-group connects with other key partnerships and groups for example the missing person panel, the district community safety partnerships and the children in care council. The CSE sub-group has oversight of the work of Kingfisher, the missing person panel and the police prevalence report and provides support and challenge to ensure the work of partner agencies is robust. The sub-group has started to use a multi-agency performance dataset and is working closely with the OSCB Performance and Quality Assurance sub-group to ensure data and analysis informs their work plan. The CSE sub-group will include the learning from this stocktake in the action plan. The CSE sub-group chair reports to the OSCB to ensure effective oversight and the OSCB CSE co-ordinator supports the sub-group.

CSE as a strategic priority is reflected in all major partnership plans across the County[42] and the Independent Chair has instigated chief officer safeguarding summits. CSE is a priority of the safeguarding board, the county council, district community safety partnerships, the health and well-being board, the children in care council, school health plans, and policing plans. Oxfordshire county council has invested additional resources to tackling CSE, including recruiting more social workers. The Kingfisher Team, which was initially established using short term funding, is now incorporated into the base budget. In real terms children's services budgets increased by 80% between 2007 and 2014. The Chief Executive of the county council describes CSE as her "*number one personal priority*". The police have recruited a number of specialist posts to tackle CSE. Oxfordshire's funding of School Nurses in schools demonstrates new public health investment and the district councils have contributed through the safer communities budget, including a contribution towards a specialist BME worker in the Kingfisher Team.

[42] Review of Oxfordshire's strategic partnerships

Leaders in Oxfordshire have shown their commitment to tackling CSE and disrupting and bringing to justice perpetrators across the county. This report concludes that current and future strategic planning needs to reflect a more dynamic understanding of the area's diverse communities, both in terms of locally agreed priorities and the workforce employed to deliver services to these communities. Data provided for this stocktake shows that the population of Oxfordshire includes 9.2% of people from various minority ethnic communities whilst Oxfordshire county council has a workforce (excluding schools) of 6.5% from minority ethnic communities and Oxford universities hospitals trust 19%. Some partners were unable to provide useful workforce data. Examples of the apprenticeship scheme into children's social care are promising where 147 young people have been provided with opportunities including 9 care leavers and 27 young carers.

District community safety partnerships are directly engaged with the safeguarding board and in disrupting CSE. They are all now represented on the CSE sub-group. Through the intelligence they receive they take direct action from training frontline staff so that they know what to look out for and how to report what they see to closing down public houses. They have commissioned specialist services to work with children at risk through CSE, including risk as victims or as potential perpetrators, on a local level with some good examples of engagement with the faith, community and voluntary sectors[43].

All schools, including independent schools, across Oxfordshire completed a safeguarding audit in 2014, the first time a 100% return rate has been achieved. 47 of these reports were from the independent sector under section 157, with a further 285 returned from maintained, free schools and academies under section 175. Since 2014, the audit captures a wide range of information on safeguarding practice within each educational setting. In addition to the annual report and those schools who self-audited, during the 13/14 academic year, the safeguarding team at the county council undertook a total of 91 audits in schools across the county. This included audits in 12 independent schools[44].

Head teachers and their management teams have risen to the challenge of showing their commitment to working in partnership to safeguard children. More than 18,000 children have seen Chelsea's Choice, a drama that tours Oxfordshire schools to raise awareness of child sexual exploitation. Thousands more children have viewed the drama this year. In the

[43] Faith and Community Sector Focus group, May 2015
[44] Schools' safeguarding audits

autumn term 2015 secondary schools will be involved in the production Somebody's Sister, Somebody's Daughter, aimed at older students. This will reinforce and strengthen the messages they received from Chelsea's Choice. Oxford primary schools have been involved in piloting the Values Versus Violence programme which aims to develop children's core values, self-esteem and resilience and as such is seen as a very early preventive measure in terms of children becoming victims or perpetrators [28].

Prevalence reports which the police provide for Oxfordshire, detailing the current risks, hot spots and planned disruptions and operations are routinely shared with the community safety partnerships. The impact of operations and interventions and outcomes from prosecutions is monitored by the safeguarding board[17]. They use this information to inform their CSE strategy and action plan and to challenge how agencies are working together. The missing link in this report is the profile of perpetrators so that a better understanding can be derived locally and more sophisticated disruption techniques and prevention activities used. A force wide 'problem profile' has recently been developed which includes perpetrator information to be shared with partners (within which the OSCB will require the inclusion of ethnicity/cultural identity). This has been recognised by the CSE sub-group as an area for further development.

The CSE work led to a similar model being put in place in response to the emerging theme of female genital mutilation (FGM). The safeguarding board identified the significant impact that FGM has on the safety and wellbeing of girls and women[24]. A strategy outlines how the safeguarding board aims to prevent FGM from happening, improve services and professionals' responses to women and girls who have undergone or are at risk of FGM, and ensures sensitive specialist support, information and advice is available to them. Learning from work on CSE includes the use of a screening tool and the need for professionals to be curious and ask questions. One young mother, recently giving birth to her 3rd child said:

'*this is the first time anyone has asked about what happened to me*.'

The safeguarding board has mapped the community activity underway or planned throughout Oxfordshire during 2014[45]. This is extensive and some examples are given below:

- Parents groups in schools offering support to help them identify signs of abuse, and practical advice on how to manage risky behaviours and keep their children safe.
- Joint visits by the Kingfisher Team and the Community and Diversity Officer in Thames Valley Police to women's groups in the community.
- Developing and delivering in partnership with mosques child protection training to Imams and committee members in the City.
- Organising a safeguarding event and follow up training with the Oxford Pastor's Forum to raise awareness of abuse.
- City council community development team engaging faith and ethnic minority groups to build resilient and more cohesive communities as part of its CSE community development and engagement strategy[46].

A specialist family support worker in the Kingfisher team works with secondary schools to raise awareness of CSE, deliver protective behaviours work and address sexual health issues.

This is a snap shot of what is going on across the county and there is evidence to show a lot of activity and raised awareness. However, our conclusions are that because this is not overseen or co-ordinated the volume and breadth of activity is not fully understood and this remains a risk. The benefit of greater co-ordination through the community safety partnerships would be the joining up of efforts so there is no duplication, enabling targeting of scarce resources, sharing expertise and resources as well as making sure all diverse communities in Oxfordshire are reached. There needs to be a tight grip on district activity and reported progress from district authorities through the CSE sub-group of the OSCB, tasked with monitoring the CSE action plan.

Oxfordshire county council's adult commissioning team is piloting a project with adult services to provide bespoke support to young adults who disclose abuse or exploitation that took place when they were children but are not able to engage with statutory services. This

[45] OSCB CSE mapping
[46] Community Engagement, Oxford City Council

is being delivered in conjunction with the voluntary sector but at time of completion of this report it is not possible to comment on impact. The CSE sub-group has reported gaps in the amount of help and therapy that is available for adults. Recent discussions have been held with the organisation NAPAC (National Association for People Abused in Childhood) and one young survivor is being supported to participate in their programme. NAPAC are working on a plan to offer a bespoke group within Oxfordshire for adult victims identified through the on-going Bullfinch operation. Again, progress in this area must be sustained. CAMHS services provide intensive interventions to young people past their 18th birthday where this is appropriate and work is underway in Oxford health NHS foundation trust to ensure that other victims of CSE who need on-going mental health support can transition effectively into adult services. The importance of this must not be underestimated.

The stocktake found a good understanding within adult services and OCCG in how such interventions could work and they have been responsive to the findings of the SCR but progress is slow. Adult social care services have dedicated social workers who are based within the multi-agency team working on the follow up to Bullfinch and they will provide support to the (now) adult victims as well as brokering access to mental health, substance misuse and other services[47].

[47] Case study

5. What are our risks and gaps and are plans in place to address them?

The many and varied examples of new ways of working, innovative approaches to service delivery and the evident commitment to tackling CSE head on shows how far Oxfordshire has come since Operation Bullfinch. Services are listening, understanding, taking action, and never giving up; and they are making a difference to children who have suffered from or are at risk of sexual exploitation. Systemic weaknesses have been rigorously addressed and are reported to the OSCB in a more transparent way. Everyone knows the part they have to play in keeping children safe.

There is still work to do and there are five key areas for improvement. These have been widely acknowledged by the safeguarding board and its strategic partners. **As Oxfordshire continues to make progress and build upon the undoubted improvements, the need for consistent strategic grip of services and partnerships remains of paramount importance now and in future.**

i. Tackling CSE means getting the basics of frontline child protection right and children's social care must provide strong and persistent leadership working within the wider partnership. Chief officers of all organisations must take responsibility to ensure that serious safeguarding matters are escalated to the safeguarding board for challenge by the wider partnership.

ii. The safeguarding board and individual agencies (particularly the police) have a good oversight of who the perpetrators are in Oxfordshire. A better understanding of the link to ethnicity/cultural identity is required so that the right tools are used to target prevention work, disrupt individuals and bring them to justice.

iii. NHS and local authority commissioners need to work together to ensure that there are therapeutic services available for adults who disclose abuse and exploitation from their childhood. A huge focus of the work to date has been on the children currently at risk or being exploited and there is a gap in services for them as they move into adulthood and beyond. This includes ensuring that adult services are able to respond in an appropriate and timely way.

iv. Oxfordshire county council and all district councils must work more closely together to ensure that the regulation of the contracts to transport vulnerable children and taxi licensing across Oxfordshire is more robust.

v. Engaging and working with communities is key to effectively tackling CSE. The work of the district community safety partnerships across Oxfordshire must be more effectively organised in relation to safeguarding.

Appendix 1 - References

1.	Summary of Kingfisher work and outcomes
2.	Kingfisher Intelligence
3.	Letter from Louise Casey following a visit to the Kingfisher Team
4.	Analysis of completed CSE screening tools., January 2013 - March 2015
5.	Multi-agency case file audit, May 2015
6.	Oxfordshire CSE promise
7.	Engagement Report - parents, carers and young people, May 2015
8.	Evidence of escalation in Children's Services
9.	Oxfordshire's Placement Strategy for children in and on the edge of care, July 2013
10.	Update on the progress of the Placement Strategy for children in and on the edge of care, April 2015
11.	Evidence of escalation within Thames Valley Police
12.	Practice example
13.	OSCB section 11 report and peer review
14.	Foster carer focus group
15.	Minutes from meetings with district councils, including: - Cherwell Community Engagement, December 2014 - Oxford City Community Engagement, October 2014 - West Oxfordshire, Community Engagement, April 2015 - South Oxfordshire and Vale of White Horse, Community Engagement, March 2015
16.	Local Police Area CSE disruption plans: - Oxford City - South Oxfordshire and Vale of White Horse Districts - Cherwell and West Oxfordshire Districts
17.	Thames Valley Police CSE Prevalence Report, April 2015
18.	Check Consent Resources
19.	Case example of disruption work
20.	Multi-agency disruption examples
21.	Good practice examples from School Nursing Service, May2015
22.	Complex Case planning
23.	FGM training, GP impact quotes
24.	Development of the MASH - report on Oxford City pilot for district involvement
25.	Impact of work on FGM
26.	Practice example
27.	Early Intervention Service feedback fortnight 2014
28.	Values verse Violence evaluation
29.	Residential care case example
30.	Oxford Pastors Forum: - Abuse Awareness Conference, October 2014 - Training, December 2014
31.	Early Intervention Hub case example
32.	Independent Reviewing Officers Report on Kingfisher, May 2015
33.	Report from specialist nurse in Kingfisher
34.	Audit of multi-agency risk assessment and management plans (MARAMP): - MARAMP Audit, February 2014

	- Eyes on – Enhancing our Practice: Learning from the audit: Multi-Agency Risk Assessment and Management Plan (MARAMP), March 2014 - Action Plan update, September 2014 - MARAMP Audit, February 2015
35.	Building Respectful Families Project
36.	Report on Missing Children
37.	Taxi and private hire licensing information from City and district councils: - Data analysis, City and district councils - Cherwell District Council, CEO response to Rotherham report on CSE
38.	Allegations management - taxi providers, Local Authority Designated Officer
39.	Children's Services action plan, safeguarding in transport
40.	Partnership CSE training information: - Oxford Health - Children's Services - OSCB
41.	Say something if you hear something update
42.	Review of Oxfordshire's strategic partnerships, May 2015, including - Health and Wellbeing Board - Children's Trust - District Community Safety Partnerships - Oxfordshire Safer Communities Partnership - Children in Care Council
43.	Faith and community sector focus group, May 2015
44.	Schools' safeguarding audits, including: - 2014 Audit - Local Authority Designated Officer work with independent schools and tutorial colleges - OSCB education sub-group - Local Authority Designated Officer work with language schools
45.	OSCB CSE mapping - work within faith and community groups
46.	Community Engagement, Oxford City Council
47.	Case study

Appendix 2

Summary of Risks and Gaps

Work undertaken for this stocktake has confirmed the areas where further work is required to continue the improvements made to date. A learning event is planned for September 2015 to ensure all organisations are informed of the findings of the stocktake.

These include areas for local agencies to address strategic and operational improvements and two matters for national consideration:

For National Consideration

• There should be core national standards for the licensing of taxis and private hire vehicles which include safeguarding factors. This would help to eliminate risks because of differential standards across neighbouring licensing authorities. The standards should include mandatory safeguarding training and the requirement for a driver to prove that the majority of their work is in the area in which they are licensed.
• There should be national research to identify perpetrator profiles linked to the different models of abuse through child sexual exploitation including gangs and groups, on-line and 'boyfriend' models. This should also include peer on peer child sexual exploitation.
• The lack of therapeutic interventions for young adults requires a national response in relation to an evidence based approach

For local agencies

• **For Oxfordshire County Council, with district councils, to** develop a single joint operator framework covering all aspects of transportation of children and taxi licensing arrangements to ensure the highest standards of practice are in place to safeguard children
• **For Oxfordshire Children's services** to continue to work with schools to prioritise safeguarding, and ensure schools respond appropriately, including to attendance issues
• **Oxfordshire Children's Services** to incorporate learning from the feedback from parents and children into the professionals handbook
• **Oxfordshire Children's Services** to ensure a briefing is held by County Council legal services department on the use of Civil Orders
• **For district councils** to include mandatory safeguarding training in their licensing requirements for taxi drivers.
• **For district councils** to report on outcomes of community engagement work to the OSCB.
• **For district councils to** closer align licensing standards and adopt the OSCB information sharing protocol
• **For Thames Valley Police** to ensure that information about perpetrators of CSE is collated to inform a perpetrator profile and help preventative work
• **For Oxfordshire Clinical Commissioning Group** to develop a response to children who are at risk through CSE and in need of CAMHS support and other

therapeutic interventions to ensure their needs are assessed and services provided in a timescale which meets the child's needs.
• **For Oxford Health NHS Foundation Trust** to ensure that there is smooth transition between CAMHS and adult mental health services especially for the group of victims who experience difficult engaging with mainstream services.
• **For Oxford Health NHS Foundation Trust** to implement and evaluate the impact of the new model for the Sexual Abuse pathway to ensure that children receive appropriate and effective assessment and treatment in line with national best practice.
• **For Oxfordshire Clinical Commissioning Group** and the local authority to develop a response to adult survivors of CSE and ensure they are able to access therapeutic services in a timescale which meets their needs.

For the OSCB – to revise its CSE Strategy to include

• the commissioning of prevention work with potential victims and perpetrators and services to support families where a child is identified as being at risk of CSE
• a CSE dataset to ensure all strategic partnerships have appropriate data and can monitor the incidence of CSE and response in their area.
• the impact of community safety partnerships on community engagement activity
• a recommendation in relation to transitional arrangements between a child victim and adult services when they leave child social care responsibility.

The above actions have been included in the OSCB CSE Action Plan and progress will be monitored through the CSE sub-group and reported to the safeguarding board.

Appendix 3 – Letter from Ministers dated 03.03.15

Department for Education | Home Office | Department of Health

Maggie Blyth,
Chair of Oxfordshire Safeguarding Children Board
By email

Copied to: Ian Hudspeth (leader of Oxfordshire County Council), Anthony Stansfeld (Thames Valley Police, Police and Crime Commissioner), and Joe McManners (Clinical Chair of Oxfordshire Clinical Commissioning Group).

3rd March 2015

Dear Maggie,

PUBLICATION OF THE SCR INTO OPERATION BULLFINCH

We welcome your decision to publish this serious case review in full and to make no effort to hide the extent of serious, organised child sexual exploitation which occurred in Oxfordshire over a number of years. It is only by publishing in-depth accounts of what happened, what went wrong, and why, that children's social care systems locally and nationally can address the failings which have betrayed some of our most vulnerable children. That is why this government has insisted that serious case reviews be published and in full.

The account of what happened to children in Oxfordshire over a number of years is, as you acknowledge, deeply disturbing. The experiences of these girls, and the complete failure of public services to protect them, is appalling, sickening and truly saddening.

We would like to pay tribute publicly to the victims of child sexual exploitation in Oxfordshire and to their families who co-operated with this serious case review. The review makes clear the bravery required for them to speak out, as they have done, and we thank them.

It is clear from the serious case review that there was knowledge of the sexual exploitation of children in Oxfordshire from as early as 2005. But repeatedly, social workers, the police and health workers failed to look past the 'troubled teenager' to the abuse beyond. As a result they failed to act on clear evidence of sexual abuse, to protect the girls or even to pass on concerns to a sufficiently senior level.

The depth of failure is at times hard to fathom and we do not accept explanations that child sexual exploitation (CSE) was not 'widely recognised' nationally at the time. As the serious case review notes, "One does not need

training in CSE to know that a 12-year-old sleeping with a 25-year-old is not right, or that you don't come back drunk, bruised, half naked and bleeding from seeing your "friends".' (para 8.50).

As ministers it is not for us to apportion individual blame but to assure ourselves that any local or national systemic weaknesses have been addressed. We acknowledge that improvements have been made in Oxfordshire both collectively and individually in the local authority, police and health services, and welcome the fact that the Local Safeguarding Children Board has taken a lead role in coordinating the improvements. It is, however, important that you are able to demonstrate, with evidence, just how these improvements are making a difference to frontline practice; and which services and interventions are making the biggest difference to children who have suffered from, or are at risk of, sexual exploitation.

We therefore propose that the Local Safeguarding Children Board leads a specific piece of work into the impact of the multi-agency approach to tackling CSE in Oxfordshire. To support you in this, we have appointed Sophie Humphreys to work alongside you, in order to gather evidence of the effect of your reforms to frontline practice. This will offer us and the public in Oxfordshire additional reassurance, and will be a valuable contribution to the work we are doing nationally to establish a centre of professional expertise to consolidate and share evidence on what works. We will expect this report back by the end of June 2015.

Today the Government has published a report into the action we are taking to tackle CSE, in light of the findings of the Professor Alexis Jay review into failures identified in Rotherham. In that report, we have announced a national whistleblowing helpline, new duties on the police to co-operate across force boundaries, and more support for victims of CSE. The revised 'Working Together' guidance will also introduce an expectation that Local Safeguarding Children Boards undertake regular assessments of local responses to CSE.

The experiences of the children set out in this serious case review should never have happened. We all owe it to them now to do everything within our power to stamp out this horrific abuse and to bring perpetrators to justice.

Edward Timpson MP

Parliamentary Under Secretary of State for Children and Families

Lynne Featherstone MP

Minister of State for Crime and Prevention

Dr Dan Poulter MP

Parliamentary Under Secretary of State for Health

We Need to Get it Right

A Health Check into the Council's Role in Tackling Child Sexual Exploitation

A report from Overview & Scrutiny

Acknowledgement – The front cover is from "The Vanishing", a Children's Society publication. Children from a children's home in Birmingham developed the content and a staff member drew the art work. Thank you for allowing us to use the picture.[1]

[1] www.childrenssociety.org.uk/sites/default/files/tcs/the_vanishing_booklet.pdf

Contents

Further information regarding this report can be obtained from:

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Reports that have been submitted to City Council can be downloaded from www.birmingham.gov.uk/scrutiny.

Glossary of Terms

BSCB	Birmingham Safeguarding Children Board
Care First	The Council's computer system for social care case management
CMOG	Child Sexual Exploitation and Missing Operational Group
CPS	Crown Prosecution Service
CSE	Child Sexual Exploitation
DSL	Designated Safeguarding Lead
FCAF	Family Common Assessment Framework
FCASE	Families and Communities Against Sexual Exploitation
FOI	Freedom of Information
HMIC	Her Majesty's Inspectorate of Constabulary
LAC	Looked After Children
MASE Meeting	Multi Agency Sexual Exploitation Meeting
MASH	Multi Agency Safeguarding Hub
MWN UK	Muslim Women's Network UK
NWG	National Working Group on Child Exploitation
OCSET	Online Child Sexual Exploitation Team – West Midlands Police
PACE	Parents Against Child Sexual Abuse
PSHE	Personal Social Health Education
Quartet	Leader of Council, Cabinet Member for Family Services, Chief Executive, Director of People
Return Interview	Interview carried out after a missing child has returned home / to their placement
WMP	West Midlands Police
WMPCC	West Midlands Police and Crime Commissioner
WMPVVP	West Midlands Preventing Violence against Vulnerable People

Preface

By Cllr Anita Ward

Chair Education and Vulnerable Children Overview and Scrutiny Committee

For far too long, Child Sexual Exploitation (CSE) was a hidden issue, but following the recent number of high profile cases across the country the problem has been exposed and we can no longer pretend that it does not exist within our society.

After careful consideration, and having concluded that if it was happening in areas like Derby, Oxford, Telford & Rochdale it was in all likelihood happening in Birmingham, members of the Education and Vulnerable Children Overview and Scrutiny Committee determined that if, as a local authority we were to adequately protect our young people from CSE, we could not shy away from this inquiry, uncomfortable as it was.

The key question for the inquiry was "what needs to be strengthened in the way the City Council prevents and deals with CSE?" Members of the committee have spent 11 months examining issues relating to CSE in Birmingham, during which time we heard some distressing evidence. This included some horrifying examples of abuse in the city. We have included many of these, not to shock, but to show the range of challenges being faced in protecting victims, and dealing with offenders.

We learnt that policies, procedures, and teams with a greater focus on CSE have been developed. We were impressed by some of the positive work being done by the City Council and its partners in working to protect Birmingham's young people from such an abhorrent crime and the positive work by frontline staff who are supporting these young people to rebuild their lives.

The focus of the report is the City Council's role in tackling CSE, but we learnt about the importance of consistent, joined up multi-agency working too. The focus of activity must be on dealing with offenders, targeting locations, protecting victims and prevention. The Committee's report contains a number of recommendations to both the City Council and partner agencies to improve the way CSE is dealt with. We will hold them to account on delivering on those recommendations

It is important to emphasise that our inquiry was well underway when the Jay Report was published and should not be seen as a knee jerk reaction to that. However, given the findings of that report, our inquiry and recommendations are all the more timely and relevant. Ofsted also published a report on CSE, as this went to print which says:

> "In areas where there have been high profile criminal investigations, the experience has galvanised the local authorities and their partners into trying to ensure that past failings are never repeated."

My aim is for this report is to galvanise action now. We cannot and should not wait for a high profile case to rear its head in Birmingham. Much has been achieved already here, but there is more to be done. This systematic abuse of children requires our full attention.

In conclusion, I would like to thank all those who took the time to give evidence to the inquiry and for their openness in doing so. We met some amazing people in this city who are working tirelessly to protect our most vulnerable children. We could not have completed this inquiry without their insights and advice and I hope the recommendations within this report will enable us, collectively, to tackle CSE head on.

I would like to thank Benita Wishart and Iram Choudry for their work and time in supporting the inquiry and to committee members who spent a long time working on this issue.

Summary of Recommendations

	Recommendation	Responsibility	Completion Date
A	**Delivery of training and awareness raising on Child Sexual Exploitation**		
R01	That: • The "see me hear me" web site[2] be further developed and a concerted awareness and empowerment campaign for action is delivered for the public (communities, families and children); • The City Council and partners work with and build the capacity of a broad range of the city's communities to encourage identification and reporting of CSE; • Resources and sign-posting to online awareness for parents are promoted[3]; • Awareness includes online risks of grooming, the role of the Child Exploitation and the Child OnLine Protection Centre (CEOP)[4] and how to locate and use the report abuse button. • The Cabinet Member Children and Family Services explores how this can be delivered and funded jointly with partners.	Cabinet Member Children and Family Services	February 2015 - Action plan April 2015

[2] www.seeme-hearme.org.uk/
[3] www.paceuk.info/support-for-parents/
[4] CEOP is a National Crime Agency Command at ceop.police.uk/

	Recommendation	Responsibility	Completion Date
R02	That the Cabinet Member and BSCB encourage schools to ensure that: • CSE is integrated into Personal, Social, Health and Economic Education (PSHE) from year 6 upwards into ALL schools in the city and to encourage best practice in understanding and dealing with CSE in schools; • Healthy relationships and girl's empowerment (e.g. by using the "free being me" resources Girl Guiding campaign) is integrated into PSHE teaching in all years; • All teaching includes appropriate provision for boys; • All schools promote safety online including smartphone tracking; and • All school Head Teachers and recognised Designated Safeguarding Leads (DSL) are written to, raising the issue, asking for a collaborative approach in tackling CSE and for key staff to attend training; and they adapt and agree the new model safeguarding policy from the BSCB.	Cabinet Member Children and Family Services	April 2015
R03	That Governor Support Team reviews safeguarding training provided in the light of this report.[5]	Cabinet Member Children and Family Services	April 2015
R04	That: • All frontline staff and managers of caseloads in Children's Social Care including agency staff attend training on CSE. This should include definitions, the grooming line, symptoms and action including what can be done to disrupt / bring charges against and prosecute perpetrators. Particular barriers to disclosure of CSE by black and minority victims should be included in this.; • There is mandatory training on missing children and the escalation system.	Cabinet Member Children and Family Services	July 2015

[5] www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham

	Recommendation	Responsibility	Completion Date
R05	That: • BSCB continues to provide and promote training to its partners including health organisations in the city, the West Midlands Fire Service and West Midlands Police; • Partner organisations include CSE training within Level 1 and Level 2 safeguarding training.	Chair Birmingham Safeguarding Children Board	July 2015
R06	That business forums and networks are identified to work with to ensure broader understanding of CSE and to support the roll out of the *"Say Something if You See Something*" campaign and guidelines with particular a focus on the hospitality industry and taxis in order to increase awareness and reporting.	Cabinet Member Children and Family Services Chair BSCB	July 2015
R07	That: • CSE awareness features as part of induction training for all new councillors; • For all current councillors there is compulsory awareness training on safeguarding including CSE; • Regular training updates are also made available.	Leader	April 2015 (initial feedback) December 2015
B	**Policies and procedures**		
R08	That the policies and procedures across the City Council ensure CSE is properly dealt with by: • Adopting and working to the West Midlands Regional CSE protocol; • Making better use of Care First (the council's system for case management) to record and analyse and share CSE cases ensuring it is dynamic and reports can be pulled out; • Improving feedback from Children's Social Care referrals. (Feedback is meant to be provided in specified timescales which does not always happen); • Establishing CSE champions in key teams including each of the Safeguarding and Family Support hubs who have more in-depth training (and can cascade training to the team) and can act as advisor to the team; • Reviewing policies and procedures to ensure that parents are seen as equal partners in dealing with CSE and to consider	Cabinet Member Children and Family Services	April 2015 – Initial Feedback November 2015

	Recommendation	Responsibility	Completion Date
	implementing the relational model developed by PACE; • Reviewing the council's response to young runaways to ensure it meets the requirements of the new statutory guidance on missing children[6]; and • Developing and embedding a robust missing strategy with clear accountabilities, reporting to the BSCB and an escalation system that is fully understood and effectively implemented; and to investigate the protocol for information sharing when children are classified as absent by the police; and address missing from school as a significant safeguarding risk.		
R09	That the City Council, West Midlands Police and Birmingham Safeguarding Children Board make greater use of licensing to tackle exploitation by: • Strengthening the BSCB's role in supporting agencies including licensing and trading standards and West Midlands Police to use the resources and capacity to best effect; and • Licensing Committee reviewing the statement of licensing and use of powers to assess if it is possible to be more proactive in achieving the objective of: "the protection of children from harm" [e.g. in use of licensing conditions / provision of training /ensuring a clear process for reporting and developing a whistle blowing process to empower license holders and taxi drivers etc. to be proactive in reporting concerns.]	Chair Licensing Committee Chair BSCB	July 2015

[6] www.gov.uk/government/publications/children-who-run-away-or-go-missing-from-home-or-care

	Recommendation	Responsibility	Completion Date
R10	That it is demonstrated that this area of work (including children's services, third sector commissioning and other key departments such as Legal Services and Licensing) is adequately resourced including that: • It is mainstream funded not reliant on annual funding agreements and that third sector contracts abide by the compact; • Commissioning of services specifically for dealing with victims of CSE, in particular, is improved so that they are in place in good time, prior to the beginning of the financial year; • The level of resource for return interviews, plus the intensive support required to prevent reoccurrences has been risk assessed; • A review of the level of administrative support in social work teams and for the CSE Co-ordinators is undertaken to ensure this is not affecting ability to manage caseloads; • A review of the staffing and caseloads of the multi-agency safeguarding hub (MASH) team is undertaken; • Partners review how to resource a Child Safeguarding Licensing Officer post/role.	Cabinet Member Children and Family Services Deputy Leader Cabinet Member for Commissioning, Contracting and Improvement	April 2015
R11	That when the City Council commissions services, safeguarding, including CSE, be built into the service specification and monitoring by: • Ensuring that any contract which will involve direct working with children and young people, families and homes and transport services includes an appropriate level of requirement around CSE (e.g. information and training, procedures, and active involvement in multi-agency strategy and Family Common Assessment Framework meetings); and • Providing reassurance that the school nurse contract due to be re-commissioned by Public Health will include these provisions.	Deputy Leader Cabinet Member for Commissioning, Contracting and Improvement Cabinet Member for Health and Wellbeing	April 2015 – Initial Feedback November 2015

	Recommendation	Responsibility	Completion Date
R12	That in order to manage the specific risks of looked after children: • The corporate parenting strategy is reviewed to ensure it includes proper reference to CSE; • The Corporate Parenting Board provides clear demonstrable actions that CSE is a priority and that the vulnerability of looked after children to CSE is understood; • Appropriate risk assessments continue to be carried out when placing children in residential care and that decisions are needs based and not resource based; and • That there are appropriate policies and procedures (in both internal and external homes) and that staff have the confidence and tools to ensure day to day vigilance and action relating to CSE; and to ensure that these issues are considered in the children's home redesign.	Cabinet Member Children and Family Services	April 2015 – Initial Feedback November 2015
R13	That Legal Services: • Review and assess what can be done to: strengthen the disruption of suspected perpetrators in the Civil Courts; support victims through to prosecution; and increase conviction rates and successful use of warning letters and civil orders, in association with WMP and CPS; and • Review the powers available to disrupt suspected perpetrators and develop a planning tool for disruption for Birmingham, building on the tool kit developed in Derbyshire. This needs to then be used and embedded in Children's Social Care.	Deputy Leader	April 2015 – Initial Feedback
C	**Multi-Agency Working**		
R14	That the Chair of Birmingham Safeguarding Children Board: • Takes further steps to embed the CSE strategy and implementation of the action plan by holding partners to account and ensuring they take appropriate action; • Continues to provide challenge as required to schools following the analysis of the annual section 175 audits; and • Evaluates the effectiveness of multi-agency working including the Strategic CSE Sub-Group, CMOG, Multi-Agency Sexual	Chair BSCB	April 2015 July 2015 – Changes sustained

	Recommendation	Responsibility	Completion Date
	Exploitation meetings etc. (Not MASH – see Recommendation 16).		
R15	That all Birmingham Safeguarding Children Board partners improve the shared understanding of CSE cases by: • Ensuring there is consistency and all officers and partners are working to the soon to be agreed West Midlands Regional CSE operating protocol; • Developing systems to ensure sharing information across the region to enable a full multi-agency problem profile can be updated and shared to ensure patterns and associations relating to victims, offenders and locations can be examined; • Using intelligence and analysis to improve understanding of what tactics and approaches work best; and • Ensuring those providing intelligence and evidence receive appropriate feedback.	Regional CSE Co-ordinator Chair BSCB	April 2015 – Initial Feedback July 2015
R16	That reports be provided on: • The operation of the MASH: workloads, impacts, lessons learnt, and funding (after 6 and 12 months of operation); • Membership of and participation within MASH, including the role of health, the third sector and family support workers; and • Data sharing between the MASH partners.	Cabinet Member Children and Family Services Chair BSCB	April 2015 September 2015
R17	That after six months of operation (March 2015) there is a review to consider if a dedicated multi-agency child sexual exploitation hub should be developed alongside MASH that could provide end to end (case identification through to prosecution) support and action.	Cabinet Member Children and Family Services Chair BSCB	April 2015
D	**Tracking**		
R18	That the Quartet regularly tracks improvements in this area as it relates to the City Council.	Quartet [Leader, Cabinet Member for Children and Family Services, Chief Executive and Strategic Director for People]	On-going

	Recommendation	Responsibility	Completion Date
R19	That an assessment of progress against the recommendations made in this report be presented to the Education and Vulnerable Children Overview and Scrutiny Committee in March 2015. The Committee will schedule regular progress reports until all agreed recommendations are implemented.	Cabinet Member Children and Family Services	April 2015

1 Introduction

1.1 The Evidence We Heard Was Harrowing

1.1.1 The Committee heard harrowing evidence and we make no apology for including that evidence in the report as we want to ensure that everyone understands what child sexual exploitation (CSE) is. CSE is a horrendous crime that deliberately betrays the trust of a young person and can lead to them being trapped in a situation where rape and other mistreatment happens by one or more abusers. Such imprisonment is not always caused by a locked door, but by the terror of possible retribution, or just because they still think their so called boyfriend/girlfriend "still loves them."

1.1.2 We heard of many cases where lives have been put back on track due to timely interventions and we also heard of many examples of, at best, frustration with the systems in place, and at worst failure of procedures, multi-agency working or a lack of resources. The Committee feels that whether or not these were isolated incidents or indications of broader systemic failure, leaving one child vulnerable is one child too many.

1.2 Thanks to Those Making a Difference

1.2.1 Before we start we have to formally record our thanks and gratitude to so many people in Birmingham, as well as across the country, who are working tirelessly to protect children in this city. Many people we met were passionate in fighting to get services and protection in place for children. Listening to the evidence was harrowing enough for us, and we commend those who do this as part of their day job. Our children would be much more vulnerable without you and we hope that this report accurately reflects some of the fabulous work that is being done.

1.3 A Health Check

1.3.1 However in supporting that positive work, we also need to be honest about the challenges we still face. There have been a number of high profile CSE cases in the news over the last few years, for example, in Derbyshire, Oxfordshire, Rochdale and, just recently, the inquiry into systemic failure in Rotherham carried out by Professor Jay.[7] Our report was planned at the end of 2013, and so is certainly not a kneejerk reaction to that hard-hitting report, but it did further encourage us to report on what we heard in detail, aiming to reflect the views of those we listened to.

1.3.2 In the light of the Professor Jay report into Rotherham, we have been asked about the nature of our evidence and the validity of our findings. We have called this a "health check" to distinguish it

[7] Jay, A (2014) *Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013).* At: www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham

from a full scale investigation such as the Jay report, or the Serious Case Review carried out in Rochdale. At no point have we asked to look at individual files and neither have we sought to take a historical perspective. Its aim was to take an overview of the problem and to consider what is currently in place today, in Birmingham, to prevent CSE occurring to children, to protect them and to deal appropriately with the abusers. The objective is to help get policies, structures, and implementation right.

1.3.3 The Committee has concluded that there is CSE in the city, although there has been no single high profile court case. This is supported by the West Midlands Police Chief Constable who, following questioning about the Jay report at the West Midlands Police and Crime Panel in September 2014, said:

> To be really clear, we do know of this as an issue here in the West Midlands.[8]

1.3.4 We learnt, as well, that CSE does not stop at local authority boundaries and that victims and perpetrators cross these virtual lines. There have been cases in the media which have included Birmingham children or Birmingham perpetrators.[9] An alleged recent Coventry gang, for example, included a Birmingham resident.[10] Exploitation starting elsewhere can turn up in Birmingham, such as the trafficking of girls by a gang in Telford to be abused in Birmingham.[11]

1.3.5 We are aware that CSE is an issue that affects the whole country. Birmingham and the West Midlands do have challenges, but so it appears do many other places. Exploitation has no boundaries and can happen anywhere.

1.4 The Inquiry

1.4.1 The key question was:

> What needs to be strengthened in the way the Council prevents and deals with child sexual exploitation and in its working with partners?

1.4.2 The Inquiry was carried out by the Education and Vulnerable Children (EVC) Overview and Scrutiny (O&S) Committee, chaired by Councillor Anita Ward, with much evidence gathering being carried out during 2013/14 and the Committee of 2014/15 finalising the report. The Committee also invited some representation from Social Cohesion and Community Safety O&S (the Chair, formerly Cllr Zaffar and latterly Cllr Khan plus Cllr Roberts before his transfer over to EVC).

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[8] WMPCP Meeting September 2014
[9] www.derbytelegraph.co.uk/Virgin-paedophile-driven-school-police-station/story-20922329-detail/story.html; www.peterboroughtoday.co.uk/news/local/court-paedophile-who-groomed-14-year-old-peterborough-girl-jailed-1-5364955
[10] www.coventrytelegraph.net/news/coventry-news/ten-charged-coventry-sex-gang-5429952
[11] www.bbc.co.uk/news/uk-england-shropshire-22379414

1.4.3 The majority of the evidence gathering was carried out in public sessions and we are grateful to all those who assisted with that process (see list of witnesses in Appendix 1). In addition Barnardo's Birmingham Space and FCASE project[12] provided a training session open to the whole Committee. There were a number of visits and Members also attended seminars. Finally, many further conversations and emails within and outside the City Council provided clarity and examples.

1.4.4 As the evidence has been gathered over a period of a year we accept that some progress may have been made in this time. We tried to secure updates before the publication of this report, but recognise that we may not have captured all the progress made in this fast changing arena.

1.4.5 In spite of the plethora of evidence we heard, there are many more people we would have liked to meet. The direct voice of victims is missing from this report as we did not think being confronted with a group of councillors would be entirely beneficial. If there are opportunities to remedy that in the next year we would welcome the opportunity to do so. In addition, we will take the opportunity to talk formally to more frontline workers; schools and police and school panels; and third sector organisations such as St Basils who deal with vulnerable children and the SAFE project with sex workers; the Youth Police and Crime Commissioners who we know identified this as a priority; workers supporting the Traveller community; disabled children's advocates; and the Regional Anti-Trafficking Network.

1.4.6 As a result we are not intending that this be the last word on CSE from Scrutiny. Our intent in publishing this is to raise awareness of CSE activity in Birmingham, to note some of the improvements that have been put in place to protect children and to put into the public domain some of our concerns.

1.4.7 The case studies are reported as we were told them, with a couple of the more detailed ones coming from third sector submissions and publications. give an indication of the types of Birmingham children we were told about, but we acknowledge that our inability to understand the full picture and, often, what happened to the child is troubling.

1.4.8 This issue is so serious that we sought assurances that Birmingham as a whole was being pro-active and not waiting for someone else to shine the spotlight before being reactive. We were told of a lot of very positive and proactive activity that is taking place and the Committee hopes that over the next 12 months this can be replicated across the whole of the City Council and across all partner agencies. However, we do want this report to act as a wake up call so many more councillors, officers, partner agencies, communities and children themselves start to rule CSE in rather than assuming "it only happens to others". CSE should be considered in every assessment of a child.

1.4.9 We welcome the commitment the Cabinet Member gave to tackling CSE and reviewing case files to City Council in September 2014. We expect feedback on many of the queries raised in the report and action on the recommendations.

[12] Families and Communities Against Sexual Exploitation is funded by the Department of Education

Why Now?

1.4.10 Since the Committee was established in June 2012, CSE has been an area of concern but it was felt it was appropriate to wait until a CSE Co-ordinator had been appointed and had time to make some progress. By the time of publication the post will have been in place for some 18 months and we were pleased to hear that this has been made a permanent post and mainstreamed (having been funded initially by the Birmingham Safeguarding Children Board).

1.4.11 In the last three or so years a number of key documents had been published nationally raising the profile and setting out good practice.[13]

1.4.12 The background to this report is, of course, a children's social care service which has been underperforming for a long time. Although improvements are being seen, it is still facing some difficult challenges, such as social worker recruitment and retention.[14] CSE is just one pressure on the service, but the OFSTED report of May 2014 set out some concerns about how CSE is being managed.

OFSTED REPORT MAY 2014

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

a) "There is a lack of strategic planning and coordination for children and young people who go missing from education, home and care or who are at risk of sexual exploitation. A significant number of children (144) are currently missing from education and are believed by the local authority to have moved abroad. As a consequence, there can be no assurances about their safety and wellbeing."

b) "Systems to support agencies in identifying children and young people at risk of sexual exploitation are in place. However, there is no evidence to demonstrate that the multi-agency response is appropriately robust and that children and young people are suitably protected as a result. In some cases seen where young people have been at risk of sexual exploitation, effective action has not taken place to ensure that these children are adequately protected."

c) "...in eight cases, emergency placement decisions were based on resource considerations rather than on the needs of the young person. This resulted in young people being placed prematurely in semi-independent hostels and residential provision without being

[13] For example: www.gov.uk/government/publications/tackling-child-sexual-exploitation-action-plan; www.barnardos.org.uk/CSE_practitioners_guide_v2_hr.pdf; www.barnardos.org.uk/tackling_child_sexual_exploitation.pdf; www.childrenscommissioner.gov.uk/content/publications/content_743; www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/68i.pdf

[14] BCC (15 September 2014) *Capital & Treasury Management Monitoring Quarter 1 (April to June 2014)*. Report to Cabinet

appropriately prepared. Outcomes for these young people are poor, which results in an escalation in missing episodes, placing some at risk of both child sexual exploitation and increasing offending behaviour."

d) "BSCB does not receive data on children missing from home, care or education and receives insufficient data on child sexual exploitation. This is a deficit of significant magnitude, not least because it shows that the local authority and partners do not collect, collate and analyse this information in a systematic way. As result, partners cannot be assured of the whereabouts or safety of these young people."

e) "The child sexual exploitation strategy agreed by the Board in January 2014, has not yet been implemented and this delay means that agencies are not yet working together effectively to provide the appropriate level of safeguarding support to children and young people who are risk of/or are suffering sexual exploitation."

1.4.13 As we were finalising the report an inspection of West Midlands Police carried out earlier in the year was also published.[15] It concluded that within the police experiences were mixed.

Her Majesty's Inspectorate of Police
National Child Protection Inspections: West Midlands Police

"Although West Midlands Police has a small central team, it does not have dedicated local specialist teams to investigate child sexual exploitation. Child sexual exploitation is investigated by officers in the child abuse investigation team (CAIT). In the cases examined by inspectors, the police response was mixed. The service was generally good if the risk was clearly identified by another agency ….. However, five of the nine cases of child sexual exploitation examined were assessed as inadequate. Signs of risk were missed, lines of enquiries were either not followed up or took too long, and there were failures to respond to information and intelligence and to pursue offenders."

"Inspectors assessed the handling of 9 of the 11 cases of children missing from home as inadequate."

"Overall, the force's response to tackling child sexual exploitation has been slow, with inconsistent practice across the force area."

"We recommend that West Midlands Police takes immediate action to review its plans for identifying, disrupting and prosecuting perpetrators involved in child sexual exploitation."

[15] HMIC (October 2014) National Child Protection Inspections: West Midlands Police 2 – 13 June 2014

2 What is Child Sexual Exploitation?

2.1 Definitions

2.1.1 CSE is a form of child abuse. The nationally accepted definition is below.

> The sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing, and/or others performing on them, sexual activities.
>
> Child sexual exploitation can occur through use of technology without the child's immediate recognition, for example the persuasion to post sexual images on the internet/mobile phones with no immediate payment or gain. In all cases those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.[16]

2.1.2 The Association of Chief Police Constables (ACPO) additionally adds:

> A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see themselves as a victim of exploitation.[17]

2.1.3 The City Council's early help team suggest that CSE tends to be a "course of conduct" rather than an isolated incident.

> It involves relationships based on a deliberate imbalance of power. A person under 18 is sexually exploited when they are coerced into sexual activities by one or more person(s) who have deliberately targeted their youth and inexperience in order to exercise power over them.

[16] (The National Working Group for Sexually Exploited Children and Young People, 2008)
[17] www.app.college.police.uk/app-content/major-investigation-and-public-protection/child-sexual-exploitation/#definition-of-cse

2.1.4 When we started investigating the words "receive something" we found that in Birmingham the actual gifts could be as cheap as a bag of sweets or chips, a bottle of beer or some drugs. But for many of the children what they are craving, and sometimes think they are receiving, is "love and affection." Although a smartphone may be seen by a victim as a generous gift its purpose may be in the abuser's ability to then track a child using the GPS function built into the phone.

2.1.5 Grooming can occur over a course of many months or in just a short time. In one case in Birmingham that led to prosecution the grooming of a girl who was missing from home happened over a period of five days.[18] Grooming is "not a specific form of child sexual exploitation but should be seen as a way in which perpetrators target children and manipulate their environments. It is an approach to exploitation and may be the beginning of a complex process adopted by abusers. Grooming can be defined as developing the trust of a young person or his or her family in order to engage in illegal sexual activity or for others to engage in illegal sexual activity with that child or young person."[19]

2.1.6 But all such definitions obscure the real crime which one West Midlands Police (WMP) officer explained is rape and serious sexual assault.

CRIME CHARACTERISTICS:

In simplified terms, this crime consists of three stages: 'find', 'groom' and 'abuse'. When not recruiting new victims via existing ones, offenders typically search for targets in public places. After initiating conversation, they obtain the child's name, age and contact details. Grooming starts immediately and can continue during and after abuse. Both positive and negative grooming manipulations are used, such as flattering victims, providing free drink, insulting and threatening them. The actual abuse occurs at various locations, including parks, cheap hotels and 'party' flats. Victims may be abused by a single offender, multiple offenders at once, or numerous men in quick succession. Levels of repeat victimisation are high, leaving many victims embroiled in the cycle of abuse for weeks, months, even years.[20]

2.1.7 Throughout the report we refer to anyone who has not yet reached their 18th birthday as a child. Whilst it is acknowledged that teenagers would wish to be referred to as 'young people' the term 'child' in this context helps professionals stay focused on the fact that they are children being abused and not young adults making positive choices.[21]

[18] www.birminghammail.co.uk/news/local-news/sick-birmingham-duo-plied-girl-1704107
[19] www.cps.gov.uk/legal/a_to_c/child_sexual_abuse/#a36
[20] www.ucl.ac.uk/jdibrief/documents/cse/GROUP_BASED_CHILD_SEXUAL_EXPLOITATION__2-Crime_overview_
[21] www.swindonlscb.org.uk/wav/Documents/CSE%20Handbook.pdf

2.2 Who is at Risk and What Are the Signs?

2.2.1 There are many things which can make a child vulnerable to exploitation. First and foremost is low self-esteem. If a child feels they matter and are important it is easier to say "no." The screening tool now being used by all agencies cites the vulnerabilities below. We were told about the additional risks that children with disabilities and special needs face, especially those with learning difficulties, on the autistic spectrum or with poorly developed executive function.

Table 1: Vulnerability Factors

Low self esteem	Breakdown of family relationships
Unsuitable/inappropriate accommodation	Emotional abuse by parent/carer/family member
Isolated from peers/family/social networks	Physical abuse by parent/carer/family member
Lack of positive relationship with a protective/nurturing adult	Family history of domestic abuse
Sexual abuse (during childhood)	Family history of substance misuse
History of Local Authority Care	Family history of mental health difficulties
Involvement of criminal activities	Lack of awareness/understanding of being safe

2.2.2 In general families, carers and practitioners should be mindful about signs of changed behaviour or examples of the indicators below. Other risks include a child with poorly developed problem solving skills and association or witnessing of gang related activities.

Table 2: Signs and Indicators for Frontline Practitioners and Clinicians

Self harm	Bullying (Victim and Perpetrator)	Late presentation (Injury or illness)
Low self esteem	Repeated sexually transmitted infection (STI) testing	Missing/Running away
Rapid change in appearance	Pelvic inflammatory disease	Repeated school absence
Sexualised behaviour	Repeat pregnancy	Mental health problems
Disruptive/Challenging / criminal behaviours	Repeat alcohol abuse	Suicidal thoughts
Revolving door (Representing to police and A&E Departments)	Drugs and solvent abuse	Unexplained injuries
	Physical injuries	

2.2.3 The multi-agency policies and structures referred to in chapter 3 provide the framework within which individual professionals, agencies and third sector agencies need to work. Common use of these basic screening tools is necessary and is, we were told, becoming more embedded. We noted the advice of one health professional:

> If you have a gut feeling something's not OK then refer. Very subtle things can raise alarm bells. If our staff feel anxious I tell them to refer.

2.3 CSE Can Happen to Any Child

2.3.1 "CSE is non-discriminatory", we were told. Recent media attention has focussed on one model of grooming – perpetrators focussing on looked after girls. The high profile cases have largely drawn explicit attention to the girls being "White" and the perpetrators "Asian".

2.3.2 Our evidence has shouted out that exploitation can happen to anybody irrespective of where you live or your family circumstances. We have heard about girls across the city; some from unstable family backgrounds or in care, but others from previously stable and loving homes, including one who we were told went to school in an affluent part of the city. It can happen to white children as well as black and minority ethnic children. It happens in this city to boys too. WMP told us that it does disproportionately affect some of our communities, but that all are at risk. The example below is not a Birmingham case, but it helped Committee members to understand the complexities of CSE and how important it is not to make assumptions. It is, therefore, included here.

Emma's Story

Emma (a pseudonym) is now 24 years of age but was a victim from the age of 12. Emma's story started when she went to a shopping centre with friends at weekends. Lack of confidence and low self-esteem are very often a factor for teenagers and children who are groomed but Emma is from a loving and attentive family and was not vulnerable in any way. The initial approaches were from young boys, not adults, but as time went on she was introduced to older teenagers and then adult men. During the time she was being abused, Emma believed she was having a fantastic time but it was also the worst time of her life, all at the same time. The exploitation went on until Emma was 15. Since then a number of grown women have come forward with the same allegations against the same men and the police are investigating. It was easier to say "yes" than to say "no" – if victims try to say "no" they are likely to be detained and raped, and to say "yes" is often the quickest way to escape the situation. There was no education for young girls on how to avoid sexual exploitation-the perpetrators were smartly dressed, had nice cars and were nice looking - and this was never warned against.

Emma felt the professionals were no help. They gave her condoms and warned her to avoid getting pregnant, but she was not helped to escape the abuse. Their approach made Emma feel that what was happening to her was quite normal, but in fact it wasn't – she was being exploited. If she had told someone that a family member was regularly raping her and then giving her drink and drugs, professionals would have helped and immediately removed her from the situation, but in the case of CSE there was no professional help. In the end her parents removed her to another country to try and rescue her. This was not the end of Emma's problems as the psychological damage and the breakdown of trust with her parents took many years to repair.

"The important things are education and prevention. Once a child has been raped it is too late. It is not acceptable in this country in this day and age that children are being tortured and that men are acting out their sexual fantasies on children. It is not normal and we should not accept it".

Source: WMPCC Seminar: 8th Oct 2013

2.3.3 The Muslim Women's Network UK (based in Birmingham) has carried out research into the Sexual Exploitation of Asian Women and Girls called *Unheard Voices*.[22] The 35 case studies the research is based on included many in Birmingham. Overwhelmingly, the abuse in the cases were highly organised and of the group grooming model. It concluded that there are currently victims who are ignored in the reporting of and dealing with CSE victims because they do not come forward or are not seen as someone that CSE could happen to. The report indicated that the Muslim victims they identified had particular vulnerabilities relating to shame, honour and forced marriage which made it particularly difficult to speak out or seek help. Shaista Gohir, Chair of the Muslim Women's Network UK, urged other black and minority ethnic (BME) groups to carry out similar research within their own communities to identify unheard voices.

2.3.4 The evidence also shows that exploitation can be carried out by anyone. Media reporting of perpetrators linked to Birmingham indicate that many are white, and we have been told of at least two cases when women were grooming. In the light of accusations of officials in Rotherham ignoring evidence of a "deep-rooted problem of Pakistani-heritage perpetrators"[23] we have been asked if this has occurred in Birmingham. We do not have evidence of that. But, we do need to put on record that we did hear a historical allegation that some of the men preying on children in a children's home were "Asian". We understand that interventions were put in place (such as following children to parks and challenging adults who appeared to approach them inappropriately and passing details of car registration plates and sim cards to WMP). The Committee feels that it is most important that this allegation is not thought by others to be the only type of exploitation in the city as it was one example that the committee were made aware of during the evidence gathering for this inquiry.

2.3.5 To focus attention on just one community would be to let down many other children in the city. Once there is any assumption made that perpetrators are likely to come from just one group then exploitation by others and warning signs get ignored or not seen for what it really is. In making incorrect assumptions, one puts children across the city in danger. However, the Muslim Women's Network UK's evidence was that, on the whole, perpetrators tend to prey on victims from their own communities as they are most accessible.

2.3.6 The Committee considered that the media was more likely to highlight one model of grooming above others. It may then follow that a known perpetrator profile reflects the cases that have had media attention as identifying the same patterns gives practitioners and others the confidence to refer. A report back from the Police and Crime Commissioners summit on CSE suggested that this is problematic:

[22] Unheard Voices –www.mwnuk.co.uk/resourcesDetail.php?id=97
[23] Alexis Jay (2014) Independent Inquiry into Child Sexual Exploitation in Rotherham 1997 - 2013

> As CSE occurs in all communities and across all ethnicities by stereotyping the typical offender the public only look for certain types of grooming and only question certain relationships.[24]

2.3.7 However, to ignore tackling any robust evidence of prevalence in any community through a fear of racism cannot be tolerated, but, as the Leader of the Council, Sir Albert Bore said in regards to Trojan Horse, the only way to resolve this big issue is to work with all communities in the city.[25]

Myths

2.3.1 Both the Crown Prosecution Service and the National Working Group (into CSE) have highlighted a number of myths and stereotypes that can be very unhelpful. Some of those relevant to this topic are indicated below.

Crown Prosecution Service (CPS) Myths

Sexual exploitation is only perpetrated by certain ethnic/cultural communities

Perpetrators of sexual exploitation come from a range of different backgrounds and it is not restricted to one ethnic or cultural community. There is more than one type of perpetrator, model and approach to child sexual exploitation by gangs and groups. It invalidates the experience of victims abused by perpetrators from other backgrounds and risks such abuse being overlooked. What all perpetrators have in common, regardless of the differences in age, ethnicity, or social background, is their abuse of power in relation to their victims.

It only happens to girls and young women

Boys and young men are also at risk of sexual abuse and exploitation. It implies the boy or young man is not telling the truth and invalidates the experience of the victim.

Sexual abuse and exploitation does not happen to children and young people from Black and Minority Ethnic (BME) backgrounds

Victims of child sexual abuse and exploitation come from a range of ethnic backgrounds and are not restricted to just one ethnicity. What is common to all victims is their powerlessness and vulnerability, not their age, ethnicity, disability or sexual orientation. It implies that children and young people from BME backgrounds are not telling the truth and invalidates their experience. It also risks such abuse being overlooked.[26]

[24] www.westmidlands-pcc.gov.uk/media/236764/cse_uni_of_bham_connectjustice_report_final_summary_july_2013.pdf
[25] m.lgcplus.com/5073133.article
[26] www.cps.gov.uk/legal/a_to_c/child_sexual_abuse/#a36

Myth Busting by the National Working Group on Child Exploitation (the NWG)

Myth: This only happens to girls and young women – No

Myth: This is only perpetrated by male offenders – No

Myth: This only happens in certain ethnic/cultural communities – No

Myth: This just happens to young teenagers – No

Myth: This only happens to looked after 'vulnerable' children – No

Myth: This only happens in large urban towns and cities – No

Myth: There are very few forms it can take – No

Myth: Parents should know what is happening and should be able to stop it – No

2.4 Evidence and Numbers

Under-reporting

2.4.1 Unfortunately, the evidence base is not good enough at present in the city. The CSE Co-ordinator and the police have been drawing up profiles, but this is a crime that is overwhelmingly under-reported. Additionally the City Council's evidence to Parliament points out that "data collection around grooming and CSE is ... challenging ... as it is not collected at the front door as a presenting issue."[27] We believe that the Multi-Agency Safeguarding Hub (MASH - see section 3.5) has improved that situation as CSE assessments are now carried out at the front door.

2.4.2 The first point to make about numbers is that the Le Grand Review described unidentified risk as a:

> Serious potential problem confronting Birmingham's Children's Services: that of possible unidentified risk to vulnerable children. We received many comments from partners and others about the obstructions they encountered when making referrals to Children's Services. It was suggested to us that, as a result, there may be many children in Birmingham at risk who have not been properly identified as such, or, if they have been, their risks have not been properly addressed.'[28]

[27] www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/68vw04.htm
[28] www.gov.uk/government/uploads/system/uploads/attachment_data/file/297748/Birmingham_report_25.03.14.pdf

2.4.3 This unidentified risk will apply to victims of CSE as well as other children at risk. For CSE victims, even when support workers suspect a problem and are actively working with a child, it can take a whole year to obtain a disclosure. As we have seen with Operation Yew Tree it may take decades before someone discloses that they have been abused or exploited.

2.4.4 The data held about CSE is unlikely to provide a complete picture of the extent of CSE in the city of Birmingham for various reasons, including for example, victims of CSE often do not consider themselves to be victims and so do not report what is happening to them. However, as public and professional awareness surrounding CSE increases, it is anticipated that there will be an increase in the reporting/referral of cases of CSE.

Data source

2.4.5 The data below has been collated by the City Council's CSE Coordinator. This includes cases that have been referred from MASH or referred internally, for example, via social workers. The information and Early Help CSE dataset is kept through Family Common Assessment Framework (FCAF) coordinators based at the MASH.

2.4.6 The City Council does not hold information on "Universal Services", which are programmes delivered by the voluntary sector, schools, and Youth Offending Services around prevention of CSE. Data in these cases is not referred via the MASH.

2.4.7 The referral pathway for concerns around CSE, as well as the assessment process to safeguard children from CSE in Birmingham, is set out within the Birmingham Safeguarding Children's Board (BSCB) procedures as well as their Strategy and Action Plan 2013.

2.4.8 The CSE screening tool has been implemented by the BSCB's board. Associated actions for these services includes referrals into the MASH if presenting concerns are medium or significant. Where concerns are referred to the MASH, children and young people will then be assessed using a nationally recognised CSE assessment tool.

2.4.9 The figures held by the City Council include information about "Early Help". This relates to young people who have not been escalated up to the CSE Coordinator but are receiving intervention through the Family Support Teams following the CSE screening where they are displaying vulnerability factors. Those young people are still screened and reviewed, and will be escalated to a Multi-agency Sexual Exploitation (MASE) meeting if risks increase. A multi-agency CSE meeting would be held where there are medium or high risk concerns according to the CSE tool referred to above, with the intention of deciding upon the best course of action. This may include steps such as the implementation of a disruption plan. Early Help[29] is considered by the City Council and the BSCB to be a key factor in dealing with and trying to prevent cases of CSE.

[29] http://www.lscbbirmingham.org.uk/images/Early_Help_definition_-_final_draft_2.pdf

Numbers at Risk

2.4.10 In September 2014 there were 132 young people known to be currently vulnerable to or experiencing CSE.[30] This figure is broken down as follows:

- 47 considered as victims of CSE; (medium or significant risk factors identified);
- 23 considered vulnerable to CSE that have been raised with the CSE Coordinator (displaying vulnerability factors);
- 13 current ongoing assessments with young people to assess their level of risk and pitch the level of response required;
- 49 children receiving the Early Help offer.

2.4.11 Totalling those figures gives 83 children who are being assessed, who are vulnerable to CSE or are considered victims of CSE (plus 49 receiving Early Help gives 132).

2.4.12 Significant and medium risk indicators include:

- Periods of going missing over night or longer;
- Entering/leaving vehicles driven by unknown adults (not car theft);
- Unexplained amounts of money, expensive clothes or other items;
- Multiple callers/contact – With unknown adults/older young people;
- Disclosure of sexual/physical assault followed by withdrawal of allegation;
- Has been sexually assaulted; and
- Accident and emergency hospital attendance because of alcohol/drug misuse.

2.4.13 Vulnerability factors include:

- Unsuitable/inappropriate accommodation/sofa surfing;
- History of Local Authority Care;
- Involvement in criminal activities and/or at risk of gang involvement;
- History of Child Protection involvement in relation to neglect, physical or emotional abuse; and
- Family history of domestic abuse and/or substance misuse and/or mental health difficulties.

[30] FOI Number - 11402

2.4.14 Details of the 83 considered to be at risk or victims of CSE or undergoing assessment are below. As noted previously all that can be reported on is what is known.

Table 3: Profile of the known 83 children considered victims or at risk or undergoing assessment from multi-agency records, 5/9/14

Characteristics	Breakdown of known multi-agency profile
Gender	80 are female and only 3 are male.
Age	• 1 is under 13 years • 57 are 14 - 16 years • 25 are 17 or older

Ethnicity	• 39 are White British
	• 40 are from black and minority ethnic groups:
	  ○ Asian – 17,
	  ○ Dual Heritage – 11
	  ○ Black Caribbean – 7
	  ○ Other – 5
	• 4 have no data

Care Status	• 44 are Looked After Children (11 have a Full Care Order and 33 are being cared for on a voluntary basis (called a section 20))

2.4.15 The data above shows that it is not a problem for girls only; but it does show a substantial under-representation of boys amongst the known at risk children. Nationally it is thought that one in five victims of CSE might be boys, although this has been difficult to assess.[31] Given these statistics and the demographics of Birmingham it is crucial that all training and awareness raising makes reference to the likelihood of black and minority ethnic children and boys being victims. Conversely, children known to social services are over represented in those known to be at risk or victims of CSE. In one way that is unsurprising as they are the children who are most scrutinised. There is also a strong linkage with missing children. We are told that 70-80% of all "high risk missing notifications" received from WMP mention known CSE indicators in the information received.

2.4.16 The FCAF coordinators are now based at the MASH with an Early Help Offer. Working with practitioners, they have identified a further 49 additional children (as noted in section 2.4.10) who have vulnerabilities to CSE, but have not been deemed high risk enough to be escalated up to the CSE Coordinator. They are receiving a programme of intervention around their potential vulnerability to CSE to prevent escalation through the Family Support Teams.

[31] www.natcen.ac.uk/media/539627/16144-su-cse-rapid-evidence-report-v4.pdf; www.nuffieldfoundation.org/sexual-exploitation-boys-and-young-men-exploratory-study; www.barnardos.org.uk/hidden_in_plain_sight-4.pdf

2.4.17 Therefore, there are a total of 132 children in Birmingham (or possibly in the care of the City Council, if living out of city) who are at risk of being exploited or are being exploited. This figure is a snapshot from 5th September 2014 and is always changing. The CSE and Missing Operational Group (CMOG), for example, had identified 15 further young people for discussion in September.

2.4.18 Table 4 indicates children at risk of CSE who have been identified in the city over time. It indicates the numbers of children referred to a MASE meeting due to concerns that they were, or had been, at risk of sexual exploitation.

Table 4: Referrals for MASE Meetings 2011-14

	Number of children
Referrals for multi-agency CSE meetings between April 2011 – March 2012	45
Referrals for multi-agency CSE Meetings between April 2012 – March 2013	90
Referrals for multi-agency CSE meetings between April 2013 – March 2014	58
Referrals for multi-agency – CSE Meetings from April 2014 to 24 September 2014 (Year to date)	42

2.4.19 There is a serious CSE problem in Birmingham, as with many other places around the country, but not enough is currently known around the totality of the problem of CSE in the city based on current available information. The under-represented nature of boys within the data held or understood by partners in Birmingham, demonstrates that more work is needed to raise awareness with frontline professionals, universal services, community and schools of those risk indicators and associated responses in supporting this particularly hidden group of young people.

2.4.20 West Midlands Police are currently working with the 7 local authorities in the force area to produce a 'Multi-agency CSE Problem Profile'. This will help increase understanding, although given the hidden nature of this crime it will still not show the whole picture. We were not shown any mapping of the problem across the city. However we were told by West Midlands Police that every ward in the city has got risks and potential and every area has a story around CSE: victim, offender or location.

2.5 Models of Grooming

2.5.1 There are a range of different approaches or models of CSE, which tend to involve initially building a caring relationship with the child. Typical quotes from a ChildLine report[32] are below.

[32] www.nspcc.org.uk/news-and-views/our-news/nspcc-news/12-11-12-grooming-report/caught-in-a-trap-pdf_wdf92793.pdf

Children's Views of Groomers

> Getting attention from him was nice.
>
> No-one has shown interest in me like this before, he made me feel special and told me I was special and that I was the only one he wanted to be with."
>
> He makes me feel special because he pays attention to me and I like that because no-one else does.
>
> I had no one to talk to.
>
> Me and my parents weren't getting on and I had no friends I could trust.

2.5.2 Typical models of grooming are:

- Inappropriate relationships with older adults
- "Boyfriend" model with older man working alone
- Organised exploitation involving groups or gangs
- As part of initiation into gangs
- Peer on peer grooming
- Online exploitation.[33]

2.5.3 However, perpetrators' behaviour may not always be neatly categorised. The serious case review referring to the Little Stars Nursery involved "an offender who, whilst grooming young girls on the internet was also abusing a young child in the nursery, confirming the challenges involved in categorising offenders in terms of risk."[34]

2.5.4 Barnardo's set out the grooming line which shows the deliberate strategies that abusers use to target, build trust and then utterly betray that trust. We were told that in grooming there is never an intent for a long or loving relationship. One practitioner explained the process, below.

> When getting to know someone the perpetrator might give the young person a mobile phone and use lines like "You can speak to us at any time." We were told how quickly they learn about the young person and their families and the arguments with their parents. Perpetrators will build on this. They learn where parents work and about siblings and best friends. They build a relationship until

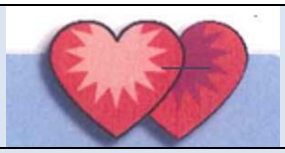
[33] Children Society evidence
[34] www.lscbbirmingham.org.uk/images/BSCB2010-11-3.pdf

the young person thinks it is boyfriend and girlfriend. Then it changes and the child is expected to pay back through sexual activity with the perpetrator and then friends and others. It grinds children down. They feel dirty, ugly, worthless and may get diseases and pain. The perpetrator isolates them so will have no one else to go to. If they try to get out the perpetrator knows everything about them. Threats are common, such as "your little brother will get stabbed".

2.5.5 Grooming involves putting in or exploiting a wedge between a child and their parents or carers so that the child will not listen to the reasoning of those who care for them, but becomes dependent on the abuser. Once in an abusive relationship a child will feel very isolated. There may be an element of "debt bondage" – you owe me back for what I have given you, and controlling or violent behaviour to ensure the child cooperates. It is often not until the end of this grooming line that victims realise they are being groomed and it can be too late. By the end of the grooming line the perpetrator may well be receiving financial gain for making a victim available.

2.5.6 Perpetrators can persuade children to bring others forward to be abused. A year 11 child might be asked to make friends with a particular year 8 child, especially if they have lost their value to the perpetrator by being too old and they might even be paid to bring in younger victims. Children can be blamed for this– but they are still victims, generally being co-coerced into this position.

The Grooming Line

			
Targeting stage	**Friendship Forming Stage**	**Loving Relationship Stage**	**Abusive relationship Stage**
Observing the Child/Young person **Selection of Child/Young person** **Befriending-being nice, giving gifts, caring, taking an interest, giving compliments etc** **Gaining and developing trust** **Sharing information about young people between other abusive adults**	**Making young people feel special** **Giving gifts and rewards** **Spending time together** **Listening and remembering** **Keeping secrets** **Being there for them** **"No-one understands you like I do; being their best friend** **Testing out physical contact-accidental touching** **Offering protection**	**Being their boyfriend/girlfriend** **Establishing a sexual relationship** **Lowering their inhibitions e.g. showing them pornography** **Engaging them in forbidden activities e.g. Going to clubs, drinking, taking drugs** **Being inconsistent-building up hope and then punishing them**	**Becomes an "unloving sexual relationship"** **Withdrawal of love and friendship** **Reinforcing dependency on them-stating young person is "damaged goods"** **Isolation from family and friends** **Trickery and manipulation-"you owe me"** **Threatening behaviour** **Physical Violence** **Sexual assaults** **Making them have sex with other people** **Giving them drugs** **Playing on the young person's feelings of guilt, shame and fear**

(Taken from Barnardos"Bwise2 Sexual Exploitation pack)

2.6 Why Don't We See It?

Organisational Culture

Case Study

Child A came from a violent family – her brothers and father were very violent. She grew up not liking herself and secretly self-harmed. At the age of 15, child A became sexually active out of choice. She had sexual relationships with boys her own age and a bit older and became known as a "slag" at school by other pupils. One day child A went to a local park with some boys and other girls and was raped by three men.

They also filmed her ordeal. No-one believed anything child A said, including what had happened to her because she was seen as a "trouble maker" at school. The men that had abused her started to offer her money, drugs and alcohol. Eventually she started to view them as her friends.

However, she was regularly raped and beaten by them and then would also suffer more violence at home. The offenders would encourage each other to rape and abuse her. Child A did not seek help as she felt this was her destiny and was also extremely scared of her abusers. She believed they were so dangerous that they would kill her and her family. Child A struggles now with serious sexually transmitted diseases, health implications and addictions.

Source: Muslim Women's Network UK, *Unheard Voices*, page 106

2.6.1 Victims are unlikely to disclose for a range of reasons and for some professionals they do not fit a standard model of asking for and being grateful for support. Worse, without training or understanding professionals can dismiss it as a "choice" or as in the example above, not believe it. We have a concern from the evidence that we heard that professionals are not uniformly seeing CSE for what it is.

2.6.2 For much of the process the child does not recognise themselves as a victim and they may not act as victims are assumed to act. They may resent, be angry and reject support and intervention from family, the police and social workers. We learnt just how easy it might be for a Police Officer or social worker to walk away if told to "**** off" by a child if practitioners do not have proper training, understanding and support. The Her Majesty's Inspectorate of Constabulary (HMIC) report into child protection in West Midlands Police found that:

> In [one] case supervisors recorded that a 13-year-old girl who frequently went missing was making 'a lifestyle choice', although it was clear from police systems that she was being, or was at high risk of being, sexually exploited.[35]

[35] HMIC (October 2014) National Child Protection Inspections: West Midlands Police 2 – 13 June 2014

2.6.3 If professionals see children as making a lifestyle choice or choosing to put themselves at risk then children do not get seen as victims of crime. Crucially, information does not then get shared.

2.6.4 Parents Against Child Sexual Exploitation (PACE), in their evidence, shared some of the comments they have heard (in their national work, not specific to Birmingham) and which should not be used as they shift the blame from the abuser to the victim.

Inappropriate views held (PACE)	
"Feral"	"Habitual liar"
"Highly sexualised"	"She's asking for it"
"Predatory"	"Promiscuous"
"Prostitute"	"Lifestyle choices"
"Tarted up"	"Prostituting herself"
"Wiling participants"	"Trouble is they enjoy it"

2.6.5 Referring to Rotherham, Caroline Lucas MP said:

> Shockingly, sexually exploited children were labelled as prostitutes by those to whom they turned for help. I think that that shaped the response, because the word "prostitute" suggests consent and volition.

2.6.6 Cllr Jess Phillips at the September 2014 West Midlands Police and Crime Panel meeting suggested:

> The thing we have to address for every single police officer and every single social worker are our own personal and values judgments. If these 1400 girls in Rotherham had been cars you can bet that more would have been done at local tasking and more would have been done at regional tasking. But they were girls; just girls. …we need to look at the values and judgements of our police officers and social workers. That they see children when they look at these girls; see vulnerable people… not people who are "asking for it.[36]

Choice and Consent

2.6.7 One of the barriers to dealing with this as abuse is that it can be seen, initially at least, as consensual by both the victims and by adults who are meant to be protecting them. One of the issues discussed has been the age of consent for sex.

[36] Webcast: www.coventry.public-i.tv/core/share/open/webcast/0/0/560/144458/144458/webcast/start_time/2126000

What is the age of consent?

The **Sexual Offences Act 2003** states that the age of consent for sex is 16 years old in England and Wales. It is not intended that the sexual offences legislation be used to prosecute mutually consenting sexual activity between under 16s, unless it involves abuse or exploitation. To protect younger children, the law says children aged under 13 years can never legally give consent, so any sexual activity with a child aged 12 years or under will be subject to the maximum penalties.

The legislation also gives extra protection to young people aged 16 to 17 years. It is illegal to take, show or distribute indecent photographs, pay for or arrange sexual services, or for a person in a position of trust (e.g. teachers, care workers) to engage in sexual activity with anyone under the age of 18 years.37

2.6.8 However, what we have heard time and time again is that "children cannot consent to their own abuse." So whatever a child's age, whether or not they believe they are willingly consenting to sexual activity, exploitation can never be consensual.

Disclosure

Case Study Child not Identifying themselves as a Victim

Child B was 14 years old when she started her relationship with her boyfriend, a few years older than her. He was known locally for dealing in drugs. He bought her lots of gifts and told her that he really loved her and wanted to marry her. He even told her that he was prepared to run away with her just so he could marry her. He eventually started taking her to his flat and ordered her to provide sexual favours for his friends. Child B is nearly 16 years old now and drinks and smokes heavily to try and block out what she has to endure regularly at her boyfriend's flat. She says she cannot refuse because she will get "slapped around". Child B has also started to self-harm and has been diagnosed with depression by her GP who is unaware about what she is going through. She will not leave her boyfriend because she says she really loves him and believes that he adores her and will marry her

Muslim Women's Network UK, *Unheard Voices*, page 119

2.6.9 Why do children find it difficult to disclose? The nature of this abuse is that for much of the time the victims may feel that the abuser is a boyfriend, or at least someone interested in their care. As we were told: "They don't see it; their heads are messed up." Further, analysis of online peer support sites covering abuse, exploitation and neglect suggests the issues are:

[37] www.nspcc.org.uk/Inform/research/briefings/definition_of_a_child_wda59396.html

- An emotional barrier, e.g. shame, embarrassment, not being able to face telling, finding it hard to find/say the words;
- Worry about the family knowing, loyalty to family and the impact on family members;
- Thinking their situation was not problematic enough to disclose to others;
- Threats from the abuser; and
- Fear of not being believed if they were to tell.[38]

2.6.10 The research by the Muslim Women's Network UK suggests the biggest barrier to Asian girls and women reporting is blackmail involving shame and honour. The *Unheard Voices* research reminds us how difficult it is to break away from a perpetrator. In their research, breaking free happened through:

- Disclosure to a friend, teacher or voluntary organisation;
- Family members discovering the abuse;
- Teacher spotting the signs and asking questions;
- Victim coming to the attention of the police who then suspected CSE;
- Referral made to a group supporting victims; and
- Victim moved out of the locality.

[38] Cossar, J t al (2013) *'It takes a lot to build trust' Recognition and Telling: Developing earlier routes to help for children and young people*. For the Office of the Children's Commissioner for England At: www.childrenscommissioner.gov.uk/content/publications/content_747

3 Multi-Agency Working

3.1 It's Everybody's Business

3.1.1 Keeping children safe from sexual exploitation is everyone's business, although different roles are played and agencies have their own statutory responsibilities. The response should never be what one manager suggested: "But that is not the job of xxx!" One witness told us:

> There doesn't seem to be a joined up approach – our Ofsted report bore that out. We are all accountable.

3.1.2 Each agency holds a part of the safeguarding jigsaw and often it is only when all the information is shared that the whole picture is seen and patterns are identified. No serious case review has ever criticised partners for too much information sharing. There is only benefit to information sharing and action planning. Each agency needs to play their role and be accountable to others for this. This chapter and the next look at how these agencies work together and specific roles they play. The statutory guidance *Working Together to Safeguard Children*[39] sets out the principles for how agencies should work together, including two principles which need to apply in dealing with CSE:

- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

3.1.3 The Children's Commissioner has set out a See Me Hear Me framework[40] which all partners should work to and which have been adopted in the new regional CSE Regional Framework. This includes principles of effective practice:

- The child's best interests must be the top priority
- Participation of children and young people
- Enduring relationships and support
- Comprehensive problem-profiling
- Effective information-sharing within and between agencies
- Supervision, support and training of staff
- Evaluation and review.

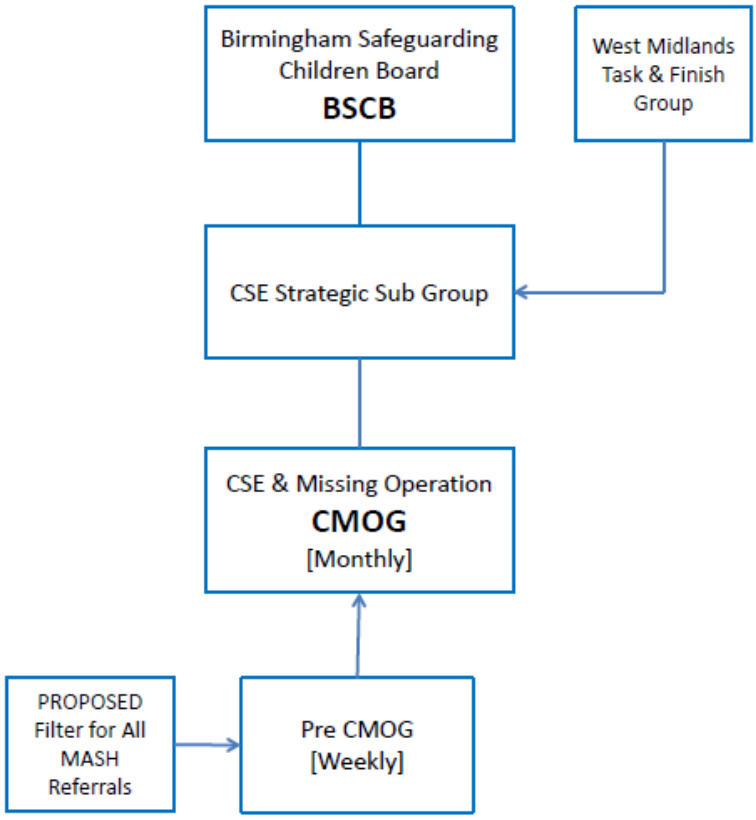
[39] Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children (2013)
[40] Berelowitz, C et al (2013) *If Only Someone Had Listened Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups*

3.1.4 It is critical for any progress to be underpinned within the multi-agency setting with effective and informed collaboration at the core. We were told that to reduce CSE risk, threats and harms then

> We need the key agencies absolutely and systematically on the case, with clear referral pathways, good analysis, effective and authoritative decision-taking and relentless follow through.

3.1.5 This should be the focus and the key structures for multi-agency working to achieve this are shown in Figure 1.

Figure 1: Multi-Agency Structures for Managing CSE



3.2 Birmingham Safeguarding Children Board (BSCB)

3.2.1 The BCSB is a statutory body which brings together key partners in the city. The BSCB is an independent body, whose role includes monitoring the effectiveness of the various agencies working in Birmingham to protect children. This includes West Midlands Police and Birmingham City Council. Its responsibilities include developing inter-agency safeguarding procedures and managing serious case reviews. It has set out a series of principles for all agencies to adhere to in responding to a child who has been, or is at risk of being, sexually exploited:

- Children and young people cannot make an informed choice to be sexually exploited or to continue to be exploited: their acquiescence is moulded by coercion, enticement, manipulation or desperation. This applies regardless of whether the young person has reached the age of consent;
- Sexually exploited children and young people will be treated as victims of abuse;
- The primary concern of the practitioner is to safeguard and promote the welfare of the child or young person; and
- The child or young person will be supported to participate as fully as possible in the decisions that affect them.[41]

3.2.2 The September 2013 Child Sexual Exploitation Prevention and Intervention Strategy and Action Plan was written in consultation with partners and ratified by the Birmingham Safeguarding Children's Board. It sets out a robust plan of action to mobilise partnership skills and experience to understand and eradicate the risk and reality of child sexual exploitation to children in Birmingham. This requires each of the partners to own the action plan and deliver against it and report back. We got the impression this was not yet happening consistently.

3.2.3 The BSCB has updated and drawn up the procedures for dealing with CSE and in September 2014 published what appears to be a useful and accessible web based manual. [42]

3.2.4 The BSCB puts on multi-agency training, which brings together practitioners from different areas of work, and is a very positive outcome from the BSCB. At the time of writing the BSCB structure was undergoing change and we trust this will enable the Board in the future to hold all agencies to account for how they are undertaking and dealing with CSE.

3.2.5 One perspective given to us is that the effectiveness of BSCB in holding partners to account to deliver the strategy has been undermined by a range of regional and local factors including the police transformation programme and misunderstanding about the responsibilities and accountabilities of the regional groups, and the local BSCB in making decisions and deciding on appropriate approaches.

3.3 Birmingham's CSE Co-ordinator

3.3.1 A lynchpin role is the Child Sexual Exploitation Co-ordinator who was appointed as a 12 month fixed term secondment in April 2013, funded initially by the BSCB. This has been a crucial appointment. We were pleased to hear during the course of evidence gathering that this post is now mainstream funded by the City Council and due to the work load a second co-ordinator was in place in September 2014. A data analyst for this team was due to be appointed too.

[41] www.proceduresonline.com/birmingham/scb/chapters/p_ch_sexual_exploit.html#Protection
[42] www.proceduresonline.com/birmingham/scb/

3.3.2 The CSE Co-ordinator's role includes:

- Collating multi-agency data to provide information about the location of hotspots and of trends identified;
- Co-ordinating awareness raising, training and prevention services for young people, parents and carers, professionals, the voluntary sector and schools;
- Assisting in the development of the city's strategic response and coordinating the operational response; and
- Supporting the safety planning of victims and the disruption of perpetrators.[43]

3.3.3 The role is not to manage cases and nor does it enable other agencies or officers of the City Council to transfer their responsibilities.

3.3.4 The co-ordinator, in addition, escalates safeguarding concerns through partners where responses do not safeguard victims and this has been key in recognising the risk and status of CSE victims. Since the appointment of the co-ordinator progress includes:

- Introduction of a performance and audit framework;
- Amendment of the Governance arrangements;
- Updated procedures in accordance with the new CSE strategy and action plan;
- CSE screening and risk assessment being embedded into practice within partner agencies;
- Collation of a dataset of those young people at risk of CSE onto a spreadsheet; and
- The development, at the time of writing of a CSE Champion structure within key services in Birmingham.

Multi-Agency Sexual Exploitation Meetings (MASE)

3.3.5 One of the key roles for the CSE Co-ordinators is chairing Multi-Agency Sexual Exploitation meetings. These devise plans to safeguard individual victims (victim safety plans) and preserve evidence and plans for the prosecution and disruption of perpetrators and agree action to include long term intensive direct work with the individual child. Between 2009 and 2013 there were approximately 80 independently chaired MASE meetings per annum. Between January and September 2014 there have already been 120 MASE meetings held.

3.3.6 To enable accountability and transparency, notes and action plans from those meetings are important. We were concerned to hear during the inquiry that without secretarial support the Co-ordinators have to chair, as well as minute, these complex multi-agency meetings. As we were finalising the report we were pleased to be told that administration support had been put in place in October 2014.

[43] BSCB (2013) Child Sexual Exploitation Prevention and Intervention Strategy

3.4 Multi-Agency Groups

Strategic CSE Sub-Group

3.4.1 This strategic sub-group, sitting under the BSCB, is chaired by the City Council's Head of Safeguarding. It focuses on the trends and patterns and examines location, victims and offenders. It might be worth reviewing membership as a third sector organisation said they would welcome representation around the table. This Chair is also a member of the Board in order to feedback on developments relating to CSE and to be open to scrutiny. Its purpose is:

- To monitor and review multi-agency management of child sexual exploitation and ensure effective arrangements are in place to tackle issues within Birmingham;
- To govern the implementation and development of the CSE Co located team in Birmingham and to ensure that service level agreement is in place for provision of resources between partner agencies;
- Take lead responsibility for implementing the multi-agency action plan to minimise sexual exploitation in Birmingham and to take a strategic lead for this work in the City;
- To identify and overcome barriers to effectively tackling the issue of child sexual exploitation, in supporting victims and prosecuting and disrupting perpetrators;
- To make appropriate recommendations to the BSCB to ensure that effective services are delivered to tackle child sexual exploitation in the City; and
- To set up and monitor a multi-agency practice group (CMOG).[44]

Child Sexual Exploitation and Missing Operational Group (CMOG)

3.4.2 A practitioners' group (CMOG) focuses on risk assessing children going missing and/or at risk of sexual exploitation and agreeing actions that need to be taken for individual cases. It is chaired by a Detective Chief Inspector from WMP. The City Council is represented by Legal Services as well as Children's Social Care.

3.4.3 It is too soon to draw conclusions from the CMOG, but our evidence suggests there have been weaknesses including:

- A lack of detail included on the risk assessments by practitioners;
- An insufficient range of multi-agency partners attending, plus sporadic attendance;
- No attendance register so no way to hold agencies to account;

[44] BSCB (2013) CSE Strategy

- There are poor to non-existent arrangements for minute taking at pre-CMOG and CMOG meetings. Apparently agencies are each sent their actions separately and feed into their own processes;
- Actions are deferred from one meeting to the next with no apparent progress;
- The communication lines between MASH (the front door – see section 3.5) and CMOG are unclear to some partners. Some partners are unclear as to who has the power to direct actions and how one escalates problems and in which direction; and
- Not enough data is said to yet be coming out of the CMOG.

3.4.4 The Committee believes that getting this structure right is crucial in protecting children, but that further work urgently needs to be done. As a starting point the third CMOG chair in its short life has recently been appointed. We sincerely hope that she is able to stay in this post for some time and embed its work. There needs to be consistency in who chairs these meetings. It is clear that accountability, action and tracking arrangements have not been robust enough. Key details of cases and shared evidence and existing interventions as well as agreed actions need to be taken and shared. Only in this way can agencies be held responsible for progress made. Early feedback on new arrangements has been positive.

3.5 Multi Agency Safeguarding Hub (MASH)

3.5.1 Established in July 2014 the MASH is the long anticipated and much welcomed co-located multi-agency team for child protection, domestic abuse, sexual exploitation and early help referrals.[45] The aim is that the MASH will improve the quality and timeliness of screening, information sharing, and decision making by MASH partner agencies, leading to better outcomes. The multi-agency project team consists of police, BCC Children's Services, and health representatives. In September 2014 Birmingham and Solihull Women's Aid joined MASH and at the time of writing we were told that a rota of designated safeguarding leads were due to start with them imminently. [46] The multi-agency aspect of this is key to success.

3.5.2 If someone has concerns about a child's welfare they can refer directly onto the MASH **(Tel: 0121 303 1888)**. It takes referrals from any sources: the child themselves, professionals, the police, health workers, family members and members of the public.

3.5.3 The aim of the MASH is indicated in the slide from the launch road show:

[45] MASH has replaced the Information, Advice and Support Service (IASS) and the Bridge.
[46] Extract taken from MASH Progress Briefing – 11th July 2014

3.5.4 There was an initial almost 50% increase in contacts through this front door compared to 12 months previously, although previously children missing or involved in domestic abuse were not counted. There were over 600 referrals each week during August 2014 and this increased as anticipated once the school term started.

3.5.5 WMP, children services and health partners carried out a dip sample of 400 cases though the front door prior to going into the MASH. They found cases that would now "scream CSE", but this was not recognised at the time. It is hoped that the MASH arrangements will resolve this. Stephen Rimmer's early assessment has been positive: [47]

> It … means that Birmingham – for the first time in many years – is managing risks to children and vulnerable people on the basis of a comprehensive picture, such is the credibility of the MASH in terms of referrals.[48]

Early Help

3.5.6 Early help is embedded in the MASH through the use of the Family Common Assessment Framework (FCAF). F CAF coordinators are now based with the MASH. The key aim of adopting an FCAF model was to stop families having to explain their situation and story again and again to professionals and to find a more effective way for the statutory and third sector to support them. It is a process that is carried out with children and families and not to them and is a way of getting support into families before a case has to be dealt with by children's social care (and a child in need or child protection process). If more than one agency is (or should be) involved with a child an FCAF approach should be instigated with a lead agency (such as a school or health visitor or a third sector such as Barnardo's). They co-ordinate a meeting with all agencies and the family to put together an intervention plan. They continue to meet to monitor this and then close down when issues are resolved. MASE meetings can feed into the FCAF process.

[47] West Midlands Strategic Preventing Violence to Vulnerable People Lead
[48] PVVP Update 10, 19/9/14

3.5.7 Even before the MASH was established the FCAF team were screening everyone coming into the service against the BSCB CSE screening tool. Two children a day were identified as being at risk, presenting vulnerabilities or actually being exploited. As noted previously, at the time of writing, 49 CSE cases were held within the family support teams.

3.5.8 The FCAF co-ordinators have integrated CSE into their effective multi-agency training and are looking to develop resources such as a pack on CSE and a series of short instructional videos on line to educate and support practitioners. In terms of dealing with children they advocate a therapeutic model, putting a child's safety first. Their advice is to look at behaviours and provide interventions to change those and help to stabilise a situation. Once that has happened a disclosure is more likely. They advise on the thresholds between an FCAF and children's social care and can escalate cases. They also feel that being able to step a case down to an FCAF can be therapeutic as gives some control back to the child.

Case Study: FCAF Interventions

Child C's mother raised concerns with children's services when she discovered her daughter had been using social media to contact unknown males. Child C was a vulnerable young person, raised by a mother who was misusing drugs and displaying violent behaviour on a regular basis. At 9 Child C first had sex with a boy at school and she ran away from home at the age of 12 and was subsequently groomed by a woman who had found her in a bus stop. She was given shelter, drugs and alcohol and was subsequently was sexually assaulted by five men. Following child protection proceedings she was sent to live with an older sibling. Even though she had been removed from the geographical area she was still considered to be at risk of CSE. The child and the older sibling and family worked well with social care and as a result the case was stepped down to the locality family support team to offer ongoing support and monitoring of CSE risks.

Intensive support was put in place for Child C to support her following a Family CAF process. A Family Support Worker visited weekly to work with Child C around keeping safe and emotional stability whilst awaiting a specialist CSE service and the school made weekly counselling available. This intervention has been sufficient to enable Child C to settle well.

3.5.9 The FCAF team is now an integral part of the MASH. We were told that only 3.6 full time FCAF Co-ordinators had gone into in the MASH to cover the whole of the city. Given the valuable early help work that they enable and the advice and training they provide to practitioners we are concerned this may be insufficient. Think Family[49] funds will continue to fund 3 additional FCAF triage staff to work on Think Family and, at the time of writing, they were looking to place additional one at the MASH. We would ask that resources for early help within the MASH be reviewed in developing the three year budget for the Directorate.

[49] Birmingham's name for the Troubled Families Initiative. www.birmingham.gov.uk/think-family

3.6 West Midlands Preventing Violence Against Vulnerable People (PVVP)

3.6.1 Birmingham is not an island. In terms of exploitation abusers do not respect local authority boundaries. We were therefore pleased to see that the seven West Midlands authorities and the late Police and Crime Commissioner (PCC), Bob Jones, committing to work together to tackle violence against vulnerable people, which includes CSE.

3.6.2 A West Midlands Strategic Leader for Preventing Violence Against Vulnerable People (PVVP), Stephen Rimmer, has been seconded in from the Home Office for two years and the role is funded by all the partners. A high level PVVP Board has been established to address violence across the area; and he has been working to develop a West Midlands wide hub to co-ordinate intelligence information and data; and introduce clearly defined standards of operating practice with regard to CSE that would be consistently applied. One aim is to develop co-located CSE teams across the region as part of a Pan West Midlands CSE Strategy.

3.6.3 The Board's action plan includes:

- **Governance, Capacity and Outcomes:** Includes capacity within key organisations, agreeing outcomes and developing a problem profile.
- **Prevention**: Includes work with schools, early help, community engagement and mobilisation
- **Protection**: Includes developing shared operating standards for CSE, working with heath and developing a multi-agency hub
- **Justice**: Includes working with Criminal Justice System partners, including work with the police, Crown Prosecution Service and courts and improving victims' experiences
- **Capability**: Includes Public Protection Intelligence Hub, leadership, supporting frontline workers, training and development and risk management

3.6.4 There has been a regional CSE group consisting of officers from the seven West Midlands authorities working collaboratively to develop and implement shared standards. Whilst this inquiry was ongoing (June 2014) the West Midlands CSE Framework and Standards went live. The shared framework aims to improve the response to CSE across the region, and to improve working together across agencies and areas, particularly recognising that many victims are moved around different areas.

3.6.5 We are impressed at the intent of all the local authorities to work together and standardise the way they record information and hope that if this can be embedded that this will be an important step forward.

3.7 Is a Multi-Agency CSE Hub Required?

3.7.1 The September 2013 CSE strategy stated that:

> Without the commitment of a multi-agency child sexual exploitation hub within Birmingham the intensive resources required will not be met.[50]

3.7.2 We feel that MASH is a huge step forward and thank each of the partners for committing resources. Given the increase in referrals we feel that resources need to be kept under review. Concerns had been raised with us as to the extent to which health was embedded in the MASH, but at the time of writing we were somewhat reassured that there were two full time health representatives embedded, plus managerial support. The health component to MASH is, at the time of finalising the report, being reviewed by providers and in partnership with commissioners in light of the resource implications demonstrated through the early weeks of MASH.

3.7.3 Overall success depends on the right action being taken following a referral from MASH. We feel there could be a danger of CSE not being prioritised, however, as the MASH has a broad remit. The Oxfordshire Kingfisher Project model (also police, children's social care and health) offers a focus solely on CSE and an end to end approach – from identifying risk to supporting victims through the court process.

3.7.4 We understand there are benefits to all safeguarding work coming together, as, we have noted that, for example children who live with domestic violence are more at risk of grooming. But we will be seeking reassurance that CSE is not being subsumed by other safeguarding pressures and that a case management process from start to finish is required.

3.7.5 The HMIC report raised a concern that:

> The strategic framework will not deliver the desired outcome unless there is a greater commitment to a multi-agency response at an operational level (for example, through specialist multi-agency child sexual exploitation teams.[51]

3.7.6 We, therefore, recommend an assessment of the MASH six months from launch about what a dedicated CSE multi-agency team would or would not offer compared to what is in place. We would like six monthly updates as to resources committed, effectiveness of multi-agency working, caseloads and capacity.

[50] BSCB (2013) *CSE Prevention and Intervention Strategy*
[51] HMIC (October 2014) National Child Protection Inspections: West Midlands Police 2 – 13 June 2014

4 Organisational Roles

4.1 Overview

4.1.1 The process for dealing with a child at risk of CSE or being abused does depend on the level of risk identified. It should fit alongside and complement existing approaches to safeguarding children, whether that is a Family Common Assessment Framework (FCAF) and early help interventions or following a child in need assessment or a child protection assessment. Each agency has specific roles to play. However, practitioners need to share some common understandings and ways of doing things and the multi-agency training provided by the BSCB is valuable. One practitioner suggested a mantra for all practitioners (and others) should be "Never assume. Assess!"

4.1.2 This short chapter considers the City Council and the police, but examples throughout the report point to the role of communities, the third sector, schools and the health service.

4.2 Local Authority

4.2.1 The Children Act 1989 makes the City Council's responsibilities to children very clear:

> To safeguard and promote the welfare of children within their area who are in need.

4.2.2 Councils have specific statutory duties regarding assessing children and following the child in need and child protection duties. They have a role on leading on some of the multi-agency working for CSE, namely managing the MASH and co-ordinating the FCAF process.

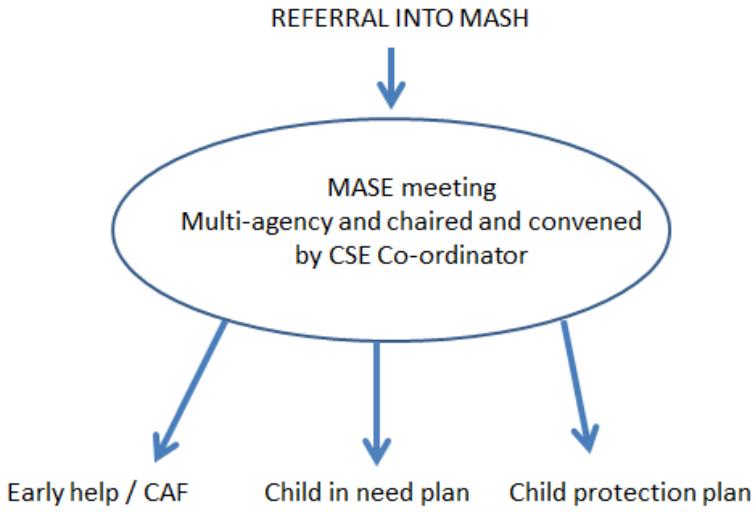
4.2.3 Section 3.5.7 referred to the screening process. If this indicates a risk of CSE a multi-agency strategy is organised. This is meant to feed into (or trigger or escalate) the different levels of working from using an early help approach to child protection. We welcome the work that has gone into getting the screening tool in place, but it has been suggested that a more robust tool could be used. The Derby SCB toolkit was suggested as best practice and there would appear to be greater clarity on that about the level of risk and the actions required.[52]

4.2.4 Some practitioners have suggested that the standard social work model and interventions do not work robustly enough for CSE as they tend to focus on protecting the child from harm within the family. In addition, a social work model that focuses on protecting the child may not give adequate weight to the need to deal with an offender through prosecution or disruption. We were told that the "test" for deciding if a safeguarding plan is needed is based on the child protection model of familial abuse. CSE, however, is extra-familial. One practitioner told us of this test being used to

[52] www.derbyscb.org.uk/scb7.asp

conclude that a safeguarding plan was not necessary on the basis that the child is safe within the home. If a case fails to hit the threshold for intervention the result is instead a Child in Need (CinN) Plan. The, problem we were told with CinN plans is that any agency can decide to close a case without reference to the multi-agency team around the child.

Figure 2: Safeguarding processes



4.2.5 The City Council uses a case management system called "Care First". We are told that this needs to be further developed to be able to generate intelligence relating to CSE.

4.2.6 The City Council also acts as corporate parent to looked after children. The Cabinet Member for Children and Family Services and the Chief Executive has specific responsibilities; all councillors have a role to play and agree to do so when they sign the oath of office; and the Corporate Parenting Board takes an overview. Getting all these responsibilities right as the data in chapter 1 indicates that looked after children are over-represented as known CSE victims.

4.2.7 The City Council also has responsibilities around regulatory services, contracting and procurement, school improvement and other frontline services for residents, which have a bearing on this area

4.2.8 The City Council's Legal Service supports the formal child protection process. They can also lead on civil orders to protect children and this is considered further in Chapter 7.

4.3 West Midlands Police (WMP)

4.3.1 WMP play a vital role in dealing with CSE in keeping children safe identifying, disrupting and prosecuting perpetrators. As often is the case we were told that police attitudes had changed following a case involving organised grooming in 2008 that was successfully taken to court but got little media attention. This started to change how victims were dealt with by the police. Some

steps were taken to avoid accusations of lifestyle choices or asking children inappropriate questions about/or consent and choice and treating them in the same way as older victims.

4.3.2 We were told that if children come into custody the system is now better geared up to assess if they are victims themselves. For example, if they are caught stealing on a week day we are told that they should be asked about why they are out of school and an opportunity should be taken to understand what the child's life is like. The message from the top is that officers should not just deal with what is in front of them, but should look into the life of a child.

4.3.3 The first Police and Crime Plan developed by the late PCC, Bob Jones, in 2012 set out a deliverable for 2013-14 to:

> Carry out activity to understand in more detail the extent of people trafficking within the West Midlands and to maintain vigilance around children.

4.3.4 For 2014-15 this is to:

> Develop tactics to tackle child sexual exploitation, modern day slavery (people trafficking) and honour based violence sexual exploitation.[53]

4.3.5 We also welcome the approach taken by the new Police and Crime Commissioner, David Jamieson. At the first Police and Crime Panel he attended on 8th September, he said:

> Over Rotherham I have been asking some searching questions of the police. "If we pretended there are no problems in the West Midlands we would not be telling the truth. There will be problems. I have asked for a number of reports on this and I will share them with the Panel when I get the contents of those reports. I want to be as open as possible because one of the major issues in Rotherham was that things were not open. They were closed. People were not discussing publicly things that they should have done, so I will be doing just that."[54]

4.3.6 The force has undergone transformation with inclusion of a dedicated resource for CSE. There is now a West Midlands Police Team offering localised support across the region. The Police describe a rapid increase in identified cases of CSE and a priority need to respond.

4.3.7 The Public Protection Unit (PPU) is a central department with responsibility for the delivery of services relating to child protection (including child sexual exploitation), domestic abuse, registered sex offender management, the investigation of rape and serious sexual offences and missing

[53] www.westmidlands-pcc.gov.uk/your-commissioner/police-and-crime-plan/police-and-crime-plan-2014-15/
[54] www.birminghammail.co.uk/news/midlands-news/west-midlands-police-investigates-rotherham-style-7743389

persons.[55] The PPU has, during the course of this year, doubled in strength to some 800 officers and staff.

4.3.8 Assistant Chief Constable Carl Foulkes has said:[56]

> That means around 10 per cent of the entire force are engaged in the fight. That displays our level of commitment It's unfortunate that the HMIC inspection came just two days into new arrangements so do not reflect our exciting changes as there was so little time for them to be in place. We cannot do it alone.

4.3.9 The police CSE Co-ordinator role was re-launched in September 2014. At the time of writing, six PPU officers were conducting the co-ordinator role across the West Midlands and discussions were progressing with PPU and LPU SLT's to increase this so each Local Policing Unit has a dedicated CSE/Child Missing co-ordinator. At the same time the new Central CSE Perpetrator Team was launched. The team provides tactical support in targeting CSE suspects who are identified via WMP intelligence systems or CMOG (CSE/Missing Operational Groups) meetings. Discussions were progressing to provide the team with a dedicated intelligence arm, to assist to prioritise activities and better map offending across the Force. CSE criminal investigations will continue to be developed by Child PPU teams/officers. There is also an Online Child Sexual Exploitation Team

4.3.10 WMP are key to the success of tackling CSE in the city and the restructure should help this. We were told that other partners can sometimes be frustrated by the reluctance of WMP to provide feedback on a case, even if they have provided the evidence. WMP, we were told, need to put greater trust in the data protection, information sharing and confidentiality systems in place that partner agencies all sign up to. This includes letting agencies know of suspected perpetrators.

[55] HMIC (October 2014) National Child Protection Inspections: West Midlands Police 2 – 13 June 2014
[56] ACC Carl Foulkes quoted in Birmingham Mail, 28 October 2014. At: www.birminghammail.co.uk/news/midlands-news/west-midlands-police-given-six-8008310

5 Prevention

5.1 Overview

5.1.1 It has been suggested to us and in the media that a conspiracy of silence enables exploitation to flourish and perpetrators to get away with it. To tackle that head on and spread knowledge about CSE there is a need to shout about it across the city. We praise the many organisations in Birmingham that have started to tackle this, like Barnardo's SPACE, the Children's Society, the Phoenix Project, the Muslim Women's Network UK, Small Heath Community Forum, Safeguarding and Family Support Hubs and the range of bodies who have been participating in training. This needs accelerating to make sure those who feel "it's not our problem / it's not a problem here" get on board too. A list of some of the bodies the CSE co-ordinator has worked with shows the very broad needs in the city:

- Schools and Head teachers; Mental Health Practitioners; Youth Offending Service; Children's Services (including area teams); West Midlands Police; Birmingham Children's Hospital; Staffordshire and West Midlands Probation Trust; Sexual Health Clinics; Sexual Assault Referral Centre; Child Protection and Review Service; Local Authority Residential Services; Private Residential Services.

5.1.2 Firstly, we feel we need to put our own house in order and councillors as community leaders, eyes and ears within communities and local facilitators need to know what CSE is and how to raise concerns. To this end we recommend some compulsory training on safeguarding, including CSE to be part of an induction training package. We need to be sure councillors understand CSE and the role they can play in gathering intelligence (such as car registrations) and passing this on. In particular we need to be sure that all councillors understand their corporate parenting duty to children in care. Officers asked for councillor support in speaking out about CSE.

5.1.3 It is crucial that frontline staff fully understand what CSE looks like and what needs to be done. It is important that practitioners do not dismiss this as just a "life style choice" as it is not. But we start this chapter by focusing on making potential victims resilient.

5.2 Building Children's Resilience

5.2.1 We learnt how important self-esteem and recognising healthy relationships was to make children more resilient to the threat of CSE.

5.2.2 Children need to understand what healthy relationships look like and what consent means. Our attention was drawn to some national research carried out by Girl Guiding that indicates there is lot of work by all agencies to be done here. Its data indicated that a fifth of girls think it is acceptable to be told what to wear by a boyfriend or to be shouted at or called names for

something they have done and less than a quarter of girls showed a full understanding of what an abusive relationship is.[57]

5.2.3 The Muslim Women's Network UK also highlighted issues around the need to challenge male attitudes towards women:

> Some boys think there is nothing wrong with slapping a girl and think girls deserve it.

5.2.4 Healthy relationship teaching, therefore, should also challenging the sexist attitudes of some boys. Many resources are available online, including specific information for girls, boys and children with special educational needs, for practitioners in the city from the National Working Group web site. It is important that whoever delivers this in schools should have some understanding of CSE.

5.2.5 Computer games, social media and the internet enable young people to access vast amounts of information quickly and easily, including inappropriate content like pornography. This can lead to young people building up unrealistic expectations of relationships, body image and acceptable behaviour. It can therefore be quite difficult for some young people to establish what a "healthy relationship" is, but we strongly feel that schools have a key role in ensuring sex and relationship education is discussed in a sensitive and appropriate manner

5.2.6 The early help team (FCAF) suggest that professionals engage the child in safety resources such as "*Cody's Choice*" and the Barnardo's app "*Wud U*?"

Schools

5.2.7 Schools must help build resilient and confident children. Whilst this is a shared responsibility schools have so many opportunities to do this through assemblies, form time and Personal, Social and Health Economic Education (PSHE). There is no excuse for any school not doing so, appropriately of course, and a whole school approach needs to be built.

5.2.8 Whilst PSHE is still not compulsory, it is best practice to incorporate healthy relationships into all years (for boys as well as girls) and to have information available for older children about CSE. A detailed PSHE resource pack has been developed in Solihull which could be shared through the Regional CSE Group and used in Birmingham. It also contains resources for one to one working for early help.

5.2.9 There are a number of resources available for schools. We heard about "*Chelsea's Choice*" which is an interactive theatre show for schools, portraying the boyfriend model of grooming. This is generally block purchased for a series of shows in an authority. We also heard about the work the Children's Society carries out in schools. We were told that the approach in Birmingham is to develop a long term resource that can be used in schools and by youth organisations. A company called Recre8 is developing a 20 minute film DVD and a lesson plan is being developed to go with

[57] girlsattitudes.girlguiding.org.uk/pdf/2025_Care_Versus_Control.pdf

it. This is being developed in conjunction with children themselves through focus groups. We feel it is important that this is launched in February 2015 as planned and that all routes are used to ensure that schools receive this and do not just put it on a shelf and that teachers feel adequately empowered to use this.

5.2.10 What seems key in any such school intervention is that there is time for workers to have one to one time with children who want more information or wish to disclose immediately following the activity. Schools using the Recre8 resource will need to bear this in mind.

5.2.11 In addition to building resilience it was suggested that all schools should explore the effectiveness of the tactical approach for schools after the first and every subsequent absence and, particularly any known truancy of any child.

5.2.12 Colleges also play an important role and further work could be carried out with them too.

5.3 Building Resilience Online

5.3.1 Social media provides opportunities for perpetrators to identify, contact and groom children in a way unimaginable 20 years ago. Children are accessible to offenders online, nine out of ten households have access to the internet and 12 to 15 year olds spend over 17 hours online each week.[58] It also enables both them and the abuser to hide behind different personalities.

5.3.2 The NSPCC explain that this type of abuse involves grooming children online (such as through chat rooms, social networking websites, email and texting) for the purpose of sexually abusing them.[59] This can involve getting them to take and share indecent photos, display sexualised acts which are shared through recording or live web cam and agreeing to meet them in order to sexually abuse them. The CEOP risk assessment makes it clear that this grooming can happen very quickly nowadays.

Case Study: Child D

17-year-old Child D, was befriended over Facebook by two men who were both friends. One of the men wanted to date Child D and convinced her into meeting him. When she met him he appeared to be in his early 30s rather than 18 years old which he claimed to be. He continued to contact her online and coerced her into sending naked photographs of herself online. Child D was made to believe she was in a relationship with this man. However, he then started to blackmail her and threatened to post her photographs online and send them to her family unless she agreed to have sex with him and his friend. Child D confided in one of her friends and the police were contacted.

Source: Muslim Women's Network UK, *Unheard Voices*, page 119

[58] ceop.police.uk/Documents/ceopdocs/CEOP_TACSEA2013_240613%20FINAL.pdf
[59] www.nspcc.org.uk/preventing-abuse/keeping-children-safe/online-safety/

5.3.3 For some perpetrators this can be big business or a consuming part of their lives. Two men from Yorkshire in 2013 were found guilty of grooming 55 boys with the CPS holding details of other cases which did not go to trial.[60] They are said to have contacted 2700 boys through the internet[61]. This also indicates the geographical scope of perpetrators, as one child was said to come from Birmingham.[62]

5.3.4 Equally, another case of a Birmingham teacher and a Cannock and Reading abuser of a 15 year old Birmingham girl indicates the complicated overlap between online and "real life" abuse. In this case the abusers befriended the girl in chat rooms online and met up with her in a local hotel. However some of the footage of sexual activity was then streamed for other abusers to see.[63]

5.3.5 We heard about a huge range of social media sites and were particularly shocked by the case of a young boy (primary school) who was led into danger through his Xbox. He had been having a conversation with "friends" about the game he was playing and arranged to meet them to learn how to win. Luckily, the vigilance of his mother meant that the police got to the hotel first and found a man and a woman in a hotel room waiting to abuse him.

5.3.6 We were also shocked by the operating model of perpetrators using bluetooth. We were told they might go into a fast food café and send a generic message which would be picked up by anyone in there who has their blue tooth switched on saying something like "you're looking good today. I really like that top". It only takes one young person to think "they are talking about me." By looking around and seeing who seems to be smiling about it and responding the groomer would tailor his responses and then maybe go and introduce themselves. The groomer then lures the child in. What teenager would not mind a "boyfriend" with a car to pick them up from school? We were told that social apps could be used to identify the precise location of an individual and give someone the opportunity to pretend that they had met the prospective victim by accident.

5.3.7 The additional vulnerabilities of children with special educational needs and disabilities was also mentioned when e-safety was raised with us.

5.3.8 Parents, carers and schools need to be vigilant and drive home messages about online security to children. This does require some understanding of the latest tools. After being informed about the above examples, we recognised that we didn't understand the latest online risks and the current power of the internet. We asked Frank, a 15 year old work experience student for some advice for parents and children. His view, and it is a personal view, not a professional one, is included below.

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60 www.cps.gov.uk/yorkshire_humberside/cps_yorkshire_and_humberside_news/op_klan__2_paedophiles_plead_guilty_to_abusing_young_boys/

61 www.theyworkforyou.com/lords/?id=2013-10-15a.479.0&m=101084

62 www.wearebarnsley.com/news/article/3911/married-paedophiles-admit-to-grooming-young-boys/

63 www.telegraph.co.uk/news/uknews/crime/10128169/Former-teacher-streamed-sex-footage-of-underage-girl-on-to-web.html

Keeping your child safe
A Personal View by Frank, Aged 15

"One major point for parents with young children is that you can block what websites they can visit or use! Also it's important that a young child doesn't have an iPad or laptop of their own. If you do have a family computer make sure it's in a lounge or open room where what they are doing can be monitored. Remember that on Facebook, chatting sites or places where you can chat online (e.g. Xbox Live) and other social media sites there is always a "block communications" button which you can press anytime such as when you feel unsafe or uncomfortable due to what someone is saying.

Parents should also make sure that their young child DOESN'T have an account on Facebook (Messenger IS a part of Facebook and is just an independent app for Facebook messaging), Tumblr, Kik, Skype, Snapchat, Instagram or Twitter, 'Why?' Well these are all forms of social media where your child could be contacted by anyone.

Some tools that forbid children under 13 to create an account: Facebook, Steam, Snapchat, Tumblr, Apple.

You can also find parental controls on Xbox which can stop a child from talking to people who they don't know. Parents should be wary of some of these new messaging apps and sites like Kik, where anyone can contact anyone without needing to send a friend request or anything! You can still block unwanted people on Kik, but you can still message anyone at anytime.

Snapchat is the most dangerous when it comes to Child Sex Exploitation as the site is about two people sending pictures between each other which last from 1-10 seconds but you can screenshot any Snapchat which means that they have the image forever, and you can probably guess what that could lead to!

Skype is another popular social media site. This does include messaging, but is mainly a place for live chats using a webcam. This can be of serious concern as any two people if they are friends on Skype can at any time Skype each other. This is a problem for very obvious reasons. Even though Skype has no age limit the site is still a concern when it comes to younger users.

If you do have an Apple device then you probably know about FaceTime, which is just the same as Skype but you can call anyone and there's no blocking (I believe) and it uses your Apple account. All of this can be linked to Apple as most of these apps started and are used on Apple devices (Apart from Skype and Facebook which can be accessed on lots of devices).

Remember to peek your head round the corner or check on your young children when they are on social media or gaming just to check what they are saying and who they are talking to! For all you know your child could be planning to meet up with one of their online friends who says

they're the same age but in fact could be about a 30 year old paedophile.

Also if your child is old enough to have a Facebook you should check that they know everybody on their Facebook and have spoken to them or seen what they're like in real life. If they have never seen them in real life then ask them why, and ask them where they met them online! The reason you want to check that they've heard their voice is because even if you haven't seen their face or what they look like, it's very hard to make a convincing child's voice, especially if they are being loud!

Parents should always remind children that if they do feel threatened by the comments which they have been sent then they should contact the police or CEOP (www.ceop.police.uk/Ceop-Report/) and report it to them at once!"

5.3.9 Both schools and parents have responsibilities to educate children as to the risks and to understand how to respond appropriately to inappropriate approaches. CEOP is an online national crime agency project which, as noted above, has a "report abuse" button monitored by the police. The website also has many really good resources (such as short videos) which explain the nature of exploitation.

5.4 Building Parents and Community Resilience

5.4.1 There needs to be a greater understanding of CSE by adults too, not just parent and carers. Practitioners and a broad range of voluntary, community and faith leaders who work with children, plus the general population need to understand the issue. Councillors also need to know about CSE and their corporate parenting responsibilities and training needs to be put in place for them so they are confident in dealing with it. Greater awareness across the city would help build an environment where this crime is known for what it is and that children at risk and inappropriate activity are flagged.

5.4.2 We heard of a number of local organisations who were working to educate communities. If partners can do more to support and spread this work we would hope that this would increase reporting of offenders and disclosures of victims.

5.4.3 We would agree with the West Midlands Lead on PVVP and the new Police and Crime Commissioner that:

> We have to get to the point where it is the communities themselves who are confident enough, with our support, to say to perpetrators "our community is not putting up with this."[64]

[64] PVVP Update 10 19/09/2014

5.4.4 There are many different resources that have been developed to raise awareness. It was noted above that the West Midlands authorities have launched a *See Me Hear Me* website. Whilst this is a starting point which we really welcome it would benefit from development – such as routes through for the seven authorities and links to some more of the great resources that already exist.

5.4.5 During 2013 WMP ran Operational Sentinel to improve the service given to vulnerable victims, including improving tackling of CSE. This included training within the police and also awareness raising for the public. A second operation is being planned.

5.4.6 There needs to be a concerted awareness raising campaign over the next year– with strands to meet the needs of children and parents, community, voluntary and faith sector and professionals. This enables children to better protect themselves, it provides them with a language to be able to understand and articulate their concerns. It enables adults to spot the signs and to know where to ask for help or where to direct a child to. We were told that as well as using 'tried and tested' community leaders, practitioners need to work to find representative community leaders who can work with all members of the community.

5.4.7 All the key statutory partners need to work together in Birmingham to deliver this, including the BSCB, the City Council, and WMP, and it will require wider buy in. The West Midlands PVVP Action Plan indicates an intent to have a regional campaign in early 2015 to raise awareness and promote route to support.[65] In addition, a national "Stop CSE Day" is planned for 18th March 2015.[66] We would ask the City Council and all the agencies that deal with this to work together to use that date (or agree another) to, again, get the message out and signpost where to go for help.

5.5 Building Practitioner Awareness and Action

5.5.1 Overall, whichever agency is involved, there should always be awareness of the potential for CSE. Practitioners need to know how to share the information and discuss the situation. For this group particularly, awareness is not enough – they also need to know how to make a good referral and what they need to do to protect a child.

5.5.2 The horror of the crime can get in the way. We heard the term "professional helplessness" being used. It is not that practitioners are unwilling, but they may feel they just do not know how to support or deal with victims. It was also suggested that sometimes CSE is like opening a Pandora's Box which practitioners would rather keep the lid on. Instead, we were told that they should have to "think the unthinkable."

Schools

5.5.3 We had insufficient opportunity to talk to schools, but are aware there is much good practice in ensuring robust relationship and sex education is on the curriculum. We feel that the worst

[65] PVVP Update 10 19/09/2014
[66] www.stop-cse.org/

response a school can have to this issue is to suggest that CSE does not affect their pupils. We have been told this does happen; sometimes even in the face of the evidence. We were told that "teachers are not identifying sexual exploitation issues". One agency said it was difficult "to get engagement with schools as many thought this was not an issue for them." More worryingly, there was a suggestion that some schools may not engage as it could harm their reputation.

5.5.4 We do feel strongly that all teachers need to understand what exploitation is and to recognise some of the symptoms. In addition, the Designated Safeguarding Lead (DSL) in every school needs an understanding of risk, multi-agency responses and referral mechanisms. Safeguarding governors also need to be aware of this and to be able to hold the school to account on this. Although we are aware of events and training available to teachers in the city we were told training for teachers in respect of CSE was very sporadic. There is, therefore, a need for further training and we suggest that the matter should be pursued through the Primary and Secondary School Head Teachers' Forums with the suggestion that work takes place at District and Ward level. If there is any resistance from particular schools they needed to be able to justify why they did not wish to engage on this topic.

5.5.5 Schools have to carry out a Section 175 audit each year for the BSCB which asks for a self-assessment on whether:

- The school offers regular briefings to parents and children on e-safety which includes online exploitation (commercial and sexual exploitation)
- The PHSE Curriculum incorporates issues such as internet safety, anti-bullying, homophobia, child sexual exploitation and abuse. This includes lessons on keeping safe and recognising behaviour that is not acceptable based on guidance given in the Framework for Personal, Social and Health Education.

5.5.6 The BSCB received the self-assessment from 97% of schools in the city. Those schools that failed to respond have been referred to OFSTED and will be visited by Birmingham Audit. We believe that schools who do not appropriately tackle safeguarding and CSE should never be defined as outstanding by OFSTED.

5.5.7 We were told of the school and police panels that exist across the city which ensure good relationships are built and data is, therefore, shared more easily. Schools not taking part in these panels should be encouraged to do so and it is an issue local authority governors and local councillors should raise.

5.5.8 It has been suggested that the police are an untapped resource in terms of building awareness and resilience. Schools and also community groups can ask neighbourhood police teams to work closely with them and attend sessions or be around after to enable disclosures.

Health

5.5.9 Health plays an extremely important part in protecting children. A child may disclose directly to a GP; a sexual health services nurse may notice that a girl has suffered from more than one urinary

tract infection or unwanted pregnancy; or an accident and emergency (A&E) doctor may notice and act upon the older "boyfriend" or "uncle" who insists on staying with a girl during a consultation. Health professionals have a unique role to play. They can identify risks, signpost and be involved through multi-agency working in protecting the child. On-going training to ensure a consistent response is important here, as with all practitioners. They also are key in protecting children. A report from the Children's Commissioner said that 85% of identified victims of CSE had self-harmed, or attempted suicide as a result.[67]

5.5.10 We were told of concerns about misdiagnosis, especially in the case of learning disability, mental illness and mental incapacity. There are some fears that children diagnosed with autistic spectrum disorders such as Asperger's are in fact suffering from post-traumatic stress disorder, and another case where diagnosed mental illness has been used to explain a young person's "story telling".

5.5.11 Health is a complex area. We did not try to interrogate the plethora of provider and contractor health services in the city. We did, however, aim to get a flavour of how health organisations work with the City Council on this issue. There are also some very good publications supporting the role of health organisations.[68]

5.5.12 We were very pleased to hear that a Health Link Group formed by the health community providers and commissioners has been established. The Health Link Group supports the work of the CSE coordinator and the BSCB, police, Children's Services and third sector partners across the city. It meets quarterly and has the support of the NWG for using best practice sharing of learning and raising standards of practice across health providers.

5.5.13 It helps ensure all partners are engaged and enables good two way communication between health and the city's CSE co-ordinator and West Midlands Police. This is the first of its kind in the country and is seen as a model of good practice.

5.5.14 Good practice we heard of included:

- Birmingham Community Health Trust, for example, has a safeguarding plan which is monitored monthly and has provided a leaflet on CSE to all staff. They have developed action plans around CSE to ensure practice is embedded. Their children's workforce have been targeted for specific training but all safeguarding training contains information and advice around CSE signs and referrals as it is a whole staff issue;
- They ensure that all their nurses have had training in safeguarding and exploitation. This is being embedded into induction onwards to ensure that they all know what to look for and how

[67] Children's Commissioner (2012*) I thought I was the only one. The only one in the world: The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups, Interim report*. At: www.childrenscommissioner.gov.uk/content/publications/content_636

[68] www.nwgnetwork.org/media/pdfs/Shine-a-Light.pdf; www.gov.uk/government/publications/health-working-group-report-on-child-sexual-exploitation

to react. They recognise that all staff need this, not just those who are mainly in contact with children;

- B&S Mental Health Trust ensure that they keep an eye on children of their clients, especially when doing home visits; and
- All staff at Whittall Street Clinic (dealing in sexual health issues) are trained to risk assess all under 16s using the "spotting the signs" document and any concerns are referred to children's social care and organisations such as Barnardo's Space. If they do not get a response from children's social care they have an escalation policy and will contact the CSE co-ordinator or even the police.

5.5.15 We have some concerns about the inconsistent coverage of school nurses and were told that there is a national shortage. We understand that they have a key safeguarding role to play in schools, especially secondary. However, school nurse provision across the city's education providers varies in its origins of provision and its support of the professional development of its nurses. Many are employed through Birmingham Community Healthcare NHS Trust. Given the additional vulnerabilities of children with disabilities and special needs we were pleased to hear that the Trust is developing nursing champions in special schools who will be trained to identify signs of CSE.

5.5.16 We understand that Public Health will be undertaking a procurement process for school nursing and have been told that the key objective of this contract is to improve school attendance. The Committee believes that the aim of the school nurse role needs to be reconsidered and that safeguarding and involvement in multi-agency working should be integral to this and needs to be embedded in the specification and monitoring of the contract, as we are told is planned. We were pleased to be told that the commissioning process for sexual health services has made great efforts to ensure that safeguarding, sexual exploitation, violence and coercion is a priority in the specification and the tenders. This will increase the dedicated resource coming from sexual health.

5.5.17 On this topic we also worry that there are children who do not have access to this type of external source of help and advice. Maybe they are being home educated, have recently moved into the area or otherwise have no school place, or are not in mainstream provision. All schools need adequate school nurse provision and their work should explicitly include safeguarding.

5.6 Building Business Resilience

Overview

5.6.1 The Children's Commissioner's inquiry into CSE identified hotels, bed and breakfasts (B&Bs), shops and food outlets as key locations in which abuse takes place.[69] CSE can pose risks for business especially, the leisure, food and tourism industries and the Committee considered taxis and hotels in particular. To safeguard both children and reputation the City Council, BSCB and WMP need to

[69] Children's Commissioner (2012) I thought I was the only one. The only one in the world:

work in partnership with businesses in the city and ensure they are using powers to protect, not to inadvertently put children at risk.

5.6.2 The Children's Society and the National Working Group have developed the *Say Something if You See Something* campaign with local businesses. Covering the hospitality, retail, transport and leisure industries it helps tackle CSE taking place on their premises. The campaign and toolkit helps staff in these industries to recognise the signs that sexual exploitation is taking place and sets out what action they can take in response. We understand that *Say Something if You See Something* has been used in Birmingham, but it is a tool and approach that needs to be owned, driven and implemented through a multi-agency approach.

5.6.3 We are aware of some excellent practice elsewhere in the country, notably Sheffield where the Licencing Committee and police work closely to promote good practice to businesses, to provide advice to business and to seek to impose and enforce licensing conditions.

5.6.4 The Licensing Committee has a role to play in their oversight of premises selling alcohol, sex entertainment venues and taxi drivers. The fourth licensing objective under the Licensing Act 2003 is to protect children from harm.

Taxis

5.6.5 In the light of many of the high profile CSE cases elsewhere where taxi drivers had been involved it is timely to review procedures in Birmingham. Obviously, Licensing needs to consider how their approach best safeguards children. For us the greater challenge was that we feel there needs to be strong partnership working with taxi firms and drivers as they do act as the eyes and ears of the community. They need to know what to look out for and how to report suspicions. Even carrying a child as a paying fare for another adult to a venue where they will be abused means that trafficking legislation can be used. (Trafficking is not just an international crime, but the same legislation can be used in taking a child to another city, or just to another neighbourhood). Drivers need to be aware of this and what to do if they have suspicions as they would not want to fall foul of this and risk imprisonment. We commend the workshop held by Muslim Women's Network UK and Small Heath Community Forum with taxi drivers as we went to print.

5.6.6 Birmingham has, we were told, one of the most robust systems in place when it comes to the employment of taxi and private hire drivers. Licensing has the ability to suspend or revoke licenses on the "balance of probability" (although a magistrate can overturn this). They cannot do this just because a driver is hanging around where children congregate or near a children's home. However they can summon a driver in for an interview, but concerns need to be raised with them. The Licensing Officer had never, as far as they could recall, had any concerns raised by Children's Social Care. Frontline staff need to know how to report concerns (about taxis and other licensing issues) directly to Licensing, and WMP should review procedures for sharing such information. Legal Services were, at the time of writing, developing a process and form for this. This needs to be agreed and used by practitioners. If a licence is revoked because of sexual offences, the age of the victim is not recorded. This should be reviewed.

5.6.7 Taxi drivers, too, need a mechanism to be able to be the "eyes and ears" of communities. Licensing and the BSCP partners should look into the development of a whistle blowing system (possibly anonymous and online) to enable drivers to report suspicions/illegal activity etc.

5.6.8 There is a strong case for a regional approach as taxi drivers can work in Birmingham, but be registered elsewhere. We suggest that the licensing conditions and procedure for both Hackney Cabs and private hire drivers is reviewed to determine if there is a way to ensure safeguarding is robust. We were told that a basic training session is being introduced for all new licensees and will be rolled out for drivers as they renew their licenses. We welcome this and suggest that a trainer with CSE experience is involved in this.

5.6.9 The annual newsletter for taxi-drivers is a good mechanism for communication and the next two editions should include a suitable article about CSE. Developing a positive relationship with drivers and the drivers' trade association could lead to in-taxi advertising about how to get help with phone numbers in the back of cabs and leaflets available.

5.6.10 The Law Commission have, earlier this year, published a response to a consultation they had undertaken into taxis and private hire vehicles and a draft Taxi and Private Hire Bill has been published. These propose allowing "non-professional drivers" to use private hire vehicles when the vehicles are not "on duty". We reflect the serious concerns of the Licensing Committee and we too "consider that … this opens the door to abuses by unscrupulous drivers that would pose a reputational risk to Birmingham as a licensing authority."[70] The Committee urges the Chair of Licensing and the Cabinet Member for Children and Family Services to reiterate this to the Law Commission.

5.6.11 Finally, we would like reassurance that safeguarding is fully written into the council's taxi contracts, whether that be home to school transport or transporting children in care to and from case conferences.

Hotels

5.6.12 A particular concern for us was hotels as we heard that one model of CSE was "hotel parties". On the crime triangle (mentioned in section 6) hotels and B&Bs are a key location due to their ease of use, anonymity and relative privacy

5.6.13 We looked at some of the user review web sites and a few hotels caused us unease as possible signs of CSE could be seen, reoccurring over time. Users complained about a lack of oversight of the hotel, drug dealing and men hanging about in car parks and entrances; no attention to cleanliness and condoms being left in rooms or outside; pornography left in rooms; teenagers running about or even a room appearing to be the local youth club; people coming and going through the night; the smell of marijuana; and screaming coming from rooms. Not all of this did refer to children and none of this, of course, proves CSE, but it does indicate that in some hotels

[70] Licensing Committee July 2014.

CSE could probably occur unchallenged. Further, we were told by a practitioner that one of the hotels we raised concerns about was used for the abuse of one girl. Although the hotels concerning us were mainly at the budget end of the market, no hotel can afford to be complacent as at least one upper end hotel has been named to us, too, as a place a girl was taken to be abused.

5.6.14 We commend Travelodge for their approach, highlighted in the case study.

Case Study: Travelodge – Best Practice

Travelodge have understood the risks that CSE poses to children and to the reputation of the company and have taken rigorous steps to ensure it does not occur on their premises. Firstly they have good policies in place. For example, walk in bookings have to show photographic identity and posters urge staff to call 999 if they have a suspicion that sexual abuse is taking place. Secondly, they have implemented a rigorous training package, including for receptionists and housekeepers who can spot things no-one else does. They have backed this up by giving staff access to a support line in conjunction with NSPCC. Thirdly, they monitor patterns of behaviour over their whole estate to see if there is evidence of unexpected behaviour, such as frequent use of hotels near to the post code a card is registered and will not accept further bookings if there is evidence of fraud and prostitution. There is a Board level commitment to bar bookings relating to CSE, but better feedback from the police is required. They have concerns about data protection, but are developing a data sharing protocol with the Metropolitan Police.

5.6.15 It was suggested to us that CSE is like bedbugs in that neither are talked about. It is a problem for the whole industry; and the only way to resolve and prevent it is by talking and sharing good practice, but that no-one wants to admit it is happening or could happen to them. Overall, given the vulnerability of hotels there cannot be complacency about children's safety. In the light of this report we would like all procedures and training to be reviewed to ensure that nothing more can be done to ensure safety of children in hotels and B&Bs and to develop effective business engagement to tackle CSE.

5.6.16 The Committee feels it is important to work with all relevant networks and forums working with hotels and other relevant leisure businesses to ensure that their procedures and training all demonstrate good practice. We understand that CSE may have to be introduced as part of a wider discussion on safety as a CSE label may currently put managers off. If the data sharing protocol being developed by Travelodge is successful we would urge WMP to adopt it and for partners to find a way to get other hotels to adopt this too. The recent Anti-social Behaviour, Crime and Policing Act gives police new powers to request data from hotels, enabling them to be more proactive in their surveillance and disruption. Committee would welcome an update on how these powers are being used.

Licensing

5.6.17 As noted, one specific aim of the Licensing Act 2003 is to protect children from harm. The original BSCB strategy of 2013 notes the need for an improved interface between the Licensing Officer, the CSE data set and information sharing via MASE meetings and the WMP.

5.6.18 Under the Act responsible authorities have to be notified of any new Licence applications or any variations to an existing licence and any objections they make need to be properly considered. Without a Safeguarding Children's Licensing Officer in post there appears to us to be a gap. The benefit of this post would be a specific officer making representations based on their risk assessment of a location or type of venue or a licensee which would enable Licensing Committee to make better decisions. The lack of an officer making representations in order to protect children from harm is a risk that needs to be reviewed by all partners at the BSCB.

5.6.19 There appears to be a difference in opinion as to where the resources should come from and during the inquiry we came up against differing expectations about the role the BSCB should have and whether or not they could be a responsible body. We are told that the ring fenced licensing account does not cover the costs of any responsible body carrying out that role. At the time of finalising the report we were assured that discussions would clarify and resolve this issue.

Licensing in Coventry[71]

Coventry SCB has a Safeguarding Children Licensing Officer who is responsible for overseeing licence applications and scrutinising each one thoroughly. They are responsible for providing advice and guidance to licensees on matters relating to the protection of children from harm. Where licence applications do not meet the needs of protecting children, the Safeguarding Children Licensing Officer works with the licensee to help do so within the 28 day objection period. If this fails however, a representation will be put forward to the Licensing Authority explaining reasons for doing so.[72] There is a particular focus on premises where they believe alcohol could be sold to customers under the age of 18 years; entertainment is provided which is of an adult/sexual nature; a member of staff has previously been convicted of serving alcohol to a minor or is on the Sex Offender's Register; there are activities specifically for children; or there is gambling.

Licensing In Sheffield[73]

Sheffield has built on the *Say Something if You See Something* approach and developed an effective partnership between the Child Safeguarding Board and South Yorkshire Police. They are

[71] www.coventrylscb.org.uk
[72] www.coventrylscb.org.uk/files/Statement_of_Licensing_Policy.pdf
[73] NWG Annual Conference 2014

proactive and believe that the Licensing Act 2003 has powers that need to be used to protect children. Really positive work has been done with hotels who have been receptive. They have used a working in partnership approach: "We need you to help protect children and you wouldn't want your premises to be used for this would you? Think about the reputational and financial risks to the business." They have met with the Chamber of Commerce's Hospitality Trade Group and delivered free training. Building trust did take some time and required going to meetings, answering phone calls etc.

Over 30 hotel managers and 350 hotel staff have received training.[74] The training they provide suggests the type of CSE signs that can be spotted in hotels such as: what to look for e.g.:

- Paying in cash;
- Complaints of noise;
- High traffic to a room such as a number of men visiting a room at regular intervals as a perpetrator may have arranged for men to visit the room where a child is being sexually exploited;
- Teenage girls loitering in public areas/external areas of premises;
- Guests with local address renting a room or frequent visitors to the hotel who do not appear to have a reason for being there;
- Guest rooms with a lot of condoms/condom wrappers, drugs/drug paraphernalia, especially if child known to have stayed too (housekeeping can be invaluable reporters); and
- Guests who do not have any luggage or ID.

To protect their businesses hotels can embed some good practice including verifying ages of guests, keeping refusal records and incident logs, having police reporting protocols, regular training and to develop a "trigger plan" – what we would do if this happens.

In Sheffield the Local Safeguarding Children Board Licensing Officer goes to licensing hearings and makes representations. She often asks for licensing conditions. There cannot be a blanket condition, but if they can demonstrate that there is not a big costs involved (e.g. by free training) conditions can be seen as reasonable and have a huge impact. One example was an application for a sauna. Licensing Committee set a condition to ensure all employees showed two types of identification (to ensure they were over 18), and a National Identity number and proof of eligibility to work in the UK. In that case the sauna withdrew their application. Another condition was imposed on a club where the DJ would bring in children through the back door. They ensured that there was a rigorous control of admission by age.

[74] Safeguarding Sheffield Children Board Newsletter Summer 2014

Community Safety Partnership in Durham[75]

The Safe Durham Partnership's alcohol seizure procedure, which over a two year period has identified 2200 children as consuming or being in a group where alcohol was being consumed and removed it. In addition 300 adults have been found with these under 18s in possession of alcohol and they have all received letters about the proxy provision of alcohol. Their details have also been recorded which "will serve as an early warning system forming part of an intelligence picture around Child Sexual Exploitation."

5.6.20 Licensing Committee is, at the time of writing, consulting on a Statement of Licensing Policy. The Committee requests that the policy is strengthened in regards to CSE to both set out some basic expectations (as Chester and West Cheshire have done[76]) or, in so far as the law will allow, set out expectations about conditions. We know there are limitations to conditions that can be set, but there are opportunities to see if the safeguarding conditions could be stronger.

5.6.21 In addition, through the West Midlands CSE Group working collaboratively, Dudley Metropolitan Borough Council is leading on developing a toolkit for Licensing. We welcome this and wish to receive feedback about its development and adoption in Birmingham.

5.6.22 We were also told that there should be strong communication between councillors and Licensing and WMP. Councillors should understand how to submit intelligence to WMP and ensure that Licensing have the information to aid putting conditions on and enforcing them.

Using Statutory Powers

5.6.23 Licensing can set conditions for some hotels, but only if they are serving alcohol or have an entertainment licence. Many of the hotels the Committee had concerns about were not licensed. There is, however, in Birmingham a Joint Licensing Task Force which we were told carries out periodic joint visits and partners will use appropriate powers so owners have to improve and know that they are not operating "out of sight, out of mind." West Midlands Fire Service can, for example require a temporary closure to improve fire standards or a hotel can be pursued for tax avoidance or illegal alcohol sales. It is important that all partners support this and also ensure that someone who has been trained to spot the signs of CSE joins in these visits. We also suggest that user review sites such as Trip Advisor are used to help identify premises where a visit may be needed, as well as intelligence gained from return interviews (see 6.5.5).

5.6.24 Statutory agencies' use of hotels and B&Bs concerns us and it is an area where Scrutiny should carry out further work. It was suggested that there is a lack of co-ordination across the City Council when it comes to placements of vulnerable people with the homelessness team and

[75] democracy.durham.gov.uk/documents/s40082/Alcohol%20Misuse.pdf

[76] www.cheshirewestandchester.gov.uk/your_council/policies_and_performance/council_plans_and_strategies/review_of_licensing_polices.aspx

children's services and those managing registered sex offenders placing people in accommodation. There needs to be a better system of sharing intelligence.

5.6.25 Youth homelessness is a major risk factor and can also arise due to the wedge that CSE can drive between a victim and their family. We were informed that during 2013/14 75 unaccompanied children had been placed in B&Bs and hotels due to homelessness, although this appears to have been stopped during 2014/15. Ten premises were used, some of which were hotels which the Committee had concerns about. At the time of requesting information for this inquiry, however, there were no unaccompanied children in hotels/B&Bs.

5.6.26 We were assured that all B&Bs used by the homelessness team are licenced as houses in multiple occupation (HMOs) and that new providers are assessed. The homelessness team also carry out unannounced visits of hotels, particularly if any concern is raised by a resident. The homelessness team and the HMO licensing team do work very effectively together, we were told. We have also been told that known sex offenders would never be placed in accommodation with children. However, licensing for HMOs does not include safeguarding requirements. The City Council should explore using an accredited provider system as it would enable the authority to take immediate action if terms are breached. Certainly this is an area where contract specification, monitoring and enforcement needs to be placing safeguarding centre stage.

5.6.27 Currently, there is no "problem" profile about hotels. The BSCB and City Council should agree how this can be developed and where responsibility for this should sit.

Prevention Next Steps

5.6.28 This is a complex area, but is one where improvements can reap real rewards. Key areas for improvements are identifying and sharing details across the City Council of all current travel and accommodation contracts which are for children and risk assessing these; developing a joined up approach to placements within the City Council; making strong use of contract conditions; developing a hotel problem profile; and the City Council and all partners risk assessing each placement of a child.

5.6.29 Concerns were also raised that any staff who work by themselves in hotels and B&Bs and have access to room keys should be required to have an enhanced Disclosure and Barring Service (DBS) clearance, but that DBS were not accepting this. Doormen and bouncers at entrances to venues are security industry association vetted. The Committee intends to write to the Security Industry Association and Skills for Security to ask what their training includes about safeguarding and CSE and to urge them to include this if not.

5.6.30 A single corporate approach needs to be developed which puts safeguarding at the centre of how the directorates and BSCB work with such businesses.

6 Protecting Children

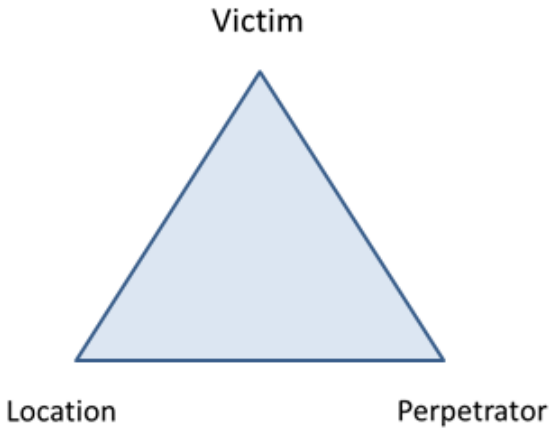
6.1 Overview

6.1.1 This section considers steps to protect children and the specific needs of groups with additional vulnerabilities and services are explored: children in care ("looked after children"), children involved in gang activity, children who go missing and those who have been offending.

6.1.2 There are other specific groups too. For example, we know that some educational and behavioural issues increase children's vulnerabilities and increase their likelihood of grooming. We think it particularly important that professionals working with children with special educational needs and disabilities understand CSE. Around a third of the children the harmful sexual behaviours team work with have autism or other learning difficulties which indicates the difficulties this group might face in recognising appropriate, healthy relationships. We would also have liked to look in more depth at the needs of homeless children.

Dealing with CSE needs a focus on victims, offenders and locations. This can be seen as a crime triangle.

Figure 3: The Crime Triangle



6.1.3 If all three exist a crime occurs; remove one and a crime can be prevented and a child protected. Crimes can be avoided:

- If a victim is removed (either through forced removal or because they choose to step away from a situation);
- If a perpetrator is removed – by jailing them, removing them from a locality by e.g. by the use of an injunction or removing their ability to travel, such as a licence; or
- If a location becomes undesirable or is closed down due to police or regulatory pressure.

6.2 Third Sector Role

6.2.1 We were told that third sector agencies have been at the forefront of dealing with victims as they have been able to adapt quickly to changing circumstances. We have certainly been incredibly impressed at the relentless work done with victims and families in Birmingham by the Barnardo's Space Project, the Children's Society Streetwise project, the Spurgeons' Phoenix Project and Parents Against Child Sexual Exploitation (PACE).

6.2.2 Barnardo's Birmingham Space and FCASE project provides support for children (under 18 years old) who are living in Birmingham and are in vulnerable situations which may lead to abuse and sexual exploitation. It works directly with children in Birmingham who are abused or are at risk. It also carries out awareness raising events for practitioners and children. In 2013/14 it processed over 150 referrals and worked with 190 children directly one to one or in intensive small groups and raised the awareness of almost a further 180. Of the children worked with directly almost all were aged 14-18, the biggest group being 14 and 15 year olds. There were some boys. Around half were white and half were other minority ethnic children. Funding comes from the City Council and the Community Safety Partnership, but predominantly from Barnardo's itself.

Case Study: Barnardo's Space One to One Working

Child E was referred by a Safeguarding Social worker to Barnardo's Space on in 2013. Child E is a 13 years old girl. Information provided on the referral included the following:

In 2013, Child E was referred to Social Care after she was discovered meeting a group of young males (aged up to 18). Child E had made contact with them initially through 'blackberry messaging' and did not know of them before meeting up a few months previously. Gradually, she has been introduced to more people in the social group. There were concerns that she was being sexually exploited.

In the previous year, Child E went with 9 males to park, and after a 'dare', gave a boy (a few years older) oral sex.

Child E was assessed as high risk of CSE. The Needs Assessment outlined the following Work Plan:

- To build trust and confidence;
- To increase knowledge of sexual health issues;
- To support Child E to move to safe situations and to stay safe;
- To support Child E to develop positive and non- abusive relationships; and
- To inform Child E about key risks (in particular in relation to sexual exploitation) and to support her in dealing with these.

Starting three months after referral, ten sessions took place over a three month period. Child E identified the areas she wanted to work on. Following an introductory meeting to explain the service, and obtain consent the themes covered in these sessions included:

- How much am I at risk?
- Understanding what makes a positive relationship.
- Decision Making
- Sick Party DVD learning about how young people are sexually exploited
- Grooming Line
- Risk and Keeping Safe
- Sexual Health & pregnancy

Child E said at the end of the work:

> "Space has made a big difference to me. I now think about the choices that I make. It was fun doing the work and I liked everything about working with M."

As importantly, the risk to Child E was felt to have decreased.

Conclusions

6.2.3 The BSCB strategy notes that "The use of the voluntary sector proved crucial in engagement and risk management." The third sector has, we were told:

> a uniquely trusting relationship with young people. Feedback from young people from RIs shows that only 5% would contact the police and 10% would contact Social Care. The third sector can reach parts that council services can't.

6.2.4 Talking, however, to third sector partners we heard of more than one case when they could not get the statutory agencies to deliver the services they need to in a timely manner. The third sector are vital in dealing with CSE in the city. However, we were told that sometimes the third sector organisations do not know until well after the end of the financial year if they are to be recommissioned for another 12 months. We also have concerns about unacceptable delays in payments for third sector organisations. The City Council has signed a compact which sets out guidelines and principles which supports good practice, better and effective working relationships between public authorities and the voluntary and community sectors. These principles should be

followed when working with the third sector.[77] Given the funding and resources they bring to the table, the City Council should see the third sector as more equal partners in dealing with CSE. This can be done by better join up across partnerships to jointly fund services for more than one year at a time.

6.2.5 Commissioning of services for dealing with victims of CSE needs to be improved so that they are they are properly resourced, longer term, and in place in good time, so that agencies do not have to work at risk at the beginning of the financial year.

6.3 Working with Parents and Families

6.3.1 CSE differs from child sexual abuse as the abusers are generally from outside the immediate family. This means that families can be seen as part of solution rather than part of the problem. Parents need to be able to identify signs of their children being at risk. They also need support if their child is being groomed.

6.3.2 An organisation which does this is Parents Against Child Sexual Exploitation (PACE) works across the country with parents and children affected by CSE to ensure a family-centred approach in preventing CSE. They are currently supporting a handful of cases in Birmingham and would like to extend this. Support ranges from a national 9-5 helpline, to network days to ensure parents do not feel so isolated, emotional support, and practical support though the court process. They also advise professionals.

6.3.3 Often the outcome of the grooming process is that victims become deliberately estranged or isolated from their families. Groomers' lines may include:

> "They don't love you like I do. They cannot care about your happiness if they are trying to stop you seeing me. You know I always have time for you when they never do. …."

6.3.4 However, parents (as well as carers for looked after children) can play a vital role in both protecting their children and gathering evidence. A PACE survey indicates that the majority of professionals working with children feel that support and information to parents is key in preventing CSE, but half do not feel that parents have the right information to protect their children from CSE.[78] Parents too can gather intelligence such as car registrations and forensic material. We were told of one mother who has wrapped up her daughter's knickers following contact with her abuser to pass onto WMP, but then did not get any feedback as to whether or not that was useful. Inadequate feedback from statutory agencies was a recurring issue for witnesses.

[77] www.bvsc.org/birmingham-compact
[78] www.paceuk.info/wp-content/uploads/2013/11/YouGovReport-Parents-in-the-Picture-FINAL-for-release-19112013.pdf

6.3.5 It is important that parents know how they can raise concerns and that frontline staff understand how to deal with concerns about CSE. When officers phoned the MASH number to ask whether parents can phone direct they were assured that concerns relating to a child (even if seemingly non-critical such as change of behaviour, going out, drunkenness and bad associations) will be taken from parents and that a visit to the child by a social worker will take place.

6.3.6 Once a child is being groomed we were told of the importance of working with the whole family, not just the victim. Elsewhere in the country they have some family workers embedded into multi-agency teams which would appear to be good practice and would be welcomed here if funding could be identified. PACE have developed a relational model which means that practitioners work in partnership with parents, facilitating and supporting them, in order to maximise the ability and capacity of statutory agencies and families to safeguard a child at risk of/being sexually exploited.

6.3.7 The relational safeguarding model includes:

- Maximising the capacity of parents and carers to safeguard their children and contribute to the prevention of abuse and the disruption and conviction of perpetrators;
- Early intervention and prevention;
- Enabling family involvement in safeguarding processes around the child, including decision making; and
- Ensuring the safety and wellbeing of the family in recognition of the impact of CSE.[79]

6.3.8 Working with the whole family can really help a child being abused. A case study from the Spurgeon's Phoenix Project explains how.

Case Study: Spurgeons' Phoenix Project Family Interventions

Child F was 14 at the time of the offence. She was referred from school where they had concerns about her current understanding of her own vulnerability. Child F was groomed online by a 35 year old male who she agreed to meet; he took her to a hotel and raped her. Her father had no idea that his daughter was accessing sites and chat rooms online but after his daughter was assaulted he did what he could to track online information and a mobile phone number of the perpetrator, collecting evidence to give to the police who were able to trace the perpetrator and prosecute. However, the perpetrator denied the rape and despite forensic evidence was let off with a caution. The father subsequently closed down his daughter's Facebook account and monitors her internet use more closely.

Child F's mother speaks basic English, and her father informed the Phoenix Project that he had to deal with the shock and horror of what happened to his daughter alone. He was close to breaking point due to strong feelings of guilt as he felt he had failed to protect his daughter.

[79] www.paceuk.info/wp-content/uploads/2013/11/Relational-Safeguarding-Model-FINAL-PRINTED-May-2014.pdf

Child F received some support after the assault and learnt about general safety issues including online skills. However, she was not able to talk about her real feelings properly: her violent sexual awakening, how 'dirty and cheap' she felt, her worry if she will be able to marry without her virginity, and how she feels from her own faith perspective. She also feels pressure from the home, often taking care of her younger siblings. She tries to please her mum and dad because she feels that they are always sad and not always available. She also believes that her dad is really disappointed with her and cannot really talk to him about her feelings, while her mum does not know exactly what happened and Child F does not have enough skill in her mother's first language to talk about it.

Child F does not like to complain though as the most important thing in her life is her family, who she loves, and knows love her. Child F does not have a friendship group outside of school. She does not particularly enjoy school but tries her hardest in her subjects, as she would like to be a Teacher.

Phoenix Project Intervention:

- One-to-one sessions/group work with Child F looking at healthy friendships/relationships;
- Bullying at school, sex education with an emphasis on emotions, sexual exploitation awareness;
- Looking at religion and today's society and her place in it. Working with school to support Child F's career plan;
- One-to-one sessions with parent's separately and then together with Child F, at the appropriate time;
- Help for her mother to access and accompany Child F to a youth group, to meet local police officers, and a women's group in the community to help her make friends and gain support; and
- Arranging for a school liaison officer to come to the home with an appropriate interpreter to support Child F and her family.

6.4 Looked After Children

Numbers

6.4.1 Time and time again we were told how vulnerable looked after children are to CSE. This is not to say there is an inevitability. The City Council is corporate parent to Looked After Children who are over-represented amongst the known victims in the city. There are around 1800 children in care[80], of whom, we believe, 170 are in residential care (with a third of those in the City Council's own children's homes and the remainder in external provision).

[80] www.chimat.org.uk/resource/view.aspx?RID=101746&REGION=101632

6.4.2 As with all the data about CSE across the city we may only know about the tip of the iceberg. The statistics in Chapter 2 showed that just over half of the known children currently on the list of those being exploited or at risk are looked after children.

Corporate Parent Strategy

6.4.3 There is currently a draft corporate parent strategy which sets out some promises to children in care and some indicators to be able to demonstrate improvement. Currently, the only reference to CSE is an indicator relating to:

> Increasing the number/percentage of children who are identified as being of high risk of sexual exploitation who are receiving specialist support/service.

6.4.4 The Committee considers this to be insufficient and to raise more questions than it answers. First, one would hope that every one of the few children in the city at high risk has access to specialist support and if they refuse it then it is made available to their parents or carers. Second, we have demonstrated the grooming line and emphasised the importance of appropriate support at all points to stop escalation. There must be a promise and measure to children at risk, but not yet at high risk.

6.4.5 We recommend that when the corporate parent strategy is finalised it is updated to include CSE risks in it.

Residential Care

6.4.6 Once it is identified that a child requires a residential placement, the Commissioning and Brokerage Team become involved to ensure a secure placement is found for the young person. One of our concerns is that of association. The risk to a vulnerable child at risk increases if they have close contact with someone already being exploited. This may be when a child sees themselves as having a boyfriend they would want to introduce a new friend into that circle. Alternatively they may choose to bring someone else in to divert attention from themselves or because they are under pressure from the abusers to provide another victim. We were told that a compatibility risk assessment is carried out in such cases and that a child will not be placed where it is felt that there is a risk from other children in place. We were also informed that in addition to usual safeguarding procedures training, staff are required to be trained in CSE. In responding to our recommendation on procedures for commissioning places in children's homes we would want reassurance that there is a clear compliance clause requiring staff to have training on CSE and it is being followed consistently.

6.4.7 The Directorate informed us that within the past three years girls from one children's home were being abused by a local group of men. We know that the Children's Society was involved in trying to resolve this and that staff training was improved. However, we heard different views as to whether any of the children placed in the City Councils' own homes are currently being exploited

or at risk. With this vulnerable group the best mantra seems to be "if you cannot rule it out rule it in" and care workers, social workers and councillors in their roles as corporate parents can never be complacent about the risks. Any feedback from the Rights and Participation Unit and the Children in Care Council on this matter needs to be carefully acted upon.

Case Study – Children in Residential Care

Child G was 13 years old when she was admitted to a children's home following a family breakdown: mother was unable to control Child G's behaviour. Child G was heavily under the influence of alcohol and cannabis misuse and was noted to be grooming other young females to be exploited by local men. It was noted that Child G was receiving gifts of mobile phones and clothing and was seen getting into different cars following phone calls received on her mobile.

Child H was 14 years old when she was admitted to a children's home following family breakdown, she was placing herself at direct risk by offering sexual favours to men in the local park. She met another young girl at the home who was being paid for sex with sweets. She was also found to be grooming other vulnerable young girls to do the same.

A Home Manager said they had recently met with three young female ex residents who had turned their lives around by securing jobs and going to college. When speaking to these residents they said that they did have regrets for not listening about sexual exploitation at the time, but that they fully understand now.

6.4.8 A concern was raised with us about the ability of children's homes to be equipped to deal with high risk CSE as these children have very serious and complex needs and may need a specialist therapeutic setting to deal with psychological and mental health issues.

6.4.9 Skills, awareness and training for staff in residential care is key. We were told that:

> Often workers in children's homes are the least trained, but are dealing with the most vulnerable in society.

6.4.10 Birmingham's residential homes (including those for disabled children) have, however, taken the initiative to train all residential staff. At the time of finalising the report we were told that around 95% of staff were trained in CSE and arrangements were being made for the others.

6.4.11 There is a small team of nurses within the Birmingham Community Healthcare NHS Trust who are geared towards the health needs of looked after children. These staff have been trained on CSE. This is a crucial resource.

Understanding of children placed in Birmingham

6.4.12 Children from outside the city can be placed in Birmingham in homes or foster care, although they remain the responsibility of the appropriate local authority. At the time of evidence gathering 25 children from outside the city were placed in the city. The home local authority does notify the City

Council that placements are taking place, but not the reasons behind this. As evidence to Parliament in 2012 made clear:

> There is a concern because of private children's homes in the city that, whilst we are notified of a looked after child being placed by another Local Authority in the city, we are not notified of reasons why—for example; are they subject to exploitation in the authority in which they live and that is why they are moving to an external placement. The notification often comes after a child is in placement so a discussion about the appropriateness of the placement based on local knowledge is not possible. In Birmingham; there are over 50 private units.[81]

6.4.13 Given the cross border nature of CSE and the risk of association – others getting embroiled due to being drawn in by a victim – this would appear to be a weakness in the system. We feel it important to ask Children's Social Care to find out more about the background of a child being placed in Birmingham to determine if CSE is involved. This is an area where further work is required to identify how to achieve this both nationally and through the regional working.

6.4.14 Overall, as corporate parents with responsibility for our most vulnerable children, we were reassured that some steps are taken, but we seek ongoing reassurances that these procedures are being carried out in all cases and that they are working.

6.5 Missing Children

6.5.1 The usual definition is:

> Missing child: a child reported as missing to the police by their family or carers.

6.5.2 However, the police now use two new definitions:

- Missing: anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of crime or at risk of harm to themselves or another
- Absent: a person not at a place where they are expected or required to be.[82]

6.5.3 The consequence of this means that if a child's whereabouts are known, for example in a named hotel or at a usual place of suspected abuse the police would not now define this as either 'missing' or 'absent' under the police definitions. We felt that there is some tension between WMP, Children's Social Care and Third Sector organisations over this. We were told that if the police do

[81] www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/68vw04.htm
[82] www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

not believe a child is at risk then they will not intervene, even when it would be impossible for many parents and carers to go and retrieve their child.

6.5.4 We know that those children and young people going missing are at increased risk of CSE. 216 young people between the ages of 0-17 were reported missing in Birmingham between the 1 April 2013 and 30 June 2013 in 327 separate missing episodes.[83]

6.5.5 Statutory guidance sets out roles for the City Council, police, BSCB and others.[84] On recovering a missing child the police are meant to carry out a safe and well visit and the City Council needs to offer each of them an independent return interview (RI), held within 72 hours. The City Council has contracted the Children's Society's Streetwise project to do these to ensure children have an independent professional. It is a chance to understand why a child went missing, but also whether the professional response to it was appropriate and to reduce the chance of it happening again.

Case Study: Return Interviews

Child J is 14 years old and had been missing 8 times in 2 months.

During the last missing episode Child J was missing for four or five days. Child J had not been reported missing by her mum until the 8th time of going missing. The referral was immediately picked up as Child J had reported to her mum and the police that she had been raped whilst she was missing, but at this point would not provide further details.

A project worker from The Children's Society met with Child J at her home to complete a return interview and explore the missing episodes with her. Child J told the project worker that during the last missing episode she was with her friend Child K.

Child K is 17 years old. Child K asked Child J if she wanted to meet up with some of her friends for a drink and "a good time". They met a couple of Child K's friends who were older males. They took the girls to a hotel and were taken into a hotel room where there were 15 older men. The girls were given alcohol which was laced with drugs. Child J was then locked in the bathroom and raped repeatedly for 4 days until she was released by the men.

The return interview was crucial in gaining further information and details for the police, as well as providing a safe person for Child J to talk to. Child J and her mum were supported by The Children's Society in taking the statement forward and the project worker followed the return interview with a specific session with Child J around 'Keeping Safe and Healthy Relationships'. There have been no missing episodes reported since.

[83] BSCB (2013) *CSE Intervention and Prevention Strategy*
[84] www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

6.5.6 Return interviews provide robust early warning and early intervention tools for CSE and contribute to problem profiling triangle (see Figure 3) which has been weak in Birmingham. Return interviews have a crucial role in identifying the "unidentified risk" in the city.

6.5.7 The number of missing return interviews that have CSE as a concern is high. We were told that 70-80% of all high risk missing notifications received from the police mention known CSE indicators in the information received. Return interviews, therefore, play an important role in early identification of CSE risk and early intervention.

6.5.8 We suggest that not enough independent RIs take place. We note that the Children's Society receive just £80,000 to conduct return interviews for all missing young people in the city and offer intensive support to runaways. This equates to 2.2 full time workers for the whole of Birmingham to triage 20-25 missing referrals a week, conduct RIs on the most at risk, and provide intensive support to those young people most in need. Due to resource availability they have found that they have to triage the most serious and decide which CSE case they can prioritise for an RI and subsequently allocate for intensive support. Despite this, they say "we are committed to contacting every single missing young person who is referred to us, even if this just means providing the lowest risk young people with information about where they can get help. We are desperately concerned about the level of risk we are working with and the lack of resources we have to respond."[85]

6.5.9 We understand that Streetwise has been awarded a further one off £83,000 until March 2015 to conduct return interviews on all high risk (traffic lighted red) missing episodes. They intend to analyse the results, including comparing impact on those that receive RIs only with those that also receive follow up intensive support from Streetwise. They will also use the opportunity to gather more intelligence using the problem triangle.

6.5.10 They have learnt lessons around persistence, and building long term relationships to get disclosures. They may flag issues with social workers for action or refer children onto Barnardo's Space for further support.

6.5.11 We also need to set on record our concern about the vulnerability of children without school places. We understand, at the time of writing, this numbered 120. Whilst we accept that not all school children without a school place are vulnerable to CSE, officers should still be mindful and aware of the signs. It was suggested to us that there is a need for services to be more proactive in clarifying the education placements of children when they come into contact with agencies and then to be proactive in notifying the local authority if they believe the child/ren to be without school places. This should include housing and homelessness services, GPs and hospital and out of hours health providers.

[85] Email

6.6 Offending

6.6.1 There is a strong link between being a victim of CSE and offending behaviour. We were told that the majority of children identified as being at risk of sexual exploitation are known to the Youth Offending Service and that national research suggests exploitation occurs before offending. We were pleased to visit the Youth Offending Service and its Female Gender Specific Programme (FGSP). The Service is in a good position to intervene as young people are on statutory orders or pre-court interventions, which allows a full assessment to understand the causes of their offending behaviour and to highlight vulnerabilities.

6.6.2 Children may often become dependent on drugs or alcohol in order to distance themselves from the abuse they have suffered or as a result of the perpetrator of CSE forcing them to use or deal drugs. Boys and young men are often seen more readily as criminals than as victims and the service is able to carry out a CSE assessment for all young people, male and female, to identify victims of and those at risk of CSE .

6.6.3 The FGSP programme (adopted from Oregon's guidelines for establishing a gender specific programme) is "relationship based" and consists of one to one support and some group work, all delivered by a small consistent group of female workers from the Youth Offending Service and seconded Barnardo's staff. They have embedded the CSE screening tool and so consider the potential for all the cases they deal with. The programme aims to build resilience, provides the young people with mentoring support (via Barnardo's) and a range of skills to help them move forward in a positive manner to keep themselves safe. The service has strategic and operational links with the CSE co-ordinator and relevant CSE meetings.

6.6.4 We were also told that a number of young people on the programme would not have been identified as having problems or identified as victims of abuse or neglect as they were primarily in the system due to offending. Due to the holistic nature of the FGSP, the staff are able to build relationships with the girls and very often disclosures of abuse and exploitation do come to light, which are shared with Children's Services and police. The aim of the programme is to ultimately reduce or stop re-offending, promote healthy relationships and keep young people safe.

6.6.5 Those who are identified as victims of CSE include young people who are first time offenders as well as more persistent offenders. The team are advocates of early intervention as they felt a lot of the "damaging" behaviours were already entrenched by the time a young person comes through the youth justice route. The Committee would concur.

6.6.6 They also run a Sexually Harmful Behaviour Service, which takes referrals from children as young as six to those who are under 18 years. Children are referred from a number of agencies including children's services, police, health and school professionals if they are displaying abusive sexual behaviour to someone else, such as rape, inappropriate touching, and distributing sexual images. The Service undertakes evidence based assessments and proven interventions and works with over 100 young people each year. A multi-agency thematic inspection led by HMIP (Probation) was

carried out in May 2012. Findings included good inter-agency working with evidence of effective planning within structured safeguarding and risk management arrangements; capable and committed child-focused workers who have high aspirations for young people; the specialist Sexually Harmful Behaviour Service was noted as an "excellent, unique resource", delivering services through a range of methods with good outcomes.

6.6.1 The team fired a warning shot about how easy access to pornography and a lack of positive role models about relationships and how women are treated are leading to a culture where poor sexual behaviour is seen as acceptable:

> We need to ask ourselves what we're doing to our children?

6.7 Gangs

6.7.1 Street gangs can be linked to CSE, although exploitation is not the reason for a gang's existence. There are over 40 gangs in Birmingham, we were told, and girls' involvement in gangs is risk factor for CSE. The Gender Specific Unit and Birmingham and Solihull Women's Aid (BSWA) both have experience of this group of children. Girls have particular vulnerabilities caused by involvement in gangs, whether as girlfriend" to a gang member or a sister.

Case Study: Gangs

Child L, arrested as a first time offender in 2011, was given intensive support by the project team. Eventually, she disclosed to the workers that she had been a victim of gang rape as part of an initiation into the gang. It took approximately a year to build up her confidence and intense support to build her back up again. She needed to know that she was supported and safe and believed. She also admitted that she was regularly missing from both school and home. This was how she coped with the trauma. She was no longer engaged in education as a result of the traumatic abuse she had suffered. Child L continued to have contact with the Gender Specific programme following her completion of her statutory order. To date, she has successfully completed college and works part time with a view to applying to university.

6.7.2 BSWA has run a pilot programme and the understanding from this needs to be used. They were commissioned to undertake specialist work around street gangs and young women by Birmingham Community Safety Partnership, (through Ending Gang and Youth Violence funding). They said

> This work uncovered issues of child sexual exploitation as a much larger problem than we had anticipated.

6.7.3 This work was funded to deliver:

- "She" – a theatre production in partnership with Birmingham School of Acting;

- Peer mentor support programme from year 10;
- Intensive 1-1 support programme from age 11-29; and
- Education and awareness amongst young women & agencies

6.7.4 The work shows a complex web of power and networks, but girls, mainly, might be expected to act as a drug mule or store weapons or perform sexual acts on other gang members. This pilot once again demonstrated that many girls did not recognise when they were being groomed. They didn't always recognise that "she" in the play was them. They thought "I'm in control. This is what he does for me. There's no way I will get caught up in any trouble. I get to go to McDonalds, Kentucky and the ice cream parlour. It's OK!" But when BSWA carried out the interventions and broke it down the girls recognised "she" was her and that running with gangs brought risk as well as reward. BSWA also got disclosures.

6.7.5 Although the other areas of work above touched upon CSE, it was the one to one work that really uncovered the shocking levels of abuse that young girls in particular are subject to, and particularly those who are enmeshed with street gangs. It was suggested to us that this is not recognised as CSE because the perpetrators themselves are so young.

6.7.6 On the face of it this seems to have been a very effective pilot. However, as it was a pilot, and not withstanding the work of the GSP, we do have concerns about whether the important work of safeguarding children involved in gangs is being supported in other ways.

6.8 Therapeutic Interventions

6.8.1 Mental health services, counselling and therapy can help at all points in the rollercoaster of grooming. It helps build resilience, protect children at risk, and help overcome long term damage once out of risk. It is therefore key.

6.8.2 Abusers seek out vulnerabilities in children. The importance of access to mental health services for children cannot be underestimated. A school who deals with low self-esteem or early signs of behaviour change by offering counselling can nip a problem in the bud. This can make a child more resilient and less vulnerable to grooming.

6.8.3 The current child and adolescent mental health service (CAMHS) and the Therapeutic and Emotional Support Service (TESS - an emotional well-being service for children looked after by the City Council) currently play a role. Yet we were told that there needs to be more services to support young people with emotional needs and that the current lack of services in Birmingham will impede efforts to help the children recover from trauma. We would like reassurance that the commissioning for mental health services for under 25s will address this. A therapeutic programme with young people has to be systemic, addressing the broad lives of a child including school and family.

6.8.4 We heard of one boy who had been in foster care following abuse. We were surprised to hear that counselling and therapeutic interventions do not get routinely offered to children. He had received no therapeutic intervention, until he abused a foster "sibling". Children like him are vulnerable to exploitation and struggle to believe things would change if they told someone. These children may need intervention when they come into care, especially if relationships have broken down with parents and carers. We were told that there is a lack of after-care, support and counselling for victims which needs to be addressed.

6.8.5 In addition to therapeutic interventions practical support needs to be made available to children. A report on prostitution, which also considered the implications for children who have been abused for financial gain, noted, for example the importance of secure housing and making sure that 16-18 year olds do not fall through the system. The report also notes that education has often been disrupted and so education and support into training or back into education can be invaluable in getting young people back on their feet.[86]

6.8.6 Committee will ask for a follow up report on support available for victims in Birmingham including therapeutic support for victims and families; transition to adult services and joining up for vulnerable adults (especially for any CSE victims leaving care); peer mentoring; and witness intimidation of families.

[86] www.gov.uk/government/uploads/system/uploads/attachment_data/file/97778/responding-to-prostitution.pdf

7 Perpetrators

7.1 Who Are They?

7.1.1 Firstly we learned that there isn't a profile for a typical groomer and they are not necessarily a "dirty old man in a mac". A groomer is likely to be friendly, a good communicator and listener, an acute observer (which means they can identify weak spots or 'hooks' very quickly), is skilful with young people and manipulative and clever.[87]

7.1.2 We did not find out enough about the perpetrators of these crimes and would want to understand more about how many people are known or suspected of involvement and more about them such as their gender, ages, ethnicity and localities. To reiterate section 2.3 this crime can be carried out by anyone and to shine a light on just one community or type of person puts other children at risk. For example we were told of one intervention with three girls who realised that they were all being groomed by the same boy. However, as he was an A* student everyone's first thought was "it cannot be him." Women can also be offenders.

7.1.3 The aim has to be to make Birmingham a city where abusers know they cannot freely operate and to wish for the same across the country. To achieve this requires each and every one of the partners in the city to work as best as possible to gather and share intelligence and use this to disrupt and prosecute. All stakeholders have a role here from frontline workers and parents and carers as well as Police Officers.

7.2 Legal Measures and Disruption

7.2.1 There are three areas for taking legal action in cases of CSE. First, is the standard child protection route which can include secure accommodation and care orders. Second, are criminal prosecution and third is the use of civil orders.

7.2.2 The police can also use a broad range of their powers to get in the way and try to interrupt grooming or abuse. Disruption can mean picking up a perpetrator on any breach of the law, such as tax disc, minor drugs possessions etc. so they know that the police are keeping an eye on them or they can be locked up for drunk driving. As the BSCB guidance says:

> The prosecution and disruption of perpetrators is an essential part of the process in reducing harm. It is the responsibility of the police to gather evidence, investigate and interview perpetrators and prepare case files for consideration by the Crown Prosecution Service (CPS) with the intention of obtaining the successful conviction of offenders.

[87] Barnardo's training

7.2.3 Legal interventions can provide a twin track approach. Successful prosecutions are generally reliant on victim's disclosure, forensic evidence, evidence from technology such as mobile phones and CCTV. It can take a long time to complete the court process during which the victim needs to be kept safe, and it can be difficult for them to move on with their lives with the threat of a court case hanging over them. If evidence is robust enough prosecution should always be pursed.

7.2.4 There is, therefore, also a need to increase use of civil court orders as this can be swifter and decisions are made on the balance of probabilities. The types of orders include civil injunctions, gang injunctions, Anti-Social Behaviour Injunction (ASBI), legislation used for domestic violence, police protection orders and emergency protection orders. Child disruption notices (formerly "harbouring notices") can stop an adult associating with a child and so can be used to stop perpetrators picking up children outside children's homes.

7.2.5 Given this complex nature, numerous teams within Legal Services deal with specific parts of the law dealing with CSE. We would welcome reassurances that there are mechanisms for sharing information and meeting victims' needs in a co-ordinated manner within the Department. At the time of writing we were told the boundaries were being pushed and test cases had been identified to go to the High Court and work was being undertaken to secure wardships for a small number of children. A multi-agency approach between Legal Services, WMP and the CSE Co-ordinator was developing.

7.2.6 The City Council can also use court procedures to remove the victim not the perpetrator, which is not ideal. However, it may be necessary to keep a child safe, by getting order for secure accommodation which is valid for up to three months. When we heard evidence there was one child placed in secure accommodation due to CSE. At the time of writing the CSE strategy (Autumn 2013) there were three children subject to a Secure Accommodation Order and a sample of cases then suggested that:

> Disruption planning seemed to focus on the disruption of victim behaviour not Perpetrator behaviour, utilising out of area placements and Secure Accommodation Orders – although there have been some successful and Unsuccessful prosecutions and use of Harbouring Notices and S2 Abduction Warnings.

7.2.7 At the time of writing the Public Protection Unit in WMP were investigating 57 live criminal investigations into CSE and a further 130 cases were being looked at where there are concerns that CSE is involved.[88] Whilst the police have pursued some offenders (through, for example, harbouring notices), Legal Services have, historically, not brought any charges against offenders. To take action solicitors need to gather and assess evidence and although time has been made

[88] www.west-midlands.police.uk/latest-news/news.aspx?id=1593

available for social workers and practitioners to discuss cases, to date progress on this has been slow.

7.2.8 Legal Services officers acknowledge that child protection remedies have proved insufficient and so have been working to redress this. Members were, therefore, delighted to hear when finalising this report, that the High Court has granted some injunctions to prevent a number of men from approaching under 18 year old girls in public. The case had been taken by the City Council with the support of WMP to protect a girl in the care of the local authority who had been found at a hotel with different men at different points in time.[89]

7.2.9 A range of different options need to be developed to make the most of legal remedies. This can be pulled into a toolkit that makes clear what action can be taken, what is needed, who needs to act and what outcome is expected. We were directed to the Derbyshire toolkit as an example of good practice.

7.2.10 The Committee welcomes the fact that a further two cases are now being finalised to test legislation in the courts.

7.2.11 Moving forwards, the following steps need to be taken:

- Frontline social workers and practitioners need to look beyond the immediate protection of the child and understand the role they need to play in offender disruption, enforcement and prosecution. We recognise that, for some, there can be a tension between safeguarding a child and dealing with perpetrators to make all children safer. However, civil orders do protect a child. Practitioners should, whenever appropriate, ask for specific information from children at risk, such as names of the people they were with, a taxi driver's firm and a time and location, the name of a shop where alcohol was purchased and what an individual actually did. This may require further training;
- Frontline social workers and practitioners need to be given a procedure for sharing relevant information with Legal Services. Independent Reviewing Officers (linked to each case of child protection / child in care) provide oversight and challenge. Briefings and training for them should be available so they can encourage pursuing offenders and sharing information in this way;
- Work with WMP to ensure that frontline police officers prioritise sharing intelligence and making a statement when asked to by Legal Services; and
- Ensure consistently good information sharing between WMP and Legal Services. If the police decide there is not enough evidence to pursue a case, or the CPS inform a Police Officer that a court case would not be successful, a process needs to be put in place to ensure this information is shared with Legal Services so they can take the lead on a civil legal remedy.

[89] www.birminghammail.co.uk/news/midlands-news/five-birmingham-men-banned-approaching-8008740; cypfbirmingham.wordpress.com/2014/11/19/injunctions-obtained/

7.3 Prosecutions

7.3.1 We are still unclear as to the extent of prosecutions to date and being prepared. In part this is because the categories of crimes that involve CSE are very varied and within the Crown Prosecution Service do not come up with a CSE marker.

7.3.2 We have noted some cases in this report (including the successful case against an organised grooming gang in 2003) and the internet has revealed some further cases such as:

- Male nursery nurse jailed for internet grooming as well as offences within the nursery in 2013;
- Male operating alone, previously jailed for sexual offences, convicted of contacting girls through social media and by phone and coercing them into sex, 2014;[90]
- Conviction of Police Officer who groomed a girl, 2014;[91]
- Jailing of a male shop keeper for grooming of a 12 year old, 2011;[92] and
- At least two convictions for sting operations when men were led to believe they were meeting someone underage for sexual activity. One concerned a Bolton man in Birmingham and one a Birmingham man in Tamworth – again emphasising cross boundary nature of this crime.[93]

7.3.3 Notwithstanding evidence of some prosecutions, the conclusion drawn in the CSE prevention and intervention strategy was that:

> …perpetrators of these horrific crimes remain at liberty and continue to target other children. The absence of prosecutions of these offenders is startling. Partner inaction may indicate that there is sometimes a reluctance to use the statutory powers available to them and this is unacceptable.

7.3.4 We were also told by one witness that they felt there was an emphasis on securing successful prosecutions in other parts of the country which was not evident enough in the West Midlands. The voice of young people, as well as effective, co-ordinated multi-agency planning is key to prosecuting those offenders who are targeting vulnerable children.

7.3.5 The West Midlands Crown Prosecution Service CPS has also pulled together a specialist team: since 2012 all its rape and sexual abuse specialist lawyers and dedicated caseworkers have been located together in Birmingham. They describe this now as a high performing flagship unit. Conviction rates for rape and sexual offence in general are 66% and 80% respectively. Some of the good practice they highlighted included:

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[90] ww.birminghammail.co.uk/news/midlands-news/birmingham-paedophile-jailed-grooming-underage-6911058
[91] www.birminghammail.co.uk/news/local-news/birmingham-policeman-jailed-sexual-activity-6489108
[92] www.thefreelibrary.com/MAN+GROOMED+12-YEAR-OLD+GIRL.-a0254296566
[93] www.theboltonnews.co.uk/news/northwest/10980999.Accrington_teacher_spared_jail_after_he_was_caught_in__paedophile__sting/

- Linking in with police leads to ensure there is early referral to build strong cases;
- Providing charging advice which is then overseen by the same reviewing lawyer until conclusion of the trial;
- Using Counsel or Advocates in rape cases who are approved to conduct this business;
- Working closely with Advocates and trying to ensure the same Advocate is briefed throughout the case;
- Deploying para legal assistants to provide witness support at court;
- Seeking support for these approaches from the judiciary;
- Often involving local lawyers from an early investigative stage in giving advice and guidance;
- Working with police, Independent Sexual Violence Advisors (ISVAs) and witness services to ensure victims and witnesses are given the benefit of special measures to assist them with giving evidence e.g. giving evidence by TV link or behind a screen; and
- Building strong links with the region's ISVA's.

7.3.6 The CPS web site and policies now show an understanding of working with victims of CSE and the need to overcome stereotypes and poor cultures (see for example, section 2.3.1). This is to be built on as all specialists are to receive on-going training regarding CSE.

7.3.7 The CPS note that there are current agreements and 'Memorandums of Understanding' that are in place between stakeholders to share information and that this is a vital tool that they already use in bringing perpetrators to justice. But they note:

> These lines of communications have to remain open and accessible to all so that the prosecution process is not frustrated by bureaucracy. It is vital from the outset that CPS is able to consider relevant material held by third parties to comply with our duty of disclosure under the Criminal Procedure and Investigation Act 1996, and to avoid raising expectations of victims if we later discover the same material contains undermining information. It is vital that we obtain all available information from the outset of cases to ensure that cases can proceed smoothly through the criminal Justice system. Sometimes this is a time consuming process.[94]

7.3.8 It is difficult in complex cases of CSE, without undertaking an in-depth investigation to know where the blockages really are in the justice system. However, in spite of the above steps being taken we were told about a couple of West Midlands' cases when the informants felt the CPS was to blame for a lack of success.

[94] Email

7.3.9 Certainly, we have had requests from partners that CPS share lessons learnt on why cases do not make it to court. There seems to be a lack of knowledge and understanding about this amongst some agencies dealing with victims.

Next Steps Legal Remedies

7.3.10 It can also be frustrating for the police and courts if victims retract evidence. It was suggested that this may happen as there is not yet enough confidence in police that victims will be safeguarded. Therefore, more work needs to be put into developing pathways for victims in high risk situations.

7.3.11 An information sharing protocol now exists between Children's Services and WMP which Legal Services helped develop. A specialist disclosure team within Legal Services helps ensure that WMP has any information that the City Council holds to aid them with prosecutions.

7.3.12 Overall, we are not yet sure how effectively all agencies are working together to achieve legal protection and justice. For the sake of the children at risk or currently being sexually abused we would ask the city's Legal Services, WMP and the CPS to collectively review if any further steps can be taken together to share information on cases and to increase the number of successful court actions. This may also need to be underpinned with continuing professional development about the meaning and complexity of CSE.

8 Progress, Challenges and Recommendations

8.1 Meeting the Challenge

8.1.1 The aim of this report has been to build a culture of awareness and proactive action with partners and communities in Birmingham.

8.1.2 In general, we heard of good practice in all types of organisations, but there is always room for improvement. In addition, in the course of the inquiry we heard of a few cases when appropriate action had not been taken at the right time or of attitudes that mean action will not be taken. The Committee feels that whether or not these were isolated incidents or indications of broader systemic failure, leaving one child not adequately protected is one child too many.

8.1.3 This report should act as a wake-up call as it is important for everyone to understand that CSE is occurring in Birmingham and can occur within any part of the city or community and to boys as well as girls. Public sector organisations (including the City Council, West Midlands Police and the other blue light organisations, health providers and commissioners, schools and colleges), and third sector organisations who work with communities and families need to acknowledge this and act. Priority needs to be established from the top in such organisations, but understanding and action needs to be embedded throughout.

8.1.4 We need to ensure reporting increases and expect zero tolerance of this crime. We need to ensure victims have the confidence to come forward and offenders are reported. By working together and redoubling all of our efforts, we want a clear message to be sent to perpetrators that they cannot work with impunity in Birmingham.

8.1.5 We cannot and will not wait for a high profile Rotherham, Rochdale, Derbyshire or Oxfordshire case before CSE in Birmingham is taken seriously by all. To achieve this we set out a number of recommendations later in this chapter. The Committee intends to track progress to ensure this report does elicit action. As one practitioner said:

> These young people are the adults of our future. THEY ARE WORTH IT.

8.1.6 The Committee also endorses the recommendations of *Unheard Voices* by the Muslim Women's Network UK.[95]

[95] www.mwnuk.co.uk/resourcesDetail.php?id=97ref

8.2 Progress

8.2.1 The Committee concludes that much progress has been made to get a framework in place over the past two years that can safeguard children. Notable progress includes the BSCB strategy and action plan; the restructure of organisations (the City Council and WMP) to enable CSE to be tackled; putting in place two CSE Co-ordinators, funded by mainstream People Directorate funding; the focus by West Midlands PVVP Board and the development of pan-West Midlands standards; and the use of CSE screening tools by the City Council, many health organisations and other bodies. Importantly, good progress has been made against the BSCB 2013 action plan. The Committee reiterates its view that there are some fantastic champions for CSE within the City City Council and partner agencies. Without their hard work, children would be at greater risk.

8.2.2 We were also reassured to hear that at a West Midlands level, following the Rotherham report that

> No-one is remotely complacent about these threats, both historic and current, facing some of our young people across the region.[96]

8.2.3 However, there is still a long way to go. First, the Committee is not yet assured that the criticisms in the 2013 CSE strategy and the 2014 Ofsted report into safeguarding (see sections 3.2.2 and 1.4.12) have been fully overcome. Second, many examples of great practice in Birmingham have been referred to throughout this report, but the Committee is not yet convinced that these approaches are embedded in all organisations or that organisation's approaches are consistent, regardless of which officer is dealing with a case or providing advice. Third, not enough people "get it" yet. Until CSE is better understood by children themselves, parents and carers, practitioners and communities, perpetrators will remain hidden. Overall, the Committee was not assured that there was enough effective action being taken. In part, this is because although there is a multi-organisational approach, it still needs to be better joined up.

8.2.4 We recognise that the BSCB now does have a CSE strategy and did initially fund the CSE Co-ordinator, both of which have been major steps forward. In spite of that, the Committee feels that further work needs to be done to hold partners to account in dealing with CSE.

8.2.5 We are pleased that much work has been carried out to ensure that there is a standardised approach across the West Midlands and also in setting up multi-agency working. However we do require further assurances that all partners are playing a robust enough role; and have the resources and capacity to deal with the current and future case loads.

[96] PVVP Update 10 19/7/2014

8.3 Working with Children

8.3.1 We identified some of the principles of working with children to tackle CSE and suggest that there are currently challenges in meeting these. The cultures of the City Council and the partners in Birmingham need to be developed to ensure principles of:

- **Child centred:** Various Serious Case Reviews should have taught practitioners to look beyond an initial situation to understand the life and viewpoint of a child. In the case of CSE looking beyond the behaviours to understand why things are happening is important;
- **Working with and not doing to**: Professionals need to work with the children involved until they can see the risks and can discuss options available, and not just do things to them. One practitioner explained that they validate the experience of young people by letting them take away the report about themselves and being involved in the needs and the risk assessment;
- **Accessible services:** Children do not just face risk or tough decisions 9-5 and it is important that they do have access to someone to help them at such times. One practitioner said:

> We leave our phones on after hours. Doing that may stop that girl making the wrong choice. But there need to be enough people to leave their phone on after hours.

- **Long-term relationships with professionals:** As with other types of child abuse CSE involve a breach of a child's trust. It is important that long-term relationships with professionals are able to flourish and provide assurance that actions are followed through. A stable children's social care workforce would help make a difference. This is a current risk;
- **Professional persistence:** We were told of examples where practitioners would visit numerous times, every week, with constant rebuttals until, finally, trust was built. We were also reminded that organisational norms, such as striking a client off after two missed appointments, does not fit the needs of this group of vulnerable children; and
- **The right services at the right time:** A range of preventative, protective and therapeutic interventions need to be available for children. These should include gender specific services.

8.4 Challenges

8.4.1 Firstly, awareness, understanding of CSE needs to increase for professionals, communities, families and children themselves. This needs to go beyond the media stereotyping and needs to encourage action. As councillors have specific responsibilities for Looked After Children, all need to understand how to raise concerns about individual children (through the MASH) and also to ensure that if they have concerns about, for example, locations they know how to contact the appropriate people e.g. WMP local team, CSE Co-ordinator and Licensing officers.

8.4.2 Councillors are leaders within their communities and have an important role to play in raising awareness of CSE and signposting to support. It is felt there is, on the whole, a lack of awareness and understanding regarding CSE amongst Councillors and especially how it affects corporate parenting responsibilities.

8.4.3 In terms of children's social care we heard a number of concerns from many different partners. The types of issues and frustrations raised about the Directorate included:

- Difficulty in getting a social worker allocated quickly to a child;
- Social workers may have a range of experience, but not enough expertise to pick up the issues around CSE;
- A repeated feeling of having to fight at times to get cases investigated properly and to keep cases open;
- Children's Social Care closing cases that other professionals feel should be open;
- Inadequate response;
- In discussion there were anxieties expressed about the speed of feedback from children's social care when referrals have been made. Although this is meant to occur within set timescales (24 hrs or 5 days) partners did not always find this was happening. (We hope that, at least at the stage of referral, the MASH processes is improving this); and
- Partners suggested they do the risk assessments but do not see interventions following through.

8.4.4 **A joined up council with a shared aim to protect children:** We are not the first Committee to say the City Council needs to be more joined up and nor will we be the last. For example, various parts of the City Council make placements into accommodation – homelessness, children's social care, sex offenders. To what extent are contracts reviewed collectively; are terms included about safeguarding and is information shared on a live basis as to who has been placed who could pose a risk and who is vulnerable?

8.4.5 We have been particularly mindful of the frustrations that third sector organisations have expressed about both the City Council and West Midlands Police. In particular, they cited specific cases when an appropriate or **timely response** was lacking. As is often the case with both large organisations it seemed to reflect more on getting the right or wrong person rather than the procedures themselves being wrong.

8.4.6 **Information sharing** with a purpose is crucial in protecting children. For example, we were told that better sharing of information, such as known hotspot locations, would help in risk alerting professionals to children who might be at risk. We were told that sharing of information is not always proactive enough. For example, if WMP have not got enough evidence to charge a perpetrator does a conversation automatically take place with Legal Services as to what the City Council could do about it using civil orders?

8.4.7 We have been told that the **data** on CSE needs to be improved. Care First is the database of Children Social Care's case loads. It needs to be developed to make it easier to pull out information and share it to examine patterns relating to victims, offenders and places, such as parks and takeaways. It needs to be developed into an improved data base that is evidenced, trackable, and sharable.

8.4.8 We were told that improvements still need to be made in developing a full multi-agency evidenced understanding the current CSE picture. Currently, there is dependence on a single spread sheet held by the CSE co-ordinator, plus partners' individual case files and assessments. There needs to be a collective evidence base that can be up dated at the click of a button. This will enable a more robust understanding so that resources can be targeted much more effectively. This would also help to identify and prosecute offenders. Moving forward it should be possible to use the intelligence and analysis in a much more informed way and actually learn which tactics and approaches do work and those which do not.

8.4.9 We heard frustrations around the **quality of referrals** both from officers and external partners. It seems as if a lot more work has still to be done with agencies across the city to ensure that referrals are good quality. We were told that too many referrals lack information and so get sent back for further details to be added. Any professional referring into the MASH does need to be able to complete the referral form fully and enable a risk assessment to be made on that child at the multi-agency CSE meeting. Insufficient information will delay. Appropriate training and the rolling out of CSE champions to support practitioners would support that.

8.4.10 As with much in safeguarding **thresholds** are an area of tension when one agency believes a case should be dealt with at a higher level, but the local authority deems it is not so. For example, a practitioner wanting Children's Social Care to take responsibility rather than managing a child through an FCAF. [We are hoping that the MASH will help to appropriately allocate cases based on a more detailed understanding of risks.]

Case Study: Challenges in Agreeing Thresholds

Child M was referred to the Children's Society Streetwise project aged 16 for a return interview, which was promptly undertaken. She is a persistent missing person and regularly goes missing three to four times a week. At the interview they found that Child M was living with an older relative who wasn't coping with Child M's behaviour. Child M has learning difficulties, and also a diagnosed mental health problem for which she is prescribed anti-psychotic drugs. Whilst going missing she mixes with homeless people, who supply her with alcohol and street drugs and tries to coerce her into dealing as well. This includes heroin and crack. She has admitted to being sexually active with the men. Whilst missing she does not take her prescribed drugs, so that her behaviour becomes erratic, even delusional and hallucinatory. Streetwise referred her for urgent action to the children's social care team and initially the social worker said there was no risk and that Child M tells stories. Streetwise persisted and Child M was eventually placed in an out of city foster home, but this broke down within a fortnight as the foster carers couldn't cope with her

behaviour. She is now back with the relative and the problems persist.

Streetwise had tried for two months to call strategy and review meetings, but felt frustrated by lack of progress. One meeting held could not go ahead because the social worker and his manager did not turn up; only the chair and Streetwise were present. Streetwise say that the police do not believe Child M's claims of CSE and that the social worker questions their assessment of the level of risk. The council's Safeguarding Manager and CSE Co-ordinator have supported in trying to escalate this issue but with no result.

A MASE meeting was finally held but only after high level complaints were made to the Director of Children's Services and the Birmingham Safeguarding Children Board Business Manager. Child M was finally sectioned under the Mental Health Act and placed in a specialist mental health unit. It took over 3 months for a mental health assessment to be done and at the time of being told about this the section 47[97] child protection investigation was not complete. A safeguarding plan was finally in place. During the delay that accompanied this case Child M, in a delusional state, was charged with attempted robbery of a packed and busy city centre betting office and so is now likely to have a criminal record that could affect her for the rest of her life.

8.4.11 To reiterate, tackling CSE and making sure all children in the city are better protected requires actions – each partner playing its role. A particular area we would like to see concerted action on is taking action against perpetrators.

Resources and contracts

8.4.12 "It's underfunded and precarious," a practitioner suggested. CSE is a hugely resource intensive area of work for the city. The 2013 CSE Prevention and Intervention Strategy sets out resources that were specifically made available for CSE in 2013/14, but in addition to this will be mainstream resources for social workers, police investigation, the CPS etc. It was suggested by some witnesses that this table does not include all funding brought to the table by non-statutory agencies.

Table 5: Resources for CSE 2013/2014

Organisation	Contribution £,000
Barnardo's	100
Department for Education	100
Third Sector	47
Community Safety Partnership	66
City Council	96
Children's Society	120
TOTAL	529

Source: BSCB CSE Strategy and Action Plan. Contribution of health has not been included.

[97] Of the Children Act 1989

8.4.13 We have some specific concerns about the adequacy of resources. One officer did admit that:

> Responses to young people at risk of sexual exploitation are undermined by resource constraints.

8.4.14 In this inquiry we have noted areas of concern relating to resources. For example, if cases of missing children have to be triaged to prioritise return interviews we will be missing valuable opportunities for intervention. We have not been assured that adequate therapeutic support is available for children. The closure of youth provision may be having unconsidered consequences for CSE. In addition, there may be other areas where additional resources could improve the way CSE is managed. Parent support workers, for example, could help build both resilience and evidence.

8.4.15 Officers are a hugely important resource. We were told about the time it can take to build a trusting relationship with a professional to enable disclosure and tackling the problem. We heard of the real benefits of long term relationships between a child and a key professional and continuity of care. We do have some fears that the work force challenges being faced in Children's Social Care will mean that opportunities may be lost for children.[98]

8.4.16 We were reminded that proper interventions and support can pay back dividends. For the gender specific project, keeping one child out of the care system can pay for the whole team. Reducing budgets in this area of work could lead to some unintended consequences.

8.4.17 At the time of writing a three year budget was being drawn up for children's services. It is imperative that sufficient resources for tackling CSE are made available in this, including money to continue and expand the work of the third sector.

8.4.18 As more services seem to be contracted out to help meet the budget challenges, the Committee recommends that all specifications and contract monitoring arrangements are checked for relevance for safeguarding requirements. Contracts let directly by Children's Social Care would, one hopes, include this, but we would ask for assurances. However, other contracts which might be focused at children (such as in Public Health) or directly with families or in homes (such as contracts relating to council house management) must all include the appropriate set of requirements for safeguarding and CSE. This might include a requirement for staff to have training; adoption of procedures to follow and even active involvement in a multi-agency process such as the FCAF. We would ask that the Cabinet Member for Children and Family Services and Commissioning, performance and the third sector both take action on this.

[98] For example report to Cabinet 15 September 2014 showed that there 25% of frontline posts are vacant.

8.5 Recommendations

8.5.1 **The focus of activity must be on relentless implementation of the operating model, particularly around effective multi-agency working, so that Birmingham is bearing down with increasing impact on victims, locations, institutions and offenders. Progress on the recommendations below should be measured on contribution to achieving this key aim.**

A Delivery of Training and Awareness to Enable Action

A properly planned and co-ordinated local campaign targeting a wide range of organisations, communities and businesses.

Public and Communities Awareness Raising

RO1 That:

- The "*See Me Hear Me"* web site[99] be further developed and a concerted awareness and empowerment campaign for action is delivered for the public (communities, families and children);
- The City Council and partners work with and build the capacity of a broad range of the city's communities to encourage identification and reporting of CSE;
- Resources and sign-posting to online training for parents are promoted;[100]
- Awareness includes online risks of grooming, the role of the Child Exploitation and the Child OnLine Protection Centre (CEOP)[101] and how to locate and use the report abuse button.
- The Cabinet Member Children and Family Services explores how this can be delivered and funded jointly with partners.

Schools Awareness Raising

RO2 To encourage schools to ensure that:

- CSE is integrated into PSHE from year 6 upwards into ALL schools in the city and to encourage best practice in understanding and dealing with CSE in schools;
- Healthy relationships and girl's empowerment (e.g. by using the "free being me" resources Girl Guiding campaign) is integrated into (PSHE) teaching in all years;
- All teaching includes appropriate provision for boys;

[99] www.seeme-hearme.org.uk/
[100] www.paceuk.info/support-for-parents/
[101] CEOP is a National Crime Agency Command at ceop.police.uk/

- All schools promote safety online including smartphone tracking; and
- All school Head Teachers and recognised Designated Safeguarding Leads (DSL) are written to, raising the issue, asking for a collaborative approach in tackling CSE and for key staff to attend training; and they adapt and agree the new model safeguarding policy from the BSCB.

RO3 That Governor Support Team review safeguarding training provided in the light of this report.

Practitioner Empowerment

RO4 That all frontline staff and managers of caseloads in Children's Social Care including agency staff attend training on CSE. This should include definitions, the grooming line, symptoms and action including what can be done to disrupt / bring charges against and prosecute perpetrators. Particular barriers to disclosure of CSE by black and minority victims should be included in this. There is mandatory training on missing children and the escalation system.

RO5 That BSCB continues to provide and promote training to its partners including health organisations in the city, the West Midlands Fire Service and West Midlands Police; and that partner organisations include CSE training within Level 1 and Level 2 safeguarding training.

Business Resilience

RO6 That business forums and networks are identified to work with to ensure broader understanding of CSE and to support the roll out of the "*Say Something if You See Something*" campaign and guidelines with particular a focus on the hospitality industry and taxis in order to increase awareness and reporting.

Councillor Awareness Raising

RO7 That CSE features as part of induction training for all new councillors; for all current councillors there is compulsory awareness training on safeguarding including CSE; and regular training updates are also made available.

B Birmingham City Council

Policies and procedures within the City Council

RO8 That the policies and procedures across the City Council ensure CSE is properly dealt with by:

- Adopting and working to the West Midlands Regional CSE protocol;
- Making better use of Care First (the council's system for case management) to record and analyse and share CSE cases ensuring it is dynamic and reports can be pulled out;
- Improving feedback from Children's Social Care referrals. (Feedback is meant to be provided in specified timescales which does not always happen.);

- Establishing CSE champions in key teams including each of the Safeguarding and Family Support hubs who have more in-depth training (and can cascade training to the team) and can act as advisor to the team;
- Reviewing policies and procedures to ensure that parents are seen as equal partners in dealing with CSE and to consider implementing the relational model developed by PACE;
- Reviewing the City Council's response to young runaways to ensure it meets the requirements of the new statutory guidance on missing children; and
- Developing and embedding a robust missing strategy with clear accountabilities, reporting to the BSCB and an escalation system that is fully understood and effectively implemented; and to investigate the protocol for information sharing when children are classified as absent by the police; and address missing from school as a significant safeguarding risk.

Making Better Use of Licensing Powers

RO9 That the City Council, West Midlands Police and Birmingham Safeguarding Children Board make greater use of licensing to tackle exploitation by:

- Strengthening the BSCB's role in supporting agencies including licensing and trading standards and West Midlands Police to use the resources and capacity to best effect; and
- Licensing Committee reviewing the statement of licensing and use of powers to assess if it is possible to be more proactive in achieving the objective of: "the protection of children from harm" [e.g. in use of licensing conditions / provision of training /ensuring a clear process for reporting and developing a whistle blowing process to empower license holders and taxi drivers etc. to be proactive in reporting concerns.]

Resources

R10 That it is demonstrated that this area of work (including children's services, third sector commissioning and other key departments such as Legal Services and Licensing) is adequately resourced including that:

- It is mainstream funded not reliant on annual funding agreements and that third sector contracts abide by the compact;
- Commissioning of services specifically for dealing with victims of CSE, in particular, is improved so that they are in place in good time, prior to the beginning of the financial year;
- The level of resource for return interviews, plus the intensive support required to prevent reoccurrences has been risk assessed;
- A review of the level of administrative support in social work teams and for the CSE Co-ordinators is undertaken to ensure this is not affecting ability to manage caseloads;
- A review of the staffing and caseloads of the multi-agency safeguarding hub (MASH) team is undertaken;

- Partners review how to resource a Child Safeguarding Licensing Officer post/role.

Safeguarding at the heart of contracts

R11 That when the City Council commissions services, safeguarding, including CSE, be built into the service specification and monitoring by ensuring that any contract which will involve direct working with children and young people, families and homes and transport services includes an appropriate level of requirement around CSE (e.g. information and training, procedures, and active involvement in multi-agency strategy and Family Common Assessment Framework meetings); and providing reassurance that the school nurse contract due to be recommissioned by Public Health will include these provisions.

Protection of Children in Care

R12 That in order to manage the specific risks of looked after children:

- The corporate parenting strategy is reviewed to ensure it includes proper reference to CSE;
- The Corporate Parenting Board provides clear demonstrable actions that CSE is a priority and that the vulnerability of looked after children to CSE is understood;
- Appropriate risk assessments continue to be carried out when placing children in residential care and that decisions are needs based and not resource based; and
- That there are appropriate policies and procedures (in both internal and external homes) and that staff have the confidence and tools to ensure day to day vigilance and action relating to CSE; and to ensure that these issues are considered in the children's home redesign.

Legal Remedies and Offenders

R13 That Legal Services review and assess what can be done to: strengthen the disruption of suspected perpetrators in the Civil Courts; support victims through to prosecution; and increase conviction rates and successful use of warning letters and civil orders, in association with WMP and CPS; and review the powers available to disrupt suspected perpetrators and develop a planning tool for disruption for Birmingham, building on the tool kit developed in Derbyshire. This needs to then be used and embedded in Children's Social Care.

C Multi-agency working

Multi-Agency Working in Practice: Safeguarding is never someone else's responsibility

R14 That the Chair of Birmingham Safeguarding Children Board:

- Takes further steps to embed the CSE strategy and implementation of the action plan by holding partners to account and ensuring they take appropriate action;

- Continues to provide challenge as required to schools following the analysis of the annual section 175 audits; and
- Evaluates the effectiveness of multi-agency working including the Strategic CSE Sub-Group, CMOG, Multi-Agency Sexual Exploitation meetings etc. (Not MASH – see Recommendation 16).

Intelligence and Analysis

R15 That all Birmingham Safeguarding Children Board partners improve the shared understanding of CSE cases by:

- Ensuring there is consistency and all officers and partners are working to the soon to be agreed West Midlands Regional CSE operating protocol;
- Developing systems to ensure sharing information across the region to enable a full multi-agency problem profile can be updated and shared to ensure patterns and associations relating to victims, offenders and locations can be examined;
- Using intelligence and analysis to improve understanding of what tactics and approaches work best; and
- Ensuring those providing intelligence and evidence receive appropriate feedback.

MASH progress

Whilst we welcome the recent launch of the MASH it is too soon to assess its effectiveness in this area.

R16 That reports be provided on:

- The operation of the MASH: workloads, impacts, lessons learnt, and funding (after 6 and 12 months of operation);
- Membership of and participation within MASH, including the role of health, the third sector and family support workers; and
- Data sharing between the MASH partners.

R17 That after six months of operation (March 2015) there is a review to consider if a dedicated multi-agency child sexual exploitation hub should be developed alongside MASH that could provide end to end (case identification through to prosecution) support and action.

D Tracking the Progress of Recommendations

BCC Leadership

R18 That the Quartet[102] regularly track improvements in this area as it relates to the City Council.

[102] Leader, Cabinet Member for Children and Family Services, Chief Executive and Strategic Director for People

Reporting Back to Scrutiny

R20 That an assessment of progress against the recommendations made in this report be presented to the Education and Vulnerable Children Overview and Scrutiny Committee in March 2015. The Committee will schedule regular progress reports until all agreed recommendations are implemented.

Appendix 1: Witnesses

The witnesses who formally presented to the Committee are shown in the table below.

Witnesses	
Presenter	**Organisations**
Shaista Gohir	Chair, Muslim Women's Network UK
Stephen Rimmer	West Midlands Preventing Violence Against Vulnerable People lead
Jane Held, Simon Cross	Chair & Business Manager, Birmingham Safeguarding Children Board
Liz Murphy	WM Executive Board for CSE / Solihull MBC
Tim Bacon	Head of Public Protection Unit, West Midlands Police
Bryan Thomson , Junior Patterson	Operations Manager & Homes Manager, BCC
Elaine Webster	Head of Service, BCC
Leon Bonas	CSE Co-ordinator, BCC
Cllr Barbara Dring,	Chair, BCC Licensing Committee
Chris Neville	Head of Licensing, BCC
Jenny Mahimbo	Programme Manager, Children's Society
Tom Duffin	Partnership Worker, PACE Parents Against Child Sexual Exploitation
Debbie Southwood and Marrian Web	Children's Services Manager, Assistant Director Children's Services, Barnardo's Space
Nasheima Sheikh and Fiona Douglas	Birmingham and Solihull Women's Aid
Jerome O'Ryan	Solicitor, Legal Services, BCC
Rakesh Mistry and Andy Merker	Commissioning and Brokerage Manager, BCC
Garry Billing	Assistant Director, BCC
Julia Davey and Jon Needham	FCAF Area Co-ordinator, CAF Co-ordinator, Multi-agency Safeguarding Hub (MASH), BCC
Wendi Grizzle	Team Manager, BCC Children's Social Care (and team)
Claire Edwards	Head of Child Safeguarding, Birmingham Community Healthcare NHS Trust
Fiona McGruer	Associate Director of Operations, Birmingham and Solihull Mental Health Foundation Trust
Meg Boothby and Jara Phattay	Whittall Street Clinic
Jackie Keegan	Nurse, Birmingham Community Healthcare NHS Trust.
Emma Danter	Phoenix Project-Spurgeons

Member Training and Visits

Member CSE Training session	Provided by Safina Bi of Barnardo's Space
Visit to the Gender Specific Project (Youth Offending Team)	Dawn Roberts, Interim Assistant Director (and team)
Visit to Travelodge	Claire Shinton, Head of Safety

Appendix 2: Who to Contact

If you have concerns about the safety of a child please do raise your concerns with someone.

Immediate danger

If you ever think a child is in immediate danger phone the police on 999.

Referral to the MASH

Anyone who has concerns about a child's welfare should make a referral to the Multi Agency Safeguarding Hub (MASH). The telephone number is: 0121 303 1888.

You should first phone to talk this through with someone at the MASH and then follow through by completing and sending a detailed and accurate multi-agency referral form found on the BSCB or the council's website:

www.lscbbirmingham.org.uk/index.php/birmingham-multi-agency-safeguarding-hub-mash

www.birmingham.gov.uk/child-referrals (this includes a "what makes a good referral guide").

Out of hours the contact is the Emergency Duty Team on 0121 675 4806.

Barnardo's Space

The Barnardo's Birmingham Space and FCASE works with children vulnerable and abused through sexual exploitation. It can be contacted on 0121 359 5333.

National Children's Advice Agencies

There is a free 24hr NSPCC helpline on 0808 800 5000.

Children and young people who need to talk can contact ChildLine 24 hours a day on 0800 1111 or visit: www.childline.org.uk

Other Birmingham Support

Service	Brief Description	Telephone
Brook Advisory Service	Sexual health advice for under 25s	0808 802 1234
St Basil's	Services for young people homeless or at risk of homelessness	0300 30 30 099
Healthy Gay Life	Works with men and boys to promote sexual, mental and social health and well-being	0121 440 6161
Education Welfare Service	Promotes regular school attendance and investigates reasons for poor attendance	0121 303 8900
Children's Rights and Participation	Rights and advocacy service for children in care	0121 303 7217
Rape and Sexual Violence Project	Works with survivors of sexual violence and abuse. Provides sexual violence councillors and independent sexual violence advocates	0121 643 0301
The SAFE Project	Promoting health and well-being of women involved in the commercial sex industry	0121 440 6161
Spurgeons Phoenix Project	CSE project in East Birmingham working with children and families at risk of CSE and carrying out awareness raising of CSE	0121 678 8816

Resources for Practitioners

Currently all National Working Group on CSE (NWG) resources are available to all Birmingham practitioners. Their web site is: www.nwgnetwork.org/resources. Resources include:

E learning CSE awareness package
Resources to teach safety to children:

- Cody`s Choices- Girls
- Deans 'Choices – Boys
- Olivia` Choices – children with learning disabilities (soon to be released)

As the choices range is visual and interactive programme it is also suitable for children with ADHD / ASD

Barnardo's have also released a new resource called Real Love rocks with separate approaches for primary and secondary. This teaching is designed for both boys and girls and comes with train the trainer sessions. www.barnardosrealloverocks.org.uk/

Resources for Families & Communities

Parents Against Child Sexual Exploitation have, in partnership with Virtual College, launched an interactive online package for parents on the signs of child sexual exploitation. It takes less than half an hour to complete and can be found at:

www.paceuk.info/the-problem/keep-them-safe/

A parent with any concerns that their child is being exploited or is at risk, can call the PACE national support team on 0113 240 3040 (during Mon-Fri office hours). They can talk through your immediate concerns, help a parent to assess the level of danger their child is in, and signpost parents to local agencies. See more at:

www.paceuk.info/support-for-parents/telephone-support/#sthash.CYV4q7bH.dpuf

Online

The **Child Exploitation and Online Protection Centre** (CEOP) is police-led and part of the national crime agency. Further information is available at:
www.ceop.police.uk/safety-centre/

Online problems / threats can be reported at: www.ceop.police.uk/Ceop-Report/

TACKLING CHILD SEXUAL EXPLOITATION

Policy Communications

Conference Chair:

JON BROWN

Head of Strategy and Development

NSPCC

Policy Communications

GRAHAM RITCHIE

Principal Policy Advisor on Child Sexual Abuse

Office of the Children's Commissioner

Policy Communications

Understanding the scale, nature and impact of CSE

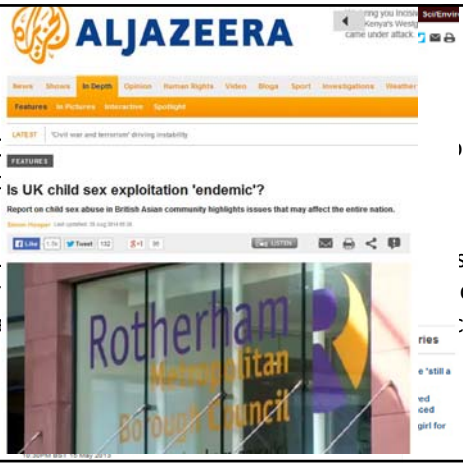
Dr Graham Ritchie
Principal Policy Advisor
@_GrahamRitchie

Children's Commissioner
Promoting and protecting children's rights

Office of the Children's Commissioner (OCC) for England

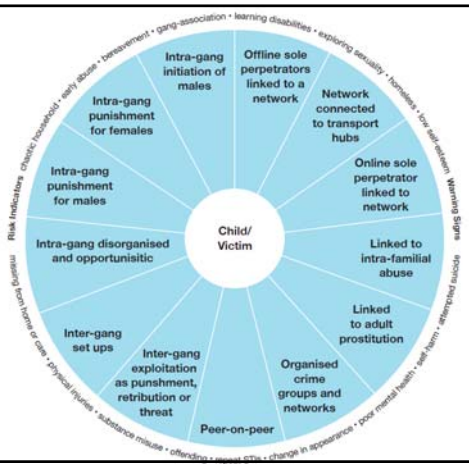
- Functions, duties and powers enshrined in Children Act 2004, as amended by the Children and Families Act 2014
- Promote and protect the rights of children, as outlined in the UN Convention on the Rights of the Child
- Unique position in the policy landscape – importance of research cannot be overstated

"Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability".



OCC CSEGG Inquiry

- The OCC conducted a two year Inquiry into Child Sexual Exploitation in Gangs and Groups
  - Engaged 800 children and young people
  - Analysed over 1000 pieces of submitted evidence
  - 25 site visits, involving over 100 agencies
  - Produced 6 reports – CSE children in care, impact of pornography, consent, CSE in gang-affected neighbourhoods, phase 1 (prevalence) and phase 2 (practice).



'She could have refused to do it... I don't think it would have been hard' (Young man, year 10)

'I don't think he's really asked if she's ok with that, he's decided for her' (Young man, 18)

***'She said no but he made her do it anyway which he shouldn't have'* (Young woman, year 10)**

***'He didn't make her do anything and she came on to him sending him photos then said yes to doing stuff and said she liked it'* (Young man, 16 years old)**

Gang research

- 188 young people aged 13 – 28; 50% under 18; 21% under 16
- 76 professionals
- 6 sites across England
- Ethnicity reflected demographics of local area

"Like, sometimes you have, trouble with the geezer, but at the same time, like, he's got a sister or something like that, or, and then, kind of, like, you're kind of like fucking his sister just to violate him, just to take the piss out of him, really. Obviously, that's going to make the geezer more angry, knowing that you're actually fucking his sister... Like, they can kidnap a person's sister and threaten her and probably beat her up and that, and then make her sleep with you and that, or rape her, or they can get her family, like, one of the family members and then hold them for ransom or something like that"

(Participant P, 17 year old young man)

"This girl came to school upset really. She had sex with every boy in a gang just to be part of their gang, and it was really terrible when I heard about this, and I do remember, she came to school crying... I think it probably was under pressure, because she wanted to be a part of them and they gave her an option"

(Participant W3, 16 year old young woman)

"In gangs if it goes wrong, then you have the whole gang on your back. They like to gang rape you. I've seen pictures. There's one going round my college – a girl has a sign up saying 'I'm a slag' with her clothes off, naked, crying her eyes out, everything, with bandanas in the background"
(Participant H2, 18 year old young woman)

"Like just go round the whole of the gang giving brain an that... Like if one boy gets a blow job, then another wants it... he expects it, obviously. Why not? If she's giving blow jobs, she might as well give me some"
(Participant F2, 15 year old young man)

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violence, parental mental health issues, parental criminality).
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of 'honour'-based violence, physical and emotional abuse and neglect).
- Recent bereavement or loss.
- Gang association either through relatives, peers or intimate relationships (in cases of gang-associated CSE only).
- Attending school with young people who are sexually exploited.
- Learning disabilities.
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families.
- Friends with young people who are sexually exploited.
- Homeless.
- Lacking friends from the same age group.
- Living in a gang neighbourhood.
- Living in residential care.
- Living in hostel, bed and breakfast accommodation or a foyer.
- Low self-esteem or self-confidence.
- Young carer.

The following signs and behaviour are generally seen in children who are already being sexually exploited.

- Missing from home or care.
- Physical injuries.
- Drug or alcohol misuse.
- Involvement in offending.
- Repeat sexually-transmitted infections, pregnancy and terminations.
- Absent from school.
- Change in physical appearance.
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites.

Key messages

- CSE does not occur in a vacuum
  - Many young people are confused about consent
- CSE is a national issue
  - Risk indicators / warning signs are well established
  - There are multiple forms of CSE

Questions

Dr Graham Ritchie
Principal Policy Advisor
@_GrahamRitchie

Children's Commissioner
Promoting and protecting children's rights

SHEILA TAYLOR

Chief Executive

NWG Network

Policy Communications

NWG Network

Tackling Child Sexual Exploitation

Linguists

Julia Penelope

Describing Domestic Violence

John and Jim raped Mary

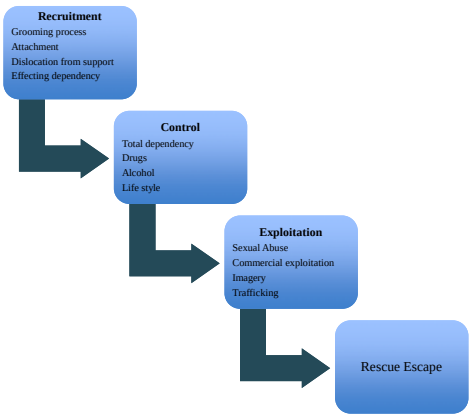
Mary was raped by John and Jim

Mary was raped

Mary was sexually exploited

Mary is a sexually exploited child

NWG CSE Process



Observations from Reviews

- **The LSCB and partners should take responsibility for ensuring that the strategy and action plan on CSE is carried forward within the agreed timescales and allocated resource.**
- LSCB's and partners should encourage robust scrutiny and oversight at all levels i.e. from elected members, to Senior Managers, to middle managers, to operational implementation. This should included reviewing randomly selected cases that have reached thresholds and those that have not reached thresholds. There appears to be a gap in many areas between strategy and operational implementation that needs to be monitored.
- Low & medium risk CSE cases to have a mechanism for multi-agency discussion & safety planning
- LSCB's and partners need to ensure that clear information sharing pathways are in place for all partners, which will also allow non-partner organisations and members of the public to access. But equally importantly to sharing information is the mechanism to sharing information in organisations and between partners.

- There is often no specific mention of boys and young men, or trafficking of young people, but overall the strategies, could produce an effective response to CSE across the areas. As with all strategies, however, the real challenges come with the implementation, especially in the current climate of cuts in public services.
- The multiagency structure of the CSE teams could be enhanced with the inclusion of family and parent support work, multiagency meetings and increased partnership engagement with third sector organisations, foster carers and residential centres, both private and LA.
- Consideration should be given to vulnerable adult status to victims of CSE and incorporate vulnerable adult services within the specialist team as a link into adult services.
- All members of the specialist teams should have access to clinical supervision to assist them to manage any secondary trauma caused by dealing with CSE cases.
- Refer to the Summary of Recommendations Document for all 400 recommendations from reports

Training

It is important to ensure all the frontline workforce are adequately trained

Weaknesses are:-

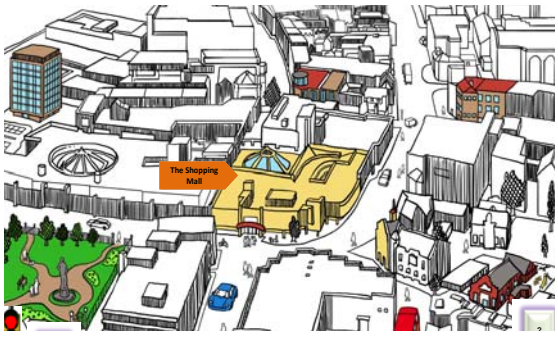
- Recognition of boys and young men's indicators
- Trafficking (and now Modern Slavery)
- Frontline responders responsibility for the NRM
- Marginalised groups i.e. LGBT &Q , travellers, BME, Learning Difficulties
- Local processes and referral pathway and escalation procedures
- Social workers and supervising social workers supporting foster carers should be given specific CSE training and should be able to provide effective supervision to the foster carers.
- Staff Turnover and training

E Learning

Education

- LSCB's should be encouraged to support the Schools Strategy and work with the Directors of Education and the Children's Board to ensure a local action plan to engage all schools in CSE education, in order to raise awareness with young people on healthy relationships, the grooming process, risks and dangers of CSE, and how to keep themselves safe both off and on-line.
- Education/prevention work to be delivered in all schools and youth provisions, to ensure that young people from all cultural backgrounds, understand the meaning of consent and the law relating to sexual offences. This work should include a focus on issues of capacity to consent such as the impact of drugs and alcohol.
- LSCB's should encourage an engagement between all schools and Police, and consideration could be given to models of positive engagement between schools and police.

Cody's Choices



29/10/15 Child Sexual Exploitation 29

Prevention

Actions should include:

Public Awareness

- LSCB's should oversee the delivery of a community awareness raising campaign, including hotel, leisure, sport, retail (licensed and unlicensed premises), and transport industries, to ensure they are aware of CSE and know how to respond and refer to the appropriate authorities. Consideration should be given to forming a Project Team to carry out this public awareness campaign underpinned by a comprehensive multi agency communications strategy.
- LSCB's should consider the powers held through the Licensing Authority and the Community Safety Partnership and utilise these to take action upon premises placing young people at risk of CSE.
- A zero tolerance of sexual harassment should be encouraged and developed to include an education programme that is inclusive of all communities. This would incorporate multi-agency engagement in investigating and identifying behaviour that is not acceptable to children's welfare.

A young girl narrates her story of being sold for sex and wondering why hotel workers did nothing

SSSS

Operation Kern

South Yorkshire POLICE

South Yorkshire POLICE

South Yorkshire POLICE

The toolkit to date;

- Posters
- Roller Banners
- Wristbands
- #SaySomething webpage

DR LOUISA THOMSON
Senior Consultant, OPM

DR DAVID JONES
Chair, Independent Association of LSCB Chairs

Policy Communications

PRESENTATION BY:

Dr Louisa Thomson (OPM)

Dr David N Jones (People Need People Consulting)

Child Sexual Exploitation: A study of international comparisons

Tackling Child Sexual Exploitation Conference

14th October 2015

OPM Helping you to improve social outcomes

ADCS virtual staff college Developing People : Building Capacity

ilm Approved Centre

TODAY'S PRESENTATION

- **Overview** of the research report into international comparisons of CSE
- **Findings** from some of the countries reviewed (OPM)
- **Global challenges** for the UK (David N Jones)
- **Future research**

OPM ADCS virtual staff college

ABOUT THE RESEARCH

Department for Education

- DfE commissioned the review to understand:
  - How is CSE defined in selected countries?
  - Is there any consistency in the response of public agencies internationally?
- What can the UK learn from elsewhere?
- Are there lessons or implications that could help us address this 'national threat'?

OPM ADCS virtual staff college

METHODOLOGY

- Focus on **high income countries**
- **Light touch desk review** – from government documents, reports, media articles, academic journals
- **Interviews** with key contacts and experts in each country
- Review took place over 6 weeks – published **July 2015**

KEY QUESTIONS

- What is the **extent** or **scale** of CSE?
- What is the **media narrative** around CSE?
- What is the national level and regional level **policy responses**?
- What is the **role of different agencies** at a local level?
- **Who is involved** in driving the debate?

REPUBLIC OF IRELAND: A JOURNEY OF CHANGE

- More common to refer to child sexual abuse, trafficking and online sexual abuse than CSE
- Child abuse in Catholic Church has dominated debates (Ferns, Murphy, Ryan)

- Revealed extent to which the child protection system was ineffective at protecting children from harm
- Lack of emphasis on intervening early
- Large regional variation and lack of information sharing

REPUBLIC OF IRELAND: A JOURNEY OF CHANGE

- Major reform of child protection and welfare services
- National guidance and policy (Children First and Better Outcomes/Brighter Futures)
- New departments (DCYA) and agencies (Tusla)
- Strengthened legislation
- Garda established dedicated child protection units to work with Tusla
- National model for sexual abuse services

AUSTRALIA: RAISING AWARENESS OF CSE

- CSE as a term not used by government and child protection agencies
- Opportunistic behaviour by those at risk rather than an organised activity
- Lack of national data, and each state has different approaches and laws
- Clear national policy – National Framework for protecting Australia's children. Within this – raise awareness of CSE
- Focus of activity on keeping safe online

AUSTRALIA: RAISING AWARENESS OF CSE

- Royal Commission – big impact
- Recognition of child sexual abuse in institutions and extent of problem
- Range of institutions involved
- Encouraged others to come forward
- Child protection – underfunded, and too reactive
- Acknowledging the need for more collaboration and coordination between social services and the police

Royal Commission into Institutional Responses to Child Sexual Abuse

AUSTRALIA: VICTORIA CASE STUDY

- Concerns about girls in out of home care being targeted by pedophile gangs
- Office of Professional Practice – CSE prevention project with Victoria police – co-location, trained 2000 people
- More proactive response – team work and info sharing between social care, residential care and police
- Creating environment where young people more likely to disclose, and staff more likely to see patterns

USA: FRAGMENTATION AND CRIMINALISATION

- Dramatic increases in commercial sexual exploitation of children and online sexual exploitation
- Federal level – mainly justice system responses
- Slow to trickle down to state level
- Each state has own systems for identifying and responding
- No high profile cases to fuel public concern

USA: FRAGMENTATION AND CRIMINALISATION

- Not recognised as victims – many young people arrested for prostitution
- 85% of victims of CSE have history with child welfare system
- Cultural perception – justice issue
- That is changing – several states decriminalised prostitution for young people
- New York Safe Harbour Law

USA: FRAGMENTATION AND CRIMINALISATION

- Increasing focus on child welfare led responses
- Connecticut – Department of Children and Families
- Education based approaches – My Life My Choice Curriculum
- PREVENT in Atlanta
- Not for profit sector campaigning to raise awareness – and it is growing

ELSEWHERE: SWEDEN, NEW ZEALAND AND CANADA

- **Sweden**: Nordic model of prostitution. Deterring traffickers?
- **New Zealand:** prostitution tended to be seen as an active and free choice. Media narrative has shifted – high profile cases, more responsible reporting
- **Canada:** disproportionately affects children from Aboriginal communities. Big shift in narrative mid 1990s (compared with the US)

GLOBAL RECOGNITION OF CSE

- World-wide reality – some groups operate on global scale – profitable business
- United Nations, Council of Europe, European Union agreements
- Nothing unique about the problems experienced by UK
- Profound social & attitudinal changes – power & subjugation
- Failures of professional values, duty of care & recognition

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Realising the potential in human services

CSE IS A DIFFERENT FORM OF ABUSE

- Child protection & safeguarding have tended to focus on home and alternative care settings
- CSE can involve social groups, strangers & organised crime – need different responses
- Victims may not see selves as victims – frequently resist intervention
- Essential support for care leavers
- More research on effective interventions needed

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Realising the potential in human services

HISTORIC ABUSE

- All English speaking countries witnessing public focus on historic and non-recent abuses
- Likely to continue for at least a decade
- Focus on historic behaviours & system failures detracts from recognising current practice and achievements

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Realising the potential in human services

VULNERABILITY & RISK: POVERTY, MINORITIES & INDIGENOUS COMMUNITIES

- Vulnerable children & young people most at risk of CSE
- Over representation of young people from indigenous communities
- The more unequal the society the more serious the social problems which emerge
- Understand lived experience & context of abused and exploited young people
- Sympathy for survivors has to extend to empathy for their circumstances

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Realising the potential in human services

MOVE FROM CRIMINAL TO MULTI-AGENCY RESPONSES

- Effective intervention requires multi-agency coordination, blending criminal justice and social intervention strategies

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Realising the potential in human services

ORGANISED CRIME

- Organised and informal criminal networks play a significant role in CSE, including trafficking, commercial and online sexual activity.
- Techniques for investigating & disrupting organised crime can give rise to ethical questions for human services - is it ethical to leave young people at risk whilst gathering evidence over time?

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ROLE OF MEDIA

- Stimulated public interest and concern
- Given voice to survivors
- Generally negative and critical of agency responses
- Essential to develop media strategies to explain professional responses and achievements

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Realising the potential in human services

MULTI-FACTORIAL, COMPLEX AND CHALLENGING – NO SIMPLE ANSWERS

- Many international examples of multi-agency strategies
- No country has fail-safe system for prevention and intervention
- More research needed into skills for effective work with young people at risk
- Suspicion of vulnerable young people in UK – blamed for their predicament
- CSE is a symptom of deeper social challenges

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RECOMMENDATIONS

- Prevention
- PHSE compulsory
- Report all abuse – lead from highest level
- Stop sexualisation of children in media
- Training – judiciary, night economy, carers
- Intervention
- Distinctive abuse – specific strategies
- Research on effective interventions
- Ensure young people not treated as criminals
- Distinguish past from current practice

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CONCLUSION

Multi-factorial, complex and challenging – no simple answers

Build culture of respect for those who are vulnerable and at risk

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NEXT STEPS?

- More evaluation of different approaches – can they translate into different contexts?
- Strengthening legislation – common theme. What impact has this had?
- Comparative study of world wide CSE

People Need People Consulting
Realising the potential in human services

DR LUCIE SHUKER

Research Fellow

The International Centre: University of Bedfordshire

Policy Communications

The International Centre

- Committed to increasing understanding of, and improving responses to, child sexual exploitation, violence and trafficking in local, national and international contexts
- Achieved through:
  - academic rigour and research excellence
  - collaborative and partnership based approaches to applied social research
  - meaningful and ethical engagement of children and young people
  - active dissemination and evidence-based engagement in theory, policy and practice

University of Bedfordshire — The International Centre

Making Justice Work: key themes

Professional attitudes	Need for compassionate/empathetic response
Communication	Quality affects sense of safety and engagement
Wellbeing and support needs	Advocacy, long-term, coordinated and therapeutic support – improves investigation
Power and control for victims and witnesses	Disempowerment parallels loss of control in abusive situation
A sense of justice	Young people's experiences/perceptions challenge systemic definitions of justice
Policy and practice dissonance	Measures to address these are already feasible or recommended in current policy and guidance

University of Bedfordshire The International Centre

Recent policy responses

- ACPO CSE Action Plan
  - National lead on Child Protection
- HMIC Child Protection Inspections
  - Joint Inspections
- Amendment of Sexual Offences Act – 'sexual exploitation of children'
- NCA Strategic Assessment of serious and organised crime – prioritised CSE

Tackling CSE Action Plan

- Requirement to train all police to respond to CSA
- Information sharing guidance
- Updated professional guidance
- Network of regional CSE coordinators and analysts
- CSA identified as national threat in Strategic Policing Requirement

University of Bedfordshire The International Centre

Improving Policing Responses

- Developing national hub of expertise: improving police responses to CSE, other forms of CSA and associated vulnerabilities in adolescence
- Funded by HEFCE/College of Policing Knowledge Fund
- 2016/2017
- Led by UOB; supported by four other universities across England and Wales to ensure national reach
- Working with National Policing Lead for Child Protection and Abuse Investigation
- Seconded police officer to research team to ensure relevance

University of Bedfordshire The International Centre

Improving Policing Responses

- Funding criteria: embedding research in policing
- Police mapping & consultation with CYP and other key stakeholders to determine priority focus areas
- Pairing CSE coordinators/analysts with academic mentors
- Support for solution-focused police-led research
- Learning exchange between CYP and police
- Online knowledge hub – webinars; briefing papers; resources
- Research and practice forum for police
- Training for police trainers

University of Bedfordshire The International Centre

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For more information on our work including research publications, short films and outputs from young people please visit
www.beds.ac.uk/ic

University of Bedfordshire The International Centre

JUDITH MILLION OBE

Programme Director – Protecting Vulnerable People and Joint Inspection

Her Majesty's Inspectorate of Constabulary

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Policy Communications

TIM LEESON

National Co-ordinator
National CSE Action Plan

College of Policing

Policy Communications

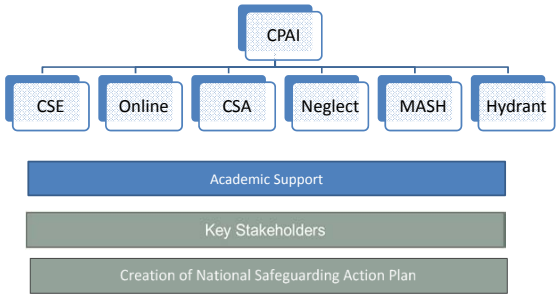
CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

Objectives:

- To provide the background and context of CSE as a major issue for policing.
- Increase awareness of the scale of CSE as an issue and the demand being placed on services.
- To provide an overview of the National Policing Response to CSE.
- To provide an overview of the Regional CSE Co-ordinator and analyst roles announced in the "Tackling CSE Report" by HM Government.

CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

Overview



CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

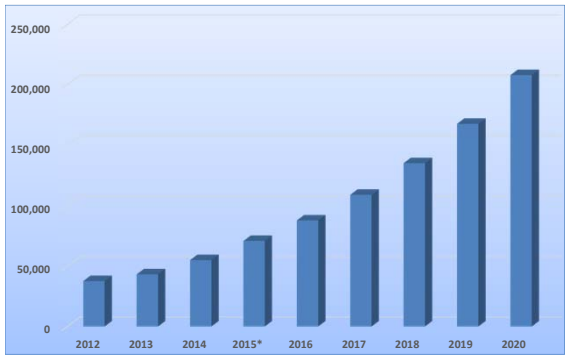
CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

CSE has become a social norm
Tony Lloyd – PCC

….and there are common themes for every Authority!

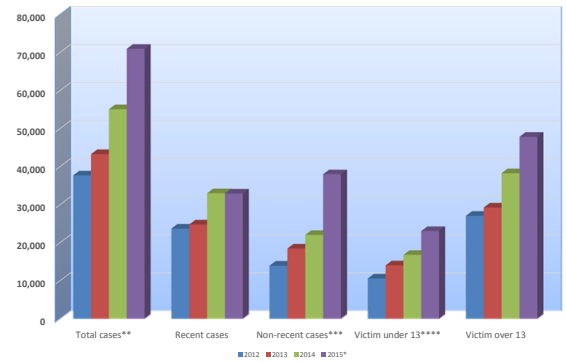
CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

Projected CSA Case Load



CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

Child Sexual Abuse Workload in England and Wales



CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

Online CSE Threat

Online IIOC Threat

EXPERT

COMMITTED
Encrypted forums

FOCUSED
File sharing (P2P)

CASUAL
Image hosting, webmail

SPECULATIVE
Inquisitive internet searches

Online Child Sexual Exploitation

Grooming

Sexual Extortion
Blackmail, webcams etc

Live Streaming Commercialised

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CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

The Why:

CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

Jimmy Savile *(Celebrity)*

CHILD SEXUAL EXPLOITATION
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Rochdale CSE Gang

CHILD SEXUAL EXPLOITATION
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Rotherham CSE Gang

CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

Oxford CSE Gang

CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

Victims and Offenders

Victims	Offenders
Mostly female (80%)	Mostly male (90%)
Mostly white (90%)	Mostly white
Mid Teens (particularly 14-15yrs)	18-35yrs
White	Group CSE - high percentage Asian
At least 1 identifiable vulnerability factor	High proportion unemployed, students or retired

CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

THE TIMES

Max 21C Min 1C Wednesday August 27 2014 | thetimes.co.uk | No 71286 Only 60p to print members £1.20

Scandal of the 1,400 lost girls

Officials failed to stop grooming by gangs amid racism fears

Andrew Norfolk
Chief Investigative Reporter

Failings by social workers and police allowed 1,400 children in a northern town to suffer years of "appalling abuse", almost all at the hands of men of Pakistani origin, an independent inquiry has found.

The leader of Rotherham council resigned yesterday and offered "heartfelt apologies" to girls as young as 11 in the South Yorkshire town who were routinely gang-raped, abducted and trafficked to other cities. Gangs acted with virtual impunity for 15 years while frontline staff were fearful of highlighting their ethnicity "because it might damage community cohesion" and displease their bosses.

However, no official who worked in a senior managerial position for the local authority during that period has been subjected to any disciplinary action.

The inquiry report described how one girl had petrol poured over her and another had a gun put to her head to ensure compliance with her abusers' demands.

Senior professionals charged with protecting children were warned of what was happening, yet young victims who spoke out were treated with disbelief or contempt by police and social services.

Some were even blamed for the crimes committed against them, the report said.

When frontline youth workers submitted research in 2002, 2003 and 2006 to support their growing alarm at the scale and nature of the child-sex offending, the reports were suppressed or ignored by senior officials.

Evidence was also found of a "macho, sexist and bullying" culture within the town hall. Female social workers were advised by senior managers to wear short skirts if they wanted to make progress in their career.

Rotherham's Labour council leader, Roger Stone, resigned as soon as the inquiry report was published yesterday and apologised to victims.

The year-long inquiry, ordered by the council in response to a lengthy investigation by *The Times*, found no definitive explanation for senior professionals' consistent failure to protect children and hold offenders to account.

However, the report's independent author, Alexis Jay, noted that "almost all" the offenders identified by the young, white victims were of Pakistani heritage. She said there was a "widespread perception" among frontline workers "that some senior people in the council and the police wanted to play down the ethnic dimension".

Some staff were unsure about how to speak about the crime pattern "for fear of being thought racist".

"I was told that some elected members seemed to be in denial about the

Continued on page 9, col 3

CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

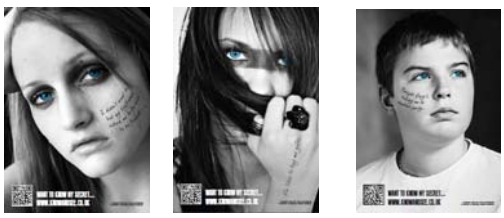
Prime Ministers CSE Summit – Tuesday 3rd March 2015

- Give child sexual abuse the status of a national threat in the Strategic Policing requirement
- A whistleblowing national portal
- A national taskforce, and a centre of expertise
- A network of regional police coordinators and analysts, located in Regional Organised Crime Units

CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

The How

So what is the national policing response to CSE?



www.college.police.uk

CHILD SEXUAL EXPLOITATION THE MORE YOU KNOW THE MORE YOU SEE — Regional Coordinators

Implementation and enhancement of national action plan:
- Quarterly progress updates based on initial benchmarking exercise to be provided
- Prioritisation of activities against gaps highlighted in HMIC, Peer Reviews, local consultation and enhancement where additional gaps identified/ action required.

Coordination of activities between local, regional and national
- Improved tasking processes for CSE
- Include establishment of regional CSE meeting and CSE disruption meetings
- Awareness raising activities

Capture and dissemination of good practice:
- Polka, good practice papers, gangs and groups tracker, Beds Uni.

Working in conjunction with analysts and forces to deliver:
- Regional problem profiles, national intelligence requirement, national data requirement

Quarterly progress updates to be provided complete with a quantitative assessment of progress and narrative examples of outcomes / activities.

CHILD SEXUAL EXPLOITATION THE MORE YOU KNOW THE MORE YOU SEE — Regional Analysts

Development of regional intelligence picture and structures at a tactical / strategic level in conjunction with local intelligence leads and regional coordinators:

Tactical:
- Identification of highest risk victims, perpetrators and locations.
- Delivering targeted intelligence development work and analytical products.

Strategic:
- Development of robust regional problem profile.
- Delivery and enhancement of national partnership data collection plan and intelligence requirement
- OCG tracker.

Progress to be reported alongside coordinator quarterly returns along with qualitative measures and narrative examples of outcomes / activities.

CHILD SEXUAL EXPLOITATION THE MORE YOU KNOW THE MORE YOU SEE

www.college.police.uk

HEATHER POPLEY

Barrister

No5 Chambers

Policy Communications

Protective Legal Remedies: A jigsaw approach

- When considering a case involving Child Sexual Exploitation (CSE) each case should be assessed on its own individual circumstances.
- The advantages of the recent injunctions in the case of BCC v Riaz et al [2014] EWHC 4247 (Fam) are that they enable both the immediate protection of the child from the person involved in CSE; whilst acting as a deterrent to dissuade and disrupt the abusive and exploitative practices of the perpetrators.

bbc.co.uk

Men in Birmingham 'exploitation' order named

19 November 2014
Birmingham & Black Country

Birmingham City Council had launched civil court proceedings against 10 men, a High Court judge had been told

Six men banned from contact with young girls after a council became the first to use civil injunctions to block child sexual exploitation can be named,

Protective Legal Remedies: A jigsaw approach

- The use of the High Court's inherent jurisdiction to protect children in need in such cases involving CSE was considered an entirely appropriate use of its powers:

"the use of the inherent jurisdiction to make injunctive orders to prevent CSE strikes at the heart of the parens patriae jurisdiction of the High Court. I am satisfied that none of the statutory or the "self imposed limits" on the exercise of the jurisdiction prevent the court from making the orders sought by the local authority in this case."

BCC v Riaz et al [2014] EWHC 4247 (Fam), Keehan J's judgment paragraph 46

Protective Legal Remedies: A jigsaw approach

- However, the use of injunctive orders should be seen as an essential piece of the jigsaw in combatting and disrupting CSE, alongside the criminal process and other child protection and civil remedies.
- Practitioners should be aware and astute to the variety of legal remedies that may be of assistance in preventing and/or disrupting CSE ranging from civil, family and criminal remedies.
- We should not simply focus on an application for an injunction pursuant to the inherent jurisdiction without consideration of other possible remedies either to run concurrently or to be implemented instead of an injunction application.
- London Borough of Redbridge v SNA [2015] EWHC 2140 (Fam) Hayden J

Protective Legal Remedies: A jigsaw approach

- To assist in considering the available remedies a **multi-agency approach** should be adopted in order to consider and obtain all of the available evidence to help to decide what child protection methods and other legal remedies may be required or can be applied for in each case.
- For example, such possible remedies are provided in a number of statutes, for example:

The Children Act 1989 (including Wardship and seeking leave to invoke the court's inherent jurisdiction – as per the civil injunctions in the case of BCC v Riaz)
Family Law Act 1996
Anti-Social Behaviour, Crime and Policing Act 2014
Child Abduction Act 1984
Sexual Offences Act 2003
Crime and Disorder Act 1998
Protection from Harassment Act 1997
Housing Act 1996 Part 5 Chapter III
Policing and Crime Act 2009
Violent Crime Reduction Act 2006
Local Government (Miscellaneous Provisions) Act 1976

Possible Child Protection Remedies

The following are some of the child protection remedies to be considered:

- Child in Need Plan / Child Protection Plan
- Prohibited Steps Order (section 8 Children Act 1989)
- Section 20 Children Act 1989 accommodation
- Emergency Protection Order (section 44 Children Act 1989)
- Care Order / Supervision Order (section 31 Children Act 1989)
- Secure Accommodation Order (section 25 Children Act 1989)
- Exclusion Order (sections 38A and 44A Children Act 1989)
- Non-molestation Order (section 42 Family Law Act 1996)
- Forced Marriage Protection Order & Power of Arrest (Part 4A Family Law Act 1996)

100

Examples of possible remedies –
Public Law Children - Care Order section 31 Children Act 1989
(some issues also apply to other Children Act 1989 remedies)

Advantages	Disadvantages
Local Authority will share Parental Responsibility for the child and can act quickly to safeguard the child	Child may feel distrust of the local authority
Placement options if child is not in the parents' care to provide therapy and help in educating the child about CSE– ie foster placement and then can consider residential placement if needed	Unfortunately the child could abscond from care – often victims of CSE are not aware that they are victims and seek to resume/continue relationships with their abusers
Can work with the family as a supportive and protective factor	May require a secure accommodation order to give additional protection to the child
Can have other orders running concurrently, e,g. inherent jurisdiction injunctions, Forced Marriage Protection Orders, non-molestation orders, etc..	May need other orders in place to provide further safeguarding for the child

Child Protection Remedies – Advantages & Disadvantages

Examples of possible Public Law Children Orders - Secure Accommodation Orders

Advantages	Disadvantages
Can apply quickly to safeguard the child	Order of **last resort** – deprivation of liberty and the impact on the child's human rights
Removes the child from the risky adults	Child may view this remedy as punitive rather than a safeguarding remedy
Can work with the family as a supportive and protective factor	Short term option and cannot prevent the risky adults associating with the child in the long term

Tight regulations by way of the Children (Secure Accommodation) Regulations 1991 and the Children (Secure Accommodation No.2) Regulations 1991 & statute section 25 Children Act 1989

For further information see the High Court case of:
London Borough of Barking and Dagenham v SS [2014] EWHC 4436 (Fam), Hayden J

Protective Legal Remedies: A jigsaw approach

Examples of possible Public Law Children Orders
Exclusion Orders – Section 38A & section 44 Children Act 1989

Advantages	Disadvantages
Can be sought upon the application for an interim care order or Emergency Protection Order	Ceases upon a full care order and only an option with an ICO or EPO
A power of arrest can be attached to the order (sections 38A(5) and 44A(5) CA 1989)	If during the period while an ICO is in force with an exclusion requirement, the local authority have removed the child from the dwelling-house covered by the exclusion order; after 24 hours that exclusion order will cease (section 38A (10) CA 1989)
Covers a defined area or dwelling where the child is	Cannot cover an unlimited area

Protective Legal Remedies: A jigsaw approach

Private Law Children - Examples of possible orders –
Non-Molestation Orders – section 42 Family Law Act 1996

Advantages	Disadvantages
Can protect the named individual from the perpetrator and any third party acting on their behalf	Only applies to those 'associated' with the child and applicant – legal definition as per section 62(3) Family Law Act 1996
Criminal offence if the order is breached	If a stand alone application, it is often reliant upon the victim recognizing that they are a victim of molestation – often victims of CSE do not realise that they are a victim of such abuse.
The court can make the order of its own volition	

Protective Legal Remedies: A jigsaw approach

Examples of possible criminal remedies –
Sexual Risk Orders and Sexual Harm Prevention Orders

- A Sexual Risk Order can impose restrictions on a perpetrator, such as limiting their internet use, preventing them from approaching or being alone with a named child, or restricting their travel abroad. It can be issued by a court after police application if it is satisfied that the individual has done an act of a sexual nature.
- Sexual Harm Prevention Orders can be applied to anyone convicted or cautioned of a sexual or violent offence, including where offences are committed overseas. The court needs to be satisfied that the order is necessary for protecting the public, or any particular members of the public, from sexual harm, or protecting children from sexual harm from the defendant outside the United Kingdom.
- The Orders prohibit the defendant from doing anything described in the order, and can include a prohibition on foreign travel (replacing Foreign Travel Orders which were introduced by the Sexual Offences Act 2003).
- A prohibition contained in a Sexual Harm Prevention Order has effect for a fixed period, specified in the order, of at least 5 years, or until further order. The Order may specify different periods for different prohibitions. Failure to comply with a requirement imposed under an Order is an offence punishable by a fine and/or imprisonment.

Protective Legal Remedies: A jigsaw approach

Examples of possible remedies

Closure notices and hotel information requests – helping to disrupt CSE within the community

- The 2014 Anti-social Behaviour, Crime and Policing Act brings in new measures for police to disrupt child sexual exploitation, such as the power to close down premises used to commit sex offences. To issue a closure notice, the police officer must have reasonable grounds to believe that the premises were, or are likely to be, used for child sex offences and that closure is needed to prevent the place from being used for activities related to child sex offences. The officer must also be satisfied that reasonable efforts have been made to consult the local authority and to establish the identity of any residents or anyone with an interest in the premises.
- Police can also request information about hotel guests, such as their name and address, from hotels or similar locations if they reasonably believe that child sexual exploitation is taking place there.

For further information please see - http://www.paceuk.info/wp-content/uploads/2013/11/Working-with-the-Police-final.pdf

Protective Legal Remedies: A jigsaw approach

Concluding remarks:

- Think 'outside of the box' regarding the possible legal options and child protection remedies.
- Be open to the range of possible remedies in civil and criminal law to provide the best 'package' of protection.
- Transparency and multi-agency co-operation, for example between the local authority and the police. This is crucial for information sharing and gathering and assists with concurrent proceedings.
- Consider each case individually looking at the specifics facts and issues involved– there is not a 'one size fits all' method.
- The principle concern should be the welfare of the child (and for some of the available legal remedies this is the paramount consideration for the court) and should be the focus of all agencies when considering the remedies most suited to each case.

Protective Legal Remedies: Completing the jigsaw

Thank You For Listening

Tweet us your Comments and Questions to @No5Chambers

Presented By
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Email@no5.com

No5 CHAMBERS

Raising the Bar
www.No5.com
Birmingham • London • Bristol • East Midlands

HAZEL CHAMBERLAIN

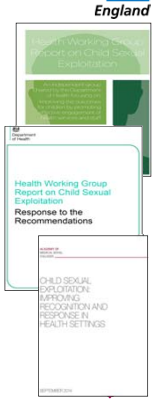
NHS England
Child Sexual Exploitation Sub-Group

and Designated Nurse, Children's Safeguarding, NHS Heywood, Middleton and Rochdale Clinical Commissioning Group

Policy Communications

Health Publications

- Department of Health Working Group report on Child Sexual Exploitation published January 2014. Response published May 2014 (www.gov.uk)
- Academy of Medical Royal Colleges report published September 2014 (www.aomrc.org.uk)
- Focused on improving outcomes for children by promoting effective engagement of health services and staff
- All included recommendations for health agencies, which complement a range of positive work and actions currently in place
- Clear direction regarding the specific responsibilities for health services and staff. With a focus on leadership; sharing information; education & training



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"Health professionals, and those concerned with improving the health and welfare of their local population have a responsibility to tackle child sexual exploitation. Agencies and organisations from different sectors need to work together to engage children, young people and local communities to do this effectively."

CSE Sub Group Core Objective – Provided by Jane Ellison, Parliamentary Under-Secretary for Public Health.
(Department of Health Working Group report on Child Sexual Exploitation published January 2014)

Role of Health Services and Staff in CSE

- Significant contribution to make in identifying children and young people at risk of CSE
- Can present with a range of physical and or emotional problems to Sexual Health Services; Unplanned/Urgent Care Services; Mental Health Services; Drug and Alcohol Services
- Essential that staff are aware of the range of presentations and that they know how to respond appropriately
- Vital that information is shared and received as part of local multi-agency arrangements
- Key to supporting the treatment and long term recovery of those harmed
- Partner in MASH/MASE meetings/CSE Teams

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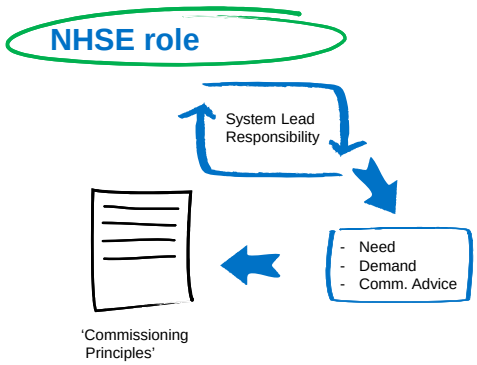
This service called Health

www.england.nhs.uk

NHSE role



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Responsibilities of the National CSE Working Group

- Provide 'Expert Reference' via representatives across the health system including Regional eams; Designated Professionals; Public Health England; Care Quality Commission; CSE NWG
- Delegated responsibility from the National Safeguarding Group to take responsibility for child sexual exploitation issues
- Adopt a shared learning approach, creating a repository for national best practice to be shared and arranging national learning events
- Responsible for cascading information to relevant stakeholders.

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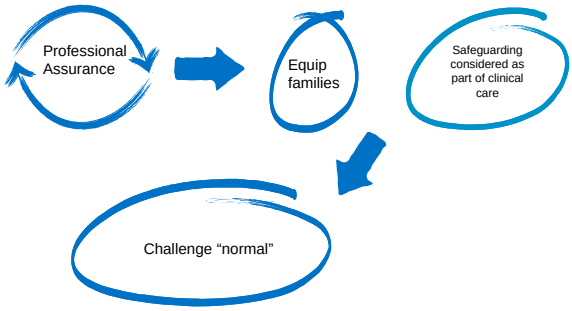
Health Standards

- Prevention
- Protection
- Intervention
- Prosecution

www.england.nhs.uk

Prevention



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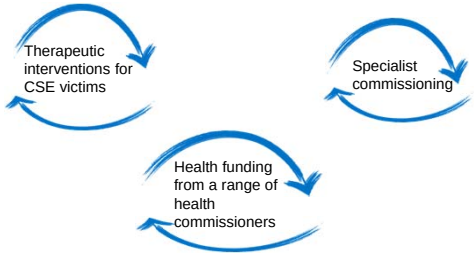
Protection

www.england.nhs.uk

Interventions



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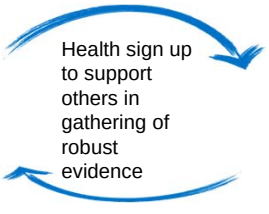
Prosecution



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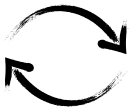

Future Considerations

NHS England

- Challenging the imposed conflict
- What does routine enquiry look like on the coal face?
- Further learning and health contribution to National Centre of Excellence
- Changing the mindset!

www.england.nhs.uk

NHS England

"Thank You"

Hazel Chamberlain- designated Nurse Safeguarding – NHSE CSE Sub group

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DAVE MCCALLUM

Senior Responsible Officer – West of England CSE Victim Identification and Support Service

Avon and Somerset Constabulary

Policy Communications

The West of England Child Sexual Exploitation Victim Identification and Support Service

Key aims of the project:

- More children are prevented from becoming victims of CSE
- More victims are identified, safeguarded and supported to help them to overcome the physical and emotional consequences of abuse
- More perpetrators are brought to justice

Principles

- Identifying and supporting vulnerable young people early will prevent them being victimised, improve their outcomes and save money on interventions
- Improving the safeguarding of victims will improve their outcomes, identify perpetrators and save money on interventions
- Improving identification and targeting of perpetrators will reduce CSE and stop the cycle of serial offending

How the objectives will be achieved

- Proactive specialist victim identification and support service **using existing management infrastructure**
- Additional specialist workers to support vulnerable and victimised young people
- Support to local information sharing and risk management processes
- Development of an academically evaluated evidence based toolkit to inform activity
- Agree 'fast track' health commissioning processes to support victims/vulnerable young people
- Dedicated training officer to enable enhanced training and awareness raising activity

Additional resources to support LSCBs

Funded by Wiltshire and Avon and Somerset Local Authorities, PCCs (44%) and The Home Office Police Innovation Fund (56%):

- A specialist trainer to deliver 'Train the trainer' packages to CYP workforce
- Additional specialist workers for every LSCB area to support victims and vulnerable YP
- Central co-ordinator/administrator providing business support
- A Senior Responsible Officer for the project
- Academic evaluation of effectiveness of CSE responses

Barnardo's Victim Support work – Avon and Somerset

- Meeting the needs of children and young people at risk of child sexual exploitation
- 4As – Access, Attention, Assertive Outreach, Advocacy
- Tailored support and interventions focussing on areas that make the most difference to the child or young person
- Working with the child in the context of their family/home life

Governance

- Senior Governance Group comprising Directors of Children's Services, Police and Crime Commissioners, Barnardo's and Home Office meeting six monthly
- Operational Group includes CSE Sub-Group Chairs and additional Children's Social Care representatives chaired by SRO, meeting quarterly
- Single grant agreement between Avon and Somerset Police and Crime Commissioners and Barnardo's and agreement Wiltshire OPCC and Wiltshire and Swindon councils

Progress so far…

- 7 LSCBs all with active CSE sub-groups and existing CSE Strategies
- Agreed commitment to respond effectively
- Issues of LSCB autonomy v consistency of operation
- Police - Proactively responding to CSE with existing resources
- Children's Social care - managing harm from outside the family
- CSE as part of normal child protection/safeguarding management
- Accessing accurate data to inform progress/development
- Transitions to adulthood

Dave McCallum
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West of England CSE Victim Identification and Support Service
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AMANDA NAYLOR

Senior Manager – Children and Young People's Programme

Victim Support

Policy Communications

WHAT DOES VICTIM SUPPORT DO?

Key support and campaigning agency that provides support at all ends of the Criminal Justice System

Services include:

- Core victim support services
- IDVA and ISVA teams
- Specialist Adult abused in childhood programme
- Safer Schools Programme – whole school approach
- Specialist Young Witness Services
- Specialist Young Victims Services including DA, CSE and Gangs projects

YOU&CO

You & Co is Victim Support's youth programme that helps young people cope with the impact and effects of crime. Young People do not have to report the crime to the police to get support from us.

We concentrate our work on helping young people to:

- feel safer and be safer
- reduce the risks of them becoming a victim again by helping young people and adults around them to make surroundings safer
- enable young people to develop protective behaviours, make safer choices and get ready to accept support

CO-CREATION

All development is a collaboration between –

- Children – who bring their own solutions
- Parents, Teachers and other community members/ professionals reinforcing safety messages is what keeps children safe

THERE HAS BEEN PROGRESS

- Youth Justice & Criminal Evidence Act 1999 - Introduction of Special Measures
- Victims Code/Witness Charter 2013
- Advocates Gateway
- Achieving Best Evidence in Criminal Proceedings 2011
- Equal Treatment Benchbook 2013/ training judiciary
- CPS/NPCC Guidance 2013 (CSE) – increase in prosecution
- Home Office National Action Plan
- MASH development
- Research and inquiry reports and recommendations

KEY ISSUES

1. Early Identification of young people at risk
2. Risk management excluding young people's needs and right to engage
3. Clear intervention framework and evidence of what works
4. Understanding young people's experience of poly victimisation
5. Journey through the Criminal Justice System

PREVENTION AND RISK IDENTIFICATION

- OOC checklist and other risk identification tools developed
- NWG Say something!
- Excellent schools programmes/ sessions developed

But:

- Identification of CSE and early intervention remains an issue
- Specialist services overwhelmed with young people who have experienced CSE
- Where does prevention/ early identification work happen?

SAFER SCHOOLS PROGRAMME

Last year we delivered to over 10,000 children in schools.

From this we learnt important lessons:

- × One off PSHE lessons don't work
- × Shock tactics don't work
- × Different agencies delivering different sessions can lead to confusing messages
- × Children remember very few safety messages – need stronger embedded and reinforced safety strategies
- × Teachers need help to pick up on concerns and integrate protective behaviours across school

BUILDING ON YOUNG PEOPLE'S STRENGTH AND RESILIENCE

"When was the last time you came out of a meeting and thought that discussion has made a young person safer?"

Leanne 17

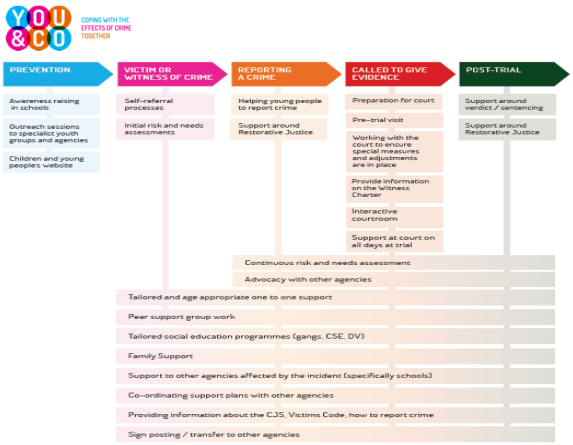
VICTIM SUPPORT DELIVERY MODEL

Aim to reduce **Risk** factors
Increase **Protective** factors
Increase **Resilience** levels

THE JOURNEY IS A LONG ONE

It just felt like there was times when it was empty waiting time – then times when there was everything happening like a big production, then there was nothing….

Sam, 15



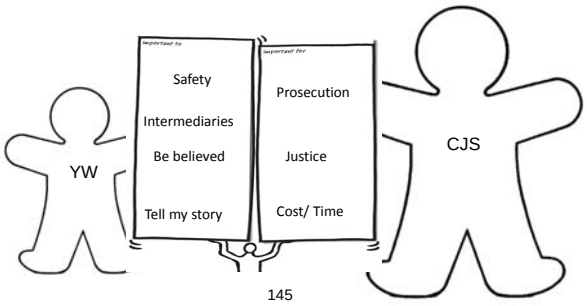
POLY VICTIMISATION (FINKLEHOR ET AL.)

Children exposed to even one type of violence, are at much greater risk of other types of violence.

A child who was physically assaulted in the past year is 5 x as likely to have been sexually victimized and 4 x as likely also to have been maltreated during that period.

VS examining the experiences of 1,000 children being supported in specialist domestic abuse projects - 610 of those had experienced or were at high risk of sexual exploitation. (Safe and Sound risk measurement tool)

BALANCING THE CJS AND YOUNG WITNESS NEEDS



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Website – www.youandco.org.uk

INTERACTIVE COURTROOM

For copies of these resources or to discuss training course options please email:

COPING WITH THE EFFECTS OF CRIME TOGETHER

www.youandco.org.uk

youandco@victimsupport.org.uk

SUZANNE ELWICK
Business Manager
Waltham Forest
Safeguarding Children Board

NEIL THURLOW
Community Safety Team Manager
London Borough of Waltham Forest

Policy Communications

The Campaign - approach

An integrated campaign which aims to support licencing, enforcement and education activity being undertaken by the WFSCB through targeted advertising, social media, PR and partnership marketing.

Two pronged-approach aimed to raise awareness and prevent CSE in the borough through:

- A reporting focused campaign aimed to encourage local hospitality business owners and taxi companies to understand CSE in the context of their business and encourage their staff to report anything suspicious to the Police and understand the consequences of not doing so.
- Awareness raising activity targeting at those residents who could be affected by CSE, including young people, parents/carers and professionals to provide the message that CSE is unacceptable and signpost to services that can help.

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

SAY SOMETHING IF YOU SEE SOMETHING
Call 101, Operation Make Safe.
www.walthamforest.gov.uk/cse

The Campaign

Business – which we targeted, how and why?

- From national and local experience the business where CSE can occur are Hotels, pubs, off licences, takeaways, internet cafes, and taxi firms. We also identify that pharmacists as providers of Emergency hormonal Contraceptive (EHC) were also important practitioners to target.
- Agreed this would be our initial target which would then widen
- Research completed by local police officers from licensing to identify those business to targeted for training and to attend our launch in October
- Engagement phrase: letter from relevant senior officer, attendance at business forums, and attendance by police officers to targeted businesses and phone calls to businesses.

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www.walthamforest.gov.uk/cse

Say something if you see something

- Campaign creative was developed for business alongside residents campaign. Using local influences and building on the work by NWG.
- Report it 101 Operation Make Safe
- The campaign includes posters, what to look out for posters, prompt postcards, air fresheners for taxis and beer mats for pubs, alongside bespoke training delivered directly in your premises.

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www.walthamforest.gov.uk/cse

The Campaign

Residents –target audience

The campaign sought to drive awareness of CSE amongst residents and signpost potentially affected individuals to where they can access help or support.

- Core target audience: 14-15 year olds. (66% of the victims are aged 14-15 years old)
- Secondary audience: Residents who may be affected by CSE in some way: i.e. Victims (especially 14-15 year olds as this is the age of the majority of the cases known), friends/peers of victims, parents and carers, family members and professionals who works with young people (teachers, college tutor, youth group leaders etc.).

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The Campaign

Approach – residents

- Research and insight from similar successful campaigns
- Largely led by engagement with representatives representative young people from the borough, and consultation from specialist partner working on CSE
- Initial designs consulted on and then creative led by their feedback
- Further creative testing was then undertaken via focus groups with older residents, including parents of teenage children.
- Campaign activity targeted outdoor, bus shelter advertising and posters at rail and tube stations, washroom advertising and display advertising in the council premises. Also in newspaper Waltham Forest News, distributed to all 98,000 households in the borough. Marketing materials were also distributed across schools, hospitals, GP surgeries, pharmacists, leisure centres and libraries.

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Creative: residents campaign

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Creative: businesses

Creative: residents campaign

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Campaign – Timescales & resources

- Timescales for delivery – 12 weeks from inception to launch
- Campaign spend - £20,000

Activity	Timing
Campaign development	Beg July – 26 Sept (8 week design and production stage)
Stakeholder launch event	15 July 2014
Partner launch event	7 Oct 2014
Provision of partner resource materials	7 Oct onwards
Advertising go live (4 week burst of advertising)	7 October
Campaign Evaluation report	February 2015

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Training

- Training has been provided in situ by the Specialist Command officer to all hotels in Waltham Forest and training resources and posters provided;
- The Specialist CSE Command trained the Safer Transport Command officers who in turn have delivered training in situ to taxi firms, with training resources and posters provided
- The Specialist CSE Command trained the local borough police from licensing section who in turn have delivered training in situ to pubs, off license's, takeaways and internet cafes
- CSE champions training delivered to 95 MA practitioners in October (75 in July) by the WFSCB business manager and Met Police, with support from members of the CSE subgroup to provide table facilitation

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

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Training and residents campaign

- Awareness raising training delivered to 75 neighbour officers, i.e. licensing, enforcement, street cleaning, housing, environmental health, civil engineering.
- Awareness raising training delivered to 43 pharmacists
- Residents campaign – posters disseminated to all schools, health centres, GP practices, pharmacists, housing offices, all LBWF offices and premises, leisure centres, and Whipps Cross Hospital

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The campaign

- **Launch of campaign** – Leyton Orient Football Club, breakfast launch inviting all business to sign the pledge. Opened by Lead Member for Community Safety, with presentations from Borough Commander, LBWF CE, Lead member for children, and WFSCB chair. 31 businesses attended and signed the pledge alongside statutory sector partners.
- Website for business to signed up after the event in development
- Campaign will continue with further engagement of other business, such as hostels etc.

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Top Tips

- Partnership approach and senior leadership sign- up from the beginning, particularly police and LA
- Involvement of young people affected by CSE in campaign development
- Have a single point of contact for development of campaign and to continue work following launch
- Agree a training approach for businesses and practitioners – training the trainers cascade for business
- Research which businesses to target first, using police intelligence
- Agree engagement approach – who is best placed to do what - letters, visits, presentation etc.
- Deliver a range of training to those working directly with children and those who can be the eyes and ears on the street and in businesses
- Launch with pledge sign by businesses and statutory agencies and local publicity/media
- Evaluation and continue building and raising awareness

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

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www.walthamforest.gov.uk/cse

Moving Forward/next steps

- Revisiting the businesses via intelligence lead tasking
  - Internet cafes
  - Fast food outlets
  - Off licenses/mini markets
  - On license premises
- Joint partnership work
  - Days of action
  - Regular engagement between Police and Neighbourhood Officers
  - Development of business crime reduction programmes

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

SAY SOMETHING IF YOU SEE SOMETHING Call 101, Operation Make Safe. www.walthamforest.gov.uk/cse

Moving Forward/next steps

- Development of service provision
  - CCTV
  - Licensing checks
  - Food safety inspections

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

SAY SOMETHING IF YOU SEE SOMETHING Call 101, Operation Make Safe. www.walthamforest.gov.uk/cse

Challenges

- Identification of business owner(s)
  - Use of business rates
  - Use of private rented licensing legislation
  - Need businesses to buy in to the campaign
- Employee challenges
  - Language
  - Right to work status
  - Reluctance to report
  - Lack of understanding in regard to CSE

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

SAY SOMETHING IF YOU SEE SOMETHING Call 101, Operation Make Safe. www.walthamforest.gov.uk/cse

Challenges

- Business continued
  - Lack of intelligence
  - Poor/no CCTV operating/recording
  - High staff turn over
  - Concerns around repercussions and responsibility when reporting

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

SAY SOMETHING IF YOU SEE SOMETHING Call 101, Operation Make Safe. www.walthamforest.gov.uk/cse

The sell/request

- Installation of posters/cards
- Asking “think of the victim as your sister/niece/daughter” what would you hope someone would do?
- Emphasising that by calling 101 and quoting Op Make Safe can be anonymous
- Emphasising that for WF/statutory partners employees safeguarding is everyone's duty

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

SAY SOMETHING IF YOU SEE SOMETHING Call 101, Operation Make Safe. www.walthamforest.gov.uk/cse

Contacts for resources

- Visit the WFSCB website www.walthamforest.gov.uk/lscb to access resources.
- Contact WF communications for campaign creative Mehreen.Hussain@walthamforest.gov.uk
- Neil.Thurlow@walthamforest.gov.uk
- Suzanne.Elwick@walthamforest.gov.uk

CHILD SEXUAL EXPLOITATION IS ABUSE. DON'T MASK THE PROBLEM.

SAY SOMETHING IF YOU SEE SOMETHING Call 101, Operation Make Safe. www.walthamforest.gov.uk/cse

LISA WITHERDEN

Child Sexual Exploitation Coordinator

Safer London Foundation

Policy Communications

Safer London

Our vision is for young people in London to feel safe and achieve their potential.

We work to improve the safety and wellbeing of young people in London affected by violence and crime.

saferlondon

Our Projects

ASPIRE Skills Development

Aspire provides early intervention mentoring to those close to becoming caught up in the cycle of violence and crime.

safe & secure TRANSFORMING LIVES

Safe & Secure is a unique intervention project for gang-affected young people who are at high risk of harm.

LDAP

London Domestic Abuse Provision is an innovate service delivered in partnership with Victim Support. This Pan-London strategic support increases the capacity and impact of services delivered directly to DV victims/survivors.

EMPOWER

Empower is a support programme addressing young women's experiences of sexual exploitation, primarily through gangs.

saferlondon

Our Newest Projects

Young Men's Project

Supports young men 11-18 displaying **Harmful Sexual Behaviour**. Intervention focuses on the young men's vulnerabilities and aims to provide them with the knowledge, skills and confidence to make appropriate choices.
We also provide consultancy and deliver training to professionals on working with young men displaying sexually harmful behaviour.

Missing Project

Partnership with NSPCC, Croydon Council, Croydon Safeguarding Children's Board, and Railway Children.
Increase understanding and awareness of issues and upskill professionals to be better able to respond to the needs of young people who go/are at risk of going missing.

SPECIALIST TRAINING & CONSULTANCY

Training and consultancy

Services are available on a wide range of Safer London's areas of expertise. We can develop bespoke training packages, using a foundation in academic research, policy development and expertise from Safer London practice, and the addition of local research to ensure that trainings are tailored to the audience.

saferlondon

EMPOWER

6-stranded programme for young people experiencing sexual violence or exploitation

1) Young women's intensive 1:1 support
2) Specialist advice & case consultation
3) Young women's education programme
4) Young men's education programme
5) Parents and Foster Carers workshops
6) Professionals training and events

saferlondon

EMPOWER

Our History:

- Group work with young women
- Identified need for work with young men too
  - Victim blaming and shame
  - Responsibility for sexual violence with the perpetrator
- Societal issues that contribute to VAWG
- Need for 'climatic' change

saferlondon

Core Components of Intensive Work/Whole School Approach

- Policy
- Teacher Training
- Awareness raising
- Menu Of Options
  - Group Work
  - CSE Advisors
  - Crisis Intervention
  - Parents Work
  - Community Engagement

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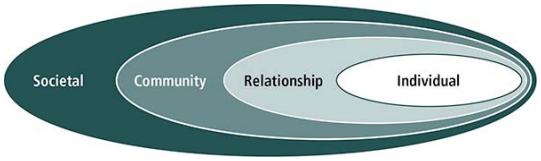
Understanding Gender Based Violence



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Gender Responsiveness

- Gender-neutral policies and provision can have the outcome of disadvantaging women (CEDAW, 2008)
- Substantive inequalities between women and men mean that services need to address these inequalities in order to provide the same outcomes for women as they do for men

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Gender sensitive approach

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Why gender specific?

Dromey for the YWCA (now Platform 51) in 2005 and later the Women's Resource Centre published findings regarding single gender service provision: Increase in young women's attendance

- A greater sense of solidarity
- Increased self-confidence, willingness to try new things and to speak openly.
- Increased feelings of physical safety e.g. not worrying about sexual harassment
- Young women being able to express feelings openly and try new things
- Female group leaders provided positive role models that helped break down stereotypes
- Improved relationships between young women
- Encouraged girls to take more risks

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Our Stance:

Our survey:

- 30% of parents/carers spoke to their children about sex and relationships

- Some Schools deliver effective PSHE
- PSHE is not on the curriculum, can be limited to biology
- Influences of the Media
- Overwhelming need to engage the whole school community in addressing the societal and cultural issues that enable the perpetration of VAWG.

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What young people say:

"I do not laugh about rape and take it seriously"

"I have changed my attitude towards girls"

"I know who to go to when I am feeling unsafe"

"One thing that has changed is that I am more confident in myself"

"I know what consent is and I know what a healthy relationship is"

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Further Reading

- If it's not better, it's not the end: Inquiry into Child Sexual Exploitation in Gangs and Groups1 year On (OCC Feb 2015)
- Female Voice in Violence Final Report: This is it, this is my Life (ROTA 2011)
- The London Child Sexual Exploitation Operating Protocol 2nd Edition (LSCB March 2015)
- Safeguarding children affected by Gang Activity and/or serious youth violence (LSCB 2010)
- Safeguarding Children and Young People from Sexual Exploitation (DCSF 2010)
- Teenagers at Risk: The Safeguarding needs of Young People in Gangs and Violent Peer Groups (NSPCC 2009)

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Links

- PACE: Parents against Child Sexual Exploitation http://www.paceuk.info/
- Blast: Blast support's and works with boys and young men who have been, are being, or are at risk of being sexually exploited. http://mesmac.co.uk/blast
- Barnardo's: Children's charity http://www.barnardos.org.uk/
- NSPCC: http://www.nspcc.org.uk/
- Child Exploitation and Online Protection Centre: http://www.ceop.police.uk/ (Think U Know)

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TACKLING CHILD SEXUAL EXPLOITATION

Policy Communications