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Sexual Exploitation of Children - Rochdale Safeguarding Children Board Review of multi-agency response

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Summary

Rochdale Borough Safeguarding Children Board has published a *Review of Multi-agency Responses to the Sexual Exploitation of Children*. The report looks at how agencies including the Council, Police, NHS, Crown Prosecution Service and other support services worked between 2007 and 2012 to safeguard children and young people who were at risk of sexual exploitation. 'The findings have been used to identify the required changes that have now been made, supporting the development of the local [Rochdale] Child Sexual Exploitation Strategy and action plan.'

Alongside other recent publications aimed at improving the system for preventing such abuse, and protecting its victims, this report offers a straightforward and highly critical account of what happened in the borough during the five-year period leading up to the trial of nine men earlier this year; it is likely to be of relevance and help to many in other areas around the country.

Overview

Rochdale Borough Safeguarding Children Board (RBSCB) has published a *Review of Multi-agency Responses to the Sexual Exploitation of Children*. The review was commissioned (in line with the statutory reviewing and investigative functions of LSCBs as defined in *Working Together to Safeguard Children*) to look at how agencies including the Council, Police, NHS, Crown Prosecution Service and other support services worked between 2007 and 2012 to safeguard children and young people who were at risk of sexual exploitation. 'The findings have been used to identify the required changes that have now been made, supporting the development of the local [Rochdale] Child Sexual Exploitation Strategy and action plan.'

Alongside other recent publications (see 'Related briefing') aimed at improving the system for preventing such abuse and protecting its victims, this report offers a straightforward and highly critical account of what happened in the borough during the five-year period leading up to the trial of nine men earlier this year. A Serious Case Review (SCR) will be published in due course, but it was felt that the SCR model 'was not the most suitable vehicle for extracting the lessons in relation to multi-agency working with sexually exploited young people in a timely way'. The preliminary review was undertaken

while the criminal proceedings were current, culminating in a learning event involving senior officers from the local authority, the police and partner agencies. The aim of the review was to ensure that agencies were best placed in future to:

- identify sexually exploitative activity locally
- engage with affected and vulnerable young people
- disrupt any such activity in a timely manner
- prosecute alleged perpetrators.

The review considered the events and circumstances in the life of one young person, taking into account contemporary national and local policies and practices, so that the account is both personal and representative. The voice of other young people involved were sought after the trial finished, and are included as an addendum.

Briefing in full

The report includes the case study; a chronological account of events, how agencies judged their practice, and an overall analysis; and the lessons learned and associated recommendations. These are summarised below.

The case study

Suzie (not her real name) is the subject of the case study on which the review focussed, and was a victim of sexual exploitation. Briefly, when Suzie was 15 there were already signs that she was a troubled and vulnerable young person. In the course of that year, she told two separate agencies that she had been the victim of serious sexual assaults by a number of adults who were linked to takeaway premises in the area. Police investigated, but the possibility of sexual exploitation was not initially recognised; professional focus was on providing individual support for Suzie, and on assisting her parents to set boundaries to keep her safe, but these actions appeared to have little effect. Whilst still a teenager, she became pregnant.

At the beginning of 2009, Suzie made a detailed complaint to the police about the abuse she had experienced during the previous six months, and a number of men were arrested; she reported that she was being threatened by the offenders and by other victims, and said that she did not feel that agencies could protect her. In the following months, Suzie continued to receive support from specialist sexual health and alcohol services, but children's social care ended their involvement with her as a 'child in need'. At the same time, an initial assessment was made of her capacity to provide care for her child. In the same month, the men whom Suzie and others had accused were 'refused charge' by the Crown Prosecution Service (CPS).

Some months later, Suzie reported further abuse to the police and, again, referrals were made to children's social care, who took no action in response – but were concerned for the safety of her baby, specifically about the risk posed by Suzie's alcohol abuse and by the male visitors to the family home.

In November 2010, a man was arrested as a result of Suzie's evidence, and the following month Greater Manchester Police (GMP) launched Operation Span. Suzie's mental health was deteriorating, and child protection processes were instigated in respect of her baby.

The chronology, agency judgements and analysis

The purpose of the review was to consider and improve practice in tackling child sexual exploitation (CSE); it attempted to identify national as well as local factors which influenced how agencies responded to CSE in Rochdale.

2007: local and national awareness of CSE was growing, but the scale of the problem and the way in which victims were targeted was only just becoming clear; in Rochdale, as elsewhere, professionals were not skilled at recognising and responding to the problem. A Sexual Exploitation Working Group (SEWG) and Sexual Exploitation Steering Group (SESG) were formed; no distinction was made between children looked after by Rochdale Borough Council and those placed in Rochdale by other councils. [According to a BBC report, a quarter of the children's homes in England are in the north west; there are 41 in Rochdale, and the vast majority of children in them come from outside the Borough.] During 2007, the SEWG identified 50 children and young people who were considered to be affected by, or at risk of, sexual exploitation. They were overwhelmingly girls, aged between 10 and 17; just over half were in education, and 15 were looked after children. Clear links were identified to take-away businesses in an area of town, and to associated taxi companies. Three individual perpetrators were reported to have been convicted as a result of police investigations.

2008: there was national consultation on draft guidance on safeguarding children from sexual exploitation which established a definition of child sexual exploitation and proposed protocols for working with children and young people, in response to which Rochdale Borough SCB (RBSCB) developed multi-agency protocols – but their impact was unknown as there were no arrangements to support or monitor their use. In June the SESG reported that the incidence of CSE locally was similar to that found in other LA areas in the north west, but it identified several weaknesses in the local safeguarding response, including 'uncoordinated multi-agency working', and recommended the establishment of a dedicated multi-agency team (the 'Sunrise Team') as a matter of urgency – but progress was slow. The RBSCB provided training and awareness-raising sessions to local agencies, and individual agencies undertook training on CSE, which resulted in more effective joint arrangements between Early Break (the young people's drug and alcohol advisory service) and the Crisis Intervention Team; the latter made several referrals to children's social care, but knowledge from working with children was not systematically passed to the police, which hindered development of the larger picture. There were improvements in practice, but front line practitioners and managers in children's social care did not consistently recognise or understand CSE. The review identified a number of significant factors:

- no specific assessment tool existed, so behaviours indicative of sexual exploitation were seen rather as problematic, and essentially wilful, behaviours on the part of the child
- older children were considered to have the capacity to make their own decisions, and were not perceived to be as 'at risk' of harm as younger children
- professional focus was more frequently on the perceived ability of parents to manage the child's behaviour, rather than on the child's vulnerability to abuse outside the home.

Also, the most significant safeguarding issue at the time was the response to the SCR of the death of Peter Connelly (Baby P), and the priority was to ensure that the danger to young children at risk was assessed and reduced. Nevertheless, the review acknowledged deficiencies in how children's social care responded to Suzie's needs. In December 2008, funding was identified for a social worker and health worker for the Sunrise team, which it was anticipated would be formally launched in April 2009.

2009: in January, Suzie made further disclosures to the Crisis Intervention Team, and was interviewed by the police – but it is acknowledged that the investigation was poor. At the same time, a further referral in respect of Suzie was made to children's social care, but again no action resulted; at 16 years old Suzie was considered to be 'making her own decisions' but, when it was reported that she was pregnant, focus shifted to the welfare of her unborn child. Focus on suspected perpetrators began to intensify, and the LA licensing department provided intelligence to the police so that their activities could be disrupted. However, progress on developing the specialist team remained slow; no social worker had been recruited by June (two months after the target launch date). The potential prosecution of the perpetrators suffered a setback when the men were 'refused charge' by the CPS.

In August, the Government published *Safeguarding Children and Young People from Sexual Exploitation: Supplementary guidance to Working Together to Safeguard Children*, which changed the language of what had previously been referred to as 'child prostitution' to 'sexual abuse' and 'exploitation'.

2010: In January, the Sunrise team became fully operational. Its first progress report in May identified 79 children and young people who had been experiencing or were at risk of sexual exploitation, and made recommendations to overcome operational difficulties, including 'fast-tracking' social care involvement. In June, Ofsted inspected the LA's safeguarding and looked after children services, and acknowledged that the Sunrise team showed encouraging early signs and levels of engagement, but it was too early to report on success. In September, the RBSCB appointed a Local Authority Designated Officer (LADO) to act as a single point of contact for all allegations that a person who works with children had harmed, or might have harmed, a child or might be unsuitable to work with children; the terms of their licences meant that this included allegations against taxi drivers. Suzie reported further abuse to the police, resulting in a number of arrests; no charges were brought but perpetrators who worked as taxi drivers had their licenses suspended. In the last quarter of 2010 a number of developments took place within Greater Manchester Police (GMP), including changes in the way that investigations were managed; clarification of the role of the Public Protection Division in investigating CSE; investment across the force, leading to identification of other CSE activity within the GMP area; and the launch of 'Operation Span'.

Nationally, the Coalition Government was formed, commissioning the Munro review of safeguarding and publishing several White Papers signalling major changes in the NHS, police and children's trusts; in October, the public spending review indicated budget reductions for local authorities, police and other public services.

In November 2010, the RBSCB appointed a new Independent Chair, and it was decided that the Board would be reconstituted with a separation of the strategic and executive functions. Within

children's social care, a restructuring of looked after children services was taking place, and the death of Peter Connelly continued to have an impact.

2011: In January, Suzie's circumstances were considered by the SCR Screening Group of RBSCB, and a CSE strategy meeting considered information about Suzie. Children's Social Care undertook an initial assessment, identifying a number of concerns about her welfare, but no further action was taken in respect of Suzie, who was now almost 18 years old, but a core assessment was completed in respect of her child. Also in January, Barnardo's published *Puppet on a String: the urgent need to cut children free from sexual exploitation*, which found that, despite new national guidance, CSE was not recognised in most LAs as a mainstream child protection issue; it called on the Secretary of State to take the lead in ensuring a fundamental shift in policy, practice and service delivery in England. Shortly after, CEOP announced a thematic assessment of 'localised grooming' following a number of prosecutions for grooming and sexual exploitation across the UK, published in June as *Out of Mind, Out of Sight* – which noted that 'agencies which do not proactively look for child sexual exploitation will as a result fail to identify it'.

Locally, premises in Rochdale suspected to be associated with CSE were identified through regular meetings between the licensing authority, police and the Sunrise team and checks were carried around local schools, with taxi drivers being questioned and their legitimacy verified. Information and awareness raising activities were carried out at local mosques and the RBSCB formed a multi-agency CSE Strategic Group with a police lead and a focus on communications with the media and local communities as interest in the issue was growing in the wider public. Recruitment to the social care senior practitioner post in the Sunrise team remained problematic, and the Crisis Intervention Team supported 20 young people during interviews with police; the CPS reversed its decision not to bring charges against alleged perpetrators identified by Suzie.

In October, the University of Bedford published *What's going on?*, a report on the response of LSCBs to the 2009 government guidance on safeguarding children and young people from sexual exploitation. It found that where the guidance was being followed there were examples of developing and innovative practice both in supporting young people and in investigating and prosecuting their abusers – but this was far from the norm [the report said that only a quarter of LSCBs were implementing the guidance, that awareness raising was taking place in only half the country, and that prosecution of abusers was rare and young people's experience was intolerable].

A developed day, focussed on the Sunrise team, led to a proposal for a revised structure and expansion. A new CSE Strategy Group was established, incorporating the previous police-led group, and the Children's Social Care Service Director took the lead in developing the strategy. In November, a proposal to secure funding for the revised Sunrise team was put to the RBSCB. Rochdale Community Safety Partnership made the formal link between CSE and serious crime, reflecting national developments, and the national action plan (*Tackling child sexual exploitation*) was published. But local partnership working to disrupt activities associated with SCE were thwarted when recommendations to rescind licenses were not endorsed by the Licensing Authority; neither was the outcome communicated to partner agencies at the time.

2012: In January, the RBSCB endorsed a recommendation that Suzie's case and others met the criteria for a SCR; the Sunrise team recruited a social work senior practitioner and a team coordinator; and the local Residential Care Provider forum wrote to placing LAs with a 'position

statement' about CSE in the borough, and developed inter-home protocols for sharing information and for managing the care of children and young people who go missing.

At the time of the review's learning event, a number of serious incidents of alleged CSE were being addressed by managers from a range of agencies; GMP were reviewing investigations of CSE; a number of alleged offenders were being brought to trial, and a second investigation was underway.

Analysis: there is no doubt that Suzie suffered significant harm from 2008 onwards. Social work practitioners and managers 'wholly over-estimated the extent to which Suzie could legally or psychologically consent to the sexual violence being perpetrated against her', and there was no escalation of agency concerns that the needs of this group of young people were not being adequately assessed and dealt with by the local authority.

The absence of knowledge of the appropriate response to CSE was a significant feature, but not the whole story. Review participants acknowledged that, had existing legal and safeguarding processes been used effectively, the harm that Suzie was suffering could have been mitigated and her risk of suffering harm in the future could have been reduced.

Key lessons and recommendations

The review identified nine key lessons and made 15 associated recommendations; lessons of relevance to other areas are summarised below (and many of the recommendations will also be applicable elsewhere):

- without a single multi-agency strategy, it is impossible to develop a shared understanding of the problem of child sexual exploitation; the leadership of the LSCB is crucial
- children and young people are more likely to be protected from child sexual abuse if professionals, young people, parents and the wider community have a better understanding of the problem, can recognise key signs and know how to respond
- children are more likely to be protected from sexual exploitation if professionals engage actively with the local community
- for those children who are identified as being at risk of, or suffering harm through, child sexual exploitation, it is essential that their needs are comprehensively assessed and that they are provided with good services, specific to their needs; this requires clear single and multi-agency policies and procedures and good practice guidance
- once perpetrators have been identified, it is crucial that police build the case against them and that prosecutions are secured. If this does not happen, children and young people will continue to suffer abuse and violence and lack confidence that agencies can protect them
- disrupting the activity of perpetrators can reduce the incidence of abuse and sends a very valuable message to young people, their families and their carers; it is crucial therefore, that the LSCB strategy requires both early preventative measures to be put in place, as well endorsing the use of more intrusive interventions
- the effectiveness of multi-agency work to safeguard children and young people from sexual exploitation needs to be measured by evaluating progress against a set of key indicators
- it is important that regular 'scoping' takes place to establish target potential offender and victim populations and to identify changing 'hotspot' locations.

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Comment

The review report makes uncomfortable reading, but it performs a valuable function in identifying important lessons – not only for the Rochdale area but far more widely. It is clear from a range of recent publications that progress on tackling child sexual exploitation remains patchy, from a generally low starting point, though the considerable publicity generated by the trial earlier this year will doubtless have prompted many LSCBs to review what they are doing and, if necessary, to 'rebalance' their priorities. The report is likely to prove helpful to this process.

External links

Review of Multi-agency Responses to the Sexual Exploitation of Children Rochdale Local Safeguarding Board

Related briefings

Tackling child sexual exploitation and protecting children who go missing from residential care (August 2012)

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