



## Review of Multi-agency Responses to the Sexual Exploitation of Children



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## 1. Introduction

This purpose of this report is to review how agencies in Rochdale Metropolitan Borough Council, hereafter known as Rochdale, worked together from 2007 until 2012 to safeguard children and young people who were at risk of sexual exploitation. This review was commissioned by Rochdale Borough Safeguarding Children Board (RBSCB) in line with its statutory reviewing and investigative functions as defined in *'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children'* (2010).

In December 2010, Greater Manchester Police (GMP) launched Operation Span to investigate a large group of men who were suspected of sexually exploiting children and young people in Rochdale. The Serious Case Review Screening Panel (SCRSP) considered, in depth and over the following year, the information provided by the police, the local authority and other agencies and organisations, about the work they had undertaken with young people affected by sexual exploitation. In December 2011, the SCRSP concluded that there were grounds to consider undertaking serious case reviews.

The Panel felt strongly, for a wide range of reasons, that the serious case review model, as described in *Working Together*, was not the most suitable vehicle for effectively extracting the lessons in relation to multi-agency working with sexually exploited young people, in a timely way. The Panel recognised that an initial alternative approach would need to be just as robust and transparent as the serious case review process and should be measured by the extent to which it would make a difference and eradicate any poor practice which still existed.

In January 2012, The Chair of the RBSCB received the recommendations of the SCRSP and agreed that the threshold for undertaking serious case reviews had been met, while acknowledging the views of the SCRCP in respect of the methodology. Consequently, the RBSCB determined that it would: conduct a preliminary review of how agencies had worked together; identify any additional learning from the criminal trial; and aggregate lessons from individual organisational reviews. When those tasks were completed, the Board would determine whether a Serious Case Review was



required to ensure that all the lessons are learned and that there is a comprehensive plan for improvement in place.

On 1 February 2012, therefore, while the criminal process was current, the Board undertook its preliminary review of how partner agencies had responded to the allegations made by the young people. The review process culminated in a facilitated learning event which involved senior officers from the local authority, the police and its partner agencies. The stated aim of the review was to ensure that agencies were best placed in future to:

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



## 2. Methodology

The learning event was designed and led by Clare Hyde, independent facilitator, from The Foundation for Families, a not for profit Community Interest Company established in July 2010. Over a period of four days, Ms Hyde worked with a small group of Board members to develop a model that would enable participants both to consider the events and circumstances in one child's life while, at the same time, to take into account contemporary national and local policies and practice developments. In this way, the child's story was to be both personal and representative. The results of this dynamic exercise informed the second part of the review which focused on identifying actions for RBSCB's strategy to counteract and manage child sexual exploitation, including actions specific to the specialist multi-agency child sexual exploitation team (Sunrise). It was agreed that the learning from this event would inform a review report which would be published to ensure transparency.

## 3. Participants

In addition to the facilitator, the participants in the review day were:

Independent Chair	Rochdale Borough Safeguarding Children Board
Executive Director Children's Services	Rochdale Metropolitan Borough Council
Chief Superintendent	Greater Manchester Police
Chief Inspector	Greater Manchester Police
Chief Inspector	Greater Manchester Police
Detective Inspector	Greater Manchester Police
Operational Manager Children's Service	Pennine Care NHS Foundation Trust and Heywood, Middleton and Rochdale Community Healthcare
Designated Nurse Safeguarding	Pennine Care NHS Foundation Trust and Heywood, Middleton and Rochdale Community Healthcare
Safeguarding Nurse	Pennine Care NHS Foundation Trust and Heywood, Middleton and Rochdale Community Healthcare
Team Manager, Crisis Intervention Team	Pennine Care NHS Foundation Trust and Heywood, Middleton and Rochdale Community Healthcare
Service Director, Targeted Services	Rochdale Metropolitan Borough Council
Service Manager, Duty and Assessment, Targeted Services	Rochdale Metropolitan Borough Council
Service Manager, Safeguarding, Targeted Services	Rochdale Metropolitan Borough Council
Youth Offending Team Manager, Targeted Services	Rochdale Metropolitan Borough Council



Senior Practitioner, Sunrise Team	Rochdale Metropolitan Borough Council
Coordinator, Sunrise Team	Rochdale Metropolitan Borough Council
Business Manager	Rochdale Borough Safeguarding Children Board
Local Authority Designated Officer	Rochdale Borough Safeguarding Children Board
Independent Chair, Serious Case Review Panel	Rochdale Borough Safeguarding Children Board
Team Leader, Licensing Authority	Rochdale Metropolitan Borough Council
Head Teacher	Brownhill School, Rochdale
Director	Early Break, Rochdale
Operational Manager	Early Break, Rochdale

Neither the private providers of care for looked after children nor the Crown Prosecution Service (CPS) were represented in the review meeting: this is an acknowledged gap. However the Chair of the Board and the Boards Business Manager subsequently met with the managers of the care home which had supported one of the young people involved in Operation Span and the subsequent trial to review the service offered and latterly the provider forum which agreed to conduct a review of safeguarding in the children's care home sector in Rochdale. This review is expected to be completed towards the end of the year.

Additionally, the RBSCB Chair has discussed with the Chief Crown Prosecutor from CPS North West how alleged sexual exploitation cases are managed within the criminal justice system. It is noted that Chief Crown Prosecutor is to share the learning from the internal review of CPS practice in relation to sexual offences with the Board.

Due to the timing of the learning event, prior to the trial, it was agreed that the voice of the young people would be sought at a later date. The issues raised by them are to be found in the Addendum to the report. The Board would like to thank the young people for agreeing to share their experiences with us and for the courageous offers of support from them to help us make the improvements necessary to safeguard other young people who may find themselves in similar circumstances.



## The case study

Suzie is the subject of the case study on which the review focussed. Suzie was a real victim of sexual exploitation, although this is not her real name and some details of her circumstances have been omitted to preserve her anonymity.

When Suzie turned 15, there were already signs that she was a troubled and vulnerable young person. In the course of that year Suzie disclosed on two separate occasions and to two different 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. Although police investigations were carried out, to begin with the possibility that she was being sexually exploited was not recognised. At that time, professional focus was on providing individual support services for Suzie and on assisting her parents to set boundaries to keep her safe. It seems, however, that these actions had little impact on Suzie's circumstances: she remained at risk of sexual harm, compounded by her abuse of alcohol and possibly drugs. Whilst still a teenager Suzie 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. As a result, a number of men were arrested in connection with offences against her and against other young people. Suzie reported that she was being threatened, both by the offenders and by other victims. Suzie stated that she did not feel confident that agencies could protect her.

In the months which followed, Suzie continued to have the support of specialist sexual health and alcohol services. However, children's social care ended their involvement with Suzie as a 'child in need', while 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 disclosed further abuse to the police. Again, referrals were made to children's social care for support to Suzie. However, children's social care took no action in relation to these referrals. The agency was, however, concerned for the safety of Suzie's baby. Their concerns were specifically, the risk that was posed to the baby by Suzie's alcohol misuse and by male visitors to the family home.



At this point, it appears that Suzie felt both under pressure from professionals about her parenting and frightened by the offenders who were using other young victims to gain access to her and to threaten, intimidate and coerce her.

In November 2010, a man was arrested as a result of Suzie's evidence and the following month GMP launched Operation Span. In the weeks that followed it was evident that Suzie's mental health was deteriorating: she was self-harming, using alcohol excessively and going missing for periods of time. Child protection processes were instigated in respect of Suzie's baby.





## 4. How did agencies judge their practice?

It is acknowledged that the case study raises potentially a large number of practice issues, both for individual agencies and for the RBSCB, not all of which are related to issues of child sexual exploitation. However, as noted above, the purpose of the review was to consider and improve practice relating particular to this area. This means that, inevitably, other issues have not received the same level of attention.

### Chronology

The review attempted to identify national as well as local factors which influenced how agencies and organisations responded to child sexual exploitation in Rochdale. It found that only some factors related directly to practice in this area. Other factors had an associated impact on practice which was sometimes consequential and sometimes unintended. This report concentrates on those developments which are specific to child sexual exploitation, although reference is made to significant external events where these are considered to be particularly pertinent. The chronology includes the reflections of review participants on events and developments.

### 2007

By 2007, local and national awareness of child sexual exploitation was growing, but the scale of the problem and the way in which victims were targeted was only just becoming clear. Just as was the case nationally, it is evident that professionals in Rochdale were not skilled at recognising and responding to child sexual exploitation. However within the borough there were two distinctive developments. These were:

- the formation of a Sexual Exploitation Working Group (SEWG), whose remit included gathering and analysing information about the incidence of the sexual exploitation of children resident or placed in the borough; and
- the subsequent formation, under the auspices of the RBSCB, of a Sexual Exploitation Steering Group (SESG) to provide guidance and direction to the SEWG; to report the findings of the survey to the Board; and to make recommendations for improvements.



Between January and December 2007, the SEWG identified 50 children and young people who were considered to be affected by, or to be at risk of, sexual exploitation. The children in this group were overwhelmingly girls; they were aged between 10 and 17 years old; just over half were in education; and 15 were looked after children. No distinction was made in the survey between those children who were looked after by Rochdale Borough Council and those who had been placed in Rochdale by other local authorities. Clear links were identified to take-away businesses in an area of the town and to associated taxi companies. Three individual perpetrators were reported to have been convicted as a result of police investigations.

Reflecting on practice at that time, the review group acknowledged that children at risk of sexual exploitation were being provided with support by agencies such as Early Break, the young people's drug and alcohol advisory service, and the Crisis Intervention Team, which provides one-to-one advice to vulnerable young people in respect of their sexual health. However, for those children who came into contact with children's social care, it often appeared that 'no further action' would be taken. Case files state that the children were often considered to be 'making their own choices' and to be 'engaging in consensual sexual activity'. The poor response by children's social care to cases where children were at risk of sexual exploitation was aggravated by the fact that professionals did not make consistent reference to the procedures for dealing with vulnerable young people or to guidance about working with young people engaging in underage sexual activity.

As noted above, professional focus generally, at this time, was on individual cases rather than on the wider picture. As a result, there was little evidence either of disruptive action, such as the involvement of the Licensing Authority, or the use of Civil Orders which might have curtailed the activities of actual and potential offenders.

## **2008**

In the early months of 2008, national consultation took place in relation to issues of child sexual exploitation, prior to the publication of guidance the following year. This consultation document established the definition of child sexual exploitation and proposed protocols for working with children and young people. In response to that initiative, RBCSB developed its own multi-agency Child Sexual Exploitation Protocols. However, the impact of these protocols was unknown as no arrangements were put in place to support or monitor how they were used by local agencies.



Then, in June 2008, the SESG reported to the Board. Its report analysed the SEWG data and concluded that the incidence of child sexual exploitation locally was similar to that found in other North West local authority areas. However, it also identified a number of weaknesses in the local safeguarding response to young people at risk of sexual exploitation: one of which was ‘uncoordinated multi-agency working’. For those reasons, the SESG recommended that a dedicated multi-agency team, based on models which existed elsewhere, should be established in Rochdale as a matter of urgency.

From August 2008, a small working group was set up to develop the specialist team proposal, looking at the role of such a team, its funding and management, and the relationship to the wider network of services. However, strategic progress to develop the specialist team was slow and, on occasion, halted completely. Review participants identified a range of problems in setting up the specialist team. These problems included:

- a. there was no agreement for sustainable funding;
- b. governance arrangements of the team were uncertain;
- c. there was no business plan;
- d. a performance framework had not been created; and, crucially,
- e. no support and supervision were in place for team members.

At the same time, the RBSCB provided training and awareness-raising sessions to agencies across the Borough<sup>1</sup>. In addition, individual agencies, such as Early Break, and a number of discrete groups of professionals from within the health service undertook agency-specific training in relation to child sexual exploitation. As a result, Early Break and the Crisis Intervention Team developed their own practice in this area and put in place more effective joint working arrangements. These two agencies in particular began to recognise and to respond to children and young people as victims of abuse and exploitation, rather than as consenting young adults. At the same time, the Crisis Intervention Team made a number of referrals to children’s social care, expressing concerns about children’s welfare or safety.

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<sup>1</sup> Between 2007 and 2011, the Board provided 3 sets of 2 day training ‘Sexually Active under 18s and Sexual Exploitation’ and 7 half-day seminars on Child Sexual Exploitation. Total No. staff trained = 207



At that time, however, knowledge gained from work with children was not systematically passed to the police as intelligence and this hindered the development of the larger picture.

Although areas of improved practice were developing, this was by no means universal. Crucially, front line practitioners and managers in children's social care did not consistently recognise or understand the nature of the sexual exploitation of children and young people. Review participants considered that a number of factors were significant in this. Primarily, there were difficulties specifically related to identifying and managing cases where child sexual exploitation was a feature. These difficulties included:

- a. No specific assessment tool existed, which meant that behaviours indicative of sexual exploitation were seen rather as problematic, and essentially wilful, behaviours on the part of the child;
- a. Older children were considered to have capacity to make their own decisions and were not perceived to be as 'at risk' of harm as younger children;
- b. 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.

Less directly, it was also the case that the most significant safeguarding issue at this time was the response at a national and local level to the Serious Case Review of the death of Peter Connelly (Baby P). This saw increasing numbers of referrals to children's social care; more children becoming the subjects of child protection plans; and a rise in the number of children being taken into local authority care. As a result, professional safeguarding priority was to ensure that the danger to younger children at risk of neglect and physical harm were assessed and reduced.

However, even taking these contributory factors into account, review participants acknowledged that there were clear deficiencies in the way that children's social care responded to Suzie's needs.

In December 2008, agencies identified funding for a social worker and health worker to be allocated to the Sunrise Team. It was anticipated that the team would be formally 'launched' in April 2009.



## 2009

In January 2009, Suzie made further disclosures to the Crisis Intervention Team. In her statement, Suzie 'catalogued' her experience of abuse and exploitation. As a result, Suzie was interviewed by the police. GMP acknowledges, however, that the investigation of Suzie's detailed complaint 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. Suzie, at 16 years old, was considered to be 'making her own choices'.

This sequence of events confirms the review participants' beliefs that while, within certain agencies, improvements were being seen in skills, confidence and response to issues of child sexual exploitation; this was not consistent across agencies.

When it was reported that Suzie was pregnant, children's social care's focus shifted to the welfare of her unborn child.

At a tactical level, focus on the suspected perpetrators of sexual exploitation began to intensify and the local authority licensing department provided essential intelligence to the police, so that the alleged perpetrators' activities could be disrupted.

However, progress in developing the specialist child sexual exploitation team continued to be slow. Recruitment and staffing issues continued and the absence of key managers at relevant planning meetings impeded the development of the team's role and functions. Nevertheless, work went on to produce multi-agency information-sharing protocols for the team and to begin to tackle the issues of record keeping and intelligence systems. However, by June 2009, two months after the original target date for the team launch, only a health worker and a police officer were established in post: no social worker had yet been recruited.

The potential prosecution of the perpetrators suffered a serious setback, when the men were refused charge by the Crown Prosecution Service. Review participants identified several factors which led to this. These included:

- a. issues with forensic evidence;
- b. cost;



- c. officer workload which led to delay; and, significantly,
- d. a view that Suzie would be an unreliable witness.

Also in 2009, the government published, *'Safeguarding Children and Young People from Sexual Exploitation: Supplementary guidance to Working Together to Safeguard Children'*. This guidance provided local safeguarding children boards and their partners with a strong framework for developing strategic and frontline responses to child sexual exploitation. Importantly, it also changed the language of what had previously been referred to as 'child prostitution' to 'sexual abuse' and 'exploitation'.

## 2010

In January 2010, the Sunrise Team became fully operational, albeit with a different structure from the team that had been envisaged. In its first progress report in May 2010, the team identified 79 children and young people in Rochdale who had been experiencing, or who were at risk of, sexual exploitation. All 79 children and young people had been worked with by at least one member of the four person team. However, although the team was functioning, difficulties existed in relation to how the team operated. This meant that their first progress report also contained 14 separate recommendations for change. Key issues for the team included:

- a. strengthening team relationships;
- b. accessing and sharing information,
- c. supervision,
- d. 'fast-tracking' social care involvement; and,
- e. improving the team's 'physical space'.

In May 2010, a coalition government was formed, following the UK general elections. In June 2010, the government commissioned Professor Eileen Munro to conduct a review to improve child protection. In addition, a number of white papers were published which were significant for the Board and for individual agencies. These included changing arrangements for commissioning within the NHS, plans to abolish Police Authorities and changes to the role and function of Children's Trusts.



Locally, in June 2010, Ofsted inspected the local authority's safeguarding and looked after children services. The inspection report acknowledged that for the Sunrise team, early signs and levels of engagement were encouraging: however, it recognised it was too early to report on the success of this team.

In September 2010, the RBSCB appointed a Local Authority Designated Officer (LADO). The role of the LADO was to act as the single point of contact for all allegations that a person who works with children had 'harmed, or might have harmed a child; had possibly committed a criminal offence against a child or who, in other ways, might be unsuitable to work with children'. The terms of their licence meant that allegations against taxi-drivers fell within these procedures. Strategy meetings and allegations management meetings, therefore, offered opportunities to share information between the police, the licensing authority, children's social care, schools, local authority solicitors, voluntary agencies and private child care providers.

Also in September 2010, Suzie disclosed further abuse to the police and a number of arrests were made. Although no charges were brought the perpetrators who worked as taxi-drivers were arrested, their licences were suspended and discussions with proprietors continued. The Sunrise Team health practitioner continued to provide support to Suzie, but her fear of her abusers was escalating. At the same time, from a children's social care perspective Suzie's potential to abuse or neglect her own child was coming under increasing scrutiny.

In October 2010, the government presented its public spending review which, among other measures, indicated that there would be reducing budgets for local authorities, police, probation and social housing over the next four years. The extent to which these reductions would impact on the functioning of the Board and its partner agencies was unknown.

In the last quarter of 2010, a number of events, with implications for the investigation of child sexual exploitation, took place within GMP. These included:

- a. A review by the police modernisation team that changed the way that investigations were managed;
- b. Clarification of the role of Public Protection Division in investigating child sexual exploitation;



- c. Investment of resources across the force, leading to identification of other child sexual exploitation activity within the GMP area; and
- d. The launch of 'Operation Span'.

In November 2010, RBSCB appointed a new Independent Chair. It was determined that the Board would be reconstituted and that there would be 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 2011, Suzie's circumstances were considered by the Serious Case Review Screening Group of RBSCB. In the same month, a child sexual exploitation strategy meeting was held at which information about Suzie was considered. Children's social care undertook an initial assessment, which identified a number of concerns about Suzie's welfare, including alcohol misuse; self-harming behaviours; and being 'missing'. However, no further action was taken in respect of Suzie who was, by this time, almost 18 years old. A core assessment was completed in respect of Suzie's child.

Also in January 2011, Barnardo's published '*Puppet on a String: the urgent need to cut children free from sexual exploitation*'. This report acknowledged that recent high-profile cases had meant that child protection had been firmly focused on babies suffering abuse and neglect at the hands of their parents, relatives or carers in the family home. The report found that despite new national guidance, in most local authorities, child sexual exploitation was not recognised as a mainstream child protection issue. This report called on the Secretary of State for Education to take the lead in ensuring a fundamental shift in policy, practice and service delivery in England.

Shortly afterwards, CEOP announced it would carry out a thematic assessment of the phenomenon known as 'localised grooming' following the prosecutions of adult males for the grooming and sexual exploitation of children in various towns and cities in the UK.

Locally, in the early months of 2011, premises in Rochdale suspected to be associated with the sexual exploitation of children were identified through regular meetings held between the licensing





authority, the police and the Sunrise Team. In addition, checks were carried out around local schools, with taxi drivers being questioned and their legitimacy verified.

Around the same time, information and awareness raising activities were carried out at local mosques and RBSCB formed a multi-agency Child Sexual Exploitation Strategic Group with a police lead and a significant focus on managing communications with the media and local communities as interest in this subject was growing within the wider public. Effective Multi-agency planning ensured a quiet response to an English Defence League march in Rochdale in March 2011.

RBSCB also subscribed to ECPAT UK (End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes) at this time.

In May 2011, the Munro Review of Child Protection was published: this did not, however, explicitly address issues of child sexual exploitation.

In the summer of 2011, CEOP published *'Out of Mind, Out of Sight'*; the report of its findings following the thematic assessment carried out earlier in the year. However, the report acknowledged that the data was significantly weighted towards the relatively limited number of areas which had provided a comprehensive response: areas which generally already had stronger partnership arrangements to address child sexual exploitation. The assessment could not be seen, therefore, as fully representative of the nature and scale of child sexual exploitation in the U.K., or, indeed, of the 'localised grooming' model. CEOP noted that 'agencies which did not proactively look for child sexual exploitation would as a result fail to identify it'. Nevertheless, the report provided a specific definition of 'localised grooming' as a discrete aspect of child sexual exploitation. The findings suggested that both the victim experience in Rochdale and the multi-agency responses to this kind of child sexual exploitation were similar in many ways to the picture across much of the country.

Planning meetings took place amongst a wide range of professionals to co-ordinate support to meet all Suzie's needs.



The Sunrise Team continued its work, although recruitment to the social care senior practitioner post remained problematic. The Crisis Intervention Team supported 20 young people during interviews with police and a Sunrise Team worker, with health practitioner background, was trained in Achieving Best Evidence interview techniques. The CPS overturned its decision not to bring charges against alleged perpetrators identified by Suzie.

In October 2011, the University of Bedfordshire published 'What's Going On?' a research project which explored the extent and nature of the response of LSCBs to the 2009 government guidance on safeguarding children and young people from sexual exploitation. This found that where the guidance had been followed, there were examples of developing and innovative practice to protect and support young people and their families and to investigate and prosecute their abusers. However, the researchers found that the delivery of that dual approach to child sexual exploitation was far from the norm.

This document and the CEOP survey served as references to undertake analyses of two cases and underpinned a development day, focussing on the Sunrise Team. As a result of this development day, a revised structure for the Sunrise Team was proposed: this included increasing the size of the team and having a co-located team coordinator. A Child Sexual Exploitation Strategy Group was established and the children's social care Service Director took the lead in developing the strategy for the Board. This group incorporated the former police-led strategic group.

In November 2011, a proposal to secure funding for the revised Sunrise Team was put to the RBSCB.

Also in November 2011, Rochdale Community Safety Partnership made the formal link between child sexual exploitation and serious crime, reflecting national developments and the publication the Association of Chief Police Officers (ACPO), '*Strategy for Policing Prostitution and Sexual Exploitation*'. This report confirmed that: 'In the case of children and young people, the emphasis is always on safeguarding the young person and on the proactive disruption and prosecution of their abusers'.

Generally, review participants found that around this time partnership work between the licensing authority and the police was providing an effective vehicle for making connections between



individuals and premises and for disrupting the activities of perpetrators. They also noted that Criminal Records Bureau (CRB) checks began to confirm that applicants had been investigated in relation to allegations of child sexual exploitation.

Again in November 2011, the national action plan for tackling child sexual exploitation was published and brought together, for the first time, actions by the Government and a range of national and local partners to protect children from this form of child abuse. The action plan considers sexual exploitation from the perspective of the child. It highlights areas where more needs to be done and sets out specific actions which government, local agencies and voluntary and community sector partners need to take.

Towards the end of 2011, partnership working to disrupt activities associated with child sexual exploitation was thwarted, as multi-agency recommendations to rescind licences were not endorsed by the Licensing Authority. This outcome was not communicated to partner agencies at this time.

## **2012**

In January 2012, the RBSCB endorsed a recommendation that Suzie's case, and others, had met the criteria for serious case review.

Also in January 2012, the Sunrise Team recruited a social work senior practitioner and team co-ordinator. The local Residential Care Provider Forum agreed to send letters to placing local authorities providing a 'position statement' about child sexual exploitation in the borough. This same group also developed inter-home protocols for sharing information and for managing the care of children and young people who go missing. The forum continues to meet monthly to discuss issues affecting the market and local providers, but specifically also now discusses safeguarding, to establish protocols to ensure safety.

At the point that the review learning event was held, a number of very serious incidents of alleged child sexual exploitation were being addressed by Strategic and Operational Managers from a wide range of agencies. GMP were reviewing how investigations of child sexual exploitation has been managed and investigated across the city and liaising with the Independent Police Complaints



Commission. A number of alleged offenders were being brought to trial and a second investigation was underway.

## **Analysis**

There is no doubt that Suzie was suffering significant harm from 2008 onwards: indeed, Suzie told several professionals, on several occasions, that she was being sexually abused and exploited by a number of men. The nature of the harm and of the 'relationship' between Suzie and the offenders was understood by members of the Crisis Intervention Team and the Early Break Service, however their referrals were generally not acted on by children's social care. 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. This was frustrating for referring practitioners. However, 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 in respect of the appropriate response to child sexual exploitation was a significant feature of practice. However, it was not the whole story: participants in the review acknowledged that, had existing legal processes and safeguarding processes been used effectively in all other aspects, the harm that Suzie was suffering could have been mitigated and her risk of suffering harm in the future could have been reduced. The review found, therefore, that, while some organisations were consistently supportive in their response to Suzie, overall, child welfare organisations missed opportunities to provide a comprehensive, co-ordinated and timely response to her as a child in need and, in addition, the criminal justice system missed opportunities to bring the perpetrators to justice and so to protect Suzie and other young people from their criminal behaviours. It was not until 2011, that a comprehensive assessment of Suzie's needs was carried out and a support plan put in place; and, it was 2012 before the alleged offenders were brought to trial.

More generally, agencies and organisations in Rochdale made faltering early progress in developing a satisfactory framework for managing allegations of child sexual exploitation. The need for a specialist resource was identified in 2008, but its development was inadequately co-ordinated and supported. Specific training to frontline practitioners in the borough was patchy and lessons were absorbed inconsistently. Efforts were made to identify the extent of the problem locally, but



responses to individual children, although evident in some instances, were not sufficiently comprehensive. In children's social care, as in similar organisations across the country, the focus was on younger children at risk of abuse from family and household members, rather than on vulnerable adolescents.

Activity to disrupt alleged offenders was developing on the ground, but this was not always followed through at a more senior level. The early investigations of crimes and the prosecution of alleged offenders were flawed.

Although between 2009 and 2012, some improvements had been consolidated; overall, the review group acknowledged that there were many missed opportunities, over the last five years, to safeguard children and young people who have been affected by sexual exploitation. It also recognised that there is still much to be done to ensure that children and young people are better protected in future.



## 5. What were the key lessons and associated recommendations?

### LESSON 1

***Without a single multi-agency strategy, it is impossible to develop a shared understanding of the problem of sexual exploitation; progress is likely to be piecemeal and uncoordinated; and agencies cannot be held to account for their actions or failures to act. The leadership of the RBSCB is crucial to this task.***

#### Associated recommendation

RBSCB should develop an effective local strategy, ensuring there is a co-ordinated multi-agency response to child sexual exploitation, based on the knowledge which already exists about the extent and nature of child exploitation locally. This should include:

- Revising Terms of Reference for the RBSCB Child Sexual Exploitation Implementation Group and ensuring effective reporting arrangements;
- Ensuring that formal structures are in place to deal with 'cross-border issues';
- Ensuring that commissioning is well planned, informed, and effective;
- Ensuring involvement of non-statutory agency partners at all levels;
- Conducting a self-assessment of current arrangements; and
- Clarifying governance arrangements for the Sunrise Team and how the Strategy Group links to other bodies such as the Children's Trust.

### LESSON 2

***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.***

#### Associated recommendations

1. Awareness-raising briefings should be held as a matter of urgency at high schools across the borough;
2. 'Train the trainer' sessions should be provided for professionals working with children and young people at risk of sexual exploitation as a basis for effective training of the wider workforce;



3. The RBSCB strategy should identify and ensure that appropriate levels of training/ awareness-raising/ information is provided for:
- those professionals for whom training in respect of child sexual exploitation should be mandatory;
  - those professionals where 'awareness-raising' activities are required;
  - those community groups where 'awareness-raising' activities are indicated, and
  - parents and carers.

### **LESSON 3**

***Children are more likely to be protected from sexual exploitation if professionals engage actively with the local community***

#### Associated recommendations

1. Partner agencies, particularly the local authority and the police, should review how they work with local communities and consider how communications and opportunities for representation can be further developed. This should include using third sector partners to gain access and build trust.

### **LESSON 4**

***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.***

#### Associated recommendations

1. RBSCB should ensure that policies and procedures in place for managing referrals in relation to children at risk of, or suffering harm through child sexual exploitation are used effectively.
2. RBSCB should provide good practice guidance for practitioners and managers to build their knowledge and support their work with children and young people at risk of sexual exploitation.

### **LESSON 5**

***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.***



#### Associated recommendations

1. GMP should ensure that all their staff are aware of appropriate legal compliance in evidence gathering requirements and that, when arrests have been made, that there are appropriate bail conditions in place to protect the victim/s.
2. Criminal justice organisations locally should work together to ensure that support is provided for sexually exploited young people throughout the whole process of reporting the crime, making a statement, pre-trial preparation, going to court and after the trial.

#### **LESSON 6**

***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 RBSCB strategy requires both early preventative measures to be put in place, as well endorsing the use of more intrusive interventions.***

#### Associated recommendations

1. The RBSCB should ensure that the use of disruption tactics permeates the work with young people; work in particular locations; work with local businesses; and targeting offenders.
2. GMP and a representative of the Sunrise Team should attend Licensing Panels to assist the Chief Officer in determining applications where applicants have been interviewed about the sexual exploitation of children.

#### **LESSON 7**

***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***

#### Associated recommendations

1. RBSCB should establish a specific performance management framework to evaluate progress made by agencies in preventing child sexual exploitation; in diverting those at risk; in responding to the needs of those young people who are being sexually exploited; and in reducing the overall incidence of this type of abuse. RBSCB should provide challenge to agencies against that framework.





## **LESSON 8**

***Although review participants considered that there was currently a good understanding of the local prevalence of child sexual abuse, they recognised that this knowledge needed to continue to be updated, if prevention, disruption and intervention strategies are to be effective. It is important, therefore, that regular ‘scoping’ takes place to establish target potential offender and victim populations and to identify changing ‘hotspot’ locations.***

### Associated recommendation

1. The RBSCB should establish multi-agency information-sharing meetings.
2. The RBSCB should ensure that these meetings collate and analyse information about offender and victim profiles and identify changing hotspot locations, so that disruptive action can be planned and taken.

## **LESSON 9**

***The review participants recognised the centrality of the Sunrise Team in safeguarding children and young people from sexual exploitation. However, the group concluded that there specific actions were required to develop and support the team.***

### Associated recommendation

The RBSCB should ensure that agreed actions to develop and support the Sunrise Team are implemented. Agreed actions include:

- Oversight and governance of the team should be co-ordinated by RBSCB to ensure an effective multi-agency approach;
- Commissioning arrangements should be formally agreed and integrated into a service level agreement with clear outcome and other performance measures;
- Consistent, high quality staff supervision and professional support is essential to enable practitioners to deal with complex and difficult safeguarding issues. This supervision and support should be provided within the team structure;
- The role and responsibilities of the Sunrise Team should be communicated to all agencies/ professionals who work or come into contact with children and young people;
- The referral pathway into the Sunrise Team must be clearly communicated to all agencies and potential referral sources: the referral pathway should be simple and accessible;



- The Sunrise Team's should be supported to provide physical, psychological, social and emotional assessments, plus immediate and ongoing assessments of risk, witness protection measures, support for the family and a key worker system.



## 6. Summary of review recommendations

1. RBSCB should develop an effective local strategy, ensuring there is a co-ordinated multi-agency response to child sexual exploitation, based on the knowledge which already exists about the extent and nature of child exploitation locally.
2. Awareness-raising briefings should be held as a matter of urgency at high schools across the borough.
3. 'Train the trainer' sessions should be provided for professionals working with children and young people at risk of sexual exploitation as a basis for effective training of the wider workforce.
4. The RBSCB strategy should identify and ensure that appropriate levels of training/ awareness-raising/ information for:
  - a. those professionals for whom training in respect of child sexual exploitation should be mandatory;
  - b. those professionals where 'awareness-raising' activities are required;
  - c. those community groups where 'awareness-raising' activities are indicated and,
  - d. parents and carers.
5. Partner agencies, particularly the local authority and the police, should review how they work with local communities and consider how communications and opportunities for representation can be further developed. This should include using third sector partners to gain access and build trust.
6. RBSCB should ensure that there are clear policies and procedures in place for managing referrals in relation to children at risk of, or suffering harm through child sexual exploitation.
7. RBSCB should provide good practice guidance for practitioners and managers to build their knowledge and support their work with children and young people at risk of sexual exploitation.
8. GMP should ensure that all staff are aware of the appropriate and legally compliant evidence gaining requirements and that, when arrests have been made, that there are appropriate bail conditions in place to protect the victim/s.



9. Criminal justice organisations locally should work together to ensure that support is provided for sexually exploited young people throughout the whole process of reporting the crime, making a statement, the pre-trial preparation, going to court and after the trial.
10. The RBSCB should ensure that the use of disruption tactics permeates the work with young people; work in particular locations; work with local businesses; and targeting offenders.
11. GMP and a representative of the Sunrise Team should attend Licensing Panels to assist the Chief Officer in determining applications where drivers have been interviewed about the sexual exploitation of children.
12. RBSCB should establish a specific performance management framework to evaluate progress made by agencies in preventing child sexual exploitation; in diverting those at risk; in responding to the needs of those young people who are being sexually exploited; and in reducing the overall incidence of this type of abuse.
13. The RBSCB should establish multi-agency information-sharing meetings.
14. The RBSCB should ensure that these meetings collate and analyse information about offender and victim profiles and identify changing hotspot locations, so that disruptive action can be planned and taken.
15. The RBSCB should ensure that agreed actions to develop and support the Sunrise Team are implemented. Agreed actions include:
  - a. Oversight and governance of the team should be co-ordinated by RBSCB to ensure an effective multi-agency approach;
  - b. Commissioning arrangements should be formally agreed and integrated into a service level agreement with clear outcome and other performance measures;
  - c. Consistent, high quality staff supervision and professional support is essential to enable practitioners to deal with complex and difficult safeguarding issues. This supervision and support should be provided within the team structure;
  - d. The role and responsibilities of the Sunrise Team should be communicated to all agencies/ professionals who work or come into contact with children and young people;
  - e. The referral pathway into the Sunrise Team must be clearly communicated to all agencies and potential referral sources: the referral pathway should be simple and accessible;
  - f. The Sunrise Team's approach should include physical, psychological, social and emotional assessments, plus immediate and ongoing assessments of risk, witness protection measures, support for the family and a key worker system.



## **Addendum**

### **Meeting with the victims and witnesses**

When the CSE review was planned, it was the RBSCB's intention to meet with the young people who were victims and witnesses to the abuse that had occurred. Their voices and opinions would be of the utmost importance when considering what lessons needed to be learnt and to help plan and inform future service interventions. Officers from GM Police and Children's Social Care (CSC) that were still in with contact and offering services to the young people made initial contact. An independent worker facilitated and conducted the interviews with the young people and their families. Not all of the victims of the Court case were willing to take part in this part of the learning process. Suzie did take part in this process. The following highlights the key themes raised by the young people and the parents who took part in interviews.

#### **1. Assessments and interventions by agencies**

All of the victims clearly identified agencies which they considered helped them and those agencies that had not been supportive. They expressed frustration with the initial response from CSC and the police and described these services as 'not listening' to them. They felt that they had cooperated fully with police processes and given sufficient information for the agencies to help protect them but nothing changed and the abuse carried on. CIT and Early Break were identified by two of the victims as being particularly helpful and acting as advocates on their behalf. CIT identified which services could help them and tried to get CSC and the police to do something. One of the victim's parents reported that the police and CSC did not tell them what was happening and said that their 16-year-old daughter was just hanging out with a 'bad crowd' and was making choices about relationships and sexual partners. He informed that no one told him that these choices involved his daughter having contact with such men.

#### **2. Power of the perpetrator**

All the victims described in detail the control the perpetrators had over every element of their lives. The threat of and in some cases the use of violence to control the victims was evident. These threats often included proposed violence against the victims' families. This intimidation was given as one of the reasons the young people did not tell their parents what was happening and why they did not engage with services earlier. The victims explained that the perpetrators told them that they had committed the crime that they were prostitutes and that no one would believe them.



### 3. Isolation

The victims describe being trapped with no hope of escape from the abuse. They felt unable to tell their parents or friends what was happening as they felt they would not be believed. A common disclosure by the young people was that even when they cooperated with agencies, nothing changed, the abuse continued.

The interviewer would like to comment on the engagement of the young people in this process. They were open, honest and engaged fully during what must have been an ordeal in reliving past events. The bravery shown by these young people was a humbling experience.