West Sussex Safeguarding Children Board

Kevin Harrington Associates Limited

## SERIOUS CASE REVIEW KEY

# A Serious Case Review into Child Sexual Exploitation in West Sussex

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## 1. INTRODUCTION

1.1 In 2012 a school in West Sussex made a number of referrals to West Sussex County Council Children's Social Care services (CSC) and to Sussex Police. The school had concerns about young teenage girls frequently visiting a local address, using illegal drugs and having sex with older men. This led to investigations, focussed on five girls, which did not result in any continuing involvement by police or CSC. The young people interviewed either denied any harmful activity or did not want to support a police investigation.

1.2 In 2014 the school made further referrals of the same nature which again led to activity by police, and by CSC. Again, this did not result in continuing involvement by either agency.

1.3 In 2015, at the request of a teacher, police carried out a review of the previous criminal investigations. That review led to a re-investigation, Operation Staple, in which the extent of the influence that the suspects had over young people in that locality, over a number of years, became clear. Eventually more than 250 children and young adults were interviewed as either victims or witnesses in the enquiry.

1.4 As a result of that investigation two men were eventually brought before the courts where they faced charges of rape, sexual assault and sexual activity with a child. The alleged offences were committed over a period of four years, from 2010 to 2014, and the victims, in these prosecutions, were twelve girls aged between 13 and 15 at the relevant times.

1.5 The men denied all charges. This led to a six week trial. One man, aged 31, was convicted of eight offences against five girls and imprisoned for 14 years. The second, aged 25, was convicted of ten offences against seven girls and sent to prison for 11 years. Both men will be registered sex offenders for life. The jury's verdicts in each case were unanimous.

## 2. THE DECISION TO CONDUCT A SERIOUS CASE REVIEW

2.1 These matters were considered by the West Sussex Safeguarding Children Board (the Board), and discussed initially at the Board's Case Review Group (CRG). The group focussed on the five young women who were at the heart of the original investigations in 2012.

2.2 At its meeting in July 2015 the CRG considered the events in the light of the government's guidance[1]. That guidance sets out the circumstances in which Safeguarding Boards should conduct a Serious Case Review (SCR). *"A SCR is always undertaken where (a) abuse or neglect of a child is known or suspected; and (b) either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child".*

[1] Working Together to Safeguard Children 2015 (Working Together)

2.3 At that stage it was clear from the initiation of new police investigations that abuse was at least suspected. The CRG further judged that there was evidence that these children, and probably others, had been seriously harmed. In some cases there were indications of enduring impairment of mental health and emotional well-being.

2.4 The CRG also found that there was evidence indicating that agencies had not worked well, separately or together. The key issues were that

- The investigative responses of a range of agencies, particularly police and CSC, had not been adequate in some individual cases.
- Co-ordination of the agencies' responses had not been effective.
- The agencies, and the Board, had not been sufficiently alert to the wider implications of these matters, particularly the developing understanding of child sexual exploitation.

2.5 In that light the CRG made a recommendation to Board's Chair that a Serious Case Review should be conducted. The Chair concurred and the formal decision to conduct an SCR was, as is required, notified to OFSTED on 19/6/15. This SCR is referred to as SCR Key, a random name chosen to assist in promoting confidentiality.

## 3. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

3.1 The Board, through the CRG, was mindful that this would not be a "standard" SCR, where the circumstances of a particular child or a sibling group are considered. The events leading to this review concerned, to various extents, a large number of young people over a period of several years. There are correspondences with an SCR, published in February 2015 by the Oxfordshire Safeguarding Children Board[2] and an SCR published in April 2016 by the Bristol Safeguarding Children Board[3].

3.2 It was decided to use the experiences of the original five girls, now in their late teenage years, as the basis for drawing together a picture of what had happened, and how the agencies had responded to events.

3.3 The following agencies were required to contribute to the SCR because of the nature and / or extent of their involvement:

- West Sussex County Council, Children's Social Care services (CSC)
- Sussex Police
- A local school (the school)
- Sussex Partnership NHS Foundation Trust, Child and Adolescent Mental Health Services (CAMHS)
- Western Sussex Hospitals NHS Foundation Trust (WSHFT)
- West Sussex Safeguarding Children Board (WSSCB)
- NHS Coastal West Sussex Clinical Commissioning Group (the CCG)
- West Sussex Youth Offending Service (YOS)

[2] Operation Bullfinch SCR
[3] SCR Operation Brooke

- West Sussex County Council, Elective Home Education Service (EHE) – one of the girls was said to be “home educated” for part of the time under review
- Arun District Council[4]

3.4 The SCR has been chaired by Mrs Natalie-Brahma Pearl, Director of Community Services for Horsham District Council and a member of the Board. The Lead Reviewer and author of this report is Kevin Harrington, an independent person with relevant qualifications and experience in this area of work. (Please see Appendix A for further details). They have been supported by a panel (the Panel) of senior managers and service representatives from across the relevant agencies and by the officers of the Board itself.

## 4. METHODOLOGY

4.1 Agencies were asked to provide an outline chronology of events between January 2012 and March 2015, and then to comment on operational and strategic responses to a number of key issues and challenges. The Board itself was also asked to review and comment on its involvement in these matters. These submissions from the agencies were reviewed and in due course were all accepted by the Panel

4.2 The criminal proceedings were lengthy and the men were not convicted until May 2016. A number of those needing to contribute to the SCR could not do so until the trials had been concluded. Nor could approaches be made to some of the young people and families at the centre of events. This Overview Report was duly completed in December 2016 and presented to the next Board meeting in January 2017.

## 5. A SUMMARY OF THE EVENTS LEADING TO THIS REVIEW

### 5.1 2012

5.1.1 During 2012 the school raised concerns about the sexual exploitation of girls by older men. Multi-agency strategy meetings were held and a criminal investigation commenced. In the course of that investigation a picture emerged of a number of children, some as young as 13, frequenting a local address where they used drugs and alcohol and where girls had sex with, principally, two men in their twenties. There were some indications of violence towards the girls. Some of them were said to be “runners”, delivering drugs for the adults at the premises. These events dated back to at least the summer of 2011.

5.1.2 Some of these children had a range of difficulties before this exploitation began. Some of the girls had experienced very complex, disrupted family backgrounds including domestic abuse, parental neglect and abuse, parental

[4] In fact Arun District Council had no significant knowledge of the events under review and had no continuing involvement

ill health, both physical and mental, and the misuse within families of drugs and alcohol.

5.1.3 Some of the girls, and their extended families, had been referred to CSC on previous occasions because of child care and child protection concerns. In some cases those concerns had been recent and of a serious nature but had not always led to appropriate or adequate action by CSC. None of the families had ongoing involvement with CSC when the concerns about sexual exploitation came to light. Similarly, some relevant matters had come to police attention previously but had not been classified as crimes or had not been fully followed up by police.

5.1.4 The concerns raised in the summer 2012 did not lead to continuing contact between CSC and any of the 5 girls at the heart of this review. In some cases they were not followed up by CSC on the basis that police investigations were proceeding. Some assessments were conducted by CSC but concluded that the various concerns were being dealt with adequately by the girls' families.

5.1.5 Similarly, the matters raised did not lead to any criminal charges. The girls and, sometimes, their families were reluctant or fearful to pursue that course of action. The police investigation was closed with no arrests made. The Sussex Police submission to this review states that
*"During the investigation reviews were carried out by Detective Sergeants but they did not address the issues identified. No arrests were made during the investigation. Additional crimes that were identified as result of speaking to other victims were not recorded".*

5.1.6 Police also note that their procedures for dealing with young people missing from home – as some of these girls often were – were not followed properly. The girls were repeatedly classified as being "absent" rather than "missing" from home. The consequence was that the situations were not then reviewed so regularly by senior officers and the onus to follow up was largely left with the family or with the person reporting that the child was not at home. This is discussed further below.

5.1.7 Four of the five girls saw their GPs in relation to contraception during 2011/2012, when they were 14 or 15 years old. A 15 year old was pregnant when she approached her GP though this pregnancy did not continue to full term. Some of the girls mentioned that there was a significant difference in age between themselves and their sexual partners. Some of the girls also presented with symptoms of mental ill health, mainly low mood and depression. In some cases medication was prescribed but none of the presentations led to continuing contact with CAMHS.

5.1.8 The school continued to provide pastoral support to four of the girls until they left school during 2013. The fifth girl had been withdrawn from school by her family during 2012, ostensibly so that she could be home educated. In fact there had been a substantial problem of her failing to attend school and the so-called elective home education was largely a response to this. There is no

indication that any home education was ever arranged, despite the attempts of the Education Service to assist with this, and this child's education effectively came to an end when she was 15. Consequently she did not receive the same pastoral support as the other girls.

**5.2 2013**

5.2.1 The issue of the sexual exploitation of these girls did not re-present, in its own right, during 2013. However there were continuing indications of cause for concern for all five girls during that year. These were most evident in the case of the girl who had not remained in education. She became involved with the YOS after repeated instances of violent or disruptive behaviour, associated with the misuse of drugs and alcohol. The YOS, reviewing their involvement which continued into 2014, conclude that
*"the YOS worked well with the young person and her family in addressing the presenting concerns associated with her offending and vulnerability".*
However the YOS also accepts that the issue of the child's sexual activity was not adequately explored and the concerns which had arisen in 2012 were regarded as
*a historic issue … investigated by Children's Services… and subsequently closed, ( and therefore) was not a matter for further (consideration)".*

5.2.2 One of the girls had a termination of pregnancy during 2013 and another became pregnant, giving birth the following year when she was 17. Some of the girls continued to receive advice and treatment in relation to depression. One, who spoke to her GP about being depressed for many years, was referred to CAMHS but did not respond when contacted by CAMHS.

5.2.3 There was very little contact between CSC and any of the girls during 2013. There were isolated instances of some of the girls coming to police attention in connection with criminal matters but no sustained involvement.

**5.3 2014 to 2015**

5.3.1 By 2014 all of the five girls identified in 2012 had finished school. However the school had continuing concerns about many other students whom staff knew to have links with the address previously investigated. Those concerns were communicated to CSC and police and, in June 2014, a Strategy Meeting was convened under formal child protection procedures.

5.3.2 This led to a series of meetings within and across agencies but no productive investigative activity. The school's frustration is clear when they report attending meetings where there was little consistency of representation from other key agencies, after initially being asked by CSC to make individual referrals in respect of each child for whom they had concern – at least 20 at that stage. Eventually, the investigations which were conducted in 2014 led to no disclosures or other evidence which police or CSC felt were sufficient to

support further action. It was decided that a number of Child Abduction Warning Notices[5] should be served but police did not follow this up.

5.3.3 School staff remained dissatisfied with the situation and raised their concerns with a senior manager in CSC, who liaised with police. This led to a re-opening of the investigation, now designated Operation Staple.

5.3.4 Police conducted various investigations until March 2015. They were then ready to make arrests and liaised with CSC to consider next steps. The agencies had to take account of and balance

- The need to make effective arrests
- The need to protect the health, safety and security of a large number of victims and potential witnesses
- The potential need to make arrangements for the children / families of those arrested
- Wider implications for the impact on the local community.

5.3.5 Pan – Sussex Complex Abuse procedures were followed and a plan was devised for a number of social workers to be allocated to support the police intervention. Five social workers and officers from the police Child Protection Team agreed arrangements for working individually with the five young women at the heart of this review. Those arrangements prioritised the need to individualise the approach being taken for each young woman, and reduce the number of other professionals who might need to be involved. Community impact and specialist health support were also taken into account in that plan.

5.3.6 These interventions were planned and agreed within a couple of days and two men were arrested. The young women were asked if they would consider providing a formal statement in respect of previous allegations, something they had not agreed to do in 2012. Staff were very clear with them about the process of an "Achieving Best Evidence" (ABE) interview[6] and its implications for further criminal proceedings. They were also spoken to about their sexual health, in the light of concerns relating to the sexual health of the suspects. While social workers did not disclose any confidential medical information they emphasised the importance of accessing a health screening and supported those young women who wished to take this action.

5.3.7 As well as routine daily contact between the agencies a programme of weekly meetings between CSC and police was established. These arrangements were designed to ensure that

- all relevant information was shared
- there was a process for co-ordinating which young people should be seen, in what order, when and by whom

[5] Child Abduction Warning Notices can be issued against individuals who are suspected of grooming children by stating that they have no permission to associate with the named child and that if they do so they can be arrested under the Child Abduction Act 1984 and Children Act 1989.

[6] This refers to the government's guidance on interviewing witnesses and victims, and using special measures where necessary to do so.

- interviews were co-ordinated and properly supported
- there was a clear procedure for following up information emerging from the investigation which identified other young people to be seen
- there was a forum for determining whether there were any matters that should be followed up under formal child protection or “child in need” arrangements

5.3.8 CSC and police eventually interviewed 15 young people who were victims of exploitation and abuse. The men continued to deny any wrongdoing.

### 5.4 2016

5.4.1 By February 2016 a trial date was in sight and planning had commenced for the arrangements to provide support to the young women, before, during and after the trial. The court proceedings extended over six weeks as a consequence of the men’s protestations of innocence, which meant that many witnesses had to be called and cross-examined. However, as described in the introduction to this report, the jury was in no doubt about their guilt, and the sentences they received reflect the seriousness of their crimes.

## 6. THE YOUNG PEOPLE AND THEIR FAMILIES

6.1 The Lead Reviewer set out to see all five of the young women at the centre of the 2012 investigations. Two of them were clear from the outset that they had put these matters behind them and did not wish to make any contribution to this review.

6.2 Two of the young women did express an interest in making a contribution and arrangements were made, through the police Family Liaison Officer (FLO) to set up meetings with the FLO and the author of this report. The FLO had remained in contact with the young women and spoke to them on a number of occasions to remind them of these arrangements. However neither of the women attended the meetings that had been arranged – one did not turn up and the other contacted the FLO shortly before the planned meeting to report that she was unwell. This was disappointing but it is perhaps not surprising that these young women would not wish to discuss or relive the events leading to this review.

6.3 The fifth young woman, with members of her family, did meet the Lead Reviewer, accompanied by the social worker who had supported them through the trial. This was a helpful meeting which threw some light on the apparent lack of community response to events which are now clearly of concern. The perpetrators were well known, and had some influential contacts, in what is a small, quite closed community. There is still a degree of denial locally of what had happened and a feeling that the young people should take some of the responsibility for that. The issue of public perception and education in relation to CSE is at the centre of the learning from these events.

## 7. ANALYSIS: THE KEY ISSUES

### 7.1 How sound were the agencies' operational responses to child protection concerns?

7.1.1 Child sexual exploitation is not a discrete, stand-alone category of concern. It includes and overlaps with neglect and physical and sexual abuse – areas of activity that agencies with child protection responsibilities have managed for many years. It is important that weaknesses in agencies' responses to the crimes of rape and sexual abuse of children, or even to under-age sexual activity, are not explained away by the "discovery" of child sexual exploitation.

7.1.2 Some of the girls considered in this review were in need before they were sexually exploited. They had complex family backgrounds in which there was compelling evidence of, for example, parental mental ill health, or substance abuse. CSC describe how one fourteen year old
*"was not (in)… education, she was taking drugs and alcohol, known to be having unprotected sex with older boys, going missing and had a difficult relationship with her mother who was suffering from poor mental health".*
but
*"It seems that neither she nor her mother engaged with CSC and a decision was made to close (the case)… after the Core Assessment was complete".*

7.1.3 This girl was being sexually exploited by men, which is what brought her into the scope of this review, but there were fundamental causes for concern within her family. The operational response from CSC, the lead child protection agency, was to decide that the case should be closed in the face of non-engagement, while the serious concerns identified in assessment went unaddressed. This was not an isolated decision: the report from CSC describes similar service weaknesses which had previously been highlighted by Ofsted[7] in 2011.

7.1.4 Another girl, aged 15, was seen at school in 2012 by a social worker and a police officer. The account of this meeting which was submitted to this review by police describes how
*"(a named man) gave children younger than her alcohol, cigarettes and offered them cannabis. She confirmed sleeping with (that man and another man). She said she agreed to have sex with (one of them) but she was drunk when she had sex with (the second man) and didn't know much about it except that it was anal sex".*

7.1.5 The identity of the second man was known to police but he was never interviewed. A social worker had a telephone conversation with him and put it to him that he was known to have had sex with underage girls, despite particular risks relating to sexually transmitted disease, and to deal in drugs. The social worker then spoke to a police officer who judged that police should not do any more, because

[7] Inspection of local authority arrangements for the protection of children

*"everything within reason has been done, and at least he now knows that police / social services know about his situation".*
That decision to take no further action was reviewed and ratified by a CID sergeant and a Child Protection Team sergeant.

7.1.6 Again, as with children's services, the weaknesses in this response are not explained solely by a failure to keep up to speed with the "new" social phenomenon of child sexual exploitation. At a basic level, police were aware here of a number of alleged or potential crimes, for example in respect of illegal drugs, that could have led to further action. Police could have sought to tackle those matters as part of a comprehensive initiative to disrupt the harm these men were doing. The fact that they did not do so suggests that there were attitudinal factors involved: the significance and seriousness of the crimes were played down; the girls were not seen as victims but willing participants.

7.1.7 The report in respect of GP services tells us that
*"Out of 9 contacts with GP surgeries when the girls were under 16 and either requesting contraception or advising of pregnancy, only one consultation had evidence of Fraser Guidelines[8] assessment".*
The original case, leading to the Fraser guidance, was in 1985. The Department of Health issued further relevant guidance in 2004, followed by the GMC's updated guidance in 2007. The girls being considered in this report were being seen between 2012 and 2014. It is disappointing to see so little evidence of compliance with, or even awareness of, such long-standing guidance in what is clearly potentially a difficult area, ethically and clinically.

7.1.8 Sexual health services were not well developed in West Sussex until at least 2014 and that is reflected squarely in the report from their parent agency, WSHFT. Their report describes how, even within such a specialised service,
*"staff until late 2013 / early 2014 had not heard of the term CSE and did not fully understand the risk factors".*
The report equally identifies weaknesses in the service's understanding of their safeguarding responsibilities and, again, attitudinal factors. Recording, relating to girls under 16, describes them having "*consensual*" sex while, equally, describing them as "*very drunk*" at the time.

7.1.9 The Youth Offending Service (YOS) only had any involvement with one of the five girls. Their review of that involvement concludes that it led to a
*"specific intervention to manage identified concerns associated with offending and vulnerability"*
and that, overall,
*"the delivery of services to the child and her mother and the level of practical and emotional support provided was very good".*
That is not disputed but the report from the YOS is right also to conclude that they could have been

[8] The guidance for doctors dealing with sexual activity by girls under 16 , set out by Lord Fraser in his judgement of the Gillick case in the House of Lords in 1985.

*“more curious and pro-active in exploring the issue of underage sexual activity or abuse with the girl and her mother, or by finding out more from Children’s Services and other professionals about the expressed concerns”.*

7.1.10 A number of the reports to this review have flagged up the significance of the ways in which agencies responded to young people who might be missing from home. In fact, at the start of the period under review, multi-agency guidance on CSE was entirely contained within the guidance on children missing from home, rather than being recognised as an issue in its own right.

7.1.11 Sussex Police explain their differentiation between someone who was “missing”, defined as
*“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”*
and someone who was “absent”, that is,
*“not at a place where they are expected or required to be”.*

7.1.12 The police response to someone who is “missing” is much more extensive and thorough than the way in which they deal with someone who is “absent”. However, police tell us,
*“On occasions the girls were recorded as being absent rather than missing. Due to the information provided at the time that they were at risk of harm through sexual abuse, drugs or alcohol the use of the absent protocol was not appropriate”.*
Police also note that this is an issue which has been identified as a cause for concern in previous case reviews locally.

7.1.13 CSC have also identified weaknesses in their response to children who were missing from home. When children were identified as “missing” by police, that was notified to CSC by police. Often those reports were logged by CSC without further action. Sometimes that was in contravention of a procedural requirement that
*“a strategy meeting should have been considered when a child had been reported missing on 3 or more occasions in a 12 month period, for a single longer period or; if a parent failed to report their child missing following reasonable attempts to find them”.*

7.1.14 These weaknesses in the responses from police and CSC again have their roots in the agencies’ attitudes at that time to these young people. They were seen as troublesome rather than troubled, responsible for their actions when they could not be. Potential criminal or safeguarding implications of their situations were set aside.

7.1.15 The agencies describe a range of service improvements they have made, largely arising from a recognition of the vulnerability to exploitation of young people who are “missing”. Those improvements include increased resourcing by police and better co-ordination across the agencies. The three

Sussex LSCBs are working with Sussex Police to include a standard data set which will include CSE and missing children.

7.1.16 However the 2015 Ofsted inspection of the WSSCB concluded that *'return interviews for children who have been missing from home or care are a particular weakness. They are carried out in too few cases and when they are carried out, they are not always of good quality. This means that the local authority lacks a comprehensive picture of the reasons for children going missing, limiting its ability to respond in a positive way to improve safety for children and young people.'*
The local authority has told us that these matters have been addressed by the commissioning of a new service for return interviews.

7.1.17 Overall there was a continuing failure to recognise and respond to the sexual abuse and exploitation of girls by adults. However it is important that this issue of sexual exploitation is not seen as something separate, which can be easily identified and sorted out. What happened to these girls must be seen in context, and part of that context is the evidence of weaknesses in basic child protection services in West Sussex at the relevant times. The roots of those weaknesses lie in issues of attitude, resourcing, leadership, training and an overall lack of professional robustness. The underlying problem is summed up in a comment in the report from the "Operation Bullfinch" SCR in Oxford:
*"The issue is not only about how much agencies / professionals knew about …organised exploitation….The question is also whether they did well enough with what they **did** know was happening".*

### 7.2 How well did the agencies work directly with the girls and their families?

7.2.1 It is important to remember the context in which the agencies were, or were not, engaging with these girls and their families. As discussed below the issue of sexual exploitation was not "on the radar" of the agencies; there was little understanding of how that might affect any willingness to engage, or how agencies might pitch their attempts to achieve engagement. The report from CSC illustrates how children were considered to be
*"making informed choices without consideration (by CSC) of coercion, enticement, manipulation or desperation".*

7.2.2 However, again, the failure to recognise sexual exploitation does not explain a failure to respond to the rape and sexual abuse of children. Moreover these were vulnerable girls whose families were struggling to support them. Even without any expectation of alertness to the consequences of sexual exploitation, there is a mixed picture of how well the agencies recognised their responsibility to protect children, sought to work with troubled families, and were successful in doing so.

7.2.3 The YOS is satisfied that there was good engagement and can demonstrate that they adapted the way they approached the family to maximise the effectiveness of that engagement (which relates only to one

girl). Police contrast how well they engaged with the girls in 2015 with their readiness in 2011/12 to conclude that nothing could be done because of, ostensibly, an unwillingness to co-operate. CSC reflect that
*"there was a culture, at that time, that there was little that could be done with teenagers that were seen as 'out of control' unless they were on the edge of care"*
Consequently they made little attempt to try to form relationships with the girls and their families.

**7.3 Did agencies work together effectively?**

7.3.1 There were some very evident failures of agencies to work together effectively. The clearest example is that of the school repeatedly raising well-founded concerns which did not lead to productive interventions. In the course of the review we heard of a range of initiatives which had sought to promote the understanding and use of challenge and escalation between agencies. It is an appropriate time to review those arrangements and how they are used.

7.3.2 Police have identified a number of instances where they failed to involve CSC adequately or at all in their investigations. For CSC themselves, there is evidence of assessments and actions which are not informed by consultation and collaborative interventions. The GPs have identified evidence of unproductive attempts to involve CAMHS, where CAMHS may have been using a high a threshold and GPs have not robustly challenged that:
*"at this point this 15 year old girl had presented with several months of feeling depressed, taken an overdose, tried two antidepressants under the care of the GP, reported poor attendance at school and evidence of drinking alcohol".*
CAMHS had asked this girl to refer herself to a counselling service and the GP, though worried about the girl, did not query that advice.

7.3.3 The report from the YOS illustrates how easy it is for services to set aside things they are not looking for, so that opportunities to share information are missed:
*"because sexual abuse/ exploitation was not verified or analysed as central to the assessment, this information was not routinely highlighted or shared with (the) professionals involved with (the child)".*
whereas
*"In respect of other safeguarding and welfare concerns, information was clearly recorded and shared between professionals"*

7.3.4 But the greatest concerns about failure to work together arise from those situations where the agencies are talking to each other, but that conversation becomes counter-productive and an end in itself. In 2014, when the school tried again to raise a range of serious concerns, the child protection response got lost in a welter of informal and inconsequential meetings.

7.3.5 The Board has reflected on its own part in leading and supporting the agencies" response to the emerging issue of CSE. This was in a context of underlying structural weaknesses - in 2012 the new independent Chair inherited a situation where the Board only met twice a year. Between 2012

and 2015 the Board was committed to developing a range of overarching improvements, tackling weaknesses in the arrangements for sharing information and tracking progress against objectives set.

7.3.6 The Board established a dedicated CSE sub-group, set up with more autonomy, scope and resources to tackle this complex area. The scope of that group is being expanded to include "Missing Children" and "Local Trafficking", with a view to expanding further to include "e-Safety" in 2017. This is designed to allow greater co-ordination and understanding across these overlapping areas. The Board as a whole is seeking to develop a more strategic, scrutinising role, and that scrutiny should include a continuing appraisal of these changes – so that the advantages which have been seen to arise from a targeted response to CSE do not get diluted by giving the dedicated group too broad a scope.

**7.4 Was child sexual exploitation recognised as an important issue locally and / or nationally by the agencies, at both operational and strategic levels?**

7.4.1 In 2009 the government published guidance[9], supplementary to the then current version of Working Together, on responding to CSE. There was a further significant milestone in January 2011 with the publication of the Barnardo's report[10] "Puppet on a string: the urgent need to cut children free from sexual exploitation", and then the government's response[11] to that.

7.4.2 Yet there is a consensus across the reports to this review that it was not until 2014 that local agencies in West Sussex started to respond specifically to child sexual exploitation. That appears slow in this context of national policy development.

7.4.3 The submission from CSC to this review is helpful in explaining that slow response, operationally. It recalls
*"the organisational pressures …following the (very critical) Ofsted Inspection in 2011".*
Managers have noted that those pressures included
*"a focus on the protection of young children, pressure on improving the performance of referral and assessment teams (and)… a culture, at that time, that there was little that could be done with teenagers that were seen as 'out of control…."*

7.4.4 Police confirm that nationally there was a growing recognition of CSE, and the role of police in responding to that, from 2012. This was the time when the former National Police Improvement Agency started to raise awareness that this was an operational issue for police. Police report that this was beginning to be recognised in Sussex but, as we have seen in their operational response to the issues leading to this SCR, progress was slow.

[9] Safeguarding Children and Young People from Sexual Exploitation
[10] Puppet on a String
[11] Tackling CSE DFE 2011

7.4.5 Progress among GPs was perhaps even slower: they report that *"there has been relatively little local awareness of CSE until the last 12 months when it has been incorporated into training sessions for GPs and highlighted by the Named GP in update emails".*
This was despite the Royal College or General Practioners publishing a Safeguarding Children and Young People Toolkit and NHS England publishing a guide for Safeguarding Children in 2014 that specifically included CSE and the role of the GP in recognising and managing CSE. Both of these were circulated widely to GP practices and practice safeguarding leads in 2014.

7.4.6 The other NHS services reporting to the review paint a similar picture. Even specialist sexual health services report that they
*"had not really known about CSE, heard of the term or connected CSE with safeguarding".*

7.4.7 Overall the agencies have openly acknowledged that they were slow to respond to a developing problem, and this is incontrovertibly illustrated in the matters leading to this review. However the report from the LSCB paints a rather different picture:
*"Identifying and responding to CSE was prioritised in 2012 with the establishment of the WSSCB CSE strategic sub-group. Throughout 2013 the focus on the CSE grew with the establishment of the Multi-agency CSE operational group which identified young people at risk of CSE (red, amber, green rating) and coordinated a multi-agency response."*

7.4.8 The Board can also demonstrate actions taken to try to equip the workforce to meet this developing challenge:
*"In 2012 the Barnardo's Sussex Be Safe service was commissioned to deliver multi-agency awareness raising training. These were two hour briefing sessions on spotting and responding to the signs of CSE".*

7.4.9 However the discrepancies with the reports from the agencies suggest that the Board's strategic response was some way away from what was happening "on the ground". The 2015 Ofsted inspection of the WSSCB found evidence of good work with some individual young people but still recommended that:
*'The LSCB should improve its understanding of the local nature and prevalence of child sexual exploitation (and associated issues)…. to support the development of strategic multi-agency responses in these areas.'*

7.4.10 The importance of that recommendation is underscored by the events leading to this review. The Board will need to satisfy itself that it is accurately informed by the feedback from operational agencies, and that there is an appropriate response to that.

**7.5 What did local communities know, and do, about the issues leading to this review?**

7.5.1 The events leading to this review centred on an address in a small, local shopping precinct. Over the years that address attracted visits from very many young people, who at times must have been visibly affected by their experiences at the flat. It is hard to imagine that local residents and workers did not have concerns about what they will have seen. The flat was near to the secondary school the girls attended. The girls would leave school, come to the flat and the men would purchase cigarettes and alcohol for them. It is highly likely that the local shops would have been aware of this activity.

7.5.2 However, there is no significant indication of local concern in the reports submitted to this review. Police, the agency most likely to have picked up community concerns, identified only one relevant instance: while they were responding to a complaint about noise caused by local children, a resident also complained about the number of young people who were going to the flat, and being rude and troublesome to other residents. No action resulted from this and, overall, police report that
*"There are no police records that indicate that local communities were aware of the activities involving young girls at (the address)"*

7.5.3 The "child care" agencies working in the community, CSC and the YOT, did not pick up any concerns. The local GPs had no inkling of these matters before this review was initiated.

7.5.4 Even the school, the agency most alert to these issues, responded to the observations of their own staff, not because parents were raising concerns about their own children or others:
*"There is no evidence within the school records …that suggests there were any concerns raised by local residents to the school about school aged children frequenting the address".*

7.5.5 This was not Bradford[12] or Rochdale[13], localities with large Asian communities within which vulnerable white girls were abused. These events took place in a small, largely white suburban community. The fact that, in that context, the men were black and all the girls, it is reported, were white might have been expected to lead to some community response, but we have received no indication of that.

7.5.6 This review has not received enough information about the local community to allow us to comment reliably on why there was no identifiable moral outrage at what was happening to these children, although the input from the family which did contribute to the review (Para 6.3) was enlightening. Nonetheless the Board needs to ensure that wider communities know what to do, if they should have such concerns. As the CSC report notes
*"Raising community awareness to the risks of sexual abuse and exploitation is critical to preventing further abuse".*

[12] Autumn, a Serious Case Review - 6 December 2016 http://bradfordscb.org.uk/?page_id=60
[13] Rochdale SCR

**7.6 What still needs to be done to ensure that local agencies can identify and respond effectively to the concerns that have led to this review?**

7.6.1 The agencies have demonstrated that there has already been action in response to the concerns arising from this review. In 2015 the local authority commissioned external consultants to review safeguarding practice generally, and the Board carried out an internal review of its own operations. These initiatives resulted in an improvement plan for the agencies' approach to CSE which is currently being implemented. Key features of the plan are

- development and implementation of a local CSE strategy.
- development of updated CSE policy and guidance
- redesigning the function and delivery of the Missing & Child Exploitation Group (MACSE)
- redesigning forms and documentation to support a localised approach

7.6.2 The role of the MACSE Operational Group is important. This monthly meeting now provides a forum for sharing information and developing responses across the key agencies. From that a lead officer is responsible for evaluating information, identifying trends and patterns, and reporting back to the group on, for example, serial perpetrators or links with particular localities / addresses.

7.6.3 Many of the agencies have introduced new training / awareness raising initiatives and the Board has prioritised this issue in its future training plans.

7.6.4 Sussex Police identify the need to resist complacency by using an approach that does not restrict itself to responding to crime reports.
*"… Police and partner agencies need to develop a more proactive way of identifying those at risk of CSE and then actively investigating the suspected perpetrators and creating a safety plan around the potential victim. The suspected perpetrators would undoubtedly already be committing offences against other victims that the Police and other agencies were not aware of".*

7.6.5 A number of agencies comment on the need, once procedures are in place, to ensure that those procedures are followed. CSC refer back to a recent SCR in West Sussex, SCR John[14], where a central issue was abuse perpetrated by a child on other children. There were arrangements in place to guide staff in responding appropriately to this but those procedures were not followed. A key resonance with this review is that issues of public protection were set aside as a result. The Board, as well as the individual agencies, will need to take responsibility for monitoring compliance with procedures and requirements, both old and new.

7.6.6 All of the agencies have demonstrated a range of individual and joint service improvements. However the report from the Board tells us that
*"The 2015 Ofsted inspection highlighted the local lack of understanding of prevalence of CSE and the lack of a local profile".*

[14] SCRJohn.pdf – website link

Ofsted’s judgment in October 2015, suggests that there is more to be done. Any further action is now to be identified through a major audit of CSE processes and procedures in place across the LSCB and its agencies.

7.6.7 One area that needs further development is the continuing support available to young people who have been abused and exploited, as those young people become adults, perhaps parents themselves. They may no longer be eligible for young people’s services or transitional arrangements, while perhaps not meeting eligibility criteria for adult services. From what we know that would have been the case for the five girls considered here. The Board should promote a creative, enabling approach to these challenges across the agencies.

## 8. SUMMARY OF KEY CONCLUSIONS

8.1 Ignorance of CSE should not be accepted as an explanation for a failure to recognise and respond to the rape and sexual abuse of children. There were fundamental weaknesses in the standard of the work of the key agencies – the local authority and the police - from 2012 to 2015. We have described situations where there were clear failures to carry out adequate investigations in the face of clear cause for concern. Basic requirements that agencies check and track what they and their partner services are doing were not followed.

8.2 There are correspondences with the involvement of health services with these girls and their families. It is more than thirty years since health services started to develop and follow formal guidance on how to deal with under- age sexual activity. However there was minimal evidence of any awareness of this guidance in the contact between these girls and health services.

8.3 Those weaknesses stem from issues of attitude, resourcing, leadership, training and an overall lack of professional robustness, within and between the agencies. We have quoted this comment from the report from the "Operation Bullfinch" SCR in Oxford:
*"The issue is not only about how much agencies / professionals knew about …organised exploitation….The question is also whether they did well enough with what they* ***did*** *know was happening".*

8.4 At the same time, local agencies, and the Safeguarding Board itself, were slow to recognise that nationally there was emerging evidence of a widespread problem of child sexual exploitation. Then, as local awareness of the issue began to develop, that new knowledge at a strategic level did not lead to changes in operational practice, both within and between the key agencies. The Board did not act with sufficient alertness and authority.

8.5 One agency, the school, repeatedly sought to raise concerns but their voice was not heard. It was the persistence of the school, and one member of staff in particular, that eventually led the key agencies to act. However the school had not followed any formal route for escalating their concerns to more senior staff in the other agencies, or to the Board itself. This is one of the most frequent findings from SCRs and staff in all agencies need to be routinely reminded of the mechanism and arrangements for escalation.

8.6 There was no reaction or response from local communities to the abuse of these girls, even though local residents and employees must have seen the evidence of cause for concern. There is a need to raise the public profile and understanding of what child sexual exploitation is, and what can be done to prevent it.

## 9. RECOMMENDATIONS

9.1 This SCR has been overtaken by an Ofsted inspection of the Board, conducted in October 2015. One of the findings of that inspection was that *"The LSCB should improve its understanding of the local nature and prevalence of child sexual exploitation, children missing, female genital mutilation, forced marriage and trafficked children to support the development of strategic multi-agency responses in these areas".*

9.2 That recommendation includes most of the issues at the heart of this review, and there is no point in repeating them in a further list of recommendations here. The Board is already engaged in promoting and monitoring a detailed action plan in response to the Ofsted report. Links to the relevant documents are provided below[15].

9.3 There are areas, arising from this review, which are not reflected in Ofsted's report, or in the recommendations and action plans from the reviews carried out by the individual agencies. The first is the issue of the public perception of the exploitation of these girls and the absence of any evidence of public concern about what was happening. The Board has already taken some action in this respect but should continue to give this issue a high priority. This leads to the first recommendation from this SCR:

**RECOMMENDATION 1**

**The Board should**
**a) review the outcomes and impact of recent campaigns which aimed to promote public awareness of the issue of child sexual exploitation, when and how concerns should be raised and what should happen as a result**
**b) ensure that this issue continues to have a high public profile**

9.4 It was essentially the perseverance of one individual, a teacher, which eventually brought the statutory agencies to take the actions that brought exploitation and abuse to an end. Though the teacher and the school had been disappointed by the responses to previous expressions of concern, they had not taken action under formal escalation arrangements – the procedures which guide agencies and individuals where they feel they have not received an appropriate response to reports of concern. The review found that there was a need to promote a "culture of challenge" and there is consequently a second recommendation.

[15] Ofsted inspection 2015f.pdf – find weblink – of LSCB

**RECOMMENDATION 2**

**The Board should review local arrangements for escalation of safeguarding concerns so as to ensure that**
**1. those arrangements are fit for purpose and that**
**2. agencies and individuals know how and when they should be used**

9.5 The review found evidence of very basic failures, particularly by health professionals, to respond appropriately to the issues of consent which arise when children and young people present in connection with sexual activity. This leads to the third and final recommendation from the review.

**RECOMMENDATION 3**

**The Board should produce information which reminds agencies and practitioners of their duties, responsibilities and of best professional practice when receiving reports of sexual activity by children and young people.**

## APPENDIX A: THE LEAD REVIEWER

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on some 50 Serious Case Reviews in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile Serious Case Review reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He served as a magistrate in the criminal courts in East London for 15 years.