



Bristol Safeguarding
Children Board

making safeguarding everybody's business

The Brooke Serious Case Review into Child Sexual Exploitation

Identifying the strengths and gaps in the multi-agency responses to child sexual exploitation in order to learn and improve.

Final Report

Jenny Myers and Edi Carmi

Contents

1	INTRODUCTION	1
1.1	Why this review was undertaken	1
1.2	Terminology	2
2	CHILD SEXUAL EXPLOITATION - CURRENT POLICY, PRACTICE AND DEFINITIONS	3
2.1	Introduction	3
2.2	Local context Bristol	3
2.3	Local context the other Authority	4
2.4	Definition of CSE	6
3	SUMMARY OF THE CASES	8
3.1	Brooke 1	8
3.2	Brooke 2	8
3.3	The Children and their families	9
3.4	The professionals involved	9
3.5	The perpetrators of abuse	9
4	MESSAGES FROM THE CHILDREN INVOLVED	11
4.1	Introduction	11
4.2	Messages for professionals	11
4.3	Messages for other children who may be at risk	12
5	METHODOLOGY AND PROCESS OF THE REVIEW	13
5.1	Introduction	13
5.2	Methodological comment and limitations	14
5.3	Timeframe	14
6	APPRAISAL OF PRACTICE	15
6.1	Introduction	15

6.2	Overview	15
6.3	Before recognition of wider sexual exploitation in Bristol [October 2011 to December 2012]	16
6.4	Incidents of abuse increase, leading to police identification of organised sexual exploitation in Bristol [January to May 2013]	18
6.5	Practice during police investigations [June 2013 -May 2014]	22
7	THE FINDINGS	24
7.2	Finding 1	26
7.3	Finding 2	33
7.4	Finding 3	38
7.5	Finding 4	43
7.6	Finding 5	46
7.7	FINDING 6	52
7.8	Finding 7	54
8	CONCLUSION	61

1 Introduction

1.1 WHY THIS REVIEW WAS UNDERTAKEN

- 1.1.1 This serious case review (SCR) was commissioned jointly by Bristol and an unnamed local safeguarding children board (LSCB) in August 2014 following the decision made by the respective LSCB independent chairs that the criminal investigations into child sexual exploitation (CSE) in Bristol between December 2012 and May 2014 met the criteria set out in Working Together To Safeguard Children (HM Government, 2013) for a serious case review (SCR). The unnamed LSCB is subject to reporting restrictions to protect the identity of the victims, some of whom are now over the age of 18. Hence the report will refer to this LSCB and local authority as the 'other authority or LSCB'.
- 1.1.2 This complex serious case review concerns the sexual exploitation of a number of children, which the police began to investigate from May 2013. The police named the investigation Operation Brooke. It commenced following the recovery of a vulnerable 14 year old missing girl from an address in Bristol. The girl came from the unnamed authority. Three men were initially arrested and subsequently placed on police bail. This victim gave a video interview detailing concerning events at this address that led to the identification of more victims and more suspects.
- 1.1.3 The investigation became increasingly complex and challenging in both size and nature and as such it was decided to transfer management of the investigation into a major crime setting. This was the first time Avon and Somerset Police had managed a CSE investigation in such a manner, an approach traditionally taken for other major crimes such as murder. At a very early stage engagement took place with the Crown Prosecution Service and the allocation of a specific senior lawyer from the Complex Case unit advised and supported the team. The operation continued to develop in size and as such was split into Operation Brooke 1 and 2.
- 1.1.4 Brooke 1 concentrated around the original address where abusive activity with children was intertwined with other criminality such as the supply of controlled drugs. This offending was reflected in the subsequent indictments. Nine men were charged with offences relating to three victims. They were tried at Bristol Crown Court and eight were convicted, two men for drugs offences alone. Sentences totalled over 76 years.
- 1.1.5 Brooke 2 developed as links were identified between other cases from 2012 with further perpetrators and further victims. This involved disparate events at various locations. It is evident that there was a greater degree of planning of the abuse than with Brooke 1 which could be described as more opportunistic in nature and involved different models of offending. Brooke 2 involved a further nine defendants and six victims who were tried at a later date at Bristol Crown Court. Seven men were convicted and two acquitted. Sentences in this case totalled 40 years.

- 1.1.6 The investigation in total lasted 18 months and encountered many challenges. Advice was sought from best practice developed in other nationally significant CSE investigations both to better inform the investigation process and trial management.
- 1.1.7 There have been a number of high profile SCRs into CSE across England recently; the aim of this review was to build on this previous work. The focus was to consider the way the multi-agency system responded to CSE during the period under review (December 2012 to May 2014), to examine how effective that response was and what it tells us about the strengths and vulnerabilities of the way agencies work together to protect children at risk of sexual exploitation. Section 5.3 on methodology explains this in more detail.

1.2 TERMINOLOGY

- 1.2.1 Throughout the report the term child is used rather than young person. Whilst we acknowledge that many teenagers prefer not to be described as children, we have accepted the view of Louise Casey, expressed following the Rotherham inquiry into CSE:

"child sexual exploitation is sexual and physical abuse, and habitual rape of children by (mainly) men who achieve this by manipulating and gaining total control over those who cannot consent to sex either by virtue of their age or their capacity. It is therefore important that professionals working in the field of CSE refer to anyone under 18 as a child so their status is never overlooked."

2 Child Sexual Exploitation - current policy, practice and definitions

2.1 INTRODUCTION

- 2.1.1 Since 2009 there has been growing government scrutiny of local authority and LSCB arrangements for identifying and responding to child sexual exploitation alongside an increasing media interest. Any statutory serious case review of CSE has to be understood in the context of such public interest and at the same time ensure that there is a balanced view. By its very nature CSE is shocking and it is easy with the benefit of hindsight to be critical of professional practice that children at risk were not recognised as such. CSE is complex and we hope that this review provides more understanding of the systemic difficulties there have been for professionals working with children at risk of sexual exploitation and what we have learnt about the way agencies can work together to better protect children from perpetrators of this form of abuse.
- 2.1.2 Some of the findings are not new and have been explored before in the recent serious case review in Oxford (2014) and the inquiries into CSE in Rotherham (Alexis Jay, 2014). But the circumstances in this review are very different to that which existed in 'Rotherham'. Through the lead reviewers' additional scrutiny of local leadership as part of the process, alongside professional practice, we have been reassured that there was no endemic failure to act on concerns once they were clearly identified. The Brooke 1 and 2 investigations are recognised by the senior leadership to have demonstrated a model of good policing and multi-agency practice with a child led rather than crime led focus and this should be acknowledged.

2.2 LOCAL CONTEXT BRISTOL

- 2.2.1 In Bristol multi-agency guidance on CSE has been in place since 2010. The Bristol Safeguarding Children Board (BSCB) recognised the importance of CSE and in 2012 established a CSE strategy group that reported into the full Board. BSCB undertook a CSE self-assessment exercise in 2013 and an audit of CSE cases in 2014. Ofsted stated of this audit that CSE work was 'much improved in quality and is appropriately focussed around the "See me, hear me" framework'.
- 2.2.2 The BSCB reconfigured the strategy group into the CSE sub group of the LSCB in October 2014. The chair of the group is a member of the executive group and the full strategic safeguarding board. It has good membership and a clear action plan that sits under the BSCB Business Plan. The Violence against Women's and Girls Strategy Group under Safer Bristol also reports into the BSCB.

- 2.2.3 A children missing from home and care strategy group has been in place since 2009. It was established in response to the *Statutory guidance on children who run away and go missing from home or care (DCSF, 2009)*¹ and reports annually to the BSCB. BSCB Guidance was first published in 2011, and revised 2015.
- 2.2.4 Since 2007, BSCB has commissioned Barnardo's BASE service, to provide partners with regular training relating to CSE and missing children; training has increased recently to four times a year. Data on which agency has attended training is reported on a quarterly basis. In response to the lack of schools attendance on the training, which was highlighted as an issue in 2013/14, head teachers were provided with a separate briefing. Plans are in place to link training with the new Safeguarding in Education team. Since 2011 health professionals accessing the CSE course have included: Child Protection Trainer/Liaison Nurse, Health Visitors, a GP - Link GP for Child Protection, Chlamydia Screening Nurse, Family Nurses, a sister and child protection nurses.
- 2.2.5 As part of 4YP Bristol (Public Health commissioned sexual health services), a number of sexual health courses are delivered by Barnardo's BASE open to everyone who works with children in Bristol.
- 2.2.6 The recent CSE strategy for Bristol been praised by the Home Office review (Understanding Local Response to CSE, March 2015) which stated:
- “Bristol is building on its successful large operation and has put together a strong strategic vision and action plan. It benefits from a long established partnership with Barnardo’s which provides strategic input and challenge as well as delivering a range of support services to children and young people at risk of sexual exploitation as well as victims and survivors.”*
- 2.2.7 CSE network meetings were established in 2013 but have currently stopped. They are in the process of being re-convened but this will be in line with the successful Innovation Fund Bid by Police, Barnardo’s and local authorities across SW on West of England Child Sexual Exploitation Victim Identification and Support Service.
- 2.2.8 The Ofsted report commented “the lead member for children has used her role on the scrutiny commission to challenge the people’s directorate about how it is responding to CSE in the light of the Jay report and to maintain a sharp focus on this area”. The lead member has attended the BSCB training on CSE and has recently requested a briefing from the training to be circulated to councillors.

2.3 LOCAL CONTEXT THE OTHER AUTHORITY

- 2.3.1 The local Council and LSCB recognised the issues around CSE in 2010 and had a functioning CSE Sub group earlier than many other LSCBs. There was a strong strategic understanding

¹ <http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/DCSF-00670-2009.pdf>

and lead. It was understood that the desired approach to service delivery would inevitably take time to embed in the front line, something that Ofsted also highlighted when they conducted an inspection using the new 'Single Inspection Framework' for Children's Services.

- 2.3.2 The LSCB Child Sexual Exploitation and Runaways sub-group was established in 2008 and worked to address the 'Tackling Child Sexual Exploitation: Action Plan' as set out by the Department for Education in November 2011. The sub-group was reconfigured recently and renamed CSE and Missing Children. The sub-group has had a consistently strong membership of multi-agency partners and reports to the LSCB annually and to its Executive quarterly.
- 2.3.3 Working with another LSCB, the LSCB developed the Joint Protocol for Children Missing from Home and Care in 2012. The protocol was designed to support effective collaborative safeguarding response from all agencies involved when a child/young person goes missing.
- 2.3.4 The LSCB led on the development of a Risk Panel in 2012 aimed at supporting multi-agency protocols used to identify and coordinate support for children deemed as being at risk or at high levels of risk, including those at risk of CSE. Children's Services then, in early 2013, established a multi-agency risk panel (MARP) with its partners, explicitly and pro-actively action planning, risk assessing and intelligence gathering on known or suspected cases of CSE.
- 2.3.5 The LSCB also developed a 'Professional's Handbook for Tackling CSE' in 2013. This was designed to support professionals in the identification and assessment of CSE and also outlines the board's approach to tackling exploitation. The Board also developed CSE pocket guides to raise awareness and provide guidance to workers.
- 2.3.6 The creation of the board's CSE Action Plan enabled the prioritisation, resourcing, co-ordination and progressing of key deliverables of the CSE Strategy. The plan is being refreshed against its new priorities, developed in line with the findings of two joint Police led intelligence and information sharing profiles, sometimes called 'problem profiles'.
- 2.3.7 As part of the CSE Action Plan, the LSCB commissioned 'Chelsea's Choice'² to raise awareness of CSE in Secondary Schools. The first performances were delivered in early 2014. In 2015, the production was taken up by every secondary school for year 8 pupils plus additional performances at the Pupil Referral Unit and a special school, in total reaching 1,500 children. There were three additional performances, at a local FE college, a session for 150 workers and volunteers, and a session for parents held at a local centre. Since 2013 the Board has provided multi-agency training in relation to CSE commissioned from external specialist providers.

² 'Chelsea's Choice' is a powerful theatre production aimed at highlighting the risk of child sexual abuse and on line grooming to raise awareness of CSE in secondary schools.

- 2.3.8 The Council Children's Services were going through change during 2013 and into 2014 with some key staff vacancies at senior, first tier and social work levels being covered by interim or agency staff. During 2014 there was a restructure of the social work service that aimed to enhance the manager/worker ratio, and improve oversight and supervision. There was explicit recognition of the need to further improve services including in the area of CSE as well as other key roles and aspects of child protection and safeguarding work and this was supported by a recruitment campaign and additional funds. During this period of time there had been overt police action, working alongside Children's Social Care that enabled a reasonable understanding of possible CSE activity noting that there were no explicitly known groups or gangs, but a profile of opportunistic and boyfriend model of grooming, predominately (but not exclusively) white British men.
- 2.3.9 The Council also had good elected Member engagement with the Lead Councillor for Children's Services taking a pro-active role in raising awareness across the whole Council and its partners, Councillors were briefed on CSE and presenting factors and offered training. Other senior managers reported to the lead reviewers that there has generally been good engagement and working across all the political parties towards this area of work.
- 2.3.10 A Council CSE strategy was agreed in early 2014 to ensure a whole Council approach to its work and to supporting the work of the LSCB and its partners. The Council was very much aware of the issues and alert to the learning being shared from across the Country. This is reflected in the LSCB CSE strategy.

2.4 DEFINITION OF CSE

- 2.4.1 The sexual exploitation of children (under 18) involves exploitative situations, contexts and relationships where the young person (or third person/s) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing and/or another/others performing on them, sexual activities (UK National Working Group for CSE (NWG)). A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see himself or herself as a victim of exploitation this can refer to:
- Inappropriate, sexually exploitative relationships where the young person believes the abuser to be their boyfriend or girlfriend, perceiving him/herself to be in a romantic relationship with this individual
 - Groups of adults abusing children, often through a particular adult seen as a "boyfriend" by the victim of the abuse
 - Abuse of children via the internet, which can include online grooming of children, particularly through social networking applications; this could be either 'non-contact' abuse (for example, through encouraging the child to share sexually explicit images or streaming of sexual abuse) or develop from online abuse into face-to-face meetings, which can lead to contact abuse.
 - Peer-on-peer exploitation, particularly by gangs and other peer groups, including sexual abuse as part of group's rituals of 'initiation' or 'punishment'

- Trafficking - where children are moved away from their locality, hometown or from abroad to other locations, for the purpose of sexual exploitation
- Violence, coercion and intimidation are common; involvement in exploitative relationships being characterised in the main by the child or social/economic and/or emotional vulnerability.

2.4.2 There was a significant difference in the way the children in Brooke 1 and 2 experienced sexual exploitation and this is highlighted in the findings and analysis of why at times there was a delay in professionals recognising the abuse, especially when it was perceived as underage sexual activity more in line with the boyfriend model. Finding 2 discusses more about the way definitions of abuse including sexual abuse can detract and confuse from safeguarding children.

2.4.3 It should also be recognised that one of the features of the Brooke investigation and subsequent prosecutions was the intertwining of criminal activity centred on drugs with the sexual abuse and exploitation of children.

3 Summary of the cases

3.1 BROOKE 1

- 3.1.1 The offences centred on activities at an address in Bristol from January 2013 to May 2013, where a vulnerable 16 year old girl was living in supported housing following a Youth Court direction for her to be placed out of her home area and accommodated by the local authority. She quickly became involved with a group of Class A drug dealers who identified her premises as an ideal location from which to run their drug dealing activities. These men were mainly aged in their early twenties. The flat was used for drug dealing and frequent parties. A number of men sexually exploited the young person by paying her and selling her for sex, they also encouraged her to provide them with other young victims. She was paid in money, drugs and alcohol. She subsequently disclosed that she had been raped on two occasions.
- 3.1.2 Other children (including three other victims) came to the flat invited by the older girl, at different times, where they also came into contact with the offenders in Brooke 1. The other victims were aged fourteen and fifteen years old.
- 3.1.3 In May 2013 police started working with one of the victims to gain her trust and seek information as to what was happening at the address. She had initially been viewed as colluding with the perpetrators to entice girls to the flat, but once interviewed was recognised by police as a victim. She disclosed that she had recently been raped and the men alleged to have been present were arrested. Significant forensic evidence was found to provide evidence that an offence had taken place. Subsequently other victims made allegations of rape against different men.
- 3.1.4 Considerable work over a lengthy period of time was undertaken to build up trust and confidence with the victims, so as to enable them to disclose the extensive sexual and physical abuse they had suffered, including rape. Close liaison with the Crime Prosecution Service led to the charging of 9 men. Offences included, possession of indecent images, paying for sexual services of a child, rape, and Class A drug offences.

3.2 BROOKE 2

- 3.2.1 Brooke 2 police investigation related to allegations around the sexual exploitation of 6 vulnerable children in the Bristol area. The offending dated back to early 2012. The defendants were all young men (18 to 23 years old) and whilst they cannot be described as a cohesive group there are links between them. Some of the offences have involved multiple offenders and victims.
- 3.2.2 The trial covered some 35 offences, which took place at various locations and times within the Bristol area. The offences cover allegations of rape, arranging payment for sexual services of a child, sexual activity with a child under the age of 16 and trafficking (for sexual purposes). Only one of the defendants also stood trial in Brooke 1. He was acquitted of the rape of a 14-year-old girl but pleaded guilty to drugs offences.

3.3 THE CHILDREN AND THEIR FAMILIES

- 3.3.1 The child victims came from a range of backgrounds and ethnicities. We cannot emphasise enough the trauma that the children who were subjected to sexual abuse and exploitation experienced. Many of the crimes committed against them were horrific and beyond most people's comprehension. However the bravery of the children who were interviewed and also those who gave evidence to the courts should be commended. For some they are moving on with their lives, for others, it is important to recognise that a court conviction does not make everything better and their lives continue to be chaotic, abusive and risky.
- 3.3.2 The review team offered the victims the opportunity to participate in this review. Five chose to do so: two of the three girls who were the primary focus of the review, one from Brooke 1 and one from Brooke 2 met with members of the review team as did three other child victims from the Brooke 2 investigation. Their courage, wisdom and wish to contribute to the learning for professionals and other children should be applauded and we are very grateful for their input. Where possible we have tried to incorporate or share their specific experiences without identifying them. We have also included their messages to other vulnerable children and to professionals in section 4.
- 3.3.3 The review team also met with four of the parents; again their stories and experiences were traumatic and it was hard to hear how at times they felt they had not been taken seriously or listened to at an early enough stage. There is much to learn from them and where applicable we have incorporated their feedback into the report and findings.

3.4 THE PROFESSIONALS INVOLVED

- 3.4.1 All the professionals involved in this review have been affected by the emotional trauma that the children suffered. The review team worked hard to engage the key practitioners that had worked alongside the three children and the wider cohort of children and are very grateful for their commitment to participate, especially those staff who have retired, left the area or who are on career breaks, all of whom willingly agreed to come back for conversations, and case group discussions. For many of the staff it is important to recognise the emotional impact that this work has on them, something that is often underestimated.
- 3.4.2 Three case group events were held involving 38 practitioners and managers all of whom had had contact with the children. The lead reviewers facilitated two GP practice meetings, and individual conversations were held with a number of staff.
- 3.4.3 The lead reviewers also met senior leaders, including LSCB chairs from both authorities on two occasions to consult and brief them on the review and then ask them some pertinent questions about what was known at the time and where they felt they were now.

3.5 THE PERPETRATORS OF ABUSE

- 3.5.1 The group of perpetrators in Brooke 1 and 2 were young men in their early 20s at the time of conviction and this feature is significant and different to previous CSE reviews. They all have a Somalian background; many of them came to the UK as refugees fleeing violent conflict

and trauma in their home country. It has not been possible to explore the impact of this background context on their own development but it is an area that should be considered. However, the review could find no evidence that their ethnic origin was a key feature; they were a diverse group who had no obvious connections.

3.5.2 As part of the review two of the convicted offenders, one from Brooke 1 and one from Brooke 2 volunteered to be interviewed by the lead reviewers. Their experiences of life in the UK were very different, one coming from a well-educated background, the other who had experienced more hardship. Both young men very much identified themselves as western and integrated in the UK. There is much more to learn from perpetrators childhood experiences in order that professionals gain more of an understanding of risk areas and how to identify early warning signs.

3.5.3 Whilst there has been quite rightly a spotlight on the experiences of victims the need to focus more on perpetrators and prevention was highlighted by Louise Casey reflecting on Rotherham in March 2015:

“child sexual exploitation is child abuse and it is a crime. Our efforts need to be directed towards perpetrators in order to detect, prevent and disrupt that abuse at the earliest stages as well as the prosecution of individual perpetrators...”

4 Messages from the children involved

4.1 INTRODUCTION

The five children who agreed to participate in this serious case review have articulated important messages for professionals and other children. Their views are not all the same, but include wanting to provide messages for both professionals and other children at risk of sexual exploitation.

4.2 MESSAGES FOR PROFESSIONALS

- *Recognise that it is very hard for us to see ourselves as victims and therefore to have any insight into what help we need. When we are displaying difficult and challenging behaviour, we want professionals from all agencies to have a greater awareness of this, especially schools. "Don't just exclude us for not wearing the right uniform, help us if we are being bullied" We also want schools to know how to work better with parents especially when you are being bullied or having trouble making friends.*
- *Know it is really embarrassing to talk about sexual things to adults, especially if those sexual experiences have hurt you. We want professionals, including sexual health nurses and GPs to ask us better questions, be more inquisitive and if necessary to examine us when we ask for morning after pills, or seem very young for contraception. We may have hidden bruises and marks, so do not take everything we say at face value. Don't get so hung up on confidentiality, sometimes you do need to share what we have said.*
- *Understand that if we do talk about sex it is really important that you must not look embarrassed or go red, this just shuts us up. Your embarrassment stops children talking.*
- *Some people became really important to us leading up to court and when the trial is over we miss them.*
- *Be clear that it is so hard to say what is happening and we really worry it will get back to our families; we are also worried that we may get hurt by some of the people who did this if they found out I/we had told (an attempt to tell resulted in one child being gang raped).*
- *It is difficult to trust teachers, as soon as you speak we worry they will ring our family and this will get back to the perpetrators. However we want teachers to notice behaviour changes, to try and talk to us and notice our unhappiness. Do not blame us or ignore us, but explore behavioural changes with us and sensitively involve our parents understanding risks for us.*
- *Having BASE (Barnardo's CSE project) there was really good, we met others in the same situation and workers are kind and listened to us but also we did stuff, like cooking and making things, at CAMHS they just want us to talk about the past and that is too difficult. If you want us to share, do stuff with us; find places that are comfortable out of your offices, though not just McDonalds. The Barnardo's healthy relationships and risk awareness project was very good. All children at risk need a safe refuge to go to like BASE; this is very important.*

- *If we go missing our families need advice quickly on what to do. If you don't trust us or don't believe what we say, follow us and check it out. Parents should not get angry if we go missing but try and make us feel loved and that we can tell them anything.*
- *Think about whether social workers could be called something else as it does not describe their job very well. One child said social workers are, "suffocated by rules and professionalism". We wanted social workers to listen better, build relationships and find ways to connect with us. They wanted agencies to employ the right people. Also understand we are really scared of being taken into care, please support us better at home. Our Mums' need a separate social worker not the same one.*
- *The public need to be aware of what can happen and report what they see, if children are in a hotel with a group of older males this is not normal, ring and tell the police.*
- *Have services available on demand and at night, this is when we really need you, when you need support it can be really lonely at night. We need help over a long period of time as it takes time to build trust and confidence. Once we are over 18 we will still need help, and BASE are not allowed to stay with us: we may not be ready for adult services.*
- *Passing on information makes us very anxious, so a lot of stuff does not get said. We know you need to do it, but it puts us in very risky situations if it gets passed around the community.*

4.3 MESSAGES FOR OTHER CHILDREN WHO MAY BE AT RISK

The key tip was, "don't hang around with people that you are not willing to take home or that you would not hang around with together with their families". Other important tips are:

- *Stay away from Facebook*
- *Don't try to fit in with your friends by using drugs and smoking, try and have self worth and self-respect and talk to an adult. True friends can be helpful but sometimes it hard to see whom your true friends are and they may spread stuff about you around.*
- *Go home and call police, tell someone- don't worry about being embarrassed, it happens to others and they will understand*
- *Speak to teachers*
- *Try not to dwell on things that have happened, think of other things*
- *Let counsellors talk to you and help you sort your head out*
- *Having someone work with your Mum and family really helps*
- *Finally, if you feel someone is not safe (what was described as the Jimmy Saville feeling) tell someone, you are almost certainly right.*

5 Methodology and process of the review

5.1 INTRODUCTION

- 5.1.1 Bristol and the other LSCB commissioned two independent lead reviewers Jenny Myers and Edi Carmi, both of whom are accredited with SCIE to undertake a serious case review using a systems based approach. Both LSCBs wanted to identify not just what happened but why, to enable a drawing out of wider factors that influence not only local professional practice but also strategic leadership more generally in order to identify specific findings for learning and improvement. They also wanted to ensure that the experiences of the children involved and their families were an integral part of the process.
- 5.1.2 In light of the recent report into CSE in Rotherham (Alexis Jay 2014) it was important to ask how much was known at a senior level as well as front line practice about the risks to children and how well coordinated was the multi-agency response, including the identification of perpetrators.
- 5.1.3 The key question that the review wanted to answer was, 'What were the strengths and gaps in the current multi-agency strategic and operational response to CSE in both Bristol and the other authority?'
- 5.1.4 The data was gathered from a variety of sources, including agency records and documentation, alongside information provided directly by front line practitioners and their managers with involvement with the victims or perpetrators during the time line under review. Within the report these individuals are referred to as '*the case group*'.
- 5.1.5 The review has involved a number of key strands:
- Engagement with senior leaders in both authorities to understand what they knew at the time and whether they had an effective response to the growing recognition that a number of children were being sexually exploited by young men from the Somalian community who were involved in drug and substance related criminal activities.
 - Involvement of a case group of practitioners who worked primarily with three of the children who were witnesses at the Brooke trials.
 - A review team of senior managers from both LSCBs who worked with the lead reviewers to undertake the review
 - Wider conversations with parents, and children who were victims of CSE in Brooke 1 and 2
 - Interviews with two of the convicted perpetrators who were serving prison sentences.
 - Group discussion with practitioners and managers in the National Probation Service.
- 5.1.6 Further information about the Learning Together SCIE methodology for case reviews can be found on the web site <http://www.scie.org.uk/children/learningtogether>
- 5.1.7 More details on the methodology, data sources and structure of the review process including any acronyms used and terminology is found in the glossary at the end of this report.

5.2 METHODOLOGICAL COMMENT AND LIMITATIONS

- 5.2.1 Any serious case review of this nature has to work hard to be proportionate and limit the amount of data and details that it can explore. The decision to focus on three children in depth was made by the joint operations group, (established to oversee the commissioning scope and governance of the SCR) from the two LSCBs in consultation with the lead reviewers. The aim was to ensure that by looking at a smaller number of children with different experiences, but who gave evidence at the trial it would help make the review proportionate and enable the group to consult with practitioners who had worked with the girls throughout the time period.
- 5.2.2 In addition, in order to obtain a wider understanding of the strengths and weaknesses in the multi-agency system the experiences of the other victims and two perpetrators were additionally explored.
- 5.2.3 This review has been more complex because it has been jointly commissioned by two LSCBs. Whilst there have been many benefits of looking at both authorities and partner agencies and working jointly, there are some limitations too; because the events took place mainly in Bristol inevitably more has been learnt about Bristol multi-agency practice than that of the other authority. This is reflected in the findings. In addition both authorities are different in size, in composition of diverse communities and have a different culture and political leadership.

5.3 TIMEFRAME

- 5.3.1 The time period considered for victims of Brooke 1 was Oct 2012 to May 2013, and involved a focus on one girl's experience with exploration of common factors with the three other victims. The time period for victims of Brooke 2 was Nov 2011 to May 2014, and involved a focus on two girls and an exploration of common factors with the wider cohort of victims.

6 Appraisal of Practice

6.1 INTRODUCTION

- 6.1.1 The appraisal of practice provides an overview on what happened in this case. This clarifies the view of the review team about how timely and effective the help that was given to the children and their families, including where practice was below expected standards. The reasons for this are explained and/ or cross referenced to **section 7 [The Findings]**, where what happened provides evidence of wider systemic vulnerabilities in local and/or national safeguarding practice.
- 6.1.2 The key features of professional practice in relation to the victims are detailed and appraised below. Whilst Brooke 1 and Brooke 2 involved children from different local authorities the Review Team found that there was significant commonality in the appraisal of practice relating to all the children. Hence we have only identified separate comments where the judgements specifically relate only to one of the LSCBs.
- 6.1.3 See section **1** and **3** for the description of the offences that have led to the review.
- 6.1.4 This practice appraisal will not provide an account of professional practice relating to each of the children, so as to avoid detailed confidential information being provided on any of the children. Instead it examines the professional responses over time and how this changes.
- 6.1.5 The appraisal relates to three separate time frames characterised by the stages at which professionals were aware of the nature of the risks to the children and the associated professional response:
- 6.3: Before recognition of sexual exploitation [October 2011 to December 2012]
 - 6.4: Concerns increase, eventually leading to police identification of organised sexual exploitation [January 2012 to May 2013]
 - 6.5: Practice during police investigations [June 2013 -May 2014]

6.2 OVERVIEW

- 6.2.1 The Review team were struck by the professional commitment to the children by many of the practitioners; the efforts made to support and protect the children and the quality of relationships built with them over time. There is though recognition that despite such commitment, these children suffered significant harm, that there was a considerable delay at times in identifying what was happening to them and understanding the nature and extent of the abuse and exploitation they were experiencing. Where it was identified, professionals did not always receive adequate supervision to provide them with the tools and advice needed to respond or escalate their concerns effectively. The consequences of this was that especially for some, professional boundaries became blurred as workers felt very responsible for trying to keep the children safe and working all hours to react to increasingly difficult situations without adequate single or multi-agency support. Barnardo's BASE workers, were however particularly praised by both other professionals and the children, for their immense support and expertise.

6.3 BEFORE RECOGNITION OF WIDER SEXUAL EXPLOITATION IN BRISTOL [OCTOBER 2011 TO DECEMBER 2012]

- 6.3.1 In this early period various reports were made to the police and children's social care from BASE³ and others about some of the children being involved in sexual activities and sexual abuse concerns. In general professionals from all the key agencies were slow to recognise during this time period that sexual exploitation of any of the children was taking place. They did not listen enough to the concerns of parents who were describing it and seemed to view it as consensual underage sexual activity. In school, head teachers responded to poor attendance and difficult behaviour by excluding children, often not being notified by other professionals that the young person had just been missing and had experienced significant sexual assaults. The limited communication and sharing of information between professionals and agencies is discussed in finding 1.
- 6.3.2 The lack of proactive police investigation in the absence of a consistent allegation by a victim was a feature of practice at this time. This meant that criminal investigations were ended prematurely, alleged perpetrators not interviewed or not in a timely manner. There were times, when for very understandable reasons the children were unable to engage or be consistent in what they were reporting and this caused problems for the police who were keen to uphold evidential thresholds. Moreover other sources of evidence were not followed up sufficiently quickly, such as potential evidence on mobile phones. The impact of this was twofold, no steps were taken to protect the individual victim from specified alleged abusers and other children were left at continued risk. At the same time information was not being gathered from other sources, such as GPs.
- 6.3.3 The case group explained, that apart from BASE staff, they felt they had received little training on indicators of sexual exploitation and although they knew something was wrong they could not name it. At the time in both authorities there was training available but even workers who had attended this struggled to link what they were seeing when working with the young person. For one child an original complaint to Avon and Somerset police of sexual assault, made in August 2012, was not followed up for five months and even then it was done so superficially. The young person at the time was aged 11 and it would seem that had investigating police officers looked into it, that there was video and other social media evidence of her assault. The Police officer reported to the lead reviewers that they felt the decision not to do anything was heavily influenced by the police view that a successful prosecution was unlikely. The young person reported to one of the lead reviewers that this failure to make further inquiries or validate her assault had greatly affected her mental health and relationships with her peer group.
- 6.3.4 The risk of sexual exploitation was recognised after two girls aged 15 years old went missing and travelled to other parts of the UK to meet males they had 'met' on Facebook. However,

³ Barnardo's against sexual exploitation (BASE) is a specialist CSE service based in Bristol.

on their return the girls did not themselves make allegations and the police did not consider they were being groomed so no further investigations were undertaken. However as a result of this, one young person was appropriately referred to the UKHTC (UK human trafficking centre) for her to be assessed as a victim of internal trafficking and to BASE. This was good practice but also highlights that there may be an inconsistency regarding whether other children at the time were recognised as potential victims of human trafficking.

- 6.3.5 All of the girls began to be seen during this time period by both their own GP practices and other local sexual health providers, though at the time no patterns or links were made and information about early prescribing of contraception, and other concerning sexual health related matters, were not viewed as concerning or worth sharing. This is discussed in finding 5.
- 6.3.6 One Brooke perpetrator aged 18 was involved with a 12 year old child in this period, but both the child and her parent perceived this man to be under the age of 16 years old himself, as well as being in a relationship with the girl concerned. Professionals were unaware of this relationship and when the GP in Bristol became aware she was in a sexual relationship she was then aged thirteen years old. Contraception was provided, as it was understood to be a consensual relationship with a 14 year old boy. At the time she was accompanied to the GP by a family member, which may have influenced the view that she was living in a protective environment and able to consent. In discussion with the lead reviewers the health staff at the GP practice acknowledged that actually it was unusual for a 13 year old girl to seek contraception, or emergency contraception and that it should have triggered more professional curiosity and action, as indeed the child herself commented (see section 4).
- 6.3.7 A GP made an appropriate referral to children's social care at the end of 2012 following his concerns about the sexual health of a young person aged 13 and information that the parent had shared with him. This resulted in a child protection conference and a service being provided by BASE. However, it had taken months to reach this stage of recognition despite a history of sexual health problems and concerns about her emotional health following an earlier sexual assault.
- 6.3.8 Information provided to police and partner agencies in December 2012 suggested at least two children had been taken to a hotel and raped by a group of men. The investigation had shortcomings. Without health representation at the initial strategy discussion one child was taken to the SARC (Sexual Abuse Referral Centre), which did not have a paediatric focus and is not recommended for children under 14. She subsequently chose not to make a complaint to Avon and Somerset police or consent to a medical examination. There was no real knowledge at this stage of any perpetrators of sexual abuse and exploitation against any of the girls, and the criminal investigation was closed without identifying perpetrators of sexual abuse or exploitation. Conversations with the children conducted by the review team emphasised they need time to build up relationships and trust before they disclose sensitive information (see section 4).

6.4 INCIDENTS OF ABUSE INCREASE, LEADING TO POLICE IDENTIFICATION OF ORGANISED SEXUAL EXPLOITATION IN BRISTOL [JANUARY TO MAY 2013]

- 6.4.1 During these five months the incidence of allegations and reports to police involving the victims in these two cases increased, until by the end of May 2013 both Brooke investigations were initiated.
- 6.4.2 The unnamed local authority moved one young person to the Bristol address (that later became part of the Brooke 1 investigation), following the imposition of bail conditions for criminal offending which prevented her being placed in her home authority. Magistrates made the decision to bail out of area to stop further association with co defendants and any risk of reprisals from other criminals in the area.
- 6.4.3 The young person had previously been a looked after child, but at the time of the court appearance she was a care leaver. However following the imposition of bail conditions that she 'live and sleep as directed by Children Services', legal advice to the serious case review has confirmed that her legal status would again have been Looked After⁴. She therefore continued to be subject to looked after children review processes until October 2013, when she made it clear she wished to cease being 'in care'.
- 6.4.4 As a looked after child, the unnamed local authority should have notified Bristol of her placement, but this did not occur. This may have been due to the social work team at the time not realising that the child was legally again a looked after child. Moreover, the bail conditions that were imposed by the court were clearly not in the child's best interests, and best practice would have involved some negotiation in the child's best interests prior to court, if it was anticipated, or subsequently at the earliest point. This is an unusual circumstance and legal advice and management support should have been accessed immediately the likelihood of such conditions being made was known.
- 6.4.5 The court hearing was on a Friday afternoon when there were several other children who also needed placements and suitable accommodation was hard to find. The other local authority had a good pre-existing relationship with the housing agency at this point and trusted them to provide suitable accommodation. However, the social worker herself recalled feeling distinctly uncomfortable when she took the child to Bristol, but felt helpless to find an alternative at that point of the evening. When she phoned the young person on the Monday morning, she was re-assured by her that she was fine, so did not try to find an alternative. The child has said that she felt very vulnerable and described vividly what it felt like to be left there alone on that Friday night. Finding 1 explores more about the difficulties

⁴ 'a young person who needed accommodation and therefore in accordance with the Southwark Judgment (May 2009) (Law Lords judgment: G vs. Southwark, which considered how local authorities support homeless 16 and 17-year-olds), the placement would be deemed to be under the Children Act 1989 section 20 (3) or (4)'

that agencies have in providing an effective response for troubled adolescents at the time and the pace that they need it.

- 6.4.6 This address was a supported housing scheme in an area that was widely known by the local population and professionals in Bristol to be populated by those involved in drug crime, as well as other criminal activity. To have opened supported independent accommodation for vulnerable children in an area well known for its street crime and drug dealers seems hard to understand. Neither the other local authority, who were under pressure to find three 'out of area' placements on the same day for adolescent looked after children following the court hearing, nor more surprisingly the housing agency providing the assisted accommodation to the children, knew the area at the time. In interview with the lead reviewers one of the perpetrators commented that the area was well known by everyone to be the territory of drug dealers. The young person concerned has also told the review of her shock at being left all alone in such an area as a 16 year old, how frightened she felt and the consequent attraction of becoming under the protection of the perpetrators of Brooke 1.
- 6.4.7 The housing provider's management explained to the review that their ignorance of the area's characteristics arose because of difficulties getting such information from the police and from the local authority. However in the view of the review team, the fact that the characteristics of the area are so well known, means that basic research and visiting should have alerted the provider of its unsuitability for a vulnerable young person. (The housing scheme has subsequently been relocated and now has an arrangement to obtain such information from the police).
- 6.4.8 Police were called to the flat a number of times and the young person on occasions made limited disclosures of sexual offences to social workers and care workers, but would subsequently re-assure staff that everything was now fine. What was notable on the many occasions that the young person told staff of having sex in return for drugs or money, was the lack of any child protection enquiries being initiated by the other local authority's children's social care⁵ and police. This was due to this being perceived as consensual activity by the front line staff and the fact she was over 16. Finding 3 explores why they were not more aware of the broader child protection risks.
- 6.4.9 Housing support workers who were part of the housing providers service commissioned by the local authority visited the child every day but continued to be unaware of what was taking place at the flat, including the sale of drugs, hiding of a missing child, and multiple sexual assaults. Support staff acknowledged they were also refused entry to the flat on occasions, and that the flat was broken into when she was away for a few days. In conversation the child described that she was able to manipulate workers and keep them out, but that she did tell about her abuse. Her father told the lead reviewers that he also

⁵ The local authority where the abuse is alleged to have taken place is responsible for undertaking s.47 enquiries. In this case, that was Bristol, but Bristol was only made aware of one allegation, and that was passed to the other local authority.

spoke to the housing support staff of his concerns at what was going on at the flat as his daughter had also refused him entry and he was suspicious.

- 6.4.10 The girl was asked on more than one occasion if she would like alternative accommodation but did not take up the offer. This highlights the strength of control the perpetrators had over her, how difficult it is for children to feel safe just by being moved and the dilemma staff have when they want to support a vulnerable young person without 'forcing' them to move. Finding 2 discusses how again frontline professionals lacked the support, tools and supervision to be able to effectively identify and or respond to the increasing concerns that were being raised.
- 6.4.11 For a number of the children under the age of 16, school attendance had become erratic during this period along with behaviour that teachers found hard to manage or understand. Schools struggled to distinguish the difference between disruptive behaviour and early signs of vulnerability where low attendance, poor engagement in learning, missing episodes and bullying was a feature. This resulted in a number of school exclusions, school moves or referral to alternative educational provision. The schools staff in the case group explained that whilst they perceived the children as troublesome they did not recognise fully the impact of what was happening to them or the impact on their social, emotional and mental well being, often believing that with enough support, as they were academically able, they could get the children to re-engage with mainstream school. There was not enough sharing of intelligence or information with schools by police and social care about the children's missing episodes. One child was missing for three days before the school was told. This led to a lack of understanding by school staff about the significance of missing episodes, relying only on what parents told them. They had no awareness at this time that sexual exploitation may be a factor.
- 6.4.12 A number of school staff tried hard to engage the children and keep them in school but the complexity of their behaviour was hard to manage within mainstream settings and there was a lack of adequate mental health or pastoral support available. Members of the review team explained that the reducing emphasis in schools on pastoral support and increased emphasis on learning appears to reduce the schools ability to be flexible. In addition, internal systems for record keeping in schools did not co-ordinate well with other processes for recording pastoral support, hence it has been hard to obtain any accurate records that reflect both aspects of a child's school experience.
- 6.4.13 Social media played a significant part in bullying with messages and pictures being spread easily round whole peer groups in Bristol making it very difficult for them to sustain peer relationships. School were aware of how this was impacting on their ability to engage and maintain school attendance but did not know how to address it, feeling that their own skills in this area was limited. This lack of 'tools in the tool box' was a feature of professional practice that was experienced by a number of professional groups and is explained more in a number of the findings.
- 6.4.14 The girls in the case review continued to be seen numerous times by doctors and sexual health providers all presenting with similar complaints of heavy bleeding, abdominal pains, urinary tract infections and needing tests for sexually transmitted diseases alongside

requesting contraception, pregnancy tests and emergency contraception. Often these visits coincided either with the girls just about to go missing or coming back from being missing. The reasons for such a delay in identification of child safeguarding and child protection concerns in GP surgeries and the lack of shared information between sexual health services and GP practices is discussed in finding 5.

- 6.4.15 Police officers in Bristol in the period under review were under pressure. In Bristol as a consequence of the need for austerity and cuts the police reconfigured their specialist teams into one large team, combining investigative teams dealing with domestic violence and abuse with child abuse and vulnerable adult abuse teams. The positive outcome being that combination of skills would strengthen the awareness of domestic abuse within investigations of child abuse and vice versa. All officers were expected to deal with a significant number of serious crimes and live investigations on a daily basis, the consequence was that less urgent incidents, where there was no obvious crime to investigate drifted with follow up to general concerns about what they perceived as under age sexual activity, being left for months. Finding 7 explores the impact of this more. Cases were passed between officers, incidents were logged as 'outraging public decency', rather than pertaining to child sexual abuse offences and there was no mapping of patterns and connections to other children and perpetrators.
- 6.4.16 For one of the children, there was a delay in allocating an original complaint reported to the police in March 2013, (prior to the Brooke investigation) until the following September. This delay contributed to them and other children continuing to be subject to continued sexual exploitation on a regular basis. One officer though is to be commended for her tenacity in pursuing the case further, which helped to put the jigsaw of intelligence together, which became the Brooke 2 investigation. For another young person, a disclosure of oral rape was described by BASE staff as being mishandled by Avon and Somerset police and Bristol after the victim was woken up the following morning by a number of police officers taking her to the police station alongside her social worker and parent, all wanting to question her. This not surprisingly led to her retracting the original statement. There was no recognition of the time and courage it takes for a young person to disclose and support they need to do this.
- 6.4.17 At this time police officers in the case group reported that in their view there was significant lack of management oversight and supervision by senior police officers in Bristol, there were staff vacancies and sickness and the team were viewed as underperforming. One police officer reported to us that the detective inspectors inbox could have over 100 plus crimes to review at any given time. Their view was that they could not cope and relied heavily on the detective sergeant and detective constables to raise crimes with them that were causing concern. In the other authority an officer in the case group said that the proportion of cases was fewer but that they still did not have the time to complete meaningful reviews. Finding 7 discusses more about the impact of the changes on the police service.
- 6.4.18 The police response in the unnamed LSCB to children who went missing was poor. One of the children had gone missing a significant number of times and this was seen as 'a nuisance'. One social worker commented to the review team that she and her team manager were made to feel personally responsible by the police for not being able to keep the young person in her placement and were challenged, 'do you know how much this

costs'. The other police force had some untested intelligence on the main victim including that she was being paid for sex and this was not taken account when allegations and concerns were raised. There was no evidence of agencies working together well at this time or any recognition by police officers of the increased risk and vulnerability for children who go missing, or any mapping of concerns about what might be happening in the area.

- 6.4.19 In general, the multi-agency professional response to work together and escalate concerns around the troubled and troublesome behaviour of children was not joined up during this time period. This is discussed more in finding 3.

6.5 PRACTICE DURING POLICE INVESTIGATIONS [JUNE 2013 -MAY 2014]

- 6.5.1 From May until September 2013 there continued to be some delay by police in Bristol responding in a timely enough way to early intelligence on the sexual exploitation of children. Specifically they delayed interviewing a couple of key witnesses/victims. Other agencies at the time were also slow to escalate concerns, challenge police or use their own child protection procedures.
- 6.5.2 Once the designated police teams for Brooke 1 & 2 took over the investigations there was a significant improvement in the way agencies worked together to support the children and build trusting relationships that enabled them to disclose more details of their exploitation and name perpetrators. Significant support was provided to the victims by a dedicated and skilled team of BASE staff, supported by the consistent involvement of a small team of police officers and social workers.
- 6.5.3 Victim care was at the core of all investigative and trial management decisions and processes. The senior investigating officer (SIO) told the lead reviewers that a three-tiered approach was developed to manage an effective bespoke multi-agency care package throughout, and beyond, the process. This involved the instigation and maintenance of a multi-agency gold group at the top level. This was chaired by a senior police officer and involved senior representatives of each interested organisation and agency. Strategic decisions were made to ensure resources and arrangements were in place to allow for effective victim care. At a second tier this involved group meetings on a more local level with managers from key agencies ensuring practical arrangements were in place. At the third tier a local meeting chaired by the Senior Investigating Officer ensured a core group was developed and in place for each victim and that a detailed bespoke package of care with individual responsibilities listed was in place.
- 6.5.4 During this time many of the children continued to be abused and exploited and it was hard to protect them from further harm as they continued to go missing. BASE workers continued to build relationships and trust with the children and support them to build healthy relationship and better protect themselves, slowly supporting any disclosures of information and sharing that with other agencies appropriately. However, there were little or no police disruption activities or covert work in Bristol with perpetrators during this time and the pattern of focusing primarily on the children involved and less on the perpetrators, to some extent resulted in their continual abuse. This is discussed more in Finding 4.

6.5.5 In the other authority at this time there was intelligence and covert police work being undertaken, although this was not directly in relation to Operation Brooke it did involve dealing with drugs and vulnerable persons at risk of CSE; whilst the group of children in Brooke were not part of this cohort there were other children that were identified through intelligence as being at risk of CSE.

7 The Findings

Introduction

The Learning Together methodology is based upon an approach which uses an individual case to provide a 'window on the system'⁶, finding out whether weaknesses or strengths that have been identified in a single case are more systematic and widespread, and so leading to a broader understanding about what supports and what hinders the reliability of the multi-agency child protection system.

The difference for this review was that it involved a number of children and two different authorities, nevertheless the heart of the SCIE methodology has been applied.

Summary of findings

The Review Team has agreed a number of findings that are a feature of the way professionals work together to safeguard children in the two local authority areas.

Many of the findings have national significance and whilst they manifested locally, the review team believe them to have a much wider application.

The findings highlight inconsistencies in current practice norms and the potential consequences of leaving these unaddressed. They will need to be discussed thoroughly in order to agree a way forward most suited to local circumstance.

Some of the following findings apply to both LSCBs, whilst others relate more to one locality; where this is the case it is specified in the text. Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other children and families, because they undermine the reliability with which professionals can do their jobs.

All the findings in this serious case review are in the SCIE Learning Together category of 'management systems', because they relate to national and local ways that safeguarding practice has developed across agencies in the understanding of and responses to 'troubled' adolescent behaviour in general.

Whilst most of the findings relate to the systemic obstacles in safeguarding children, we have also highlighted examples where the multi-agency system did work well following the identification of child sexual exploitation.

⁶ Analysis of clinical incidents: a window on the system not a search for root causes. C A Vincent, Quality and Safety in Health Care, (2004)

Number	Findings applicable to both Bristol and the other LSCB
1	The multi-agency system is not set up to provide an effective response for adolescents (including those at risk of CSE) with a complexity of needs at the time and pace they need it, leaving children with a fragmented and reactive response to different aspects of their behaviour.
2	A confused and confusing stance in national policy about adolescent sexual activity, leaves professionals and managers struggling to recognise and distinguish between sexual abuse, sexual exploitation and/or underage sexual activity; this risks leaving some children at continued risk of exploitation in the mistaken belief they are involved in consensual activity.
3	The child protection process in England has primarily been designed for familial child abuse/neglect; in the absence of concerns about abuse or neglect by parents/carers, victims of sexual exploitation are likely to receive an inconsistent response to their safeguarding needs.
4	In cases involving sexual exploitation, there is a pattern of focusing primarily on trying to stop victims having further involvement with perpetrators, and less on the prevention of the abuse in the first place and the disrupting and prosecuting of perpetrators: this means victims often continue to be at ongoing risk of abuse by the same perpetrators.
5	Our current working methods and recording systems do not reliably identify patterns in individual and group behaviour. This reduces the chances of a timely response in the detection of victims and perpetrators of child sexual exploitation and leads to a more reactive rather than proactive approach.
6	The decision to make the investigation of these crimes into a complex investigation in May 2013 enabled the police to adequately resource an enquiry, which led to the successful prosecution of the offenders and the co-ordinated multi-agency support for the victims.
7	Locally LSCBs and the wider multi-agency partnership have collaborated to develop CSE/Missing strategy and action plans but these take time to embed so there is a disconnect between strategic understanding to drive improvement and the reality on the front line.

7.1 FINDING 1

The multi-agency system is not set up to provide an effective response for adolescents (including those at risk of CSE), with a complexity of needs, at the time and pace they need it, leaving children with a fragmented and reactive response to different aspects of their behaviour.

- 7.1.1 Much has been written about the complex but often neglected needs of adolescents who are often viewed as being difficult to help and hard to engage. Typically the multi-agency safeguarding system becomes involved with children due to increasing concerns about their vulnerability, which put them at risk of harm. Their previous life experiences are often, though not always, a factor in their increased vulnerability to CSE and other risky behaviour. Concerns include challenging behaviour, non-school attendance, alcohol and/or substance misuse, being missing from home, criminal activity, antisocial behaviour and vulnerability to abuse through underage sexual activity/sexual abuse and exploitation.
- 7.1.2 This finding concerns the extent to which current systems are sufficiently sensitive and flexible enough to respond to the range of teenage problematic behaviour, with particular emphasis on the risks of children being missing and them being victims to sexual abuse and exploitation, including criminal exploitation. This becomes more complicated for those children who have been Looked After, as when children reach the age of 16/17 there is an element of legal choice about whether they wish to continue to be a Looked After Child. However, local authorities still have duties towards them, and care plans need to reflect that continuing responsibility and any unintended consequences of a child ceasing to be looked after.
- 7.1.3 During adolescence, both parents and (for looked after children) 'corporate parents', struggle to keep adolescents safe. It is clear that from what children tell us that without significant help, if you are experiencing sexual exploitation it is very difficult to protect yourself. Often there is an overreliance that the non-abusing parents will be able to cope even if their child is involved in risky behaviour. There is also an unrealistic expectation that by becoming 'looked after', the 'corporate parent' will succeed in ensuring the child ceases to be involved in such behaviour.

How did the issue manifest in this case?

- 7.1.4 Many of the children in this review demonstrated challenging and difficult behaviour, both at home and/or in school. They were often involved in low-level criminal activity, had poor school attendance, went missing and were either in care or on the edge of care and a number of them were known to misuse drugs. There were also, for some, intermittent concerns around underage sexual activity and sexual abuse, before sexual exploitation was identified.
- 7.1.5 Often the children needed help at points of crisis: as they told the review team (see section 4), frequently this would be out of normal working hours when the practitioners who knew them were unavailable and their daytime support services could not be accessed. However, as was pointed out by one of the managers leading on child sexual exploitation strategy at

the time, out of hours services are not set up to respond to many of the emotional cries for help by children, at the time they need them.

Social work support

7.1.6 In recognition of the challenges faced by social workers trying to meet the needs of teenage looked after children, a committed and stable team of social workers and managers in the unnamed authority developed a service model for looked after children which provided consistency in relationships, drop in facilities and (dependent on circumstances) some support out of working hours. This provided children in local authority care with a consistent base, where they could crash out (in office hours) and access their own social worker, or in her/his absence other members of the specialist team, including the managers. Social workers described knowing all the children who dropped into the office, where they were able to access a lounge and kitchen facilities.

7.1.7 Such a model of service delivery was at immense personal and emotional cost to staff. One of the team managers in the case group reported that she felt totally responsible for the young person's missing episodes and impact it was having on police time. The social worker and team manager gave vivid examples where they were out at night and weekends looking for the young person or bringing them back to a safe place, saying:

"I was the only consistent person in their life, I felt totally responsible, I would pick her up in the night....I felt like I had a parental role....It was a difficult thing for me" "People didn't understand how we worked" "I felt blamed for not being able to control her behaviour"

7.1.8 Whilst there was supervision and support within the team and initially from the then service manager there was no access to expert advice. It is likely that the old model would have provided much emotional support to children, albeit did not succeed in terms of intervening and protecting them from sexual exploitation. Workers described feeling they had no tools in their toolbox to know what response they should make and the situation coincided with a period of instability and change in senior and middle management roles.

7.1.9 This particular model of social work delivery in the other authority has since ceased. It has been developed to a service that provides increased supervisory support to staff, and one that ensures adolescents with similar behaviour patterns receive an equivalent service, regardless of whether they are looked after or living with their family.

7.1.10 In Bristol, the social work response in one team working with one of the children in the review was initially variable; a lack of experienced social workers, effective supervision and some staff sickness resulted in an inconsistent response. However, Bristol City Council was forward in recognising they needed an expert service to respond to the growing need and had previously provided a grant to BASE to provide a CSE support service. Appropriately, BASE has the role of complementing the social workers input by building up trusting relationships and consistency with the children. However this was not and still is not a 24/7 service, although there is a continuing need for it to be so.

7.1.11 There was also some good internal social work practice in Bristol. One young person told the lead reviewer that her social worker had remained with her for over four years, and that this had a significant impact on a more positive outcome and met her needs for consistency of support.

Lack of appropriate supported housing/residential placement

7.1.12 Staff and parents struggled with children being constantly missing from home or care and being moved from one placement to another, or between care and different family members, trying to find a resource able to meet their complex needs. However, none of the specialist resources or different family members was able to protect the children consistently over a period of time. This applied to both Bristol and the other local authority.

7.1.13 Secure residential provision was able to keep the children (from the other local authority) physically safe, but made no difference to subsequent risk of harm on release. Indeed for one victim the use of secure provision reinforced that she was being treated like a perpetrator, alienated her even more from professionals and made her more vulnerable to being 'pulled' back to being exploited.

7.1.14 One of the vulnerable children, following direction by the courts for them to be bailed outside their own area, was placed in a supported housing scheme, which the social worker who drove her to it, realised when arriving there, was in an area of Bristol known for its night time economy. The young person quickly met her subsequent abusers on the street, being easily identified as someone who had a flat and could support their drug running activities.

7.1.15 The staff in the supported housing placement, both in Bristol and then back in the unnamed authority tried hard to provide her with 24 hour access to support, however their mostly inexperienced low paid workers were on duty at night and acknowledged in this review that at times they felt they had very limited ability to do anything constructive or meaningful.

7.1.16 Parents in the other authority who spoke to the review team referred to their concern at the quality of the residential and foster care placements commenting that they felt it should be renamed '*the not looked after system*'. This demonstrates the gap between the expectation of the care system to succeed in being able to intervene and keep children safe any better than their parents can when children are being manipulated by others, including peer groups, drug dealers and particularly perpetrators of sexual exploitation.

The multi-agency response and missing episodes

7.1.17 The children went missing from home or care on a regular basis. The review team found that for two of the children in the other authority this equated to over 50 recorded episodes of them being reported missing over a period of 12 months.

7.1.18 The strategic response to missing episodes differed in the authorities. In Bristol they responded to the statutory guidance on Missing Children (DCSF 2009, (revised 2014 DfE)), and established a Children Missing from Home and Care strategy group. Barnardo's were then commissioned to support children missing from home and from 2012 to undertake return interviews but only with children who did not have a social worker (as of October

2014 they also undertake return interviews for children open to a social worker but not looked after). Return interviews for looked after children were done through social care, though attempts were made to ensure they were an independent person as per the DCSF guidance, and not the named social worker.

- 7.1.19 In the other authority prior to April 2013 all return interviews for children missing were carried out in house. In January 2013 an invitation to tender for a Children's Rights Service was published. At the request of the then Head of Children and Families' Services, included in this tender was the provision of a maximum of 50 return interviews with children who had been missing from care or home and were identified as being at significant risk. A charity was awarded the contract to deliver the Children's Rights service in May 2013. When return interviews with children were undertaken the findings were shared directly with the police. In the summer of 2014 another charity, in collaboration with the local Police and Police Crime Commission, started to undertake the return interviews.
- 7.1.20 The local response from the police in the other authority appeared to be primarily focused on closing down the report or crime, with a mind-set that they were dealing with troublesome adolescents rather than collating information about why they were missing or risk and vulnerabilities. Parents in both authorities reported to the review team that they had a variable response when they reported their children constantly missing.
- 7.1.21 The key issue here is that in order to be effective the system needs to be organised and resourced enough to be flexible to respond effectively to immense strain on resources that children who go missing place on it. It also has to provide children with a response that meets their varying needs, including some consistency of staff dealing with children who are missing as well as opportunities for independent return interviews.
- 7.1.22 The police do prioritise missing children, dependant on risk, but do not always share information from missing safe and well checks with partner agencies, other than children's social work services.

Specialist help

- 7.1.23 Referrals for specialist support for children were made to CAMHS and BASE but waiting lists; lack of capacity, resource and strict threshold criteria resulted in delay for some, especially before Operation Brooke. For one young person it took 12 months and three referrals before being accepted by the Barnardo's BASE project, by which time they were being sexually exploited on a regular basis. Some of the delay for others was felt by BASE workers to be as a consequence of a slow response by social workers to making proper referrals to them.
- 7.1.24 Once the children were accepted by BASE there was an appropriate reliance on them to develop relationships with the children, working with them to build their trust and enabling them to speak of what they had experienced. A key purpose being to work intensively with them to help them recognise risky behaviours and develop strategies for more healthy relationships to stop them being victims of CSE as well as supporting any police prosecutions. This part of the intervention was in fact successful, but it takes considerable time to accomplish and only works with children who accept such help. One of the features of this intervention is the recognition that children will not be quickly made safe, that

support is needed over a considerable period during which the young person may continue to be sexually exploited or involved in other risky behaviour. This ability to work within the capacity of the child highlights the limits of what practitioners can achieve. However it took police officers some time to accept that this model of practice was more likely to result in successful prosecutions than a more reactive approach.

Education

- 7.1.25 The educational experience of the three children that we looked at in more depth deteriorated as they progressed through secondary school. Although one of the wider cohort, reported good support, most felt very let down by school staff. One of the children fed back to the lead reviewer that they felt both schools were really unhelpful and did not make any link between her poor behaviour and attitude, to the fact that she was in distress. She says, *'the thing they were obsessed about was being in correct uniform'*: but as she spent so much time at school more help should have been available.
- 7.1.26 From a Bristol schools perspective they had not been party to information about missing episodes as information sharing by the police and children's social care to them was inconsistent, this left schools struggling to distinguish the difference between disruptive behaviour and early signs of vulnerability. In the wider cohort, low attendance, poor engagement in learning, missing episodes, number of school moves and bullying were features. This led to a lack of understanding by school staff, who felt that with enough support, as the children were academically able, they could get them to re-engage with their mainstream schools.
- 7.1.27 School staff in the case group told the review team that their understanding of the disappearances was often based only on what parents told them; they had no awareness initially that sexual exploitation may be a factor. It is also true that school staff tried hard to engage with the children and keep them in school but that the complexity of their behaviour was hard to manage within mainstream settings.

Sexual health

- 7.1.28 Sexual health staff reported in the case group that they were often not invited to conferences/reviews for children and that sexual health needs and the clues that sexual health data give about what might be happening to a young person can therefore be easily ignored. Confusion by health professionals over what, who with and when confidential sexual health data on children can be shared, does not help. **Finding 5** highlights the missed opportunities to identify patterns in the way children accessed sexual health services and the parallel systems operating between GP practices and specialist sexual health services which also contribute to the piecemeal approach to children's' health provision.

How do we know it is an underlying issue and not something unique to this case?

- 7.1.29 One of the features of the practitioners and managers involved in this review was a sense of 'helplessness' in their efforts to support both these children and others, and to prevent such children from suffering further harm, whether it be from sexual abuse / exploitation, criminal activity or substance misuse. The phrase, as mentioned previously, *'no tools in the*

toolbox' was used by staff to describe the lack of knowledge of resources that would work. Staff also reported and gave vivid examples of the secondary trauma they suffered as part of the impact of trying to provide adequate support to children leading up to and after the Brooke trials.

- 7.1.30 There was a sense that this has always been problematic with a child safeguarding system largely focused on children perceived to be more vulnerable, usually in terms of their age. However, staff in the other authority also reported that it is becoming increasingly difficult because of the loss or lack of facilities that meet the needs of adolescents, especially those who are Looked After. In recognition of such problems Bristol have refocused some services around adolescents.
- 7.1.31 The central government policy drive towards improving access to early help for families alongside the importance of statutory agencies intervening early in any maltreatment on younger children may have impacted on the system's ability to respond to the needs of older children. Nationally it is reported that resources have been redirected and youth work services have been cut. This alongside an assumption that adolescents have a greater resilience to the impact of abuse (Gorin and Jobe,⁷ cited in *Research In Practice (2014)* has left a gap that leaves adolescents without a system that can adequately respond to their complex and differing needs except on an agency-by-agency basis.
- 7.1.32 Another reason for this being an underlying problem is that the local and national configuration of services is based around a 9-5 culture, with different services providing wholly distinct parts of the care provision. This is possibly least suited to adolescents who tend to be more active later in the day and at night. Also, some adolescents will perhaps have less understanding and tolerance of the need to obtain help from several places and many different people. A one-stop shop approach, with flexible forms of access at different times of the day is more likely to meet their needs.

How prevalent and widespread is the issue?

- 7.1.33 This is not just problematic locally. The recent report by NSPCC (2015)⁸ highlights that child protection processes and procedures tend to be designed for work with young children in the family context. Handson, E and Holmes, D (2013)⁹ (Cited in RIP 2014), suggests that adolescents need a more sophisticated model of risk and prevention.
- 7.1.34 A whole system approach to protecting vulnerable children is required that includes specific consideration to those at risk of going missing and becoming vulnerable to CSE as described in the *Research in Practice briefing 2013*¹⁰. Local authority decisions on placements for

⁷ That difficult age: developing a more effective response to adolescence. Research In Practice, 2014.

⁸ How safe are our children? NSPCC, 2015.

⁹ That difficult Age: Developing a more effective response to risk in adolescence. Research In Practice, 2014.

¹⁰ Children and young people missing from care and vulnerable to CSE. Dartington, 2013.

Children Looked After can contribute to an increase of risk, going missing and becoming vulnerable to sexual exploitation, something that has been a feature of previous serious case reviews (Oxfordshire 2015, Derby 2010 & 2013). Notably in Bristol they have recently reduced the numbers of children placed over 20 miles from home and have developed clear system to assess needs before placement. The number of children placed more than 20 miles from home has always been low in the other LA and remains low.

What are the issues for reliability of the multi-agency system?

- 7.1.35 Whilst our services continue to be fragmented responses to particular needs of the adolescent, as opposed to a service designed around the circumstances and emotional developments of children, it is likely that professionals will continue to experience difficulty in reaching out to adolescents at risk of significant harm.
- 7.1.36 Barnardo's CSE projects such as BASE in Bristol recognise that you can't get children out of exploitation quickly, in order to build trust and confidence you need to work at their pace with a stable group of key workers who are consistent in their lives. The Barnardo's review team member emphasised that services need to be accessible, flexible and responsive to their needs with a variety of ways to access them on their own terms, sometimes providing text and online routes. Alongside building effective local partnerships with a range of providers to make sure the children we work with can gain access to the wider support they may need at the right time.
- 7.1.37 Relationship based work is the key to enabling children not only to disclose but also to work on aspects of their self-esteem and behaviour to make changes. Currently most child care systems are not organised in a way that is conducive to this model or recognises its value enough, relying too much on individuals giving over and above what is expected of them, leaving them stressed, sometimes traumatised and often working in isolation. Police also need to work alongside such services being more proactive in disrupting perpetrators activities.
- 7.1.38 Nationally the current workforce in children social care makes it very difficult to provide consistency for children, although this is not a feature for Bristol, which usually has a stable workforce. It is becoming the norm for some local authorities to have up to 40% locum/agency workers (though this was and is not the case in Bristol or the unnamed local authority). Specialist projects, where commissioned, can add great value but only if they are well funded and able to respond in a timely way to need.
- 7.1.39 For children who run away or go missing, the revised statutory guidance (DfE 2014) makes it very clear that the multi-agency response should be joined up and include clear protocols outlining details of how local arrangements will effectively support those children who runaway, go missing or are deemed absent. This should include, how data will be collated, additional responsibilities for Children Looked After, and provision and access of helplines and emergency accommodation, which can be accessed directly at any time of day or night. All of which if commissioned would support a more joined up and flexible approach for adolescents.

Questions for the Board to consider:

- How will the Board support and monitor the extent to which services for adolescents are provided collaboratively, working in alignment and sharing information appropriately
- How does the LSCB assure itself that the DFE 2014 guidance has been implemented sufficiently for children who go missing, runaway or are absent and that children will be effectively safeguarded?
- How can services be provided that better meet the needs of vulnerable adolescents: this would involve the provision of a flexible focussed relationship based service model, available out of normal working hours and through a 'one stop shop'?
- Do all agencies provide effective reflective supervision and support to staff working with vulnerable adolescents?

7.2 FINDING 2

A confused and confusing stance in national policy about adolescent sexual activity, leaves professionals and managers struggling to recognise and distinguish between sexual abuse, sexual exploitation and/or underage sexual activity; this risks leaving some children at continued risk of exploitation in the mistaken belief they are involved in consensual activity.

7.2.1 This finding addresses the reasons behind the challenges that some practitioners face in recognising when a child is being sexually abused and exploited, as opposed to them being involved in consensual underage sexual activity. Whilst a contributory factor may be a lack of recognition by practitioners of risk indicators of sexual abuse and exploitation (see finding 7), there is an underlying complexity related to the contradictions within our culture about teenage sexuality, as well as in the way the law is interpreted.

How did the issue manifest in this case?

7.2.2 When the review team considered the history of the children, in hindsight it was possible to identify a large number of missed opportunities to recognise that the children were at risk of significant harm through sexual abuse, and that in some cases this abuse constituted sexual exploitation. However, through discussions with the practitioners we became aware that, at the time, this was not recognised and instead the children were considered to be involved in consensual (and in most instances, under age i.e. under the age of 16) sexual activity.

7.2.3 Because of this perception of consensual sexual activity, referrals were not always made to police and children's social care, and when they were made, this did not always lead to a child protection response.

7.2.4 The way that this confusion manifested in this case included:

- Staff in the supported housing scheme and social workers not identifying concerns about sexual exploitation of the girls from the unnamed authority prior to the police initiation

of the Operation Brooke investigations. The girls were perceived to be involved in repeated consensual sexual activity, despite a history of earlier recognition of child sexual exploitation and reports of sleeping with friends for drugs and money.

- The above lack of recognition of exploitation was particularly marked when the victim was aged over 16 years old, and the fact that she was legally able to have sexual intercourse, contributed to staff not understanding that her descriptions of receipt of money, drugs etc. meant that this was exploitation.
- There were different understandings of the threshold for services for sexual exploitation between police, CYPS, CAMHS and BASE with regard to:
 - a girl first referred at age twelve was said not to meet the threshold, but BASE accepted the third referral from CYPS when she was aged thirteen and subject to a child protection plan for sexual abuse: this was despite her mother having articulated concerns about sexual exploitation at an earlier stage when she was meeting men via Facebook.
 - a 12 year old girl sexually abused by her peers: social workers and police considered this to be sexual exploitation and referred to BASE, but did not follow child protection procedures for sexual abuse - meanwhile BASE deemed she was not eligible for a service for sexual exploitation and as a consequence the girl was left without support.

7.2.5 A complicating factor here is that the children themselves also did not see themselves as being sexually abused or exploited **at the time**, although those that have contributed to the review (see section 4) are now able to see what was happening as abuse. One of these children spoke (as part of this review) of how the behaviour became normal and that she didn't know that relationships with males could be any different.

7.2.6 Even when children did consider they were being abused, some felt unable to share this with professionals. Two children spoke to us about their embarrassment at the time speaking about the sexual assault, in terms of a fear of shocking practitioners by discussing the details as well as blaming themselves for getting into the situation. One mentioned attempting to tell a social worker, but stopping when she saw the social worker had '*gone red with embarrassment*'.

7.2.7 One set of parents who contributed echoed this confusion in professional response, saying 'people would say she brought it all on herself'. A parent recounted the response by one of the investigating police officers (to the report of her daughter being raped twice) being she 'was making lifestyle choices'.

How do we know it is an underlying issue and not something unique to this case?

7.2.8 The inconsistent recognition of and response to the indicators of sexual abuse and sexual exploitation for all the victims indicates that this is not unique to the experience of any one of these children. It reflects the wider societal mixed messages about sexual activity of children, which leads to some challenges and inconsistency in the identification of sexual abuse and/or the identification of sexual exploitation.

Identification of sexual abuse

- 7.2.9 Sexual abuse of children came to the forefront of professional practice in the 1980s and 1990s. Since that time the use of sexual abuse as a category of child protection plan has decreased, with only 4.5% of child protection plans in the year 2013-2014 being under this category¹¹. The reasons for the decline is not clear, although it may be associated with the general use of only one category for a plan, and the increasing focus on neglect and emotional harm of children. However, it is also likely to be associated with the embarrassment of staff who no longer encounter/identify sexual abuse routinely in their work. Some practitioners involved with the children spoke of not feeling trained or comfortable speaking about sex with children.
- 7.2.10 The recognition of sexual abuse for those aged under thirteen years is legally clear, as a child under 13 is not legally capable of consenting to sexual activity and an offence of rape is committed if there is intentional penetration of the vagina, anus or mouth of the child with a man's penis. However, knowledge by health professionals of recurrent sexual health problems to a girl under the age of 13 years, even in the context of previous sexual abuse, did not lead to consistent reporting of such concerns to CYPS.
- 7.2.11 For the older child, recognition of sexual abuse can be more challenging. The legal context is that sexual activity with a child under the age of 16 years is an offence. However, Home Office Guidance¹² and the Crown Prosecution Service (CPS) factsheets¹³ are clear that there is no intention to prosecute teenagers under the age of 16 where both mutually agree to sexual activity and where they are of a similar age and are judged to have capacity to make such a decision. This means that professionals with knowledge of such sexual activity have to try to establish both whether consent is involved, the age and power difference between those involved in the relationship and their mental capacity to make such decisions. Such individual professional judgments will be variable and will be highly dependent on the accounts provided by the child her/himself.
- 7.2.12 It is even more difficult to engage children to talk about their sexual activity if/ when they know it is illegal. Moreover children involved in underage sexual activity are likely to be subject to pressure not to disclose the age of sexual partners, often referring to them as 'boyfriends', even though they are adult males, (if they know their actual age themselves), nor the extent of, or lack of, informed consent. It was striking in this cohort of victims that discussions with doctors and nurses regarding contraception or sexual health consistently involved (misleading) accounts of sexual partners of just a year or two older than themselves.

¹¹ <https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014>

¹² Home Office, Children and Families: Safer from Sexual Crime – The Sexual Offences Act 2003. London: Home Office Communications Directorate, 2004.

¹³ www.cps.gov.uk/news/fact_sheets/sexual_offences/ replace with http://www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/youths/

Child sexual exploitation

7.2.13 When it is identified that children are being sexually abused it is not always easy to identify if such abuse constitutes sexual exploitation. The government guidance on sexual exploitation¹⁴ replaced the earlier 'Safeguarding Children involved in Prostitution'¹⁵. The terminology was changed from 'prostitution' to 'exploitation' in recognition that children were being abused and exploited by adults. It provided a much broader definition of this form of sexual abuse, namely:

*'Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.'*¹⁶

7.2.14 However, a result of such a broad definition of sexual exploitation is that it is possible for all forms of sexual abuse to be included in its scope, including familial abuse. Such a broad definition may be helpful in identifying sexual abuse *per se*, but has the unintended consequence of making it more difficult to identify when referrals specifically about sexual exploitation should be made to specialist services and to the police.

How prevalent and widespread is the issue?

7.2.15 The recent reports in child sexual exploitation in Rochdale, Rotherham and Oxfordshire all discuss delays in identification of child sexual exploitation. The Oxfordshire serious case review¹⁷ refers to various factors influencing this delay:

¹⁴ Safeguarding Children and Young People from sexual exploitation. DCSF, 2009.

¹⁵ Safeguarding children involved in Prostitution. DOH, 2000.

¹⁶ This definition of child sexual exploitation was created by the UK National Working Group for Sexually Exploited Children and Young People (NWG) and is used in statutory guidance for England.

¹⁷ Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F. OSCB, 26.02.15: <http://www.oscb.org.uk/wp-content/uploads/SCR-into-CSE-in-Oxfordshire-FINAL-FOR-WEBSITE.pdf>

- 'There was insufficient understanding of the law around consent, and an apparent tolerance of (or failure to be alarmed by) unlawful sexual activity' (page 92).
- 'The result was that inappropriate or illegal sexual activity by children who were clients, patients or looked after children was subject to a higher tolerance threshold than would be the case than, say, the average parent'.
- 'There can be little doubt that the earlier sexualisation of children, the age of perceived self determination and ability to consent creeping lower, and the reluctance in many places, both political and professional, to have any firm statements about something being 'wrong', creates an environment where it is easier for vulnerable young people/ children to be exploited. It also makes it harder for professionals to have the confidence and bravery to be more proactive on prevention and intervention. This is an issue reaching way beyond Oxfordshire and requires a national debate' (page 104).

7.2.16 There is also literature about the contributory factor associated with the delays due to difficulties children and those around them have in identifying sexual exploitation because the abusers identify themselves as 'boyfriends'. Barnardo's term this as a 'Boyfriend model of exploitation and peer exploitation'¹⁸.

Implications for the reliability of the multi-agency child protection system?

7.2.17 The most effective intervention should be, as described by the recent NSPCC report,¹⁹ at a preventative stage before sexual abuse occurs. Whilst treating sexual abuse as a public health issue, as discussed in this report, it is important to provide support and intervention to children suffering or at risk of suffering sexual abuse (and for some exploitation) as early as possible, so as to prevent further harm.

7.2.18 The current political and media focus on sexual exploitation is likely to trigger an increased recognition of this extremely harmful abuse of children. However, there remains an underlying confusion for practitioners in distinguishing between underage but consensual sexual activity between peers and child sexual abuse and sexual exploitation. Such confusion is rooted in the complex and contradictory cultural, legal and moral norms around sexuality, and in particular teenage sexual experimentation.

7.2.19 In such an uncertain environment it becomes extremely important that children, parents and professionals become comfortable in discussing teenage sexual behaviour, so as to be able to identify the risks of sexual abuse and the nature of such risks, such as sexual exploitation. Being able to distinguish the type of sexual behaviour and abuse is important so that the appropriate intervention is provided, including disrupting and investigating the perpetrators. The importance of schools having dedicated time for PHSE (Personal, social and, health including SRE – sexual relationship education) is an essential part of enabling children to distinguish between what is 'safe' and what may be risky or harmful.

¹⁸ Puppet on a String. Barnardo's, 2011.

¹⁹ Preventing Child Sexual Abuse. Brown & Saied-Tessier: NSPCC, 2015.

Issues/questions for the board to consider

- How can the workforce be equipped with the necessary skills to enable them to support children in being able to speak about sexual behaviour without embarrassment?
- How can the Board be confident that staff are supported to be able to identify and report suspicions of sexual abuse (including exploitation) and understand the distinctions between different types of sexual abuse?
- Are child sexual exploitation screening tools being used effectively by practitioners?
- How can the Board be assured that schools and post 16 providers are supporting children in relation to the risks around what is 'safe' and what could be harmful in sexual behaviour and that additional educational messages are being promoted via public health?

7.3 FINDING 3

The child protection process in England has primarily been designed for familial child abuse/neglect; in the absence of concerns about abuse or neglect by parents/carers, victims of sexual exploitation are likely to receive an inconsistent response to their safeguarding needs.

7.3.1 In summary the child protection process consists of:

- a strategy discussion between professionals to decide whether or not to initiate a s.47 enquiry and to plan how such enquiries are to be undertaken
- the s.47 enquiry itself to investigate the circumstances of the concern and to undertake an assessment of the risk of harm to the child with a potential outcome of deciding if concerns are substantiated and if the child is at continuing risk of likely or actual harm
- a child protection conference system: if concerns are substantiated and there is continuing risk of likely or actual significant harm, a child protection plan is formulated if the criteria is met
- if relevant the use of further legal intervention or voluntary agreements with parents can be initiated.

7.3.2 The process is generally used to address concerns about the abuse or neglect by parents/carers. When the source of the abuse is external to the family, the child protection process is not consistently used and sometimes seems not to be appropriate to practitioners, especially the use of the child protection plan. This finding explores the reasons behind this and the significance for safeguarding children.

7.3.3 The difficulty distinguishing what is consensual underage sexual activity and what is abusive (as explained in finding 2) will contribute to some inconsistency of response. However, there are additional factors due to the lack of clarity in national guidance about the use of child protection conferences and plans, especially in relation to looked after children. There is also evidence in both authorities that strategy discussions and s.47 enquiries are used inconsistently, despite procedure in Bristol that these apply for abuse outside of the family.

How did the issue manifest in this case?

- 7.3.4 The extent to which child protection processes were used in response to reports or allegations of the children being subject to sexual exploitation varied, with inconsistent use of s.47 enquiries and even rarer use of the child protection conference process.
- 7.3.5 There were instances of children being sexually abused / exploited without any s.47 enquiries and sometimes without police investigations. Examples included:
- 16 year old vulnerable care leaver made allegations to the staff of the accommodation provider of having sex for money and cannabis and being raped: no evidence the police were informed and no s.47 enquiry held as the girl did not want police involved
 - 16 year old talks to social worker about being sexually exploited previously, but said it had stopped: no s.47 enquiry held or police investigation, because it had stopped
 - Bristol YOT contact the YOT from the other authority about police intelligence reports and concerns that 16 year old a victim of CSE (men found in flat and condoms strewn on the floor): no strategy discussion, no s.47 enquiry or police investigation at that point about CSE, but a professionals meeting which decided on a referral to BASE
 - Reports indicative that girls were continuing to be exploited and experiencing violence, such as young girls reported as being drunk in company with a group of 'boys', one of the girls slapped and dragged off from a pub and missing for the week-end; one of the girl's mother reporting a number of men telephoning her daughter's old mobile - there is no evidence of any strategy discussions or s.47 enquiries in response to these reports
 - 15 year old girl in foster care missing and found by police drunk and partially dressed in bed with a 20 year old and her mother subsequently reported she had bruises: the police investigation ended due to the girl saying 'nothing happened that she didn't want to happen' and there was no s.47 enquiry by children's social care
- 7.3.6 In two instances child protection procedures were progressed and children became subject to child protection plans. In one case this was after a GP made a specific child protection referral about sexual exploitation and a conference was held. The other example was in the unnamed authority, where one young person was subject to a child protection plan at one point, whilst she was Looked After. However, the plan was discontinued partly, according to practitioners, because the young person was no longer considered to be at risk of sexual abuse. Practitioners also said the plan was ineffective and led to conflicting plans with those made at the Looked After Child Reviews and the Multi-agency Risk Panel (MARF).

How do we know it is an underlying issue and not something unique to this case?

- 7.3.7 The national guidance about the use of child protection processes for child sexual exploitation has not always been clear, and even current guidance, although stating that s.47 enquiries should be used, makes no mention of child protection conferences. For Looked After Children, the guidance is less clear whether s.47 enquiries are to be undertaken. Consequently it is not surprising that practice on the use of s.47 enquiries and child protection conferences varies both between and within different authorities.
- 7.3.8 The child protection process as outlined in *Working Together to Safeguard Children (2015)* was primarily designed to assist in the safeguarding of children from abuse or neglect by

their parents or carers. The first 'Working Together' published in 1999, did acknowledge the existence of 'extra-familial abuse', 'abuse carried out by children or children' and 'organised abuse', and said that such concerns to be referred, investigated and assessed, but the way this should be done was left at the time to be decided locally.

- 7.3.9 Over time, more government guidance was provided on how to deal with what was termed as 'special circumstances' and in the field of both sexual exploitation and complex [or organised] abuse, the government produced separate guidance which formed the basis for local procedures. Subsequently there was nationally, 20 years ago, a drive to lower numbers of families brought into the child protection process, in response to the DOH publication *Messages from Research* (1995)²⁰. The lead reviewers and others in the review team recall that this resulted in many authorities adopted the policy of not using the child protection process for children considered beyond parental control, if the child/ren's parenting was not neglectful or abusive.
- 7.3.10 The government published Safeguarding Children Involved in Prostitution in 2000²¹ and Safeguarding Children and Young People from Sexual Exploitation in 2009²². Both of these documents confirm the need to use a s.47 enquiry if there is 'reasonable cause to suspect that this child is suffering, or is likely to suffer, significant harm'. But neither refers to the use of a child protection conference.
- 7.3.11 Both editions speak about the particular circumstances of Children Looked After. The first appears to suggest that their circumstances will be addressed by the Looked After Children system and it is not clear if the use of s.47 enquiries is being advocated for these children. The current national guidance does make it plain that enquiries should be undertaken for Children Looked After but it makes no reference to the use (or not) of child protection conferences and plans in circumstances when a child is at risk of sexual exploitation.
- 7.3.12 The tool of the child protection plan is one that is particularly used to support parents and professionals to work together to protect children. It tends to focus on ways that parents can work together with agencies to improve their parenting, often through the use of parental agreements. In the context of parents who are already trying to do everything possible to protect their teenage child, this is less likely to be effective. Moreover, some parents and professionals consider the conference process as being insulting to a parent who is trying to do everything possible to protect their child.
- 7.3.13 Further tensions arise with the use of the child protection process for children looked after. Partly this is due to the concern about duplication of processes, with double the amount of

²⁰ Bullock Roger, et al. Child protection: messages from research. HMSO, 1995.

²¹ Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children. DOH, 2000.

²² Safeguarding children and young people from sexual exploitation. DCSF, 2009.

meetings and two different planning systems, but perhaps also because it suggests that the 'corporate parent' is somehow unable to protect the children in the care system.

- 7.3.14 In Bristol the procedure is clear that the child protection process should be used, involving strategy discussions, s.47 enquiries and a child protection conference, if the criteria are met. However, the practice in these cases indicates that there is variation in the application of this, possibly because of the reasons explained in finding 2. Also there is inconsistent application of child protection conferences for looked after children in these circumstances.
- 7.3.15 The LSCB in the other authority has historically used and continues to use child protection plans for children who are both looked after and victims of CSE. The authority ratified the 'Looked After Children with a Child Protection Plan' Policy in 2014, which allows for child protection conferences for looked after children. The policy states that: 'Where a looked after child remains the subject of a child protection plan there must be a single plan and a single planning and reviewing process, led by the Independent Reviewing Officer (IRO)'. This means that the timing of the review of the child protection aspects of the care plan (under the requirements of the local child protection procedures) should be the same as the review under the Care Planning, Placement and Case Review Regulations and the accompanying statutory guidance Putting Care into Practice. This will ensure that up to date information in relation to the child's welfare and safety is considered within the review meeting and informs the overall care planning processes.

How prevalent and widespread is the issue?

- 7.3.16 This inconsistent use of child protection processes in relation to child sexual exploitation can be seen as happening in reports in recent years on child sexual exploitation such as those pertaining to Rotherham, Rochdale and Oxford.
- 7.3.17 In some areas a parallel process has developed, which indicates that there is a common confusion about whether or not to use the child protection process in these circumstances. For example the London Protocol²³ describes the Multi-agency Professionals meetings (MAP) that are convened by children's social care for each child at risk of sexual exploitation and involve all the professionals. No mention is made of the child and family, but the earlier guidance of 2006 referred to their inclusion if appropriate. The purpose of this meeting is to:
- '... manage identified cases of CSE share all relevant information and agree a plan to safeguard the individual child to achieve a positive outcome'.*
- 7.3.18 Further monthly Multi-Agency Sexual Exploitation Meetings (MASE) are held to co-ordinate the intelligence locally and chaired by the Metropolitan Police Service. The purpose of this meeting is to act as

²³ The London Child Sexual Exploitation Operating Protocol, March 2015 (2nd Edition)

'the driver for agreeing the appropriate operational activity necessary to tackle CSE threats within each borough and across borough boundaries'

- 7.3.19 Whilst this system does not replace the child protection process, the MAP tends to be used instead of a strategy meeting to decide whether the case should go down the s.47 and child protection route.
- 7.3.20 The development of such a parallel process has its own risks in terms of potential confusion and inconsistency, but demonstrates the prevalence beyond Bristol and the other authority of the national lack of clarity about the use of the child protection process for child sexual exploitation.

Implications for the reliability of the multi-agency child protection system?

- 7.3.21 Because of the lack of clarity over time in the national guidance, different ways of managing professional responses have developed in different authorities. In both Bristol and the other authority, as described in sections 7.4.14-15 there is inconsistent use of aspects of the child protection process in relation to child sexual exploitation and for Looked After Children.
- 7.3.22 The main implication for the reliability of the multi-agency safeguarding system is that when decisions are taken to use other processes, opportunities may be lost to fully investigate what has happened in relation to particular incidents, as well as evaluating the risk to the individual child concerned. This is best undertaken by the section 47 process, initiated by a strategy meeting/discussion. The risk of using *other* meetings to discuss how to respond to concerns is:
- the participants may agree a plan, without fully undertaking the investigation first to establish the levels of risk and the people involved
 - the possible lack of all agencies at the meeting, in particular the lack of police if the meeting is held as a general professionals meeting or a Child Looked After review instead of a strategy meeting
 - The presence of family may mitigate against the formulation of an adequate investigating strategy
- 7.3.23 Additional issues arise if there is duplication of planning processes and different plans with two or three parallel processes operating: child protection conferences, Children Looked After planning and any specialist sexual exploitation planning processes. In these circumstances there may be professional overload and possible confusion if the plans are not compatible. In Bristol and now in the other authority there is clarification that the specialist sexual exploitation meetings are to discuss more than one victim with a focus on the risks of perpetrators. Bristol is also developing a specialist CSE MARAC for particular locations and perpetrators. This is a commendable innovation.
- 7.3.24 The view of the review team in this serious case review was that there is a need to fully use the child protection process in child sexual exploitation as this signifies that the child is at continuing risk of significant harm, regardless of where the harm emanates from. The ability of the parents/ carers or foster carers to be able to keep the child safe is relevant in that

decision, rather than whether their parenting is itself abusive or neglectful. The same criteria should be used for Children Looked After as for children living with their family.

Questions for the board to consider

- To what extent is the entire child protection system being used for planning for older children?
- Are the child protection needs of Looked After Children recognised and addressed in the same manner as for children in the wider community?

7.4 FINDING 4

In cases involving sexual exploitation, there is a pattern of focusing primarily on trying to stop victims having further involvement with perpetrators, and less on the prevention of the abuse in the first place and the disrupting and prosecuting of perpetrators: this means victims often continue to be at continual risk of abuse by the same perpetrators.

7.4.1 Much of the multi-agency safeguarding effort with children considered at risk of sexual exploitation, is focused on keeping the children safe through considering if they need to be moved from the locality and what support can be provided e.g. via counselling. The onus has been on supporting the victim to stop associating with risky people. However, very often the young person finds it extremely difficult to avoid being drawn back into being exploited by the same perpetrator/s or new ones, despite specialist placements and the involvement of services such as that offered by BASE.

7.4.2 In contrast traditionally there has been insufficient effort made on the prevention of such crimes through:

- Preventative multi-agency work with children regarding healthy sexual relationships and learning what is abusive behaviour through the PSHE curriculum within schools
- Early identification of vulnerable children who may have experienced significant trauma as a consequence of coming from world conflict zones and living with refugee status
- Disruption activity by police with suspected offenders
- Proactive investigation by police, in the absence of allegation or a witness perceived to be credible: in this case once Operation Brooke had commenced, police undertook a proactive investigation and through this process, of interviewing potential witnesses and obtaining forensic evidence, developed trust with the victims/witnesses so that allegations/disclosures were made.

How did the issue manifest in this case?

7.4.3 Some of the children from the unnamed authority were Looked After and had experienced multiple placements in an effort to keep them safe. However, they continued to be exploited even when moved considerable distances from their home authority. When victims agreed to give evidence against the perpetrators, it was understood that some continued to be exploited, but by different perpetrators, despite being moved to a different location.

- 7.4.4 The onus remained on children's social care to try to keep these victims safe, as opposed to measures to disrupt the exploiters, detect and prosecute them. An example of this was that despite concern about the large number of male visitors to one young person's accommodation in the other local authority, the CCTV camera that had been installed to help keep her safe and identify potential perpetrators was not accessed by police to identify the adults who were visiting.
- 7.4.5 In Bristol, there was no evidence of police activities to disrupt the activities of the perpetrators of Brooke 1 and Brooke 2 investigations. There was also delay in investigating the earlier allegations, prior to the instigation of Operation Brooke, when there was the launch of the major crime investigation and the proactive investigation to seek evidence by interviewing potential witnesses. During this period some of the children continued to be abused without sufficient multi-agency consideration about how to keep them safe, involving both police action to disrupt perpetrators and the involvement of other agencies working together with the family to try to keep the child safe.

How do we know it is an underlying issue and not something unique to this case?

- 7.4.6 This was not just a feature for one or two of the children's experience but was common to the victims of both sets of Operation Brooke perpetrators. This suggests that this is not an isolated occurrence. Practitioners and managers also reported this as a feature of practice at that time.
- 7.4.7 The focus on being able to keep victims safe rests on an assumption that once they understand what has happened to them they will be able to resist the 'pull' factors at play, which are often based on threats and fear for themselves or family, as well as the attraction of money or addictive drugs or other risky behaviour. Also the emotional component is difficult to predict; one victim described to staff at the time, and in her contribution to the review, the comfort she got from being held and not being alone, as well as the fact that this life style became 'normal' to her.
- 7.4.8 The experience of BASE is that it can take a considerable period for children to be able to consistently change their behaviour, being drawn back to sexual exploitation at times. Therapeutic support is needed for a long time, at least months or even years. Some of the victims of the perpetrators in this case are still seeing their BASE counsellor. However, this tends to rely on the ability to provide a consistent therapist, which is not always easy to achieve.
- 7.4.9 The lack of pro-active policing traditionally has been based on an investigative approach which only provides resources if there is a reasonable chance of being able to bring a prosecution. Consequently without a complaint and a 'credible witness', the investigation ended, or was put on the back burner, without following up potential witnesses and consistently seizing computers and mobile phones for analysis. Now that CSE has become a higher priority for all agencies, there is likely to be more pro-active policing, but capacity and resources remain a real challenge for the police.

How prevalent and widespread is the issue?

7.4.10 We have moved, as reflected in government guidance²⁴, to a culture which has in recent years recognised the serious abuse and trauma suffered by victims of CSE. Previously children were seen as being out of parental control and as exercising some choices in their lifestyle. Consistent with this change has been the recognition for police and other agencies to be more pro-active. For example the 'Strategy for Policing Prostitution and Sexual Exploitation'²⁵ 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'.

7.4.11 However, the extent to which this happens is less clear and indications from other reports into child sexual exploitation suggest change is slow against a backdrop of limited resources. The Oxfordshire²⁶ serious case review refers to:

'insufficient disruption activity, insufficient focus on potential abusers, and difficulties in getting to prosecution given the evidential difficulties these cases threw up'

7.4.12 One of the growing features of how children are being exploited is through social media. In this case most of the children were being contacted through social networking, as well as by mobile phone. They were encouraged to send photos and to meet men, sometimes in different parts of the country.

7.4.13 There is increasing widespread national recognition that both boys and girls are vulnerable to being groomed and exploited via social media, including a growing issue of young boys being enticed by older women.

7.4.14 This activity does not limit itself to geographical boundaries, but it is very difficult for local agencies to intervene, albeit there are police operations, which have done so, and police can and do actively search social media when a child has been identified to be at risk of harm.

7.4.15 Preventative strategies therefore need to involve both measures and messages aimed at children and parents (including those with corporate parenting responsibilities), but also interventions to make the online arena a safer place and to be able to police such activities, within the legal framework.

What are the issues for reliability of the multi-agency system?

²⁴ Safeguarding Children Involved in Prostitution Supplementary Guidance to Working Together to Safeguard Children DOH 2000 and Safeguarding children and young people from sexual exploitation DfE 2009

²⁵ November 2011 the Association of Chief Police Officers publishing the 'Strategy for Policing Prostitution and Sexual Exploitation'

²⁶ Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F (OSCB 26.02.15) <http://www.oscb.org.uk/wp-content/uploads/SCR-into-CSE-in-Oxfordshire-FINAL-FOR-WEBSITE.pdf>

- 7.4.16 Much of the focus of work in this area is about providing support for the child to keep her/himself safe, through consideration of where s/he lives, education and therapeutic inputs and also that s/he is able to use social networking safely. However, this is not always effective as this puts the responsibility with the victim and some will have difficulty extricating themselves from risky lifestyles, and be drawn back to what may have become normalised behaviour.
- 7.4.17 The opportunities to groom children have grown considerably with the use of social networking and preventative measures need to keep constantly up-to-date, both in terms of children and parents awareness, but also in the ability of society to 'police' the internet.
- 7.4.18 To be more effective in protecting children, the balance of preventative work needs to give equal weight to the need disrupt and detect perpetrators of CSE as to equip children (and their parents) with knowledge of how to keep themselves safe.
- 7.4.19 Moreover, a truly preventative approach should incorporate strategies to make it less likely that children become offenders. This may be helped by education. However, to maximise preventative strategies more information is needed, from the offenders themselves, on how they came to consider this behaviour was acceptable, and whether any intervention could have been successful. No other review until this one has had any input from convicted offenders in CSE cases or the circumstances that might have led them to do what they did.

Issues and questions for the Board to consider

- Is the board assured that there is sufficient priority given to educating children and their parents about healthy relationships and the risks of child sexual exploitation?
- How is the use of social media being understood in multi-agency practice; what is expected of practitioners and agencies to keep children safe and assess risks? Do practitioners have the skills to be able to do this?
- What understanding is there about the profile of perpetrators in the area?
- Are there robust disruption processes to act as a deterrent?
- Have the police got adequate resources to undertake pro-active policing and investigate without an allegation/disclosure?
- Does intelligence sharing include the right people such as children, friends, family, carers and early help?

7.5 FINDING 5

Our current working methods and recording systems do not reliably identify patterns in individual and group behaviour. This reduces the chances of a timely response in the detection of victims and perpetrators of child sexual exploitation and leads to a more reactive rather than proactive approach.

- 7.5.1 This finding is concerned with the ability of our individual and multi-agency safeguarding systems to collect and analyse information effectively so as to enable earlier intervention

with children at risk of harm, especially at risk of harm through sexual exploitation. This relates to:

- The extent to which we can reliably analyse available information held within an agency or commissioned service about a young person and her/his family, so as to be able to identify patterns of behaviour and potential risk factors.
- The ability and use of single and multi-agency systems to use information to identify links about individual children and between individuals and then share that information in a timely way.

How did the issue manifest in this case?

- 7.5.2 This finding was demonstrated in different ways in different agencies. It was a particular problem within health services in this review where there were missed opportunities to identify potential patterns of information about a young person's sexual health. The multi-agency chronologies highlight how frequently the children accessed health services either via their GP or other sexual health services such as the Brook sexual health service or through BASE, and how this intensifies as their involvement in sexual exploitation and missing episodes increases.
- 7.5.3 Whilst GPs are usually provided with all information about their patients accessing health services, this is not true for sexual health services. This means that no one health practitioner has knowledge of what was being prescribed for each young person or the frequency or nature of health presentations. A significant factor, appears to be the wider implications of information sharing protocols and patient confidentiality within sexual health services, arising from the need to encourage children to seek help and the fear they may not do so if their family GP is informed. There is also stringent legislation that creates a barrier to sharing sexual health information.
- 7.5.4 There are also problems identifying such patterns from information available within the GP surgery. Although the IT system makes it possible to track medical history, the way children access medical help, predominantly through obtaining an emergency appointment at the end of the day, meant their health records or history were not consistently reviewed by the doctors who saw them, so the longer-term picture was missed. This was very obvious when the lead reviewers met with staff from both GP practices, when the patient records were read as whole, as one GP commented, *'it was b...y obvious-but we never looked'*.
- 7.5.5 The difficulty spotting patterns within health was prevalent in the wider cohort of children and not just one of the cases. The difficulties are compounded for looked after children when it becomes even more difficult to keep track of their sexual or other health needs especially if they have not been registered with a local GP, something that professionals and those responsible for overseeing their care should be supporting and be included as part of identifying their health needs.
- 7.5.6 One young person's (from the other LA) health records were transferred multiple times. The sexual health nurse from the other local authority reported to the review team that the need for her contraception implant to be replaced was discussed at her LAC review though this action was not followed up and so there was an increased risk of pregnancy. This

situation was a result of her having moved several times out of area and her medical records had been transferred multiple times. The health professional in the case group and review team told us that this was a systemic issue and one that affects any child that moves. It is particularly risky when a child is sexually active and being sexually exploited.

- 7.5.7 A further challenge in identifying patterns of behaviour is the 'information overload' experienced by some professionals. GPs told the review team that they were overwhelmed by the amount of data received into the practice. All of which needed to be coded and where necessary flagged up to the GPs. Where information was shared in a timely way, after an initial child protection conference or from a CAMHS service, there was an over reliance on administrators to make decisions as to the relevance of the information. Decisions regarding coding of information were being taken on the sometimes misleading heading of the communication, as opposed to reading the entire contents. One GP commented feeling that they were dealing with their hands tied behind their back as they '*had so much information coming in*' they could not '*see the wood for the trees*', hence it was easy for significant information to be missed.
- 7.5.8 When responding to early reports of anti social behaviour and small scale drug dealing at the flat in Bristol, the police lost opportunities for earlier identification of child sexual exploitation, as a result of an initial failure to recognise potential evidence as significant. Had valuable information, when received, been considered alongside other incidents and analysed over time this should have resulted in an earlier detection and recognition of sexual exploitation. However, this either did not occur or did not do so in a timely manner. There appear to have been weaknesses in the intelligence gathering process, and miscoding of concerns about the address. Responsibility for this activity had moved from experienced police officers to (at that time) inexperienced civilian staff.
- 7.5.9 Barnardo's BASE does not have IT system that enables the collation or cross referencing of wider information about children, their sexual partners and potential perpetrators. Any links made continue to rely on individual practitioners own local knowledge and ability to spot patterns and links.

The ability and use of single and multiagency systems to identify links between individuals and share information in a timely way.

- 7.5.10 The ability to identify both individual and group patterns relies on being able to analyse available information and identify links within and between individual cases over time. Within this review, there were links between different victims and between some of the convicted offenders, as well as other alleged perpetrators. Sometimes these links were evident to staff, for example girls having been missing together, but at other times such links were not so obvious.
- 7.5.11 Practitioners reported that they felt that local knowledge of potential perpetrators and their connections to children were very much held in individual practitioners' heads, or embedded

in detailed case records. Hence knowledge was not easily available to subsequent workers through the electronic case recording systems, without reading the detailed records, or holding a complex strategy discussion. Thus the fact that a number of the girls believed themselves to be in a relationship with the same man was not identified.

- 7.5.12 The police in the other authority did have access to a database that has the functionality to cross reference with the local authority, however it is not used to its full capability and relies on individual expertise in knowing how to make best use of it.
- 7.5.13 The increasing use of multi-agency specialist forums should provide environments for co-ordinated thinking and making links together. However, practitioners told us that in reality the ability to make such links early enough is often dependent on individual staff being able to recognise patterns and identify consequent risk of sexual exploitation. This did eventually happen in these cases, but only after the children had been suffering significant harm for some time.
- 7.5.14 Once the links were made and child sexual exploitation identified, the system utilises tools to assist in the identification of patterns:
- In the other local authority area, the girls were discussed at the Multi-Agency Risk Panel [MARP], which is then able to obtain a better understanding of the links between victims and offenders in the area and obtain an understanding of the risks to vulnerable children. But it is essential that the scope and function of these groups is well understood by agencies and that there is evidence to show they are effectively linked in to other child protection processes.
 - In Bristol, the decision to initiate a major crime investigation facilitated the use of HOLMES. This is a police IT system: it's strengths include the ability to organise and search through large amounts of data to identify commonalities or links by being able to:
 - *Collect and manage vast amounts of information and intelligence data*
 - *Process and prioritise information to assist in the identification of suitable lines of enquiry*
 - *Analyse information through graphical representation*

How do we know it is an underlying issue and not something unique to this case?

- 7.5.15 When detecting organised child abuse it is important to be able to identify both the patterns of behaviour of the individual child, but also the links between different victims and different alleged abusers and associates.
- 7.5.16 Within most agencies, other than the police, the database is based on the individual child and not a family or a peer network and recording systems have limited functionality to achieve this. The potential for being able to make links is reliant on the individual practitioners recognising and flagging as significant such a relationship within electronic recording systems.

- 7.5.17 Very often we rely on the ability of consistent staff to be able to identify such patterns. This may be successful when services have stable workforces, who hold vital local knowledge about the individual child, the family and the social environment. However, increasingly this is no longer the case, due to staff turnover, and service re-organisations that lead to less stability of relationships between children and individual professionals and between professionals in different organisations.
- 7.5.18 Whilst HOLMES does enable the recognition of links and patterns, it is not suitable for everyday police investigations, as it requires a team of trained operatives and significant resources on a daily basis to input text and information, index and categorise. Also, it is not linked or integrated into police intelligence databases, nor the Police National Database (PND), which was created as a result of the Bichard enquiry. 'Niche' and 'Guardian' (Avon and Somerset), the police intelligence data bases do have the functionality to be able to cross reference, but many officers do not have the skills and training to do this.
- 7.5.19 All police forces use a variety other databases to manage their day-to-day crime investigations, these databases are integrated with intelligence systems and the PND. They are networked across the whole force area but have limited ability to search and identify links or if they do have the ability are not utilised to their best effect.

How prevalent and widespread is the issue?

- 7.5.20 Repeated findings of serious case reviews have consistently highlighted weaknesses in information sharing between agencies.
- 7.5.21 The Rochdale SCR (2013) reported a similar characteristic of GP services to not use the significant information held to help identify the possibility of sexual exploitation at earlier points. Again a lack of knowledge of CSE and focus on the clinical rather than the wider needs of the young person presenting with sexual health needs was noted.
- 7.5.22 The recent reports into CSE from Rotherham, Oxford, and Rochdale all identify health professionals as playing a key role and have flagged up similar issues that show how current systems, issues of confidentiality and a fragmented response to patient care make it increasingly difficult to identify links to risk and vulnerability.
- 7.5.23 Research published by the National Working Group on CSE²⁷ found that sexual health workers were unlikely to share information with each other, and a similar pattern of children attending different clinics presenting with chlamydia and other sexually transmitted infections (STI). If this information were shared it would also make the possibility of tracing other vulnerable victims with STI's who had shared sexual perpetrators much easier. They argue that sexually transmitted diseases must be seen as marker for child sexual exploitation by all health professionals and consideration given to how information can be shared across authorities in order to better identify children at risk.

²⁷ *If you shine a light, you will probably find it.* NWG, 2013

7.5.24 This was also reported on in the Rochdale SCR (2013) where GP services had significant information that could have helped them identify the possibility of sexual exploitation at earlier points.

What are the issues for reliability of the multi-agency system?

7.5.25 There is little accurate data about the prevalence of CSE in England, though we know from recent reports (NSPCC 2015)²⁸ that it is an issue facing every local authority. However, there has been limited recognition of the importance of professionals utilising information systems that assist with the early identification of the indicators of CSE in order that links and patterns can be identified.

7.5.26 Following Rotherham, the cross government letter issued to all Chief Executives of local authorities, Directors of Children’s Services, Police and Crime Commissioners, Local Safeguarding Children’s Boards, Health and Wellbeing Boards and GPs on the 03/03/2015 emphasised the importance of information sharing across the multi-agency partnerships.

'There can be no justification for failing to share information that will allow action to be taken to protect children. We know that skilled frontline staff can be hesitant and uncertain as to when and how they should be sharing information with other agencies. There can be many reasons for that, including a blame culture, bureaucracy and a fear of being challenged. Professional staff need to be able to make these crucial decisions on a day to day basis. They need clarity and simple guidelines about when and how personal information should be shared.'

7.5.27 The issue however is more complex than this suggests, first professionals need to be able to recognise patterns that might give rise to concern, then they need to be clear about how to share it with others, and lastly there needs to be better system for easily tracking patterns across other children, and agencies to make linkages. It is not as simple as just expecting people to share information if the systems in different organisations do not collect all the relevant information, do not easily talk to each other and are unable to analyse the data to identify patterns of behaviour and links between people. Locally MASH arrangements, or other front door to service arrangements must act as the focal point for receiving and linking CSE information, and there should also be clear information sharing protocols on CSE to support such work and feed into other processes such as MARP or MAP.

Issues and questions for the Board to consider:

How effective are current local processes (including those of sexual health agencies) for identifying patterns of individual and group behaviour? Consideration needs to be given to:

- Analysis tools for identifying and linking patterns between individuals
- Analysis tools for identifying individual patterns of behaviour

²⁸ How safe are our children. NSPCC, 2004

- Information sharing
- Current arrangements for information sharing by sexual health providers
- Is the Board reassured that all agencies have early help systems in place where risks are indicated?
- Better use of inter-agency chronologies.

7.6 FINDING 6

The decision to make the investigation of these crimes into a complex investigation in May 2013 enabled the police to adequately resource an enquiry, which led to the successful prosecution of the offenders and the co-ordinated multi-agency support for the victims.

7.6.1 The investigation of child sexual abuse is complex and requires:

- Sufficient investigative resources to pro-actively investigate concerns, even without actual allegations
- Well co-ordinated multi-agency information and intelligence sharing
- Support to the victims throughout the investigation and prosecution
- A gold group of senior leaders to oversee and ensure effective cooperation and collaboration

7.6.2 The investigation of associated crimes where children are also being sexually exploited and abused is even more difficult and has, as demonstrated by previous large-scale investigations across the country, resulted in delay, a lack of coordinated multi-agency action and early disruption of perpetrators.

How it manifested in this case

7.6.3 The police had been aware for some time about possible concerns in relation to drug dealing at a particular address in Bristol. In May 2013 following the receipt of an allegation and further enquiries, the investigating officers were able, with the help of information from partner agencies, in particular BASE and children's social care staff in both authorities, to make enough connections between different concerns to gather evidence of child sexual exploitation.

7.6.4 The decision by Avon & Somerset Constabulary to make this into a complex investigation led to the ability of police, with help from partner agencies, to discover the extent of the crimes that had been perpetrated, to identify further victims and suspected (now convicted) offenders.

7.6.5 This decision meant that instead of two or three full time staff, the police investigation team grew to over twenty staff, and the use of HOLMES, the Home Office major crimes database.

7.6.6 Through this operation, the victims were able to receive help, including therapeutic support from BASE and continuing support from an identified police officer throughout the

investigation and prosecution of the offenders. For some of the victims this has enabled them to start their long road to recovery and in particular realise that they were victims.

- 7.6.7 The successful convictions demonstrated that justice had been done and sent out a strong public message in the South West that sexual offences against children will not be tolerated.
- 7.6.8 The strong working relationships between agencies on the case at all levels, including senior management, highlighted that sexual offences against children must be recognised as a priority for all agencies.

How do we know it is an underlying issue and not something unique to this case?

- 7.6.9 There are increasingly limited police resources available to investigate and detect crime. By classifying this as a complex investigation it was possible to obtain additional resources to be able to investigate and prosecute the perpetrators successfully. However, it is not possible to have this level of resourcing for all CSE investigations, and therefore the investigation of such crimes remains a challenge to police.

How prevalent and widespread is the issue?

- 7.6.10 The review team have been unable to find any research relating to the need or not of major crime/ complex investigation status for detection of CSE offenders. However, the failure to do so at an early enough stage in other CSE large-scale investigations in South Yorkshire and Oxfordshire had a significant impact on the poor outcome for victims.

What are the issues for reliability of the multi-agency system?

- 7.6.11 The lead investigating officer considers that without the resource of a major crime investigation it would not have been possible to obtain the successful prosecutions in this case.
- 7.6.12 Some of the police officers participating in this review were though concerned about what this means for current investigations into child sexual exploitation cases, which have not attracted such resources. Also there was concern articulated about the loss of expertise that had been developed through the disbanding of the major crimes investigation.

Issues and questions for the Board to consider

- Is the Board assured that there is sufficient priority and expertise consistently available to enable the criminal investigation of child sexual exploitation?

7.7 FINDING 7

Locally LSCBs and the wider multi-agency partnership have collaborated to develop CSE/Missing strategy and action plans but these take time to embed so there is a disconnect between strategic understanding to drive improvement and the reality on the front line.

- 7.7.1 Following a growing number of high priority CSE cases, there have been a number of government publications and communications to LSCBs, police, health and local authorities since 2009 to ensure that there is an effective strategic response to CSE across the multi-agency partnership. This finding is concerned with:
- the extent to which LSCB and other strategic local initiatives around CSE can adequately influence local agencies to ensure that staff are adequately supported, and trained so as to be able to identify and effectively respond to early signs and indicators of child sexual exploitation
 - even if staff are trained how this is then transferred into effective practice
 - the consequences of the reconfiguration/restructuring of a key service which impacts on local practice.

How did the issue manifest in this case?

- 7.7.2 Members of the case group from all agencies, except BASE, explained to the review team that a key factor in their failure to recognise that children were being sexually exploited early enough was explained by their lack of knowledge and awareness of CSE and how children might indicate that they are at risk. This was a puzzle to the review team who understood that there had been early strategic moves by the respective LSCBs to improve awareness across the multi-agency workforce and that this was integral to their own LSCB strategic priorities and CSE action plans where these existed.
- 7.7.3 As part of this serious case review the lead reviewers met with senior leaders and LSCB chairs to understand more about what the local strategic response was to CSE within the timeframe of this review. The lead reviewers examined key documents from both authorities to look at the join up between the LSCB, wider partnership plans, joint strategic needs assessment (JSNA), and other visionary documents.
- 7.7.4 Organisations have to periodically reconfigure services in line with changing strategic policy and available resources: sometimes, though temporary, this can have unintended consequences even when the aim, and the eventual result leads to an improvement in services.

- 7.7.5 Such consequences are both internal to the agency, but in the field of safeguarding, where the safeguarding of children relies on partnership working between agencies, changes in service delivery in one part will inevitably have an effect elsewhere in the system.
- 7.7.6 Organisational change can also impact on staff morale, sickness rates, staff turnover and levels of experience and training of those that remain.

The other authority

- 7.7.7 The outgoing independent chair of the other LSCB told the lead reviewer that they had led, what they felt at the time, was an effective early strategic response to CSE, setting up in 2010 a dedicated CSE sub group of the LSCB. This was recognised by a recent Ofsted inspection where the strategic overview of CSE was judged to be robust. However the significant point was that it was not translated into consistently high quality and timely practice by staff working within children's services. It was noted that they needed a more, specific, measurable and timely plan to improve operational recognition of sexual abuse and CSE. In reflection the chair noted that it was not only children's social care but also the police that struggled, with a '*churn of police officers attending meetings and a lack of consistency.*' At the time they said they were not aware that front line practice was not improving, mainly because they did not look at auditing impact sufficiently.
- 7.7.8 The Director of Children Services from the other authority, felt that, as described in Finding 1 national systems were just not set up to respond effectively to the challenges of CSE and neither workers nor managers were skilled or aware early enough. Although there was a stable workforce, there were entrenched models and ways of working in teams that were hard to challenge, alongside an Independent Reviewing Officer service that was not functioning well. The authority were addressing this through a process of improvement at the time of the Brooke 1 case which put additional pressure and strain on the workforce. Although CSE was seen as a 'hot topic', it was not the only priority within the local authority, accounting for only around 4% of cases at the time.
- 7.7.9 In 2013 the other local authority set up a MARP (multi-agency risk panel), which brings together key agencies who work with children considered 'high risk' of sexual exploitation or other risks such as missing and develops multi-agency risk management plans. The panel meets monthly and cases are referred using a Vulnerability Checklist. The Panel met nine times from May 2013 to January 2014 and discussed 20 children, including four of the subject to this review. Whilst the risks to children of sexual abuse and exploitation were understood by staff, Ofsted judged that interventions have been ineffective and plans not changed when concerns remained or increased. '*The panel is more effective in maintaining an operational overview of issues such as the sharing of information on alleged perpetrators of sexual exploitation.*' This was certainly evident in one of the key children, who remained on the MARP agenda every month, but with no evidence that it resulted in any effective change in her circumstances.
- 7.7.10 The risk of having panels such as MARP is that they can, if not part of both a strategic and operational approach, sit outside the wider local child protection processes and exclude

education, health or other agencies who may have important to share, though this was not an issue for the other authority at the time.

Bristol

- 7.7.11 In Bristol the Local Safeguarding Children Board and wider partnership whilst slower to have a written dedicated strategy and action plan, had established as mentioned previously (see section 2 local context) a CSE strategic group, which reported into the LSCB and later became a sub group of it. A programme of work was developed, which included multi-agency guidance and training on CSE and Missing, available several times a year to all agencies. The LSCB received regular reports and feedback highlighted that there were issues with school attendance, so head teachers were provided with separate briefings (There are now plans to link training with the new S Safeguarding in Education team who have a specific portfolio to co-ordinate CSE support to schools) .
- 7.7.12 The previous Bristol LSCB chair stood down prior to the case review starting so was not able to comment on their view of how effective these moves were at the time. However the Ofsted inspection into safeguarding arrangements in Bristol City (2014) reported that within the multi-agency arrangements for the delivery of CSE services, responses are insufficiently coordinated and practice is not consistent. *'Not all professionals are alert to the warning signs of CSE and social workers do not always use a specific screening tool for children and young people at risk.'*
- 7.7.13 The CSE thematic inspection (Ofsted 2014) highlighted that there was some good practice by individual social workers and BASE workers. Children spoken to say they understood why their social worker was working with them and that their social workers talked to them about risk. The lead inspector stated that Bristol had all the 'ingredients' but needed to ensure there was a CSE strategy in place. The response to CSE was not piecemeal, it was coordinated but without enough strategic oversight.
- 7.7.14 During the Operation Brooke investigation and trials a Gold Command group was established which provided the strategic oversight. The Gold Group operated very successfully and was a positive achievement. Significant work was undertaken with community leaders through this group.

Professionals in the Bristol case group reported that since the start of Brooke in May 2013, they had experienced more support and that there was 'a localised heartfelt response ' to the challenges of CSE. There had been a programme of multi-agency training delivered by Barnardo's and from their perspective they now felt much better supported and trained, but still relied heavily on expertise of BASE staff and other specialist CSE posts. Social workers are currently encouraged to use the SERAF (sexual exploitation risk assessment framework) as a tool by the South West Child Protection Procedures. (The SERAF was developed by Barnardo's and includes four categories of risk intended to inform appropriate responses in relation to children's safeguarding needs). Barnardo's and Bristol LSCBs were clear that whilst useful the tool should always be used alongside professional consultation and supervision.

- 7.7.15 Other documents such as the Safer Bristol Partnership Plan 2012-2015 mention CSE and link to the specific work being done to reduce violent crime against women and girls, especially as sexual crime in Bristol for girls from age of 15 was rising. They report on their effectiveness to the BSCB. The JSNA and Mayoral Vision document link to aspirations to address CSE and sexual violence, but make no explicit reference to join up with the LSCB Business Plan or priorities.
- 7.7.16 Senior leaders reported to the lead reviewers that they agreed that at the time there was no coordinated CSE strategy on paper, and joined up partnership working on it was somewhat disconnected.
- 7.7.17 Since 2011, a range of health professionals have attended the BSCB CSE training courses. The health professionals in the case group and the GP practice staff told the reviewers that although all GP's had received basic single agency training on safeguarding which included some reference to CSE, they had not understood enough about indicators to make the link for children in their practice. One young person told the lead reviewers that she was amazed that at just 13 years old she was given the morning after pill by her GP. She said that at the time she wanted to say something more about what was happening but felt everything she said was taken at face value, on another occasion she says she had bruises and scratches on her thighs (she had been raped) but was never examined, again she wanted someone to be more curious.
- 7.7.18 As discussed in finding 4, only sexual health workers from Brook sexual health service and BASE had experience of using a health screening tool for identifying risk of CSE and were comfortable using sexually explicit language, so expertise can be very localised and not integral to all services providing sexual health support.

Police

- 7.7.19 Until 2012, the Child Abuse Investigation Team [CAIT] in Bristol (Avon and Somerset Constabulary) had responsibility for investigating crimes against children, including some of those alleged to be committed by perpetrators outside of the family. However, decisions about case responsibility was decided on a case by case basis, with CID sometimes taking responsibility, especially when the victims were aged 14 or over. CAIT officers had the advantage of being knowledgeable about child abuse and the possible absence of direct allegations. Because of the nature of many crimes that involve children taking time to build an evidence base, this team were accustomed to the need for these concerns / allegations to receive a timely response to avoid drift.
- 7.7.20 As part of a wider police efficiency drive and structural reconfiguration in 2012, Avon and Somerset Constabulary merged the staff from the child abuse investigation team (CAIT), into new Public Protection Unit (PPU) with responsibility for crime against vulnerable adults, children, hate crime and domestic abuse. The reason for this change was recognition by senior management that in the context of government cuts and austerity measures, the constabulary had to make changes in the way it operated. Moreover, it was (and is) important for all officers to have an understanding of safeguarding, and the potential links

with domestic abuse made it sensible to combine the units, together with hate crime and vulnerable adults.

- 7.7.21 As a consequence some of the specialist trained officers from CAIT were re-allocated to other units and the review team was told that for a short while the revised team had only one officer with any expertise in child protection.
- 7.7.22 Police officers told the review team that the impact on them was significant. They were under extreme pressure, with officers being expected to deal with a significant number of serious crimes and live investigations on a daily basis. In consequence the less urgent incidents where there was no immediate risk to life and limb were delayed and in some cases drifted for considerable periods. For one of the children this meant that an original complaint reported to the police in March 2013 remained unallocated and was not followed up properly until September.
- 7.7.23 Child abuse investigations, unlike some of the other emergency situations in the PPU, tended to take longer, often not needing an immediate response. Typically they would work on a child abuse case over a four-week period. In contrast the domestic abuse cases, usually involved an immediate response, and tended appropriately to take priority.
- 7.7.24 Alongside this structural, change some officers were unhappy at the loss of the specialist CAIT, some transferred to other units, a few had reported as unfit for work through sickness and others were inexperienced and lacked sufficient training. It also meant that disruption and pro-active policing were of lower priority.
- 7.7.25 This reconfiguration had an impact on colleagues in other agencies, due to the disruption in established working relationships and understanding the way the new system developed. Police officers reported to the serious case review that they were not resourced sufficiently at the time to support the building of evidence that they needed for sexual exploitation cases. Other resource problems, according to one officer, were the lack of appropriate interview suites for children and inadequate maintenance of mobile equipment. This resulted in postponed interviews with child witnesses.
- 7.7.26 Whilst CAIT officers were used to working jointly with social workers the new officers tended to investigate crimes on their own. The communication of the changes with partner agencies did not help the transition, as there was little prior communication and consultation.
- 7.7.27 Police officers in Bristol reported to the review team that in 2012 they had no specific training around child sexual exploitation. CSE was not (and still is not) a criminal offence in its own right, this contributed to a lack of pro-active investigation of CSE perpetrators. Officers reported that they felt pressure to complete investigations rather than invest time disrupting those perpetrators. The officers said that they felt in some instances they were dealing with children involved with consensual underage sexual activity rather than children who were being or at risk of being sexually exploited and this was partly due to their lack of awareness; other contributory factors are discussed in finding 2.
- 7.7.28 In Bristol the police drugs team did not initially take account of other evidence that children may be a risk whilst undertaking drug raids even when there was evidence of other activity, such as condoms on the floor, or children present. They were slow to share with police

safeguarding unit's information or code appropriately the risk that there may be safeguarding issues, something they explain by a lack of awareness and having a single focus.

Education

7.7.29 School staff in the case group reported that they had had no training on CSE or any access to tools or support that might help them identify vulnerability factors such as children who are absent or go missing. Moreover school staff said they were 'out of the loop' and were not routinely notified when children went missing. They could therefore not respond appropriately to existing risk or identify potential risk. The difficulty that schools have in providing the right support, at right time and recognising when children who are being subject to or at risk of child sexual exploitation has been noted in previous serious case reviews reports (Oxfordshire 2015, Rochdale 2013 & Rotherham 2012).

How do we know it is an underlying issue and not something unique to this case?

7.7.30 Both LSCBs in this case review reported the challenge of implementing better processes in line with the national political agenda, in the context of a smaller group of staff to implement the changes. This creates continual difficulty in the timely development of resources and processes that are meaningful and make a difference to children. In addition the logistics involved in embedding new practice in an environment of staff turnover and increased demand across services contributes to the delays in ensuring all staff receive the appropriate training.

7.7.31 All agencies have to reconfigure services at times, with the changing demand of government priorities and strategic policies and resource provision. When this happens, there is an inevitability that staff become involved with internal debate and anxieties about their own careers and futures. Also part of the change process is the adaptations that occur within the organisation, with changes of working teams and managers.

How prevalent and widespread is the issue?

7.7.32 The wider Ofsted thematic inspection into CSE (2014), which included Bristol, concluded that child sexual exploitation has not been treated as the priority that events in Rotherham and elsewhere strongly suggest it should have been, as a result, in some cases local arrangements to tackle the problem are often insufficiently developed in part due to the fact that some professionals have simply failed to properly apply child protection processes to children at risk of being sexually exploited, as it is still not well understood, as specific training is not reaching all those who need it. As a result, many of those working with some of the most vulnerable children are not equipped to identify and respond to the signs of sexual exploitation. The report also highlights that some LSCBs have shown poor leadership and failed to adequately challenge slow progress in developing both child sexual exploitation strategies and meaningful action plans. Local arrangements where they do exist, are often poorly informed by local issues and self-assessments and do not link up with other local strategic plans.

What are the issues for reliability of the multi-agency system?

7.7.33 In Bristol and the other authority they had tried hard to improve the way they tackled CSE. LSCB's across the country need to recognise that it takes time to embed any strategy and needs a significant investment and join up at all levels across the multi-agency partnership to ensure the workforce is fully supported and equipped. There also needs a clear means of evidencing its impact on the front line. The plan itself, or delivering lots of training will not make any measurable improvement on practice. It must be clear who will hold whom to account, what are the agreed tools and support processes, and what the role of LSCB is and how there will be good feedback from front line as to the impact and effectiveness of any such plans.

7.7.34 Whilst organisational change is usually in the interests of improved service delivery, any unintended consequences which impact on the effectiveness and safety of children need to be identified and addressed and shared with the local partnership including the LSCB, before implementation, or as soon as possible afterwards once they become apparent.

Issues and questions for the Board to consider

- Is the Board reassured that there is now a robust CSE strategy to coordinate and measure the impact of services to tackle CSE and to support children who go missing from home or care?
- How is the board reassured that staff across the partnership are receiving consistent and effective training on:
 - CSE
 - children missing from home and care,
 - trafficking of human beings and that the impact on practice and outcomes for children are clearly understood
 - To what extent is the national/ local political agenda, including financial cuts to services in local areas impacting on keeping children safe generally and specifically regarding Child Sexual Exploitation?
 - Is the Board confident that member agencies understand the need for consultation and communication with partner agencies when reconfiguring services that will impact on joint working?

8 Conclusion

- 8.1.1 This serious case review was commissioned by Bristol and another unnamed LSCB in response to the sexual exploitation of children in Bristol between December 2012 and May 2014. The subsequent police investigation known as Brooke 1 and Brooke 2 culminated in the successful prosecution of 15 offenders all of whom received significant sentences for their crimes.
- 8.1.2 Section four of the report highlights the key messages that children who contributed to this review want professionals to hear. It is essential that we not only take notice of their feedback, but also acknowledge their bravery and tenacity. For many of them, they continue to live chaotic, abusive and traumatic lives: professionals need to be alert to the fact that successful prosecutions do not in themselves guarantee that their young lives will return to normal, the trauma of CSE needs long term therapeutic investment and a 24/7 support service.
- 8.1.3 The review team also heard from a number of parents, who tried very hard to keep their children safe. The importance of professionals and particularly the police, listening to what they are saying and acting on information and intelligence they share is crucial.
- 8.1.4 The research question that this review focused on was around the adequacy of the strengths and gaps in the multi-agency strategic and operational response to CSE in both Bristol and the other unnamed authority at the time. The following is a summary of the findings that it is hoped will inform not only local best practice improvements around the response to CSE, but also wider learning across the UK.

Strengths

- 8.1.5 There were many strengths identified in the response to CSE by agencies in both local authorities. The staff involved in the two Operation Brookes worked very hard to try and support the children and keep them safe, something which as the report highlights, is very difficult to do when children are experiencing sexual exploitation and some staff are untrained and/or unsupported and not clear themselves what is sexual abuse, sexual exploitation or underage sexual activity. The review team has received a significant amount of feedback from these practitioners and managers that has informed our findings in section 7. The impact and trauma that staff are subject to when working with such harrowing cases should not be underestimated and services need to provide adequate support and reflective supervision.
- 8.1.6 The police response to CSE whilst initially slow, did improve greatly once the police resourced the major investigation processes that became Brooke 1 and 2. However the early lack of joined up intelligence and professional mindset, which saw underage sexual activity rather than sexual exploitation left children at risk for too long.
- 8.1.7 Barnardo's BASE, which receives a grant from the local authority, played a key part in supporting police and social workers to manage the investigation work with children differently and from a more victim led perspective. They also provided intelligence to the

police and built trusting relationships with the children to enable them to disclose abuse and give evidence in court.

Gaps

- 8.1.8 The multi-agency practice leading up to the trials was well-coordinated and frontline practitioners and a number of children fed back on how they valued the way they worked together. However, this was not every child's experience and professionals must be wary of children feeling used in order to obtain convictions without ongoing support (this was clearly stated by the children from the unnamed authority). The vulnerability of these children to continue to be sexually exploited continues whether or not there is a trial. Agencies must plan for a continuation of long-term therapy after any convictions. There is also a need to ensure that post trial the support continues for the staff too.
- 8.1.9 The role of health services and schools in the early identification of children at risk of sexual exploitation is key. Had information that a range of health professionals had on the children been viewed chronologically and shared between sexual health services and GPs it would have identified that children were at risk. The confusion created by national guidance on patient confidentiality, data protection and legal rights appears to get in the way of keeping child safeguarding as the most paramount consideration. For schools, the importance of multi-agency communication and sharing of information is vital in order that staff can recognise that some difficult to manage and disruptive behavior may be as a result of sexual exploitation.
- 8.1.10 The importance of social media as a vehicle that perpetrators use to groom, and then control children is still not understood enough by professionals and there continues to be a deficit in professional skills to use it to gather intelligence and disrupt perpetrators.
- 8.1.11 Going forward we must ensure that learning from complex CSE investigations is retained and applied effectively, especially where key staff in the police and other agencies move on and new investigations are required:
- There must be more effective use of IT systems both within and across agencies to enable the identification of victims and perpetrators who may be linked to each other. Too much reliance on individuals holding knowledge and identifying patterns and links with perpetrators and other children is not a sustainable or safe approach to take.
 - All professionals need to appreciate that safeguarding children must be the priority and all other constraints in respect of patient confidentiality and information sharing regarding potential perpetrators must be seen as subordinate.
- 8.1.12 The small input into this review from the two perpetrators serving prison sentences, show how important it is for them to be engaged in case reviews and research in order to develop an understanding of their lives, what led them to be involved in the sexual exploitation of children and what might have helped prevent their offending. Early identification and prevention has to start in schools with better and compulsory input on healthy sexual relationships and links to other early help services.

8.1.13 Finally to finish with one of the top tips that one of the children who contributed to this review wanted all children to recognise- *if you feel someone is not safe - tell someone, you are almost certainly right.*