Child Sexual Exploitation Thematic Child Safeguarding Practice Review

Clare Hyde

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Thematic Child Sexual Exploitation Child Practice Safeguarding Review

Executive Summary

Part One

This review was commissioned by the Chair of the former Bradford Safeguarding Children Board prior to the establishment of the current Bradford Partnership. In accordance with guidance at the time responsibility for the review transferred to the new Partnership at the conclusion of transitional arrangements in September 2020. It was carried out by an independent person, Clare Hyde of the Foundation for Families. It was overseen by a panel of senior officers representing local agencies in accordance with national guidance.

Five children were included as the main case sample, three now adults, two of whom were abused during the 2000s. The review also considers the impact of learning from two other SCRs carried out locally in 2015 and 2016.

The terms of reference for this review required the independent reviewer, the review panel members, over 40 practitioners and managers from a wide range of agencies and crucially people who are still living with the consequences of child sexual exploitation (CSE) to consider whether or not there had been sustained improvement in the way agencies and individuals respond to CSE in Bradford. The review had three terms of reference and set out to establish:

1. Whether lessons have been learnt from multi-agency responses to non-recent cases of CSE within the Bradford District and beyond and are embedded in current policies and procedures.
2. The extent to which analysis of the responses of all agencies to current cases provides assurance that working practices and responses that exist now are robust, child centred and effective in protecting children from sexual exploitation and related harms; and
3. To what extent good practice lessons around placement provision for looked after children at high risk of, or experiencing, CSE are embedded in practice.

At an early stage in the process of conducting this review it became clear that despite some significant improvements in agency understanding of and responses to CSE between the less recent and current cases, agencies and individuals in Bradford have not always got it right. CSE is a complex crime and continues to be an area of concern and action in Bradford, as it is in many other places in the country and the learning from this review informs this process.

What is Child Sexual Exploitation?

CSE is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. CSE does not always involve physical contact; it can also occur through the use of technology. The term child sexual exploitation sanitises the reality of what that means for children. In several of the cases included in this review this meant being raped, sexually assaulted, physically assaulted, being afraid and anxious, being forced to take drugs and alcohol, being involved in criminal activity, being homeless and being lonely and isolated from family and friends.

Most of the children included in this review have lived with domestic abuse, physical and emotional abuse and neglect for most of their lives and this therefore poses a challenge for commissioners, managers and practitioners as it is the failure of the system to protect children from these harms which *creates* vulnerability to further abuse from CSE and also child criminal exploitation (CCE).

Part Two

The Children included in this review, a summary.

More detailed information about the lives of the children and their experiences of services is included in the overview report with more detailed chronology of multi-agency involvement in Appendix 2.

Cases 1 and 2 are less recent cases covering a period between 2001 up to 2012.

Case 1- Anna

Anna experienced multiple disadvantage and abuse as a child. Her mother first raised concerns about CSE when Anna was 14 and services were put in place including social care and a specialist voluntary sector provider. These services did not keep Anna safe, and the review concludes that they colluded with a situation in which Anna had an older abusive boyfriend, appeared to support a religious marriage with him and set up a foster placement for Anna with his family outside of normal processes. Many reports of abuse and assault were not addressed, and Anna had two children whilst she was still a looked after child.

Multi-agency working and the placements did not keep Anna safe.

Case 2- Fiona

Fiona was a child who came from a home with significant domestic abuse. Fiona's distress resulted in deteriorating mental health and her behaviour become increasingly concerning. Fiona came into care in 2008 but was not referred for CSE support despite assaults which resulted in her attendance at A&E. Fiona did try to tell services about her CSE abuse, but this was not heard or acted upon. Fiona gave birth to a child who was subsequently adopted, which compounded the impact of her sexual exploitation causing lifelong sustained trauma to her. In February 2019 nine offenders were convicted of twenty-two offences against Fiona.

More recent cases 3-5

Case 3 – Samara

Samara was a child who grew up in a home with domestic abuse and where parental mental health issues were a factor. Her parents raised a concern about CSE risk when she was 12. She was referred to social care who did demonstrate some areas of good practice in responding to her. There was a timely police response, and two arrests were made.

Despite this there were delays in responding to Samara. There was professional challenge about the risk she faced. There were also examples of use of language that placed

responsibility on Samara - “putting herself at risk”. This related to Samara creating profiles online where she claimed to be an adult in order to meet men. She was aged 12 at the time.

Case 4- Ruby

Ruby had a disrupted childhood which included the death of her mother when she was a very young child. Ruby was identified as being at risk of CSE aged 13 and came into care aged 15. Ruby suffered from significant mental health issues and a physical condition which impacted on her behaviour and may have impacted upon her understanding of what was happening to her. Ruby experienced 14 different placements including secure placements. Services did respond to Ruby, but the review finds that there was too much emphasis on the impact of Ruby’s behaviour on staff rather than the cause of it. Services did not keep her safe.

Case 5- Ben

Ben is a child with a disability which significantly impacted on his communication. There were concerns during his childhood in relation to domestic, physical and sexual abuse. Concerns were also identified from an early age about Ben’s use of pornography, cocaine and alcohol. Ben had a severely disrupted education and was a victim of CSE from both male and female perpetrators.

He and his siblings were on child protection plans, but there was a difference between the response to Ben and his female siblings in respect of CSE.

Examples of changes in Policy & Practice since 2011.

Since 2011 there has been a significant focus on CSE in the Bradford District, in a non - recent trial of CSE; 9 perpetrators were brought to justice for 21 indictments and sentenced to a total of 132 years; the formation of a multi-agency CSE hub; a systematic trawl of historic cases revisiting data on missing children through Operation Dalesway, and a number of victims have come forward as a result of this. The Police have made over 120 arrests in relation to non-recent cases in Bradford with investigations continuing still. Current processes are in place to identify children, assess risk and to put services in place. The following provide some examples from current practice:

Response to missing incidents and Domestic Abuse

4.2 A report of a child at high risk of CSE going missing now triggers an immediate response and full investigation. Adults who may be involved in high-risk children going missing are considered as suspects, located, arrested and interviewed. A social care referral is made and a CSE assessment follows. At the time of Fiona`s and Anna`s cases many missing incidents were treated as “unauthorised absence” rather than missing, resulting in a lower-level response. This categorisation is no longer used.

4.3 The Philomena Protocol was introduced in Bradford in 2020 and has resulted in improved management of missing children.

4.4 The Philomena Protocol is a scheme that asks carers to record vital information about children in placements which assists with both risk assessment and the response to any

children who may go missing enabling the information to be immediately available to help find them quickly and safely.

4.5 There is a specialist police team dedicated to protecting children vulnerable to exploitation which works closely with other agencies.

4.6 Domestic abuse incidents between those in a relationship when under 16 are now treated as child protection, not domestic abuse cases. Over 16 they are dealt with as domestic abuse, and all are risk assessed. Where there is concern that they are high risk and there may be further abuse they are considered at a MARAC meeting.

4.7 Where children live in households where there is domestic abuse, children's social care (CSC) and the child's school are informed of any incident so they can assess impact and monitor well-being.

4.8 Where perpetrators can be identified new preventative and protective legal provisions are used and the perpetrators arrested where there are sufficient grounds.

Teenage Pregnancy

Specialist nurses/midwives support teenage mothers and pregnant children looked after by the local authority (LAC) and they are more highly trained in safeguarding matters. There is a process for documentation and sharing of concerns with CSC. The Bradford Teaching Hospital and Airedale Hospital Trust's safeguarding teams also review all A&E attendances for self-harm or possible abuse and refer on to CSC as appropriate.

Executive Summary

Part Three

Findings

Terms of reference 1:

To what extent have lessons been learnt from the multi-agency responses to non-recent cases of Child Sexual Exploitation within the Bradford District and beyond and how well is this embedded in current policy?

While the review found that there had been substantial improvements in practice since the response to the non-recent cases, it found that there was also learning for children in the more recent sample. The LCSPR process reflected upon the learning from two previous local CSE SCRs and asked why although there have been improvements, not all learning has been fully embedded into practice. This review also identified the impact of an adverse Ofsted Inspection of Children's Social Care and the consequent instability in the children's social care management and workforce.

- Policy changes had been made in relation to CSE in all agencies, but this was not always seen in sustained practice changes. New standard operating procedures were issued in

2019 and a compliance audit revealed a positive response and high levels of compliance but some continuing issues with the quality of service.

- The short-term nature of funding for some CSE and family support services was also evident. This means that staff turnover can be high with experienced practitioners moving on to different roles or different areas. A further consequence of this is likely to be that 'organisational memory' across the system and learning from local SCRs and other reviews is lost too.

Terms of reference 2:

To what extent does analysis of responses from all agencies to current cases provide assurance that working practices and responses are robust, child centred, and are effective in protecting children from sexual exploitation and related harms?

While there was evidence of good practice in strategic activity, the evidence of quality of practice was not there in all cases and all agencies.
A CSE risk assessment tool is used once a possible risk has been identified. There was however evidence that risk was not always recognised even where there were clear signs and indicators suggesting sexual exploitation and there were examples of assessments being very delayed.
The language used about the children did not always reflect their vulnerability and they were, on occasion, deemed to be making choices.
At times, the response and attitudes to the male victim was different to that of the female victims.
Where risk was identified, changing levels of risk were not always responded to quickly and there was variance in how different professionals interpreted levels of risk.
Good supervision within CSC is critical to the quality of practice, particularly with cases where there is constant change and challenge. Case load size is also a factor as working with CSE is complex and time consuming. High levels of staff turnover in children's social care have made it difficult to measure the take up and impact of essential training. All three factors were identified as an issue in the Ofsted inspection in 2018 and so it is no surprise that these were found in the review.

Several wider issues were evident:

- The role of drugs and alcohol in grooming, control and exploitation was not addressed by a referral to specialist services.
- Response to young people with disabilities and with behavioural problems
- Recognising and responding to online abuse.
- Lack of consideration of any possible grooming/ radicalisation or in the later cases a referral to Prevent.

Terms of reference 3: **To what extent are good practice lessons around placement provision for looked after children at high risk of experiencing child sexual exploitation embedded in practice?**

In the sample the review found many examples of children at risk of, or being, exploited being placed in expensive placements which could not meet their needs. They experienced many moves and went missing on a regular basis.
The review did identify some good practice, but this could not be sustained. The children struggled to achieve their aspirations, such as attendance at college, and lacked the confidence and skills to engage successfully in the routines of everyday life.

Additional analysis and matters identified throughout the review.

- The use of drugs and alcohol as tools of exploitation was present in all cases. None of the children were referred to specialist services.
- The impacts of physical, sensory and learning or cognitive disability on children and young people compounded the risk to them of becoming exploited and abused.
- Half of the female children considered in this review became pregnant as a result of their abuse. Two of the babies were placed for adoption and all were subject to child protection arrangements. Long term impacts of early pregnancy are well-understood but there is little UK research about the impact of bearing a child as a consequence of abuse.
- There is little wider focus on and therefore little understanding of what, if any, common factors, including adverse childhood experiences, perpetrators of CSE share. Understanding how and why people become perpetrators of sexual abuse is important if we hope to reduce the harms caused by them to individuals and communities.
- There is a strong relationship between child sexual abuse and adverse mental health consequences for many victims.
- Four of the five children in the case sample have experienced being arrested and held in custody and some have been convicted of offences in response to their behaviours. There was little contextualising of the offences, and this is also true for cases in the detailed audit. Research clearly demonstrates that a trauma informed response works best in these circumstances.
- All the children considered in this review experienced significant disruption to their education causing them to miss out on a basic education, miss out on the protective factors provided by regularly attending school and miss out on social interactions with peers. Their early histories of abuse, neglect and trauma resulted in them displaying very challenging behaviours.
- The long-term impacts of sexual exploitation on mental health and wellbeing is significant.

Summary of Recommendations

The full recommendations are set out in full in the review but can broadly be grouped into key areas of action.

1. That agencies work closely together to learn from local and national learning and to ensure that the pervasive, long term and sustained impacts of CSE on children and then later as adults is understood and;
2. That there is a system wide approach to jointly commission, long term approaches which address the human and financial costs of a child's lifetime exposure to trauma, abuse, neglect and exploitation.
3. That services should recognise that drugs and alcohol are used as part of the grooming coercion and control of victims by perpetrators and that responses need to be developed to reflect this. All services and professionals should understand the warning signs and act quickly.
4. That the additional vulnerability of disabled children is recognised and that services respond appropriately.
5. Those practitioners are professionally curious in relation to changes of cultural identify in children.
6. That the impact of placement change is recognised, and the lack of suitable local placements is addressed by commissioners.
7. That action is taken to ensure school placements are available for children such as those considered in this review and steps taken to improve school l attendance of those who are missing out on education.
8. That the long-term mental health and wellbeing needs of children and adults who experience CSE, and coexisting traumas is prioritised and understood by commissioners and practitioners.
9. That the outcome for children (and their children) who become pregnant as a result of sexual exploitation or abuse is better understood and responded to.
10. That more is learnt and understood about the perpetrators of child sexual exploitation

An executive summary can never fully reflect the information and events that these children suffered. The full details are contained in the substantive review and appendices.

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Thematic Child Exploitation Serious Case Review

Foreword

Jane Booth, Independent Chair and Scrutineer

The Bradford Partnership – Working Together to Safeguard Children

In March 2019 nine out of 10 men were sentenced to a total of 132 years' and 8 months' imprisonment following sexual exploitation of a child who had been in the care of the Local Authority. Now an adult, she had shown considerable courage in coming forward and speaking about her experiences as a child during the years between 2006 and 2011.

Following the trial, a second woman who had suffered similar abuse came forward and criminal investigations have been carried out in respect of alleged sexual offences she suffered when also in the care of the local authority in the years between 2001 and 2006.

In April 2019 I commissioned a serious case review, this was passed to the Bradford Partnership following changes in legislation and the development of new safeguarding arrangements. The work to complete the review was conducted under their auspices as a Local Child Safeguarding Practice review (LCSPR), I recognised that it was important to understand the experiences these two young women had suffered and to ensure that steps had been taken to improve the way agencies work together with children today to better protect them from exploitation. I felt it was equally important to understand the issues around more current practice and concerns that had been raised in respect of more recent cases. These cases are therefore also included in this review.

The review therefore considered multi-agency responses to five people who were children at the time of their abuse, enabling more recent development in multi-agency practice to be included.

The Bradford Safeguarding Children Board had previously completed two other SCRs following sexual exploitation of children, one in 2015 and the other in 2016 and I asked that the review consider the extent to which learning from these reviews had been actioned and embedded in current work with children and their families.

Alongside this LCSPR, a number of audits have been undertaken both by the Partnership and by single agencies which are relevant to the review. These were shared with the independent author to inform the review.

The review makes difficult and, at times, distressing reading. The children suffered abuse that no child should have to experience and, in most cases, had suffered other traumas and abuse long before they were sexually exploited. We must do all we can to ensure support for children at risk of or experiencing sexual exploitation is as good as it can be, includes preventative work, protects those at risk and pursues those who commit such crimes. We can always identify things that could have been done better and in looking at these cases we can see many occasions where opportunities to protect children were missed and, in some of the most heart-rending situations, where children were left at risk and subsequently abused.

We must also recognise that work to protect those at risk of exploitation is complex, requires resources and is very reliant on the commitment of staff who are entitled to good supervision, support and appropriate training.

A further challenge exists in identifying and prosecuting the offenders who prey on these vulnerable children. Our work inevitably focuses on victims, but the perpetrators must be made to take responsibility for their actions and the success of a number of prosecutions in Bradford is very welcome.

The Partnership and local agencies are committed to continued development and delivery of good quality services. They have welcomed this report and are actively pursuing improvements in the ways they work, singly and together, to reduce the risk of children being abused, to better support those who are and to deal with perpetrators.

I hope this review will be widely read and will help to inform the development of services elsewhere. Both the young women who shared their experiences want the analysis of what happened to them to lead to change and reduce the risk to others. We owe it to them to make sure it does.

Acknowledgements

The author of this report and the Chair of the Bradford Partnership and the Serious Case Review Panel members would like to thank the practitioners who shared their views, insight and experiences for this review. Also, thanks to Jaci Quenelle for her expertise in designing and delivering the practitioners learning events.

Most importantly, thanks go to the survivors of child sexual exploitation who contributed to this review often reliving difficult and traumatic experiences.

Although not all the children in the case sample, and their families made a direct contribution to the review, all wish to see the complete review. If any further learning comes from their responses, then this will be built into action plans and plans are in place to develop learning tools based on victim and family experiences of exploitation.

1.0 The Review

Part One

1.1 Bradford Safeguarding Children Board (BSCB), replaced in September 2019 by the Bradford Partnership – Working Together to Safeguard Children, commissioned this thematic serious case review (SCR) of child sexual exploitation (CSE) in April 2019.

1.2 The review was agreed following concerns regarding historical multi-agency responses to CSE. In addition to information held within agencies, the victim of a non-recent CSE enquiry had waived her right to anonymity following a successful criminal court case and had spoken openly about her experiences and the nature of the engagement agencies had with her.

1.3 It was agreed that a thematic SCR would be commissioned looking at both non-recent and current CSE cases to link lessons from the past with current practice across the agencies. Responsibility for the review was passed to the new Safeguarding Partnership in September 2019 and work continued as a Local Safeguarding Child Practice Review.

1.4 The review had three terms of reference and set out to establish:

I. Whether lessons have been learnt from multi-agency responses to non-recent cases of CSE within the Bradford District and beyond and are embedded in current policies and procedures.

II. The extent to which analysis of the responses of all agencies to current cases provides assurance that working practices and responses that exist now are robust, child-centred and effective in protecting children from sexual exploitation and related harms; and

III. To what extent good practice lessons around placement provision for looked after children at high risk of or experiencing CSE are embedded in practice.

2.0 Methodology

Working Together to Safeguard Children (2018) provides guidance for undertaking a LCPSR.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

2.1 The Thematic LCPSR was designed and led by Clare Hyde MBE from The Foundation for Families (a not-for-profit Community Interest Company). Ms. Hyde developed a review model that would enable participants and stakeholders to consider Bradford's responses to CSE. Ms. Hyde is also the author of this report and the methodology included elements of the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

https://gov.wales/sites/default/files/publications/2019-05/guidance-for-arrangements-formulti-agency-child-practice-reviews.pdf

3.0 Case Selection

3.1 Five cases were selected for inclusion in the scope of the review by the Panel members in consultation with the independent reviewer. The decision regarding which children and adults should be the focus of the review included a number already identified as likely to meet criteria for review with the sample selected to ensure a cross section of cases (age, ethnicity, disability and sex).

3.2 In two of the three more recent cases key front-line practitioners and their managers participated in learning events which aimed to understand the context of current practice and involve practitioners in identifying improvements and good practice.

3. 3 The outcome of a more recent procedural compliance audit has also informed this review.

4.0 Independence

4.1 The independent reviewer, Clare Hyde, was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody.

4.2 Ms Hyde has also designed and facilitated a number of multi-agency reviews including a CSE review in Rochdale in 2012 and is currently the Independent Chair of several SCRs and Domestic Homicide Reviews and has designed and led several Learning Reviews on behalf of Local Safeguarding Children and Adults Boards Serious Case Review Panel

4.3 The review panel comprised senior and specialist representatives from partner agencies, (see Appendix 1), to provide oversight and assist the independent reviewer in considering the evidence, formulating the recommendations and quality assuring this report.

4.4 The panel met on a number of occasions between July 2019 and July 2021. The overview report was ratified at the Bradford Partnership meeting on 15th July 2021. The COVID-19 pandemic and the additional pressures this placed on agencies impacted upon the expected timescales of the review and caused a significant delay in completion.

4.5 Two learning events were held with over 40 practitioners and managers who were involved of the lives of Ruby and Ben (the two most recent cases). The events were designed to.

- Share research and theory
- Consider current practice and work together in 'imagining what a good life' would look like for Ruby and Ben and how that differed from what was currently happening to them.
- Identify what needed to change at an individual and system wide level to achieve this.

4.6 During the course of the review the independent reviewer met with two of the subjects of this review. Their views are reflected throughout this report. The other 3 children and families have been made aware of the report and plans are in place to enable them to share their views if they choose to do so in the future.

5.0 Backgrounds of the children in the review

5.1 The children included in this thematic review are from a variety of backgrounds. One child is of Asian heritage and four children are white British. Three of the children had a combination of learning, physical disabilities and communication difficulties.

5.2 The following is a list of conditions considered to be disabilities from the NSPCC.

- Autistic spectrum / ADHD
- Learning disability
- Deafness
- Physical disability
- Visual impairment
- Long-term illness

https://learning.nspcc.org.uk/safeguarding-child-protection/deaf-and-disabled-children

6.0 Parallel Processes

6.1 There were ongoing police investigations in one of the non-recent cases. In addition, the National Independent Inquiry into Child Sexual Abuse (IICSA), which was established to examine how the country's institutions handled their duty of care to protect children from sexual abuse was in dialogue with the Bradford Partnership during 2020. They engaged with a range of agencies across the district and offered the local population the opportunity to engage with the Truth Project to inform the outcome of the National Enquiry.

7.0 Non-recent Cases and the national context

7.1 The two less recent cases included in this review relate to two women who are now in their late 20's and early 30's. The timelines for their individual experiences of CSE cover the period 2002 up to 2012. It is, therefore, useful to consider the national 'picture' regarding CSE during that period and how this was reflected in public and professional attitude, policy and practice.

7.2 As a previous Bradford SCR notes *"Any systemic failure has a complex and particular causality. Some of it, as the Serious Case Review into CSE in Oxfordshire (2015) concludes, relates to a general context and moment in the wider coming to terms with sexual exploitation as a society and as a culture*". 'Autumn' Serious Case Review Bradford 2015

8.0 National CSE Timeline

8.1 In 2000/01 Guidance was issued by the Home Office as a supplement to Working Together to Safeguard Children. It was called '*Safeguarding Children involved in Prostitution*' and was aimed at police, CSC and education and recommended that children involved in prostitution be treated as victims of crime.

8.2 In 2003 the Sexual Offences Act closed a loophole which prevented an adult from being prosecuted for sexually abusing a child if they could prove it was consensual.

8.3 In 2009 the Government published '*Safeguarding Children from Sexual Exploitation'*. This followed years of public campaigning by Barnardo's (who were the major provider of CSE related services at the time), the Children's Society and others about the sexual exploitation of children. The term 'child sexual exploitation' and acronym 'CSE' was adopted into common usage around this time reframing the child as a victim.

9.0 CSE Services in Bradford

9.1 Specialist services working with children at risk or victims of CSE have been operating in Bradford for over 25 years. The practice landscape for these services has been shaped by a range of activity at local and national level. Bradford was one of the first areas to set up a multi-agency CSE Hub in 2011. Despite reductions in public finances, national and local agencies have been expected to invest in and improve their response to CSE. CSE continues to be recognised as a national and local threat and can manifest in many different ways and has clear links to other forms of abuse and exploitation. The Home Office and the Department for Education are the government departments leading on the response to CSE.

9.2 Additional local context for Bradford is that the Ofsted inspection of children's services in December 2018 found that, while CSE support was seen as good, services for children overall were inadequate. This led to a focus on those areas which had been identified as most in need of improvement but also resulted in a period of very significant instability in service management which has been described as impacting on all areas of service. The service has seen some increasing stability since the establishment of the new leadership team consisting of the Director of Children's Services who came into post in July 2019 followed by the Deputy Director in October 2019. In addition to their posts, increased capacity and resource have been created by recruiting a senior leadership team which aims to bring stability, vision and clarity to the workforce and partnerships.

9.3 An Innovation and Improvement Programme is supporting the development of the 'foundations' which are required to consistently improve the quality of CSC practice in Bradford.

10.0 Local CSE Data and Safeguarding Arrangements

10.1 Data is collected in respect of both CSE and child criminal exploitation (CCE). Sexual exploitation is the most prevalent exploitation risk category for children in Bradford, shortly followed by children who are at risk of criminal exploitation. Over 50% of children with an 'Exploitation marker' are aged between 13 and 15.

10.2 The Ofsted Inspection of Children's Services in 2018 identified the departmental response to exploitation as effective, bound by multi-agency interventions and achieving positive outcomes for young people. This was largely delivered through the Multi Agency Safeguarding Hub (MASH) which was a co-located team of professionals from statutory and non-statutory services. The team complement in the MASH consisted of social workers, police, health and the third sector. After comments by Ofsted about police led decision making, the colocation arrangements were reconfigured although the overall resource remained the same.

10.3 At the time of writing this report, though still referred to as the MASH, the initial response to CSE referrals is managed by a team which consists of CSC staff who liaise with other agencies on a regular basis. There is also a separate multi-agency police and social care team which responds to non-recent sexual abuse investigations although staffing has been depleted significantly over time. The police team that investigates non-recent CSE - such as the cases of Anna and Fiona referred to in this report - still exists and has not diminished in role. In 2019 the police team was re-located to police premises to continue its work. The police CSE team was renamed as the 'Children Vulnerable to Exploitation Team' (CVET) to encompass child criminal exploitation as well as CSE.

10.4 Within the MASH a daily multi-agency risk assessment meeting (RAM) is held to consider the vulnerabilities and safety plans for children at risk of Exploitation.

10.5 Any children who are considered to be 'significant risk and stuck' are discussed at a six weekly multi-agency child exploitation (MACE) panel. The MACE panel has a strategic lead from all agencies and voluntary providers in attendance, which provide relevant updates from their respective areas for example 'hot spots` and key perpetrator information. On the same day, social workers and managers attend and provide an update on specific children deemed at high risk, or that may have been deemed to be drifting without a clear plan of action. These cases are reviewed, and agencies provide information to ensure all aspects of safety planning are in place and to determine what further action is required at a strategic level to assist progress or provide solutions. The allocated social workers for children who are open to CSC are invited to contribute and attend the above meetings. For children who do not have a social worker, consideration is given to whether they need one and appropriate referrals are progressed.

10.6 In spite of no longer being co-located, communication between agencies is regular and decisions are generally made collectively. Audit activity has identified that the response often 'starts off strong' but the intensity of interventions can tail off and on too many occasions, services (statutory and non-statutory) are not working in synergy. This is largely due to the logistics of working in different sites and a pressure to close cases to make way for new referrals due to rising demand.

Part Two

11.0 Case 1 Anna

11.1 Anna was known to CSC from a very young age and suffered multiple adverse childhood experiences including severe abuse and neglect. Anna also had caring responsibilities for her mother who had severe mental health problems and for her sibling who had complex needs. She was the subject of Child Protection Plans several times during her childhood. She moved between different households, mother, father, grandparents, family friends, as relationships broke down and her mother became increasingly unable to provide safe care.

11.2 In 2002, when Anna was aged 14 her mother expressed concerns about possible CSE. Anna was referred to a specialist project "Streets and Lanes" (SALS) which was a service for children abused through prostitution. In December 2002 Anna was placed in residential care and frequently went missing from the placement. In January 2003 Anna is recorded as having an Asian "boyfriend" who is variously recorded as being aged between 18 and 27. At this time Anna was said to have begun following the Islamic religion.

11.3 Throughout the time Anna was being supported by the SALS project she made frequent disclosures of sexual abuse and coercion, including rapes, when missing from the residential unit (she went missing on more than 70 occasions). At that time, SALS' policies offered service users complete confidentiality, and this meant none of this information was shared with police or CSC. She also told SALS that she was being subjected to assaults which were referred to as domestic abuse though she was still a child under the age of 16.

11.4 In June 2003, a LAC review took place, and it is recorded that Anna is "engaged" to her boyfriend and has converted to Islam. Her boyfriend attended the review. The IRO records that his being invited to the review "is an acknowledgment of the significance of the relationship".

11.5 In July 2003 Anna (now aged 15) told the SALS worker that she had married her Asian "boyfriend" in an Islamic ceremony. It appears that there was collusion with this by her CSC social worker who allegedly attended the ceremony and assessed that her marriage was likely to reduce the risks incurred when Anna was missing.

11.6 In the December 2003 Looked After Child Care Review, it is recorded that Anna is pregnant and wishing to be fostered with the family of the man referred to as her "husband". The review records this as unacceptable but within days she was placed with the family as a foster child, and they were paid a fostering allowance though there is no record of any assessment or approval process. It is hard to understand how this decision can have been made and it resulted in Anna being entirely reliant on her abuser and his family. Anna reported significant restriction of her freedoms by the family which would today be seen as coercive control. She also reported further assaults from her "husband". These were not passed on to CSC.

11.7 Anna moved to a flat, rented by her "husband" in 2004 and her baby was born while she was living there, although her "foster mother" is recorded as having been present at the

birth. Shortly after this Anna reported that her “husband” had forged papers in order to get a passport for the baby and was threatening to take the baby abroad. In the following months, her residence is unclear from records, and she seems to have moved in and out of placements as the nature of her relationships fluctuated.

11.8 In December 2004 Anna was taken to a refuge following an assault by her “husband”. At this point she was still a looked after child. By February 2005 Anna was pregnant with her second child.

11.9 What we do not see in the agency chronologies is that, during the time Anna was in care, she was being sexually abused and exploited by dozens of adult males, some of whom were known to her “boyfriend/husband”. More than 20 arrests have been made connected to the investigation of Anna’s abuse and investigations continue.

12.0 Key Themes Anna

12.1 Anna experienced severe neglect and abuse from a very young age. She was affected by severe parental mental illness and significant domestic abuse. She was subject to child protection arrangements on several occasions and finally came into the care of the local authority when she was aged 14.

12.2 As she came into care it is likely that Anna was already being sexually exploited. This escalated very rapidly and within a very short period of time she was being groomed, exploited and sexually abused by adult males.

12.3 Anna’s placement at the residential children’s home in Bradford did not keep her safe. She went missing frequently (over seventy times) and the staff there were aware that she was getting into cars with males including the male they referred to as her ‘boyfriend’. (This male was referred to as her ‘boyfriend’ and then later as her ‘husband’ by other professionals CSC, police, and health agencies).

12.4 It is apparent from conversations with Anna and from information contained in agency chronologies that the local authority did not reflect what was happening to her in terms of sexual abuse and exploitation.

12.5 It was whilst she was still living in the residential placement that Anna began to wear full Muslim dress, adopted a Muslim name and told CSC that she had been married to the adult male ‘boyfriend’ in a Nikah ceremony. (Nikah is a Muslim wedding at which the bride does not have to be present as long as she sends two witnesses to the drawn-up agreement). Anna was aged 15.

12.6 The willingness of some professionals to legitimise this wedding is clear from agency records. The adult male was thereafter referred to by professionals as her ‘husband’ and his parents as her ‘mother-in-law’ and ‘father-in-law’. The ‘Nikah’ marriage far from being challenged and perceived as coercive or exploitative was accepted and Anna’s social worker at that time attended the ceremony.

12.7 The decision to consider and approve a fostering placement with the adult male's parents is difficult to understand. The adult male was her abuser. It was also clear that she was not regarded with respect and affection by her abuser's family. In fact, they were also controlling and abusing her.

12.8 The Panel members discussed the placement of Anna with her abuser's family at length. This placement did not protect Anna from harm but did in fact place her at greater risk and made her entirely dependent on them. Whilst in the 'care' of these adults she was subjected to further sexual abuse and exploitation, domestic abuse including assaults and coercion and what we would now recognise as domestic slavery during the time she lived there.

12.9 Anna told the SALs project about her difficulties concerning her male social worker when she was living in her abuser's home. Although the SALs worker attempted to contact a SW manager about this her attempts were unsuccessful, and she did not formally escalate her concerns and Anna's situation did not improve.

12.10 Once she had become a mother herself Anna continued to be subjected to several further assaults and abuse by the adult male 'husband'. The way in which agencies; including CSC, the police and the SALs project responded to this was poor and did not protect Anna or her very young children from further harm. Anna was still a looked after child herself at this point in time.

12.11 What we do not see recorded in agency chronologies is that during the time she was in the care of the Local Authority Anna has described to the independent reviewer that she was being sexually abused and exploited by dozens of adult males some of whom were known to her 'boyfriend'.

12.12 Anna who was described as a bright child by her primary school did not receive any consistent education after the age of thirteen and there is little information in agency records to suggest that plans were put in place to address this.

12.13 In conversation with the independent reviewer, Anna was able to describe the ongoing impact of the trauma and abuse she experienced and the effect that this continues to have on her mental health and emotional wellbeing. She says:

"*Numerous social services assessments were carried out throughout my very early years from the authorities with a "being at risk" noted but nothing ever acted on, and I was failed for more than two decades. My needs as a child were not met my education was non-existent throughout my teenage years. From around 12 years old it was apparent to social services I was absconding from home and was being trafficked all-over west Yorkshire. I was at great harm however they allowed me to continually be subject to sexual, physical, and emotional abuse and psychological abuse and harm. Safeguarding risk assessments were carried out and acknowledged that I was being sexually abused by grooming on a large scale. Recommendations were put forward at various strategy meetings to remove myself as I was at escalated risk from sexual perpetrators and to be place into a secure unit or foster carers away from the area, but recommendations were ignored time and time*

again. I was regularly missing for numerous weeks at a time with no sightings, and no contact from myself. Social services and the police did nothing to locate me this could have ended in a homicide case as I was suffering from severe domestic violence. I was co-dependent from being 13 I was psychologically suffering throughout my teenage years, but no intervention was offered. I was a minor, unstable as well as unable, as any child is to make the correct choices which were life changing decisions these have had a major impact on my life. I was 15, but the authorities thought it was in the best interest and to minimise the severity of my absconding and placed me in a foster care placement while being fully aware with the parents of my abuser. We had no similarities in race, religion or culture and I continued be subject to domestic violence and was subject to a coercive controlling sexual relationship with a known perpetrator. I was frightened to leave, in fear of an honour-based killing. At 14 years old I was engaged to be married, taking on the role of an Islamic wife fulfilling the needs of my husband and the extended family somewhat like a maid. I was identified as a vulnerable and naïve child converting to Islam wasn't a case of wanting to embrace Islam for my own individual choices. I was manipulated and controlled while I was on a local authority care order the authorities should have protected me however they allowed abuse to occur for numerous years. Resulting in living a life of dual identity despite only being 15. The local the authorities allowed and witnessed a sharia law Nikah wedding to take place allowing a man to carry out sexual activity on a child to occur on a daily basis which is illegal.

If only the authorities had done what was recommend for me, the secure unit or accommodation. I wouldn't have been subject to sexually and physical abuse for many years. And because I wasn't looked after as a child should have been under a local authority care order. Contact arrangements with parents was minimal bonds were damaged with close family which can now never be rectified. I'm left with my adult years to educate and work on my mental health state of mind and coming to terms with the realisation I will always be in recovery. I'm not in control of my anxiety and only feel at ease with my nerves, when I'm in another county living a life that nobody knows who I am or what I've been subject too. Throughout my late adult years, I've had a significant number of disturbing dysfunctional relationships as I've not healed as a victim of child sexual exploitation and physical abuse.

I've found courage and been courageous in coming forward and I sincerely hope other victims will speak out about their child sexual abuse".

13.0 Case 2 Fiona

13.1 In February 2019, nine offenders were convicted of 22 offences against Fiona, including rape and inciting child prostitution.

13.2 Records of domestic abuse between Fiona's mother and her partner go back eight years prior to the first contact with CSC. In 2006 Fiona's relationship with her mother became very volatile with an incident of Fiona assaulting her. She moved initially to her grandmother's and later to friends and was frequently missing from home. Her behaviour in school deteriorated and she was excluded. Records reflect concern about her being in contact with males but the possibility of her being groomed and abused was not explored at this time.

13.3 Throughout her involvement with services Fiona expressed her distress and was clearly seeking help. Police powers were used to protect Fiona in 2008 and a CAMHS

assessment recorded that her low mood and distress were due to her home circumstances (domestic abuse) and that if returned there she would likely self-harm. Three placements with crisis carers were used but Fiona would not stay. There were differing agency views about the suitability of placements and CSC had no care order in respect of Fiona – her mother retaining the decision-making power. She was eventually admitted to care in March 2008.

13.4 Fiona continued to express her distress, to self-harm, to struggle to care for her own wellbeing and to go missing. A placement move did not bring about positive improvement and Fiona's behaviour had become more aggressive resulting in her being arrested on a number of occasions. Missing episodes escalated and there were clear concerns about CSE, however no risk assessment appears to have been in place.

13.5 In June 2008, a strategy meeting took place (very delayed). Warning letters were sent to potential harbourers and hotels but there is no record of Fiona being referred to CSE services or taken for a sexual health check and a risk assessment had still not been carried out.

13.6 On more than one occasion Fiona attended A&E with significant physical injuries but would not give information about who had assaulted her.

13.7 In December 2008 Fiona told her CAMHS worker and the Looked after Child nurse that she was pregnant. There is no record of discussion about the father. Fiona continued to go missing and her mother told the police she believed her "boyfriend was a paedophile". There is no record of follow up action.

13.8 A number of placements moves followed, including bed and breakfast and periods back at home, and in this period, Fiona was convicted of battery.

13.9 Fiona's baby was born in July 2009, and they were placed in a mother and baby home but were asked to leave due to her "boyfriend" being there outside permitted hours – again there is no evidence that any enquiries were made about this person. She returned to her mother's but assaulted her and was arrested – the baby remained with her mother.

13.10 In the months that followed (Fiona was still only 16) her accommodation changed frequently, her mental health deteriorated, she went missing, she was physically assaulted, and she alleged rape by a former boyfriend.

13.11 In the August specific concerns about CSE were raised by a support worker, a number of other reports followed. Fiona was removed from the premises of a 44-year-old man and recognised as being very vulnerable and in contact with a number of men. Fiona stopped engaging with CAMHS and was reported to be using drugs and "fragile" and likely to self-harm.

13.12 Fiona continued to be described as at high risk of CSE but was clearly being abused. She moved into independent accommodation (still under 18) but reported visits from men who assaulted her. Police records report concerns from a neighbour that the property was "being used as a brothel and smelt of Cannabis".

13.13 Similar circumstances continued and in 2012, when Fiona was 18, her child was made subject of a care order and subsequently adopted.

13.14 There was little stability for Fiona both before and after she came into care. There was clear recognition that she was being sexually exploited but none of the actions taken, nor the placements made resulted in her being safe. She was also physically assaulted numerous times and criminalised for behaviours that were a likely response to her own abuse and distress. An assessment that she could not safely care for her child led to adoption which has caused her ongoing grief and she continues to have mental health issues as an adult including Complex PTSD.

14.0 Key Themes Fiona

14.1 Fiona's early life was characterised by serious domestic abuse and her mother's poor mental health. Agencies were aware of the domestic abuse including physical abuse and Fiona was explicit about how this impacted upon her. Despite this nothing changed for her, and the outcome was that she left the family home and the perpetrator continued to live there.

14.2 Fiona's mother expressed concerns about CSE as early as January 2008 and there was evidence that Fiona was in contact with adult males. This was not acted upon by the police or CSC.

14.3 There was little stability for Fiona before and after she became a looked after child and she experienced frequent moves. She went missing on an almost daily basis and the police (and other agencies) response to this was, at times, poor. Fiona was described by the police, more than once, as 'street wise' and this implied that she could look after herself. Her missing from home/ care episodes were also graded as 'unauthorised absences' which resulted in a 'downgraded' response compared to a grading of 'missing'. This also meant. that missing from home interviews did not take place with Fiona and there was no missing strategy plan in place to help manage the risk to her.

14.4 There appeared to be agreement by all agencies that Fiona was either at risk of CSE or was actively being sexually abused and exploited (including by a known 44-year-old abuser) but this was not addressed by any single agency until the Turnaround service worked with her (with sporadic engagement; from November 2011).

14.5 When Fiona became pregnant at the age of 15 there was little curiosity or enquiry about who the father was and whether or not Fiona was safe. Similarly, when Fiona reported that she had a boyfriend there was little consideration of how safe this 'relationship' was for Fiona.

14.6 During the timescale considered by this review Fiona was assaulted at least seven times (beginning when she was aged eight or nine). There is nothing in any agency records to describe how this would have affected Fiona or how it might contextualise her own aggressive behaviour. The assaults included rape and sexual assault and these allegations were not given the same credence and response as had they been made by an adult or even by a different child and a medical was not undertaken.

14.7 Fiona ended up with several convictions for behaviours some of which may well have been a symptom of the levels of fear and distress she was experiencing (see also the Criminalisation of Sexually Exploited Children below).

14.8 The language used by CSC and the police to describe what was happening to Fiona between 2008 and 2011 was striking. She was described as *exchanging sexual favours for alcohol and drugs* (aged 14 or 15) and *soliciting and operating a brothel* (aged 17). She was a looked after child during these periods.

14.9 An assessment that she could not provide her child with a safe environment meant that her child was adopted against Fiona's wishes. This decision was made after many years of Fiona herself being unsafe and experiencing significant harm whilst in the care of the local authority. The trauma and loss from the adoption of her baby will have lifelong implications for Fiona (and for the adopted child and siblings).

14.10 Fiona, as an adult, suffers from ongoing mental health issues including a diagnosis of Complex PTSD.

14.11 In conversation with the independent reviewer Fiona described the impact of how she was treated by professionals as being as "*bad as the abuse*" and exploitation.

14.12 Fiona asks, "*Why was my child removed from me because of concerns over me being a victim of CSE but I, still under the age of 18, was left to carry on being abused"?*

14.13 In summary Fiona was not kept safe by agencies who had responsibility for her wellbeing and the abuse, assaults, exploitation and other harms she experienced were not acknowledged or addressed.

15.0 Case 3- Samara

15.1 Samara's family were known to CSC and health agencies throughout her life due to domestic abuse within the household and to her parents' mental health difficulties. When she was aged 12 her parents contacted the police reporting that she was in contact with several adult males she had met initially online. She was sexually exploited both when living in the Bradford District but also when she moved to another area.

15.2 A striking difference in Samara's case was the involvement with her family who identified possible CSE. Following her parent's contact with the police, the case was immediately picked up by the relevant services and dealt with in accordance with procedures and, with the exception of some medical interventions, there was evidence of good practice. A suspected perpetrator was arrested and charged with rape.

15.3 Despite her young age and the timely response to concerns, it is of note that the Specialist Health Practitioner (SHP) and police described Samara as "putting herself at risk" and encouraging men. Her brothers blamed her for her abuse and felt she had brought shame on the family.

15.4 Samara suffered considerable distress in the following months and was particularly anxious about the court case and possible approaches from her alleged abuser or his contacts. She

was provided with consistent support by the SHP throughout. She was also distressed by her brothers' response to the abuse and blame being levelled at her. The trial resulted in a finding of not guilty.

15.5 There were significant delays in planned work with Samara to help her to understand grooming and exploitation and professional disagreements about the continuing level of risk of further exploitation. Nor had any therapeutic work been completed though the CAMHS were planning to do some desensitisation work to treat her PTSD.

15.6 When Samara subsequently moved to another area to live with a family member she went missing and her CSE risk rating was increased too high. She was 14 at this point. Two men were arrested, one for abduction. The police response was timely and effective with steps being taken to protect Samara using Police Powers of Protection and to arrest the suspects. However, records indicate that the out of area CSC failed to carry out a child protection investigation. This was noted in Bradford and a follow up investigation completed but clearly not within required timescales. There were issues with the health responses, but the forensic health profession did identify Samara as being at high risk of CSE.

15.7 Over time the required work did take place with Samara and by 2019 she appeared to be much more settled, back in school most of the time and no longer subject to a Child Protection Plan. In 2019 her CSE risk assessment was recorded as low risk.

15.8 The evidence in relation to continuing challenges in developing good practice mirrored the findings in the case sample itself.

16.0 Key Themes Samara

16.1 A striking difference between Samara and the other children's cases was the involvement of her family with agencies at a very early stage. Her parents had recognised the warning. signs for CSE, such as changes in Samara's behaviour; staying out late and being evasive about who she was meeting and her use of a mobile phone to contact a number of men and they reported their concerns to the police.

16.2 What is also documented is the impact of this on Samara's parent's already troubled mental health. It was also apparent that they and Samara's brothers believed that she was responsible for the CSE. This understandably caused Samara further distress.

16.3 A further striking difference between Samara and the other children's cases is the consistent relationship Samara and her family had with the Sexual Health Practitioner (SHP) whose commitment and holistic understanding of the issues Samara was coping with (especially those within her own family) meant that Samara's voice was heard and understood. The Sexual Health Practitioner was able to use professional challenge effectively and did so on three occasions. Of particular note was the occasion in September 2018 upon which the SHP challenged agencies who had been tasked with actions in Samara's CPP and had not started/ progressed these.

16.4 The SHP's excellent record keeping enabled the independent reviewer and author of this report to understand Samara's vulnerabilities and the ongoing distress caused by her family's response to the CSE.

16.5 Samara also received a speedy and pro-active response from the police and consistent. support from the police officer allocated to her leading up to the trial of the first suspect. The officer demonstrated similar understanding of Samara's needs and her family context and responded accordingly.

16.6 Similarly, Samara's first school provided sensitive support and valuable information to the police and other agencies when Samara went missing in Cambridgeshire.

16.7 There were, however, some instances when Samara was not supported well, and her experiences of forensic medicals followed by STI screening was one of these. The record keeping by the company providing this service was incomplete and therefore fell below expected standards.

16.8 It is also of note that professionals including the SHP and a police officer described. Samara's behaviour as 'putting herself at risk' or 'putting herself in risky scenarios. Samara was quite clearly an extremely vulnerable 12-year-old child whose understanding of sex, relationships, exploitation and risk was appropriate to her age. She could not therefore assess risk to herself and continued to believe that one of the men 'had been nice to her' because he had brought her food and drink. The SHP identified that Samara felt unloved and was seeking affection from the adult males. This was exploited by the older men, and it was this that led to Samara being sexually and physically abused.

16.9 The judgement made and shared by a police officer that Samara had not been sexually exploited but had encouraged the men and lied about her age had a direct impact on Samara as it influenced what services she was referred to by healthcare providers in 2018. Whilst Samara had lied about her age and this would have impacted on the possibility of a successful prosecution, the phrases used by the police officer to relate this could have influenced how Samara was responded to or to imply that she was to blame for what happened to her.

16.10 The confusion regarding who would undertake S47 enquiries between WYP and Cambridgeshire police led to a delay in these being carried out and it is unclear why this confusion occurred.

16.11 In summary, whilst there were no significant or prolific concerns about how agencies worked together to safeguard Samara the author of this report considers that without the challenge of the SHP this might not always have been the case.

16.12 Despite the examples of good practice and swift agency responses described above, there was a delay in providing Samara with therapeutic interventions which may have contributed to her going missing in Cambridgeshire as, at that stage, she did not recognise that she was being exploited. Samara suffered significant harm and was trafficked, raped and sexually exploited. This was compounded by the not guilty verdict and her family's response caused her further distress.

16.13 There may well still be learning from Samara's case about the 'cultural' response of family and community to CSE and TBP and partners may wish to focus upon this in their plans following this review.

17.0 Case 4- Ruby

17.1 Ruby had a disrupted childhood following separation from, and the subsequent death of her mother. From a very early age, her behaviour was described as problematic, leading to school moves and exclusions. As she became a teenager her father asked for support from CSC.

17.2 She was first identified as being at risk of sexual exploitation in 2014 at age 13 and became a looked after child at age 15. She had been diagnosed with a disorder affecting learning ability when aged 14, giving some context to her behavioural problems. Over time she had 14 placement moves with all but three being out of the authority boundaries. She frequently went missing and had two secure placements one in a secure children's home and one in a mental health hospital. Ruby prolifically self-harmed, requiring hospital admissions, the most serious self-harm incidents focussing on her genitals.

17.3 There were numerous incidents where Ruby went missing and was believed to have been sexually exploited, including allegations of abduction and rape.

17.4 The information provided by agencies shows an almost exclusive focus on Ruby's behaviour and the impact of this on placement staff rather than as a possible manifestation of her distress or symptom of sexual exploitation. Not all professionals recognised her level of risk and there were professional disagreements about how best to respond to her needs with concerns from the police being escalated at the highest level and there were examples of very poor practice. Agency interventions with Ruby did not keep her safe.

17.5 When Ruby began to dress in "Muslim clothing" and talk of getting married and moving to Afghanistan this was not responded to as possible grooming and no referral into the prevent programmes were made.

18.0 Key Themes Ruby

18.1 The root cause of Ruby's early behavioural and emotional difficulties may well be a combination of the separation from and subsequent sudden loss of her mother, the physical and cognitive impacts of a chromosomal disorder, a diagnosis of ADHD, and the fractured relationship with her father, stepmother and half sibling.

18.2 There was an almost exclusive focus by CSC and the placement staff on Ruby's behaviour and the impact of this on residential placement staff at critical time for Ruby (huge escalation in risk and harm from CSE) rather than a focus on Ruby's behaviour as a manifestation of distress or as a symptom of sexual exploitation.

18.3 Despite evidence of increasing risk there was no assessment or recognition of Ruby's vulnerability to CSE by her SW who perceived Ruby as low risk. (September 2018)

18.4 There were professional disputes between Police and CSC in respect of the risk to Ruby and the ability of her placement to keep her safe and these were not resolved.

18.5 Ruby moved placements 14 times and the scarcity of suitable placements locally was noted by practitioners. Her move out of the area did not keep her safe and in fact, the area to which she moved has higher than average reported CSE rates than the rest of the county.

18.6 Ruby had a number of fixed term and a final permanent exclusion from school and suffered a disruptive education journey which further compounded her vulnerability and isolation.

18.7 Ruby began to dress in 'Muslim clothing' in January 2019 and talked about getting married and moving to Afghanistan. It is not clear from agency records at that point in time how this was responded to. This does not appear to have been assessed as a sign of grooming or exploitation or to have triggered Prevent: Protecting children from radicalisation strategies.

18.8 At this point in time Ruby has a diagnosis of ADHD, a chromosomal disorder and specific learning difficulties. Her understanding of her world and her life experiences are not always consistent with her age. "*She is an eight-year-old in an 18-year old's body*" (Reflections from a practitioner who attended the learning event), meaning that assumptions cannot be made about her understanding of consent, healthy relationships and what constitutes abuse.

19.0 Case 5 - Ben

19.1 Ben has a severe disability and needs support with communication. Interpreters were not always used by professionals and family members were often allowed to interpret for Ben, running the risk that they mediated his views.

19.2 Throughout his childhood there were concerns about physical abuse, neglect, domestic abuse when he was aged six. There were physical and behavioural indications that Ben may have been sexually abused.

19.3 Agencies became aware of concerns about sexual exploitation in respect of Ben's extended family when he was aged ten and it was known he had been exposed to pornography. Aged 12 Ben was known to be using cannabis, alcohol and cocaine. Records described him as being "sexually active" with an older 'girlfriend' and there was concern that he might pose a risk to siblings. The children, including Ben, were subject of child protection plans several times but agency interventions did not meet Ben's needs or keep him safe.

19.4 There was a marked difference in how agencies responded to Ben's abuse and to that of his female siblings.

19.5 Ben's behaviour was at times violent within the home and at school and he went missing several times. He was also subject to physical assaults by both parents. When 13, he was assessed as being at risk of sexual abuse by older males connected to the family, from both within and outside the district.

19.6 When 15, he was “found in bed” with an older female but police investigations did not proceed to charge due to evidential difficulties.

19.7 Finding appropriate education for Ben has been a challenge and there have been significant periods when he has had no school place.

Key Themes Ben

20.1 Ben experienced neglect and physical, emotional abuse and was exposed to domestic abuse from a very young age. It is also possible that Ben was sexually abused at the age of 6 however this was not explored by professionals at the time. His disability meant that he was isolated and the use of family members as interpreters meant his voice was mediated by them and his own voice was rarely heard. Ben’s father in particular was regularly relied upon to interpret for Ben and other family members. This was unsafe and further compounded Ben’s isolation and lack of voice. Professionals noted that Ben’s father was extremely controlling and that he accompanied Ben and his siblings to medical and other appointments.

20.2 The focus of interventions and assessments in respect of Ben was his behaviour and aggression. Ben’s distress and vulnerability was not always seen as an indicator that he was possibly being sexually exploited or abused or of the issues he faced at home.

20.3 The difference in how risk and need was ‘framed’ in relation to Ben and his female sibling was stark. For example, at a core group meeting in October 2018 it is recorded that “*Ben has been involved in sexual incidents and is hanging around with those involved in drugs, whilst his sibling has been sexually abused.*” “*For sibling, we are worried about the impact of the sexual abuse she has suffered upon her emotional health and understanding. Sibling will often show her emotional difficulties through behaviour before expressing this verbally”. “For Ben, we are worried about his ability to manage his emotions when things become very difficult, his choice to smoke cannabis to help him sleep and his relationship with his parents, friends and sisters*”.

20.4 The language used by other agencies in respect of the sexual exploitation of Ben was also of note. For example, there were references to ‘*underage sexual activity’* and *‘sexual relationships*` and that Ben was ‘*sexually active and had been in a relationship with a 16year-old girl’*. Ben was, at that point aged 12. In UK law a child under 13 does not, in any circumstances, have the legal capacity to consent to any form of sexual activity. These are offences of strict liability as regards to age, and there is no defence of reasonable belief in relation to the age of the complainant.

20.5 The panel members and independent reviewer considered how different agency and individual practitioner responses may have been if Ben was a girl. Would, for example a 12-year-old girl have been described as having a sexual relationship with a 15 or 16-yearold boy?

20.6 The number of time Ben’s parents called the police in respect of Ben’s aggression is also notable. WYP appropriately identified that Ben was a vulnerable child and shared information with agencies after each incident (with a few exceptions). However, this pattern of Ben’s father calling the police and/ or throwing Ben out of the family home after an allegation of assault was

not analysed and was taken at face value by professionals as a consequence of Ben's aggressive behaviour.

20.7 Furthermore, throughout the entire period of time included in this review Ben's parents were physically assaulting their children. Ben's father presented an unchallenged version of events after each incident involving Ben as alleged perpetrator. Ben remained voiceless and/ or his father interpreted for him. There was no analysis of how the incidents were triggered and what the frequency of incidents meant in terms of risk and harm to Ben.

20.8 None of the children called the police when they were assaulted (they told other adults) and it does not appear that prosecution of the parents for assault was considered apart from one occasion in 2014 when a police investigation, including interview of Ben's father as a suspect, took place. Consideration of prosecution concluded that there was insufficient evidence to proceed. Ben was a very young child when the police were first called to an incident involving him as the 'perpetrator' and the number of further such incidents is of concern.

20.9 The failure to make consistent use of suitably experienced and qualified interpreters in this case is of immediate and urgent concern. Ben has remained largely voiceless and incredibly isolated. This has compounded the neglect and the physical and emotional abuse he has experienced and has also compounded his vulnerability to CSE and criminal exploitation.

20.10 The difficulty for any child with profound communication difficulties to disclose sexual abuse cannot be understated. This difficulty, in part, relates to how children 'frame' what is happening to them because of the 'abstract' nature of abuse and the subtlety of language needed to communicate very distressing and sensitive information and feelings.

20.11 Ben was not in education for significant periods of time covered by this review which was an additional risk factor and compounded his vulnerability and isolation.

Responses to issues raised in the review.

Missing from Home episodes

21. 1 Non recent cases were often assessed as "unauthorised absence". This grading is no longer used. A missing person can be graded as 'absent' for up to 18 hrs with Inspector reviews every 8 hours. The absent grading can be used only when the risk is 'negligible', so would not apply to a child missing from care in these circumstances. Otherwise, they will be graded as low, medium or high. (For example, Ruby was never graded as absent, and consistently graded as high risk once graded as high risk of CSE).

21.2 Current practice is that missing incidents linked to a child considered to be at high risk of CSE immediately trigger a high-risk missing person response and a full investigation to

follow with investigative direction from a Detective Inspector. The awareness of CSE has changed radically. Instances where Anna or Fiona were found in the company of adult males would be responded to differently now. There is a high likelihood that this would result in the arrest of the males, with far greater emphasis on evidence gathering opportunities (digital media, forensic opportunities). A social care referral and a CSE risk assessment would follow. The contrast and better practice are evidenced in Ruby's case.

21.3 In the non-recent cases there was little evidence of follow up. Currently a return interview is always attempted even if the missing child refuses to engage. Investigative opportunities, such as seizing of underwear and examination of digital devices are considered. Any offences disclosed are recorded and investigated from the outset.

21.4 The police child missing from home coordinator sends a list of children reported missing over the previous 24hrs (48hrs at weekends) to the CSC missing coordinator each weekday so there is a regular exchange of missing child information. The top 10 missing people for the district are discussed at a weekly missing meeting.

21.5 Current policies and practice involve regular multi-agency review of incidents, follow up by way of independent return interview by a voluntary sector agency and adoption of the Philomena protocol for children in residential setting which has resulted in a significant drop in the numbers of looked after children going missing.

21.6 The Philomena Protocol was adopted in Bradford in 2019.

21.7 The Philomena Protocol is a scheme that asks carers to identify children and young people who are at risk of going missing, and to record vital information about them that can be used to help find them quickly and safely.

Investigating CSE Allegations

21.0 Police officers are far more proactive in investigation and their use of powers (which have also been widened). If a child is found in circumstances suggesting they are at risk, they are likely to be taken in to police protection. If they are found with other people in circumstances that suggest the other people may have committed an offence, those people are likely to be arrested. Where there are sufficient grounds, positive action is taken even in the absence of a disclosure from the child.

21.1 There is dedicated police 'Children Vulnerable to Exploitation Team' (CVET) with a clear remit to support children at risk of exploitation and investigate offences against them. The team includes accredited Detectives and Specialist Child Abuse Investigators.

Domestic Abuse incidents involving a child.

22.0 Now, when a victim is under the age of 16, this is addressed as 'Child Protection' rather than domestic abuse. A MARF is submitted to share information. Once over 16, this is considered

as a domestic abuse incident. A DASH assessment is completed and all DA incidents where a child or children are involved are shared with CSC. DA incidents are discussed at a daily risk assessment meeting. Where cases are high risk and there is concern those victims may be exposed to further abuse, they are referred in to the MARAC process.

22.1 The majority of the children considered in the report experienced domestic abuse in the family home prior to being exploited. As above, whenever a child is present at a domestic abuse incident, information is now shared with CSC. If the child is in education, their school is also informed so that they can monitor the impact of domestic abuse on the child (Operation Encompass).

Teenage pregnancy and looked after children.

23.0 Currently, BTHFT and Airedale have named midwifes, an associate safeguarding midwife and also has a specialist teenage pregnancy midwife who all work closely together. Midwives are also taught as part of their required training that any looked after child who presents as pregnant needs to be referred to the safeguarding midwife and that a referral to CSC should be completed for a pre-birth assessment. A safeguarding families document is initiated which contains all the safeguarding information relating to the young person and any safeguarding concerns.

Mental health assessments

25.0 Current practice is that every child who attends the Emergency Department (ED) has their ED attendances reviewed by the Safeguarding team to ensure safeguarding concerns are not missed. Details of any child attending ED with signs of self-harm, mental health issues including anxiety and panic attacks (so not always sign of physical injuries) are shared with relevant agencies. All are shared with the 0-19 service and some of them are also shared with other agencies such as CSC. It would be expected that a discussion with CAMHS would be had prior to discharge as often CAMHS will agree to see a child in the community rather than having to wait in the hospital.

Part Three

26.0 Summary Analysis of Key Findings and Associated Learning and Recommendations

26.1 This section of the report sets out an analysis of key findings and associated learning points and recommendations against the terms of reference for this Thematic Serious Case Review. The analysis also draws upon relevant research and findings from other serious case reviews. The Terms of Reference provide the headings for the following sections of the report.

Terms of Reference 1 "Policy and Procedures: To what extent have lessons been learnt from the multi-agency responses to non-recent cases of CSE within the Bradford District and beyond and how well is this learning embedded in current policy and procedures".

26.2 Examination of local reviews and those published more widely, demonstrates that lessons for policy and practice are identified, but the very nature of a complex review process and report can mitigate against some of that learning being disseminated and successfully embedded. Lengthy and complex reports can of themselves be inaccessible to many.

26.3 This review found more evidence of lessons in respect of policy being successfully implemented than of sustained practice change. National research shows this to be a widespread systemic issue and offers some insights into why this may be and how it might be overcome. The review process reflected upon the learning from two previous local CSE SCRs and asks why not all of this had been fully embedded into practice (see more detail below). It also reflected on relevant learning about the impact of neglect, physical and domestic abuse.

26.4 In line with the research findings, this review has, as described, highlighted that there are still instances where outcomes for children are not as good as they should be although it is not possible to quantify this i.e., the number of 'good practice or poor practice' cases.

26.5 This review has taken a view across the complex health, social care, VCS and criminal justice 'system' and it is obvious that responding to and working with children who are sexually exploited is difficult and nuanced work. For all of the children included in this review, that work pre-dated their sexual exploitation, often from the child's infancy. We cannot ignore that earlier work in assessing how learning is embedded into policy and practice. For example, if we know that failing to protect a child from neglect and domestic abuse and parental mental illness contribute to a child's vulnerability to CSE (and other abuse) then we must also urgently look at the system's response to those issues too.

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26.6 The research reminds us that learning lessons and implementing actions are not the same thing – indeed in this review we have seen that action plans from earlier reviews have largely been implemented but can see less impact on practice than was anticipated when those actions were planned.

26.7 A compounding factor may be that this work is often taking place in a context of shrinking resources which in some cases has caused organisational upheaval. This review also identified the impact of an adverse Ofsted Inspection and the consequent instability in the Children's Social Care management and workforce.

26.8 The precarious nature of funding for some CSE and family support services is also evident with well used and well regarded third sector and statutory services funded only for short periods of time or funding being lost altogether. This means that staff turnover can be high with experienced practitioners moving on to different roles or different areas. A consequence of this is likely to be that 'organisational memory' across the system and learning from local LCSPRs, SCRs and other reviews is lost too.

27.0 Learning from the Thematic Review cases

27.1 The two audits of recent cases recognised that the Ofsted improvement activity resulted in more regular formalised supervision by CSC.

27.2 The importance of education in supporting children and families is recognised in the current Exploitation Strategy and TBP has developed effective working relationships with the Local Authority Safeguarding Education Team to enable monitoring of children not in school.

27.3 Raising awareness with communities has been achieved through the work of Trusted Relationships, Breaking the Cycles and Youth Services and the Bradford Police Cyber Team. Trusted Relationships, Breaking the Cycles and Youth Services also provide valuable support around therapeutic services, but this is not set within an overall strategic approach to commissioning therapeutic services across the district and is insufficient against the overall demands.

27.4 The Partnership's Communications and Engagement Group is a positive function to engage with key stakeholders. Using a dedicated group reduces confusion over the source of messaging, avoids multiple messaging and provides opportunities to link with national key events/days. This brings together the key strategic boards with wider partners.

27.5 It is clear that the complexity of the cases and the scale of the challenges involved in the work risks that the cases 'run the worker' rather than the other way round.

28.0 Learning from previous Serious Case Reviews

28.1 Prior to the completion of this Thematic Review the former Safeguarding Board had completed two previous SCRs involving CSE. The SCRs for 'Jack' 2015 and 'Autumn' 2016 produced a number of recommendations for the LSCB, and partners also identified single agency learning which led to multi-agency and single agency action plans. This thematic review has considered those action plans and also the district's overarching CSE action plan. Additionally, the author has had access to an annual report to the Bradford Council Executive `Protecting Children and Vulnerable Adults at Risk of Exploitation` (2020) which provides a summary of current arrangements which is summarised in Appendix 3- Update on CSE Progress November 2020)

28.2 The following section provides an overview summary of how well learning has been embedded in current policy and procedures.

28.3 "Jack" Serious Case Review. BSCB Action Plan and Combined Single Agency Action Plans July 2017.

28.4 This review was signed off by the Case Review Sub-Group in November 2018, (although the offences it related to took place in 2012) with all actions shown as completed. The review made three key recommendations, firstly around technology assisted abuse;

secondly that assurance be provided by police and CSC that child protection processes are fit for purpose and are being applied; and lastly a challenge to CSC around an internal review relating to practice and staff. The report had wider learning that is used for analysis in this section. The issue raised in the review included the Police response to Jack's contact with an offender; the fact that a strategy meeting and section 47 were not held after a number of referrals; the fact that Jack was not protected by the police and social care; and management oversight and support to front line workers.

28.5 Autumn Serious Case Review. BSCB Action Plan and Combined Single Agency Action Plans 2016

28.6 This review was completed in 2016, again relating to offences in 2012. A number of recommendations were made regarding practice improvement in the following areas:

- Assessment and Care Planning
- Decision Making
- Supervision
- Multi-agency working and resourcing.
- Professional curiosity
- Support to and preventative work with parents and siblings
- Engagement with children at risk of CSE
- Health and Therapeutic Services
- Placements and education

28.7 The Partnership recognised the wider emergence of criminal exploitation resulting in the widening of the CSE/Missing sub-group into a Risk & Vulnerabilities in Complex Safeguarding sub-group (now the 'all age' exploitation group).

28.8 Although many of these areas of work were still found to need improvement in the Social Care Ofsted Inspection, actions to address them have been built into the Council's Improvement Plan. One incomplete action was the need to seek assurance that appropriate therapeutic services were available for victims of CSE. Despite the issue being raised with the Health and Well-being Board and with Public Health Commissioners, this remains unresolved. Further work was reported to be underway under the auspices of the Partnership`s All Age Exploitation group to currently mapping services in order to assess capacity against need.

28.9 The CSE action plan was also extended, recognising these changes and including the ongoing work (Red and Amber actions) into the new action plan.

29.0 Recommendations from Term of Reference 1

"Whether lessons have been learnt from multi-agency responses to non-recent cases of Child Sexual Exploitation within the Bradford District and beyond and are embedded in current policies and procedures".

Recommendations

R1. That TBP seek assurance that current arrangements and practice for supporting professionals with such complex cases reflects best practice and addresses the issue of specialist versus generic expertise and the time demands in doing this work well (learning from "What works" research).

R2. TBP should reflect on the evidence regarding enablers and barriers to learning and ensure it effectively disseminates the lessons from this review and that they are embedded.

30.0 Recommendations from Term of Reference 2:

"**To what extent does analysis of the responses from all agencies to current cases provide assurance that working practices and responses are robust, child centred and are effective in protecting children from sexual exploitation and related harms."**

30.1 Whilst there was evidence of some good practice in strategic activity, analysis of responses from all agencies *did not* provide assurance in all cases that working practices and responses are sufficiently child centred and protect children from sexual exploitation and related harms.

30.2 The following paragraphs provide examples, grouped into themes, which relate to some, or all of the cases reviewed during the review.

30.3 Recognising and responding to CSE.

Bradford's agencies currently use a CSE risk assessment tool to identify the level of risk in cases where there are concerns about possible CSE. However, before the risk assessment is used there is a reliance upon practitioners recognising that CSE *may* be a risk for an individual child thus triggering use of the tool. In some cases, even when there were signs that a child *was* being sexually exploited practitioners did not always recognise this. For example:

- In 2018 Ruby's SW did not believe or recognise that Ruby was being sexually exploited
- When CSE was recognised, it was not always responded to appropriately and in a timely manner.
- See examples in respect of Ben, Anna and Fiona which demonstrate use of language minimising risk.
- The detailed case audit supports this view, whilst these cases highlight obvious risks to children; the changing levels of risk and particularly increases in risk are not as well assessed, analysed or responded to.

30.4 A number of tools and checklists have been developed over the last 10 years, and are now widely used, to identify young people at risk of CSE. Research in 2016 (Brown et al) identified many issues with CSE risk assessment tools, including a lack of consistency in the risk indicators featured in different tools, and varying thresholds for being identified as a potential victim of CSE.

30.5 In 2017, the Centre of Expertise in Child Sex Abuse commissioned an exploratory study to build on this research, exploring the purposes for which tools and checklists are used and the

ways in which they do or do not support good practice in the developing field of CSE prevention. In short risk assessments are seen as ineffective in identifying true CSE risk. The study identified that there is sometimes confusion as to whether screening or risk assessment is being carried out, with debate amongst professionals as to whether one tool for both these purposes is required, or different tools for different purposes.

30.6 In summary the CSE risk assessment process is not always used appropriately or in a timely manner and the outcomes of the risk assessment process i.e., an assessment of low or medium risk of CSE did not always reflect the reality for the subject of the assessment.

Recommendations

R3. Considering the learning from this review and evidence from research TBP should consider the recommendations made by the Centre of Expertise in Child Sex Abuse in respect of the effective use of screening and risk assessment tools.

https://www.csacentre.org.uk/documents/infographic-seven-principles-recommendation/

30.7 Good supervision is vital in helping practitioners consider, recognise and respond to CSE.

30.8 In each of the review cases considered by this review, and within the two case audits, the children had a wide range of needs, and both historic and ongoing risks and harm. Often SW, education and police practice was reactive in response to fast moving incidents (for example several missing episodes in one day, several allegations of assault/ rape within a short timescale). In this context the role of good supervision is vital and can ensure that practitioners are challenged and supported to recognise and respond well to CSE. It is vital that supervision is well resourced in terms of time, space, and opportunity and that supervisors are also offered developmental and supervisory support and oversight themselves. It is clear from the cases included in the review that supervision was not always effective at providing oversight and challenge and TBP may wish to explore what can support supervisors in their roles. The case load of staff working with children with such complex needs and risks should reflect the intensity and time-consuming nature of the work and the need for regular supervision: i.e., caseloads should be small.

30.9 TBP may wish to use existing quality assurance methodologies e.g., *S11 and *S175 Audits to assure themselves that partner services, training, awareness raising, practitioner experience and supervision are of the standard required to provide a good response to children who are being sexually exploited.

30.10 The high turnover of staff from some disciplines, e.g., social work, means that it is difficult to measure the impact and uptake of CSE and associated training. Investment in a learning system which enables this to be measured and evaluated may help to assess this.

30.11 Existing training programmes may not always be mandatory and TBP may wish to review which elements of training need to be so. Minimum requirements could be built into future Section 175 and Section 11 audits that are undertaken by partners including schools. **Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.*

**Section 175 of the 2002 Education Act requires local education authorities and the governing bodies of maintained schools and FE colleges to make arrangements to ensure that their* functions are carried out with a view to safeguarding and promoting the welfare of children.

30.12 To what extent are other signs of exploitation and coercion, and the religious conversion of the children responded to?

30.13 A striking feature of Ruby and Anna's histories is that they suddenly began to wear Muslim dress and talk about becoming Muslim, marrying Muslims and in Ruby's case she discussed getting a passport and moving to Afghanistan. For both Ruby and Anna this sudden change occurred when it was known by agencies that they were being sexually exploited by adult males. It does not appear from agency records that this sudden and dramatic change was considered as a possible sign of grooming or coercion.

30.14 In Anna's case this change was described as '*confusion about her identity'*. In Ruby's case the change was recorded but not analysed or explored in the context of CSE. This change in behaviour and dress was not responded to as possible radicalisation and Prevent Strategies were not used. The NSPCC guidance 'Protecting Children from Radicalisation' states 'Children who are at risk of radicalisation may have low self-esteem. They may feel:

- Isolated and lonely or wanting to belong.
- Unhappy about themselves and what others might think of them.
- Embarrassed or judged about their culture, gender, religion or race.
- Stressed or depressed
- Fed up with being bullied or treated badly by other people or by society.
- Angry at other people or the government
- Confused about what they are doing.

30.15 In Anna and Ruby's case more professional curiosity should have been exercised in respect of any potential risk of radicalisation.

30.16 Recommendations

R4. TBP should seek assurance that practitioners and managers are aware that changes in cultural identity may be a sign of coercion, exploitation and/or radicalisation and:

- ***Display appropriate professional curiosity to recognise any potential risks.***
- ***Would have the confidence to challenge.***
- ***Would know how to respond.***
- ***Would know who else to inform if they suspected this.***

R5. TBP should seek assurance that grooming and radicalisation of girls within the context of CSE is understood and considered by the Prevent Panel (Channel Panel) in Bradford

30.17 The role of drugs and alcohol in sexual exploitation

For each of the children and young people included in this review and in the detailed case audit, drugs and alcohol were used by their abusers as tools of exploitation. Ruby, Ben,

Anna and Fiona were exploited by adult males who were dealing drugs and who used alcohol and different drugs as part of the grooming and abuse process. Ben was using cannabis at the age of 12 or earlier. This may have been supplied to him by a family member. By 2018 concerns were being expressed about 'county lines', criminality and Ben's drug use. He was aged 14 at this point. (There are similarities between different forms of exploitation and the criminal and sexual exploitation of children may overlap. Victims of child exploitation may, at any one time, be subject to both. Perpetrators of CSE and child criminal exploitation (CCE) can share patterns of behaviour in respect of coercion, violence, intimidation and the power imbalance inherent in them and many other offences).

30.18 Agencies did not appear to respond to the drug and alcohol use by the children and young people in the ***context of their sexual exploitation*** and no direct work was therefore done with the children and young people in respect of this or in respect of any potential / future substance misuse issues.

30.19 Referrals to substance misuse services or work done in respect of the harms of alcohol and drug consumption were not made in the cases included in this review.

30.20 Recommendations

R6. TBP should seek assurance that:

- ***practitioners have the understanding that drugs and alcohol are being used by abusers within the CSE context.***
- ***appropriate safeguarding leads and relevant practitioners in partner agencies know how to respond to children who have been coerced and groomed using alcohol and drugs including referral to appropriate services.***
- ***relevant practitioners working in substance misuse services and those involved in direct CSE work have regular opportunities to share information, expertise and knowledge and ensure that a holistic response to children who are being coerced and exploited is developed and maintained.***

30.21 Children and Young People with Disabilities

Both Ruby and Ben had significant diagnosed conditions / disabilities which impacted upon the way in which they processed information and were able to communicate their distress. Evidence that working practices are not always child centred, robust and effective in protecting children from sexual exploitation is found in the way in which their behaviours were interpreted and responded to. Their behaviours included significant self-harm, suicide threats (and attempts) and aggression and were the focus of many discussions and interventions. This was also apparent in the detailed case audits.

30.22 'Unprotected, overprotected: Meeting the needs of young people with learning disabilities who experience, or are at risk of, sexual exploitation' was published by The Children's Society in 2015 and makes the point that "***Professionals described how a lack of knowledge and understanding of CSE & learning disabilities can lead professionals to view some young people with these impairments who experience CSE as 'challenging,' as a 'management problem', rather than recognising that this masks***

their vulnerability, or is an outward sign that sexual exploitation is occurring". This is evident in respect of both Ben and Ruby.

30.23 The impacts of physical, sensory and learning or cognitive disability on children and young people compounded the risk to them of becoming exploited and abused.

30.24 Practitioners who contributed to the learning events in respect of Ruby and Ben expressed willingness (and also had the experience and skills) to work with managers and commissioners in order to re-imagine the response available to children with additional vulnerabilities.

30.25 Recommendations

R7. TBP should seek assurance that the training which was developed in response to the 2015 report (Under-protected/Over-protected) which is now provided in Bradford is effective and reaching all relevant practitioners who come into contact with children with disabilities and additional needs.
R8. TBP should seek assurance that relevant practitioners recognise that children with disabilities are at increased risk of sexual abuse.

30.26 Pregnancy and CSE

30.27 A long-term impact of CSE on health and wellbeing is pregnancy. This is discussed in more detail below.

30.28 Of the five review cases and five cases in the detailed audit included in this review, five of the girls became pregnant as a result of their abuse. Of these, two babies were placed for adoption and all children born to the girls were/ are subject to child protection arrangements.

30.29 The long-term negative impacts of becoming pregnant as a child are well known. However, less is known about the long-term impacts on mother and child if that child was born as a result of rape and/ or sexual abuse. Rape-related pregnancy is recognised as a public health problem (especially in the U.S.) and is where sexual violence and reproductive health connect.

30.30 In UK law a child is defined as any person under the age of 18 and child sexual abuse involves "*forcing or inciting a child to take part in sexual activity, whether or not the child is aware of what is happening and not necessarily involving a high level of violence. This may involve physical contact including rape or oral sex, or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing*". Crown Prosecution Service

30.31 Typically, the victims of CSE do not recognise themselves as victims and if they do become pregnant it may be many years before they consider their pregnancies within the context of their sexual exploitation.

30.32 There is also evidence (including from Anna) that children born as a result of CSE may be used by the perpetrator as a further means of control and coercion.

30.33 The author of this report has found very little research which has considered the long-term impacts on both mother and children of having become pregnant or being born as a result of CSE.

30.34 However, what we do already know from research, from other SCRs and from the 5 review cases and 5 cases in the detailed audit is that the outcomes for *some* children born to very young mothers who were themselves looked after children is very poor. It is not currently known if outcomes worsen for the children of children who are taken into care because of CSE and who then give birth.

30.35 For example, one study found that adults who were taken into care when they were children are 66 times more likely than their peers to have their own children taken in to care (Jackson and Smith, 2005).

30.36 For the girls included in this review the issues associated with becoming a very young mother will undoubtedly be further compounded by the fact that their children were born as a result of sexual exploitation.

30.37 Recommendations

R9. TBP should take steps towards understanding the scope of the issue of pregnancy of girls who are at risk of or who have been exploited in the district, and develop responses which provide long-term, highly personalised support to the girls (and their children).

30.38 Recognising and responding to Online Grooming and Exploitation

30.39 The use of the internet and mobile phones to groom and commit offences against the children and young people was a feature in *all* of the cases included in this review.

39.40 Ben was involved in several online incidents where he was either filmed or shared 'pornographic' films of other young people. It is not clear from agency records how this aspect of his exploitation was specifically responded to. (*Devices seized have been examined and no indecent content of children found. However, that does not mean that it wasn't on the Cloud or social media platforms, just that no evidence was found*).

39.41 In each of the other cases mobile phones were used by abusers to contact and control the children and young people. In some cases, phones were given to the victims for exclusive contact with the abusers. Similarly, the internet was used to contact and coerce children and young people in some cases to arrange to meet with them.

39.42 Agencies do not currently know whether or not the other children and young people included in this review were filmed or photographed by their abusers and this would not routinely be identified in other cases. It is not always possible to establish this.

39.43 Online grooming, exploitation and abuse feature in practitioners training and awareness raising and Bradford have the Police Cyber Team, a group of (CEOP) trained PCSOs who can give one to one online safety advice to victims. There is a 'police online investigations team' (POLIT) with the sole remit of investigation of online CSEA. They have also run proactive investigations working with specialist regional resources. This is recognised as a growing crime area, and resourcing has been increased with planned significant investment in digital forensic capability.

30.44 Recommendations

R10. TBP should seek assurance that the training described above is taken up by practitioners who have relevant contact with children, and opportunities to engage with hard-to-reach communities are maximised through the work in schools.

R11. TBP should ensure that online exploitation and abuse feature strongly in training, strategy and planning.

31.0 Term of Reference 3

"Good practice lessons around placement provision for looked after children at high risk of or experiencing CSE are embedded in practice".

31.1 Safe and high-quality placement provision for children and young people who are experiencing CSE is ***not*** readily available in Bradford.

31.2 A 2016 study 'Child sexual exploitation: support in children's residential homes research report' (Ivana La Valle and Berni Graham with Di Hart) showed that children affected by CSE placed in residential care were very vulnerable and had a range of complex, high level needs. These children were typically highly traumatised due to CSE, compounded in some cases by other traumatic experiences common among children in residential care, Traumatic experiences meant that these children were very vulnerable, with substance abuse, self-harm, depression, violent behaviour, low self-esteem, and sleep and eating disorders being common.

31.3 This early childhood experience of multiple traumas and loss is reflected in four out of the five review cases included in this review and all five of the cases included in a detailed case audit exercise which has been shared with the author. What this means for children and young people is that they experience many moves, often out of the area away from family and friends and the placements do not keep them safe. The standard in placement provision for children with histories of significant trauma, loss, neglect and abuse is that they are long term, stable, relationally secure and therapeutic. The placement should be

able to offer highly personalised, trauma informed packages of care to such children and also focus on the child's strengths and aspirations.

31.4 The current provision in Bradford (and often elsewhere) does not meet this standard and the challenge of developing services which meet these standards is significant.

31.5 Recommendations

R12. TBP should call on commissioners and senior decision makers to rise to the challenge and reinvest the considerable costs attached to current provision and move towards developing appropriate standard residential placements in Bradford.

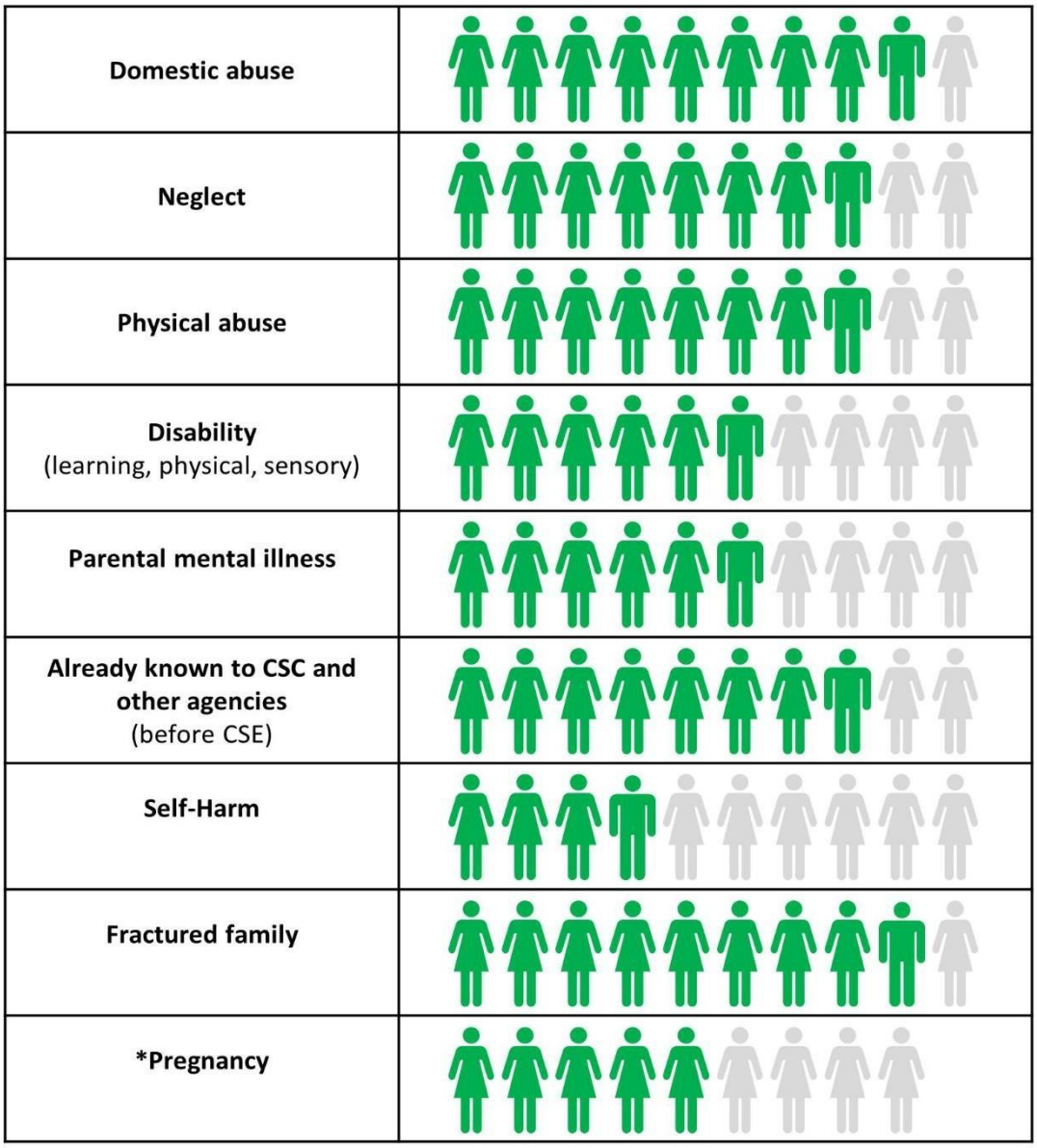
32.0 Additional Analysis and Learning

32.1 This section of the report details further key themes and analysis which emerged during the review.

32.2 Reframing Vulnerability

32.3 The graphic below shows the shared experiences of each of the five children included in the review and the five children who were the subjects of the detailed case audit. As is shown each of the children is living with or has experienced multiple traumas and disadvantages. This has significant implications for safeguarding policy and practice.

Shared experiences of the children and young people



*All CLA when they became pregnant 4 out of the 5 children born are subject to child protection arrangements and 1 adopted

32.4 As is clear, all but two of the children were known to CSC and other agencies *before* their sexual exploitation was known to have begun.

32.5 A March 2020 publication Child Sexual Exploitation Practice: Innovation and Moving Forward (Dr Jessica Taylor) makes the point that:
"*One of the most common methods of identifying and responding to children who are, or are suspected of, being sexually exploited is to measure factors known as 'risk indicators' and by changing or reducing the 'risk level' of the child by changing their behaviours in some way. Professionals in multi-agency teams measure the risk of CSE happening to the child using a matrix of 'CSE risk indicators' on a toolkit adopted by each local authority,*

police force or larger strategy area. Note, that they do not measure the risk of the offender, but the risk of the child."

32.6 The report then goes on to say:

"*Lists of vulnerabilities to CSE are widely used in practice, with many lists of vulnerabilities attached to the previously discussed CSE risk toolkit. The lists of vulnerabilities vary widely from toolkit to toolkit and have not been validated or evaluated to show causation or correlation as yet. Vulnerabilities include having a learning disability, being a looked after child and witnessing domestic abuse at home. Generally, the lists of vulnerabilities include adverse experiences from throughout the lifespan of the child, however, some are vaguer and include moving to secondary school, illness of a family member and having lowered self-esteem. It is thought that the more vulnerabilities the child has, the more likely they are to be sexually exploited. This approach to working with children represents a deficit model of children, rather than a strengths-based model of understanding their lives and potential*."

32.7 This was borne out by the practitioners who attended the two learning events in respect of Ruby and Ben. When asked to discuss and consider what 'good would look like' for Ruby and Ben their responses focused on positive aspirational outcomes and included the following.

- Consistency of relationships with key workers
- Aspirational; focus on positives not just disabilities or 'problems. Focus on self-esteem building.
- Positive peer supports in place.
- Access to appropriate interpreters
- Long term therapy which addresses multiple layers of trauma and loss
- Long term holistic plans which include opportunities for volunteering, work experience, education

32.8 A reframing of vulnerability might be helpful in tackling CSE in Bradford and the reality that children who are exploited have often experienced a wide range of traumas and disadvantages for many years *before* they are exploited.

32.9 Much direct preventative work in CSE involves efforts to 'reduce vulnerabilities' of children in order to protect them from a sex offender, who is assumed to only target children with vulnerabilities. This framing of vulnerability and risk seems peculiar to children (the majority of whom are girls) with pre-existing vulnerabilities who are being sexually exploited and there are no similar narratives, for example, in respect of the sex offender Barry Bennell a football coach who was convicted in 2018 of over 50 child sex offences. None of the commentators or experts in child sex abuse or offending behaviour discussed the risky behaviour of the boys who had been sexually abused. Nor did they discuss the boys' vulnerabilities other than in general terms. Barry Bennell was recognised universally as a predatory sex offender and the boys as 'straightforward victims`.

32.10 We also know from the Bennell case and others (clergy and teachers) that child sex offenders place themselves where they have access to children. There is evidence that perpetrators of sex offences we describe as CSE place themselves outside schools, outside

children's homes and in public places like parks and shopping centres where they can 'spot a likely looking' victim.

32.11 The efforts of many agencies working with children who are being sexually exploited is focused on teaching children how to protect themselves with an emphasis on them not taking risks. The perception that children 'put themselves at risk' of CSE is still widely held.

32.12 In light of this the next chapter of this report considers how a different focus on perpetrators of child sex offences may be required. This review presents TBP with an opportunity and a challenge to reframe how victims and perpetrators of CSE are currently perceived and responded to by the multi-agency system.

32.13 Recommendations

R13. TBP should seek assurance that.

- ***the current work taking place to develop a Bradford wide strategy in respect of Adverse Childhood Experiences (ACEs) reflects the learning from this review.***
- ***specifically, that CSE is, for many children, a consequence and a continuum of early trauma, and abuse and that CSE does not happen in isolation.***

32.13 Perpetrators of Sex Offences

32.14 The current focus of most agencies (with the obvious exclusion of the police and probation) is on victims of CSE and their families and agency efforts are focused on keeping children and young people safe from sexual exploitation.

32.15 There is little wider focus on and therefore little understanding of what, if any, common factors, including adverse childhood experiences, perpetrators share. Understanding how and why people become perpetrators of sexual abuse is important if we hope to reduce the harms caused by them to individuals and communities.

32.16 For example, a key study* carried out in 2009 by Colin Hawkes of the National Clinical Assessment Treatment Service (NCATS) into sexually harmful behaviour noted that "*neglect and maltreatment (often including sexual abuse) experienced within the family is a core influence on child development, in particular on closely linked relational faculties of attachment and sexuality. Genetic predisposition and unresolved trauma suffered by a parent, in particular the mother, tend to erode resilience to maltreatment in boys. This results in disorganised/disoriented attachment in infancy, and a diminished capacity to contain emotions and to reflect on them. Subsequently, in childhood they adopt externalised coercive strategies to manage relationships. After an experience of sexual victimisation, these strategies take on a sexual character*."

32.17 Hawkes' study findings relate to a sample of 27 boys who began to cause sexual harm before the age of 10. All the boys in the sample were known or suspected to have been victims of child sexual abuse – on average by the time they were five years old. This may

be particularly relevant in Ben's case as he has been both a victim and a perpetrator of sexual harm.

32.18 Research also demonstrates that the accessibility of on-line pornography plays a role in sexual offences and the Deputy Children's Commissioner in her foreword of the 2013 report '*Basically… porn is everywhere'* states:

> "*The use of and children's access to pornography emerged as a key theme during the first year of the Inquiry. It was mentioned by boys in witness statements after being apprehended for the rape of a child, one of whom said it was "like being in a porn movie"; we had frequent accounts of both girls' and boys' expectations of sex being drawn from pornography they had seen; and professionals told us troubling stories of the extent to which teenagers and younger children routinely access pornography, including extreme and violent images. We also found compelling evidence that too many boys believe that they have an absolute entitlement to sex at any time, in any place, in any way and with whomever they wish. Equally worryingly, we heard that too often girls feel they have no alternative but to submit to boys' demands, regardless of their own wishes*."

32.19 There is much to learn about the 'pathway' to becoming a sex offender and whilst data is currently collected by the police, Youth Offending Service and Probation Service this information, on the whole, is collected after an offence has or is suspected to have taken place. This is particularly relevant for Ben whose own possible childhood sexual abuse and exposure to pornography was never addressed and who is suspected to have become both a victim and a perpetrator of sexual offences.

32.20 In the 'here and now' there should be a change in risk assessments to firstly consider perpetrator behaviour, then contextual issues, risks posed by failure to protect and impact of under-resourced services. This should lead to a decrease in locating the 'risk' in the child; a decrease in 'score' based risk assessments; a decrease in tools that conflate predicted and actual risk and a decrease in using 'risk factors' that have no evidence base.

32.21 What we would expect to see is an increase in evidence-based risk assessment, participatory risk assessment, in peer and situation/location risk assessment, in assessment of risk posed by families or services failing to protect and an increase in recording and escalating situations where the required service does not exist or is not being funded.

32.22 Without this 'reframing' of how we respond to both victim ***and*** perpetrator we continue the narrative that sexual exploitation and abuse is inevitable for some children.

32.23 Recommendations

R14. TBP should ensure that data collected about the perpetrators of CSE, and research is effectively used to inform practice and strategy.

R15. TBP should seek assurance that general preventative multi-agency activity is effective; particularly within the night time economy and around CSE hot-spots and locations of risk.

32.24 The Long-Term Impacts of CSE on Health and Wellbeing

Research has long established a strong, albeit complex relationship between child sexual abuse and adverse mental health consequences for many victims.

32.25 Negative mental health effects that have been consistently associated in the research with child sexual abuse include post-traumatic symptoms (Canton-Cortes & Canton, 2010; O'Leary & Gould, 2009; Ullman, Filipas, Townsend, & Starzynski, 2007); depression (Fergusson et al., 2008; Nelson et al., 2002); substance abuse (Lynskey & Fergusson, 1997; O'Leary & Gould, 2009); helplessness, negative attributions, aggressive behaviours and conduct problems; eating disorders (Jonas et al., 2011); and anxiety (Banyard, Williams, & Siegel, 2001; Nelson et al., 2002).

32.26 More recently child sexual abuse has also been linked to psychotic disorders including schizophrenia and delusional disorder (Bendall, Jackson, Hulbert, & McGorry 2011; Lataster et al., 2006; Wurr & Partridge, 1996) as well as personality disorders (Cutajar, 2010b). Child sexual abuse involving penetration has, in particular, been identified as a risk factor for developing psychotic and schizophrenic syndromes (Cutajar et al., 2010a).

32.27 Anna and Fiona's stories bear out much of this research and in discussion with the independent reviewer both adults were able to describe their symptoms of Complex PTSD and other mental health diagnosis, fluctuating mental health, the ongoing threat of retaliation from perpetrators and the anxiety this causes.

32.28 As discussed elsewhere throughout this report the disruption of a child's education because of CSE and the co-existence of other issues also has a long-term impact on children and can have a further negative impact on their wellbeing and life chances.

32.29 Recommendations

R16. TBP should seek assurance that current interventions and responses recognise and address the potential long-term impacts of CSE on health and wellbeing.

32.30 The Criminalisation of Sexually Exploited Children

Four of the five young people who are the subjects of this review have experienced being arrested, spending time in custody and in some cases convicted of offences. Each of the offences was dealt with as it occurred sometimes with little contextualising of the extreme distress of the child. There is a similar picture for the children from the detailed case audit.

32.31 The criminalisation of traumatised children and young people is well researched and the 2018 National Protocol for Reducing Unnecessary Criminalisation of Looked After Children and Care Leavers makes the point "*However, although the vast majority of looked-after children and care leavers do not get involved with the justice system, they remain overrepresented compared with others in the criminal justice system."*

32.32 The protocol and other guidance and research are clear that trauma informed approaches work best with children and young people who share similar experiences with the subjects of this review. There was, however, little evidence that trauma informed approaches were consistently used or considered or that the child's challenging behaviour was understood to be a symptom of distress and fear and, in some cases, a lifetime of trauma.

32.33 It was of note however, that in Ben's case, officers responding to one or two of the incidents at the family home where Ben was the alleged aggressor did recognise and respond to him as a traumatised child.

32.34 Recommendations

R17. It is recommended that TBP engages with the Home Office seeking to promote that the good progress made in decriminalising children who offend in the context of CCE should be extended to CSE.

32.35 Missing out on Education.

All of the children and young people considered in this review experienced significant disruption to their education. In some cases, the children did not receive any education (including sex and relationships education) for several months or years. The impact of this is threefold.

32.36 Firstly, their basic human right to receive an 'effective education' was not met and this has long-term impacts on their life chances and makes seeking further education or employment more difficult. It also results in a lack of routine and structure which again impacts on their ability to manage further education and employment.

32.37 Secondly, the protective factors provided by regularly attending school are well known and come from teaching and non-teaching staff getting to know a child (and often their families) very well. They understand the community context in which the child lives and are well placed to identify any changes in a child's wellbeing. Crucially, if a child is in school and not therefore 'wandering the streets' they are less vulnerable to being targeted by organised and/or opportunistic sexual predators.

32.38 Thirdly the 'normal' social interactions with peers are denied to children not in education. This interaction and the friendships and wider community connections formed through these friendships are also important for a child or child's sense of identity, wellbeing and safety.

32.39 The majority of the children included in this review had significant and multiple disadvantages and were living with domestic abuse, parental mental illness, neglect, poverty and other issues. This means that school was even more important as a place of potential stability and safety.

32.40 These multiple disadvantages and ongoing traumas also meant that the children displayed a range of behaviours which were 'difficult' or 'challenging'. Trauma informed education would recognise that these behaviours were as a result of a child's lived experiences and

would put plans in place, including extra-curricular interventions, to support the child to remain in education.

32.41 This review has identified some good practice; for example, Ruby's relationship with one of her schools was very good, however she moved to an out of area placement and this relationship was lost.

32.42 The difficulties of providing safe and effective education were, in Ben's case, compounded by his communication disabilities. His absence from education for many months left him vulnerable to criminal and sexual exploitation.

32.43 The case audit also identified the challenges in further education. Children struggled with following their aspirations in successfully pursuing courses and attendance at college. Children felt intimidated by the "busy" lifestyle of colleges and lacked confidence with new environments.

32.44 Recommendations

R18 TBP should assure themselves that there is sufficient provision planned within the SEND sufficiency plan and the School Sufficiency Plan to enable the delivery of adequate special and mainstream education places for pupils of a statutory school age.

R19. TBP should seek assurance that appropriate action is being taken to improve the attendance of children who are persistently absent who are known to children social care.

32.45 Joined Up Service Responses, the System.

This section of the report describes some of the current service response in Bradford and reflects the conversations held by the independent reviewer with practitioners and review panel members.

32.46 The practitioners who attended the learning events described feeling frustrated by a shortage of good residential and education placements for some children and young people in Bradford, a view supported by Social Workers spoken to during the detailed case audit.

32.47 A further very important issue was the scarcity of therapeutic services which could be highly personalised and tailored to meet the children and young people's needs. (Therapeutic services need to work with the child in the context of their very unsettled lives and be able to work more imaginatively than through rigid appointments).

32.48 Therapeutic services could provide a range of responses which do not have a 'mental health' label for example mentoring, safe space to relax and talk, and peer support through to structured and intensive trauma informed therapy which recognises that children and young people may very well still be experiencing trauma.

32.49 The work with children and young people experiencing sexual exploitation is very demanding and requires a well-supported, highly trained and experienced workforce.

32.50 The various practitioners currently providing the response to at risk and exploited children describe the short-term nature of funding for some services and initiatives. This creates further frustration in the system and a perpetual effort to retain funding or apply for new funds.

32.51 In summary the issues described above result in a 'system' that can feel fractured and one that works against itself. An example of this came from the case of Ben and the difficulties his CSC workers had in securing funding for a residential school placement which resulted in him being badly let down, confused and frustrated.

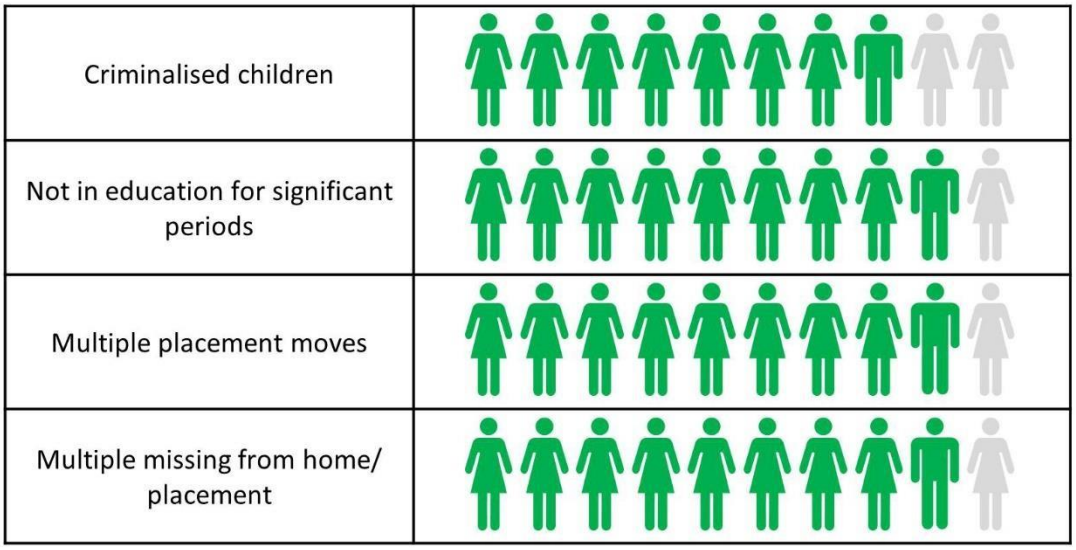
32.52 Learning event participants, Panel members and stakeholders described what an improved future response for the children and young people of Bradford who are at risk from or already experiencing CSE could look like. This improved response would be consistent but flexible, child-centred and trauma-informed.

32.53 Much discussion took place about the transition points in children's lives; in particular, reaching the age of 16 and 18 and what that means for children and young people who are experiencing CSE. The ideal response would be consistent services which could provide support and advice without a cut -off point when a child reaches 16 or 18 years of age.

32.54 A child centred, holistic system which recognises the pre-existing disadvantages and complexities in the lives of children and young people experiencing CSE would require the commitment of health, social care and police commissioners to work together with service and support providers in a different way using systems learning and improvement approaches.

32.55 The graphic below summarises the key system issues which impacted upon practice and outcomes for the 5 children who were the subjects of the review and the 5 children who were the subjects of the case file audits.

System issues



32.56 Recommendations

R20. Involving front line practitioners in system wide and single agency CSE improvement and development work is recommended. TBP and partners should also consider how children and adults who have experienced CSE can contribute to this work.

R21TBP should challenge agency partners to demonstrate that there is a system wide approach to jointly commissioned, long term approaches which address the human and financial costs of a child's lifetime exposure to trauma, abuse, neglect and exploitation.

33.0 Operational Learning Perspectives

33.1 The review and case audits highlighted a number of areas of learning from an operational perspective. Partners should consider these in future planning, processes, quality assurance and training and ensure:

33.2 Practice and Procedure

- Consistent approach to how risk is assessed, analysed, responded to and also recorded.
- Recognition and assessment of cumulative harm and wider holistic assessments, particularly reflecting on the impact and influence of parents and siblings, changes to cultural identities in a trauma-based approach.
- Consistent approach in the production and recording of care plans, around structure, detail, approach and use of signs of safety model. Plans should be forward thinking and not reacting to incidents.
- Timeliness in moving to formal statutory processes at an earlier stage, recognising increases in complexity and risks.
- Quality assurance of assessments and care plans to recognise over optimism, prevent drift and delay and allow partners an opportunity to challenge the effectiveness and escalate concerns where necessary.

- Section 175 Schools Audit and Section 11 organisational audit to seek assurance based upon the learning from this review.
- Good practice – plans separating out areas of risk, providing a detailed balance of expectations for the child, prompts and partner responsibilities.
- Good practice – use of trigger plans for missing episodes and use of dedicated resource to provide one-to-one support and the use of a specialist services in developing positive pathways.

33.3 Information, Disruption and Prevention

- CSE profiles that utilise information from all available sources and partners to fully inform the threats and risks around CSE (Note: The West Yorkshire Risk and Vulnerability Group have set up a task and finish group to look at information sharing and threat profiles).
- Effective information sharing with front line partners and practitioners, including those in non-safeguarding roles, to identify CSE hot spots and locations of risk and contribute to preventative opportunities. TBP may wish to consider the reintroduction of dedicated resource for the Night Time Economy.
- Preventative plans based upon locations of risk /perpetrators particularly around alcohol/substance misuse.
- Technology-based abuse – continued education and preventative activity.
- Further awareness raising campaigns through the Communications and Engagement Group, with a focus on hard-to-reach groups.

33.4 People

- Complex cases should be allocated to suitably qualified and experienced staff in social care and caseloads recognise that complex cases are often more time consuming.
- Front Door expertise should support practitioners dealing with CSE to understand what specialist support provision is available and share good practice, including care planning.
- Regular supervision should take place across the partnership, across all partners and particularly where risk escalates, and the existing plan cannot mitigate the risks or is not effective.
- Training requirements set and agreed for practitioners working with children.
- TBP may wish to review the current multiagency training offer to include learning from this review.

33.5 Parents

- Support and guidance for parents who are unable to adequately care for children at times of increased complexity and vulnerability.
- Good Practice – increased support for parents of preventative approaches, the use of the Police Cyber Team, Trusted Relationship and other similar initiatives are recognised as valuable methods.

33.6 Engagement with children at risk of CSE

- Capturing the voice of the child for specific periods or interventions and placements would provide a more specific and informed method of feedback for particular decisions and parts of a plan.

- Review the use of the Viewpoint letter and consider a more user-friendly method to capture the voice of the child.
- Support for children seeking further education.
- Partners should display professional curiosity in the use of alcohol and drugs, frequenting CSE hot spots, sources of money and lifestyles.
- Adequate provision of therapeutic services and continued use of initiatives such as Trusted Relationship, Breaking the Cycles and the Youth Provision.
- Professionals would welcome more opportunities around psychiatric assessments in understanding why children were at risk and also in assessing mental health.
- Effectiveness of contraception and relationships and sex education may be an area of learning.

34.0 Summary and Conclusions

34.1 The terms of reference for this Serious Case required the independent reviewer, the Serious Case Review Panel members, over 40 practitioners and managers from a wide range of agencies and crucially women who are still living with the consequences of CSE, to consider whether or not there had been sustained improvement in the way agencies and individuals respond to CSE in Bradford.

34.2 During the process of conducting this review it became clear at an early stage that agencies and individuals in Bradford do not always get it right and some children remain unprotected while some perpetrators remain unknown and unchallenged. This is despite some significant improvements in agency understanding of and responses to CSE between the less recent and current cases.

34.3 The Panel members and other stakeholders were beginning to consider what an improved future response to the perpetrators of sexual abuse and exploitation might look like. This might involve working with academic partners and others to begin the process of understanding how people (overwhelmingly males) of all ages and all backgrounds become perpetrators. Only by doing this will communities and agencies be able to focus on preventing abuse happening in the first place.

34.3 The term ‘at risk of Child Sexual Exploitation’ is used in cases where children and young people are actively - here and now - being exploited and abused. The term Child Sexual Exploitation sanitises the reality of what that means for children. In several of the cases included in this review this meant being raped, sexually assaulted, physically assaulted, being afraid and anxious, being forced to take drugs and alcohol, being homeless and being lonely and isolated from family and friends.

34.4 The multiple disadvantages and the traumas experienced by the majority of the children included in this review pre-dated their sexual exploitation and abuse. Sexual exploitation and abuse should not, therefore be viewed as a single ‘new’ issue but as an important part of a continuum of trauma and/or abuse.

34.5 As described, most of the children included in this review have lived with domestic abuse, physical and emotional abuse and neglect for most of their lives and this therefore poses a

challenge for commissioners, managers and practitioners as it is the failure of the system to protect children from these harms which creates vulnerability to further abuse from CSE (and CCE).

34.6 Abuse does not occur because of a child's vulnerability. It occurs because there is someone who is willing to take advantage of this vulnerability and because there are inadequate protective structures (around the child and their family) in place to prevent this.

34.7 The thematic review has looked in detail at both non recent responses to CSE and more recent practice. Through the lens of children some of whom are now adults, the review has shone a light on responses to CSE in Bradford over a 17-year period. The stories of the children are difficult to hear. It is also clear that while there has been considerable work in the district in relation to CSE there are still lessons that need to be learned and the responses to victims of this complex crime is not yet good enough in all cases.

Glossary

ADHD	Attention Deficit Hypertension Disorder
AIM	Assessment Intervention and Moving On
CAMHS	Child Adolescent Mental Health Service
BPP	Be Positive Pathways
TBP	The Bradford Partnership (formerly the Local Safeguarding Children Board)
YOS	Youth Offending Service
CIN	Child in Need
CAWN	Child Abduction Warning Notice
CAF	Common Assessment Framework
CPP	Child Protection Process
CPS	Crown Prosecution Service
CSA	Child Sexual Abuse
CSC	Children's Social Care
CSE	Child Sexual Exploitation
ICPC	Initial Child Protection Conference
IRO	Independent Reviewing Officer
LCSPR	Local Child Safeguarding Practice Review
MARAC	Multi -Agency Risk Assessment Conference
MACE	Multi- Agency Child Exploitation
MASH	Multi -Agency Safeguarding Hub
NICHE	Police Records Management System
OFSTED	The Office for Standards in Education, Children's Services and Skills
RAM	Risk Assessment Meeting
RCPC	Review Child Protection Conference
RSPCA	Royal Society for Protection of Animals
SCR	Serious Case Review
SNSC	Senior Nurse Safeguarding Children
SNS	School Nursing Service
SHP	Specialist Health Practitioner
TAF	Team Around the Family
Misper	Missing Person

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Appendices

1. Panel Members
2. Detailed multi- agency responses to the review
3. Recommendations
4. Summary of progress