Somerset Safeguarding Children Board

The Fenestra Serious Case Review into Child Sexual Exploitation

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

Final Report

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1 INTRODUCTION

1.1 CONTEXT OF SERIOUS CASE REVIEW

1.1.1 The Somerset Safeguarding Children Board (SSCB) Learning and Improvement subgroup were notified in 2015 about nine children who were victims of child sexual exploitation (CSE) from two men identified through the Operation Fenestra police investigation. These two men are called Perpetrator A and Perpetrator B in this report.

1.1.2 The offences against the children occurred between 2010 and 2014 in Somerset. They were subject to police investigations, in 2011, 2012 and August 2014. This investigation resulted in the prosecution and conviction (in 2016) of the 2 men for sexual offences against 6 victims aged between 14 and 15 (when the crimes were committed) and a 7th victim aged 18. At the time of conviction Perpetrator A was aged 34 years old and was convicted on 2 counts of rape and 7 of sexual assault, and sentenced to 20 years imprisonment. Perpetrator B, aged 29, was convicted of 1 count of rape and 6 of sexual assault and sentenced to 12 years imprisonment.

1.1.3 The SSCB chair, Sally Halls, agreed in November 2015, that the criteria for a serious case review (SCR) had been met by two of the victims (Child C and Child Q). These young people had suffered significant harm as a result of persistent sexual, physical and emotional abuse, which resulted in serious mental health problems, including suicide attempts. In addition, both children had several pregnancies, ending in miscarriage and termination, prior to having a child by one of the perpetrators.

1.1.4 It is also recognised that there will be learning from the experiences of several of the other seven young women, who were also identified during Operation Fenestra as having been sexually abused by the perpetrators when they were children. This learning will appear within the findings.

1.2 SUMMARY

1.2.1 This serious case review aims to identify the strengths and gaps in the multi-agency responses to child sexual exploitation (CSE) in order to learn and improve. Whilst there were 9 victims identified in Operation Fenestra, the police investigation initially commenced in 2012 and then intensified in 2014 due to concerns and allegations reported to statutory agencies in relation to 2 of the victims, children C and Q.

1.2.2 There was evidence in the records from 2010 for Child Q and 2011 for Child C: both were aged 15 when agencies learnt that they had an older 'boyfriend', albeit the actual age and identity of any boyfriend was not known initially. The parents of Child Q however recalled raising such concerns earlier when Child Q was aged 13 years old.

1.2.3 Records also show allegations that the premises where the perpetrators worked was a location for men to have sex with under-age girls.

1.2.4 The police investigation identified the other alleged victims. Some, but not all of these victims, were known to CSC and/or police for a variety of reasons, but there was no information, known by the agencies, which would have identified that they were being sexually exploited by either of the perpetrators.

1.2.5 The reason for this is largely linked to the type of sexual exploitation that was occurring. C and Q identified themselves as 'girlfriends' as they each had long term relationships with a perpetrator, in which they were sexually, physically and emotionally harmed. This constituted child sexual exploitation (CSE), but was not recognised as such by the victims themselves at the time. This is usually described as the 'inappropriate relationship' model of CSE (see section 1.3). The nature of the exploitation of the other victims was in relation to a sexual assault / rape on one or a few occasions and there was no information known by any agencies to link those victims with Perpetrator A or B.

1.2.6 Section 3 explains the missed opportunities for more effective earlier intervention, which was partly a reflection of local practice weaknesses at the time, as identified in the inadequate Ofsted inspection rating of Somerset in 2013. It was though also linked to national and regional obstacles to good practice as highlighted by the Brooke Serious Case Review (2016)[1] . This SCR looked at Avon & Somerset Police practice in Bristol during this period as well as the underlying national contributory factors to safeguarding. Findings 1- 5 from this Bristol SCR apply equally to professional practice in Somerset during the period the victims were being exploited:

1. The multi-agency system is not set up to provide an effective response for those adolescents with a complexity of needs (including those at risk of CSE), at the time and pace they need it, leaving children with a fragmented and reactive response to different aspects of their behaviour
2. A confused and confusing stance in national policy about adolescent sexual activity, leaves professionals and managers struggling to recognise and distinguish between sexual abuse, sexual exploitation and/or underage sexual activity; this risks leaving some children at continued risk of exploitation in the mistaken belief they are involved in consensual activity
3. The child protection process in England has primarily been designed for familial child abuse/ neglect; in the absence of concerns about abuse or neglect by parents/carers, victims of sexual exploitation are likely to receive an inconsistent response to their safeguarding needs.
4. In cases involving sexual exploitation, there is a pattern of focusing primarily on trying to stop victims having further involvement with perpetrators, and less on the prevention of the abuse in the first place and the disrupting and prosecuting of perpetrators: this means victims often continue to be at continual risk of abuse by the same perpetrators.

[1] The Brooke Serious Case Review into Child Sexual Exploitation (Bristol LSCB 2016)

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

1.2.7 The review also considers what still needs to be in place within the multi-agency environment for improved intervention in CSE, in particular the need for in depth and resource intensive support to alleged victims, which relies on consistent relationship building and trust, along with professional expertise in working with young people involved in significant risk taking behaviours. Finally, through involvement of current professional staff and young people (including victims of CSE), the SCR has considered how practice may have changed in recent years, identifying the strengths as well as the remaining obstacles to safeguarding children.

1.3 AIM OF THIS SERIOUS CASE REVIEW

1.3.1 Because this case concerned abuse prior to 2014 it was recognised it would be likely to duplicate much of the learning from the Brooke serious case review[2], the Ofsted inspection of 2013 and the various other CSE reports and reviews around the country. In order to provide current learning for Somerset it was agreed initially that the focus needed to be on recent practice, particularly after Operation Fenestra became more intensive in August 2014. However it became clear that there was specific learning emerging from earlier periods for individual agencies and for improvements in multi-agency working to improve outcomes for children at risk of child sexual abuse. Therefore the review periods were extended to consider the period from 2009 up until 2014 during which the abuse took place.

Model of CSE

1.3.2 The type of CSE suffered by children C and Q is an ''inappropriate relationship' model. This is defined as:

'Usually involving one perpetrator who has inappropriate power or control over a young person (physical, emotional or financial). One indicator may be a significant age gap. The young person may believe they are in a loving relationship'.[3]

1.3.3 Both C and Q believed they were 'in love' and that perpetrator A was their boyfriend, who gave them presents and intended to have a permanent relationship with them. He was significantly older than them and subjected them to physical, sexual and emotional abuse as part of a controlling relationship.

[2] ibid
[3] Puppet on a string The urgent need to cut children free from sexual exploitation, Barnardo's 2011

1.3.4 This model of abuse is distinct from the models described in other high profile serious case reviews which focus on victims either being coerced into having sexual relationships with the boyfriend's associates (known as the 'boyfriend' model) or being 'passed through networks, possibly over geographical distances, between towns and cities where they may be forced / coerced into sexual activity with multiple men' [4] (known as organised/networked sexual exploitation or trafficking).

1.3.5 The inappropriate relationship model of CSE is the focus of this serious case review and should provide additional learning to previous high profile CSE case reviews.

1.4 METHODOLOGY

1.4.1 This serious case review uses a systems methodology for learning about the underlying strengths and weaknesses to safeguarding in the multi-agency system as opposed to a focus on individual practice. This uses the Social Care Institute for Excellence (SCIE) Learning Together methodology[5] and the review has used an adapted version of this model to suit the thematic requirements of the review and the terms of reference for the review agreed by SSCB.

Agency provision of information

1.4.2 Following the end of the criminal trial in November 2016, the following agencies each provided a chronology of professional involvement and in a short report:

- Children's Social Care
- Clinical Commissioning Group for primary care
- Police
- Education
- Local District Hospital NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- Barnardo's

1.4.3 In addition chronologies were supplied by:

- Youth Offending Team
- Somerset Integrated Domestic Abuse Service (SIDAS)
- Turning Point

[4] ibid

[5] SCIE Learning Together to safeguard children: developing a multi-agency systems approach for case reviews (2008) http://www.scie.org.uk/publications/guides/guide24/index.asp

Serious case review panel

1.4.4 The independent lead reviewer, Edi Carmi, worked closely with the independent panel chair, Lucy Watson, and a panel of senior managers, including the SSCB business manager. Panel members took responsibility for facilitating provision of agency information and working with the lead reviewer to involve practitioners, reflect on practice historically and currently and agree the report with the independent lead reviewer.

1.4.5 In addition to senior managers from the agencies involved in providing information to the review, the Service Manager of the Somerset Safeguarding Adult Board was a member of the panel. The inclusion of Adult Services commendably reflects the recognition within Somerset of the risks of CSE for both children and vulnerable adults, in particular around the issues of 'consent and capacity' (see Finding 1, section 5).

Involvement of practitioners

1.4.6 Individual staff who have been involved during the period of Operation Fenestra have been involved in this case review, namely the police officers and Barnardo's BASE worker, who was supporting one of the 9 victims. One member of staff involved as an adolescent support worker in 2010, spoke with the lead reviewer, providing useful insights into the thinking in that period.

1.4.7 The involvement of current professional staff in group sessions has enabled the lead reviewer to consider if practice and understanding in this case is representative of current practice. This involved staff from health agencies, Children's Social Care, Community Safety (2 different groups), Police and Education staff (2 meetings). Their views are included in the findings within section 5, in discussions about whether the finding is describing underlying features of the multi-agency system and/or if the issue occurs more widely.

Contributions of young people and parents

1.4.8 The involvement of CSE victims and their families has provided valuable insight into both the impact of the abuse, and how practitioners can better support young people and families. The victims included 3 of those involved with perpetrators A and B, and 3 others who have received support via the Barnardo's BASE project. There was involvement of parents of 3 victims, one of whom was a victim of perpetrators A and B.

1.4.9 A wider perspective was obtained through meeting with groups of school children in 3 different schools in the area where the abuse occurred and with a group of Children Looked After.

1.4.10 Details of the learning provided by young people and parents is provided in section 4.

Limitations to the review methodology

1.4.11 This case involves historical abuse from 2010 to 2014. It has been difficult to obtain an understanding of why many decisions for action, or frequently, lack of intervention, occurred due to recording inadequacies and the fact that the practitioners are largely no longer in Somerset and available to participate in the serious case review. This is particularly the case for children's social care (CSC) whose workforce at that time consisted of a large number of temporary agency staff. As mentioned above, the practice shortcomings locally at this time are well documented by Oftsed, and regionally in the Brooke review. In consequence the decision was taken that it would not be proportionate to try and locate all the ex members of staff, especially as the likelihood of them having adequate and valid recall about brief involvement with a child and family so long ago, was unlikely.

1.4.12 There has been a notable lack of involvement of social workers in children's social care in the review process, as few attended the focus groups held to discuss current safeguarding practice, and none of those involved in Operation Fenestra took part in the review.

1.4.13 Only one victim gave explicit consent for disclosure of information related to her health when she was aged over 18 years old. In consequence such information was not available for the other 8 victims. There has been some limitation in relation to the provision of data from some GPs, with information provided for 6 of the 9 victims: this is a systemic issue and is addressed in finding 8, section 5.

1.4.14 To be able to advance learning about how to safeguard children from CSE, research needs to be undertaken with the perpetrators of the abuse, so as to better understand the pathway to becoming such an offender. The Brooke SCR's finding 4 (see 1.2.5) described the need for more focus on prevention of the abuse in the first place and the disrupting and prosecuting of perpetrators. 2 of the offenders in that case contributed to the learning process. In this case the SSCB decided that the inclusion of perpetrators was beyond the scope of the serious case review and needs to be part of a larger learning exercise that looks at perpetrators of CSE.

1.5 TERMINOLOGY

1.5.1 Throughout the report the term child is used rather than young person. Whilst we acknowledge that many teenagers prefer not to be described as children, we have accepted the view of Louise Casey[6], expressed following the Rotherham inquiry into CSE:

'child sexual exploitation is sexual and physical abuse, and habitual rape of children by (mainly) men who achieve this by manipulating and gaining total control over those who

[6] Louise Casey was UK's first Victims' Commissioner in 2010, then Director General of the government's Troubled Families programme from 2011-2017 and following the Jay report on CSE in Rotherham, Casey was appointed to lead the inspection of children's services at Rotherham council (published February 2015).

cannot consent to sex either by virtue of their age or their capacity. It is therefore important that professionals working in the field of CSE refer to anyone under 18 as a child so their status is never overlooked.'

1.6 STRUCTURE OF REPORT

1.6.1 The report is split into the following sections:

- Section 2 explains what happened in this case and appraises the practice
- Section 3 provides the messages about current practice from young people, families and practitioners about current practice
- Section 4 provides the findings, along with considerations for the SSCB
- Section 5 provides additional learning that has emerged, but for which there is insufficient information to know whether this is a systemic multi-agency finding.

1.6.2 The term 'considerations' as opposed to recommendations, is used. This reflects the thinking of the Learning Together model, whereby it is important that the SSCB decides exactly how to implement the improvements indicated.

2 APPRAISAL OF PRACTICE

2.1 INTRODUCTION

2.1.1 This section briefly describes the involvement of agencies with the victims from 2009, commenting on the multi-agency practice towards child sexual exploitation, in particular in relation to Operation Fenestra.

2.1.2 This appraisal focuses on the quality of professional practice in relation to the welfare of the child, with the explanation for such practice (if known) explained below, or in the findings in section 5. The passage of time and high turn-over of staff means that it has not been possible to always explain the rationale for professional shortcomings. However, the abuse at the centre of this SCR occurred during the period when Somerset's safeguarding practice is now acknowledged to have had major weaknesses as identified by Ofsted in 2013 when 'The overall effectiveness of the arrangements to protect children in Somerset County Council is judged to be inadequate'[7].

2.1.3 The aim of this section is to look at multi-agency practice, as opposed to the individual stories of the victims. Some, but not all, of the victims were known to police and/or CSC. Some, but not all, had known vulnerabilities that might have made them more likely to be victims, whilst others did not.

2.1.4 The appraisals below focus on the professional practice linked to the experiences of C and Q. Prior to 2014 this primarily concerns professional practice in relation to children (and later adults) C and Q, the two girls who are the subjects of the serious case review. Professional contact with them was often related to the impact of the unrecognised abuse they were suffering from the perpetrators (especially perpetrator A). Some of the other children will have had contact with professionals which are not mentioned here, because we have no information that it involves abuse by the 2 perpetrators. Children C and Q were the 2 victims who believed that perpetrator A was their 'boyfriend' and with whom they understood themselves to be involved in a long term relationship. This did not apply to the other 7 victims.

Missed opportunities: what this means

2.1.5 The following description of what happened refers to 'missed opportunities' to try to discover about the abuse perpetrated by the 2 men. This term should be treated with caution, as CSE is a particularly difficult form of abuse to investigate and takes painstaking investigation over a prolonged period of time **(see finding 3, section 4**). It might therefore be that none of these incidents, in themselves, could have led to the discovery about what was happening. Nevertheless they were each an opportunity that was missed to *try* and find out what was happening.

[7] https://reports.ofsted.gov.uk/local-authorities/somerset: Ofsted *at that time* used 4 categories: outstanding, good, adequate and inadequate.

2.2 PRIOR TO FIRST ALLEGATION OF SEXUAL ABUSE AGAINST EITHER OFFENDER (BEFORE MID 2010)

2.2.1 Prior to the first allegations made against either of the perpetrators in mid 2010, there had been some concerns about the welfare of several, but not all the victims. This was in the main around behavioural issues, which included aggressive behaviour at home and/or school.

2.2.2 Before mid-May 2010 there was no information in the records about either of the perpetrators in relation to abusing children, but there was some involvement of CSC with both children C and Q in relation to each girl's relationship with her parents. Child Q's parents however recall mentioning their concerns to professionals earlier than 2010, when Child Q was aged 13 years old.

2.2.3 Child C, aged 13, made allegations twice in 2009 and again in 2010, in relation to abuse by her parents. The concerns were appropriately referred to CSC by the school in all instances.

2.2.4 The first allegations in 2009 were subject to initial investigation and assessment (under s.47 Children Act 1989) by police and CSC involving a child protection medical and video interview. The case was closed to CSC shortly after these 2 incidents, although it is unclear what intervention took place (if any) to provide support to parents experiencing difficulty with perceived freedoms for teenagers in the UK culture (in contrast with their country of origin) and in relation to how to discipline their child. The school were to provide support to the child in relation to bullying at school and make a referral to CAMHS. CAMHS declined involvement as the child was judged not to meet their criteria. **Please see finding 5 in section 4** re finding relating to CAMHS.

2.2.5 In summer 2010, Child C again made allegations about her parents, and there were concerns around C self harming and feeling suicidal, as well as incidents of her being missing from home. An offer was made from a member of the public to act as an interpreter for the parents, as the daughter was routinely used, and parents were concerned she may be making up stories. It was inappropriate to use either the daughter as an interpreter or a member of the public (see **additional learning, section 5**).

2.2.6 At that point the case was closed, but the child, then aged 14, was increasingly missing school and sometimes missing from home. Moreover, the school reported her as speaking of hearing voices and sensing spirits, as well as fearing being hit by her parents. CSC closed the case at this point, having advised the school to refer the child to CAMHS. This was an inadequate response given the increasingly high level of concerns relating to Child C: possible abuse by her parents, her emotional well being, her increasingly disturbed behaviour and the indications of needing help and education about safe relationships, especially with men. The reasons for this case closure are not known due to the passage of time, except for the family going back to their country of origin for a holiday. CAMHS for their part discharged the child immediately on the basis of her having gone abroad. **Please see finding 5 in section 4 re finding relating to CAMHS for further discussion and finding 2 in relation to the lack of effective family work**.

2.2.7 Child Q, aged 14, had started truanting from school classes in 2010, as well as having an episode of aggression and smoking. This seems to have happened increasingly after an incident when she alleged being molested by a member of staff at the school, and which was subject to police investigation and prosecution for which Q continued to receive support from an adolescent support worker in the local service team. She was also thought to be having a relationship with an older boyfriend, but no details were known of him at this time and he was described as 19 years old.

2.3 1ST ALLEGATIONS INVOLVING PERPETRATORS: AUGUST - DECEMBER 2010

2.3.1 The first time one of the perpetrators came to the attention of CSC was in August 2010, when perpetrator B informed the mother of his children that he was having an affair and had made the woman pregnant. This escalated into a domestic abuse incident, with perpetrator B allegedly wielding a knife and threatening the mother of his children. No assessment followed, as the mother was considered protective and had family support. This outcome did not take into account potential risks for women, the wife and the woman who was pregnant, nor the children and unborn child. The reasons for this decision are not known: the records do not explain this and the practitioners involved at the time are no longer working in Somerset. This episode does *not* involve any of the victims involved in Operation Fenestra, but highlights the background knowledge available of perpetrator B's involvement in domestic abuse.

2.3.2 There were three professional referrals about 15 year old Q to children's social care services in September, October and November 2010, from the school, the targeted youth service , the adolescent support worker from the local service team and three referrals from Q's own father. These included concerns that:

- In September Child Q disclosed at school that she had woken up that morning in a flat with two unknown males and another female. She thought her drink had been spiked the previous evening and had no idea who the people in the flat were

- Relationship problems at home between Q and her parents, that the father had hit Q and that Q's father was concerned that Child Q was sexually active.
- That Q was in a sexual relationship with an older (26 or 28 year old) married man with children, named as perpetrator A
- Q's behaviour had deteriorated, with her truanting from more and more lessons at school, being rude and aggressive at times and going missing from home

2.3.3 Initially, in September, the focus of intervention was around Child Q's allegation she had been hit by her father, but the CPS decided not to proceed with any prosecution of the father (he claimed self defence) and CSC closed the case, against the wishes of the father, who wanted help. It is not known why there was no investigation into the boyfriend or the allegations Q made with regard to waking up in a flat without knowing how she got there, or who the other people were (**but see finding 2 in section 4**). *This was the 1st missed opportunity to find out about perpetrator A's abuse of Child Q.* See also **finding 2 in section 4** in relation to the focus on family problems, but without adequate investigation and intervention.

2.3.4 In October, the father referred his concerns again, mentioning that he thought his daughter had a miscarriage 7 weeks earlier. CSC records show that Child Q had spoken to an adolescent support worker (in the local support team) of having a relationship with someone her own age. There was though no strategy discussion, s.47 enquiry or pro-active police investigation, which would have included checking with the GP / hospital about any miscarriage, establishing the basis for parental fears and the police interviewing perpetrator A. The health information provided to this SCR does not mention any miscarriage at this stage, but the information in the GP records provided is very limited. The reason for the lack of investigation is not known, but the comment about Q's father, reflects the earlier investigation whereby the focus of professional assessment and intervention appears to be around family dynamics, without an adequate understanding of parental concerns and their role in family difficulties. *This was the 2nd missed opportunity to find out about perpetrator A's abuse of Child Q.* Please **see finding 2 in section 4** for further discussion.

2.3.5 The referral in November 2010 by the father was even more worrying, with CSC records mentioning his concerns that Child Q was continuing to have a sexual relationship with perpetrator A, who also has sexual relationships with other girls, carries a knife with him in his car, physically assaults Q, humiliates her and forces her to beg. Child Q had spoken of loving perpetrator A and that he planned to leave his wife for her when she was 16. Her father spoke of Q receiving gifts. The initial assessment concluded that family support to be provided under s.17 (Child in Need) and, because Child Q denied there was a sexual relationship, the investigative approach ended. *This was the 3rd missed opportunity to find out about perpetrator A's abuse of Child Q.*

2.3.6 Shortly after this Child Q had a miscarriage and received medical attention following the event, supported by her mother. 15 year old Q denied that Perpetrator A was responsible for her pregnancy, maintaining the relationship was not sexual. The school and the adolescent support worker made a referral to CSC and a social worker visited when Child Q said the male responsible for her pregnancy was 17 years old, but did not disclose his identity. *This was the 4th missed opportunity to find out more about perpetrator A's abuse of Child Q e.g. by investigating further the identity of the 17 year old.*

2.3.7 A police report from this period (August - December 2010) shows knowledge that Child Q stayed at the perpetrators place of work (a barber's shop) overnight sometimes, when reported as missing. Reference is made to this being a 'controlling' relationship as well as citing an example of the humiliation the girl experienced. There is also a note in CSC records to a police officer establishing that the girl stayed overnight at the flat of perpetrator B, a friend of perpetrator A. The reasons for the lack of follow up is not known, but probably relates to policing and social care practice at the time, as described in the Brooke SCR[8], of waiting for disclosure of sexual abuse by children. *This was the 5th missed opportunity to find out about perpetrator A's abuse of Child Q.*

2.3.8 In January 2011 CSC closed the case following Child Q stating her relationship with Perpetrator A was over and that he was with someone else. This case closure took place despite the father's continued concerns that they could not cope and requesting his daughter be accommodated. She had become increasingly aggressive towards her parents and was self-harming.

2.3.9 By January 2011, some agencies knew about both perpetrator A and B. The latter only in relation to police information on domestic abuse and being a friend of perpetrator A. Perpetrator A was though the subject of repeated allegations in terms of physically, sexually and emotionally abusing one 15 year old girl as well as it being also alleged he was having sex with other girls. CSC, the police, the school and the adolescent support worker all had knowledge of some of these concerns. The lack of a disclosure of actual sexual intercourse by the girl or the perpetrator appears to have led to a lack of s.47 enquiries and thorough police investigations. What is also evident during these missed opportunities is the extent of concern of the parents of the 15 year old girl and the limited response to the parents' concerns, despite a miscarriage (possibly her second). This is **discussed in finding 2, section** 4.

2.4 PREGNANCIES, TERMINATIONS & MISCARRIAGES (JANUARY - JULY 2011)

2.4.1 In the first half of 2011, the level of distress experienced at this time by both Q and C became evident, along with disclosures being made to GPs and CAMHS, which were not reported to police or CSC.

[8] **8** The Brooke Serious Case Review into Child Sexual Exploitation (Bristol LSCB 2016)

2.4.2 Child Q was 16 years old. Her emotional and mental health deteriorated, with concerns at school that she was self harming and an admission to hospital following an overdose in January 2011, being seen at CAMHS [via a GP referral] in March and April and being prescribed anti-depressants. At CAMHS she spoke of the end of a relationship with a 29 year old married man. She named perpetrator A and told her mother (whilst at CAMHS) that the relationship had been sexual, involving physical abuse and that he had got her pregnant, leading to her miscarriage. No referral was made to police or CSC by CAMHS and the reasons for this are not known. **This is discussed further in finding 5, section 4**. *This was the 6th missed opportunity to find out about perpetrator A's abuse of Child Q and particularly critical as Q herself spoke of the abuse and confirmed that the relationship had been sexual.*

2.4.3 In early May, Child Q was admitted to the local hospital again following an overdose after an 'altercation' (hospital records) with her boyfriend, which CAMHS describe as her being 'physically assaulted' after an argument where perpetrator A admitted to seeing someone else. CAMHS advised Q's father to self refer to CSC and made no referral to police or CSC. It is not clear what injuries Child Q suffered as a result of the assault, but a few days later she was back at the hospital Emergency Department following another overdose. She continued to attend CAMHS, receiving treatment for depression, speaking of still seeing perpetrator A as well as being considered to be suffering from post traumatic stress disorder as a result of his previous assaults on her. However, still no referral was made to police or CSC (reasons are not known for this). *This was the 7th missed opportunity to find out about perpetrator A's abuse of Child Q and particularly critical again as Q continued to speak of the abuse.*

2.4.4 Child C (aged 15) was missing from home in February 2011, self harming and known to be sexually active: the school appropriately shared concerns with CSC who advised a referral to CAMHS. There is no information of any referral. Given the known vulnerability of Child C, known to CSC, and the information relating to her being sexually active, an assessment needed to be undertaken.

2.4.5 In June 2011 the school appropriately informed police that Child C was pregnant, reportedly by her boyfriend believed to be aged 19-21 years old. The police incorrectly recorded this as intelligence, instead of a crime. Police noted that CSC had no concerns and were leaving the school to deal with the matter. The school welfare officer confirmed that Child C did not want to 'engage with other agencies'. The police have advised as part of this review process, that the information was not categorised as a crime and hence not communicated by the intelligence officers to those police officers dealing with child protection. *This was the 1st opportunity to discover about perpetrator A's abuse of C and eighth opportunity to investigate perpetrator A.*

2.4.6 Child C subsequently had a termination of pregnancy, without the involvement of her parents, but accompanied at consultation by a woman who, along with Child C, signed the consent form. There is no indication the healthcare staff explored the identity of this individual, or any consideration of safeguarding concerns. This is further discussed in **finding 1, section 4**. The termination was the next day and Child C was on her own. This pregnancy and termination *provided the 2nd opportunity to discover about Child C's abuse by perpetrator A, and the 9th opportunity to investigate perpetrator A*.

2.5 FIRST POLICE INVESTIGATION (JULY - DECEMBER 2011)

2.5.1 In mid-July 2011 police intelligence indicated that perpetrator A had sex with children as young as 14 years old and also mentioned the relationship with 16 year old Child Q. The intelligence was disseminated to CSC and police departments.

2.5.2 The next month, perpetrator A reported being verbally and racially abused by Q and she was prosecuted, although found not guilty at a subsequent trial. **See additional learning, section 5 for discussion of this.**

2.5.3 A further intelligence report in early September named 15 year old Child C as perpetrator A's new girlfriend. Subsequently Child Q's father called the police following a fight between children Q and C over perpetrator A. Child Q then disclosed in a video interview that the sexual relationship between her and perpetrator A commenced when she was 14/15 and he was 28.

2.5.4 A police investigation was commenced. CSC records note that the school advised that perpetrator A had been Child C's boyfriend for some time and had got her pregnant. The police also found, in a search of perpetrator A's home, paperwork relating to Child C's termination of pregnancy. He was arrested for sexual activity with C, but no charges came about as C refused to co-operate.

2.5.5 Also, in the search of perpetrator A's property, indecent images of Q were found on A's telephone. However in October 2011, Q told police she had lied in the interview, so the investigation was filed as no further action, on evidential grounds. Moreover, the crime record noted this as 'consensual sex,' whereas in law a rape had been disclosed, because of Q's age when the abuse first occurred (and the 13/14 year age difference between her and perpetrator A)**.** It is not clear what support was provided to Q after her disclosure, or what understanding there was, at that time, of how to support young people in such circumstances. **See finding 5 for discussion of these issues.**

2.5.6 This was the 9th missed opportunity. Whilst the police had discovered about perpetrator A's abuse of C and Q at this point the opportunity to prosecute him was missed. The main reason behind this was the misunderstanding about the role of consensual sex in such inappropriate relationships and the police accepting the witnesses' retraction of evidence at face value, without further exploration of the reasons behind her changing her account. See **finding 1 section 4** for further discussion.

2.6 BIRTH OF BABIES: 2012

2.6.1 During 2012 both Q and C were pregnant and gave birth to Perpetrator A's children.

2.6.2 In December 2011 Q booked into the hospital for her pregnancy on her own, providing no details of the prospective father. In February 2012, there was police intelligence disseminated to other agencies that perpetrator A was the prospective father and he had threatened Q with a knife wanting to terminate the pregnancy. Also he and other staff at the barber's shop were using the premises for sex with underage girls. It is not clear what further investigations were taken by any agencies as a result: this was the *10th missed opportunity to discover about the CSE.* Of particular note here was the way the place of work of the perpetrators, a barber's shop, that also offered tattooing and piercing, may have acted as a way of attracting young girls to the premises. **See finding 7 for further discussion.**

2.6.3 In the summer of 2012, Q's baby was born. In the autumn Q reported to police on 3 occasions her concern that perpetrator A was following her and/or tried to take her baby, as he believed he was the baby's father. On the second occasion the police served a harassment notice on perpetrator A and informed the local authority where he lived of Q's allegations.

2.6.4 CSC had been involved with Child C continuously from the end of 2011 as she had moved out of her parents home when aged 16, was still attending school but staying with friends (who were linked to perpetrator A). CSC records note in January concerns about her boyfriend being 28 years old. Following a suicide attempt 16 year old C was admitted to a mental health in-patient unit in January 2012, where she spoke of her 23 year old boyfriend who visited her and also took her out in his car. The unit was concerned about this, appropriately sought safeguarding advice and informed CSC, but this did not lead to further investigation to discover the identity of her partner. Given the extent of concerns there were around C's welfare at this time this was an unfortunate *11th missed opportunity*, albeit highlights challenges in hospitals about visiting arrangements to young people considered Fraser competent, as well as the need to use escalation processes if another agency does not respond to reported concerns.

2.6.5 C discharged herself at the end of the month, returning to live with her parents. On her return home and return to school C was wearing a wedding ring, telling the visiting social worker and CAMHS worker that she and her boyfriend had a wedding blessing ceremony, so could now have sex.

2.6.6 There was continuing concern about C's welfare, including reports from the parent's interpreter that C had asked her parents for her boyfriend to stay overnight and was wanting to be in foster care. Following 2 suicide attempts in April 2012, it was confirmed during her admission to the local hospital that C was pregnant.

2.6.7 During the pregnancy there were concerns raised about C being sexually exploited by her 'Turkish boss and landlord' because she lived above the premises where she worked, and did not earn much. This man was a friend of perpetrator A, although it is not clear that practitioners were aware of this link at the time. The first time (September 2012) this suspicion was raised was within CAMHS to the NHS Trust safeguarding team but it was not reported to other agencies. A month later, at a professionals meeting at the ante-natal clinic, there was reference to the 'Turkish boyfriend' and the landlord, her friend, without any suggestion of any link between them. When the social worker queried motives of the landlord, others refuted the suggestion (for which no evidence has been found to date). *It is of note that this is the first time CSE was queried, but in relation to C's landlord as opposed to her 'boyfriend'. This was a missed 12th opportunity to discover what was happening.*

2.6.8 C's baby was born in early December and perpetrator A was present at the birth, although the hospital understood him to be a 'friend'. *This was a 13th missed opportunity to learn more e.g. the identity of the father, the relationship between C and A.* **See finding 1 for further exploration of why this opportunity was missed.**

2.7 INITIAL OPERATION FENESTRA (NOVEMBER 2012 - MARCH 2013)

2.7.1 At the end of November 2012, Q disclosed to a social worker that she had been physically, sexually and emotionally abused by perpetrator A and that he and other Turkish males were having sex with underage girls.

2.7.2 Three comprehensive strategy meetings were held which considered what information was needed and where to source it, including the welfare of the children of perpetrators A and B, Interpol police checks and the need for educational input into local schools on CSE. This was good practice.

2.7.3 A video interview was undertaken with Q. However, C did not co-operate with the police at this time, denying all allegations, telling her social worker and CAMHS worker she worked with perpetrator A, was friendly with his wife and babysat for them. The police spoke to a few other young people who were named as possible victims of perpetrator A and / or B, but none were prepared to engage with the police and at the end of March a decision was taken to cease actively pursuing the allegations. It was noted that Q's account, although more serious than previous allegations was similar to the earlier allegations and was considered not to provide sufficient evidence to progress a police investigation. Police have since learnt (from the social worker who was involved at this time), that there appears to have been a misunderstanding over exactly what Q had alleged in 2011, and a belief that the allegation of rape made by Q, had been covered in her earlier interview, so was not discussed again in this new video interview. This contributed to further delay and *a 14th missed opportunity to establish what was happening*.

2.7.4 The police agency report explains the changes in police organisation that had occurred and which resulted in the Detective Sergeant managing this investigation not being trained in child protection and possibly not having a full understanding of CSE.

2.8 OPERATION FENESTRA INVESTIGATES, OBTAINS EVIDENCE AND PROSECUTES PERPETRATORS A AND B: AUGUST 2014 - OCTOBER 2016

2.8.1 In August 2014 Q's mother sent an email to the Police & Crime Commissioners (PCC) with her ongoing concerns about young girls continuing to be sexually exploited in the locality by perpetrators A and B. This led to police obtaining more detail of the concerns, the appropriate holding of a strategy meeting and a Detective Constable (DC) being allocated to research previous crimes, known information and ascertain any new lines of enquiry.

2.8.2 At the same time C began to suffer harassment and damage to her home from perpetrator A and she contacted the police.

2.8.3 From this point there was a patient and painstaking investigation, involving one particular investigating officer working largely full time on the crimes. He visited the Operation Brooke team in Bristol and learnt more about how to best investigate CSE. He slowly got to know the victims concerned and built up their trust over time.

2.8.4 C agreed in October 2014 to make a statement, but was very scared and wanted to wait till she moved from the area. In November 2014 C was interviewed for the first time and disclosed the abuse she had suffered, including sexual and physical abuse, and being beaten so she would have a termination of pregnancy in 2011 (when she was 15 years old). She also spoke of the impact this had on her mental health and that she got pregnant again, whilst an inpatient in the hospital unit, as perpetrator A visited her there. She spoke of a 'marriage ceremony' that was performed by a man acting as a pastor, after her discharge from hospital.

2.8.5 Q was interviewed again in January 2015 and made a full disclosure commencing with being raped the first time, when she was aged 14 years old and the impact this had on her behaviour, going 'off the rails' and having 3 miscarriages by the age of 15. She described how perpetrator A supplied her with alcohol and cannabis, was violent to her sometimes and lovely at other times, proposing to her when she was 15. She spoke of the impact on her including a suicide attempt and recent diagnosis of PTSD.

2.8.6 In November 2014, both perpetrators were arrested for offences of rape and sexual activity with children. In August 2015 they were charged with offences and in November 2016 they were convicted as detailed in section 1.1.

2.8.7 Despite the shortage of police resources at that time, police considered the support needs of the victims. The only victim who was still a child by this stage was provided with support from the Barnardo's BASE project. The police initially spot purchased this service, before commissioning arrangements were made with the local authority. This demonstrated excellent practice and the chronology shows the good joint working that existed between the BASE worker, the police officer and the leaving care worker. The support needs of other victims were also explored. One had a PROMISE mentor and others did not want any more support.

2.8.8 The BASE worker providing support to a child in this case had also been involved in the Brooke case, and noted that the level of support available in Bristol was not present in this particular locality in Somerset, such as preparatory visits to the Court. Partly this was associated with the long distance to the court in this case, but more critically to the fact there was only one consistent investigating police officer in the case. The Detective Inspector (DI) and DC described to the lead reviewer how difficult this was in terms of managing the practical arrangements around getting witnesses to Court, with an ever-changing timetable for witness appearances. They also spoke more generally about the lack of resources in this more rural part of Somerset, as opposed to those in larger towns and centres of population.

2.8.9 Once the investigation had progressed to arresting and charging the perpetrators Operation Fenestra was managed via a Gold and Silver Group. From this point the groups addressed the strategic and operational needs of the investigation. They were clear of the need to learn from the Brooke investigation and from the Brooke SCR. Notably they took on board the 'messages from victims' in that operation, particularly about how some felt abandoned at the end of the court case. Commendably a multi-agency meeting was held in December 2016, so as to plan what further support the victims needed and the police officer has carefully paced his withdrawal over a prolonged period.

2.8.10 Overall this investigation demonstrated impressive and very thoughtful detective work, but was an immensely challenging task for one officer to undertake, largely on his own, with the support of the DI. This reliance on one officer, working on a long complex investigation which was reliant on building trusting relationships (see **finding 3 section 4**), risked accusations (by the defence team) that the DC was too personally close to the victims.

2.8.11 What appears to be missing from this investigation is evidence of multi-agency work, with the exception of the BASE and Leaving Care workers. This may be due to there being only one victim who was still a child (aged under 18) at the time of the investigation.

3 LEARNING FROM CHILDREN AND FAMILIES

3.1 INTRODUCTION

3.1.1 The period when the victims in this case were being exploited was prior to 2014. In consequence much of the learning may be about historical practice. In order to learn about current professional practice and current views and needs of adolescents the serious case review undertook a series of focus groups with different professionals and young people, as well as individual meetings with victims and parents. The latter included victims of perpetrators A and B as well as victims receiving a service from BASE, and who volunteered to participate in this review.

3.1.2 This section outlines the main learning points from speaking to the children and families. Where appropriate it is included in the review findings in section 4. The perceptions of the professionals are included in the findings in section 4.

3.1.3 Children, young adults and parents participated in the review as follows:

- 2 individual interviews with CSE victims in this case
- 3 individual interviews with CSE victims (from other perpetrators) receiving a service from Barnardo's BASE project
- 2 parents of CSE victims who are receiving a service from Barnardo's BASE project (their children are not victims of these perpetrators)
- 4 focus groups of school children from 3 different schools in the area the CSE occurred: 2 groups of girls and 2 of boys
- Meeting with Children Looked After

3.1.4 Please see section 4 finding 5 and section 5 additional learning for the improvements.

3.2 MESSAGES ON CSE FROM YOUNG PEOPLE

3.2.1 The young people consulted were 2 different groups of girls and 2 groups of boys from Year 9 and Year 10 (from 3 local schools), a group of children Looked After by the local authority, individual meetings with 3 young people who have been victims of child sexual exploitation that are not involved in this serious case review, and 3 victims of perpetrator A and/or B.

3.2.2 The main learning points that emerged from the young people are as follows.

Relationship and sex education

- Learning about CSE is mainly from documentaries, internet, especially on blogs – there is scope to develop CSE educational resources on Youtube and via PC games, with boys in particular saying that this is a medium they would find helpful

- Unanimous view of children (as opposed to professionals) was that there is a need for such education to be provided in smaller, single sex groups so as to avoid embarrassment and facilitate more open discussion
- Girls spoke of school input mainly focusing on biological aspects of sex, as opposed to understanding relationships and exploitation: the view was that there needs to be more information on CSE in schools and specifically more information on grooming, so children are better able to recognise when this is happening to themselves and to friends (victims felt this more strongly than others)
- What is most helpful is hearing about people's experiences, people coming in with information to the school
- Whilst there is teaching about older people who pretend to be young, or something they are not, on the internet (known as 'catfish'), this input is basic and needs to be more informative
- Children need more understanding that you don't trust people just because they are professionals e.g. on the internet (this was from a victim)
- Most, but not all, felt there needed to be earlier education and more availability of leaflets and posters from health providers in the schools
- Victims felt their parents needed to be provided with education, especially on grooming
- The experience of a person with a private school background suggests that the school may provide less educational input on relationship and sex education (including CSE) and also have less understanding of how to support those children who have experienced such abuse

Recognition of abuse and CSE

3.2.3 Whilst the schoolchildren appeared generally very knowledgeable about child sexual abuse and their ability to keep safe, those who have been victims of CSE had a deeper understanding of how they did not recognise it was happening to them at the time and only understood through the help of workers at Barnardo's BASE: one said this took a year or more of counselling before she was able to see it. The feelings of love for the perpetrator make it difficult to identify abuse.

Reporting of abuse / getting help

3.2.4 Those who had been victims of CSE spoke about the following obstacles they experienced in asking for help:

- The fear of the perpetrator for victims - one victim in this case described being locked up for 3 days on an occasion and that if she told anyone what was happening her parents would be killed
- One young person spoke to her GP, but s/he did not listen and understand what she was saying and offered anti-depressants

- One young person (a victim) spoke of the obstacles in being able to receive help from CAMHS due to the lack of :
    - privacy in the waiting room - the embarrassment of being seen to be there
    - flexibility of appointment times, which can lead to you being cut off 'by the clock' as opposed to when is right in terms of the session
    - consistent use of interview room, so facing unfamiliar surroundings
    - age appropriate surroundings for teenagers, as opposed to younger children
- The two victims for this case and one of the other victims spoke of the need to develop relationships with practitioners and that this takes time and that the helpful relationships have been with consistent individuals who are able to offer a more personal relationship (see finding 8)

3.2.5 The other young people considered that the following factors would deter them from being able to express concerns about a friend or themselves:

- There was a view that it is not possible to express concerns about a friend being abused as that would be 'grassing' and that is unforgiveable - this feeling was stronger for girls, including victims, than for boys
- Where schools have a facility to report concerns anonymously via school intranet, pupils felt this to be helpful
- The fear of repercussions - parents knowing, going to Court, involvement of social workers is off putting for victims
- The need for 24 hour support services: to be able to access support / help at time when needed, often out of hours
- Being available by phone outside of work times, e.g. providing a mobile telephone number for out of school hours was mentioned by victims and Children Looked After

Status of having relationship with someone older

- In general the young people considered that more than a 2 year age difference was unacceptable, but a victim spoke of having an older boyfriend as being considered to be 'impressive and help make one popular'

What can parents do?

- One victim described feeling anger at her parents removing her IT equipment and reading her messages. Even though she understands why they did this and that it helped her in the long term, she still thinks it was wrong.

What can teachers do?

- Notice and enquire when children are absent from lessons, including music tuition (as opposed to just absent from school): this applied to both state and private schools - one victim spoke of the perpetrator 'dragging' her out of school

- Some, but not all, felt more accessible leaflets and posters were needed (this view may depend on the school and the availability of such material)

Where and when does it feel unsafe

- The views of places which feel unsafe varied and variously included:
    - where older people 'hang out', where drugs sold, 'prostitute houses'
    - parks can be unsafe due to the presence of drug dealers, drug users and needles
    - in rural areas common to have parties organised in fields with 100+ people there, organised by someone unknown from outside, who provides the drink and drugs
    - alleyways in town centre
    - abandoned buildings
- Accepting lifts from strangers was seen as risky, but one young person living in a rural area spoke of nevertheless doing this to avoid long walks
- Night time was perceived as more dangerous than daytime

Legal position

3.2.6 There was confusion about the legal position and a wish for more clarity about what is and isn't ok legally. In particular comments included:

- Need clarity around the legality of sex: when is it really legal from? what age discrepancy is ok?
- Several mentioned that anything more than a two year gap was problematic.
- One victim (not from this case) suggested that it should be illegal under the age of 16, then only with people no more than 2 years older than you until you are aged over 21.

Messages for professionals from victims of CSE

3.2.7 The following messages come from one or more of the victims of CSE who contributed to the learning [the 2 victims of this case who contributed to the review and the 3 victims of other perpetrators]. Please note that there is not consistency about all these points; one of the victims pointed out on reading the report that what is right for one child may not be right for another:

- Professionals need to understand differences between personalities of individuals and that not everyone will respond the same e.g. different forms of abuse (physical, sexual, emotional) hold different significance in their impact for each individual
- This is serious and can lead to depression and suicide attempts
- Notice changes in children's behaviour
- 'Just sit and listen' , 'you don't have to say anything, but be there for us'
- Teach young people better way of social life: encourage them to go to youth groups and promote this to parents - need safe places to meet together

- Need continuity of professionals as difficult to speak openly, takes time to develop a trusting relationship
- Always explain why you have to do things e.g. when police searched bedroom
- Make CAMHS more sensitive to the needs of adolescents, including respecting their needs for confidentiality in waiting areas, consistent environments, flexible timing to the circumstances and emotions being discussed and adolescent appropriate environments
- Get rid of stereotypical ideas - CSE can happen to anyone

3.2.8 The view of the need for consistent and trusting relationships to facilitate speaking openly was strongly expressed by victims and is discussed further **in finding 6, section 4**. In particular, the perspectives provided by the 2 victims of perpetrators A and/or B are explained there.

Additional messages from Children Looked After

- 'make sure our parents / carers are safe' as they should be role models

Messages for parents

- Talk and listen to your children about CSE, e.g. risks of older people
- You need to understand grooming behaviour and why your child may continue to think well of those who abused her
- A two way relationship helps, enabling trust and being comfortable speaking about concerns
- That it is ok to break down and show emotion to your child
- Take away our phones and tablets at night, but do not to snoop on messages unless something obviously wrong
- Get rid of stereotypical ideas - CSE can happen to anyone, and the abuser could be anyone
- Don't jump to conclusions without knowing the full story and don't blame the child

Advice to young people

- Think before you do anything, it may have a long lasting effect: once something is on the internet, a future employer may look online.
- Don't talk to strangers: do not accept friend requests on social media unless you know the person
- Don't have a boyfriend more than 2 years older than you
- Keep yourself safe, protect yourself and get treatment for STDs
- Social worker can be very supportive, and with you at the police station
- Cannot always trust professionals, especially on social media, as they could also be grooming you!
- You need to understand grooming to recognise what is happening

- Get rid of stereotypical ideas - CSE can happen to anyone, and the abuser could be anyone

Advice for children who may be vulnerable or who are currently being exploited?

3.2.9 It was suggested that what was important was the ability to say 'No'.

3.3 MESSAGES FROM PARENTS OF CSE VICTIMS

3.3.1 Two individual conversations were held with the mothers of girls in receipt of services from Barnardo's BASE project. The parents of Q did not wish to participate and the parents of C were unavailable .

Recognition of risk

3.3.2 One parent spoke of it still being regarded by teenagers as 'cool' to have older boyfriends with cars.

3.3.3 Parents were concerned about the use of social media in accessing their children, and the lack of ability of parents to keep their children safe. Mention was made of:

- not knowing who they speak to on the phone
- worrying over the use of snapchat and inability to trace photos on this, and also use of Tinder and Whisper
- 'normal' behaviour now seems to include 13 year old boys asking girls for photos, with sexting usual by age 16/17, along with photo requests, young people watching porn and openly laughing and joking about it

3.3.4 This form of abuse has meant that children who were never considered vulnerable before are now as they can be abused and exploited in the perceived safety of their own bedrooms.

3.3.5 There is insufficient understanding of grooming and children feel that the abuse is normal.

Experience of professional responses

3.3.6 The experience of police responses were variable depending on the individual officers attending, although once abuse was reported there was a positive response from the police, albeit felt very intrusive. However, each episode was treated in isolation by police, with attending officers unaware of history and context which was very distressing to the family.

3.3.7 Even more distressing was when the child hit an officer when she was distressed and trying to run away: the child was taken into custody in the middle of the night and initially the parents not allowed access (as they were witnesses). The police took 3 months to drop the case and there has been no police response to parental concerns of this incident.

3.3.8 The service from CAMHS was criticised after a suicide attempt by a child, because CAMHS decided on no further action because the girl would not talk openly **(see finding 5).** Following a subsequent suicide attempt there was good intervention from a psychiatrist, but s/he was only covering and the next one was 'not good'.

3.3.9 The lack of female psychiatrists for sexually abused girls is problematic, along with the lack of continuity of staff.

3.3.10 The support provided by Barnardo's BASE was seen to be 'brilliant' helped by an initial home visit, slowly building up the relationship and realising that being driven provided the best venue for conversations with the girl.

3.3.11 The involvement of children's social care was short, for which the parent concerned was grateful, particularly because of the stigma attached. Also mentioned was what seemed to the parent to be lack of training or skill in terms of professionals' communication with her daughter.

Messages for other parents

3.3.12 Experience of parenting a child who was exploited has led to the following advice to other parents:

- Keep your wits about you, try not to pry too much but carry out random checks on your child's phone and social media communications
- Help children to have the right privacy settings on their phone
- Help your child be aware of what is happening e.g. hearing of Saville's crimes helped understanding
- If you see your child struggling and cannot work out why, consider looking at their devices
- The impact of internet sexual exploitation can be as bad as if it physically happened
- Your child may require lengthy therapy afterwards
- The only way to change things is by speaking openly about this

Messages for professionals are:

- Young people generally perceive CSE as a laugh, or a game and need more education at schools, as early as possible
- Parents need more information provided of the risks for young people: suggestion of parenting groups

- Emotional support for parents if child has been abused, so as to help understand and cope with the long delay in legal processes, the role of the myriad of professionals involved and most critically how best to support your child through this
- The need to better protect the victim during the wait for the legal proceedings, so that s/he is not at risk of bumping into her/him in the street and understands why s/he is able to be free given what s/he has done
- Kids are more technically savvy than parents and professionals
- Police provision of warning of intent to speak to perpetrators gave the perpetrators time to delete messages and hide evidence
- CAMHS should not give up on children who won't speak openly - they might be the ones needing help most
- CAMHS need to provide continuity of psychiatrists
- CAMHS need to be able to offer female psychiatrists when required, such as for girls who have been sexually abused
- Help parents understand the impact of abuse on their children, in particular the relevance of the 'Stockholm syndrome' where victims can have some sympathy with their abusers to aid their understanding
- Is there a need for parents groups?
- Whilst there may be a role for children's social care and CAMHS, the stigma attached to this is off putting to parents, especially in the context of internet CSE
- The only way to change things is by speaking openly about this
- How to change society in what has become 'normal' sexualised behaviour in children?

4 FINDINGS

Introduction

The methodology used is based upon an approach which uses an individual case to provide a 'window on the system' [9] finding out whether weaknesses or strengths that have been identified in a single case are more systematic and widespread, and so leading to a broader understanding about what supports and what hinders the reliability of the multi-agency child protection system.

4.1 FINDING 1:

Due to difficulty interpreting and reconciling national guidance and the law relating to sexual activity, professionals sometimes find it difficult to distinguish between informed consent for adolescent sexual activity and coercion / 'inappropriate relationships'; this can leave children being at continued risk of child sexual exploitation, especially if they are judged to be 'competent' and/or 'capable' to make such decisions themselves.

4.1.1 Barnardo's in 2011[10] defined 3 different types of child sexual exploitation:

- inappropriate relationships
- boyfriend model and
- organised / networked sexual exploitation, or trafficking

4.1.2 As explained in section 1.3, the primary focus of this review is on the 1st of these models, which differs from the other 2 in terms of this not involving being coerced into having sexual relationships with other people.

4.1.3 This finding looks at the particular difficulties practitioners face when working with older children (aged 13+) in deciding if there any grounds for concern about the sexual activity of children under the age of 18 years old. Practitioners need to be mindful of both the law in relation to age of consent, but also of issues around competency and/or capability in making that decision. This finding also has relevance for vulnerable adults, where the issue of capability / competency can be extremely complex to evaluate.

[9] C A Vincent, Analysis of clinical incidents: a window on the system not a search for root causes (2004)
[10] Puppet on a string The urgent need to cut children free from sexual exploitation, Barnardo's 2011

How did this finding manifest in the case?

4.1.4 There was frequent contact between health agencies and the victims who were known to be sexually active, were known not to be using contraception and who stated they wanted to have a child. Some had one or more pregnancies, miscarriage/s and termination of pregnancy. What is also evident is the lack of pro-active investigation by police and CSC when under-age children were pregnant or had given birth to a baby, even when, as in this case, C and Q were known to be in a relationship with perpetrator A.

4.1.5 There was awareness amongst professional staff from 2010 that Child Q had an older boyfriend. He was initially believed to be aged 19, when she was 14 years old in 2010. Later that year, when she was 15, there was information that she was in a sexual relationship with a named man (perpetrator A) believed to be 26 or 28 years old. This was reported both by her father and by the adolescent support worker (see sections 2.2 and 2.3). Also reported was that Q had one or more miscarriages at age 15 and that perpetrator A physically abused Q and humiliated her in front of others. The next year, when Q was aged 16 in 2011, concerns continued, with Q's deteriorating mental health and for the first time speaking of being sexually, physically and emotionally abused by a 29 year old married man, leading to pregnancy and miscarriage. These concerns were known at the time (2010 and 2011) but were not investigated by professionals but have since been confirmed by information provided to police since August 2014.

4.1.6 In 2011 there was concern about 15 year old Child C being sexually active, self harming, and then subsequently becoming pregnant by what was understood to be a boyfriend aged 19-21 years old. She subsequently had a termination. She was at that time, aged 15, named to police as being perpetrator A's new girlfriend, and subsequently suffered severe mental health problems requiring inpatient treatment.

4.1.7 In 2012 both girls gave birth to perpetrator A's children. Child C was 16 years old at this time and Q was 17 years old.

4.1.8 Because staff have moved on and the rationale for decisions is not evident in the records, we do not know *why* practitioners did not investigate the concerns about the girls being abused and sexually exploited at this point in time. This is discussed further though in the next finding. However, in conversation with the lead reviewer of this serious case review, the adolescent support worker at that time recalls clearly being concerned about both children C and Q and their relationships with the perpetrators, and that she informed CSC. However, her recollection was that the view by CSC, as well as her own managers, at that time, was that the girls were 15 years old and involved in a consensual relationship.

4.1.9 This view of a consensual relationship was compounded at times by the girls mentioning boyfriends in their late teens or early twenties, and providing a different name to that of perpetrator A (who was in his late twenties at that time). This was further complicated by the probable view that both C and Q were capable and competent to make decisions about their sexual relationships, decisions about a termination of pregnancy and about the choice of visitors when in a mental health inpatient unit.

4.1.10 The issue around 'consent' is a particular challenge for health staff. In this case they did not record any decision making around whether there were safeguarding issues in relation to the girls' sexual relationships and whether they were capable and competent to agree to have such a sexual relationship, to have a termination of pregnancy or to decide who could visit them in hospital or even who could provide agreement for a termination of pregnancy.

4.1.11 The following are examples of how this manifested in this case:

- Little or no recorded information on sexual partners of teenagers in terms of their age and the nature of the relationship
- Lack of exploration of identity of person accompanying pregnant child at appointments, and their relationship with the child
- Accepting that 15 year old pregnant child was Gillick competent and did not want her parents informed of her pregnancy, but then when it came to a termination of that pregnancy accepting written agreement for this procedure from an adult female friend who accompanied her [in fact having accepted the child as competent/capable, her own signature was all that was required and the friend should not have also been asked to sign permission]
- Acceptance of a 16 year old being competent / capable to decide on visitors in an inpatient health unit, without checking with parents or considering safeguarding issues e.g. having older 'friend' (perpetrator A) visiting her

4.1.12 Moreover, this also applied to the provision of sexual health services to all the victims, not just Q and C. Some of the other victims had repeated presentations for sexually transmitted infections and/or vaginal infections, without there being any record of consideration of safeguarding issues.

4.1.13 The general lack of information on partners and relationships within health records may be a reflection of the limited enquiries made or the careful avoidance of any identification of older partners by the girls concerned. Certainly both C and Q provided misleading information on the age and identity of the male responsible for their pregnancies.

4.1.14 What is surprising though is that even when the age difference of the sexual partner was known by police and social care to be 10+ years, no action was taken purely on this basis. Moreover, when the girls lied and gave ages variously 3 - 7 years older, this was accepted without reporting concern.

Is this an underlying feature of the system and not unique to this case?

4.1.15 Finding 2 in the Brooke serious case review addresses the underlying nature nationally of:

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

4.1.16 This is particularly a challenge in cases of an 'inappropriate relationship' involving older teenagers who present as consenting to a sexual relationship and who are considered to have the capacity to do so. The complexity arises due to the mixed societal messages provided by the law, its implementation and the government guidance.

Legal position

4.1.17 The age of consent to any form of sexual activity is 16 for both men and women; however, the following guidance shows that the situation is far more complex than indicated by the law.

Government guidance on legality of sex

4.1.18 Children under the age of 13 are not legally able to consent to sexual activity, but whilst sex is also illegal for 14 and 15 year olds, Home Office Guidance[11] and the Crown Prosecution Service (CPS) factsheets[12] are clear that there is no intention to prosecute teenagers under the age of 16 if both mutually agree to sexual activity and are of a similar age and are judged to have capacity / capability to make such a decision. This means professionals have to judge whether the child has given consent, has the capacity /capability to do so, and that there is no major power or age difference.

4.1.19 When children are aged 16+ they are legally able to engage in sexual activity: this means there is a tendency to accept that a 16+ year old involved in sexual activity is consenting (and has the capacity / capability to do so), unless s/he is alleging otherwise.

[11] Home Office, Children and Families: Safer from Sexual Crime – The Sexual Offences Act 2003, London: Home Office Communications Directorate, 2004.
[12] ww.cps.gov.uk/news/fact_sheets/sexual_offences/

Government guidance on CSE

4.1.20 Government guidance until 2009 referred to children involved in 'prostitution'[13], and would therefore not have covered the 'inappropriate relationship' model as defined by Barnardo's. The 2009 guidance did refer to child sexual exploitation[14] and provided a broader definition, albeit one that would have included any form of sexual abuse. Although intended to cover 'consensual sex', this was not explicit in the definition:

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

4.1.21 In February 2017, new guidance was published which should have the effect of making it clearer that apparently consensual sexual activity *is* covered within models of child sexual exploitation as it is included in the definition and also that the guidance covers children aged 16+.

'Child sexual exploitation 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****. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'*

'Even where a young person is old enough to legally consent to sexual activity, the law states that consent is only valid where they make a choice and have the freedom and capacity to make that choice.'

4.1.22 The changed guidance should be helpful in supporting professionals in the recognition of CSE with older teenagers, albeit it still remains challenging for professionals to always identify this form of abuse, in the absence of knowledge of the identity and age of sexual partners. Both in the Brooke SCR and in this review, professionals were given misleading information on the age of sexual partners.

[13] Safeguarding children involved in Prostitution, DOH 2000
[14] Safeguarding Children and Young People from sexual exploitation, DCSF 2009

Competence / capability

4.1.23 At the heart of the challenge for professionals is the responsibility to decide whether:

- there is an age or power imbalance, without there being any set age difference to help such judgements
- the relationship is consensual: often, especially for health clinicians such judgments will be based on very little information and
- the individual is ' capable' and 'competent' to be able to make decisions around sexual relationships and health interventions

Criminal Injuries Compensation arrangements

4.1.24 Whilst it is illegal to have sexual activity with anyone under 16, the Criminal Injuries Compensation Authority (CICA) does not automatically make payments to all victims. The Guardian (18.07.17) report that:

'Sexually abused children as young as 12 are being denied compensation by a government agency on the grounds that they gave consent, according to a coalition of charities.

The Criminal Injuries Compensation Authority (CICA) has refused payments to almost 700 child victims even if their attackers have been jailed, freedom of information requests have revealed.

Five charities – Barnardo's, Victim Support, Liberty, Rape Crisis and the National Working Group (NWG) – have written to the justice secretary, David Lidington, demanding he reviews CICA guidelines'.....'

'The coalition is calling for the rules to be changed so that "no child groomed and manipulated into sexual abuse is denied compensation because they complied with their abuse through fear, lack of understanding, or being brainwashed into believing their abuser loved them and developing feelings for them".

In one example, a gang of older men were jailed for 30 years after being convicted of raping and sexually assaulting a 14-year-old girl. Her case was taken up by Victim Support; she was denied compensation by CICA on the grounds that "she had not been the victim of non-consensual sexual acts".'

4.1.25 This stance of CICA highlights the confused and contradictory attitude there is in the UK towards children being abused through sexual exploitation.

How prevalent and widespread is the issue currently?

Views from focus groups of professionals

4.1.26 Practitioners involved in the focus groups spoke of the difficulties identifying child sexual exploitation, especially when children themselves believe they are in a loving relationship with a particular partner, as is typically the case in the 'inappropriate relationship' model of CSE .

4.1.27 Health professionals are often the ones having to try to elicit information about a child's sexual partner/s when providing sexual health services. Staff within hospitals mentioned that the limited amount of time available to spend with each patient can make this extremely difficult. GPs face similar problems, especially if the child sees different GPs on different occasions.

4.1.28 Whilst there was an understanding that the age of consent 'should be irrelevant when it comes to being exploited', health professionals said that the issue of consent and '16 and 17 year olds can feel like a mine field'.

4.1.29 In general health professionals spoke of there being not enough time to discuss these matters with children and that there is not enough understanding of what constitutes exploitation in Somerset, with a view of there still being much naivety here.

4.1.30 Police were concerned at the lack of training for uniformed officers on CSE, yet the expectation that they would be able to recognise it.

4.1.31 There was a wide variety of opinion about the CSE screening tool that has been introduced, and how well it helps identify CSE and issues around consensual sex and competence.

Views of children

4.1.32 Children expressed their confusion around what age difference is or is not ok between sexual partners, and a desire for more clarity about this, as well as the age when it is legal to first have sex. The age difference most considered to be reasonable was for a partner to be no more than 2 years older until adulthood, or when aged over 21 years old.

Applicability to adults

4.1.33 In March 2016, the Somerset Safeguarding Adult Board received the review exploring the care of a young woman with learning disabilities who had been the victim of domestic violence and sexual exploitation at the hands of her partner. These matters came to light early in 2014 against a backdrop of raised alertness to the dynamics of the sexual exploitation of disadvantaged young women by predatory men. Key to these cases were the assumptions made by responsible agencies about the capacity and consent of those victimised and the assumption that they had entered into these abusive relationships freely.

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

4.1.34 The recognition of children aged 14+ being exploited when they are in inappropriate relationships (Barnardo's model) poses a challenge for professionals, especially when the children believe the relationship is consensual and if the information provided suggests a smaller age gap. These children are often those most likely to believe they are in a 'loving' relationship and not identify themselves as being exploited, until much later.

4.1.35 The confusing and contradictory messages being given by the law, CICA, statutory and professional guidance reinforces the mixed messages to children and professionals alike.

Issues / questions for the SSCB to consider:

- Are practitioners sufficiently aware of the different models of exploitation, including that of 'inappropriate relationships and do they understand how to reach decisions about whether they are seeing abuse/ exploitation?
- Does the culture within local organisations facilitate professionals to have professional curiosity enabling them to recognise and respond to CSE?
- Are primary care and sexual health services sufficiently resourced and organised so that health practitioners are able to explore with children the nature of the sexual relationships being experienced and identity (and age) of any sexual partners?
- How to provide the children, parents and the wider public with consistent messages about sexual exploitation, given the contradictory and confusing national context
- Do practitioners need more training, guidance and access to expertise locally about issues around consensual sexual activity and competence / capability?
- Do current arrangements for children receiving termination of pregnancy/ sexual health services / mental health treatment ensure practitioners adequately assess the risks of child sexual exploitation and inappropriate relationships to safeguard children?

4.2 FINDING 2

There is a tendency for practitioners to focus on short term intervention for perceived parenting deficits, without taking sufficient time to listen and hear the parents' own worries of risks outside the family. This can lead to the provision of insufficient support to the child and family.

How did the issue manifest in this case?

4.2.1 CSC was involved at times with children C and Q, as well as some of the other 7 victims of perpetrators A and B. The children's behaviour was of concern, and the response generally was in relation to the parenting of the children. Although appropriate, what was missed was a holistic assessment which took into account the parents worries about the causes of the behavioural changes in their children.

4.2.2 In the case of Child Q, her father identified that she was being sexually, physically and emotionally abused by an older man, but this was not investigated at all in 2010 and 2011. The focus instead was in relation to allegedly punitive parental responses to Child Q's increasingly out of control behaviour. Social workers do not appear to have taken the father's concerns about a much older boyfriend seriously, as reflected by the comment that the father's concerns 'cannot be assumed to be correct'.

4.2.3 Similarly with Child C the focus of intervention was around her parents' ability to parent her, the methods of discipline they used and their difficulties in understanding the relative freedoms of children in the UK as opposed to their country of origin.

4.2.4 For both Child C and Child Q, the very real parental concerns appear not to have been heard by professionals, with the exception of the adolescent support worker. Moreover, in both cases, there was insufficient help and support to the family once it was judged that allegations about the parents' care and treatment of their child did not constitute child protection.

4.2.5 Child C told the lead reviewer that she found the input of the adolescent support worker helpful, speaking with her and her parents, and mediating. She was not sure why this service suddenly ended, when progress was being made. Continuing the support to help her relationship with her parents was the main help that could have been provided to enable her to talk about what was happening to her.

Is this an underlying feature of the system and not unique to this case?

4.2.6 Finding 3 of the Brooke serious case review addresses the history of the child protection system in England and that it was designed to assist in the safeguarding of children from abuse or neglect by their parents or carers. Within this model of social work service, when children's behaviour appears to be beyond the control of their parents, there has been an appropriate view that the children must not be blamed, and an assumption that the root of the problems will be within the family.

4.2.7 This model of intervention is not likely to be effective when children are being sexually exploited by perpetrators outside of the family, who are able to exert control over the child in a variety of ways.

4.2.8 With the increasing focus on CSE in recent years, it is expected that professional intervention in Somerset will broaden to develop strategies to listen to parental concerns, and where there is a possibility of CSE, to investigate and intervene. However, the focus groups of professionals, although they all felt they and colleagues are more aware of CSE, were less confident of their professional ability to intervene.

4.2.9 Allied to this over many years has been the discouragement of long term social care intervention in cases that fall below the child protection threshold, with a focus on providing targeted short term intervention as a way of managing resources. However, this does not address the types of cases where there are ongoing problems within families, which appear to be around difficult adolescent behaviour. This needs longer term intervention provided by a consistent worker able to develop a trusting relationship with the adolescent.

How prevalent and widespread is the issue?

4.2.10 It is not known to what extent intervention, especially by social workers, still:

- Focuses on parenting concerns, to the exclusion of listening and hearing parents' real concerns about their children being abused out of the family
- discourages the use of longer term interventions in families which are assessed as being below the child protection threshold.

4.2.11 Recent Safeguarding Adult Reviews in the county have also explored the extent to which agencies have responded in a timely and appropriate manner to concerns being raised by family members and carers. One review ('Tom'), published in June 2017, highlighted that 'although (his) family was an obvious source of information….their role with services became one of pleading for engagement and help' and concluded that 'family involvement' be prioritised.

4.2.12 The advice from the serious case review panel is that the culture remains difficult to change for both children and adult's services, locally and nationally, in relation to:

- the focus on the family, to the exclusion of external risks
- provision limited to short term intervention when a family needs longer term support to respond to concerns and risks of exploitation.

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

4.2.13 If the practice demonstrated in this case remains a feature of current intervention (especially in CSC), there is a risk that there will be missed opportunities to safeguard children from CSE, through:

- not listening to parents' concerns sufficiently and
- the lack of support and help to the child and family over a longer time period, to enable the development of trusting relationships, by practitioners skilled in family interventions

Issues / questions for the SSCB to consider
• How to effect the cultural change needed for social care practitioners to listen and 'hear' parental concerns about their child's safety external to the family, even if the assessment initially focuses on relationship and parenting problems within the home? • Do social care practitioners understand the changing model of social work practice as a result of sexual exploitation and the need to consider factors internal AND external to the family when children are exhibiting significant risk taking behaviour? Parental strength and a protective family may not be enough to keep a child safe. • Is it possible now to provide consistent longer term family intervention to address relationship problems, especially in relation to concerns about the changed and challenging behaviour of children?

4.3 FINDING 3

CSE investigations need a multi-agency investigative model able to develop consistent relationships with alleged victims over a long period; without this the likelihood of being able to provide support to the children concerned, protect them from further harm and establish the evidence needed for a successful prosecution is severely reduced

How did the issue manifest in this case?

4.3.1 Despite knowledge from 2010 that perpetrator A was abusing Child Q and subsequently Child C in 2011 it took another 4 /5 years for the police to establish exactly what had happened to these 2 girls and the identity of other children who had also been sexually abused by the perpetrators. Whilst the police operation Fenestra started in 2012, it did not uncover the evidence for another two years.

4.3.2 The learning from this case centres on the changes that occurred in 2014, which enabled a successful investigation and prosecution to occur which led to the conviction of the perpetrators A and B.

4.3.3 The Detective Inspector (DI) in charge of the investigation since 2012 explained that she never closed the investigation. The lack of investigative activity in 2013 was due to there being no disclosures from the 18 additional girls identified in the police investigation: these victims were visited once (all but 2 in single agency visits), but without the support of staff from other agencies in this task and a lack of capacity of detectives in the police team at that time to build a rapport with the victims.

4.3.4 When the DI acquired responsibility for a wider area in 2014, she was able to enlist the help of a Detective Constable (DC) and a Detective Sergeant (DS) with capacity and relevant experience and skills to review what had been done already, look for new lines of enquiry and continue investigations. At this point the case started to make progress again. By autumn 2014, the investigation intensified following a complaint made by Child Q's mother about the unsuccessful investigation along with new intelligence that the perpetrators were targeting other children. Critically, the DC was given sufficient time to undertake the immense work required.

4.3.5 The components that led to the successful police investigation were:

- time to research and review what was previously known
- dedicated office space to work from and dedicated telephone line access for the victims
- consultation with the officers involved in Operation Brooke in Bristol to learn how to work with CSE victims
- understanding that it would take time and the development of trusting relationships with each alleged victim, so that they would get the confidence firstly to tell the police what had happened, and then to be prepared to provide evidence of this

- the implementation of Gold and Silver multi-agency strategy meetings, once it was clear the investigation would go to court: this enabled improved co-ordination and immediate learning
- Following on the learning from the Brooke serious case review, a victims' planning meeting was held after the criminal trial to agree an appropriate exit strategy so victims were not suddenly left without support

4.3.6 Through the painstaking work of the investigating officer, supported by the DI, Operation Fenestra was able to successfully prosecute the perpetrators, and in so doing has prevented further children being abused by them for the foreseeable future.

4.3.7 When asked what had worked well for C in terms of professional responses, C told the lead reviewer that it was the investigating officer because she was able to trust him. Also that she was given time to develop such trust and to understand what was being asked of her in terms of making a statement.

4.3.8 Despite the successful investigation, it is acknowledged that this investigation was in no sense ideal. Its weakness was the lack of resources, with a dependence primarily on one main investigating officer and one agency. The DI recalls that at the time the police were very stretched following the organisational re-structuring. Despite being declared a Critical / Major Incident, no additional resources were provided, such as a dedicated team of staff or a decision to use HOLMES (Home Office Large Major Enquiry System) or the equivalent paper system. Instead the Guardian Crime recording system was used, which is not usually considered fit for purpose for recording major incidents, as it does not provide the same level of functionality for making links, cross referencing and managing large amounts of actions and enquiries.

4.3.9 What was also initially missing was the involvement of other agencies in the actual investigation and in the provision of ongoing support to the victims. The police are to be commended in commissioning a service from Barnardo's for the only victim who was still a child. However, other victims did not have such expert support through the investigation and criminal trial, albeit the DI did work very hard to provide support for other victims, through use of victim support officers.

Is this an underlying feature of the system and not unique to this case?

4.3.10 Although successful some police officers consider that the investigative approach described above is not sustainable and cannot be replicated.

4.3.11 Within the police, the area in Somerset concerned is described as 'out on a limb' from the overall Avon and Somerset Constabulary area, with the majority of specialist resources which are required for an investigation of this nature located within Bristol e.g. the Hi-Tec Crime Unit (responsible for forensic examination of digital and media devices) and the Major Crime Investigation Unit (MCIU).

4.3.12 The police re-organisation that occurred in 2014 (in response to the comprehensive spending review) merged the public protection unit into the 'omni-competent' investigation teams. This meant a loss of officers with specialist experience in this area of work. Feedback from police officers involved in this review, including the focus group, was that they were concerned that it would be difficult to have the right level of expertise and resources available for future CSE investigations as a result.

4.3.13 However there have been changes made which will support best practice:

- BASE have now been commissioned to provide a support service for children in Somerset
- Reorganisation of police intelligence functions and increased use of crime recording practices will provide links across both functions - see finding 4 below.

4.3.14 Initial weaknesses in the multi-agency response were due to the lack of silver and gold senior management groups to oversee the strategy and operation of the investigation. These were only convened once there was a decision to prosecute suspected perpetrators.

4.3.15 A victim, offender and location focussed approach is essential to effectively tackle CSE. Police based in Bristol are now piloting a new approach to CSE named Operation Topaz which started 9th January 2017. This is a trial CSE team, which is focused on the barriers that have been identified, around investigation, CSE disruption and victim engagement. It aims to intervene early, at a pre-investigation stage, before there is sufficient evidential disclosure to pursue a full investigation. It is a proactive approach to identify potential CSE victims and perpetrators which are shared with partner agencies in order for them to consider early intervention approaches for disruption, prevention and safeguarding of those identified subjects. To date this has provided very good outcomes at identifying and flagging potential victims and perpetrator and enabling early action. This is something that should be continued and replicated across the force. It is acknowledged that dedicating resources in this way will be challenging for the force going forward.

How prevalent and widespread is the issue?

4.3.16 The success of Operation Brooke was considered to be closely linked to the decision to initiate a 'complex investigation' in May 2013 (Finding 6 in Brooke serious case review). Officers involved in that case were also were concerned whether future CSE criminal investigations would be adequately resourced to provide the components identified as required. They, like their colleagues in Somerset, also spoke about the loss of expertise arising from the loss firstly of child protection teams and then the Public Protection units.

4.3.17 What was also seen as integral to the success of Operation Brooke was the support provided to victims by BASE and social workers in CSC.

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

4.3.18 The learning from the successful outcome of Operation Fenestra is that CSE investigations need a different approach to that used generally in criminal investigations. This requires adequate resourcing to support a multi-agency investigative approach which facilitates the building of consistent relationships with victims of CSE and providing support for victims through the legal process.

4.3.19 The components of such a multi-agency service should include:

- Accessible and timely emotional and mental health services (see finding 5)
- Pro-active use of intelligence reporting as part of system to build up evidence and link patterns (see finding 4)
- Pro-active investigation which understands that it takes time for victims to be able to provide evidence

Issues / questions for the SSCB to consider:

- What further measures are needed to achieve an effective multi-agency investigation into CSE concerns and allegations e.g. the instigation of multi-agency strategic and operational coordination of the investigation from the point at which a Complex Crime / Critical Incident decision is declared?
- Should police officers be the professionals to provide the consistent role over an extended period, as occurred in this case and has been valued by child victims in building trust leading to disclosure? Is there scope for this function to be shared with or led by partner agencies, depending on the needs of each child?
- Are the police sufficiently resourced to be able to support complex crime investigations in CSE in the future?

4.4 FINDING 4

Linking information within and between agencies is an integral part of the safeguarding system to protect children from harm: improvements have been made in recent years, but there is scope for further development of this to protect children, especially from sexual exploitation.

4.4.1 This finding is about the need for intelligence and information about potential perpetrators and victims of CSE to be analysed and shared pro-actively, so that it is possible to increase the probability of detection and prosecution of offenders, and safeguarding of children.

4.4.2 The finding is not about the issue of information sharing, which is an issue in most serious case reviews. These are pointed out in the appraisal of practice and also in relation to CAMHS staff in the next finding.

How did the issue manifest in this case?

4.4.3 There were several references in the chronology of police intelligence and allegations being made that underage girls were having sex with the perpetrators at the perpetrators' place of work. The police agency report to the serious case review refers to police intelligence not being used adequately. For example in 2011:

' ... at this time is that police intelligence showed [perpetrator A] was having sex with underage girls. This was a clear signal for CSE which was not identified and responded to appropriately. The investigation was considered and progressed in isolation and whilst positive action and basic investigatory steps were taken the wider issues of CSE were missed and were not considered'.

4.4.4 Over the period under review, improvements in practice were made. In October 2014 the force introduced a threat, harm and risk assessment matrix (THR) to assess information, intelligence and incidents on a daily basis. This creates a scoring system to assist in prioritising demand across the force and has gone some way to ensure that CSE cases are highlighted through the force tasking system and brought to the attention of senior officers within the organisation to check and test the police response and resourcing of such cases.

4.4.5 However, the author of the police agency report states that'

'The organisation still is not effective in efficiently joining the dots and linking suspects and victims. There were opportunities for this information to be reviewed and multi-agency work to be started far sooner.'

Is this an underlying feature of the system and not unique to this case?

4.4.6 The police report to the serious case review explains that recent changes have led to fewer incidents being treated as 'intelligence' as opposed to crime reports, so they are more likely to be subject to an investigative response and joined up with other information. Also, the force is reported to have reorganised its intelligence functions 'to create a more consistent approach to the scanning and analysis of police information and intelligence'. The report author comments that 'whilst this is moving in the right direction more needs to be done to enable this form of research and analysis to happen more widely and regularly to help frontline staff identify and respond to risks of CSE'. Currently there remains an unrealistic reliance on frontline officers to make connections, due to the limited capacity for scanning and analysing the vast amount of information held within police systems.

4.4.7 Another recent improvement within the police has been the introduction of a new tool ('Qlik sense') which pulls on a number of sources of police information at a touch of a button and produces instant results visually. This has potential to enable staff to make vital links early on. There is still much work to be developed in raising staff awareness of this tool and building up their understanding to competently use and interpret the system to its full.

4.4.8 Whilst in the case this manifested as an issue in relation to use of police intelligence within the police force, the Brooke serious case review (finding 5) highlighted the fact that the ability to link information is an issue for each agency and the multi-agency system. The finding stated that ' Our current working methods and recording systems do not reliably identify patterns in individual and group behaviour. This reduces the chances of a timely response in the detection of victims and perpetrators of child sexual exploitation and leads to a more reactive rather than proactive approach'. It considered:

- The fact that no one health role holds all health information on a child, including sexual health presentations
- Difficulties identifying patterns within the GP surgery due to lack of reviews, patients seeing more than one GP
- Particular difficulties associated with tracking Children Looked After's health information, if they move placements
- General limitations in capability of IT systems in agencies, which are based on individual children, and not able to collate and cross reference information on children, sexual partners and potential perpetrators: the reliance of front line workers to keep this in their head, which in turn relies on a stable workforce to do this.

4.4.9 A major recent development in improving the capacity to identify patterns and provide strategic oversight of investigations is the police led Avon and Somerset Child Sexual Exploitation Network. This is held every 2 months to bring multi-agency responses to complex investigations. The extent to which this network is succeeding in this task is not clear and needs evaluating.

How prevalent and widespread is the issue?

4.4.10 The findings of other serious case reviews have focused largely on the shortcomings in information sharing as opposed to the systemic obstacles in identifying patterns in behaviour and links between children and potential abusers. However it is likely that this is a widespread problem as current agency systems are not designed to create links between groups of victims and perpetrators. Moreover, there is currently no way to link perpetrators across different IT systems and across different agencies.

4.4.11 This issue is not just a local problem: perpetrators of sexual exploitation access victims across county and national borders, particularly with the ever increasing risks to children and vulnerable adults through the opportunities provided by the internet.

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

4.4.12 There has been progress in recent years in terms of the ability of the police to use intelligence to pro-actively detect and investigate concerns about possible CSE. The Avon and Somerset Child Sexual Exploitation Network is a positive initiative to be able to map risks and identify patterns and links with the wider multi-agency network.

4.4.13 What is less clear is the ability of each agency to identify such patterns and links within the work of their own agency, as described in the Brooke serious case review.

Issues / questions for the SSCB to consider:

- How effective are current local processes (both within and between agencies) for identifying patterns of individual and group behaviour? Consideration needs to be given to:
  - Are we making full use of available processes to share information and protect children from harm, e.g. the BSE network, Team around the School?
  - Collation and analysis of the effectiveness and consistency of use of CSE screening tool
  - Analysis tools for identifying and linking patterns between individuals
  - Analysis tools for identifying individual patterns of behaviour
  - Analysis tools for identifying locations which may be of concern
  - Current arrangements for information sharing by sexual health providers
  - Potential use of multi-agency chronologies.
  - Capability of IT systems in each agency to do this
- Whether the work of the CSE network meetings should be evaluated to assess the extent to which it is able to provide a process to identify patterns of behaviour and links between suspected perpetrators and children in Somerset
- What are the main obstacles in achieving the identification and analysis of gaps in information? Are these a local or national problem? If the latter what can SSCB do about this?
- Do data protection issues [legal requirements, the implementation of these and practitioners understanding of these] cause particular obstacles in this task, especially in relation to sharing information between agencies e.g. sexual health clinics, GPs and CAMHS? If so, what is the implication of this for safeguarding children and does this need to be raised nationally?
- What strategies need to be implemented to develop improved linking of information nationally and internationally and how can this be taken forward?

4.5 FINDING 5

Children who have experienced or are at risk of experiencing CSE need accessible, timely and skilled support for their emotional and mental health problems: this is developing in Somerset, but requires further improvement to provide for the range of need

How did the issue manifest in this case?

4.5.1 6 of the 9 victims of perpetrator A and B were known to have been referred to Child and Adolescent Mental Health services (CAMHS) one or more times during the period under review.

4.5.2 Child C was known from 2010 to have episodes of self harming, feeling suicidal, missing from school, hearing voices and sensing spirits. She was referred to CAMHS at age 14, but CAMHS discharged her immediately, without seeing her, as she and her family had gone abroad on holiday. Following a suicide attempt when C was aged 16, she received in patient treatment at a mental health unit and had extensive support from CAMHS for the next 9 months.

4.5.3 Child Q at age 16 in 2011 was self harming, took an overdose and was prescribed anti-depressants. She received a service from CAMHS at this point, where she was able to speak about the abuse she had suffered for the first time, including identifying perpetrator A, that he got her pregnant and that she suffered a miscarriage at age 15. No referral was made to police or CSC by CAMHS: the reasons for this are not known: the agency report to this serious case review suggests it may be related to an assumption that this event was in the past and the relationship was over. Whatever the explanation, the lack of referral suggests a worrying lack of knowledge and understanding of professional responsibilities in safeguarding children. Shortly after this Child Q overdosed again and disclosed seeing and being assaulted by Perpetrator A: once again CAMHS failed to report this to CSC or police, merely advising Q's father to do so.

4.5.4 A 3rd child displayed emotional difficulties and angry behaviour, as well as concerns around self harming. She was referred by her GP to CAMHS on 3 occasions in 2009, 2010 and 2011 aged 13, 14 and 15. The 2009 referral was not accepted and following assessment at CAMHS in 2010, CAMHS asked the GP to refer her instead to CSC, as the parents were concerned about her relationship with an older boyfriend living abroad. In 2013, the child was offered some counselling sessions but was discharged when she failed to engage, albeit had some service between April and June that year when she was pregnant and suffering from low mood.

4.5.5 A 4th child was referred to CAMHS in 2010 and 2013, but both referrals were declined on the basis that she 'had no mental health issues'. The next year she took an overdose, and in 2014 was referred again by CSC, but was discharged due to a lack of engagement.

4.5.6 A 5th child was referred aged 15 (in 2012) by her GP who cited the recent termination of a twin pregnancy and low mood. CAMHS did not accept the referral and instead suggested the child was referred to a Pregnancy Crisis Centre. Not only was this inappropriate on the ethical basis of a service that did not support termination of pregnancy[15], but it ignored the safeguarding aspects of a 15 year old pregnant child.

4.5.7 A 6th child, aged 16, was referred to CAMHS with a history of self exclusion, self harm and alcohol misuse, leading a vulnerable lifestyle and stating she was 'looking forward' to having a baby. She was diagnosed with ADHD, provided with medication and discharged.

4.5.8 The above description of the referrals made for mental health services raise the following issues:

- the difficulty experienced by some children in obtaining CAMHS support
- the lack of alternative more accessible support available
- the difficulty some children will experience in being able to engage in CAMHS services
- the tendency for CAMHS to discharge children following a lack of engagement / attendance, regardless of need, without consideration of alternative support services
- the lack of understanding of the need to refer concerns about children being sexually exploited, even if the relationship is reported to have ended and/or when the child is aged 16+ (see finding 1).

Is this underlying feature of the system and not unique to this case?

4.5.9 The impacts of all forms of abuse on children's emotional and mental health are well documented. Children consequently need a range of services able to provide therapy and support at a time and place suitable to their needs. However, the above description suggests that the current resources do not provide this adequately.

4.5.10 The feedback from a victim (explained in section 3) provides further explanation of why the CAMHS service does not always meet the needs of children who are or have suffered abuse due to the lack of:

- privacy in the waiting room - the embarrassment of being seen to be there
- flexibility of appointment times, which can lead to you being cut off 'by the clock' as opposed to when is right in terms of the session
- consistent use of interview room, so facing unfamiliar surroundings
- age appropriate surroundings for teenagers, as opposed to younger children

[15] See http://www.telegraph.co.uk/women/womens-health/10621459/Abortion-will-make-women-child-sex-abusers.html and http://www.brook.org.uk/index.php/about-brook/education-for-choice for further information

4.5.11 The parent of the victim added that the issue reflected in the experiences described above of the service being terminated because her child was unable to open up in the sessions. She also highlighted the lack of availability of female psychiatrists for her daughter and the lack of continuity of staff, which is likely to decrease a child's engagement in the service.

4.5.12 The focus group of health practitioners identified that CAMHS staff do not have the relevant skills, training and expertise to work with CSE.

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

4.5.13 The availability of counselling and therapeutic services for children who are at risk of suffering harm, or who have suffered harm is a vital part of the safeguarding system, both in terms of enabling disclosures by children and facilitating the child's future well being.

4.5.14 The extent to which the current provision of CAMHS is able to provide this for the range of different children who need help is not known, but from the descriptions above it is unlikely due to high and specific thresholds, lack of accessibility in terms of location, facilities and ability to provide a timely response.

4.5.15 Since the period under review the local authority has commissioned the BASE service from Barnardo's, which will provide a very helpful resource for children once the risk of CSE has been identified.

4.5.16 Both BASE and CAMHS are referral based specialist resources with those receiving a service having to meet the criteria to receive a service. There is though arguably a need for less specialist counselling resources which are more accessible for children, such as school based services.

4.5.17 Whilst BASE staff have specialist knowledge and experience in CSE, all those providing such therapeutic services need to have sufficient knowledge and understanding of the risks and impact of CSE, and when referrals need to be made to CSC and police.

Issues / questions for the SSCB to consider:
• Is the SSCB satisfied that the development of current commissioning arrangements for improving children's emotional and mental health support will provide services able to meet the range of needs of CSE victims, or those at risk of becoming victims? If not, what further resources are required to be able to meet needs? NB Commissioning arrangements should include the need for long term therapeutic relationships, the potential use of volunteers to provide additional long term support, accessible services for young people and ones that understand how to support a victim in engaging in services. • Is the SSCB assured that there is sufficient knowledge and expertise of CSE in the CAMHS service to inform an appropriate response to children who do attend appointments and to those who do not attend appointments? • How will staff within these services be equipped to have sufficient knowledge and understanding of safeguarding children at risk of, or already harmed by, CSE? This includes the need to share early concerns about CSE with other agencies to assess risk and understand when there is a need to use child protection procedures • The SSCB should explore the extent to which adult services understand the issue and respond appropriately to those who continue to be abused by perpetrators once they turn 18 or 21, or survivors who are no longer being abused but disclose previous CSE or those that are suffering from the impact of earlier abuse.

4.6 FINDING 6

There is a need for good early multi-agency collaboration along with consistent and persistent relationship based intervention in this complex area of work; without this there is the potential of unrecognised risk and individual practitioners feeling isolated in the safeguarding of children considered to be vulnerable to sexual exploitation

4.6.1 This finding is about the need for an approach to support suspected victims of CSE with intervention which is based on:

- The development of consistent trusting relationships with one or more professionals
- Effective early multi-agency work to share information so as to identify risk and plan effective intervention to be able to undertake assessments provide support, learn more about the level of risk involved and to make referrals to CSC and police when appropriate

How did the issue manifest in this case?

4.6.2 Section 2 provides repeated examples of schools and the adolescent support worker reporting concerns about the victims in this case and there being little subsequent intervention by social care and police, contributing to some of the 14 missed opportunities to discover what was happening to Q and C in their relationships with the perpetrators in this case.

4.6.3 In the absence of social care involvement, there was a lack of any co-ordinated multi-agency involvement as is provided under the child protection and child in need processes, involving sharing of information and planning intervention and support. There was some good input from individual practitioners, such as the adolescent support worker and (according to C) a Promise mentor and a teacher at the school. However support was not provided as part of co-ordinated multi-agency input based on assessment of risk of CSE delivered to an agreed plan.

4.6.4 Both the victims in this case who participated in the review process spoke of the importance of the support of practitioners they could trust, with both mentioning the investigating police officer. The development of a consistent relationship with him was credited with making it possible for them to disclose the abuse they had experienced. It is of note that the officer concerned was provided with a dedicated mobile number the victims could call and reach him directly.

4.6.5 C also mentioned the Promise Mentor who is a volunteer and has provided support over some years. She explained how initially she had been reluctant to engage, but over time has become able to talk about anything and regards her as a friend.

4.6.6 C additionally mentioned a teacher at a school who she felt she may have been able to confide in because the teacher 'really cared' reaching out to her as a person and giving her personal mobile telephone number to call.

4.6.7 The second victim who participated in the review echoed these views, saying 'if I'd have known someone a little bit more I'd have said sooner'.

4.6.8 What is clear from the descriptions of what had worked well to enable the victims to speak was a persistent caring approach by a professional which led to a consistent trusting relationship.

4.6.9 In contrast what did not work well was the approach of professionals who took less interest in the welfare of the victims. C cited the staff at the inpatient mental health unit as not being persistent, so accepting too easily her response that she was 'ok', taking her answers to questions at face value (e.g. her 'friendship' with perpetrator A was not subject to challenge or questioning). C told the lead reviewer she had evidence at the time on her 'phone and may have shared these and disclosed what had been happening had staff been more curious, taken more interest and persisted in asking questions.

Is this an underlying feature of the system and not unique to this case?

4.6.10 The nature of CSE is that children can be groomed over a considerable period by perpetrators and it can take a long time for practitioners who have concerns about the welfare of a child to obtain sufficient information to understand what is happening sufficiently to meet the threshold for social work intervention.

4.6.11 The practitioner focus groups spoke about the challenges to them of working with young people who they suspected were being sexually exploited, and the difficulty in getting the help and support of colleagues in other agencies, and in particular in getting referrals to CSC accepted. They described feeling isolated with the concerns about the welfare of particular children and a certain level of helplessness when the risks identified do not meet the threshold for CSC assessment and intervention. The lack of current CSC social workers attending the social care focus group meant that their perspective was not known.

4.6.12 Many practitioners spoke very positively about the process of MASH CSE meetings which used to be held. What appeared to be valued most was the chance to speak openly about the concerns about a child, share information and develop strategies and plans to support the child, even when the case did not lead to social work involvement.

4.6.13 These meetings no longer occur. The reason for this is that CSE cases should follow the usual pathways for child in need and child protection, with multi-agency meetings that meet the threshold for CSC being held as child in need reviews or strategy meetings or child protection conferences. In practice this means that some children who would have been discussed at MASH CSE meetings do not meet the threshold for CSC led meetings; hence practitioners felt a loss of this multi-agency support.

4.6.14 This has more recently been addressed by the development of local One Teams, an initiative by the police to get local professionals together to plan how to tackle local concerns. The new team around the school initiative is also expected to assist in planning and monitoring how to support children thought to be vulnerable to CSE. However, One Teams do not exist in all areas and the extent to which teams around the school meet this need for multi-agency support in suspected CSE cases is yet to be evaluated.

How prevalent and widespread is the issue?

4.6.15 In Henry Singer's documentary film 'Betrayed Girls' [16] Sara Rowbotham vividly describes the process of suspecting the victims in Rotherham were being sexually exploited and the isolation of her and her team of sexual health workers when their referrals to social work services were not progressed. However, what was not evident was any form of multi-agency collaboration in Rotherham between the other agencies.

4.6.16 The issue of CSE victims needing to develop consistent and persistent trusting relationships with one or more professionals was mentioned by some of the other young people who participated in this serious case review, including the CSE victims (from other perpetrators) and the one of the Children Looked After group. Also mentioned was the need to be able to contact the professional directly and out of office hours.

[16] Shown on BBC1 on 04.07.17

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

4.6.17 Finding 3 addresses the type of investigation needed for CSE cases, involving a lengthy period of building up relationships with victims and developing trust. To get to the stage of sufficient information to initiate an investigation, it is likely that there will need to be good multi-agency working to share information and assess risk and an identified lead professional to develop the trusting relationship and co-ordinate other required support. This may be before there is sufficient information to meet the threshold for social work involvement.

4.6.18 A lack of such co-ordinated multi-agency work in the initial recognition of CSE may leave children at greater risk of being exploited, or exploited for a longer period.

Issues / questions for the SSCB to consider:
• Is the SSCB confident that the One Teams and the Teams around the School are providing the multi-agency information sharing, co-ordination and planning needed in suspected CSE cases below the threshold of CSC involvement? • If not what are the obstacles and how can these gaps be addressed? • Are there problems relating to lawful information sharing at these meetings and if so, how is this being managed? • Does the current way services are delivered enable practitioners to provide a consistent trusting relationship with children? Do senior managers in agencies understand the time commitment for staff in developing the relationships needed for vulnerable children? • Do practitioners and managers understand the need for persistence and curiosity when developing such relationships? • Does the mental health inpatient unit provide a system of key worker / lead professional with responsibility to develop such a relationship with each child? • Is the SSCB confident that multi-agency pathways based on multi-agency risk assessment are now working well to safeguard children from harm from CSE?

4.7 FINDING 7

The current arrangements nationally in relation to piercing and tattoo salons does not adequately address safeguarding risks for children

How did the issue manifest in this case?

4.7.1 Perpetrators A and B both worked together in a barber's shop which also offered piercing to the public. The author has seen the application made out by perpetrator A to register with the District Council in 2010 for cosmetic piercing. He had not previously held such a registration, although another man had done so from 2008 at that location. There is no record that perpetrator B ever applied for or held any form of licence for piercing.

4.7.2 This location was the subject of allegations and police intelligence as being a place where A and B had sex with underage girls. It is also the place where some of the victims allege abuse took place. It appears to have functioned as a place that young people were attracted to, perhaps initially because of the piercing and where it is suspected there may have been piercing of children too young to give informed consent.

4.7.3 We do not know how many of the young people used the services of A and B for tattoos. The police have provided a document of their summary of evidence for the trial: whilst this relates to the evidence of sexual crimes, there are some references to girls being at the salon, and sometimes of a girl being pierced by one of the perpetrators:

- One witness reported seeing girls who looked about 14 or 15 years old in the shop during school hours
- A witness saw perpetrator B take a 15 year old upstairs - B told the witness she was a friend having a piercing
- A victim said that when she was 14/15 years old perpetrator A pierced her tongue, belly button and ear, and B pierced her right wrist

4.7.4 The police investigating officer told the lead reviewer that he considered 2 cases of 15 year olds having their nipples pierced, but the CPS did not agree with prosecution for this.

Is this an underlying feature of the system and not unique to this case?

4.7.5 This finding arises from concerns about young girls being attracted to the barber's shop at the centre of this case, and the suspicion that some of the victims in this case, or other children, may have been subjected to piercing. On looking into arrangements for piercing, the review team were surprised to learn that arrangements for registration focus on health and safety issues, but there are no criteria about the training of either piercing or tattooing practitioners, and that the safeguarding of children does not feature in the registration process.

4.7.6 The following information has been provided by the police and by the Public Health Specialist on the review team.

The law

4.7.7 The law relating to tattoos and body piercing covers the health, safety and licensing of premises that carry out skin piercing and permanent tattooing. These provide a variety of legislation for local adoption and to support good practice. All tattoo and piercing businesses must be registered with their local authority and this covers both the premises and the practitioner. Local authorities have the powers to inspect any premises that carry out piercing and tattooing to make sure they are observing the byelaws that relate to hygiene of their premises, staff and equipment. There is no standard requirement for compliance and premises are not routinely inspected. Trading Standards applies if a tattoo was not what a customer expected.

4.7.8 The main emphasis of the local byelaws and health and safety requirements relate to infection control. There are no requirements relating to safeguarding children.

Consent

4.7.9 There is no legal consent for body piercing so anyone under the age of 18 can have a piercing if they have consented to it. However, children under the age of 16 can't legally consent to genital (and for girls, nipple) piercing as this would be considered indecent assault. There are no national plans to introduce an age of consent but some local authorities have introduced recommendations in relation to minors.

4.7.10 The 'Tattooing of Minors Act 1969' imposes a statutory minimum age of 18 years for permanent tattoos, and the offence is with the person carrying out the tattoo. New guidelines recommend that proof of age is requested and recorded. Practitioners need to ensure a fully informed consent procedure is adopted: the practitioner has a defence if they can show that they had good reason to believe a person was over 18, but the consent of a client under 18 years of age is not a defence.

Qualifications and training

4.7.11 There is no nationally recognised accredited training, standards for practice, agreed knowledge and skills framework or arrangements for monitoring and reporting professional competence. Most learn within the industry or may have been an apprentice or trainee; some businesses have in-house training for ear piercings.

Safeguarding

4.7.12 The current registration process is, according to the police statement of the District Council's licensing and enforcement officer 'not fit for purpose':

'...nothing more than recording the applicant's details in a register. No checks are made on the applicant whatsoever, no CRB check, no safeguarding check, no identity or address check..unless there are complaints made, no checks are made on premises and we have no power to look around anyway'..

4.7.13 There is nothing in the regulations regarding chaperones or anything specific to safeguarding. However it is possible for local authorities to advise on chaperones as in the case of Sedgemoor District Council who recommend:

' …that clients be encouraged to bring a friend for moral support and to prevent misunderstandings or allegations of impropriety, especially in the case of genital piercings'.

How prevalent and widespread is the issue?

4.7.14 It is not known to what extent there are concerns about safeguarding in piercing and tattooing premises, but given the underlying lack of standards relating to safeguarding in the registration process and the lack of subsequent inspections, this is not surprising.

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

4.7.15 Given the current fashion for both piercing and tattoos, children are likely to be attracted to premises where these are done. Given the potential vulnerability of the individual subject to such procedures, especially in relation to genital and nipple piercing, the lack of safeguarding arrangements around such premises is of major concern.

Issues / questions for the SSCB to consider:

- The SSCB to consider how safeguarding can be improved locally and whether a consistent approach can be developed for all District Councils, based on the good practice developed by Sedgemoor District Council?
- The SSCB to raise concerns nationally about the vulnerability of children given the lack of safeguarding provision in the law and regulations relating to piercing and tattoo premises.

4.8 FINDING 8

The practice of some primary care medical services (as advised by medical indemnity insurers) is contrary to statutory requirements in relation to their involvement in serious case reviews; this risks undermining the ability to learn lessons and improve safeguarding of children in the future.

4.8.1 This last finding applies to obstacles in learning from the serious case review process in general, as highlighted by this particular case review.

How did the issue manifest in this case?

4.8.2 As mentioned in section 1.4.8, there were limitations in the information available from primary care providers for the purposes of this serious case review. Of the 9 victims of perpetrators A and B, primary care information was not provided at all for 3 of them.

4.8.3 On advice obtained from NHS England, the CCG and the SSCB wrote again to the specific health providers concerned reminding them of their statutory obligations (see below), but no further information was provided.

Is this an underlying issue and not something unique to this case?

4.8.4 The health overview report refers to clarification being provided by the CCG and the SSCB about their statutory duties to share data of children (aged under 18) and quotes the following provisions:

- 'You must also cooperate with requests for information need for formal reviews carried out after a child has died or been seriously harmed and abuse or neglect is known or is suspected, to have been a factor' Protecting children and young people: The responsibilities of all doctors. General Medical Council [GMC], 2012, paragraph 47)
- Further advice provided by the GMC (paragraph 31) explains conditions to be met for sharing information, which 'in the public interest'.
- Section 14 of the Children Act 2004 sets out the objectives of the LSCBs and Regulation 5 of the Local Safeguarding Children Board (LSCB) regulations 2006 sets out the functions of LSCBs: these include the requirement for LSCBs to undertake reviews of serious cases in specified circumstances and requiring a person or body to comply with a request for information.

4.8.5 The health overview report explains the underlying conflict between such statutory requirements and advice provided by some medical indemnity insurers. What is less clear is why there is a variation in so far as chronologies were provided for 6 of the CSE victims in this case.

How prevalent and widespread is the issue?

4.8.6 The independent lead reviewer and author of this report has encountered such obstacles in provision of information by some health practitioners, usually GPs, in many serious case reviews. Whilst advice of medical indemnity insurers has not been quoted, the usual explanation (when provided) is that of data protection requirements. Somerset CCG is to be commended in this case for challenging this and persisting in its attempts to obtain the chronologies concerned.

4.8.7 The designated nurse and author of the health overview report provides information on research undertaken by the Centre for Excellence in partnership with the DfE, into information sharing challenges. As part of this work a thematic review was undertaken of 25 serious case reviews, with some in depth interviews and regional workshops. The report[17] addresses general issues relating to information sharing as highlighted in findings, but does not look at the specific problems associated with provision of information to serious case reviews themselves.

[17] http://informationsharing.org.uk/safeguarding/

4.8.8 Serious case review reports sometimes note the lack of available data in the limitations to the review, or in the 'working documents' / agency reports provided to the lead reviewer, but because this does not usually appear within the findings, the extent to which this is a problem in the UK is unknown.

4.8.9 It is possible that with the increasing involvement of private providers in social care provision (e.g. prisons, care and children's homes), there may be increasing obstacles in the provision of full information to serious case reviews, due to potential conflicts with commercial interests or with advice from insurance companies.

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

4.8.10 The aim of serious case reviews is specifically around improving the reliability of the multi-agency safeguarding systems. The lack of participation by some primary care staff in such learning exercises, in particular through the provision of comprehensive chronologies, limits both the learning of how that particular health role fits into the safeguarding system as well as how other agencies and practitioners work with that role.

Issues / questions for the SSCB to consider:
• What further strategies can the SSCB and CCG and NHS England develop to address the lack of co-operation of some local primary care providers with the statutory requirements for information sharing as part of serious case review processes? • What actions does the SSCB need to initiate nationally, alongside the CCG and NHS England, such as reporting this obstacle to both the DfE and DH?

5 ADDITIONAL LEARNING

5.1 INTRODUCTION

5.1.1 This section explains important thematic learning that has emerged in this serious case review which is being addressed by the individual agencies concerned, or which does not signify systems findings.

5.2 CULTURAL ISSUES

5.2.1 There is no evidence of professional practice in the identification of CSE being influenced by the ethnic origin of the perpetrators, who are both Turkish.

5.2.2 However, in November 2011, perpetrator A complained to the police that 16 year old Q was verbally racially abusing him. She was charged and at a later trial found not guilty. By this stage Q had disclosed to police her sexual relationship with perpetrator A, and a police investigation had been initiated, but following her retraction the investigation was filed as no further action. Moreover, at the time of the incident perpetrator A was in the street with 6 teenage girls, which should have been viewed as a cause for concern, given the history of allegations known to police. A victim support letter was sent to Perpetrator A, although it noted the history of 'domestic issues' between him and Q. The officer in charge noted that A had been in an underage relationship with Q. However, there was no senior officer involvement and these factors were not shared with the CPS who made the decision to charge Q.

5.2.3 The police report for this serious case review suggests that on occasion police officers were confused over what was the most important issue to deal with, with the alleged 'hate' crime overshadowing the real offending taking place around CSE. Hate crime is seen as a high priority offence that requires robust action, and the response in isolation would be correct, but not when placed in the context of the wider picture already known to the police.

5.2.4 The prosecution of victims of CSE for alleged 'hate' crimes against the very people already known to have abused them is a further abuse of the victims, and will undermine any trust they might have in authorities.

5.2.5 It is important for the SSCB to check how police and CPS systems have now changed so that all contextual information known to the police is taken into account when decisions are made about charging children with 'hate' crimes.

5.3 RELATIONSHIP AND SEX EDUCATION IN SCHOOLS

5.3.1 Section 3 provides the learning from the young people and the parents who contributed to this serious case review. Many of the suggestions made are in the findings and will have contributed to the issues and questions for the SSCB to consider.

5.3.2 The schoolchildren provided helpful feedback about current education in relation to relationships and sex education. A consistent message from these children was the preference for these lessons to be for single sex groups of children and for smaller class sizes. This was not accepted by the staff who contributed, who felt that mixed gender conversations are helpful. It may be that both are needed, but it is important that we listen to what children tell us would help them to speak more openly.

6 CONCLUSIONS

6.1.1 This serious case review focuses on identifying the strengths and gaps in multi-agency responses to child sexual exploitation, in particular to the 'inappropriate relationship' model defined as:

'Usually involving one perpetrator who has inappropriate power or control over a young person (physical, emotional or financial). One indicator may be a significant age gap. The young person may believe they are in a loving relationship'.[18]

6.1.2 An underlying obstacle for professionals is the difficulty in distinguishing between inappropriate relationships and permitted consensual sex, if a child is judged to be competent and capable of making such decisions. This stems from the confusing stance in national policy and statutory guidance and lack of training in this area.

6.1.3 This is compounded by a historical model of intervention and support based on short term intervention primarily around parenting deficits, which tends to minimise parental concerns about risk outside of the home.

6.1.4 Central to the learning has been the contributions of victims of the 2 perpetrators in this case and the victims of other perpetrators who volunteered to help learning in this review. They spoke clearly of the importance of having consistent professionals who persist in developing a trusting relationship which has enabled them to disclose what has happened to them.

6.1.5 The police investigation from 2014 did provide such a relationship. This enabled the victims to eventually speak about what had happened and led to a successful prosecution against the perpetrators.

6.1.6 However, the learning from this investigation and this review is the need for co-ordinated and planned multi-agency involvement from the outset, both in the investigation and earlier, so as to facilitate the initial identification of sexual exploitation.

6.1.7 There is a need for CSE victims to have skilled support for their emotional and mental health problems. This should not be restricted to a psychological service for identified high levels of need, but also provide facilities within schools and other community settings, which children can easily access.

6.1.8 An obstacle in being able to identify CSE is the difficulties within and between agencies in detecting patterns of individual and group behaviour. Whilst the ability to do this has improved in recent years, there remains further work to collate and analyse data.

[18] Puppet on a string The urgent need to cut children free from sexual exploitation, Barnardo's 2011

6.1.9 One of the features of this case was that the perpetrators workplace offered piercing, which appears to have attracted children, some of whom are known to have had piercing, including 2 cases of 15 year olds having their nipples pierced. This highlighted the vulnerability of children in such circumstances and the lack of safeguarding considerations in the registration and inspection of such premises. This is a national issue as current arrangements focus solely on health and safety issues.

GLOSSARY OF TERMS

BASE	The CSE project provided by Barnardo's
CAMHS	Children & Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CICA	Criminal Injuries Compensation Authority
CSC	Children's Social Care
CSE	Child sexual exploitation
CPS	Crown Prosecution Service
DI	Detective Inspector
DS	Detective Sergeant
DC	Detective Constable
DfE	Department for Education
GMC	General Medical Council
LSCB	Local Safeguarding Children Board
MASH	Multi-agency Safeguarding Hub
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SSCB	Somerset Safeguarding Children Board