Learning from the Serious Case Review – Children A-F

A summary of the case reviewed:

This review is about the sexual exploitation of children in Oxfordshire. It uses as background the experiences of six girls who were the victims in the Operation Bullfinch trial. When most of the abuse took place there was almost no knowledge of group or gang related Child Sexual Exploitation anywhere in the country. While it is easy looking back to say "it was obvious", at the time it was something organisations did not understand. The Review says many errors were made, and shows what lay behind them. The key findings have been identified as:

- Organisations had a weak understanding of government guidance related to the exploitation of children
- This lack of understanding meant that police and social workers did not look hard enough at what was happening to the girls. The girls were not able to make their own decisions because of the grooming, but staff tended to see them as difficult girls making 'bad choices'
- The language used by professionals described the girls' behaviour as caused by them, not their situation. As a result, the girls received much less sympathy. They were often in care for their own protection, but their frequent episodes of going missing were seen to be because they were 'difficult children'
- There was not enough investigation into what was happening and professionals relied too much on the girls statements and reporting what was happening to them
- The law around consent was not properly implemented and was misinterpreted. For example, there was confusion around the fact that young teenagers could consent to using contraception when they were having sex that might be illegal
- Young teenagers were seen too much as young adults rather than as children. Some professionals seemed to get used to knowing the girls were having sex with men, rather than having a clear view that it was wrong, full stop.
- There was a failure to recognise that the situation was so bad it should be reported to top managers, so they could start a county-wide response. Instead, the cases were seen more in isolation, with the focus mainly on protecting and containing the girls, rather than tackling the perpetrators.
- There was no evidence that the race and ethnic background of the exploiters stopped the professionals from identifying the Child Sexual Exploitation earlier.
- The Oxfordshire Safeguarding Children Board, and the committee there before it, did not show sufficient grip or curiosity when some early signs were presented, and child sexual exploitation drifted off the agenda.

The Review shows that from 2005-10 there was enough known about the girls, drugs, sexual exploitation, and association with adult men to start a more serious response. But this did not happen and most of the information did not reach high levels.

The exploitation that later emerged in the Bullfinch inquiry and trial was led, not by top managers and committees, but by more junior staff working nearer the families.

The Review identifies around 60 learning points that will help agencies understand why and what needs to happen to be sure Child Sexual Exploitation continues to be tackled well.

How was learning achieved?

The case review followed the more traditional SCR model. It was overseen by a panel representing all agencies involved and each agency nominated an author to complete a chronology of events and a management report. They were led by an independent chair and jointly drafted a terms of reference. All information was collated and scrutinised by an independent reviewer who was responsible for drafting the final overview report. He met with family members (young people and/or parents) from all families affected by this case. They contributed to the review and provided their perspective on work undertaken with them. This approach generated the learning detailed below.

Themes in common with other case reviews in Oxfordshire

- **Lack of professional's curiosity** about the full extent of what was happening to the girls and their displayed behaviour
- **Information was not shared** between agencies working with the girls, this would have helped professionals to see the pattern of abuse happening
- **Work was not sufficiently joined-up** so that safeguarding opportunities were not maximized. For example, when a child was placed in a more protective environment this was not accompanied by action against the perpetrators

Learning points for managers

- **Supervision:** the structure for supervisions should be reflective and ensure that the practitioner is making decisions based on all information and focus is maintained on the child
  Have you checked that this is happening effectively within your team?
- **Management:** ensure that all practitioners are using all available tools especially the Child Sexual Exploitation Tool and plan actions in a SMART way. Ensure practitioners are trained in responding to physical injury, missing episodes and sexual abuse.
- **Escalate:** if risks are not reducing, despite interventions from specialist support, escalate to senior managers and directors where appropriate, and make use of complex case panel according to criteria met.
  Check if you and your teams know how to escalate concerns

Action points for practitioners

- **Understand the referral process** for the Kingfisher Team to ensure you make the right kind of referral for specialist support and know what to expect for the child/young person.

- **Support the parent/s and families** – they will often be going through feelings of anxiety and despair and will also need professional support
- **Escalate:** if risks are not reducing, despite interventions from specialist support, escalate to senior managers and directors where appropriate, and make use of complex case panel according to criteria met
  Do you and your team know how to escalate concerns?
- **Keep the child in education –** the less time the child is in education and on a school/college premises, the more vulnerable they are
- **The safety and wellbeing of the child** should always be the priority, before gaining disclosures and before gaining a criminal conviction
- **Raise awareness:** Make sure your team understands issues of consent around sex and the impact of drugs/alcohol on children's ability to make choices and the dynamics of grooming

Key messages for inter-agency learning

- **Good Practice:** ensure that you are using all available tools and resources, especially the child sexual exploitation tool, the Model of Good Multi-Agency Practice and Information Sharing Protocol, and making use of the training and support available from OSCB and local partners.
- **Improve risk management:** on a multi-agency basis – do not just assess the risk and manage risk escalation by yourself in your agency. Ensure you are sharing information with other relevant agencies and monitoring changes in risk and levels of harm. Where there is no child protection plan in place, use the Multi-Agency Risk Assessment Management Programme (MARAMP)
- **Record decisions and actions at all multi-agency meetings:** ensure that minutes are clear, records show who chaired the meeting, what decisions were made and if actions have been delivered. It should be clear who owns the record of the meeting.

If you do one thing, take the time to…

- **Listen to the child –** ensure they have a trusted adult that they can talk to about what is happening, and believe what they are telling you. Look behind their behaviour and think about what could be the cause and reason – don't be put off by the child's superficial assurances or refusal to engage with you.

Training and resources

- The Kingfisher Team Tel: 01865 335276
  The team supports victims and those at risk, works on the identification of potential perpetrators, and provides general education about child sexual exploitation. The team is made up of police, the NHS and Members of Oxfordshire County Councils; Children and Adult Social Care. They offer confidential support and advice on sexual exploitation
- OSCB training – OSCB offers a variety of face-to-face and online courses including Child Sexual Exploitation and Sexual Health Awareness training
  http://www.oscb.org.uk/training/

- Use the Child Sexual Exploitation Screening Tool to identify children who may be at risk of or involved in sexual exploitation
- Multi-agency safeguarding procedures – The OSCB multi-agency procedures cover a wide variety of situations you may encounter. You can access them at http://oxfordshirescb.proceduresonline.com/
- Look at the serious case review overview report and the accessible summaries http://www.oscb.org.uk/case-reviews/
- Good multi-agency practice guidance – The OSCB have created a model of good multi-agency practice incorporating the Local Assessment Protocol
- Seven Golden Rules for Information Sharing – Professionals should familiarise themselves with the golden rules for sharing information.

The purpose of a serious case review is to:

- Establish what lessons can be learned about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

A serious case review (SCR) is not concerned with the attribution of culpability which is a matter for a criminal court.

Appendix 1
Collated Learning Points from A-F

APPENDIX 1: COLLATED SCR LEARNING POINTS

From 'Were mistakes made?'

Lack of understanding led to insufficient inquiry

- National guidance was not widely understood or followed
- The behaviour of the girls was interpreted through eyes, and a language, which saw them as young adults rather than children, and therefore assumed they had control of their actions
- At times, their accounts were disbelieved or thought to be exaggerated
- What happened to the girls was not recognised as being as terrible as it was because of the view that saw them as consenting, or bringing problems upon themselves, and the victims were often hostile to and dismissive of staff
- As a result the girls were sometimes treated without common courtesies, and as one victim described it by '*snide remarks'*
- There was insufficient understanding of the law around consent, and an apparent tolerance of (or failure to be alarmed by) unlawful sexual activity
- There was insufficient understanding of parental reaction to their children's behaviour and missing, so distraught, desperate and terrified parents were sometimes seen as part of the problem
- There was insufficient curiosity about what was happening to the girls, or to investigate further incidents or concerns which, on review, now appear to be crimes or something for formal child protection investigation
- Although there were very few formal disclosures, there were many, often stark, indications that what was happening to them was extreme and out of the ordinary
- There was insufficient attention to investigating and disrupting the activities of the alleged perpetrators (compared to the effort to contain the girls behaviour), and various available legal tools were not used.
- There was insufficient understanding of how the City Council's community safety function could contribute to the prevention and management of CSE

Day-to-day processes were not strong enough

- Insufficient use was made of Child Protection processes, and staff sometimes allowed parental reaction to prevent Child Protection processes being used
- Processes in CSC, such as supervision and the quality of reviews, were not strong, especially 2006-9
- Minutes of multi-agency meetings and review were largely of low quality or missing, which weakened planning and information sharing
- Recording of 'crimes' was inconsistent
- Transfer of educational records between schools was poor
- The provision of alternative education after exclusion, or of post-secure placement education, was slow
- In health, there was insufficient sharing of information heard from or about the girls (often for 'confidentiality') and LAC medicals were often done without full knowledge of history and context

The organisational response in Oxfordshire was weak and lacked overview

- Escalation about serious concerns about looked after children and emerging patterns did not reach governing body level or Chief Officers for several years after they had begun to emerge in 2005, and again 2006-10
- When some signs reached the ACPC and OSCB in 2005 and 2007 respectively there was insufficient curiosity and no follow through
- The OSCB, before late 2011, did not lead the scoping, understanding and prevention of CSE after the 2009 statutory guidance, and member agencies who comprise the OSCB share that responsibility
- Whilst before 2010 there was much less recognition of the connectedness of cases, or the organised nature of perpetrators, both within and across agencies, the growing awareness in 2010 still did not reach top management or the OSCB
- Before 2011 there were fewer processes in place to help form a force-wide Police view of developing problems
- There was a gap of one to two months between senior managers being aware of the bigger picture, or at least the strong likelihood of a bigger picture in late 2010, and very top management being informed

From 'What was missing organisationally in Oxfordshire'

- The risks an OSCB runs if it does not have robust processes for
  - acting on new guidance
  - performance monitoring to ensure actions are seen through
  - ensuring there are routes in for fieldwork concerns to be heard
  - its role being widely understood by staff at all levels
- The OSCB, other than the part-time presence of an Independent Chair, has no existence other than as a collective unit. This means governing bodies must be sure their organisations and leaders actively share in leadership and shaping the Board
- The importance of the District Council community safety role being proactively understood by partners, and appropriate links with County children's services being strong at operational and more strategic level
- The need to reconsider how Districts are represented on the OSCB
- Governing bodies need to be sure they are clear on what they expect to be reported to them by way of early warning, so they have an opportunity to reflect on an issue as early as is useful
- Governing bodies need to be sure that performance management arrangements identify key measures of child safety, including those around looked after children
- The benefits of relatively junior staff using their initiative to take forward discussions and explorations about concerns on child safety, but…
- … there is also a need for their managers to ensure such important work makes the right links inside and across agencies, and also what the governance framework is for the work

From 'Knowledge'

- OSCB member agencies also receive such guidance and need to share responsibility for it being considered both internally and collectively by the Board
- The value of more widely and proactively seeking out learning and good practice, as shown by the City and the Police

- There may be an assumption that the focus on CSE is so high now that the old, less unhelpful attitudes to the victims have gone. This needs on-going monitoring

From 'Escalation'

- LSCBs are strategic, but must also be sure that they have processes that allow them to hear of operational concerns at an early stage, so there can be a decision as to whether the Board needs a collective response/action
- Agencies should satisfy themselves that formal escalation processes work in practice, from the perspective of both front line staff and top managers
- Also, that there is a culture which promotes the sharing of concerns and reacts positively rather than negatively to service concerns
- There need to be clear processes that are understood and followed about resolving differences of opinion about cases or groups of cases, both internally and across agencies

From 'Tolerance'

- Staff at all levels need to be clear about the law of consent (to sex and healthcare)
- Verbal consent does not mean it is free consent, or sensible consent
- Across agencies, supervisors should test out with staff making decisions how they see the threshold for action with sexually active children
- Supervisors (and their managers) need to be aware of the tendency for the impact of an incidence of abuse or risk to lessen when such incidents happen frequently
- In the tension between inaction to be non-judgemental and action to prevent harm because an activity is wrong or inappropriate, the latter should be the overriding principle with children
- Agencies which act as parent or share parental care should, when determining what is appropriate action in the face of risky behaviour, consider what a good parent caring for a child at home would do.
- There needs to be a rethink of the national guidance regarding sexually active children, to ensure that well-intentioned policies to support the vulnerable young do not inadvertently add to a climate that facilitates exploitation

From 'Staff attitudes and rigour'

- However difficult they may appear, children need to be treated as children
- Ask if they are ok
- Use the basic niceties
- Start with the basic assumption that what the child says is to be believed
- Don't make snide remarks to possible victims (however they behave) which undermine them more
- It is important that, just as the victims are not blamed for their exploitation, parents are not blamed for their children's exploitation
- Signs of drug and alcohol use at a very young age are not normal and need real inquiry
- Signs of physical harm must always be investigated
- If you have any suspicions that a child may be being abused, do not be frightened to ask them about it… and keep asking
- Go with your instincts if something seems wrong
- Children do not go missing on numerous occasions without there being a reason. That reason must be explored rigorously
- Beware in case being more 'professional' makes it less likely that the victims will engage

From 'Investigation'

- How attitudes and understanding of CSE, or indeed 'difficult' teenagers and families, can impact on what is recorded as and acted upon as a crime
- How attitudes and understanding of CSE, or indeed 'difficult' teenagers and families, can impact on decisions about fulfilling statutory duties in CSC
- Any allegation of abuse must be investigated formally, even if it does seem to be part of teenager/parent disputes
- Strategy meetings must always be used to agree the multi-agency roles on inquiries when the criteria are met.
- The crucial importance of supervisory and review processes to ensure that staff near the front line are making sound and objective decisions
- The need to recognise that evidence around the 'bad character' of offenders can back up evidence by victims, and the presence of such evidence can give victims more confidence to give and stick to evidence themselves
- The need to investigate regardless of the cooperation of the child
- The need to ensure that there are robust processes in place to make links between victims and between perpetrators – including the use of covert actions and intelligence gathering
- Disruption of abuser activity is an essential protective process, regardless of whether a criminal case can be brought

From 'Going missing'

- Going missing does not always but may well indicate the child concerned is being exploited and therefore has eroded consent
- Going missing from residential care is an even bigger indicator as there may well be an inherent vulnerability that can attract perpetrators
- Because of this vulnerability it can be easy to see the children as running *from* somewhere, so inquiries must be made as to what they are running *to*
- There is now a statutorily requirement for local authorities to ensure a discussion with the child family or both after two or more episodes, and also a requirement to ensure previous episodes and actions are always taken into account
- The OSCB, relevant Council committees (or equivalent), including the lead member for Children's Services, and senior police performance management meetings need to not only receive the Missing Persons information regularly, but to actively consider and interrogate it to make sure that high volumes are seen as significant rather than downplayed by their commonality
- Secure accommodation may solve the problem temporarily, but is ineffective beyond the period in secure unless the groomers are disrupted or removed from the scene through conviction

From the Impact of ethnicity

- The importance of agencies individually and collectively to develop strong links with faith groups, to share understanding about CSE and to assist with each community's own efforts to protect children and prevent CSE