Independent Chair Statement to Press Conference

Good Morning. My name is Maggie Blyth and I am the Independent Chair of the Oxfordshire Safeguarding Children Board. I took up the post in May 2014.

Today, the Oxfordshire Safeguarding Children Board - or OSCB - is publishing the independent Serious Case Review **i**t commissioned in 2012 into the services provided to the victims of the seven men, convicted in 2013, of 59 offences of child sexual exploitation, through Operation Bullfinch. The report includes the shocking and distressing details about what happened to children who were systematically sexually exploited by a group of criminal men. The Review provides details of what was in effect street grooming and explains the reasons why agencies failed to identify what was happening and intervene.

In this meeting, I will summarise the key findings and recommendations of the Review and outline actions taken by key organisations to safeguard children from this type of abuse in future.

What happened to the victims, to these children detailed in this SCR, is deeply disturbing and shocking. Readers of the report will be upset and quite rightly want to know how these children could have been subjected to such appalling sexual exploitation for so long. Between 2005 and 2010 despite the efforts of some front line staff working with children individually, there was no understanding of child sexual exploitation, and no concerted or organised response across Oxfordshire agencies to

tackle street grooming. ***There were repeated missed opportunities and many mistakes were made. The review concludes that the child sexual exploitation across Oxfordshire from 2005-2010 could have been identified or prevented earlier***. In particular there were opportunities in 2007 when some early information should have led to further exploration. In 2005-8 the report states that there were significant concerns about multiple victims and abusers from the local community to a level very similar to that which in 2011 led to Operation Bullfinch

The Review also describes, mainly in their own words, the experiences of the victims and their families, of the agencies and staff that worked with them. The children were groomed by their abusers and were given alcohol and drugs, gifts and attention, and led to believe that the men were their boyfriends. They were forced to have sex and were physically assaulted, threatened, drugged, raped, trafficked and sold for sex. They were pulled into a frightening world where they felt unable to escape.

I would like to pay tribute to the family members and children who contributed so much to this Review. Some parents and carers raised concerns. Sometimes their concerns were not given the weight they deserved and no action was taken by professionals.

Why was there such systemic failing in Oxfordshire?

The different reasons for delay in action are outlined in the report and demonstrate – an absence of acknowledgement amongst social workers, police officers, health staff and teachers that children were victims of child sexual exploitation by groups of men;

the use of language by professionals that blamed the children for their plight; the lack of any understanding of why children were repeatedly running away and the pull to their groomers; insufficient use of legal tools to disrupt perpetrators, an over reliance on victim statements to get cases to court; a professional tolerance of children having sex with older men and a culture in Oxfordshire that lacked strategic oversight of the frontline sufficient to draw together the pattern of abuse. Not all these factors are unique to Oxfordshire but indicate deep rooted problems across the child protection system and professional's understanding of street grooming.

Using the conclusions from the Report… these are the key findings

Lack of understanding across organisations

- 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 a view that saw them as consenting, or bringing problems upon themselves
- As a result the girls were sometimes treated without common courtesies, and as one victim described it by '*snide remarks'*
- There were misguided interpretations 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 going missing, so distraught, desperate and terrified parents were sometimes seen as part of the problem
- There was an absence of curiosity about what was happening to the girls, or to investigate further incidents or concerns
- Although there were a number of police investigations these were not linked. There was not enough work to disrupt the activities of the alleged perpetrators (compared to the effort to contain the girls behaviour) and various legal tools were not used.

Day to day processes were not strong enough

- Insufficient use was made of Child Protection processes and supervision within social care was not good enough
- Recording of 'crimes' by police officers was inconsistent
- Transfer of educational records between schools was poor and there was not enough done about children missing from school
- Across the NHS, there was insufficient sharing of information heard from or about the girls

The organisational response in Oxfordshire was weak and lacked any management oversight

- Serious concerns about children in care and emerging patterns of child sexual exploitation did not reach those with overall responsibility for services

- When some early signs reached the OSCB through a sub group in 2007 there was no follow through to senior level
- The OSCB, before late 2011, did not comply with the 2009 government guidance on child sexual exploitation

Whilst the Review says that there was no disregard of clear warnings at top level and no denial by those in charge, their lack of understanding of what was happening on the front line caused unacceptable delays. This allowed offenders to get away with their crimes. The Review describes a culture in Oxfordshire where the value of escalation to the top was not understood.

The Review found that rather than a top-down steer, frontline staff across different agencies worked in isolation from each other. It is due to the diligence of those staff on the ground that the true picture of the awful abuse began to take shape in late 2010.

I would like to emphasise that the Review found no evidence of any willful neglect, nor deliberate ignoring of clear signs of child sexual exploitation by groups of men. However, action was too slow, the erosion of consent not recognised, and the connections between cases inadequately made. Nor was there any evidence of any holding back, or hesitancy, because of the ethnicity of the perpetrators.

The Serious Case Review sets out around 60 learning points for organisations and professionals across Oxfordshire.

The Review highlights that from 2011, when Operation Bullfinch began, organisations in Oxfordshire have worked increasingly well together, with the OSCB, to introduce best practice. In addition, the Review highlights, the personal commitment now shown by top leaders and local politicians is strong.

In fact, professionals from outside the country are now using this best practice to boost their learning around tackling child exploitation.

There has been a very significant investment in services. This includes the training of 7,500 frontline staff in Oxfordshire to look for signs of child exploitation. The numbers of specialist staff have increased. The multi-agency child sexual exploitation team, known as Kingfisher, has been operational since 2012 and professionals have identified 373 known children at risk of child sexual exploitation over a period of 15 years. A multi-agency safeguarding hub was established in 2014 for all child protection cases. The report quotes children who are now being helped by Kingfisher and how their descriptions of professionals work is much improved from before.

Notwithstanding the failures of organisations in Oxfordshire to protect and safeguard children from exploitation and abuse there is much that needs to be done to combat the exploitation of vulnerable children and this has required top level commitment from all organisations in Oxfordshire. The Review also asks Government to consider that:

- Research be commissioned by Government to identify why street grooming convictions have mainly involved individuals of Pakistani and/or Muslim heritage

- Government should consider the impact of current guidance on consent. This is with a view to ensuring that what seems to be the ever lower age at which a child can be deemed to make informed choices combined with attitudes towards underage sex, are not making it easier for perpetrators to succeed.

There are 13 recommendations for the OSCB.

The Oxfordshire Safeguarding Children Board welcomes this Serious Case Review and on its behalf I would like to apologise for how long it took organisations in Oxfordshire to see what was happening to these children and bring the perpetrators to justice.

All organisations now refer all cases of child sexual exploitation to the Kingfisher team. A CSE sub group of the OSCB has driven through changes to practice and policies. More men have been brought to justice with convictions for these crimes. Successful work in Oxfordshire indicates we will see an increase in the numbers of children identified to be at risk of abuse.

This morning I have received a letter from the Children's Minister, the Minister of State for Crime and Prevention and the Parliamentary Under Secretary of State for Health. The letter asks organisations in Oxfordshire to evidence how the improvements already made are making a difference to frontline practice and which services are making the biggest difference to children at risk of sexual exploitation. I welcome this.

To conclude I am personally deeply saddened by what happened to these children. The findings and recommendations of the review are of huge importance locally in Oxfordshire as well as being of national significance. As the new Independent Chair of the Oxfordshire Safeguarding Children Board, it is my role to hold to account the organisations within the Safeguarding system, to ensure they work together and do everything they can to protect children. I can reassure you that the findings from this review have been influential in strengthening how organisations protect children in Oxfordshire. But there is still more to do and I will do everything in my power to ensure that the programme of change continues.

Thank you

Independent Chair, OSCB