

Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F

The Oxfordshire Safeguarding Children Board (OSCB) has today (03 March 2015) published the independent serious case review (SCR) it commissioned in 2012 into the services provided to the victims of the seven men, convicted in 2013, of 59 offences of child sexual exploitation.

The Independent author of the review is Alan Bedford MA (Social Work), Dip.Crim

This report highlights failings of the OSCB and its member agencies to recognise that group child sexual exploitation was happening in Oxfordshire - prior to Operation Bullfinch in 2011 - despite the clear evidence of cases between 2005 - 2010 showing what we now know were signs of street grooming.

The Independent Chair of the Oxfordshire Safeguarding Children Board, Maggie Blyth said: "What happened to the victims is deeply disturbing.

"It is shocking that these children were subjected to such appalling sexual exploitation for so long. On behalf of the OSCB 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. It is clear that between 2005 and 2010 despite the efforts of some front line staff working with children individually, there was no understanding of the type of abuse which later emerged, a culture across all organisations that failed to see that these children were being groomed in an organised way by groups of men and therefore there was no concerted or organised response across Oxfordshire agencies working with children against this terrible child abuse."

The Review also describes, mainly in their own words, the experiences of the victims and their families. 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 in exchange for the drink and drugs and were physically assaulted, threatened, drugged, raped and sold for sex. They were drawn into the world of the abusers so much so that they lost any ability to make informed choices about what they did.

Ms Blyth added: "The OSCB would like to pay tribute to the victims and parents who contributed so much to this Review. As the new Independent Chair of the Oxfordshire Safeguarding Children Board, I will do everything in my power to ensure the programme of change continues and agencies are evidencing what they are doing to safeguard children here in Oxfordshire. I am deeply saddened and shocked by what happened to these children."

The report has identified that over 370 children have been identified as at risk of child sexual exploitation in Oxfordshire and that since Operation Bullfinch and the period of this Serious Case Review more cases have been brought to the courts. There has been tremendous investment in services to support children at risk of sexual exploitation, including the establishment of the specialist Kingfisher team, a multi-agency front line service for victims of CSE; training of thousands of front line staff in raising awareness of CSE; an increase in the numbers of front line staff and a whole system overhaul of working across organisations and with schools and communities.

Key findings of the report:

- The Review found no evidence of any wilful neglect, nor deliberate ignoring of clear signs of child sexual exploitation by groups of men
- The issue of child sexual exploitation and street grooming was not understood and national guidance was not 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, the girls 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, and the victims were often perceived to be 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 going 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
- The organisational response in Oxfordshire was weak and lacked overview
- Information about worrying cases was not escalated to the top of organisations
- The OSCB failed to follow through on some early warning signs in 2007, and organisations in Oxfordshire lacked a strategic overview of child sexual exploitation
- It was junior staff efforts which led to the eventual identification of the pattern of group child sexual exploitation.

The Review outlines 60 learning points for agencies and professionals, and 13 recommendations for the OSCB. In addition, the Review makes recommendations to central government. These include asking government to consider the impact of current guidance on consent to ensure what seems to be the ever-lower age at which a child can be deemed to consent (for example to treatment) and attitudes to underage sex, are not making it easier for perpetrators to succeed. Also, with a significant proportion of those found guilty nationally of group CSE being from a Pakistani and/or Muslim heritage, relevant government departments should research why this is the case, in order to guide prevention strategies.

Ends

Notes to Editors: Copies of the Independent Chair's statement and a link to the full Serious Case Review are available on the OSCB website <http://www.oscb.org.uk/case-reviews/>

Background to the OSCB: Local Safeguarding Children Boards were established by the Children Act 2004 to help make sure key agencies work together to keep children safe. The Oxfordshire Safeguarding Children Board (OSCB), is the means by which organisations come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The OSCB consists of 34 representatives, representing local authorities, the NHS and police, among others.

Biography for the Independent Chair of Oxfordshire Safeguarding Children Board (OSCB): Maggie Blyth took up the role of Independent Chair of Oxfordshire Safeguarding Children Board (OSCB) in May 2014. Maggie has a background in education, initially qualifying as a teacher, but managing services within social care and criminal justice during the 1990s across the Thames Valley and in Inner London. Between 2001 and 2005 she had policy oversight of the youth justice system across England and Wales as Head of Practice for the National Youth Justice Board for England and Wales. Since 2005 Maggie has held a ministerial appointment as an independent Member of the Parole Board for England and Wales.

Contact: Pasquale Brammer, Learning and Improvement Officer, Oxfordshire Safeguarding Children Board Tel: 01865 328677 Mobile: 07554 103539