

Independent Commentary - Oxfordshire Stock-Take 2015

Sophie Humphreys, June 2015

1. Introduction

- 1.1 I was appointed as an independent safeguarding expert to work alongside the Oxfordshire Safeguarding Children Board (OSCB) in March 2015. The primary purpose of my role was twofold:
 - to provide support and challenge to the OSCB as part of their evaluation into *'the impact of the multi-agency approach to tackling CSE (Child Sexual Exploitation) in 'Oxfordshire'* and;
 - to undertake my own enquires and form a view on the accuracy of the OSCB's findings and conclusions arising from this piece of work.
- 1.2 I also examined how the OSCB is perceived across the partnership in delivering against its statutory objectives of coordinating and ensuring the effectiveness of services that safeguard and support children from CSE.
- 1.3 The terms of reference for the OSCB evaluation were agreed by the strategic board convened to govern this process. It was agreed that the evaluation itself should be termed a *'stock-take'* to provide a clear distinction from the recent Serious Case Review (A-F) published on 3 March 2015.
- 1.4 Both the project team and the independent chair of the OSCB welcomed my guidance and support throughout the process and responded well to my challenge and advice.
- 1.5 The process undertaken to collect evidence was transparent, thorough and tenacious, led by the senior strategic lead for child exploitation. As the stock-take progressed, drafts and findings were openly shared with me. I gave regular feedback, highlighting areas that required further emphasis or clarity, and these have, in the main, been reflected in the final report.
- 1.6 Any reflections on the quality of practice identified were brought to the attention of the relevant service.

2. Methodology

- 2.1 I spent a total of nineteen days in Oxfordshire holding interviews with strategic leads and key stakeholders; including members of the OSCB, relevant local politicians, Members of Parliament and middle management of operational services. A significant amount of my time involved direct engagement with a range of frontline practitioners; observing their day-to-day business and combining this activity with more structured interviews.
- 2.2 I was keen to establish a good sense for the quality and style of frontline practice in Oxfordshire. It was important to ascertain whether the ethos being set at a strategic level was filtering through to the frontline and whether the respective challenges and quality of practice were known and understood at a strategic level.
- 2.3 I triangulated information brought to my attention via the stock-take and fed this intelligence back into OSCB's process so they could undertake further scrutiny where required.
- 2.4 I focused not only on areas in need of improvement but also identified areas of strength and innovative practice that could be shared nationally.

3. The OSCB stock-take

- 3.1 My professional assessment is that I agree with the overall comments and findings of the OSCB stock-take (June 2015) and their conclusion that there has been solid progress made in how CSE is understood and responded to in Oxfordshire.
- 3.2 I was met with open and honest accounts across the partnership about perceptions of how things were in the past, how they look now and what still requires improvement. The following sections are some additional points I wanted to stress:

3.3 Professional Curiosity

- 3.3.1 The key noticeable difference that was shared by all was that that the partnership is reflecting a more curious approach in its safeguarding arrangements. Stakeholders are willing to see and look for what is not always right in front of them, with a demonstrable shift in how young people are perceived being apparent; particularly when children are exhibiting challenging and concerning behaviour.
- 3.3.2 This was illustrated through the comments of a practitioner made during a visit to one of the children's homes in Oxfordshire; "*Police listen now to workers, trust our opinions, if we call them now to say a girl has not arrived home on time, they are there in minutes, they take it very seriously*".

3.4 Understanding the root causes of earlier failings

- 3.4.1 Without knowing what went wrong in the past and why, it is impossible to know what needs to change to make sure errors aren't repeated and poor practice isn't left unchallenged. The partnership has demonstrated good insight into the root causes of earlier failings and can evidence the considerable steps that have been taken to remedy them.
- 3.4.2 This transparency and clear willingness to acknowledge the mistakes of the past and learn is reflected well in the OSCB report's description of '*Oxfordshire then*' and '*Oxfordshire now*'.

3.5 Escalation of concerns

- 3.5.1 The recent Serious Case Review highlighted previous issues with frontline practitioners not escalating concerns. The stock-take concludes that escalation processes are now used appropriately.
- 3.5.2 From my discussions with practitioners I did need to push to get them to articulate that an escalation process is something that goes beyond middle management and their heads of service, particularly within children's services. This may be in part due to their stated confidence in their managers. They said they feel heard and that their concerns get taken seriously and therefore there has not been the need to escalate higher.
- 3.5.3 However there is a potential risk, when a system relies on the quality of one part of it to respond appropriately e.g. Head of operational services. Politicians, Chief Officers and Chief Executives across all services in Oxfordshire need to assure themselves that if there is an issue with the quality of decision making at any point within the system, that they have openly and directly promoted their accessibility to all staff.
- 3.5.4 It is important that escalation is not seen as a purely linear process, or one that remains within one organisation, but that challenge cuts across agencies and any hierarchy within it.

Recommendation 1: For the OSCB to continue to provide training across agencies on escalation processes, and for these to be attended by frontline practitioners and senior officers to create an opportunity for them to interact face to face.

3.6 Kingfisher

- 3.6.1 Much credit has been given throughout the report to Kingfisher, the specialist multi-disciplinary team dedicated to CSE - rightly so. I spent a day with the team, including attending high quality strategy meetings and visited a family currently open to the team.
- 3.6.2 However, as with any discreet service that is working well, there is the associated risk of over reliance, capacity pressures and the potential knock on effect of thresholds and access becoming a challenge. There was similar concern raised about how Kingfisher might impact on the system in the long term and that CSE needs to be seen as the 'day job' of children's social care. Specialist teams can by their nature run the risk of de-skilling other staff who arguably need an equal skill-set and specialist practice knowledge.
- 3.6.3 Kingfisher was an appropriate response in Oxfordshire, at a specific time, to a specific issue e.g. the findings from the Bullfinch investigation into Child Sexual Exploitation. This may well be what will continue to be required in Oxfordshire, certainly in the short to medium term, however it is important that it continues to reflect on whether it is the right response on a long-term basis.
- 3.6.4 This was acknowledged by the Director of Children's Service and is mitigated to some extent by the rotation of staff from both the police and social care, ensuring specialist knowledge and expertise is also held in the main system. I understand this will be the subject of continuing review by the Child Sexual Exploitation sub-group of the OSCB.
- 3.6.5 It was also brought to my attention by a number of staff that whilst Kingfisher is seen as being of a high standard and an excellent resource, professional communication has on occasions broken down once a case moved into the Kingfisher team, with feedback on the progress sometimes being limited.

Recommendation 2: The effectiveness of communication by Kingfisher needs to be monitored by Children's Social Care and Thames Valley Police with a report provided to the OSCB.

3.7 Disruption Activity

- 3.7.1 The report concludes that multi agency disruption activity is working well and my findings are similar. From spending time in strategy discussions and then later hearing about the same girls and potential perpetrators being discussed in police neighbourhood team briefings - the level of sharing of intelligence was robust and appropriate.

- 3.7.2 Throughout my time in Oxfordshire, I explored the level of understanding of the powers now available (March 2015) through new legislation in the shape of Sexual Harm Prevention Orders (SHPOs) and Sexual Risk Orders (SROs). Most of the staff I spoke with, other than the police, were not aware of these new Civil Orders and their potential application. This legislation gives an opportunity for creative disruption activity and needs to be taken full advantage of.

Recommendation 3: The OSCB develop a multi-agency training programme to promote the awareness of and operational application of new disruption powers available under the recent amendments to the Sexual Offences Act 2003.

This could form the basis of a training programme to be shared nationally with other Local Safeguarding Boards.

- 3.7.3 It will be important for the Department for Education to liaise with the Home Office and the Ministry of Justice to reflect early on the fact that this legislation is only relevant to children up to the age of 16, particularly when there are so many children sexually exploited in the sixteen to eighteen age bracket.

Recommendation 4: The Department for Education to liaise with the Home Office and Ministry of Justice to reflect on the recent amendments to the Sexual Offences Act 2003 and its applicability only to children up and until the age of sixteen years of age.

3.8 Local Authority Designated Officer

- 3.8.1 I would like to bring to the attention of the Minister and the Department for Education the breadth of work taking place by the Local Authority Designated Officer (LADO) service in Oxfordshire.
- 3.8.2 The LADO is working “upstream”, at a highly preventative level; anticipating areas of potential risk to children from adults in professional roles across a wide range of services.
- 3.8.3 The LADO provide comprehensive training for not only the maintained sector but independent sector schools and the far less regulated language schools that ‘pop up’ in Oxford City. The LADO is developing positive relationships in the BME Communities. There is now a system in place where all complaints regarding taxi drivers are screened by the LADO service. I think their work offers a good model for effective LADO work nationally.

4. The Five Key Areas for further improvement identified by the OSCB

- 4.1 Key Area 1: Getting the basics of frontline child protection right and Children’s Social Care providing strong leadership.**

- 4.1.1 The quality of safeguarding practice relating to CSE that I both observed and assessed through practitioner interviews was, in my view, effective and there was a clear commitment from the workforce to genuinely improving outcomes for vulnerable children. These aspects are evidenced in the OSCB stock-take report.
- 4.1.2 I agree with the stock-take finding that leaders across Oxfordshire demonstrate commitment to tackling CSE at all levels and have dedicated resources to support this.
- 4.1.3 However, it is important that work continues to ensure that any potential gaps are understood and that the quality of communication between the organisations, the district councils and the County Council (who hold the lead for safeguarding for Oxfordshire) is effective and that potential risks that might occur across the system are identified and mitigated against at every opportunity.

4.2 Key Area 2: Perpetrators and link to ethnicity / cultural identity

- 4.2.1 I agree that more work needs to be done to understand the profile of perpetrators, particularly in relation to prevention. No strategy to tackle CSE will be complete without a focus on victims AND perpetrators. This means understanding perpetrators early life experiences, how their personalities develop and what draws them to this very disturbed and criminal activity. It also means having a system that can identify harmful sexual behaviours as they emerge in children and young people and having effective responses to them.
- 4.2.2 Other factors that may influence a child when growing up cannot be seen in isolation to CSE; with the product of their life experiences contributing to a limiting and / or limited expectations about what constitutes a healthy relationship, consent or the way that boys, girls, women and men are perceived. Where this perception is driven by cultural belief systems that potentially puts young people at risk, there must be no hesitation in this being challenged.

4.3 Key Area 3: Therapeutic support for adults and children

- 4.3.1 My enquires also confirm that there is a genuine need for further 'fit for purpose' therapeutic services for adults who have been victims of sexual abuse in their childhood.
- 4.3.2 These are currently sparse, and often not adequate. There was also a need expressed across the partnership for better, more accessible therapeutic services for children from Child and Adolescent Mental Health Services (CAHMS) and that work is needed to look at the provision of services available to children as they transition into adulthood.
- 4.3.3 The children's home I visited in Oxford said they received an excellent service from CAHMS, so this could be a good starting point to learn and build from.

4.4 Key Area 4: The transportation of vulnerable children

- 4.4.1 The need for the County Council and the district councils to work closer together is indisputable in relation to the transportation of vulnerable children as described in the stock-take report. The audit undertaken by Oxfordshire into the transportation of vulnerable children raised a number of areas of potential risk to children, particularly relating to the oversight and regulation of contracts with taxi organisations and their drivers.

- 4.4.2 It is important to note that Oxfordshire County Council arrange for the transportation of approximately one thousand children by taxi every day.
- 4.4.3 Keeping children safe when using taxis for transportation has been made even harder by the recent de-regulation of licensing law allowing taxis to work across boundaries with no requirement or mechanism through which soft intelligence can be shared e.g. Suspension for inappropriate behaviour.
- 4.4.4 This is not vilifying taxi drivers as a profession. It is about having the necessary oversight in a context where vulnerable children are in contact (usually alone) with predominantly adult males. This increases their vulnerability and the opportunity for grooming or risk of harm if any of these individuals were motivated to do so.
- 4.4.5 It was disappointing that it was only through my enquiries into taxi licensing in Oxfordshire that the audit undertaken by Oxfordshire County Council and its findings came to my attention.
- 4.4.6 I understand the OSCB was aware of its existence, but not the 'extent' of its findings and that a plan was already in place to bring the audit to the next OSCB meeting in July 2015. Furthermore, it is relevant to note that safeguarding children in transport was agreed as a priority for the OSCB in their development day in April 2015.
- 4.4.7 I am now confident that the relevance of this audit and the links with CSE are fully understood, and that the OSCB has reinforced the importance of swift escalation of strategic safeguarding matters to the partnership as they emerge to maximize the opportunity for intelligence to be shared and for solutions to be identified in a timely manner.
- 4.4.8 It is a positive step that the County Council has extended the Section 11 audit requirement to include a return from the Environment & Economy Directorate on its oversight of contracts for the transportation of vulnerable children. The OSCB has agreed this approach.

Recommendation 5: Consistent with legislation and statutory guidance, organisations bound by Section 11 of the Children Act 2004 that are either providing or commissioning transport services for children must demonstrate the Section 11 compliance of those arrangements. The importance of this needs to be reinforced by the Department of Education nationally.

4.5 Key Area 5: District Community Safety Partnerships engaging the Community.

- 4.5.1 I agree with the OSCB stock-take that there is a need for better join up between services provided by the District Councils.
- 4.5.2 There is an inherent risk in two tier authorities that governance and differences in decision making can be distracting and time consuming. Whilst acknowledging the complexity of such arrangements, it is nonetheless vital that leaders demonstrate the right behaviours and do not allow themselves to be unintentionally diverted from the need for services to work in partnership to maximise safeguarding of children and for this message to be clearly disseminated to all staff. Clear systems and strong leadership needs to be in place to mitigate this inevitable area of risk.

Recommendation 6: That the OSCB continues to reassure itself that communication and joint working is effective between the County Council and District Councils in regards to Safeguarding Children.

Recommendation 7: The Department for Education and the Government need to consider how they relate directly to District Councils in regard to re-enforcing their respective safeguarding responsibilities.

5. Conclusion

- 5.1 There is clear evidence obtained from the OSCB stock-take, and through my interviews with a wide range of providers and stakeholders, that demonstrates the OSCB is both coordinating and ensuring the effectiveness of the arrangements made by all agencies in tackling CSE.
- 5.2 I have seen and experienced first-hand many examples of good practice and I have witnessed no complacency. I have been impressed by the determination and level of robust challenge that is demonstrated by the OSCB chair and representatives of partner agencies to secure progress. Much about the operation of OSCB in relation to CSE is worthy of consideration by other LSCBs.
- 5.3 Within the progress made there are some specific areas where the partnership should do more to satisfy itself that providers are on top of issues and timely action is being taken as detailed in the stock-take. I have made some additional recommendations in this commentary.
- 5.4 Tackling CSE is undoubtedly complex and the clear focus of the OSCB and partners in making sure the local response is robust, is absolutely the right thing to do.
- 5.5 Although CSE requires a level of specialist knowledge, it must not be seen in isolation, but in the context of one of a number of forms of abuse that vulnerable children are at risk from. A child who is the subject of Child Sexual Exploitation will often have been, or will still be, the subject of neglect or other forms of maltreatment. Practitioners across the system must remain alert, anticipating and expecting the 'unexpected' in whatever guise child abuse presents itself.

Summary of Recommendations

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- Recommendation 2:** The effectiveness of communication by Kingfisher needs to be monitored by Children's Social Care and Thames Valley Police with a report provided to the OSCB.
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- This could form the basis of a training programme to be shared nationally with other Local Safeguarding Boards.
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