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

Approved by the OSCB February 26th 2015

Independent Reviewer: Alan Bedford MA (Social Work), Dip.Crim

FOREWORD

i. What happened to the child victims of the sexual exploitation in Oxfordshire was indescribably awful, and a number of perpetrators are serving long periods of imprisonment following the investigation known as 'Operation Bullfinch'. The child victims and their families feel very let down. Their accounts of how they perceived professional work are disturbing and chastening. There is clearly a demand to find out how such extensive abuse could have continued for so long before it was properly identified, and why there was not speedier action. There was a strong public reaction last year and this year to two Rotherham inquiries (which were not Serious Case Reviews) and to similar concerns reported elsewhere, and there have been calls in such cases for individuals to be held to account.

ii. The Serious Case Review (SCR) has seen no evidence of wilful professional neglect or misconduct by organisations, but there was at times a worrying lack of curiosity and follow through, and much work should have been considerably different and better. There is little evidence that the local understanding of child sexual exploitation (CSE), or how to tackle it once identified, was significantly different from many parts of the country.

iii. On the surface, many of the illustrations described in the report can seem like professional ineptitude, unconcern, or inaction. They become more understandable when put in the context of the knowledge and processes at the time, practical difficulties around evidence, and a professional mind-set which could not grasp that the victims' ability to say 'no' had been totally eroded. However, understanding it does not make what happened right. The analysis of 'why', on the surface, there was inexplicable behaviour by organisations is to explain, not excuse. It is in understanding the context in which professional work took place, and what impacted on the thought processes and actions of staff, that there can be learning for individuals and organisations. This is the prime purpose of an SCR. The answers to 'why' cannot be reduced to a few simple sound bites, as there are many complex interlocking issues, which are described in detail in the Review.

iv. The County Council and Police have apologised for not preventing or stopping the exploitation, (and some agency and multidisciplinary arrangements should indeed have been better). The Chief Constable apologised that it took so long to bring the offenders to justice, and said she was "sorry that we did not identify the systematic nature of the abuse sooner, and that we were too reliant on victims supporting criminal proceedings". The Chief Executive for the County Council said that, "we would like to publically apologise for not stopping this abuse sooner and to reassure everybody listening that we have learnt a huge number of lessons in terms of how to tackle this type of abuse and that we are now taking decisive action to stop it happening in Oxfordshire". The attitude seen by the Review is not one of denying the scale of abuse or the errors, but an acceptance of what was missed and a determination to ensure things are better.

v. This SCR is not an 'inquiry', but does identify where there is evidence that things were not good enough. The fact that scores of professionals from numerous disciplines, and tens of organisations or departments, took a long time to recognise CSE, used language that appeared at least in part to blame victims and see them as adults, and had a view that little could be done in the face of 'no cooperation' demonstrates that the failures were common to organisational systems. There have been similar cases to those in Oxfordshire, most notably

in Rochdale, Derby, Bristol and Rotherham. The same patterns of abuse are seen, the same views of victims and parents, and similar long lead-ins before effective intervention. For all this everywhere to be the result of inept, uncaring and weak staff, and leaders who need to go, seems highly improbable. The overall failings were those of a lack of knowledge and understanding around a concept (of CSE) that few understood and where few knew how it could be tackled, but also of organisational weaknesses which prevented the true picture from being seen. It is important this is recognised so organisations can, and can continue to, get it right on CSE, and can respond better when the next new challenge occurs.

vi. There were many errors. Some organisations and some staff should have acted with more sensitivity, rigour, imagination or indeed common sense. Some processes and procedures should have been implemented much better, and the collective agency work around safeguarding before 2011 should have been much stronger. Over a number of years there were many signs of CSE of the type revealed in the Bullfinch trial, and whilst they were not recognised as 'CSE', the extreme nature of those signs required concerns to be escalated to top managers, but this did not happen. Even if what had been happening were unconnected individual cases, the effectiveness of professional work was not good enough. The abuse, as a result, continued for longer than could have been the case.

vii. The issue in Oxfordshire was not very top management and governing bodies knowing about CSE and not acting, but that they didn't know there were cases being dealt with that were showing indications of CSE, even if not defined or recognised as such.

viii. While much should have been better, professionals working with the families concerned, over many years, worked relentlessly (if not always very effectively) to fulfil their professional duties to the victims and their families. Ultimately, it was the efforts of staff on the ground, and their observations and persistence, which was the main driver in the eventual identification of CSE.

ix. Five of the seven convicted perpetrators were of Pakistani heritage. No evidence has been seen of any agency not acting when they should have done because of racial sensitivities. The victims were all white British girls.

x. The vast majority of the information for this SCR has come from the agencies' own internal reviews, so the accounts of any deficits in performance have come from the agencies themselves voluntarily, and reflect a laudable willingness to be open about the past. They were equally forthcoming when the author made additional inquiries. The learning in Oxfordshire has already been significant, with much good practice now in place, and a professional mind-set now attuned to CSE, with children seen as children, however they behave. There is a growing arsenal of tools to identify, prevent, disrupt and prosecute CSE. Operation Bullfinch and subsequent prosecutions have shown concerted and rigorous action.

xi. This Review focuses on what can be concluded and learned for the system overall and about the period leading up to Operation Bullfinch, and includes an overview of progress since. In an associated document, 'CSE in Oxfordshire: agency responses since 2011' the detailed learning identified by each agency is set out, together with key actions taken and points of contact for further learning.

Alan Bedford, Independent Reviewer February 2015

Para		Page
	Foreword	
1	**SUMMARY AND INTRODUCTION**	1
1.1	Summary of findings	1
1.11	The need for a Serious Case Review	2
1.13	Terms of reference	3
1.18	Independent Reviewer	3
1.19	Review process	4
1.23	Anonymity	5
1.26	Report structure	6
1.28	Definition of CSE	6
1.29	Terminology around ethnicity	7
2	**BACKGROUND**	8
3	**THE EXPERIENCE OF VICTIMS AND THEIR FAMILIES**	11
3.1	Introduction	11
3.8	Vulnerability	12
3.9	Experiences after grooming	12
3.10	The victims' experience of professionals	13
3.12	The parents' experience	15
4	**IMPROVEMENTS IN OXFORDSHIRE**	19
4.5	OSCB overview	19
4.6	Leadership commitment	20
4.15	Countywide service improvement	22
4.20	Investigation, disruption, prosecution	24
4.25	Community relations	24
4.26	Involved agency progress	25
4.34	The views of girls currently at risk	29
4.38	Moving on – an apology	31
5	**WHY THE DELAYED INDENTIFICATION AND ACTION ON CSE?**	32
5.1	Introduction	32
5.4	Why the delays?	32
5.6	Knowledge	32
5.13	Language	34
5.19	Consent and age	35
5.26	The nature of the families	36
5.38	Levels of cooperation	39
5.46	Crime/No crime and evidence	40
5.60	Lack of curiosity and rigour	44
5.68	Disruption	46
5.72	Escalation	46
5.85	'Nothing can be done'	50
5.88	Missing persons management	50
5.103	Pressures in Children's Social Care	54
5.111	Supervision	57
5.112	Working with the parents	57
5.114	'Professionalism'	58
5.115	Looked After Children processes	58

5.128	Assessments	61
5.130	Use of Child Protection procedures	61
5.135	Minutes and meetings	63
5.136	Donnington Doorstep	63
5.139	School-related issues	63
5.144	Drug and alcohol issues	64
5.146	Summary of health issues	65
5.149	Taxis	66
5.150	The whole multi-agency team	66
5.151	Ethnicity	67
5.154	Summary	67
6	**WHAT MIGHT HAVE BEEN KNOWN ABOUT CSE?**	68
6.1	Introduction	68
6.2	Guidance	68
7	**ORGANISATIONAL AND LEADERSHIP AWARENESS**	74
7.1	Introduction	74
7.2	Priorities	74
7.5	Oxfordshire's journey	75
7.6	The Oxfordshire Safeguarding Children Board (OSCB)	75
7.25	The growing awareness in Oxfordshire	79
7.66	Top of the office knowledge	88
7.71	Operation Bullfinch	89
7.73	Comment	90
8	**APPRAISAL AND LEARNING**	91
8.1	Introduction	91
8.3	Learning points	91
8.4	Were mistakes made?	91
8.6	Could CSE have been identified or prevented earlier?	93
8.7	Missed opportunities	93
8.24	What was missing organisationally in Oxfordshire?	97
8.37	Knowledge	100
8.40	Escalation	101
8.51	Tolerance	103
8.59	Staff attitudes and rigour	105
8.64	Investigations	106
8.74	Going missing	108
8.78	The impact of ethnicity	109
9	**CONCLUDING SUMMARY AND RECOMMENDATIONS**	111
9.14	Recommendations	113
App 1	Collated SCR learning points	i
App 2	Terms of reference	vi
App 3	CSE numbers- methodology	ix
App 4	Ofsted Inspection 2014: key findings	x
App 5	Acronyms	xii
App 6	Oxfordshire Safeguarding Children Board members at 26.2.15	xiii

1 SUMMARY AND INTRODUCTION

1.1 **Summary of the findings:** This Review is about the sexual exploitation of children in Oxfordshire, using as background the experiences of six girls who were the victims in the Operation Bullfinch trial. It important to recognise that the time when most of the abuse took place was when there was almost no knowledge of group or gang related CSE nationally, and it is only in hindsight that the full picture is obvious. The Review concludes that many errors were made, and identifies what lay behind the errors (listed fully in section 8).

1.2 Lack of understanding led to insufficient inquiry. That the girls had lost the ability to consent or make their own decisions due to grooming was not realised, and instead they were seen as very difficult girls making bad choices. This, and that most of their families were seen as also having many problems, deflected attention from who was drawing them away from their homes - their own or in Care. The language used by professionals was one which saw the girls as the source not the victims of their extreme behaviour, and they received much less sympathy as a result. They were often in Care for their own protection, and frequent episodes of going missing were again put in the context of them being extremely difficult children.

1.3 The law around consent was not properly understood, and the Review finds confusion related to a national culture where children are sexualised at an ever younger age and deemed able to consent to, say, contraception long before they are able legally to have sex. A professional tolerance to knowing young teenagers were having sex with adults seems to have developed.

1.4 The victims almost never cooperated with investigations (again caused by the grooming) and there was a sense that nothing could be done as evidence was therefore weak. The need for disruption, covert surveillance and comprehensive intelligence gathering, despite no formal evidence from victims, was not understood. In fact, there was limited understanding of guidance related to the exploitation of children, although this has been seen nationwide. The lack of cooperation, and attitudes of the victims, sometimes led to crimes against them not being recorded as such

1.5 Regardless of levels of technical knowledge about CSE, there was a lack of curiosity across agencies about the visible suffering of the children and the information that did emerge from girls, parents, or carers, or some very worried staff. Also, a failure to recognise that the very extreme circumstances around the victims were so bad as to need referral upwards to board/governing body level, and a strategic 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 ethnic origin of the perpetrators played a part in the delayed identification of the group CSE. The Review shows that from 2005-10 there was sufficient known about the girls, drugs, prostitution and association with adult men to have generated a more rigorous and strategic response, but this did not happen – and mostly the information did not reach strategic levels.

1.6 In part, the findings above are not new, or unique to Oxfordshire. Much research had shown that few areas were prepared for this type of abuse. However, there were reasons why in Oxfordshire the group abuse was not recognised earlier, when there were opportunities to do so. The predecessor body to the Oxfordshire Safeguarding Children Board (OSCB), and OSCB in its early years, did not show sufficient grip or curiosity when some early signs were presented, and the topic drifted off the agenda. Children's Social Care (CSC) was at the time

of much of the abuse rated as only adequate by Ofsted, and an external review showed the OSCB needed to improve. Social worker numbers were at one point amongst the lowest in the country (leading to high caseloads), and supervision of staff was not strong. Child protection processes were not always robust. Crucially, insufficient value was placed on escalating extreme cases for top consideration, and this must reflect the then management culture. The Police, then, had limited processes in place that pulled together force-wide patterns. The important role of the City District Council in terms of local knowledge and regulation was not understood.

1.7 There are indications that top-level commitment from agencies to the OSCB and its predecessor was variable, and the Board members did not create a Board which rigorously followed things through. Crucial national guidance on 2009 CSE was overlooked, and there was no strategic overview.

1.8 As a result, the discovery of what later emerged in the Bullfinch inquiry and trial was led not by leaders and strategic bodies but by more junior staff working nearer the coalface. A drugs worker for the City Council, a social worker, and a detective inspector, on their own initiative, and in the absence of any strategic work, each led a number of meetings which were unknown to the OSCB or top managers. Their efforts eventually culminated in a shared recognition that there was group-related exploitation of multiple girls. Action from this point became coordinated and successful.

1.9 Since this turning point in early 2011, Oxfordshire has responded comprehensively to the challenge, is rated as 'good', and is held as an exemplar of how CSE should be tackled. There is no denial of either the errors or the scale of abuse, and top-level apologies have been made to the victims and their families.

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

1.11 **The need for a Serious Case Review:** Concerns were identified about children in Oxfordshire being sexually exploited. The collective picture from local agencies, and the intelligence that emerged about those individual children, led to 'Operation Bullfinch'. This complex investigation was led by the Police and involved other OSCB partners. A significant number of children were identified as victims of serious sexual exploitation. Nine men stood trial at The Old Bailey in January 2013, seven of whom were convicted and received substantial custodial sentences. The charges related to six individual girls – four cases of historic abuse and two which were more recent. The abuse was described by the trial Judge as a 'series of sexual crimes of the utmost depravity'.

1.12 A decision was made by the OSCB to convene a Serious Case Review (SCR) on 26 September 2012. The cases of the six victims known as Children A, B, C, D, E, F (referred to in this report as A-F) met the criteria for an SCR as defined in the then national guidance.[1] Children had been seriously harmed and there were concerns about the way agencies had worked together. This guidance was superseded in March 2013 but this would also have justified the decision to conduct an SCR.

[1] *Working Together to Safeguard Children* (DfE 2010), chapter 8 paras 8.9 – 8.12.

1.13 **Terms of reference (TOR):** The 2013 guidance no longer provides core terms of reference for SCRs, but says that final SCR reports should provide a sound analysis of what happened in the case and why, and what needs to happen in order to reduce the risk of recurrence. The TOR are given in Appendix 2. The period covered is mainly 2005-11 (when the multi-agency Operation Bullfinch started), with older history considered where relevant. For four of the girls their abuse by the mainly Pakistani heritage group ended 2-5 years before Operation Bullfinch started in 2011. For the other two, it was still current, but near its end, by the time Bullfinch started. (In all cases the impact of the abuse has continued for them after the abuse itself stopped.)

1.14 This Review, which needs to identify 'why', was asked to look at the following two key questions:

- To what extent was the child sexual exploitation experienced in Oxfordshire preventable?
- What can be learned from the Review's appraisal of the quality of agency work, and the experiences of the victims and their families?

1.15 To answer these questions the review will need to explore:

- What was known about child sexual exploitation and how it could be tackled?
- If it was not identified quickly enough, why not?
- What, including the quality of agency work, contributed to the vulnerability of the victims to abuse?
- How did agencies respond to the growing awareness of child sexual exploitation?
- What have agencies already learned and done as a result of Operation Bullfinch?
- What still needs to be done?

1.16 The Review should identify where agency performance could have been better, but also explain the context in which that performance occurred so that the contributory factors provide learning for OSCB and its member agencies.

1.17 To fulfil these terms of reference the views of the six girls and their families were sought and reported, and they had pre-publication opportunity to hear and discuss the findings.

1.18 **Independent Reviewer:** The original reviewer was David Spicer, a barrister, and formerly Head of Legal Services to Nottingham County Council, who in recent years had undertaken 16 SCRs mainly for Welsh local authorities. When David Spicer stepped down for health reasons, Alan Bedford was appointed by the OSCB from July 2014 and is the author of this report. He has a background in child protection social work with the NSPCC, where he was also National Training Manager. Following this he spent 18 years in the NHS, the majority of the time as a CEO in Trusts and Health Authorities. Through Alan Bedford Consulting he has worked on a range of issues, from infection control to emergency healthcare, and now mainly safeguarding. From 2009-11, he was Director of Safeguarding Improvement for NHS London, leading a London-wide peer review programme, and from 2009-13 was an LSCB Chair. He led on SCRs for the Association of Independent LSCB Chairs 2102-13. He has conducted a number of SCRs, is accredited as a SCIE Systems Reviewer, and has completed the 2010 and 2013 national training for SCR authors.

1.19 **Review process:** A Serious Case Review Panel was set up to oversee the SCR, and met in 15 occasions. It had the following membership

Role/Name	Organisation
Chair	
Paul Kerswell	SCR Independent Chair
Members	
Lucy Butler	Deputy Director, Children's Social Care and Youth Offending Service, Oxfordshire County Council
Hannah Farncombe	Safeguarding Manager, Children's Social Care, Oxfordshire County Council
Peter Clark	Head of Law and Governance, County Solicitor, Oxfordshire County Council
Frances Craven (to Sept 14)	Deputy Director Education and Early Intervention, Oxfordshire County Council
Margaret Dennison (Sept to Oct 14)	Deputy Director Education and Early Intervention, Oxfordshire County Council
Melanie Pearce	Area Service Manager, Adult Social Care, Oxfordshire County Council
Rob Mason	Detective Chief Superintendent, Thames Valley Police
Adrian Roberts (Aug to Oct 2014)	Head of the Complex Casework Unit, CPS Thames and Chiltern
Adrian Foster (from Nov 2014)	Chief Crown Prosecutor, CPS Thames and Chiltern
Jane Bell (to June 2013)	Designated Nurse and Safeguarding Lead, Oxfordshire Clinical Commissioning Group
Alison Chapman (from June 2013)	Designated Nurse and Safeguarding Lead, Oxfordshire Clinical Commissioning Group
Christine Simm (from May 2013)	Chair of the Management Committee, Donnington Doorstep
Clare Robertson	Designated Doctor for Safeguarding, Oxfordshire Clinical Commissioning Group, and Oxfordshire Hospitals NHS Trust
Di Batchelor	Chair, OSCB Education Subgroup
Kate Riddle	Acting Head of Nursing Children and Families Division, Oxford Health NHS Foundation Trust
Kevin Gibbs	Head of Service, South West England & Thames Valley, Cafcass
Tim Sadler (from Sept 14)	Executive Director, Community Services, Oxford City Council
Critical Friend	
Bina Parmar	Specialist Team Member, NWG Network
LSCB Staff	
	OSCB Business Manager
	OSCB Business Officer

1.20 As the SCR started in September 2012, it had to follow a much prescribed methodology under the then statutory guidance, and the Panel decided to continue with that model when in March 2013 successor guidance introduced local flexibility on method. A core part of the traditional methodology was the production of Individual Management Reviews (IMRs), and these were commissioned from the following organisations, several of whom used independent authors.

NHS	Oxford Health NHS FT
	Oxford University Hospitals NHS Trust
	Oxfordshire Clinical Commissioning Group
Health Overview	Oxfordshire Clinical Commissioning Group
Oxfordshire County Council	Early Years/Education
	Children's Social Care
	Adult Social Care
	Public Health – Drugs and Alcohol
	Youth Offending Service
	Legal Services
Oxford City Council	Oxford City
Justice Services	Cafcass
	Thames Valley Police
	Crown Prosecution Service (Briefing Report not IMR)
Voluntary Services	Donnington Doorstep
OSCB	Oxfordshire Safeguarding Children Board

1.21 These IMRs and the combined agency chronologies amounted to around 6,000 pages of information and analysis, and the extent of agency involvement described explains in part the length of time it took for contributory documents to be finalised before the report itself could be started. Each agency IMR made recommendations and organisations have been working on their own action plans. The majority of evidence in this SCR comes from IMRs, but in the narrative it may simply say '(the agency) said' or '(the agency) told the SCR,' etc. This will include information from follow up queries from the SCR author to agencies. The author was given full cooperation with any further inquiries he felt appropriate to supplement that from IMRs.

1.22 The Panel met with the IMR authors for a two-day exploration of the key issues, and the new Independent Reviewer (the author) held a one day workshop with the IMR authors. The original reviewer met five of the six children and several parents, who provided a rich contribution to the SCR. The author met four of the victims and spoke to parents of three. He also met them again, with the OSCB Independent Chair to brief them on findings before publication. The author also interviewed a number of chief officers past and present, the former Lead Member for Children's Services, and a number of staff who had played a significant part in identifying the child sexual exploitation.

1.23 **Anonymity:** When the Review started, the national guidance required reports to be fully anonymised, and it was on this basis that most staff and family contributions were made. *Working Together 2013* no longer requires anonymity but asks the Local Safeguarding Children Board (LSCB) to consider the impact on those involved in determining publication. The OSCB believes it is important to preserve the identity of the children and families. This Review will not therefore describe the families in detail. This is also necessary to comply with the legal requirement not to publish the identity of victims of sexual offences. Members of staff are referred to by job title, and anonymity is also important if maximum learning is to be achieved through staff contribution to SCRs.

1.24 The case illustrations in this report are not associated with a specific victim, even anonymously, but as an account of the sorts of experiences and feelings experienced by the six victims and those working with them. This avoids risking a loss of confidentiality, and

allows mention of some detail which could not be used if there was a risk of linkage with a particular family. The law says that no matter likely to identify a person against whom a sexual offence has been committed shall be published during the victim's lifetime.

1.25 The Review has had to weigh up two risks when referring to the specific experiences. If the initials A-F are used, and in some way identities are revealed, it would be unfair on those involved. On the other hand, if illustrations are reported as typical, common or even 'in one case' then something might be seen to apply to any or all of the victims/families, which might also be or be seen to be indiscriminative. The author has decided, on balance, not to align experiences to victims or families by specific initials.

1.26 **Report structure:** The first Annual Report of the National Panel of Independent Experts on SCRs (which oversees the quality of reviews to ensure appropriate action is taken from the learning) comments on SCRs being produced now. It has expressed concern about undue length. It warns against a level of detail that would make publication difficult (and hence learning limited). It calls for a 'sharp focus' and 'concise accounts'. This SCR therefore uses the case detail to illustrate findings rather than describing all the very significant history, which would lead to a report of such length as to render its aim of being read and learned from impractical and unsuccessful. The SCR uses the six cases to illustrate the findings, but wherever possible findings relate to the whole system not only those cases

1.27 The report describes what happened in the words of the victims and families, and identifies the reasons why agency responses were insufficient for some time to intervene in a protective way. It goes on to look at what guidance was available to organisations and professionals, and then appraises the quality of agency work. It identifies learning points and key recommendations. Early in the report there is an account of how child sexual exploitation is addressed now and the improvements already made.

1.28 **Definition of CSE:** This Review is about child sexual exploitation (CSE) defined by government as follows:
"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." [2]
This accurately describes what happened in Oxfordshire.

1.29 **Terminology around ethnicity**: The perpetrators in this case were predominantly of Pakistani heritage. (Five were of Pakistani and one of North African heritage and the other has said he was born in Saudi Arabia.) In this report the word 'Asian' is used more than 'Pakistani'. This is

[2] *Safeguarding Children and Young People from Sexual Exploitation: supplementary guidance to Working Together to Safeguard Children* 9DCSF, 2009).

not to hide any specific ethnic origin, but because this was the description mainly used by the victims and in agency case records. It is believed that when the term 'Asian' was used it did very often refer to those of Pakistani heritage, but 'Asian' seems to be the word used in common professional parlance.

1.30 The victims were white British girls.

1.31 This Report was in final draft stage before the Report of Inspection of Rotherham Metropolitan Borough Council by Louise Casey was published on 4 February 2015.[3]

[3] *Report of Inspection of Rotherham Metropolitan Borough Council*, House of Commons, HC1050 (February 2015).

2 BACKGROUND

2.1 This section is necessarily frank about what the exploitation involved. It is the recognition of just how awful it was that focuses the mind on the suffering and how well agencies acted and reacted. It was so bad that, for a time, it was hard for staff to grasp the reality of what was happening. Concerns were identified about young people in Oxfordshire who were being sexually exploited. The collective picture from local agencies and intelligence that emerged about those individual young people led to 'Operation Bullfinch'. This complex investigation was led by the Police and involved key OSCB partners.

2.2 In Operation Bulfinch over 20 young people were identified as potential victims. Nine men were charged with offences against six children (Children A-F) and committed to trial at the Central Criminal Court in London. As a result, seven of the nine defendants were convicted on 14 May 2013. Five life sentences were given, with minimum terms ranging from 12 to 20 years. The two others were jailed for seven years, with Sexual Offence Prevention Orders. Further investigations and trials continue.

2.3 The six children whose cases illustrate this Review were the victims of between one and 24 of the convicted offences, although the testimony they have given to court, professionals and this Review makes clear that this would only be a very small fraction of the offences likely to have been committed against them. The Prosecution said the charges were *"not intended to reflect each and every act of sexual abuse performed on each of the complainants. Rather, the indictment is intended to reflect the different types of conduct inflicted on the complainants and their ages at the time that conduct was inflicted."* The offences took place between May 2004 and June 2012 when the children were between 12 and 16. For the seven convicted perpetrators, the guilty verdicts related to the following offences:

- 19 convictions for rape
- 10 convictions for conspiracy to rape
- 5 convictions for rape of a child under 13
- 4 convictions for conspiracy to rape a child under 13
- 8 convictions for arranging or facilitating prostitution
- 5 convictions for trafficking for sexual exploitation
- 4 convictions for sexual activity with a child
- 1 conviction for conspiracy to commit a sexual assault of a child
- 1 conviction for sexual assault of a child under 13 by penetration
- 1 conviction for using an instrument to procure a miscarriage
- 1 convictions for supplying a class A drug

2.4 The Prosecution's opening speech at the Operation Bullfinch trial began by saying, "*These defendants, and others not before the court, used and abused the six complainants persistently, over long periods of time, sometimes in groups, for their own sexual gratification and the sexual gratification of others. The depravity of what was done to the complainants was extreme… The facts in the case will make you uncomfortable. Much of what the girls were forced to endure was perverted in the extreme."*

2.5 The Review finds extracts from the remainder of the Prosecution speech a clear summary of the children's experiences. Some acts of abuse in the speech were too graphic to be repeated here.

"… these men, sometimes acting in groups and at other times separately, actively targeted vulnerable young girls from the age of about the ages of 11 or 12. Sometimes the men would come across the girls while the girls were out drinking or playing truant. There is evidence that the men deliberately targeted children who were out of control. They also targeted children who had been sent to live in care homes for precisely that reason. Sometimes girls already being abused by the group(s) were tasked to find other girls for the group(s).

The girls who were chosen generally had troubled upbringings and unsettled home lives which made it less likely that anyone would be exercising any normal parental control over them or looking out for them.

The girls were then groomed in a variety of ways such as being given gifts or simply by being shown the care and attention that they craved. The attention lavished on the girls at the outset was of course entirely insincere as it was merely a device to exploit their vulnerability. Having secured their confidence the men would ply the girls with alcohol and introduce them to drugs such as cannabis, cocaine, 'crack' and sometimes heroin. The girls became addicted to certain of the drugs and felt unable to live without them. This made them even more dependent on the men.

Sometimes the men would also exercise extreme physical and sexual violence on the girls and threaten them that should they ever seek to free themselves from the grasp of the group they and/or their families would suffer serious harm.

In such ways the men came to exercise control over the girls who they knew:

- *Were therefore likely to subject themselves to sexual exploitation and abuse;*
- *Unlikely to ever be able to extract themselves from it let alone complain about it;*
- *And if they were to complain, it is unlikely they would be believed in view of what others would perceive as their delinquent conduct.*

It was a lifestyle described by one of the complainants as a "living hell" from which they could not extricate themselves. The overall period covered on the indictment is from May 2004 to early 2012…

The defendants took the girls to other places, usually hotels / guest houses or empty private dwellings, for other men to have sex with them, again often in groups and often in return for money which was paid to the men and not the girls.

Most of the men were engaged in the sexual abuse of the young girls did so over many years. Each was much older than any of the girls and of an age to know precisely what he was doing; the harm he was inflicting on the girls; the fact of their suffering and that their activity was illegal and in many instances depraved. In short, their conduct was intentional and persistent.
Many of the sexual acts committed on the girls were extreme in their depravity. The girls were usually given so many drugs that they were barely aware of what was going on. Indeed, they say that it was the only way they could cope with what was going on.

The sexual abuse included vaginal, anal and oral rape and also involved the use of a variety of objects such as knives, meat cleavers, baseball bats… sex toys … It was often accompanied by humiliating and degrading conduct such as biting, scratching, acts of urinating, being…

suffocated, tied up. They were also beaten and burnt. This sexual activity was often carried out by groups of men; sometimes it would go on for days on end.

The places to which the girls were taken were often private houses and guest houses in Oxford. Some of the private houses appeared to be empty and used solely for the purposes of the abuse. The men who came to pay to have sex with the girls were not always from Oxford; many travelled from far afield, places such as Bradford, Leeds, London and Slough. It seems they came specifically to sexually abuse young girl, often by appointment with the men in Oxford who had dominated the girls.

Between acts of abuse sometimes stretching over a number of days, the Oxford men ensured girls were guarded so that they could not escape. In addition to being abused in various locations in Oxford, some of the girls were taken to other towns and cities such as London and Bournemouth for the same purpose."

2.6 Assessing the scale of CSE is a very difficult task and there is no nationally agreed means of doing this. The Police and CSC were commissioned by the SCR Panel to try to produce robust figure. Adding cases where there was some certainty to those where there was a formal conviction of offences against them, there are grounds for believing that over the last 15 years around 370 girls may have been exploited in the ways covered by this SCR. The total will be a reasonable figure from the collective research of Police and CSC, although not precise because figures, by definition, were not formally collated until the pattern was finally recognised. (See Appendix 3 for methodology.)

Original Bullfinch investigation	39
Ongoing Bullfinch investigation	58
Others from CSC records	21
Children with whom Kingfisher have worked to Dec 2014	255
Total	373

2.7 The author and SCR Panel are conscious that these numbers may seem low given the higher (estimated) figures in Rotherham, but the work was carefully done and was debated and agreed by Panel members. It is not reasonable to extrapolate from the 255 children worked with in 2011-14 back to 1999 because many of these will refer to abuse which took place before 2011.

2.8 There was a commercial aspect to the exploitation, with some of the girls forced to work as prostitutes, hired out for up to hundreds of pounds, and trafficked and sold for sex. The police officer who led Operation Bullfinch characterised the crimes as '*organised*'.

2.9 The Prosecution opening speech refers to the areas men came from to abuse these girls. It says in various statements that the girls were trafficked for sex or being abused in London, Slough, Manchester, Coventry, Torbay, and Wycombe, and accounts of men coming from a range of cities including Leeds and Bradford to have sex with the girls. In February 2014, West Yorkshire Police charged 25 men from Halifax, Bradford, Shipley, Nantwich, Huddersfield, Derby and Newport in relation to sexual exploitation. Together with other high-profile cases of CSE across the country, the spread of places suggests that CSE is a nationwide issue.

3. THE EXPERIENCE OF THE VICTIMS AND THEIR FAMILIES

3.1 **Introduction:** The stories of the children whose cases are covered by this Review are shocking. The accounts here are as told to the original reviewer, the author, or from documents seen by the Review. Little comment is made on the views given in this section as it is important to know what the victims (and families) experienced and how it made them feel, both as a result of perpetrator action and in their dealings with professionals. In later sections, the perspective of staff is described and analysed for learning, and any differences of view discussed. As explained in Section 1, no comment is attributed to a specific victim or family.

3.2 The victims' voices are reflected through this report. The bulleted comments and views in this section are mainly taken from the previous reviewer's detailed notes of discussions with them, from the author's agreed interview notes with victims and parents, and some from other documents seen by the Review.

3.3 This Review will not tell individual stories as they become easily identifiable. The Prosecution speech in Section 2 has given a powerful overview of what happened to the girls. Their views, and parents' views, are given in three sections. Firstly, there is the period when, for most of the girls, a degree of vulnerability made them more susceptible to the attention of older men and the excitement that went with being found attractive, having money spent on them, a sense of drama and of 'living', probably the buzz from doing something on the edge, and alcohol and drugs. The families would be puzzled by the absence of the girls, who they were with, the gifts the girls came home with – and, if there were no problems with school attendance, there soon would be. Some of the children were already in Care or under Social Services care for a variety of reasons. Going missing from home or Care became common , .

3.4 Secondly, there were the results of the grooming. The more extreme behaviour, the longer periods of being missing, the effects of drink and drugs, looking gaunt, non-cooperation with anyone in authority. Longer periods in Care, sometimes being locked up in secure accommodation for their own safety. And despite what any professionals did (and the sum total of their effort was massive, if not too effective), the girls were unable to break away from the men who were by then using them for sex, offering them to others, selling them for sex, and keeping them hooked in by generating dependence on alcohol and drugs, which the girls paid for through sex. They were unable to reveal, in any usable way in court, detail of what was happening to them. During this period, some parents' entire lives would be dominated by searching for the girls, or trying to get agencies to act in a proactive protective way. The more vulnerable parents had less focus on protection.

3.5 The impression given in the history as told to the Review or the Police investigation was one of remorseless drama, chaos, violence, drink, hard drugs, violent and utterly unloving sex, and of not being able to escape – even to the point that the grooming was so successful that there was ambivalence about whether to escape or not.

3.6 Thirdly, there is how the girls and parents viewed the work of staff. Whilst it must be remembered that these cases were amongst the most difficult most staff would ever face, in general, family views were not positive. They saw staff as not taking concerns seriously enough, not believing the girls, not picking up the hints that they were giving about their abuse, and not being inquisitive enough about what was happening to them. The girls saw staff as critical of them and (while all the girls spoken to acknowledged how 'difficult' they were) felt

staff were not able to make a real human connection with them. Understanding the staff perception of this dynamic is an important part of the learning later in this Review. There is more on the parents' experience in 3.12 below.

3.7 The bulleted remarks below are powerful, relevant, and no doubt will be easy headlines which could lead to superficial conclusions. It is important that they are considered in the context of the whole Review. Words in brackets are added by the author to aid clarity.

3.8 **Vulnerability:** These are descriptions by the children after the abuse. Their acknowledgement of their vulnerability does *not* imply they were responsible for what happened to them.

- *It was a bit exciting*
- *They gave us more than my Mum could*
- *Dad was violent to me. I thought it was normal*
- *I had no male love, my father was an alcoholic, he hit me*
- *I was already off the rails before [meeting the men]*
- *Other children have a parent who they can talk to and rely on*
- *My birth father was alcoholic and violent*
- *I have always been aware of my problems, I was a brat*
- *My poor early life made me vulnerable*
- *School was bad for me – I was made fun of as a foster child. So I bunked off*
- *Suddenly the guys were bringing me stuff. They said how lovely I was*
- *They would buy us things*
- *I used to run away before [the grooming]*
- *They made me trust them for months, and I was their friend. I was flattered*
- *It was exciting – Asian boys with flash cars*
- *I wanted an exciting life: after 5-6 months I was involved – it was too late*
- *For a while he was my friend – just the two of us*
- *I used to moan about my home life – I was flattered they listened*
- *I believed they were my friends, nothing was more important*
- *They paid for drinks and gave us drugs*
- *I went missing every week – I thought it was normal*
- *When the grooming started they were so kind and nice. They were a lot older. It was flattering. It was attractive – then things started to change. I was already into drugs*
- *The Asian men felt they ran Oxford. That was exciting. People were afraid of them. I felt protected. People respected them*

3.9 **Experiences after grooming:** There is no need to repeat here some of the very graphic illustrations given by the Prosecutor in 2.4-5 above. Suffice to say, as horrendous as that description is, seeing/hearing about it in the girl's words, for example in statements, is indescribably awful. The victims were describing things happening to them across ages 12-15:

- *It all began when I was about 12 years old*
- *It started with men taking an interest in me*
- *The next thing it isn't nice anymore… they gave us weed and drink to make us feel better*
- *They started nice on the first day, on the second they wanted sex – still being nice. We drank vodka*

- *They took us to a field where there were other men who had come to have sex with us. I tried not to do it. There were five of them*
- *They threatened to blow up my house with my Mum in it*
- *I was expected to do things – if I didn't they said they would come to my house and burn me alive. I had a baby brother*
- *I took so many drugs – it was just a mish-mash*
- *Now I feel I was raped – I didn't have any choice*
- *I wouldn't ever have said no – they'd have beaten the shit out of me*
- *It was always Asian men*
- *I got deeper and deeper into this group*
- *Sometimes I was driven into alleys and woods and men would have sex with me*
- *I wouldn't have done this if I was sober. That's why the men gave us so much to drink*
- *Both men had sex with me lots of times – oral and vaginal*
- *I hate them... all they do is rape you… all they want is sex… it's happened to girls I know, not me before you ask, I not like that*
- *When we were at the flats I knew I was there to have sex which whichever men were brought there.*
- *He urinated on me*
- *I was spit roasted [made to have sex simultaneously with two men]*
- *I didn't want to go to the places to do what I did, but it was my job*
- *I went to London on my own to have sex with men they arranged*
- *The fear is still very real for me – though they are in jail I still check the cars*
- *It wasn't until the trial that I realised the organised nature of the abuse*

3.10 **The victims' experience of professionals:** At the time, the power of the grooming and the fear was so strong that there was an inability to cooperate with caring and justice agencies. Nevertheless, the victims have a great sense that they still gave enough indication verbally and non-verbally of what was happening for agencies to have intervened – even when they would have said they did not want such intervention. Allegations were frequently withdrawn, or details not given. Later in the report this dynamic is analysed in more detail. The comments relate to being missing as well as the absence of intervention.

3.11 Many comments are not attributed to specific agencies, as the learning from what is said applies across all organisations:

- *I was found in the presence of the men constantly. Why were they not pulled in?*
- *Police… didn't find me except once… I didn't hide – I told people where I was*
- *If a perpetrator can spot the vulnerable children, why can't professionals?*
- *Social workers asked me questions which showed they knew*
- *They could have followed us*
- *[On why not more inquiring questions] We wouldn't have told them but it would have showed they cared*
- *Why would a 13-year-old make it up?*
- *They didn't stop to think 'why?'*
- *They did not look on me as a child. In my head I was older, but really truly I wasn't*
- *People were reluctant to see what was clearly in front of them*

- *Social Services knew what was going on – they always asked questions that showed that they knew*
- *The only person who was any good was [the support worker]. She took me to MacDonald's or Costa Coffee to talk. I wasn't confident enough to tell her... but she was taking to me and listening*
- *The support worker was great. She was an adult… she was firm and there for me... she talked about 'we', ie me and her*
- *The social worker just wanted to hear what [the worker] wanted to hear so there was no need to do anything…*
- *[A police officer] tried to get people to listen, but she was banging her head against a brick wall*
- *The same officer was kind, supportive and showed the humanity and respect that so many officers seemed to lack at the time*
- *No one believes me, no one cares*
- *They knew where I was, they didn't care when I came back*
- *I couldn't sleep or eat*
- *The Police never asked me why – they just took me home*
- *They left you in a house with Asian men and didn't even ask my age*
- *I thought if I told the Police what was really happening they would not believe me, and they would not arrest them and then… they did not do anything and that made me think that nothing could be done*
- *I was put in a secure unit because I kept going missing – I thought I was being punished. They did nothing to the men that made me go missing*
- *They should have done something to the men, not me*
- *Staff would see you get picked up by adult males in cars so they knew what you were doing*
- *[On returning from London] No one spoke to me about the men in London. There were hundreds of them – untouched*
- *I never told anyone what I was going through*
- *Taking me away from my Mum was bad*
- *I said, 'I will get burned alive'. She said come round for a coffee*
- *I made a complaint about a man who trafficked me from a children's home. He was arrested, released and trafficked me again*
- *If someone had taken the trouble to ask me I would have told them*
- *Oxford and another council argued about me to try and avoid doing anything. It wasn't my fault I was abused*
- *The old sergeant was great. He has a cigarette with you, and chatted about anything, He didn't make me feel bad about myself and treated me like a person*
- *The social worker didn't understand the extent or seriousness of what was happening. She didn't understand why I wasn't telling them [about the exploitation]*
- *I turned up at the police station at 2/3am, blood all over me, soaked through my trousers to the crotch. They dismissed it as me being naughty, a nuisance. I was bruised and bloody*
- *Social services washed their hands – 'it's your choice' I was told*
- *A WPC found me drunk with men. I said I was ok and she went away and left me with them. I was abused that night*
- *Ms X at the school – she had no idea what to do. She just listened and didn't say do this, do that. She was a rock…*
- *… She did speak to the police. It meant I was whacked around the head with a crowbar*

- *The staff in the Secure Units were good. They knew how to deal with hard cases. If you told them to f-off 20 times, they would still ask if you were ok and wanted a cup of tea*

There were a number of very negative comments from victims about one children's home, Dell Quay in Henley (closed 2008), suggesting poorly trained and inexperienced staff who set a poor example to the girls.

3.12 **The parents' experience:** The SCR Panel decided to approach only those parents where the victims agreed they could be approached. Four parents of three victims agreed to speak to the Review, so the views below do not necessarily reflect those of all parents, but it would be surprising if there were not some similarities. As will be seen later, a number of parents created strong reactions in professionals who might have a different take on some of what is reproduced below. Regardless of how 'difficult' any parents were (either innately, or as a result of the anxieties of caring for exploited children, or their frustrations with agencies), their experiences of having children who, for example, went missing up to hundreds of time, who seemed so distressed and hurt, and who would often act in a self-defeating way was truly exceptional. Any parent whose 12- to 15-year-old has gone missing even once, or had an inappropriate sexual relationship, or been attacked will recall the chaos and upset this caused and have this emblazoned on their mind for ever. These parents dealt with worrying incidents up to daily for years. They were naturally frustrated that agencies did not provide quick solutions to protection, prevention, or discovery. It shows that there was a long period when no one knew exactly what was happening, but the parents knew 'something' serious was awry.

3.13 The bulleted comments are in no special order, but aim to illustrate the range of views. The quotation below seems to sum up what it was like to be a parent of a child caught up in grooming and CSE.

3.14 *"… we... have a situation where [the daughter] is virtually living on the streets and no service or individual has been able to engage with her at all, most have not even tried. She is absolutely alone in the world apart from me and she refuses to allow me to have any influence on her. I have reached the reluctant conclusion that [her] home here is of absolutely no benefit to her and that the toll that trying to preserve it is taking on my physical and mental health and to a lesser extent the well-being of family and friends and neighbours and the police is all for nothing."* Parental comments included:

- *Police wouldn't pursue anyone unless they had a cast iron case*
- *No one thought about us – what it would be like if it was their daughter*
- *She always said she was with friends but would surface, often in A&E, anywhere – usually in London but also Essex Coventry and Gloucester*
- *She would be dirty, hungry, not in her own clothes, very distressed and clearly coming down off some substance*
- *Police wouldn't tell us addresses so we could go and bring her home*
- *She was a minor but we were told it wasn't our business*
- *We thought she was just a rebellious teenager bunking off to smoke and drink in the park – no one said we need to know where she goes*
- *I tried to tell social services about the evidence – but they weren't interested. It was obvious it was something sexual*
- *All this – it has ripped the family apart*

- *I keep emphasising 'she is a minor'. Why would other vulnerable groups be protected from themselves, but she was allowed to make the wrong choices*
- *A big chunk of her life has been taken away – when she should have been at the youth club or skating or the school prom – all that went missing because of them: the perpetrators and the police/social services for not stopping it when they knew*
- *I put window locks on and kept the key... but in the morning found someone had helped her chisel open the sashes*
- *It's in my mind all the time – what happened to my 'baby' and what I did because I didn't understand what was happening to me They knew what was happening to her and didn't tell me*
- *Every day I deal with it – dread the phone ringing in case it's something bad*
- *Why did they let it go on during the long investigation*
- *No one spoke to us about dealing with the people responsible*
- *The social worker was very abrupt, said it was my duty to look after her. I said I was not capable of dealing with it*
- *There were lots of meetings. I got very angry and said it was a load of bull shit - no one was doing anything*
- *The police said she didn't appear in danger, they said she was happy to be there, and refused to tell me where she was*
- *If I had known I would have fetched her out of [named address] – I didn't learn about it till the trial*
- *The Guardian Ad Litem never spoke to me at all, or discussed with me how to protect her*
- *They threatened to kill me and behead my daughter's baby*
- *She was missing for ten days*
- *Because she came home [from missing] they thought she was safe now*
- *Giving her a cuddle and taking her to MacDonald's was the [worker's] solution*
- *One manager said [before the exploitation was understood] 'She's streetwise, and loves it'*
- *[After a theft was investigated where a girl was with older men] The issue for the police was the burglary, not a 13-year-old with older men*
- *At interagency meetings attended no one kept any records/minutes, and there were never agendas*
- *The Children's Home didn't tell me when she went missing*
- *I despaired of ever getting an appropriate response that stood alongside us and didn't try to blame and shame us*

3.15 One parent submitted a written paper to the Review, extracts from which are included above and below:

- *"I don't blame **Social Services** for not understanding exactly what went on- the street grooming by groups was an 'unknown unknown', but I would criticise them for…*
  - *Only working with one model of abuse – intra-familial*
  - *Having no empathy*
  - *Not adequately acknowledging my concerns*
  - *Appearing to have no interest in what was happening when she was placed out of county, and being indifferent to her being trafficked 250 miles from one care home*
  - *Not having the interest and skills to engage an angry troubled child –all bar one excellent down-to-earth support worker*

- *On the whole **the Police** were the only service who tried to get a grip, or which offered interest empathy but…*
  - *Even the police back then didn't see organised abuse as the main reason the girls went missing*
  - *There was a lack of curiosity*
  - *Too many accepted her explanation of being with friends*
  - *I was asked the same questions each time on the scores of occasions I reported her missing, and they would search the house and gardens each time – a waste of everyone's time. The police were always apologetic and sympathetic*

- ***Health***
  - *Wonderful empathetic support from our GP*
  - *In mental health no one really had the skills to engage her as she didn't have a diagnosable illness and she was too challenging*
  - *They did arrange review conferences using the care programme approach*

- ***Education** Although some individuals tried to support her, education as a whole failed her… the response was to exclude her as soon as at 12 she started exhibiting difficult behaviour and truanting… which meant she had nothing else to do except hang around the square where she was first approached and groomed by predatory men. The lack of education also further reduced her self-esteem, isolated her from peers and… made her extra vulnerable to the blandishments of the child groomers.*

- ***Multi-agency meetings** convened by the mental health trust became good at general information sharing, but the elephant in the room for all of us was the fact she was being groomed and exploited. I think we all knew it but no service had the language, understanding and tools to acknowledge it, yet alone deal with it.*

3.16 The parent also described the impact on the daughter – *"now ultra-fearful and cautious and unable to enjoy age appropriate activities. She suffers nightmares, flashbacks and is depressed. She lost her childhood and education…*" The parent described "*hunting the streets of SE England night after night taking its toll on health"*, and "*having to move to escape ongoing threats…*" The parent set out some recommendations which will be referred to later in the report.

3.17 Two parents provided some feedback on staff work through listing their expectations that were not met. They gave the previous reviewer and the author a number of illustrations of these points. They made huge efforts to find their daughter when missing. "*We expected…*
- *To have our concerns listened to and believed… to be taken seriously*
- *Not to be patronised*
- *To have information about our daughter shared with us*
- *Police and Social Workers to work together... not passing the buck to each other while we got more scared and frustrated about what was happening*
- *To be told what was happening to the intelligence we gave them*
- *To get intervention sooner, especially when it as so painful to have to ask for help (as it meant we had failed to keep her safe)*
- *Social Services to listen to recommendations by other professional bodies making sound assessments- they didn't and our daughter's would go back to old ways*

- *We didn’t expect to have to do all the chasing ourselves*

4 IMPROVEMENTS IN OXFORDSHIRE

4.1 The views from families as seen in Section 3, and the analysis in Sections 5 onwards, show that there were indeed missed opportunities to identify CSE and many areas where services could and should have responded better. It is tragic that families had to go through the experiences they described before services made the improvements that are in place now. Since that time (four to ten years ago) there has been much improvement. This does not mean that everything is likely to be perfect, but that the critique later in the Report of what happened in the past can be read with the knowledge that many lessons have already been learned, and that services for children vulnerable to CSE have been improved considerably.

4.2 This will not be a time when known numbers will reduce. Almost certainly the opposite will be the case due to the joined-up rigour with which CSE is now identified and pursued, However, the chances of it being prevented, disrupted or punished are far higher due to the commitment and skill now being shown.

4.3 In light of the strengthened multi-agency work across Oxfordshire to protect children at risk of sexual exploitation, it is likely that children will now experience a persistence and continuity in the services they receive. Those services will be much more coordinated between agencies with staff who are now well trained about the signs of abuse and understand why the victims behave as they do. Perpetrators will now be actively pursued by all available means, regardless of the degree of victim cooperation. That determination, and the persistence of staff who are trained to 'never give up on a child', will give more confidence to victims to disclose and give evidence, and also provide better support for victims and their families.

4.4 This section only gives headline changes. A more complete account is given in the associated document prepared by the OSCB and its members, 'CSE in Oxfordshire: Agency Responses since 2011', which describes the system-wide and agency progress in greater detail so that more learning is available. The source of the information below is agency reports commissioned for the SCR Panel. The improvements are those reported by the OSCB and its member agencies, and confirmed by SCR Panel members. Personally quality assuring these submissions was beyond the author's remit. Recent external inspections have been positive.

4.5 **OSCB overview**: This account of OSCB action may on the surface sound rather bureaucratic, but as will be seen in following sections, the absence of such a framework and focus on CSE played a part in the delayed recognition of CSE. The following arrangements are now in place and monitored by the OSCB:

- The new (2014) OSCB Chair has assured the Review that compliance against the 2009 CSE guidance was last reviewed satisfactorily in November 2014
- There has been a subgroup of the Board focusing on CSE since 2011. It is currently chaired by a Police Superintendent, with membership from the City District Council, County Council, NHS, Police and voluntary sector
- The subgroup scrutinises and challenges prevalence and missing persons reports, oversees the ongoing development of procedures, and acts as steering group over the multi-agency specialist CSE team 'Kingfisher'. (See 4.8-9 and 4.15-17.)
- Progress in addressing CSE in Oxfordshire was last reported in the 2013-14 OSCB Annual Report (July 2014)

- The Board's Annual Conference in 2012 was themed on CSE (before the Bullfinch convictions) and its 2015 conference is to be focused on older children at risk
- The OSCB has comprehensive procedures on CSE as part of the overall Child Protection procedures which are on its website
- There is a 'Tackling CSE: Professional's Handbook: Never Give Up On a Child' covering all aspects of the understanding and management of CSE, including the CSE Screening Tool "to be used by all professionals working with children and young people aged 10 plus" (or younger if necessary). If the tool identifies a certain degree of risk, then referral to CSC is mandatory
- Since 2011 in excess of 7,500 Oxfordshire staff have received training on CSE, including all front line staff and those working with children. Take-up of training is monitored by the OSCB Training subgroup to ensure good compliance
- There is a very extensive multi-agency OSCB Action Plan covering five main themes:
  - Raising awareness
  - Improving statutory responses and provision of services
  - Improving evidence
  - Improving prosecution procedures
  - Improving disruption
- The new OSCB Chair has introduced a Chief Officer Forum on Safeguarding, and has met regularly with the County Council Full Council, Cabinet and Scrutiny Committee
- In the 2014 Ofsted inspection[4] the OCSB's effectiveness was rated as 'good', which means that the OSCB "*coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services."* The Ofsted summary of why Oxfordshire and the LSCB were rated 'good' is in Appendix 4.

4.6 **Leadership commitment:** The SCR will show how top leaders had little influence on what turned out to be CSE by groups of adult males of Pakistani heritage because, for reasons explored below, early concerns were not escalated to them – a pattern that crossed all agencies. It is fair to say that they were shocked by the discoveries, and since Operation Bullfinch there has been an impressive focus, drive and commitment from the top leaders from all agencies – in terms of personal interest, political engagement and resource commitment. In September 2014 the County, City, Thames Valley Police (TVP) and the OSCB co-hosted a major briefing session for all County and District councillors, and equivalent stakeholders. The author attended, and there was a frank assessment of what did not go well together with a positive account of across-the-board improvements. MPs have also been regularly briefed. Both County and TVP Chief Officers have given a number of national presentations on Oxfordshire's learning, and various national leaders/politicians have been to see local progress. Summaries are given for the County, City and TVP.

4.7 *County Council:* In the County Council (which is the local authority for social services and education), the Cabinet receives regular updates on CSE against national expectations, and the CEO describes CSE as her "*number one personal priority".* The OSCB Annual Report is discussed at full Council, Scrutiny Committee, and Cabinet. Children's Services budgets have

[4] *Oxfordshire County Council: Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the LSCB* (Ofsted, 30.6.14).

increased by 80% in real terms between 2007 and 2014, and an estimated £8m was committed to the Bullfinch investigation and the response to CSE, including additional social workers. For example, in 2013-14, £1.4m enabled the recruitment of 21 child protection social workers. Capital resources have been agreed to build new children's homes in-county to allow vulnerable children to be placed nearer home. After the Bullfinch trial in 2013 there was a cross-party Cabinet Advisory Group to consider arrangements for safeguarding assurance. A Cabinet review considered and accepted, in May 2014, 14 recommendations to strengthen the governance and quality assurance of safeguarding.[5] In 2014, Ofsted rated the local authority's services to children as 'good', *"…leading effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted".*

4.8 On CSE specifically, the Ofsted June 2014 inspection (reporting on partnership work, not just the Council) concluded that *"Work done by the Kingfisher service, a specialist team working with young people who have suffered or are at risk of child sexual exploitation (CSE), is of high quality. It focuses both on reducing risks and meeting wider needs for young people, as well as providing good consideration of the young person's holistic needs. Large numbers of professionals have been effectively trained to identify potential indicators of child sexual exploitation. The consistently high use of a child sexual exploitation screening tool by professionals who are concerned about possible CSE is leading to more young people being helped earlier. The Kingfisher team provides good quality consultation and advice to a wide range of professionals on child sexual exploitation. Excellent awareness-raising activity takes place with young people on a continual cycle and is now taking place with parents and carers."*

4.9 And on missing children that "*Good arrangements are in place to respond when children go missing from home and care. The police undertake a 'safe and well' visit when children return home and provide very prompt reports to the local authority. Social workers visit promptly after each missing episode of a child known to the service. They complete a return interview with the young person to understand the reasons for the missing episode. All missing episodes are effectively recorded and risk assessed, with appropriate plans to reduce the risk of future missing episodes. The authority has effective systems for identifying, monitoring and responding to those children who are missing from education and those who are educated at home. Officers provide support and, where necessary, challenge to ensure the quality of the education provided in this way."*

4.10 The Rotherham reports have highlighted the role of Council leaders. The 2014 Ofsted report said, "*Services for children and families are given a high priority by senior leaders and elected members. The local authority knows its strengths and weaknesses well. Strategic priorities are identified and informed by feedback from children, young people, parents, carers and staff. Leadership is strong and effective and services make a demonstrable difference in improving the life chances of some of the most vulnerable children in Oxfordshire. Elected members have high aspirations for looked after children and young people in Oxfordshire and have prioritised continued investment, for example in additional social worker and team manager posts. They hold senior officers to account for the quality of services."*

[5] *Recommendations of the Cabinet Advisory Group on the Strategic Assurance Framework for safeguarding children and young people* (Oxfordshire County Council, 13 May 2014).

4.11 *The Police:* Since 2011, the Police have had a new structure which enables force-wide briefing and identification of new issues. CSE is a strategic priority in the Police and Crime Commissioners Police and Crime Plan and in the TVP Delivery Plan, and a CSE Oversight Group provides strategic oversight to the more significant investigations and intelligence development operations. There has also been significant investment in line with their commitment to prevent, disrupt and prosecute CSE. The Chief Constable's Management Team approved the recruitment of five dedicated CSE officers and, for the Child Abuse and Investigation Unit, 18 detective constables, three detective sergeants, a detective inspector and a detective chief inspector. A DVD of the Chief Constable speaking with one victim and another's parent about their experiences of CSE and feedback on TVP staff has been incorporated in staff training across the force. In 2014 TVP was rated as follows by HMIC *offending, is good at investigating crime and good at tackling anti-social behaviour; the*:[6] *'In terms of its effectiveness, in general, the force is good at reducing crime and preventing offending, is good at investigating crime and good at tackling anti-social behaviour; the efficiency with which the force carries out its responsibilities is good; and the force is acting to achieve fairness and legitimacy in most of the practices that were examined this year'.*

4.12 The OSCB Annual Report is reported formally to the Police and Crime Commissioner, and TVP's Chief Officer team engage regularly with the OSCB Independent Chair.

4.13 The Superintendent, who is the TVP Area Commander for Oxford, said in February 2015,"If you ask any of my staff their number one priority they would say tackling child sexual exploitation."

4.14 *City Council:* The City (in which most of the CSE occurred) is a District Council and does not manage child safeguarding, but provides a range of services and regulatory functions which support vulnerable children and their families. In 2013, the City CEO commissioned an external review which confirmed its self-assessment that it complied with its safeguarding responsibilities under the Children Act. Four service heads act as designated officers to coordinate the Council's approach to safeguarding, within each service area there are named safeguarding officers. A Director now takes the overall lead, and has recently become a member of the OSCB. Investment has included a significant input to the Youth Ambition and Educational Attainment Programme, which aims to boost the resilience and confidence of young people, and a new safeguarding coordinator. City staff wrote the OSCB CSE training materials. Work is ongoing to clarify the interrelationships between the various community safety partnerships and safeguarding through a new community engagement work stream of the OSCB CSE subgroup.

4.15 **Countywide service improvement:** The SCR shows that coordination of work and the sharing of information around the safety of children (so that a wider picture on CSE might emerge) were not optimal in the years before group CSE was identified in Oxfordshire. There have been two major developments. From September 2014 there has been a Multi-agency Safeguarding Hub (MASH), which ensures that referrals about children are considered from the beginning on a multi-agency basis and that information is shared quickly. The Oxfordshire MASH was planned by a multi-agency steering group, chaired by the Assistant Chief Constable of Thames Valley Police. The MASH is based at Cowley Police Station and includes staff from Children's Social Care, Adult Social Care, Early Intervention, the

[6] 'Police effectiveness, efficiency and legitimacy programme (PEEL) assessment of TVP' (HMIC, 2014).

Emergency Duty Team, Thames Valley Police, and safeguarding experts from Oxford Health, Oxford University Hospitals and the Clinical Commissioning Group (CCG). There will also be input from other agencies on a 'virtual basis' such as South Central Ambulance Service, Youth Offending Service, Fire and Rescue Service, Trading Standards and Probation. The hub is a link between universal services such as schools and GPs, and statutory services such as police and social care. Oxford City is piloting MASH links on behalf of other Districts.

4.16 Specifically on CSE, there is the Kingfisher Team, a TVP, Oxford Health and Oxfordshire County Council joint team set up in November 2012 to tackle CSE. The initiative has already won two national awards for its work – for innovative partnership work to protect children at risk of CSE, and for having "successfully linked with different services and partners in innovative and constructive ways and created forward thinking services for children, young people and families". The Team has developed a CSE Screening Tool, which helps build a picture of concerns around the county. Care plans are designed to support and protect those children identified by Kingfisher as being at risk. The team has a strong focus on achieving successful prosecutions as a key way to safeguard and protect children, and also plans disruption activity.

4.17 The Kingfisher Team and the OSCB also coordinated and supported a theatre production (*Chelsea's Choice*) to raise awareness of CSE, which has been shown in numerous secondary schools across the county. Kingfisher also works closely with parents to raise awareness of the grooming process. The team has a full time CSE health nurse who provides one-to-one support for children who are Kingfisher cases. The nurse has specialist training in recognising signs and symptoms of sexual exploitation, and can fast-track referrals to specialist health services.

4.18 The range of services that were provided by Kingfisher can be illustrated by one teenage girl, who was very much like the girls described in Section 3,

Social Worker – regular visits, befriending, family work, building trust, CSE recognition and safeguarding

Specialist Nurse – general health assessment, sexual health screening, contraception, relationships, self-esteem and building trust

Police – gathering intelligence from all aspects surrounding (the girl). Offering support and guidance throughout the ongoing investigation

- Child Protection Plan in place – regular multi-agency meetings and core groups gathering information
- Good communication within the Kingfisher team, sharing information quickly so that there can be a quick response to concerns
- Escalation of concern – (the girl) requested to be taken into care of local authority. Continues to be at risk of CSE
- Further placement found out of county in a therapeutic residential placement
- Statement submitted by (the girl) to the police describing extensive CSE... Police Operation ongoing
- Work continues with same social worker, nurse and police officers

4.19 This shows a level of expertise and coordination that was not present before Bullfinch, and strong multi-agency commitment. Around 255 children have been referred to Kingfisher since it began in late 2012.

4.20 **Investigation, disruption and prosecution:** Among the problems before the Bullfinch case, and the expertise gained through it, were insufficient disruption activity, insufficient focus on potential abusers, and difficulties in getting to prosecution given the evidential difficulties these cases threw up. The Bullfinch operation itself was a major exercise with the Police and CSC working together on intelligence gathering and to support the victims through the most challenging process of agreeing to give evidence and them maintaining that commitment through court. The Police used innovative covert investigative tactics. Seven men were found guilty and imprisoned for 60 offences. There were three further, related convictions in June 2014. In February 2015, a man was convicted of five offences related to sexual exploitation of two girls. Further trials are imminent.

4.21 In the autumn of 2014 the Chief Constable reported 16 live CSE operations across the TVP area, with 35 arrested as a result of current operations and a total of 78 charges made. For example, in June 2014, seven men were arrested with 25 charges against girls of 13-16 in Banbury. It took over 12 months of intensive work by Kingfisher with a number of girls to get to the point where they felt sufficiently safe and trusting to make disclosures. This included two seeking reception into Local Authority care as they did not feel safe disclosing from home. In September, eight men were charged for offences linked to CSE in Aylesbury.

4.22 There is also a wide use of disruption process such as Abduction Notices and work with other regulatory bodies such as District Councils on matters such as housing, nuisance, licensing of premises and taxis to provide concerted action to disrupt.

4.23 There is now updated guidance on prosecuting cases,[7] which used some of the Bullfinch learning. This introduces a range of approaches which make it more possible to use the sort of evidence that girls subject to grooming may be able to give, and make it easier for such evidence to be given. For example, changing evidence or matters which might be seen to undermine a girl's credibility are now put forward as possible confirmation of exploitation.

4.24 The collective approach to prosecution and protection can be seen in one recent exploitation case where a long jail term was given. The victims were looked after children (LAC)**.** Carers concerned about one girl followed her and immediately called the Police when an adult male was involved. The man was arrested immediately and served with an Abduction Warning Notice. The victim soon disclosed a range of abuse and other victims identified.

4.25 **Community relations:** With the known perpetrators of group CSE being significantly of Pakistani heritage, there is considerable work to build relationships with these communities (and others), increase their understanding of CSE and help build a preventative approach. Some examples:

- The Children's Society runs 12-week induction programmes for young unaccompanied asylum seekers, on which CSC and the Police provide input on CSE and age of consent issues

[7] *Guidance on Prosecuting Case of Child Sexual Abuse* (Crown Prosecution Service, 2013).

- The City Council is appointing a Pakistani Father Support project worker, and has developed a new mentoring programme to prevent CSE amongst at risk BME/South Asian males
- The Superintendent in charge of the Oxford Police (who also chairs the OSCB CSE subgroup) meets Mosque leaders every two months, with for example discussions on CSE warning signs. In 2015 it is planned to extend this to include the City and County Councils
- The Superintendent also has a bi-monthly Independent Advisory Group which includes all faiths. CSE is always on the agenda, and the Group is briefed for example on disruption operations
- Police officers attend the Mosque Friday Prayers weekly
- The OSCB's revised CSE Strategy will have a major new section on community engagement
- The Local Authority Designated Officer (LADO) has led work with the Oxfordshire Mosques and their linked Madrassas on safeguarding children and has worked to ensure safeguarding arrangements are in place including DBS checks, basic training and a safeguarding policy
- Seven faith leaders attended a top-level briefing on CSE progress in September 2014
- In October 2014, Muslim representatives attended a CSC/TVP meeting, discussing trafficking and CSE with other religious leaders
- A meeting was held in February 2015 between Police, City and County representatives and the OSCB Chair with Muslim community leaders

4.26 **Involved agency progress:** Full details on progress can be found in the associated 'CSE in Oxfordshire: Agency Responses since 2011' but brief extracts are given here to show developments in agencies (on top of the progress described above).

4.27 ***Oxford City Council***

- All staff audited for safeguarding training needs
- Internal safeguarding expectations now explicit
- The Community Safety Team (with Public Health funding support) has commissioned a range of CSE-related activities in Oxfordshire including:
  - A human trafficking conference for front line professionals and members of the BME community
  - A scoping exercise on 'at risk' communities
  - A CSE awareness conference for hotels and B&Bs
  - Revision of guidance for new taxi drivers to include trafficking
- Joint operations targeting premises involved in CSE
- Landlords used to place vulnerable persons subject to fit and proper persons tests and intelligence sharing with TVP
- The City Council's taxi licencing policies on 'warnings, offences, cautions and convictions', and its application pack for licencing are published by the National Working Group on CSE as exemplars, as is their training materials. The City has a website on 'Taxi and Private Hire – Safeguarding children and vulnerable people'
- There is an information-sharing arrangement with Oxfordshire County Council's School and Social Care Transport team who will provide details to us of any concerns they have regarding a driver licensed by Oxford City Council

4.28 ***Oxfordshire County Council:***

Adult Social Care

- Joining the MASH from April 2015
- Reinforcement of escalation procedures for CSE identified by staff working with adults
- Focus on work with parents with disabilities and young carers (issues in this review)
- Adult Social Care now represented on the Community Safety Partnerships

Children's Social Care

- Commitment to funding the ten staff in Kingfisher
- Use of Troubled Families funding to support, with the voluntary sector, work with parents of children at risk of CSE
- Jointly funding a new Kingfisher post to engage South Asian communities' girls and women
- Joint work with Police and NHS on coordinating responses to girls with serious injuries
- Taking part in a national trafficking pilot about identifying and supporting CSE victims
- Monthly extended team meetings now operating across the county, led by Kingfisher and involving a wide range of partners including schools and the voluntary sector. These are proving effective in implementing the CSE Screening Tool in the early identification of children at risk and enable targeting of new 'hot spot' areas
- Independent Reviewing Officers and Independent Chairs of Child Protection conferences have worked through a programme of quality assurance audits, observations of chairing practice and team development focused on improving the quality of children's Care and Protection Plans and raising the standard of their scrutiny role. Challenges made by independent Reviewing Officers/Independent Chairs to social workers are recorded on children's files and entered on a tracking system that ensures challenges have impact on social work practice
- CSC used its IMR's critical analysis to run challenging practice development sessions with 360-plus staff and managers

Education and Early Intervention Service (EIS)

- EIS organises or conducts return from missing interviews for children not open cases
- Safeguarding on the agenda of the termly Heads/Chair of Governors meetings with the Director of Children's Services, eg dynamics of grooming, impact of absence
- Bespoke training for 250-plus staff in schools and FE colleges
- All state school year 8 and 9 shown the play *Chelsea's Choice*, a powerful drama about grooming, and year 10s will be shown *Somebody's Sister, Somebody's Daughter*
- Senior EIS managers are involved with the OSCB, and its CSE and Quality Assurance/Audit groups, the Missing Persons Panel, and three staff are seconded to Kingfisher
- Centralised easy access list of children missing from education
- Transfer of records, including safeguarding concerns, between schools to be audited
- Greater information sharing about exclusions from school
- Directory of alternative quality provision completed

Youth Offending Service

- All staff have received CSE training
- CSE Screening Tool core part of YOS assessment files
- Safeguarding a standard item for all team meetings
- Any significant risks for a child are escalated to the Chair of the YOS Management Board

Legal Services

- Improved process for monitoring the completion of actions following decisions
- Legal advisers more aware of the wider powers, beyond the Children Act, that can be used to protect children

Public Health

- School health nurse provision enhanced to be available for all secondary schools
- CSE expectation of providers more explicit, including school nurse joint work with CAMHS and sexual health services
- New drug and alcohol education programmes for year 8/9 in all secondary schools
- Permanent drug and alcohol worker seconded to MASH
- Safeguarding audit of adult case files on parental drug/alcohol use, with findings fed back to the OSCB to improve joint planning of services

4.29 ***NHS:***

Clinical Commissioning Group/NHS England

- Providers are now contractually required to use the CSE Screening Tool, provide CSE training and have agreed referral pathways. This is monitored through contract meetings for relevant services
- Providers are required to have clear internal escalation processes that link to OSCB escalation procedures.
- A specialist practitioner has been commissioned for Kingfisher to enable health assessments and referrals to be made in a timely way. This service is provided by Oxford Health
- The Designated Nurse and Doctor delivered CSE training to all GP localities as soon as the learning emerged of the extent of CSE in Oxfordshire. This is being sustained through a rolling training programme. As a result, GPs are increasingly requesting support and advice on CSE from the CCG Safeguarding team
- A review of healthcare provision in the LAC (looked after children) system has been undertaken. The intention is to identify where improvements can be made

Oxford University Hospitals NHS Trust

- CSE is included in all child safeguarding delivered to Trust staff. Targeted Level 3 CSE training has been provided for genito-urinary medicine (GUM), paediatrics, emergency department, psychology, obstetrics and midwifery. As a result of training, the Safeguarding team is now receiving regular enquiries from a wide variety of professionals for advice on possible cases of CSE
- Teenage pregnancy pathways have been updated to include the CSE Screening Tool.
- Sexual health services have a new pro-forma for assessment of CSE and use the CSE toolkit. They have weekly multidisciplinary team meetings to review notes of all under 16s seen, and flag records of potentially vulnerable young people. They have regular meetings with the specialist nurse from the Kingfisher team and where relevant share information with her, the OUH Safeguarding team, school health nurses and make referrals to the MASH

- Professionals are better at considering CSE as a possibility in young people who are admitted with self-harm and/or challenging behaviour. Where there are concerns, an MDT meeting is held before the young person is discharged
- The criteria for referring concerns to CSC have been reinforced, and professionals have been made aware of how to escalate concerns

Oxford Health NHS Foundation Trust

- The Trust provides the specialist Kingfisher nurse. The nurse undertakes health assessments and facilitates information sharing across health providers to ensure that health needs are met and attends the Missing Children's Panel
- Since 2010 the Trust has provided a specialist nurse for looked after children who works with children in residential settings and harder to reach young people, and will attend LAC reviews
- All Looked After Children have full access to CAMHS, including access to 24/7 outreach service for crisis support. The CAMHs service is now routinely considering Dialectical Behavioural Theory (DBT) for children who are looked after and who are open to the Kingfisher team
- Looked After Children's Initial Health Assessments are now completed by dedicated doctors. This results in an improved assessment which is informed by social care histories and the GP records, leading to better healthcare plans
- All young people under 16 (or older if at risk) accessing contraceptive or sexual health advice from the school nursing service have a risk assessment for sexual abuse/exploitation
- CSE is embedded in the Trust safeguarding training. Health visitors, school health nurses, college nurses, CAMHS and inpatient adolescent mental health unit have been trained in the use of the CSE Screening Tool
- New Trust escalation guidance is in place and compliance is audited

4.30 ***Thames Valley Police (TVP):***

- TVP has six dedicated CSE officers in the Kingfisher Team (based at Cowley Police station), including the Detective Inspector, who leads the team, and a Missing Persons Coordinator
- One office of the Major Crime Unit is dedicated to ongoing CSE investigations in Oxfordshire with 24 police officers, including a Detective Chief Inspector lead and five Police staff
- Each of the remaining three Major Crime Offices is conducting CSE investigations across the Force with officers and staff seconded to these investigations
- The Force has ensured clarity around the ownership of CSE investigations through allocation to the Child Abuse Investigation Unit (CAIU), Crime Investigation Department (CID) or Major Crime teams based on complexity
- All front line officers and staff, including constables, PCSOs and sergeants, have been attending bespoke CSE training since 2013, and control room staff are now trained in recognition of CSE signs; all officers have a CSE 'aide memoire'
- Bespoke guidance, 'Be confident in your powers to protect children – you may be the last chance that child has', about powers of entry and reasonable force, has been developed

- Bespoke missing persons (CSE) training for all inspectors, detective inspectors and chief inspectors since 2013, and all staff have also completed the College of Policing e-learning package, which further reinforces the link between missing children and CSE
- All officers had a laminated card with guidance on 'safe and well' checks for missing persons
- Full array of disruption tools used including, for example, Abduction Warning Notices
- Covert investigation guidance as a core tool in building cases against perpetrators (adopted as national good practice)
- Numerous actions to improve the recording and management of crime
- Four flags have been added to the Police National Computer System to ensure alerts on potential victims of CSE, repeat missing persons, the presence of Child Abduction Warning Notices (and the associated children)

4.31 ***The Children and Family Court Advisory and Support Service (Cafcass):***

- Managerial oversight within Cafcass was assessed by Ofsted as 'good' in 2014
- Cafcass now has a CSE strategy
- In response to the SCR Cafcass has significantly increased training on CSE, including for self-employed assessors who are contracted in
- Cafcass will be able to collate information about cases from its national caseload with connections to CSE from March 2015

4.32 ***Crown Prosecution Service:***

- A dedicated CSE specialist lawyer within the Complex Casework Unit, who is part of a national network of specialists
- A dedicated Rape and Serious Sexual Offences (RASSO) team of lawyers and paralegals has been established working across the area, handling early investigative advice to the Police, decisions on charging and prosecutions of rape, serious sexual offences and child abuse
- New guidance on the handling of child sexual abuse cases was issued to all lawyers in 2013
- A real focus on the credibility of the allegation rather than that of the victim

4.33 ***Donnington Doorstep:*** (voluntary organisation)

- Supervision arrangements for staff have been substantially improved
- Recording systems have been improved
- Runs (since 2011) the Step Out project providing casework support for girls and young women at risk of CSE; a staff member is part of the Missing Persons Panel
- Funding from local agencies has extended casework from the City to the County, to include boys and parents
- Donnington Doorstep's Board regularly monitors its work with CSE

4.34 **The views of girls currently at risk:** Some girls working with the Kingfisher team helped make a DVD which was shared in September 2014 at a major event hosted by the County and TVP with County councillors, City councillors, Oxfordshire MPs, Oxfordshire CCG, Oxford Health, Oxford University Hospitals Trust, the Deputy Police and Crime Commissioner, nine Chairs of Neighbourhood Action Groups, seven local religious leaders including from three mosques, eight Chairs of Independent Advisory Groups, three head teachers of local schools, and members of the OSCB. Some extracts are given.

4.35 On proactivity and support: "*Someone was involved with CSE and she mentioned my name to them. So Kingfisher came and found me, they came and spoke to me and asked me some questions about certain people."*

On building trust to get special help, three views: *"I started talking to my social worker more, started having 1-1 time with her and then I went on the Kingfisher team"* … "*'I got put in foster care and I quickly got close to my foster carer. Then I got closer to my social worker and I started telling her more on a 1-1 sort of thing" … "I feel like they [Kingfisher] are my family and they like me for me. I just get on with everyone, it's a nice environment and everyone is nice and stuff."*

On the skill needed to engage potential victims: "*I got told it [the Kingfisher team] was for girls who were being exploited. I didn't think I was being exploited. I thought I was in trouble for things I hadn't done or anything and then the more they talked about things the more I realised I was in a wrong situation. The more they talked about it [exploitation] happening to other people the more I wanted to let them know that things were actually happening to me."*

On advice for social workers: *"Just wait. Different people trust people quickly and others take long to trust people. Just wait until they get used to you. You shouldn't just assume stuff."*
And from another girl:
"This woman [a social worker] came to my house and talked to me for about ten minutes and asked lots of questions, then they talked to my parents a lot. The social worker came to see me at school. She kept asking me questions and trying to talk to me but at first I didn't talk back. It was like she was talking to a brick wall at first. It was very hard because I wouldn't give out any information about my friends." The girl went on to say, *"It was nice to have the company of the social worker, to have someone come and see me, to talk to me and be interested in what I was doing on a daily basis."*

On the balance between caring and controlling: *"I just felt she [the social worker] was really there for me, as if she was a friend. It was like having a mum, a mum who cared… but someone who would leave you alone at the same time, someone that wasn't in your face but was there."* (See 5.114 on Professionalism.)

4.36 And Kingfisher social workers also noted these comments about a departing Police case investigator and a PC attached to the team, showing the contrast from victims in the past"

A girl: *"I'm sorry he is going, he is really good and I liked speaking to him… he is really approachable and easy to talk to."*

And a social worker said : *"He took one of the statements from [a name] and she really liked him and felt comfortable with him, she was happy to see him as he made her feel safe... all the girls liked him and they remembered him."*

On the PC: *"[She] made me feel really comfortable during the trial."*

4.37 The remainder of this Review will show that it was not always like this across the County, and that opportunities to identify and act on exploitation were missed, although Oxfordshire was not alone. The progress described above has come from a willingness in organisations working with children to learn and change – which should be acknowledged.

4.38 **Moving on – an apology:** One of the children, now an adult, takes part in regular training for a range of Police staff on CSE. She told the Review that after one session an officer approached her and said, “I feel I need to apologise to you for all the girls I treated wrongly.” This was hugely appreciated by the victim concerned.

5 WHY THE DELAYED IDENTIFICATION AND ACTION ON CSE?

5.1 **Introduction:** The identification of CSE and robust action to intervene was delayed in the sense that it was going on for some years before it was truly recognised, and before concerted action was taken. This section looks in the context of the time at what will seem, in hindsight, to be glaringly missed opportunities, and offers some explanation. It also identifies underlying issues of practice that did not relate specifically to CSE, but which hampered progress. The explanations that follow do not excuse the inexcusable, but describe the complexities of work in this area. The section does not go into all the detail (which would take hundreds of pages), but describes the general reasons for the late response. This section is for describing 'why', rather than giving judgement. It describes the period before the very successful investigation that was Operation Bullfinch and the improvements described earlier in Section 4.

5.2 The explorations of 'why' given below do not imply that this Review finds what is described as acceptable. Section 8 gives an appraisal of the work. The points discussed are often not discrete and feed off, or into, other points. Most of what is described below has been addressed by agencies.

5.3 To prevent this report becoming unreadably long, the causes of the delays are rarely specifically dated, and some will have varied in strength or even presence over the pre-Bullfinch period. This SCR is not saying it was like this everywhere all the time, but is describing the 'sorts of things' that conspired to create the delays in action. It also needs to be said that most of what is described occurred before there was a real national understanding of 'group-related CSE' as we now understand it.

5.4 **Why the delays**: What follows are summaries of the main findings from the agency Individual Management Reviews (IMRs) which, in the opinion of the author, have described performance in very honest detail. The Police and CSC IMRs (which, for example, are 1,000 pages between them) describe and explain what happened frankly in a way that has allowed the SCR Panel and author to draw conclusions, and they do not shy from drawing robust conclusions of their own. The issues described may be focused on one agency more than another, but in most cases are not described under an agency heading as there is so much overlap.

5.5 In the most simplified of summaries, a combination of not grasping the extent of exploitation, the focus on the girls and their families as the source of the problems, the corresponding lack of focus on perpetrators, and a host of administrative and management issues all worked together to lead to CSE being identified later than it might have been.

5.6 ***Knowledge:*** Although there was an increasing literature from the 1990s about what we might know now as CSE, and patterns of abuse through control, the phrase 'child sexual exploitation' did not appear in the core national guidance of safeguarding management 'Working Together to Safeguard Children' 2006 (HM Govt). However, it did say: *"The identification of a child involved in prostitution, or at risk of being drawn into prostitution, should always trigger the agreed local procedures to ensure the child's safety and welfare, and to enable the police to gather evidence about abusers and coercers. The strong links that have been identified between prostitution, running away from home, human trafficking and substance misuse should be borne in mind in the development of protocols."* But the language was mainly about prostitution. The government did produce, in 2009, supplementary guidance to *Working*

Together called *Safeguarding Children and Young People from Sexual Exploitation*,[8] which set out the framework for what is now understood to be a more modern approach to concerted action. Several national reports have shown that this guidance did not catch on uniformly across the country.

5.7 The House of Commons Home Affairs Committee report, 'CSE and the response to localised grooming' (June 2013), said that *"The failure of these cases has been both systemic and cultural. Rules and guidelines existed which were not followed. People employed as public servants appeared to lack human compassion when dealing with victims. Children have only one chance at childhood. For too long, victims of child sexual exploitation have been deprived of that childhood without society challenging their abusers. Such a situation must never happen again."* (This was, of course, written after Operation Bullfinch had indeed 'challenged the abusers' and gained numerous convictions, which was only possible because of highly skilled, determined and rigorous local work.) The key to understanding 'why' therefore rests in an earlier period, which in Oxfordshire would be around 2005-10, when there were indeed indications of children suffering, but limited understanding and little intervention that could have inhibited the abuse.

5.8 It cannot be denied that there was much existing guidance (and there were some reports about the growing awareness of exploitation) but that is not the same as front line staff or even their immediate managers knowing it, absorbing it, understanding it, or feeling confidant to use it – especially when it cuts across traditional ways of interpreting or doing things. As one parent said, *"no service had the language, understanding and tools to acknowledge it, yet alone deal with it".*

5.9 The overall problem was not grasping the nature of the abuse – the grooming, the 'pull' from home, the erosion of consent, the inability to escape and the sheer horror of what the girls were going through – but of seeing it as something done more voluntarily. Something that the girls *did* as opposed to something *done to them*.

5.10 This lack of knowledge crossed all organisations and professions. The Education IMR put it well*. "It was clear to… through conversations with a range of professionals for this review, including a focus group with head-teachers and designated school safeguarding leads, that there was little understanding of child sexual exploitation and any indicators to suggest that any of the girls might be subject to or at risk of it, at the time. Certainly there was significant anxiety about their safety and well-being, but this tended to be focused on their home situation, the domestic violence they were living with and the lifestyles of their parents. The girls were labelled as promiscuous, at risk of prostitution, out of control and certainly not viewed as victims of CSE."*

5.11 The lack of knowledge also, for example, affected the therapeutic care given to the girls as risks were not identified, clues not picked up, and the presenting issue was the focus. "*Primary care* [and a listed range of sexual health and pregnancy services] *failed to recognise that these girls were at 'high on-going risk' and failed to protect them from pregnancy and sexually transmitted diseases (STDs) and failed to work together to safeguard them."*

[8] *Children and Young People from Sexual Exploitation: Supplementary Guidance to Working Together* (HM Govt, 2009).

5.12 One social worker, who played an important role in identifying the CSE in the lead up to Operation Bullfinch said in 2014, "*Even now I still can hardly believe that adult males would do what they did to children – too awful to believe it could happen in the city I live in."*

5.13 ***Language:*** The language used demonstrated the lack of full understanding of CSE at the time. It described the girls getting themselves '*into trouble'*. Other examples quoted by the Police as from the Missing Persons database (two of which were recording referrals from a parent) included

"[The missing person] is believed to be prostituting herself… to pay for drugs', '*putting themselves at risk"*

"She is a streetwise girl who is wilful…"

"She associates with adults who have warnings for firearms and drugs. It is possible she is prostituting herself"

"... Deliberately puts herself as risk as she goes off with older men that are strangers"

5.14 In some senses, parts of these examples were literally true. There was seldom from the victims an overt sense of helping agencies to affect change, but the language had a consequence which delayed the protection which the girls covertly wanted, and the parents very clearly wanted. This was because the words were judgemental and focused on the victim and their contribution, and deflected from the more proper perpetrator focus.

5.15 As the CSC Review says, *"This labelling followed the child and became a barrier to understanding their situation."* This Review does not believe that this indicated a general callous disregard of the needs of young teenagers, more that this was the longstanding way for describing children of that age who led a wild, risky life of premature sex and early excesses of drink and drugs. The problem was that the prevailing understanding of it being wayward youth tended to blind staff to something serious when it happened, and continue to see the victim as the author of their own downfall. Some of the examples quoted in the Police IMR of events that were not investigated make the point powerfully.

5.16 The IMR for the NHS Trust which provides community and mental health services describes how partner agencies reported a girl 'hanging out' with older men, and a social worker described to the school nurse men in their 20s as 'lads'. School health records used the words "*prostituting herself"*. The IMR said, *"The word 'lad' may have influenced practitioners to minimise the potential seriousness of the situation because the term is suggestive of someone who is much younger. The School Health Nurse records also state that there is a concern that (the child) was 'prostituting herself'. This raises a concern that [the child] may have been viewed as active perpetrator of criminal offences such as prostitution and as a challenging young person who creates risk and rather than being seen as a victim of abuse. These views will/may have affected how she was supported by professionals."*

5.17 There were other ways the use of words had a counter-productive impact. In particular, the use of the word 'boyfriend' deflected from the awfulness of what was happening by implying a benign or acceptable relationship. This compounded the girls' use of the word, which, as it usually applied to a much older (sometimes very much older) man, was more a sign of the grooming than fond acquaintance. 'Boyfriend' was used even when referring to a 13- to 15-year-old and males in their late teens, even to their thirties. This is not to say that 'boyfriend' was used to deliberately condone illegal relationships, but that its use did not help and at times hindered. It also conveyed confusion about what was and was not consensual and lawful.

5.18 The use of the word 'prostitution' also had the effect of deflecting from the extreme youth of the victims and the phrase sometimes heard of 'prostituting themselves' deflected attention from their groomers. Referrals to the Police from say social care settings also used language which, in the positive interests of information sharing, compounded the impression that the victim lacked credibility by detailing their difficult behaviour.

5.19 ***Consent and age:*** Related to the language of wilfully participating was the understanding of consent to sexual activity, and the relevance of age. In law, no one under 16 can consent to sexual activity, although, if the child is aged between 13 and 16, no offence is committed if the adult reasonably believed the child to be 16 or over.[9] There is no such defence if the child is under 13. The Police IMR found a number of occasions where 'unlawful sexual activity' offences were brought to Police attention, recorded and subject to initial investigations, adding that *"it was evident [to the IMR] that investigators were repeatedly wrestling with the challenge of age"*, and for example described where, in an allegation of sex with a 13-year-old, the detective said, "*she is a 13 year old girl who could easily be mistaken for being 16 years old".* The Crown Prosecution Service (CPS) reviewed the evidence and decided against a prosecution for sex with a 13-year-old girl, as her appearance, actions and saying she was 16 would, in their view, have meant there was no realistic prospect of conviction.

5.20 A CID sergeant reported that one 14-year-old appeared 18 or 19, and "*by her own admission initiated the sexual intercourse with both named males… and said she told then she was 19".* The victim refused to cooperate with any means of investigation, so a combination of issues relating to cooperation, consent, and age came together to hamper any protective action. The Police review suggested that *"… decisions being made throughout … were often tainted with the perception of these children having consented to the sexual activity. This was evidently an opinion shared amongst professionals that was only reinforced further by the way the children were presenting to them. As can be seen throughout this [IMR] the national awareness of CSE and the impact on the victims ability to consent at this time was, at best, described as 'patchy' and certainly does not appear to have been embedded amongst agencies within Oxfordshire. As such these views… had a significant impact on many of the investigations undertaken during this time.*" One of the victims found with several Asian adult males told the author that the Police did not even ask her age.

5.21 This was not just an issue for Police. CSC concluded that, *"throughout this [IMR], there are recorded instances of young girls having sexual relationships with older males. There appears to have been a tolerance of underage sexual activity and no recognition of factors such as abuse of power and coercion and the fact that this was against the law. At interview most members of staff disputed they tolerated underage sex and they did try to talk to the girls about this but that often the most they felt they could do was to stress that it was inappropriate, to ask the girls why they thought older men would be interested in young girls and to talk about safe sex."* This brief but powerful summary shows the debilitating uncertainty about the ability to take action, and the sense of powerlessness. While there is usually some understanding of sex between underage children and peers a little older, what CSC called 'tolerance' also seemed to apply to relationships with those much older. The CSC IMR was concerned to find in one record on a 13-year-old the phrase, *"an age*

[9] Sexual Offences Act 2003, section 5-15.

appropriate sexual relationship… [which]... evidenced a lack of understanding the law and/or an unsafe acceptance of young teenagers being sexually active".

5.22 The Health Overview points out: *"Skilled questioning is required to establish whether a relationship is consensual, when victims do not see themselves as victims and perceive that they are consenting to a relationship, to explore potential power imbalances. Whilst Contraception and Sexual Health (CASH) clinics established that these young people were able to give consent to sexual activity it was not specifically considered within an exploitative relationship. The Genito-urinary Medicine (GUM) service did explore potential power imbalances but from the answers given did not detect potential vulnerabilities or exploitation at the time, although in retrospect and with current knowledge can see that in some cases indicators were present."*

5.23 The IMRs which contributed to this SCR very openly describe illustrations or suggestions of terrible abuse to children, where reading them generates the immediate question of "why wasn't something done?" The author's conclusion is that there was, beyond any lack of knowledge or clarity, an acceptance of a degree of underage sexual activity that reflects a wider societal reluctance to consider something 'wrong'. This involves ascribing to young teenagers a degree of self-determining choice which should be respected. This is not altogether surprising when in Health (looked at more below) the national guidance involves an assessment of the child's ability to give true consent to receiving contraceptive advice or treatment without the involvement of parents. In a nutshell, a child may be judged mature enough to get contraceptives to have sex with an adult at an age when they are deemed in law unable to give consent to the sex itself. It is no wonder there was confusion and a lack of confidence in taking action.

5.24 What all this was not grasping was that the ability to consent had been eroded. The CPS's submission on consent in the Bullfinch trial pointed out that, regardless of perceived or stated age, there was no exercise in free choice.[10] It described the orchestrated 'incremental steps' by which any wish of the girls was squashed by the men through a progression of gifts and attention, getting physical for sex, pestering, threats, orders and "*doing by force despite protestation – despite physically being incapable through drink, drugs, or despite an unwilling body and fatigued beyond endurance"*. The Crown argued that the lack of true consent was clear, or why would the groups escalate their tactics to ever more controlling, threatening methods?

5.25 The judgemental language about the girls/families, the confusion over consent and age and the lack of knowledge led to a lack of focus on what was being done *to* the girls, and to the lack of the mental leap to focus instead on the perpetrators. The more determinedly self-assertive, disruptive or extreme the child's behaviour, the more self-determination they were assumed to have. In fact, the opposite was true.

5.26 ***The nature of the families*****:** This is a very hard section to write without risking being misleading or unfair. It describes the nature of the families with which numerous professionals from numerous agencies worked. It runs the risk of being seen as deflecting blame from professional weaknesses, but this is not the intention. The reason is that if the statutory

[10] Section 74 of the Sexual Offences Act 2003 defines consent in the following terms: *"For the purposes of this Part, a person consents if he agrees by choice, and has the freedom and capacity to make that choice".*

requirement of SCRs is to understand 'why', it is important to describe what professionals saw in front of them, and whether it was understood properly or not. Describing this is *not* blaming the victims or their families. Indeed, this report is critical of how parents were sometimes treated. It is important to put professional work in context where its quality is being reviewed if learning is to be obtained. It is also important in terms of allocating professional effort to be clear that most victims will be those with most vulnerability.

5.27 Managing the cases concerned was not at all easy. Most (but not all) of the children and parents concerned did have a predisposition to difficulties or challenges in childcare and growing up. This does not mean that family members were responsible for the CSE; they were not. The perpetrators (or at least a number of them) who *were* responsible are in jail. It does mean that the children were vulnerable to grooming, and that many parents (just like many professionals) did not have the knowledge and understanding, skills or strength to intervene and protect. Some families had had involvement with the statutory agencies for many years before CSE happened. The Review summarises some of this below – but only in broad terms in order to protect victims and their families from unintended identification.

5.28 The offences against the children were not of a lesser magnitude because they may have been 'troublesome' and/or may have experienced abuse before. In some senses it makes it worse as it added, in a most horrible way, to any experiences they may have already been through.

5.29 Most of the victims had experienced parental domestic violence at home or in their birth families. Police attended one family for domestic abuse 74 times in one two-year period. There was considerable experience of family instability. Two children were removed from their homes for their own protection long before the CSE. One of these had experienced three different LAC placements and a broken-down adoption placement in another part of the country before the age of ten.

5.30 CSC says that there is information suggesting that three of the victims had experience of sexual abuse in their families of origin. One was sexually abused when looked after (not related to Oxfordshire). One parent was an "offender who has been identified as posing a risk, or potential risk, to children",[11] and three children were exposed to such offenders in their home environment. For a number of the six there was wide experience of drug/and or alcohol problems in their birth or subsequent families, and drug/alcohol services had dealings with three of the families. One parent died of drug-related illnesses. Two had parents with criminal records, and in one of those families the parents had nearly 150 convictions. Statutory agencies had been involved with several of the families for the whole life of the girls concerned. Parental ill health or disability was prominent in two families, and in one the child was regarded as carer from a young age.

5.31 The CSC Individual Management Review (IMR) summarised: *"… girls experienced home lives which contributed to their vulnerability to abuse [and] sexual exploitation. With the… exception of [one girl] the girls experienced varying levels of neglect linked to their parents' own issues taking precedence over the needs of the child. These are 'Push Factors' which contribute to*

[11] Formerly known as 'schedule 1 offenders' under Schedule 1 to the Children and Young Persons Act 1933 (CYPA), which lists a wide range of offences against children and young persons under the age of 18, from murder to cruelty or neglect, and offences resulting in bodily injury to the victim.

pushing the child away from where they should be safe and protected from harm." It also made them very vulnerable to the 'pull' of grooming and their inability to escape once groomed. *"It is likely that their low self-esteem and experience of domestic abuse, parental drugs and alcohol use and physical and sexual abuse will have desensitised the girls to the grooming and CSE model making them very vulnerable victims…*"

5.32 There were, in addition to the above, challenges created or partially by the CSE itself. The six girls were reported missing between one and 193 times in their early teenage years. Five of the six girls had from one to 18 periods of being Looked After including spells in secure units for their own protection. The majority of 'missing' reports for the girls who had spells in care were while the children were accommodated in care.

5.33 The majority of the girls were investigated for offences ranging from acquisitive crime, drugs offences to damage and violence – including some against parents. Four were known to the YOS. These offences should be seen in the context of what they were required to do by the perpetrators, the chaotic and violent environment in which the exploitation took place, and reacting to those wanting to stop their behaviour before they themselves were able or ready to.

5.34 As an example of the crossover between underlying vulnerability and signs of the exploitation, CSC reported that*, "The six girls lived within a culture of acceptance of very early sexual activity and in some of the cases this was accepted and condoned by their parents and in others it was tolerated… The girls were attending sexual health clinics for tests and treatment and were being prescribed contraception from an early age, in most cases with their parent's knowledge."*

5.35 There was also health involvement through mental health services for four of the children. And of course the girls were in education. This extract from the Education submission to this Review shows both the challenges, but also the lost opportunities to take advantage of innate ability. *"From the educational settings' point of view… the persistent disruptive behaviour of the girls and the challenges that they posed were not easy for any setting to manage and, at times, they were at a loss to know what to do. These were girls that staff told the [IMR] author they had remembered for years, they stuck in their minds and had a significant impact on them. They were also girls that, even with all the challenges they posed, had academic ability. Staff spoke with affection about them and it should be noted that some tried really hard to support them when at school, and now feel a huge sadness at now knowing more about the reality of what was actually happening to them at the time."*

5.36 The scale of professional involvement with the families, going back many years was vast. The chronologies from agencies of their involvement provided for the Review amount to 3,900 pages. The Police had 1,561 recorded contacts with the girls during the Review period. The sheer scale of agency involvement in itself demonstrates the complexity of the task of inter-agency collaboration, and that if it were easy and obvious to identify CSE or effect change at the time, given the cumulated brainpower being applied, it would have been done earlier.

5.37 This section is not emphasising the difficulties emanating from the nature of those who needed help to deflect attention from agency performance, nor is it suggesting anything unique about A-F. The challenge remains the same now even for those with real expertise. At a conference in 2014 attended by the author, the Kingfisher team of CSE experts (with the most up-to-date knowledge of CSE and how to approach it) said of today's potential victims: *"They are the*

most difficult children to deal with", and illustrated with a case example: *"Poor school attendance, behavioural concerns dysfunctional family relationships… difficult to engage, missing episodes, attendance at sexual health clinics and third party information regarding X being seen at parties and parks with older males."* This statement was not blaming the children but simply describing the reality of trying to help exploited children, which is incredibly difficult.

5.38 ***Levels of cooperation*:** The victims were not able to cooperate with the authorities for three main reasons. Firstly, for a while, they felt they were getting something of what they wanted from the perpetrators. Secondly, they were groomed into a misplaced sense of loyalty to their abusers. Thirdly, they were trapped by fear of punishment by the perpetrators, and by the cycle of having to repay, through sex, the cost of drink, drugs and so on into which they had been skilfully led.

5.39 A senior Police officer in Operation Bullfinch said that *"The girls were 'the most difficult victims [that officer] had ever had to deal with… as a direct result of their grooming/conditioning. They were isolated so much by their abusers they trusted no one except them – so 'helping' agencies or any adult were not to be trusted or cooperated with."* An illustration was given which illustrated the hold over the victims by the perpetrators. The officer described how one girl was punished by being taken to a wood and humiliated and raped in different ways by seven men. Left alone, hurt, crying, naked and covered with semen, the person she called for help was not the parents, social worker, police or ambulance but one of the abusers who had just raped her.

5.40 The case illustrations from IMRs are full of examples of the victims, we know now because of the grooming, refusing to be interviewed or make statements, refusing to identify perpetrators, demanding that no action be taken on their behalf, and sometimes criticising any action that was taken. They did from time to time make specific allegations, and were often found in a condition when it was obvious 'something' had happened. But whilst it is the case that police investigations were not adequate by current methods, it is also the case that victims seldom assisted seeing anything through because of what we now know was fear, intimidation or misguided loyalty to the abusers.

5.41 This was compounded by the experience of one child who was prepared to give evidence in a 2006 trial but who withdrew from the case (leading to its collapse) in the face of what was to her a brutal and humiliating defence cross-examination. Also, by the victims' sense that the police were powerless to control/contain the perpetrators thus making it very risky to reveal anything in case it led to their ordeal at the hands of the offenders getting worse. While the reasons for no action against the perpetrators were extremely complex, understanding that would not have prevented the victims feeling exceedingly vulnerable.

5.42 As seen in Section 3, the parents went through the most worrying of times, could be exasperated with the inability to tackle their children's vulnerability, and felt that professionals showed insufficient tenacity or concern. But to some agencies, some parents were seen as uncooperative, collusive and even obstructive. CSC, which worked with the families on child protection processes, care proceedings, investigations and so on, reported to the Review that one parent was aggressive and difficult with the social worker, another was convicted for threatening a worker, another 'manhandled' the social worker, another was 'verbally aggressive and abusive'. Five of the six parents, CSC said, did not at times report their

children missing. There was evidence of some of the girls having sex with adult males in their family homes, seemingly with parental knowledge.

5.43 Some of the parental hostility to social work staff may have reflected the extreme frustration with 'inaction', or feeling overwhelmed by the challenges posed by their children. Some lack of cooperation by, for example, removing children against advice from children's homes may indeed have reflected their deep ambivalence about the need for care or, as the CSC IMR acknowledges, the lack of safety that care provided.

5.44 But whatever its cause, the antagonism to professionals added to the complexity of managing these cases. But, to repeat, it was not the families who committed the CSE.

5.45 The author consulted the girls he interviewed about his intention to describe their background and the four he met were all in agreement. They were all very open about how difficult anyone would have found them at that time.

5.46 ***Crime/No crime and evidence:*** Whereas now good practice is followed and perpetrators are investigated through a variety of means, regardless of victim cooperation, and CSE is well understood, during the period before the Bullfinch convictions, the Police IMR identified how only a proportion of what was reported became logged officially as a crime. The Police had only 26 recorded offences related to the six girls on the main database of 'crimes', but the Bullfinch inquiry and the IMR identified many more recorded in other ways which, in the Police view now, should have been responded to as 'crimes'. This was for a variety of reasons, which did not seem to be for reasons of deliberate disregard but because of confusing processes and many of the other issues described in this section.

5.47 There is evidence that not recording crimes as crimes, or declassifying an event as no crime inappropriately, is a national issue. Her Majesty's Inspectorate of Constabularies (HMIC)[12] in 2014 reported that its national inspection on crime data found that over 800,000 crimes reported to the police had gone unrecorded each year, *"representing a national average under-recording of 19 percent".* Also, in 20% of the cases studied, where something was reclassified from crime to no crime, that the change was inappropriate. The examples given here of Oxfordshire cases up to a decade ago, whilst regrettable, were almost certainly not unique to the County. (A 2014 review[13] of TVP's crime recording says that "*the force's approach to 'no-criming' is generally acceptable… and found that frontline officers saw the no-crime process as rigorous"*.)

5.48 One example was when a mother reported her daughter being persuaded to deal drugs. The child did not want police to visit in case the men *"f…..g kill me".* Later, the mother said the girl was out armed with a knife for protection dealing drugs in a named place, and later still said that the Police should not miss this chance to get information from the girl. This was not investigated, nor any attempt made to speak to the (unwilling) child. It is unlikely that CSC was told. In another case, at a 'safe and well' check after a child returned from being missing, a PC heard that she had been overnight with older men, drinking all night and taking heroin. The child was described as uncooperative, regarding it all as funny. Nothing

[12] *State of Policing: The Annual Assessment of Policing in England and Wales 2013/2014* (HMIC, 2014).
[13] *Crime Data Integrity: Inspection of Thames Valley Police* (HMIC, 2014).

was investigated and the officer submitted an intelligence report *"in the hope another department who knew more about her could have taken more action".* On another occasion, after another child returned home, the flat where a girl had stayed with an adult was visited, and the man (who denied sex had taken place) was warned she was under 16 and "*told he was lucky not to be arrested".* Another officer noted on an intelligence report, rather than formally as a crime, a named man attempting to prostitute two of the girls (aged 14 and 15), plying them with alcohol to get sex, the fear of the girls who could not resist the man's demands that they run off from their children's home, and how the man was attracted to their extreme youth. That officer is clear that now a crime report would be created.

5.49 There were other examples, including when Police were told of an old rape allegedly committed by a (partially) named man. When a parent reported a 'rape' and the child confirmed then denied it, the case was closed without full investigation due to a view that the original claim was manipulative, the parent agreeing the story was made up, and verbal abuse of officers by the child. This was before the current understanding that the story and denial may in themselves actually indicate CSE, which needs thorough inquiry, and at the time no 'crime' was logged. The Police IMR said that *"by not treating the reports they received as crimes, it is evident that TVP staff did not bring the necessary investigative mindset to what they were being told".* The officer then in charge of Oxford CID says cases would have been investigated if referred (within the practice of the day) and was very frustrated to find from the IMR that there were many incidents not treated as crimes, so not passed to CID.

5.50 The Police review for this SCR also identified that even if there was a 'crime' there was, at the time, lack of clarity about which branch led the investigation – from the attending officer through to CID and the Child Abuse Investigation Unit (CAIU). This meant sometimes that the necessary understanding or skills for such complex work might not be there.

5.51 In addition to the 'no crime' issue, there was a difficulty in proceeding without victim disclosure. A national CEOP report[14] said: *"Overall, victims are unlikely to disclose exploitation voluntarily as a result of fear of exploiters, loyalty to perpetrators, a failure to recognise that they have been exploited and a negative perception or fear of authorities."* Of the 26 reports the Police had of offences against the six girls, evidential statements were made in seven. Of the other 19, six were made by third parties, so the police had 'only' 13 disclosures. In no case where the report was from a third party did the victim support the police investigation.

5.52 The Police describe one process in relation to underage sex with three men encouraged by money, and reported by a children's home after one of the children returned from several periods of being missing. It was not originally recorded as a crime. The IMR identified over 24 recorded investigative actions over four months (mostly related to multi-agency liaison including several meetings). At an early stage the officer in charge said that "*there is no victim as such as she is not willing to give police a statement".* Later an Inspector recorded that *"the aggrieved is indicating that she does not wish to speak with the police and so this matter may not be progressed as a criminal investigation".* Sometimes opportunities were lost as evidence gathering was delayed for the outcome of multi-agency meetings, when it is clearer these days that there are occasions when 'now' is the only time something might be disclosed.

[14] *Out of Mind, Out of Sight: Breaking Down the Barriers to Understanding CSE* (CEOP, 2011).

5.53 Even where there was some disclosure, getting anything to a successful prosecution was far from easy. The updated CPS guidance,[15] which takes a helpful approach about using the weaknesses or contradictions in evidence as signs that courts could consider as demonstrating sexual abuse, was not published until 2013. In a speech used in many settings, including to the Home Secretary, the Detective Chief Superintendent currently overseeing CSE work in Oxfordshire said: *"The picture is not as simple as these children were completely ignored. They were not. There were attempts at investigation throughout the period but they were not sustained or coordinated or prioritised and each attempt faced almost insurmountable odds in a criminal justice system that had no real idea how to present evidence from difficult young victims (with) a whole baggage load of complex disclosure issues and problems."*

5.54 The Police also identified what was described as 'tunnel vision', whereby investigations before Bullfinch tended to look at the presenting issue only, and not 'join the dots' to other reports to the Police. They re-assembled over 40 pieces of information available about two 14-year-old girls in 2006 from the Missing Persons database, interview statements, crime and intelligence records, etc. This included information from third parties as well as from the girls. It included information about being held against their will, hard drug use, 'consenting' sex with a number of males, several accounts of sex with up to seven men, sex with a named man at 13, and a number of named men. Whilst there were a number of arrests for offences up to rape, there were no prosecutions (for the sorts of reasons given earlier, including lack of victim support). The IMR concluded that there was a lot of potential evidence that was not pursued beyond intelligence or missing persons reports, and that investigators did not make the connection – such as one girl being found at the same address where another had been the previous week, or linking names. Saying this does not necessarily imply that making the connections could, at that time, have led to successful prosecutions in the light of, say, the absence of victim evidence, but the chances would have been higher, and disruption could have been undertaken.

5.55 The Police IMR also identified that there was a risk that information recorded on intelligence systems might not get to the relevant safeguarding teams. It illustrated this with a 2007 account of a 13-year-old girl found hiding in a car with an adult Asian male, with condoms in the car. The officer also suspected drugs. Their account of being 'friends', and him not knowing she was 13 seems to have deflected focus on the risks. The man was advised and *'sent on his way'*, and the girl taken home. Only an intelligence report was submitted. The officer's open comments many years later to the IMR are repeated here as they are a useful indication of front line mind-set and how hard it was to grasp the extent of what might be happening. *"That was probably the first time I thought – what is going on here, this is a bit odd. At the time from a beat officer's point of view you don't have the knowledge and the know how to know what to do. I had 25 years' service but didn't have the experience to deal with it... my mind was that would go to a department or someone that would be more suitable to deal with it… a department or someone that would be more suitable to deal with it."* The IMR could not trace that any action was picked up. It was assessed as a 'non-crime incident', which means, says the IMR, it may not have been passed on to CSC. (However, the police officer concerned attended a professionals' meeting two days after the incident where it was discussed, so CSC was informed.). The combined agency chronology about

[15] *Guidance on Prosecuting Case of Child Sexual Abuse* (CPS, 2013).

this child shows over 80 entries during the month of this event, including major legal and multi-agency considerations, and the City Council was expressing serious concerns about the girl's wellbeing.

5.56 The CSC IMR describes how at times social work or residential staff might report concerns to locally based front line police officers who might make some preliminary inquiries but not forward to the Police CAIU, thus preventing the safeguarding team considering more formal steps. It is possible that the informal conversations were not seen as 'referrals' but might have been meant as such.

5.57 There were some unsuccessful early attempts at prosecuting or convicting men who may well have been involved in activities akin to the Bullfinch offences. Four allegations were referred to the CPS for charging advice. One case of rape against three men did get to court in 2006, but was discontinued when the victim refused to give further evidence, distressed by the cross-examination. The CPS explained to the SCR the reasons why other potential cases involving these children (not necessarily all with Pakistani group members) did not get even this far. In some respects, there is overlap with the issues around knowledge, language and consent discussed earlier. In one case, where one of the victims was 12, there were concerns about voluntary actions by the girls, a refused medical examination, and the credibility of the victims in light of their behaviour. (The CPS describes the police investigation as 'thorough'.) In another, the problems were given as poor credibility as the victim was *'out of control'*, no corroborating forensics, and that the police officer in charge was *'shocked'* the girl was only 13 (so there might be a defence on perceived age). This shows that the way of thinking about these victims was, in the mid-2000s, similar across agencies including courts. There was, at that time, a failure to focus on the actions of the perpetrators.

5.58 The author has seen CPS correspondence about a number of cases involving children from A-F and the reasons given for not taking court action. Whilst the wording may indicate that the girls' behaviour was a relevant factor, and there was no more understanding than anywhere else about how consent was eroded, the CPS arguments were in the author's view merely reflecting accurately how the defence and juries at the time would see the weaknesses in any prosecution.

5.59 It is important to show that there was indeed effort to obtain convictions for offences against the girls during 2005-8, so this was not a period of doing 'nothing,' although the hoped-for outcome was usually thwarted. The children are not identified by A-F to avoid inadvertent identification. The first chart includes any alleged perpetrator, not necessarily the group later convicted in Bullfinch. Only three investigations resulted in a conviction (italics) for the reasons given.

CHILD	**OFFENCE**	**OUTCOME**
1	Sexual activity/child under 16	CPS decided insufficient evidence/cooperation
	Sexual assault on a female 13+	4 arrested (2 later Bullfinch suspects), but victim denied assault. Men released
2	Rape of female under 13	Case discontinued by CPS on evidential grounds, although child was believed
	Rape of female under 16	2 men arrested but not charged as no cooperation with medical or statement
	Sexual activity/child under 16	No statement from victim – case filed

	Sexual activity/child under 16	*Man in 30s convicted and jailed*
	Rape of female over 16	Victim made statements but then withdrew them. Not pursued as a crime
3	Sexual activity/child under 16	*Man guilty on 3 counts and jailed*
4	Rape of female under 16	Victim would not support proceedings or have medical. CPS advised no further action
	Rape of female under 16	3 men charged, but acquitted when victim withdrew in face of cross-examination
	Rape of female under 16	Cooperation with medical and video but DNA evidence led to no further action against later Bullfinch suspect
4 and 1	Sexual activity/child under 16	Victims withdraw cooperation, and CPS decide no public interest in proceeding (a young alleged perpetrator)

The second chart records arrests of Bullfinch suspects against girls other than A-F in the period 2007-10.

Offender	**OFFENCE**	**OUTCOME**
1	Insulting words causing harassment/alarm/distress (encouraging 11- to 12-year-olds into his car)	*Fined*
	Rape of adult	Arrested but inconsistent victim evidence
2	Sexual assault of adult	Case dismissed at court
3	Rape of adult	Case filed as inconsistencies in victim account
4 plus 1	Rape of two 17-year-olds	Two men arrested – no further action due to consent and evidential issues

5.60 ***Lack of curiosity and rigour:*** CSC staff at times did not follow through some information that in hindsight needed investigation. The CSC IMR says that four of the six children alleged they were hit by their parents but, whether the allegations were true or not, none led to formal investigations*. "The girls learned that adults could hit them and nothing would happen and this added to their de-sensitisation and vulnerability, with managers signing off assessments without ensuring the allegations had been addressed."*

5.61 In another illustration, in a CSC Initial Assessment, *"an opportunity to pick up on the concerns about a thirteen year old child associating with older males and being sexually active was missed. It also failed to take full account of the information that her father was a Schedule 1 offender [now known as an 'offender who has been identified as posing a risk, or potential risk, to children]. The Team Manager should not have signed off the assessment as – no further action as a 'team around the child' in place – given this information."* There were other references to two partners of parents who were such offenders who were not assessed.

5.62 A lack of professional curiosity was described as *'a theme'* which ran through the CSC internal management review. *"There [were] unanswered questions in relation to several of the girls, for example, them associating with unknown adults… Team Managers needed to be challenging this in supervision but rarely did so."* It gave examples, asking why there seemed to be no exploration of why a girl in a deeply troubled family was using contraceptives at 12. The IMR concluded that *"what was lacking was a real sense of*

professional curiosity and the wish to really get underneath the behaviours and identify the issues. The fact that assessments were not routinely reviewed and updated compounded this issue. Team Managers should also have been picking this up and helping the case holding social workers manage the complex cases and ensure appropriate plans were in place to address all the identified issues." This is a good example of how issues described in this section relate to each other.

5.63 The lack of curiosity was not restricted to certain agencies. A senior social work manager said the Police were similarly uncurious. *"The police response lacked curiosity – they would pick the child up, give them a telling off and drop them back at the children's home",* and the Police IMR confirms this with its own illustrations. In Health, children accessing Sexual Health Services were also subject to a lack of curiosity. The Oxford University Hospitals (OUH) IMR gives a good example about an admission for excess alcohol. *"… the team did not review (the child's) sexual history other than at first presentation at a time when she was still intoxicated, when she told the admitting junior doctor that she 'regularly has sex for alcohol and drugs' – but describes those she has intercourse with as 'friends'. This information was taken at face value: at that time there was limited knowledge of potential Child Sexual Exploitation amongst clinical staff."*

5.64 *"The fact that she described those with whom she had sex as 'friends' gave the impression that she was talking of young people of a similar age. However, at a different point in the history she had explained (to the medical student who was the first person to see her) that she had run away and was staying with 'people she knows in Cowley' who she describes as much older – and uncertain of their ages. This comment is completely separate from the one about having sex with 'friends' and further questions should have been asked when the effects of the alcohol had worn off. This subject was not revisited in detail when she was sober."*

5.65 Sometimes the lack of curiosity was tactical. OUH described the concerns of staff in sensitive areas such as GUM clinics: *"If they are seen to pry too much the children might not stay, or fail to re-attend: this compromises staff's ability to give best medical treatment so there is a fine line between what staff perceive as an appropriate degree of professional curiosity and what a young person perceives as simply too nosey or intrusive."* Oxford Health also found a lack of curiosity in substance misuse services and health visiting about what was really going on behind the presenting issues. *"Although staff had significant concerns about the behaviour and disclosures of Children A-F there was a lack of professional curiosity in establishing the nature of these relationships and the identity of the individuals they were associating with…"*

5.66 The lack of follow up of concerns was also related to assumptions. Oxford Health describes how, with all the children being Looked After Children (LAC) or having a social worker, Health staff assumed that they knew about and were managing ongoing concerns. Oxford University Hospitals also said its clinical staff would assume that statutory agencies already knew about what they were hearing from their patients.

5.67 The apparent lack of rigour also related to uncertainties about Police powers – for example the right to enter property to search for a child, or the appropriateness of following children covertly to try to identify possible perpetrators. The Police look-back at the cases said that

while covert operations were used in 2007, they were not then used again until 2011. (From Operation Bullfinch onwards there was much greater clarity on this.)

5.68 ***Disruption:*** Whilst the idea of disrupting the activity of individuals and groups that are exploiting children is now a core part of practice, during the years leading up to the Bullfinch investigation and trial it was uncommon and the Police have concluded it was indeed under-used. This included not using various legal orders which had been available for many years. Disruption runs alongside safeguarding and investigation, and may protect children but also build evidence of a propensity to behave in a particular way that can be used in later proceedings. For example, Child Abduction Notices, which do not need a complaint from a victim, have been available since 1984 for under-16s, and since 1989 for under-18s. It is an offence to take a child away without legal authority. Such a notice might warn a suspect that a child was less than 16 years old, so removing belief of being older if eventually charged. The person can be arrested if the warning is breached.

5.69 The Police review showed many records of the consideration or decision to use such notices. *"However whilst this [IMR] found numerous directions to make use of these notices, there is very little evidence of them actually being served on people,"* and found only three in relation to A-F. The Police did note that it was not easy to ascertain from records if such notices had been issued, but concluded *"this may have been down to a lack of knowledge amongst the front-line staff",* quoting interviews with staff who were working on cases at the time, and there was no specific training on the use of these orders in the mid/late 2000s. It is also likely that the views discussed above about the girls being seen as voluntarily getting involved would lessen the sense of there being an 'abduction'.

5.70 Risk of Sexual Harm Orders were also available from 2003. They can be imposed on an offender who has demonstrated behaviour that suggests he may be at risk of committing a sexual offence against children, where the court is satisfied that the order is necessary to protect children from harm from the defendant. There have to be at least two specified incidents of concern but there does not need to be a previous conviction. There is no record of such orders being used.

5.71 Disruption can also include targeted surveillance, gathering of information about, say, the use of specific taxi firms, stop-checks and so on. There was an increasing use of these tactics over the years of this Review, but the Police conclude that they were uncoordinated. Looking back, the Police say they should have involved other agencies more in Police 'tactical' meetings around these cases *"to have ensured all of the information they held was made available to support the development of robust investigation and disruption plans. As it was, the professionals involved seem to have repeatedly fallen in to the same trap... relying on an approach that was doomed to fail as the children were unable to support the criminal prosecutions."*

5.72 ***Escalation****:* The CSC IMR found that, whilst casework decisions on these girls (and others like them) were escalated from the front line, both in social work and residential care, to their managers, this was not always shared with more senior managers. This meant that concerns about what might be happening (before CSE was properly recognised) were not discussed in the higher reaches of the Council (or Police), but it also affected the front line staff. CSC told the SCR that the non-escalation *"became part of the culture of the service and meant senior managers were not providing challenge and support on these complex cases'.* The extent to

which the top of agencies was aware, or should have been aware, of the exploitation of girls in the County is explored in Sections 7 and 8. Here the focus is more on those involved in operational work.

5.73 In the middle of the first decade of the 2000s, despite the formal existence of processes which would allow reports of concerns to reach high-level managers, middle managers told the CSC Review that *"staff and managers have described children's social care as being 'extraordinarily self-sufficient'. In addition middle managers said that their experience was if they took issues to senior managers it would result in criticism and blame and so they learned not to escalate but to try and manage things themselves."* The IMR says: *"One example which some managers have cited is that asking for a placement for a child to become looked after was seen as a failure on the part of the social work team, asking for an out-of-county placement was seen as a failure and an unacceptable demand on budgets... The panels were also seen as very challenging and distressing for some social workers and so they began to avoid them until absolutely necessary."* The IMR also recorded middle management concerns about an oppressive culture around 2010,[16] "*which led to them retrenching and avoiding raising concerns because to do so led to blame".* Whilst, if correct, the atmosphere at certain points would not be conducive to the maximum management of the most difficult cases, caution needs to be exercised in assuming a connection between this and specific issues about CSE, especially as middle managers may not have grasped its magnitude anyway. All that can be said is that, to find an understanding of CSE, a means to protect from it and a solution for it, systems needed to be working very smoothly indeed.

5.74 Escalation also did not happen across agencies. For example, the Drugs and Alcohol IMR says that a drugs service, hearing very worrying things from a 14-year-old, should have escalated to CSC management when there was sustained non-response to calls made to a front line CSC worker.

5.75 In the Police, there were some illustrations of more junior staff formally informing senior officers about their concerns. In 2006, the then Missing Persons Coordinator (a constable) wrote to the Detective Chief Inspector, copying in the Oxford and Oxfordshire Commanders, about a lack of inquiry into where two girls were or giving them due priority. The Police said this led to better multi-agency planning and a Police visit to Lancashire where there was more experience of sexual exploitation. In 2010, a sergeant wrote to the CAIU Detective Inspector in charge of Missing Persons describing many of the features now known as CSE, and this was fed into subsequent meetings of the Missing Persons Panel.

5.76 There is also an example where a City Crime and Neighbourhood Nuisance Officer was hugely concerned about a particular child and escalated to senior staff in other agencies, but not within his own. His Chief Executive was unaware of it until this SCR, despite the work being subject to a director-level complaint from the County Council. The Nuisance Officer was a former Detective Sergeant and acting Detective Inspector with experience in child protection sections of the Police. In 2007-8, he repeatedly raised concerns with senior CSC and Police staff (including the then Director of Children's Services, but not above his own

[16] The DCS at the time says she and the Interim Deputy, not long after their arrival, had drawn safeguarding shortfalls to the attention of County CEO and Lead Members for Children and Education and "had to lead rapid improvements in safeguarding arrangements that required constructive challenge, challenge which I considered some managers were unused to".

City team leader) about a particular family and child (one of A-F who was at times looked after), describing her behaviour and associates which today would lead to a speedy recognition that something bigger might be happening, but which at the time led to rather harsh disregard and criticism. For example, in February 2007, he reported *"men going into the flat every night and leaving in the early hours of morning"* and seeing the 13-year-old lying under a cover with an adult male (which led to a Police Protection Order). He also sought a child protection case conference after a rape allegation but this was turned down. He and a colleague told the OSCB City subgroup about the risks to children from massage parlours and reminded the meeting that his team was continuing to pass to the Police information about 14 and 15 year olds being seen in cars with older men.

5.77 This episode is one that agencies must learn from. The Nuisance Officer concerned was helping manage a situation with a very difficult challenging family where the behaviour of adults was the prime focus, but where the behaviour of one child in this review was also a serious issue. The officer gathered very significant information about the girl, her association with much older adults, and her general access to risky situations – having argued in 2007 against her coming off the Child Protection Register, as she was going missing so often.[17] He resorted to sending emails to many senior Police and CSC staff such was his concern (which seem from what is known about the child and exploitation quite justified). The SCR has seen correspondence with Police and Social Services about the girl with adult males late at night in January, February, March, June 2007 and February March and May 2008 (when she was 13 or 14 and was under Council supervision or formally in Care)

5.78 Whilst Police responses were calm and aimed at reassuring him (and implicitly supported the officer's intentions, once encouraging him to continue his communications with the County Council), responses from a CSC senior manager were, in the author's opinion, rather hostile and demeaning. The Nuisance Officer's emails included phrases like *"can we all live with risk that this young girl is exposed to in view of the intelligence we have of her association with Males".* He referred to both *'Asian'* and *'black'* males on several occasions. The child was subject to a Care Order and the risks being described were at times when resident in Council care. One CSC response to concerns about sexual association with adults said: *"The innuendo relating to her alleged associates I find a little presumptive and unsavoury, and does not in my view indicate a significant prima facie risk of harm…"* Another email said that *"the evidence beyond innuendo remains thin".* (By this point there were numerous reports collated by the Nuisance Officer of association by the then 14-year-old, late at night, with adult men.) The writer of those messages accepts that their tone was wrong, but at the time believed the course of action the Police and CSC were taking to focus on reducing missing episodes was right.

5.79 CSC, who knew the Nuisance Officer had good connections with the Police, thought the officer had unreasonable access to confidential police information about the case, but the Police IMR saw this more as good liaison between agencies. A police officer was embedded in CANACT (Crime and Nuisance Action Team), so close liaison was the norm. The County's Head of Adult Social Services was asked by the CSC Head of Service, through his contacts

[17] A view was put to the SCR that, if the child was Looked After, a Child Protection Plan was not needed, but there is nothing to this effect in the 2006 *Working Together*, which actually described the process when both were in effect. The criterion for being on a Plan was 'if the child is at continuing risk of significant harm', and is hard to argue this was not the case given what was known about her and adult males, whether the child was at home or placed with a relative or in a children's home.

with the City, to complain about the Nuisance Officer's emails and style, and the City senior manager apologised for *"the attitude of the staff member and for the unprofessional way he has acted. I am most upset that an officer under my control could act in this matter, and apologise to your staff unreservedly. Please be assured I have taken strong action to ensure this does not happen again*." The author understands that the worker was asked to stop emailing, but not told that his concerns were inappropriate. It is likely though that his managers assumed that the Police and CSC would be doing the right thing as it was their responsibility, and so did not take up the issues themselves. Only his team leader, and no one more senior, spoke to the Nuisance Officer, who said that he was told the County did not like senior staff being criticised by a junior person.

5.80 Whatever the style of the Nuisance Officer concerned, he was trying to get a child protected, and responses received (including turning down a case conference request) show one reason why the full picture of CSE was delayed. There is no evidence that the very top managers in the City knew about this disagreement but, according to CSC, *"At one stage in this correspondence the Directors of Social Services[18] and Education were copied in to the City Council employee's correspondence – the Director of Education because (the Child) was not in school. Both asked their direct reports to respond."* He also describes being so frustrated he went to the County Council and demanded to see a senior manager, and was seen, he says, by the Head of Adult Social Services[19] to whom, he says, he relayed all his concerns.

5.81 In 2008, the then Lead Member for Children's Services was copied into some of the correspondence and asked the CSC senior manager with whom the City officer was corresponding to draft a reply. The Nuisance Officer also says he spoke to the Lead Member and briefed her on the whole picture, including the association with adult black males. The Lead Member for Children made personal inquiries. *"She also met with the staff at the residential children's home, without a senior manager present, to ask them herself about the child and she was also assured that the males [the child] was being seen with were young asylum seeking males. She accepted this explanation."*

5.82 The correspondence was concerning (or the Lead Member would not have made personal inquiries) but it must be noted that was no indication of group-related CSE, but rather concerns about one child/family. However, the Lead Member also told the CSC IMR about a meeting with the CSC Head of Service, other senior managers and staff from two Homes. No minutes have been found but it seems probable the Lead Member had two meetings. The Lead Member recalls her prime concern being girls in care being out late at night and the risks that must follow that from men, rather than specific examples, and says she was unaware of abuse by Pakistani heritage men of multiple girls until 2011. She says that the County Corporate Parenting Panel saw that the missing statistics had recurring names and was concerned about the risks, but says the Panel would not have known what was happening to them when away.

5.83 The former CSC manager who had some of the correspondence with the Nuisance Officer now accepts that the strategy of trying to support the girl to learn how to cope with her

[18] The emails into which the then DCS or the Director of Adult Social Care were copied did not mention anything specific about adult males or sexual activity.
[19] It may well have been another senior manager who reported to the Head of Adult Services.

complex family situation rather than removing her from the risks was wrong, but believes it was followed with good intentions.

5.84 The Bullfinch perpetrators were found guilty of 25 offences against this child. The girl was reported missing from Council Care 69 times in 2007 and 79 times in 2008.

5.85 ***'Nothing can be done':*** The perceived difficulty in prosecuting and the lack of investigation on occasions led to a vicious circle whereby victims would either not disclose, or make only a partial disclosure, or withdraw support for the Police, because they could see that there was no guarantee of sufficient action to be safe from perpetrators if they did support the Police. Victims can describe circumstances, some quite dreadful, when they made allegations or were found in dire straits after abuse yet 'nothing happened'. Although there might be understanding now about why nothing (much) happened to end the abuse, for victims who were scared, hurt and trapped, this must have merely reinforced their sense of isolation and lack of choices. Exasperation might then reduce further cooperation or lead to withdrawal of cooperation, which would then enhance the sense amongst police and others that this was all too hard. One detective said of the pre-Bullfinch period that *"if a child did not disclose it was a matter for social services as we needed to move on to the next job".* This showed the then absence of other measures such as disruption and covert surveillance.

5.86 The limitation to investigation was reflected on by a very senior police officer looking back at that period. He told the SCR that at the time of the illustration above there was real pessimism about whether cases could successfully get to court due to evidential constraints and lack of evidence from victims, and that was a disincentive to further investigation without victim support. Attention was instead focused on a strategic approach to managing 'missing persons' and multi-agency safeguarding plans, rather than what were expected to be fruitless investigations. This was acknowledged, in hindsight, as clearly being the wrong approach with this form of CSE.

5.87 CSC/residential homes staff, felt frustrated that 'nothing was done' with information they provided. CSC say that *"the prevailing culture became, if the police can't do anything there is nothing we can do, and this became a source of frustration and anxiety for some social care professionals".* But there is also evidence in IMRs of Social Care and Health staff at times being reluctant to tell police all they knew or heard in case it undermined their relationship with the girls. Police were also frustrated by the sorts of issue described earlier, such as evidential issues and cooperation. As will be seen below, there was a growing level of shared concern at the end of the 2000s and which culminated in the excellent Bullfinch initiative, but for a period (despite vast public sector involvement) the understanding and skills were insufficient to solve that frustration.

5.88 ***Missing persons management:*** 'Missing persons' was a powerful and complex issue running through these cases and the developing understanding of CSE. The Police IMR alone took 176 pages to describe, analyse and pull out the learning from the management of those who went missing. There are 450 Police Missing Reports held on the six children in this SCR, and there were further episodes not reported. The 450 represented only 4% of the 10,600 total under-18 missing episodes in the County in 2005-13. And the 10,600 Missing Children reports were only just over half of all Missing reports, which averaged 2,450 per year. Oxfordshire figures were around a third of the TVP area overall. However, for children missing from being Looked After, Oxfordshire had a much higher proportion in 2006-9, which

may reflect the pernicious effect of the exploitation, and a reducing proportion thereafter, reflecting the increased local focus and awareness and improved joint agency systems. For the six children concerned, the episodes increased from ages 12-14 and decreased to almost none at 16, which was associated with the perpetrators losing interest as the girls got older. Five of the six girls started going missing from home, so this was an established pattern before spells as Looked After Children.

5.89 The obvious questions are – was it not obvious that these girls were being exploited in a major way, and why were they not stopped from running away to danger? An extract from the Oxford University Hospitals IMR shows one of the main causes, but also the link with other issues in this section. A 14-year-old girl was admitted with excess alcohol and there was a lot of interagency liaison. *"OUH staff accepted the view of those professionals in police, the Care Home and CAMHS that this was simply another episode in the life of a girl with significant behavioural difficulties rather than exercising a higher level of professional curiosity about what was causing this. Specifically, her comment while intoxicated about having sex with friends for drugs and alcohol was taken at face value: mainly because of an assumption that this was simply part of the 'bad behaviour' but also because of lack of knowledge amongst health professionals about grooming, and the significance of missing episodes as one possible indicator of Child Sexual Exploitation as this was not a widely publicised factor at that time."*

5.90 There was a sense of exasperation about so many missing episodes, and for too long staff found it easier to try to control those episodes rather than work on the perpetrators to weaken the 'pull' factors. One senior social worker said, *"We would get missing reports most days. I guess the view [then] was that the children were just playing up. It was always the same children."* There was also the traditional view of those who run away as running 'from' something (e.g. abuse at home or the control of a children's home). With some of the families this could be a tempting thought, and it took some time before the enormity and power of the *pull* from grooming was grasped.

5.91 There was also an assumption that the children were better off in Care, and even safer in secure accommodation. This proved not to be the case as the very numerous missing episodes from Care showed. Only official secure accommodation is allowed to lock doors or windows, and even when one girl had round-the-clock 2:1 staffing in a residential care home, windows were used to get away. More distant homes proved no barrier, as some girls would find their way back to Oxford. Whilst the girls could not get away from secure accommodation and were safe for that time, the fact that their perpetrators were untouched by such a placement meant that the abuse resumed on their discharge (unless they had become too old to be attractive to the men in the meantime). The CSC IMR was concerned about one child in the mid-2000s who was in a local children's home after two spells in secure accommodation. It said it was well known that she was being hurt when missing from the (not secure) home, and that it was *"a serious error of judgement*" when senior managers indicated that a third spell in secure would not be agreed. (Although it must be said that secure was a respite from abuse and not a solution.)

5.92 Physical restraint can be authorised, but it was virtually never granted as the social work managers who had to deal with such a request apparently regarded restraint as a sign of failure, and it could not in any case have been a continuous action. (Every parent knows there is a point beyond which it becomes impractical or unreasonable to physically control teenagers.) Removing or disrupting the perpetrators is now the solution. It was some time after Children's Homes began reporting names they knew or had heard, car registration

plates, visits by perpetrators, etc before such action against perpetrators was consistently and successfully taken by the Police.

5.93 There were a number of procedural issues that fed into the pattern of insufficient action to make a difference. A sample of those is described below. The Police told the SCR that whilst most missing reports were correctly graded for an 'urgent' response, there were some that should have been 'immediate', where for example the operator noted that the caller (a parent) "*thinks [the daughter] is being held against her will by Asian males"* or *"at risk of sexual exploitation, harassed by a group of Asian males".* The Police tried to establish why staff were not recognising vulnerability issues, and identified some confusing wording in the risk assessment questionnaire, but concluded that overall the cause of misclassification was: *"It is evident throughout this review that TVP staff did not have a sufficient understanding of CSE to be able to readily identify this as a form of child abuse and a factor that increased the young person's vulnerability. This was not surprising given the national awareness of CSE at this time, with both national guidance and TVP policy regarding missing persons not overtly recognising this link and its impact on risk. It certainly did not feature in TVP staff training nor within the force policies that….staff were following."*

5.94 Such were the numbers of missing episodes, of which A-F were a small proportion, that processes were agreed that allowed a differential approach, and the IMR found that some officers read the lack of *requirement* to attend as meaning they should *not* attend rather than use case-by-case judgement. This had the impact of lessening the impact of oft repeated (and oft returned from) spells of being missing and the Police quoted one duty sergeant: *"I do not agree that she is high risk. She has many friends who she stays with. She regularly goes missing to return in the following day. Due to her age she is of concern due to her choice of people that she associates with. This is not something that we can control. Neither can we prevent her choice of boyfriend."* The IMR commented that *"this entry highlights the impact the frequent missing person reports made by staff at the home had had on this supervisor's perception of [the 14-year-old and 21-year-old male), to the point that potential risk factors and child protection concerns appear to have gone un-noticed."* This view is enhanced by illustrations that the more a child went and came back, the lower the level of risk perceived, while it is realised now that the opposite is the case and risk of CSE is very high with more episodes. One Inspector updated a report on a frequently missing child by writing: *"Risk category changed from high to medium. Regular misper who is streetwise."*

5.95 Although Association of Chief Police officers' guidance emphasised the need to 'investigate' missing persons, and that failure to do so may leave an individual at risk, the Police identified many situations where the Missing Persons report was seen as a process, not a need to investigate. This should not be read to indicate that police officers were not in most cases attending the place from where the child was missing, checking the children were safe on their return, and so on. One mother told the SCR about their politeness and apologies for asking the same questions and searching the house yet again. She also gave fulsome praise for the Police Missing Persons Coordinator. However, the volume of reports – not just for A-F – desensitised people to the risks involved. Also, resources would have been overwhelmed by actively investigating every episode. As a result of the learning from the experience in Oxfordshire, there are significant increases in staffing, which were not there in the time of this Review. Whilst it is not hard to understand the impact of complex processes, that 'CSE' was a barely understood concept, and that the hundreds of missing episodes could have had a

wearying and desensitising effect, it is also true that there were very serious descriptions of harm or potential harm to the children, which were not investigated.

5.96 All missing children were supposed to have a 'safe and well' check by the police and also an independent 'return interview'. In the middle of the previous decade there was an agreement between the Police and the County Council that, to avoid duplication and so that the 'right person' spoke to a child, Care Homes would do many of the checks and interviews. The Police concluded in hindsight that, whilst this plan was understood, it reduced the opportunity for the Police to identify the possibility of a crime against the girls and lessened the potential linking of incidents. It also lessened the chance of another possible decision – that the Police should do all return interviews for a specific child owing to the risks involved. An example was given where there was an apparent risk to a child from a member of the children's home staff. In another case, a Missing Persons staff member saw on a child's return to a Children's Home that the 14-year-old girl had a pashmina and silver ring from a named Asian man, and had mentioned that her abuse started at 13. This never moved from an intelligence report to any investigation or inquiry.

5.97 Paragraph 5.75 described how the Missing Persons Coordinator wrote in 2006 to a number of senior officers, including her DCI and some Superintendents, seeking more action on missing children, including the following: *"The sad thing is, is that I'm not at all shocked or surprised at this lack of response as both girls appear to be labelled – repeat Mispers, Streetwise, too much trouble, not worth the effort of finding them as they will run off again... The staff at [the children's home] give plenty of information as to the vulnerability of these girls and I don't know what more can be done to ensure that these vulnerable Mispers are treated as a priority enquiry until one of them is found dead!... I know that you share my concern about these girls and I apologise for sounding off but I would like some help in both raising awareness and to try to track the people responsible for abusing these girls on a regular basis. Thanks for your time."* This did lead to some improvements, but more about Missing Persons organisation than seeing the wider picture the coordinator was trying to get across and the need for more investigatory action.

5.98 The DCI in charge of the Missing Persons Coordinator asked her and her Inspector to visit Lancashire as it was known that it was more advanced on missing persons. The report brought back to the DCI led to discussions with many agencies and to the creation of the multi-agency Missing Children and Families Panel, which went live in 2007.

5.99 At these Panels up to 38 children (August 2010) were discussed at such meetings. This was positive process but, as concerns in various agencies grew about CSE, other multi-agency meetings began and decision-making processes became unclear – who was 'doing' what and where authority lay. The YOS IMR says the meetings appeared *"to be unclear about purpose and function: was it there to agree action plans, just report, or look for patterns of behaviour for individuals and or groups?"* Oxford Health made a similar point: *"During the time frame of the review there is no evidence in the clinical records that any liaison took place with staff regarding any missing episodes a child or young person had or that relevant information was entered on to the clinical record to alert staff. Interview with the Designated Nurse for LAC (who was a member of the Missing Persons Panel) clarified the focus of the meeting was to share information with partner agencies rather than individual practitioners."* This suggests that front line staff in health may not have been in the loop on missing children.

5.100 If anything, the duplication was a 'good fault', as it represented a drive from involved staff to finally understand and act on CSE, but the Police say it led to inactivity through assumptions that others were acting. The Police looked back at the membership, and while the Police and CSC attended nearly all meetings and the key children's home (Home A) 88%, the PCT (which at the time provided the LAC health service) attended a third, and Education 6%. There was no attendance from the City Council and it is unlikely they were asked, nor from the voluntary sector. From November 2010 the Police provided CSC with daily lists of all children reported missing in the last 24 hours, up from weekly, in accordance with government direction.

5.101 The Detective Chief Superintendent now in charge of crime investigation says: *"In retrospect it wasn't 'our' problem. It was up to our local authority partners in CSC to solve it. So we set up the Panel in the hope we could find a solution down the safeguarding route... 'control your children!'… but now we know that even when our partners pressed their 'nuclear' option... secure accommodation... even that failed to make the children safe as they often returned to the same areas and continued to be abused."* While this doesn't do justice to the efforts of Police Missing Persons staff, it does show a frank recognition that there was insufficient understanding at the time.

5.102 The TVP Prostitution Strategy of 2008-11 was very clear. *"The possibility of grooming must always be considered as part of the missing person risk assessment and investigation, particularly in cases of frequently missing young persons from care settings. Regardless of the background to the grooming process, and any apparent willingness to participate on the part of the child, any young person involved in, or at risk of becoming involved in prostitution must be regarded as a victim."* The associated standard and policing guidance document was equally clear: *"Any missing person enquiry involving a young person, particularly those from care settings, should consider the possibility that the individual is being groomed or becoming involved in prostitution as part of the risk assessment and investigation procedure."*

5.103 ***Pressures in Children's Social Care:*** The issues which follow relate more to CSC. Some are related to CSE itself and some to general performance which might have an undue impact on the very complex cases around CSE. This SCR makes a number of references to management arrangements around CSC, and acknowledges that most of the information has come from the way in which CSC has contributed frankly to the SCR. In some respects, it would not be surprising if there were some problems in the way services operated as reviews, including a Joint Area Review (JAR)[20] (a multi-agency external review), reported some concerns in public reports. The author's summaries below are aimed at explaining any problems identified, not the whole report.

2005: Children's Services were 'good', although one team was struggling, with assessments behind time, and there needed to be more local placement choice of looked after children (LAC).

2006: Adequate. Too many children placed too far from home; reviews for children who are looked after need to be done on time; and the lack of placement choice on occasions puts children and young people in less appropriate placements.

[20] *Joint Area Review – Oxfordshire* (Ofsted, April 2008).

2007: Adequate. Weaknesses with the referral, assessment and child protection systems. Increases in children being de-registered and re-registered (suggesting hasty de-registration). A need to improve the timeliness of LAC reviews.

2008: Adequate. Management of referrals and assessment raised for third time. Re-arranging processes had led to 'referrals' doubling. The JAR (Ofsted plus Police and the Healthcare Commission among others) also judged Children's Services as adequate and had concerns about the public sector partnership overall, with QA underdeveloped and the LSCB needing to improve monitoring: *"Insufficiently rigorous management structures and procedures within the partnership to ensure comprehensive management oversight of processes and outcomes."*

2009: The Annual Statement said, 'Performs well'. There remained concerns about the timeliness of child protection inquiries, poor timeliness for assessments, and problems with prompt allocation to the long-term team.

2009: The unannounced inspection, which was reported after the 2009 Annual Statement, described 11 areas of satisfactory performance in the contact assessment and referral service, and five 'strengths' including the management oversight of complex cases. There were six areas for development including that some child protection inquiries had insufficient management oversight. There was one area for priority action: *"Staff turnover within one of the contact, referral and assessment teams has had a recent but marked adverse impact on its performance, particularly on the timeliness and quality of assessments and management oversight of contacts held on duty."*

2010: Performs well over the year. The unannounced inspection had some concern about supervision and support for staff, and about overly optimistic assessments that needed more attention to the background circumstances.

2011: Good overall. Ofsted asked for more involvement from Adult Services in Child Protection Case Conferences, for Child Protection Plans to be improved, and all children to be interviewed after going missing.

2014: Child Protection, LAC services, and Management were all rated 'good', as was the LSCB.

5.104 Although the external assessments improved over time, the Director of Children's Services (DCS) from 2010-11 identified issues with safeguarding, organisational structure and culture, capacity and quality of management, policy, performance management, business processes and systems and practice. The Director told the CSC IMR that there was a lack of performance information on which to judge services, and lack of compliance, for example with missing procedures. Her concerns were shared with the County CEO and Lead Members.

5.105 The years before the Bullfinch investigation had been one of considerable leadership change at the top of CSC, which had been merged with Education in 2006. From 2004-11 there were five substantive Directors, and three periods of interim directorship. Under the Director, the operational management of CSC was under a Head of Service. From a similar period (to 2012) there were four Heads of Service and at least seven spells of interim leadership. However hard anyone tried, this degree of change would have an impact on consistency and

clarity of direction.[21] This also applied to the Safeguarding Board. For example, between June 2006 and March 2008, before the first Independent Chair was appointed, six different Council officers chaired meetings of that Board. As seen at the end of that period, the external JAR inspection said there were "*insufficiently rigorous management structures and procedures within the partnership to ensure comprehensive management oversight of processes and outcomes"* (a responsibility of course shared with its members from all other agencies).

5.106 Three former Directors, speaking with CSC for this SCR, found (to one degree or another) Oxfordshire CSC to be insufficiently well organised, weak at performance management, inclined to overrate its own performance and resistant to change. It was also commented that if CSC did not do well on any national performance indicators, the view was always that the indicators were inappropriate. One *"felt the culture… was really trying to avoid the issues and pretend they weren't there and no sense of urgency, that people were not open with me…"* Directors felt the need to address some of these issues vigorously and this was at times seen as unsympathetic or over-firm leadership. The merger with Education also had an impact, with interviewees saying that CSC was the poor relation in terms of resources, and some staff saying that having no Director until 2010 with a social work background was not helpful. (Education interviewees also found this period difficult.) One CSC Head of Service said that not having a social work professional as line manager meant that one did not get professional supervision, or professional challenge. If this contributed to the lack of escalation to the top described earlier, that would not have been appropriate.

5.107 There were recurrent financial challenges impacting on, say, placement budgets but that is far from uncommon in local government, and new resources were successfully sought by the CSC Head of Service in the process described in the Cabinet paper below.

5.108 The SCR is not suggesting a direct connection between the delayed identification of CSE and the tensions and changes within CSC, but that it must have been harder for such a difficult topic to get the right attention with so much else happening.

5.109 Another issue may have been a new 2006 CSC strategy, which seems laudable but may have had unintended consequences. The model is not ideal for dealing with CSE where consent in the victims is eroded, and CSC and others need to take tough decisions to protect the children regardless of a child's, or at times their family's, wishes. For children tied up by CSE, the concept of 'choice' is not a real one. It also, in a quite unintended way, kept focus away from the non-family perpetrators by its (otherwise praiseworthy) focus on the family. A 2006 Council Cabinet paper[22] said: "*A key recommendation concerns the establishment of services and decision-making structures that replace the existing, professionally-dominated models, with mechanisms that enable and empower families and kinship networks to find solutions for, and meet the needs of, their children: the role of the public services becomes that of supporting families to take decisions and make plans for their children, ensuring that through such an approach children are better safeguarded and enjoy better outcomes as a consequence... Such an approach has a strong research and evidence base to support that outcomes improve, that families can and do make safe and secure arrangements for their*

[21] The Association of Directors of Children's Services in its *DCS analysis March 2007 – March 2014* reported that, in that seven-year period, 63% of authorities had the three DCSs that Oxfordshire had. The average tenure of a substantive DCS nationally was only 32 months.

[22] *External Review: Children's Social Care Service and Strategy Action Plan* (Oxfordshire County Council Cabinet, 11 November 2006).

children, and that numbers in the Public Care and formal child protection systems fall as a consequence of child-focused, family-centred practice and management models." This may also give context to the philosophical approach to decisions about accommodating teenagers.

5.110 The same Cabinet paper, describing the position from which improvements were to be made, said that Oxfordshire was a low spender on CSC services, in the bottom quarter nationally although overspent, (i.e. underfunded). It was 132nd lowest of 150 authorities nationally, and the number of social workers was the tenth lowest in the country, with 14.7 per 10,000 population compared to 27.2 nationally and 19.1 in the most comparable authorities.

5.111 ***Supervision:*** Anyone working on abuse needs to be supervised so their work is supported, reviewed, and challenged. This is because working in such an emotive and at times scary way increases the chance of objectivity being weakened, or finding judgement is affected. One learning point from CSC said: *"In most cases supervision took place at reasonable frequency although one manager did not provide supervision. The quality of supervision was generally poor with the focus being on updating the manager and checking that processes such as reviews were being completed in timescale. There is insufficient evidence of managerial decision making and little if anything to show that supervision was focused on reflective practice."* These cases were so hard that they needed the very best supervision. The Police IMR also points out that their supervisory processes were not always robust around cases like those in this Review.

5.112 ***Working with the parents****:* Social workers (and other professionals) found dealing with the parents very hard. This is not unique and is challenging everywhere. This took a variety of forms which CSC has identified in its own review. In two cases it appears that decisions were made to reduce the risk status around Child Protection planning because of strong parental opposition, when retaining the higher status may have been in the child's best interests. With another child, a case was (in the current opinion of CSC) wrongly closed as a mother would not cooperate. One parent was not allowed to attend LAC reviews *"as a result of... abusive and threatening behaviour".* In another case, workers could not visit alone owing to aggression. CSC concludes that this did impact on professionals' ability to work with and plan for the child. Not gaining cooperation limited the ability to conduct assessments that would illuminate the situation.

5.113 The SCR author, from the family interviews and detailed IMRs, wonders whether the dynamic was more subtle than this and, just as language suggested that the children were the author of their own downfall, workers came to see some parents too as partly responsible for the mayhem actually created by the abusers. In a multi-agency meeting in 2006 discussing two children, a CSC worker is recorded as saying that the father of one *"is obsessed with finding her when she goes missing".* The author would be worried if any parent was *not* obsessed with finding a 13-year-old girl who has been subject to rapes, excessive drug taking and alcohol, or who was running from Council Care. Later the minutes say that *"there was a discussion about the parents who moan about social services and police and that (the child) does this as well… her behaviour is a reflection of her parents".* The parents' 'moans' were about the public services not seeming able to assure the safety of their daughter. The child had gone missing from Council Care 12 times in the 10 weeks before the meeting for a total of more than 26 days.

5.114 ***'Professionalism':*** The girls to whom the author spoke acknowledged just how difficult they were with professionals and did not think the author should disguise this. They would not deny that they gave staff (they were talking mainly about social workers, but also the Police) a very hard time, but they said the more someone acted like a 'professional' the more they found it difficult to relate, and the less likely they were to disclose. They talked of staff coolness, a dispassionate approach, or not being prepared to talk about themselves, and about a sense that they did not feel they were being related to as people. In contrast, they said that unqualified staff were more down to earth, prepared to act as if they were on an equal footing, and would share something of themselves. Of course, being objective, measured and preserving professional boundaries is the basis of being professional, but it seems that with these girls (who had more dealings with adults than most, even if inappropriately) needed someone more 'ordinary' to stick with them. The professional approach, which cannot in itself be criticised, may have inadvertently acted as a barrier. (This seems to be different now, see current quotes in 4.34 onwards.)

5.115 Some staff understandably found it hard to stay dispassionate in face of behaviour that they saw as at least partly self-determined, frustrating and self-defeating. Some girls told the author of demeaning comments by some police officers (*'snide'* said one victim) and these again acted to prevent trust. It was interesting that secure accommodation staff (who almost by definition are used to the most difficult children) were praised by the girls for remaining polite and nice however they behaved

5.116 It is important when reading the above to consider the girls' views in the context of most staff members investing a huge amount of attention and care into what they did, in very difficult circumstances – even if those efforts were not always effective.

5.117 ***Looked After Children processes:*** Five of the girls were accommodated in the Looked After system at varying points. After 2005, Oxfordshire had an increasingly lower proportion of children in care. In some respects this might be a good achievement but CSC has identified that, in the mid to late 2000s, there was a prevailing culture at senior operational manager level described by staff as contributing to the IMR. Various panels were put in place to gate-keep entry to LAC status, and many staff told the IMR that when seeking such a placement they felt 'attacked' or they were told there were no placements with nothing else being offered. One manager said, *"I started to go with social workers to protect them.*" The figures do show a small reduction in children looked after in 2007 and 2008, but a big rise in 2009, so there is little evidence of policy induced drops in placements. (By 2011 Ofsted was praising the decision-making process around placements.)

5.118 In relation to the reported discouragement of placements, the County Council Legal IMR said that whilst to that point social workers had unfettered access to in-house solicitors to discuss risks and justification for statutory action, the clamp down on placements led to social work being stopped from direct access as legal services was seen as a source of encouraging care proceedings leading to additional requirements for accommodation/placements. A Panel was instituted and, although Legal say that in most cases social work managers and lawyers agreed, "*… such formality… may well have meant that legal advice was sought late on in the working of a case when earlier advice might have led to less delay and a more informed decision".* This IMR, and CSC's, also said that the use of voluntary receptions into care, as opposed to Care Proceedings (particularly when the focus was trying to maintain parental cooperation and engagement), "*resulted in a weakening of robust long term planning".* The

CSC IMR identified that at the time there was no process of performance managing decisions made in legal planning meetings, so if a conclusion to take certain action was not implemented it might not be picked up.

5.119 A senior manager at the time says that the stance on placements (which he saw as getting the *right* placement for a child) was not only to address serious financial issues, but also because being accommodated did not seem to benefit all teenagers, and there needed to be a rigorous decision-making process that examined all alternatives to residential care. The manager told the SCR he was committed to finding creative alternatives to residential care and implemented an innovative scheme to help teenagers. To some extent the manager may have been right as the victims in this case were not protected as a result of being in Care, but the CSC IMR concluded that the "*unintended consequences of attempts to manage pressure on budgets and to reduce the numbers of teenagers in care and the culture brought by senior managers meant that some of these very vulnerable girls were left in unacceptable family situations for too long".* There is some evidence to support this, but more from trying to follow good principles about supporting families and trying to avoid residential care if possible than any thoughtless approach. However, it is clear from the IMR that there was some tension with the management approach, tension between social workers and those managing placements, and limited choice of where a troubled teenager could be placed (including inappropriate co-placements with other girls who might influence each other and increase risk). CSC told the SCR, "*There was a lack of effective strategic planning as to how the local authority would meet its sufficiency duty and place looked after children close to home. This resulted in ad hoc placements which were not always matched to the child's needs and where the quality was uncertain."* Several of the girls were placed in distant homes, for example in Devon, Cheshire and East Anglia, and it appears they were not safe there either. One girl was trafficked several times from a Devon home, and according to a parent had the same staff attitudes from residential staff and Police, which suggests again that Oxfordshire was far from unique.

5.120 Caution needs to be exercised when considering the above. The girls appeared to be just as vulnerable to the abusers when in residential care, and at least one parent thought that, for all the struggles, the daughter was safer at home than in residential care. It is also, sadly, the case that three of the five girls who were looked after made allegations of sexual abuse by carers whilst in care (one was before she was living in the County). One of the children may have been the victim of two different men within Care. As CSC says, *"All three of these girls had been or are suspected to have been sexually abused within their birth family before becoming looked after and it is very worrying that they then suffered abuse when they should have been safe in care".* It is interesting that investigations into these concerns showed similar patterns to allegations against the exploiters: allegations made and withdrawn, sometimes made several times over years, sometimes the investigation was poor. With a recent concern the author has seen evidence of a very thorough assessment of risk by the Council.

5.121 There was also concern about one private children's home (long since closed) where it appears there were serious problems concerning the quality and training of staff, poor boundaries between staff and children, and a recorded instruction to staff not to share information about the girls with social worker or parents. Ofsted has confirmed to the County Council that appropriate safeguards have been put in place to identify any inappropriate future applications to lead care establishments. Despite the very high levels of going missing

from Home A, this in-county home was generally praised by the IMR for its care, effort and collation of information about predatory males.

5.122 Another issue was the review/plan for Looked After children. CSC says that LAC reviews tended to be planning forward, and missed the opportunity to re-assess risk by piecing together prior patterns of behaviour or harm. *"The overall quality of reviews was variable. Sometimes there was a failure to consider the presenting concerns, including absconding, allegations of rape and sexual assault, inappropriate calls to the homes etc. The Independent Reviewing Officers interviewed as part of this review have explained that the LAC review is seen as 'looking forwards' not backwards and this results in a failure to undertake a meaningful review of the child's placement and whether and how their assessed needs are being met."* Oxford Health said that Health staff contributing to LAC reviews were not invited to review meetings, so limiting the interchange of information between professionals, and that Health staff might do assessments with little knowledge of preceding history.

5.123 The Council Legal Department submission to the SCR points out that the legislative framework with regards to secure placements (under Section 25 of the Children Act 1989) creates significant practical difficulties for those responsible for the children. One of the main grounds for such secure accommodation is that the young person has a history of absconding and a likelihood of absconding and that when absconding they are likely to cause significant harm to themselves or to others. However, once a person is securely accommodated, the immediate risk of absconding goes and through a good response to any therapeutic input they may be able to evidence a reduced risk of significant harm. These restrictions on liberties are subject to stringent review with a strong independent element, and if the grounds are no longer met the young person must be immediately released. The focus, says Legal, is therefore on the child's current behaviour but, of course, that creates difficulties in relation to assessing the risk and likelihood of absconding from other types of placements. Cooperation and becoming more settled might be seen as a positive development of the therapy but might actually lead to the risk of premature discharge. Frequent returns to Court can also cause destabilisation within the placement.

5.124 The SCR heard that reviews of children in secure accommodation did not include wider plans for disrupting or stopping the exploitation from which they were locked up for their own safety, so nothing changed on discharge. The absence of any clear purpose and outcome of such a serious placement was not set out, so it became hard to justify its continuance.

5.125 One of the children was adopted in Oxfordshire after being placed by another authority. When there were issues (ten years ago) that needed dealing with about that child and family, there was a long debate between the authorities as to whose job it was to respond or to fund care. There was an incident where the child was found by a parent dishevelled, partially clothed, drunk in a room with seven adults, and later, after a brief spell in a police station until sober, taken by the mother to hospital (and admitted) with after-effects and injuries. The chronology suggests that debating which authority should be doing what took energy that might better have been used inquiring into what happened to her. This was distressing for the family concerned and did not get relationships within Oxfordshire off to a good start. Interestingly, the police made no inquiries as to what had happened, and when the child was admitted to A&E two weeks later complaining of assault, no link was made to the recent inpatient spell and no referral was made to Social Services. The County Council told the Review they accepted the case, so that the child's needs were met.

5.126 The Children and Families Court Advisory and Support Service (Cafcass), which provides independent support to children going through various Family Court proceedings, also found in its own review that its staff had a similar lack of knowledge about CSE and the erosion of consent. Signs that would now be seen as evidence of likely abuse were not seen as such and there was insufficient discussion of child protection issues with supervisors.

5.127 General Practices involved had little knowledge about their patients in the LAC system. The CCG IMR said, *"For all the girls in care, except (one), the registered GPs never knew anything about them. They had no background information about why they were in care, who had parental responsibility, no information about their needs and no important contact details, like the name and phone number of their social worker. This could lead to less than ideal care."* The Health Overview noted the following having looked at all the Health IMRs: *"Whilst the statutory assessments were happening, the health review has identified them occurring as single episodes and there being a lack of continuity of care following these assessments. There was no identified health professional that knew the child in a holistic way and co-ordinated health care or followed up on needs identified within the assessments. There also seemed to be a lack of multi-agency working at reviews with school health nurses not being involved in LAC meetings. There was some involvement of CAMHS with LAC reviews, when they were involved but many reviews were found to involve no health professionals."*

5.128 ***Assessments:*** As well as assessments whilst Looked After, there were of course many assessments and plans for children living at home. The CSC IMR has looked at them all and, bearing in mind some are a decade old, found that, linked to weaknesses in supervision and management decision-making, they did not make effective use of Child Protection planning or legal proceedings to bring about improved safety for the children. Social workers showed commitment and care in their dealings with young people, but plans were of limited quality, with drift, not changing direction with information about risks that were external to the family, nor leading to wider inquiries or the coordinated engagement of police.

5.129 The County's Adult Social Care service was also involved with one family which has a wide range of problems. Details are not given to preserve the identity of the family concerned. Although in the same organisation, its IMR described how at the time (many years ago) paper files in CSC meant that progress on a child could only be tracked through personal contact with other professionals, and that case conference minutes would be too late to serve an updating purpose. It also recommended a single 'case coordinator' when a case involved two or more County departments.

5.130 ***Use of Child Protection procedures:*** Throughout the pre-Bullfinch period, IMRs identify that there was a patchy use of Child Protection procedures. There was a period when, even within the Police CAIU, what the girls were experiencing (before the full situation was known) was seen as not really for 'Child Protection' as it was occurring outside the family. The lack of Section 47 inquiries into the potential offences against children as a result of 'crime' not being properly identified, or a sort of tolerance developing to what was happening, or the notion that the girls were the initiator of their abuse led to relatively few case conferences, and indeed not many 'strategy meetings'. These statutorily backed meetings are supposed to be held (to use words in 2006 guidance) *"Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, there should be a strategy*

discussion involving LA children's social care and the police, and other bodies as appropriate (e.g. children's centre/school and health), in particular any referring agency. The strategy discussion should be convened by LA children's social care, and those participating should be sufficiently senior and able, therefore, to contribute to the discussion of available information and to make decisions on behalf of their agencies."

5.131 Its purpose included *"to share available information, agree the conduct and timing of any criminal investigation, decide whether a core assessment under s47 of the Children Act 1989 (s47 inquiries) should be initiated, or continued if it has already begun to plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose, agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support. If the child is in hospital, decisions should also be made about how to secure the safe discharge of the child".*

5.132 The Police can only identify around 20 such discussions across all six children over many years, ranging from none to eight per child. None made any direct reference to CSE for reasons discussed at length above. It is clear now, although not always recognised at the time, that there were many more occasions when there was reasonable cause to suspect the presence or likelihood of serious harm. The Police give several examples where there was no strategy discussion (eg after S46 Police Protection Powers were used) and no Section 47 joint inquiry with CSC, including an extreme example, ten years ago, when a child of 15 said she was raped (by a man later convicted in Bullfinch). There was a criminal investigation, but one can see from the previous paragraph that without the strategy meeting the degree of joint-ness, information sharing, and obtaining or a joint plan of action is severely limited. There were a several 'professionals' meetings' which discussed a number of children together. These were held for the best of reasons, and were part of the movement that eventually led to the true picture of local CSE being recognised, but although they were sometimes called strategy meetings they were not. They were often not minuted. They often led to confusion about what was decided and who was responsible for actions, and confusions with other meetings discussing multiple children, such as the Missing Persons Panel. CSC has found that even when there were minutes they were not placed on each child's records – showing a blurring of meetings about an emerging pattern of abuse and decision-making meetings.

5.133 Only half of the six children were made subject to a Child Protection Plan (formerly known as 'on the register'), and CSC believes that on two occasions *"child protection processes were not used because of the hostility of the parents",* which does not seem to be child-focused decision-making, but does illustrate the challenges faced by staff. CSC says that *"professionals became aware that the parents were failing to report the child missing but this did not trigger a strategy meeting to consider the risk and implications and how these should be addressed with the parents. This failure to report should have been seen as a safeguarding issue and the appropriate child protection processes should have been triggered."* Those who were on a plan were so for reasons other than the CSE, but when events happened that were typical of what is now understood to be grooming and exploitation, plans were not changed. *"Child protection processes were ineffective in protecting the girls from CSE because CSE was not recognised as a safeguarding issue and so not included in their child protection plans. Since 2013 there has been a child protection plan category 'at risk of CSE' which was not available to workers during the timescale for this review."*

5.134 One of the benefits of being on a Child Protection Plan is that details are usually kept in A&E departments, and attendance can trigger more rigorous scrutiny or interagency checks. Lists of Looked After children are not kept by hospitals (although a call to CSC would discover LAC status).

5.135 ***Minutes and meetings:*** For both IMRs and this SCR the collation of minutes (a key record of decisions) has been a hard task. The SCR has looked in particular at those meetings called about multiple girls or to get more strategic interest. A number of meetings were not minuted or, if minuted, noted in a rather informal way. It was hard to work out where such meetings fitted into decision-making structures. Some meetings changed titles, and others were assumed to be 'strategy meetings' when they were really something else. There were indications of delays in circulating minutes, and the Police referred to a recent inspection where their files could not be updated promptly for decisions as minutes were late arriving – so it may still be an issue. The lack of clarity around minutes did not help the shared understanding of growing concerns.

5.136 ***Donnington Doorstep (DD)***: This is a voluntary organisation that worked with several of the girls and with others who have been exploited or at risk of exploitation. It has provided a wide range of support services for children, young people and families since the 1980s. It started to identify CSE in 2009 and more recently has provided specific services in support of children vulnerable to CSE. It worked with two of the six girls (not specifically for 'CSE') whose experiences illustrate this SCR, and had second-hand knowledge of a third through a parent who assisted the organisation. It played a significant part in raising concerns about the emerging picture that was finally recognised in Bullfinch. One of the features of a voluntary organisation is that it is *not* an organisation with statutory powers or duties, and so has a different relationship with its clients. This throws up issues of confidentiality, what to report, and what it should be told by other agencies.

5.137 An example is that on a number of occasions DD discussed very worrying concerns with CSC on a 'no names consultation' basis, as was allowed by multi-agency procedures, to enable a discussion without having to make a 'referral'. On one occasion it was recorded that this was due to the relationship between one child and DD being the only protective factor. The author agrees with the CSC IMR that such a process is risky and inappropriate. In this case, although very well intentioned, it meant that the statutory agencies could not either add the information to what else they held, or intervene. To some extent, the hesitation about being open is the same as seen in the girls themselves – being open is very risky without a guarantee of protection and abusers being halted.

5.138 DD did pass on much information to Police community support officers and social workers, and participated in many meetings. It experienced difficulties in tracking through decisions made, and frequently received no minutes of meetings about children. (It is not clear if this reflected a general weakness in minuting or something specific to DD.) It also found different meetings uncoordinated or not linked, which was also mentioned by the Police.

5.139 ***School-related issues:*** Education reported to the SCR that*, "The reality is that the secondary educational experiences of the six girls were in the main poor. They appear to have been responded to either through detention or exclusion and had long periods of absence from school. Alternative provision was limited, with little evidence of cross-checking against alternative provision registers and school registers, leaving young people vulnerable as*

schools were not aware as to whether they were actually attending alternative provision." It also said that many staff saw the period after 2005, when Education and CSC were theoretically merged but in their view operating separately, as one of low morale and 'chaotic reorganisations'. The IMR said that before 2008 there was view that the *"educational needs of Looked After Children (LAC) were just not seen as important as there was so much structural and leadership change",* and that *"from 2008–2010 children's homes' response to home tuition was not consist*ent*".* This may not be directly related to CSE but if it had been better could have contributed to the alternative to the groups being a little more attractive.

5.140 As with other agencies, Education says that its staff, including its Social Inclusion Officers who advised on children likely to be excluded, had no real understanding of CSE. Exclusion decisions were based on children's behaviour and attainment issues rather than wellbeing, and Heads who contributed to the Education IMR said they still see this as the national agenda. It is not surprising, given how all the other professions were seeing the girls' behaviour, that education professionals also saw the solutions as lying with the children (or excluding them), or pressing the parents to improve their children's attendance, rather than seeing the girls as victims.

5.141 The Education IMR described how a panel determined alternative arrangements after exclusion, but if the exclusion happened a day after a panel, nothing was done until the next panel. Now alternatives for Looked After children are planned promptly but, in the past (and all of A-F required alternative education provision), they *"often had to wait some time before it was provided. Some of the parents or carers of the girls were at times left trying to negotiate provision and appeared to get caught up in the administrative processes and bureaucracy of meeting thresholds and choosing from the limited range of provision on offer. This was particularly evident for [three of the girls] when they were returning from residential or secure placements to mainstream school."*

5.142 Education says that, at the time (but now improved), the transfer of education records between schools was poor, which would have affected these children more than most because of the moves and exclusions. In another administrative issue, children could be recorded as present if they were known to be receiving alternative education elsewhere, but reported that there was no real system to be sure of actual attendance elsewhere, so absences could be missed when considering a child's progress. Like Donnington Doorstep, schools used the no names consultation process, and the Education IMR says that staff found this confusing, and actual referrals were 'low'.

5.143 It summarised the position before Bullfinch: *"At no time did it appear that professionals were really aware of the increased risk and vulnerability to CSE that being out of school posed or the implications of delay in finding alterative provision. At the same time, it has highlighted that the level of disruptive behaviour that the girls mostly displayed was something that the schools were at a loss to deal with and the support available to them was minimal."*

5.144 ***Drug and alcohol issues****:* Drug and alcohol services were provided by a range of NHS and voluntary organisations. Specialist services were provided to a relative/s of three of the children. The use of alcohol and drugs, initially as a gift, then to weaken the resistance of children, and probably taken thereafter to anaesthetise their trauma, was a common feature of the exploitation. One girl who was being helped at 14 by a specialist service told of daily cannabis use, cocaine at parties, and drinking up to forty five (45) units of alcohol in one night.

She also talked about her 19-year-old 'boyfriend'. Workers tried to speak to the CSC family support worker (who had referred the girl with reference to CSE) a number of times without an answer or call back. The IMR said that the drugs worker should also have found out more about the CSE before seeing the girl to aid the forthcoming conversations.

5.145 The Drug and Alcohol IMR author, from scrutinising the combined chronology, points to the lack of referral to specialist services despite drug and alcohol use/misuse being so frequently referred to. *"Even when a social care or health record talks about excessive alcohol use, or worrying use, it is not followed up with an action to make a referral to drug and alcohol services or to work with the young person around their use. This suggests many missed opportunities to support and advice the girls about the risk associated with it, and to get them support from appropriate services."* The Oxford Health IMR says that Child Mental Health Services should have taken more initiative about drug and alcohol use revealed by the girls, with referrals to specialist services and been more curious about the source of access to it given the girls' young age.

5.146 ***Summary of health issues:*** A summary overview of health-related issues has been provided to the SCR by the Designated Nurse and Designated Doctor for Safeguarding. The issues of knowledge, language, lack of curiosity and so on are seen in health as in other sectors. There have been a number of references to Health IMRs above. The Health Overview identified that the degree to which patients were assessed to check vulnerability varied. For example, Genitourinary Medicine (GUM) used the Vulnerable Persons Questionnaire, but the Contraceptive and Sexual Health Clinic (CASH) did not (although they followed Fraser guidelines and service protocols). Records show that whilst the particular pattern of abuse in this Review was not known, there are many entries describing elements of such abuse. The Overview also pointed out that there a multiple of access points for confidential Sexual Health Services, so accessing one of them might remain unknown to others or mainstream health services.

5.147 Health notes recorded being told by girls of pregnancy terminations, but none had a termination performed by services commissioned by the Oxfordshire NHS (unless with false names). The complexities of information sharing across multiple health services was described in the Health Overview*. "The review of health information demonstrated that the GP record was not a repository of all health information and emphasised the need for dialogue and better sharing of information by all involved in a child's care to ensure understanding. Services did not consistently inform or involve the GP, often the information was incomplete or provided to them retrospectively. There were services such as sexual health services who only notified the GP when patients gave consent, resulting in gaps within the records. Communications from other professionals was generally only summarised and although added to records and reviewed by the GP who assumed that the professional sending the information was acting appropriately on it."* When other agencies are added into the matrix one can see the difficulty in getting an overall picture on one child.

5.148 The Health Overview summarised well a pattern seen everywhere else about not recognising the patterns of abuse, and added how symptoms rather than causes were the focus. *"Health care staff recognised unusual and challenging behaviours that were beyond normal parameters but did not see them as indicators that raised concern about CSE. Managing behaviour changes when identified was found to be an area of challenge for health care staff. In some situations the behaviours were treated as the diagnosis rather than as a symptom*

e.g. PTSD. Interventions and treatment often related to resolving the behaviour not asking why the behaviours were occurring."

5.149 **Taxis:** Oxford City Council is the licensing authority (although national rules allow someone licensed elsewhere to operate anywhere). The Review understands that one of the Bullfinch defendants held a licence for a year, but not at the time of Bullfinch. No drivers licensed elsewhere have been implicated. There have been concerns about links between the perpetrators and certain firms, but no evidence about this was presented at the trial. If a licence holder is arrested for a sexual offence there is Police-City liaison and the driver suspended. The City says that to date there has been no conviction of a named licensed driver. From June 2010 to April 2014 there were nine complaints about sexual assault, all but one by adults. In four cases, the driver has not had the licence re-issued, but in five cases the licence has been reinstated after no prosecution or acquittal. The City's well-regarded practices on taxis were described in 4.27. The Police told the Review that recently a taxi driver drove a girl to a Police station, worried that she was being sexually exploited, which they said suggested the training was effective.

5.150 ***The whole multi-agency team:*** Many illustrations in this section describe issues which are within one agency or profession, but in practice success with such complex cases comes from the whole group of professionals or other staff, each doing their bit. The girls might be involved with social workers, police, doctors, sexual health clinics, voluntary organisations, mental health services, schools, and so on. There is much focus on Police and CSC in this Review, but for cases of this complexity, unless every agency plays its part sharing a similar approach to and understanding about children at risk of CSE, the work of those agencies with the statutory powers to intervene will not be effective. As the 2009 statutory CSE guidance says, *"Safeguarding and promoting the welfare of children and young people in this context, like safeguarding children more generally, depends on effective joint working between different agencies and professionals that work with children and young people... Their full involvement is vital if children and young people are to be effectively supported and action is to be taken against perpetrators of sexual exploitation. All agencies should be alert to the risks of sexual exploitation and be able to take action and work together when an issue is identified."*

5.151 ***Ethnicity*****:** Only one reference was made, either in family interviews or in agency evidence, to the SCR that suggested any reticence related to ethnicity. A parent told a police station about information provided by the daughter and queried why no immediate arrests were being made. The parent says the desk officer responded by saying that such arrests could not simply be made on such information and that the Police were also under pressure not to appear institutionally racist. (The incident is likely to have been around nine years ago.) No other information has come to this SCR to suggest that any processes of identifying CSE or taking action against it was delayed due to the ethnicity of the perpetrators. In 2,000 pages of IMRs, there is barely a mention of ethnic issues.

5.152 The frankness of the IMRs suggests that, had there been indication of any 'go easy' to avoid an appearance of racism, it would have been uncovered and reported. The SCR Panel (representing all involved agencies), when considering the draft SCR and this section, confirmed no knowledge of indications of perpetrator ethnicity dampening concerns about children. In subsequent similar operations to Bullfinch, both in terms of prosecution and

disruption, the perpetrators or alleged perpetrators have mainly been from BME groups, which would again suggest no holding back on grounds of ethnicity.

5.153 The Police IMR (in 550 pages), when referring to official records and family/staff quotes, does not use 'Pakistani' and, in a similar size IMR, CSC uses it nine times. This compares to 54 and 126 uses respectively of 'Asian'. When referring to possible perpetrators, the Police IMR uses 'black' twice and CSC uses 'black' about 15 times. The Police say they would not use 'Pakistani', a nationality, in their reports, as the perpetrators of Pakistani heritage were of British nationality. It would seem that 'Asian' is the phrase predominantly used by professionals and victims in documents and interviews. The offenders of Pakistani heritage gave their ethnicity to Court and the prison as 'Asian'. One of the others, who says he came from Saudi Arabia, described himself as 'British Asian'. Whilst the terminology used is interesting, the author can find no evidence of 'Asian' being used to hide the predominance of Pakistani heritage involvement.

5.154 **Summary:** This section has described a multiplicity of reasons why CSE as in Bullfinch was not recognised for a long time after it had started to occur. An explanation does not, of course, make it 'all right'. Agency work is appraised in Section 8. The issue is not only about how much agencies and professionals knew/understood about the Bullfinch type of organised exploitation by groups. The question is also whether they did well enough with what they *did* know was happening.

6 WHAT MIGHT HAVE BEEN KNOWN ABOUT CSE?

6.1 **Introduction:** This section looks at what organisations might have known about child sexual exploitation from guidance in the years before the Bullfinch investigation in order to help assess organisational action. There was much published from the late 1990s that might be deemed relevant to CSE. However, it was not specifically about the Bullfinch type of abuse, and was generally couched around 'prostitution'. If 'trafficking' was used, it meant trafficking from abroad. The notion of sexual exploitation of young teenagers by groups in local towns was not something many people saw, or something of which they were even aware. However, although the labels were different, the signs of it were indeed covered by guidance over many years – but it was not to the forefront of thought in the public sector. This section also looks at how guidance was received nationally.

6.2 **Guidance:** The 1999 version of the statutory Child Protection guidance *Working Together*[23] had only half a page amid its 128 pages on prostitution, other forms of commercial exploitation and pornography/internet grooming, but it did list some of the cornerstones of today's management of CSE:

- *treat the child primarily as a victim of abuse;*
- *safeguard the children involved and promote their welfare;*
- *provide children with strategies to leave prostitution; and*
- *investigate and prosecute those who coerce, exploit and abuse children*.

6.3 In 2000, the government published, *Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children*.[24] It repeated the above bullets and again identified key ways of thinking which were missing in Oxfordshire before Operation Bullfinch a decade later. For example, *"Although not always prominent or visible, children are involved in prostitution… It is a tragedy for any child to become involved... It exposes them to abuse and assault, and may even threaten their lives. It deprives them of their childhood, self-esteem and opportunities for good health, education and training. It results in their social exclusion. Children involved in prostitution should be treated primarily as the victims of abuse, and their needs require careful assessment. They are likely to require…in many cases, protection under the Children Act 1989… the vast majority of children do not voluntarily enter prostitution: they are coerced, enticed or are utterly desperate. We need to ensure that local agencies act quickly and sensitively in the best interests of the children concerned. It is important that proper prevention, protection and re-integration strategies are put in place to ensure good outcomes for these children. All services… should treat such children as children in need, who may be suffering, or may be likely to suffer, significant harm*." What the Oxfordshire girls were involved in was very akin to this; some were literally involved in prostitution and some were trafficked for sex.

6.4 In 2001, the government published a *National Plan for Safeguarding Children from Commercial Sexual Exploitation*.[25] Again, it had many echoes of the current form of CSE. *"The causes of children's involvement in commercial sexual exploitation… cannot easily be*

[23] *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children* (Department of Health, Home Office, Department for Education and Employment, 1999).
[24] Department of Health (2000).
[25] Department of Health (2001), but jointly with the Home Office.

disentangled from the wider problems of poverty, family conflict and breakdown, child abuse, domestic violence and homelessness. All commercial sexual exploitation of children is utterly unacceptable. It takes away children's self-respect and dignity. It exposes them to great danger and it takes away their childhood. Tackling this evil trade needs determination, clarity of purpose and an ongoing partnership between a wide variety of organisations in the public, private and voluntary sectors… The term commercial sexual exploitation is interpreted widely in this document to include the prostitution of children and young people; the production, sale, marketing and possession of pornographic material involving children; the distribution of pornographic pictures of children over the internet; trafficking in children; and sex tourism involving children."

6.8 It also had guidance for ACPCs[26] (the predecessors of today's LSCBs): "*… It also falls within [ACPC's] remit to ensure that appropriate protective services exist to support children caught up in such exploitation or who have been abused… there is a need for the ACPC to raise awareness of the nature and scale of harm with agencies before taking action. Action is then best targeted simultaneously on the investigation and prosecution of abusers and the support of the children involved."* Note the emphasis on investigating the abusers, which was missing for too long.

6.9 The 2006 'Working Together', in a document twice as long as its 1999 predecessor, again still had half a page on 'children abused through prostitution', but it did have a larger section on trafficking – largely about trafficking from abroad. In 2006, after 'Working Together' 2006 was published, the OSCB agreed 'Guidance for Professionals Working with Sexually Active Young People under the Age of 18 in Oxfordshire'. This gave clear guidance on consent, and how to assess the risk to the young person, and included the following pointers which describe the process later identified on Bullfinch:

- *The nature of the relationship between those involved, particularly if there are age or power imbalances…*
- *Whether overt aggression, coercion or bribery was involved including misuse of substances/alcohol as a disinhibitor*
- *Whether the young person's own behaviour, for example through misuse of substances, including alcohol, places them in a position where they are unable to make an informed choice about the activity*
- *Any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship*
- *Whether sex has been used to gain favours (e.g. swap sex for cigarettes, clothes, CDs, trainers, alcohol, drugs etc.)*
- *The young person has a lot of money or other valuable things, which cannot be accounted for*
- *Whether methods used to secure compliance and/or secrecy by the sexual partner are consistent with behaviours considered to be 'grooming'*

6.10 If a young child *"may be at risk of sexual exploitation through prostitution, a referral should be made to CSC* (and if an emergency) *the Police should be contacted immediately".* Oddly, this guidance, whilst having a 'presumption' of referral, allowed for a referral not to be made even if an under 13-year-old was having sex, but this is no longer in current guidance. Whilst the reference is to exploitation 'through prostitution', the bullets above describe exploitation in general. This 2006 OSCB guidance was very appropriate, and relevant to what the girls were

[26] Area Child Protection Committee.

going through, but the links between the cases and what the guidance was describing were not made.

6.11 In 2008, the University of Bedfordshire published a government-commissioned paper, 'Gathering evidence of the sexual exploitation of children and young people: a scoping exercise'. This could not have been clearer about the key principles of preventing, disrupting and prosecuting CSE which would be advocated today. It is unlikely that it was seen widely.

6.12 In 2009, there was major supplementary guidance to *Working Together 2006* on child sexual exploitation – *Safeguarding Children and Young People from Sexual Exploitation*.[27] This was the first guidance to use the phrase 'child sexual exploitation' and, like others in this section, described the sorts of abuse experienced by the six children in this SCR- other than the ethnic origin of the perpetrators.

6.13 There is very little missing in it from what guidance written today would say. It uses the definition of CSE still used (see 1.28 above). It refers to criminal groups. It emphasises the child-centred approach required of professionals and warns that professionals *"should be aware that children and young people do not always acknowledge what may be an exploitative and abusive situation"* and that *"Sexual exploitation of children and young people should not be regarded as criminal behaviour on the part of the child or young person, but as child sexual abuse".* It describes how to manage individual cases, the roles and responsibilities of the LSCB and agencies (requiring an LSCB CSE subgroup and a lead professional in each agency),[28] and has a detailed chapter on 'Identifying and prosecuting perpetrators'. This described most of the techniques which came to be used in Bullfinch around disruption, evidence gathering, and so on. It is all there.

6.14 The 2010 edition of *Working Together*, the last before the Bullfinch convictions, required LSCBs to include in their annual reports (a statutory requirement) *"progress on priority issues (for example, child trafficking, sexual exploitation and domestic violence)".* It also said: *"Every Local Safeguarding Children Board (LSCB) should assume that sexual exploitation occurs within its area unless there is clear evidence to the contrary, and should put in place systems to monitor prevalence and responses."*

6.15 It also left little doubt that it was talking about the sort of abuse that came to be understood in Oxfordshire. *"The guidance states that LSCBs should ensure that specific local procedures are in place covering the sexual exploitation of children and young people. The procedures should be a subset of the LSCB procedures for safeguarding and promoting the welfare of children, and be consistent with local youth offending protocols. The identification of a child who is being sexually exploited, or at risk of being sexually exploited, should always trigger the agreed local procedures to ensure the child's safety and welfare and to enable the police to gather evidence about abusers and coercers… The strong links that have been identified between different forms of sexual exploitation, running away from home, group activity, child trafficking and substance misuse should be borne in mind in the development of procedures. These should include identifying signs of sexual exploitation, routes for referring concerns,*

[27] HM Govt, 2009.
[28] It is an interesting illustration of the vagaries of national guidance that only two years later this statutory guidance *'should'* had been downgraded by a new government to *"the DoE can help LSCBs to consider if it is appropriate to…". Tackling Child Exploitation: Action Plan* (DfE, 2011).

advice on working with other professionals to disrupt sexual exploitation and support victims, gathering and preserving evidence about perpetrators, as well as how to deal with more complex issues such as those relating to the increasing use of the internet in sexual exploitation."

6.16 On complex case management and trafficking it said, *"Children do not have to be trafficked across international borders to be exploited in this way. There is evidence that some UK resident children, mainly young girls, are being groomed, coerced and moved around between towns and cities within the UK for the purposes of sexual exploitation."* (This was happening to some of the girls.) "*Relevant agencies should remain alert to the possibility that this can happen, and work together to address it."*

6.17 The Police have identified eleven items of guidance on missing children from 1997-2010. In 2009, there was 'Statutory guidance on children who run away and go missing from home or care',[29] which very accurately describes what was found in Bullfinch. *"Grooming for potential sexual exploitation: In some cases, young people may run away or go missing following grooming by adults who will seek to exploit them sexually. Evidence suggests that 90 per cent of children subjected to sexual grooming go missing at some point. The supply of drugs and alcohol or the offering of gifts may be used to entice and coerce young people into associations with inappropriate adults. Both girls and boys are at risk of sexual exploitation. Looked-after children may also be targeted by those wishing to abuse and sexually exploit them, and encouraging these children to run in order to disrupt their placement is often part of this abuse. Young people living within residential care units are particularly vulnerable to being directly targeted in this way."*

6.18 In November 2010, there was some publicity (but not to the later Rochdale or Rotherham level) about the convictions of a number of Asian men in Derby and the associated SCR. The circumstances of the cases were very similar to what was happening in Oxfordshire. In early January 2011, *The Times* published a series of articles, which promoted significant media and top-level political comment, about the sequence of convictions in recent years, the overwhelming predominance of Pakistani heritage men as convicted perpetrators, and suggesting blind eyes were being turned.

6.19 In November 2011, there was a further government publication, *Tackling Child Sexual Exploitation – Action Plan*,[30] which had strong ministerial backing. Although it mentioned nowhere that group CSE had actually been identified, there can be little doubt it was talking about the sort of abuse discovered in Oxfordshire, with strong messages for LSCBs: *"LSCBs… have a central role in overseeing much of the work set out in this action plan. The University of Bedfordshire research, however, found that many LSCBs have not identified child sexual exploitation as a priority issue in their area… The Government believes that LSCBs will want to assure themselves that local services are based on a robust assessment of need in the locality, taking account of the statement in the statutory guidance that every LSCB 'should assume that sexual exploitation occurs within its area unless there is clear evidence to the contrary'. They will also want to assure themselves that local services are designed and delivered effectively to tackle the issue where it arises."* The Oxfordshire LSCB had already set

[29] Department of Children Schools and Families, July 2009.
[30] *Tackling CSE – Action Plan* (Department of Education, 2011).

up its CSE subgroup, and Operation Bullfinch had already been underway many months when this came out.

6.20 In November 2012 the Office of the Children's Commissioner produced *"I thought I was the only one the only one in the world": the Interim Inquiry into Child Sexual Exploitation in Groups and Groups*, which LSCBs would have wanted to see as they contributed to the research.

6.21 Looked at now, there is little doubt that national guidance and reports across the early years of the 2000s, and especially around the end of the decade, were giving clear indications of the approach to exploitation, describing it well (even if in different words) and requiring action. The problem was that the guidance, especially that published more than two or three years ago, just did not have the required impact across the country – whether in towns that had a major challenge from CSE or other places. Subsequent inquiries by the University of Bedfordshire[31] and the Children's Commissioner found that only a minority of LSCBs had introduced key elements of the guidance. In 2013 (after Oxfordshire had successfully implemented Bullfinch), the Office of the Children's Commissioner[32] reported very patchy take up of the guidance. That suggests a problem across systems nationwide in grasping what was happening and needed, rather than individual failings – something about the process of issuing and responding to the guidance, and how guidance may not be absorbed if one thinks the problem described is rare and is occurring somewhere else. The notion that such widespread organisational poor response is down to most professionals or responsible organisations deliberately disregarding a known problem is not one the author finds credible. It seems mostly to be connected to organisations thinking such abuse happened somewhere else.

6.22 Even in November 2014, Ofsted[33] was still finding that *"Until very recently, child sexual exploitation has not been treated as the priority that events in Rotherham and elsewhere strongly suggest it should have been. As a result, local arrangements to tackle the problem are often insufficiently developed and the leadership required in this crucial area of child protection work is frequently lacking…"* In Oxfordshire, there has been a very robust response since 2011 – see Section 4.

6.23 In addition to guidance, there were also prosecutions on CSE. Before the main Rochdale convictions brought CSE to un-missable attention in 2012, there had been some convictions in Bradford, Blackpool, Oldham, Sheffield, Blackburn, Rochdale, Manchester, Skipton and Nelson. None of these registered CSE in the national consciousness until, to some extent, the convictions in Derby in late 2010 and then very significantly with the main Rochdale convictions, which were in 2012. If anyone was aware of any of the convictions before the very end of 2010, they would have had the impression this was a 'northern problem'.

6.24 The author recalls a common reaction to the 2009 guidance and requirements for CSE, which was outside most people's area of knowledge: 'who can we find to lead a CSE subgroup, who knows anything about it; group-related CSE doesn't happen here, does it?', etc. Any new large-scale requirement can be difficult for LSCBs, with actions having to rely on agencies volunteering time when they have numerous competing requirements. Independent Chairs

[31] 'What's going on to safeguard children and young people from sexual exploitation?' (University of Bedfordshire, November 2011).
[32] *If Only They had Listened: Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Groups and Groups. Final report* (November 2013).
[33] *The Sexual Exploitation of Children: It Couldn't Happen Here, Could It?* (Ofsted, November 2014).

may only have half a day a week. It is likely that, in many areas, the assumption that group-related CSE was something others had led to insufficient attention being given. This assumption and reaction, while regrettable and wrong, is not the same as knowing about local CSE and not acting. This SCR tells of a small number of relatively junior staff in two or three agencies who began to see the risks and increasingly knew about CSE; the learning came from the bottom up and not down from leaders. It was the grassroots knowledge of vulnerable children by a small number of determined staff which eventually led to system-changing action.

6.25 In summary, two factors seemed to prevent the guidance being used in recognising and dealing with CSE before 2011. For many years, guidance, whilst describing the signs of CSE, did so in the context of prostitution and trafficking rather than the language of the group CSE later identified. But, anyway, the prostitution was not recognised either. Secondly, even when the guidance became more explicit, group CSE was thought of as something that happened somewhere else. Nevertheless, there was a lot in the guidance that would have been very helpful, and much of it remains very apt.

7 ORGANISATIONAL AND LEADERSHIP AWARENESS

7.1 **Introduction:** When there is a period when performance across agencies does not have the required outcome, it is appropriate to ask whether the leadership of the agencies was doing all it could, or whether it had knowingly not responded to CSE issues. This section will describe the level of knowledge organisations and top leaders had and, if they had little or no knowledge, why this was the case. There is no evidence of governing bodies in the major agencies being aware of the CSE in terms of organised grooming and exploitation by groups of Asian males until at least early 2011 (the year in which Operation Bullfinch was formed) and reasons for this are examined. This is different, therefore, from Rotherham, where the inquiries concluded that warnings had been disregarded at the top. The SCR benefited from detailed reviews of the national context in the Police and CSC IMRs, and the author also commissioned additional reports from each agency analysing what was known at their higher levels in the period under review, to which all responded. SCRs, especially those commissioned under *Working Together 2010*, are not 'inquiries', so rely largely on self-report, but the author's own inquiries (which were responded to openly) have found no reason to challenge agency submissions.

7.1 Parts of this section may seem in places to be rather dense and bureaucratic, but the detail will aid professional readers who can see the impact of structures and processes on outcomes for children. However, it also sets out what was known about the children's suffering. The section is structured as follows:

- The headline priorities for the Police and CSC
- Oxfordshire's journey towards identifying CSE
    - The OSCB
    - The growing awareness in the County
    - The knowledge at the top of organisations
    - Operation Bullfinch
- Overarching comment

7.2 **Priorities:** Whilst the protection of children can always be said to be a 'priority', and there has been a major focus on child protection activities since Maria Colwell in the 1970s, that is different from saying the protection of vulnerable people was always in formal priorities set by government, and on which organisations and their leaders are performance managed. If an organisation does not meet those formal priorities (often known as targets), there are serious penalties to be paid. This point should not be exaggerated, as a hurt child is a hurt child whatever the target of the day, but as far as the Police and Social Services are concerned it is interesting to consider the issues for which they were under pressure. The author has looked at all Ofsted reports on Oxfordshire Children's Services from 2004 to 2014 and the words 'sexual exploitation' do not appear until after the Bullfinch case. There is no evidence therefore that Ofsted was looking to see how the County was dealing with CSE, even after statutory guidance was issued in 2009. This suggests that the notion that it could happen anywhere so everyone needed to be well prepared was not one that was inspected in practice; rather, it was something that only happened in particular places.

7.3 The Police IMR does not hide behind the fact that sexual exploitation, or even protecting vulnerable people, was not a national priority during the pre-Bullfinch years and

acknowledges openly that many mistakes were made. Nevertheless, it does point out that the key aspects of performance on which TVP was being judged did not include an emphasis on vulnerable people. It describes how the statutory performance indicators in the National Delivery Plan 2006-9 were mainly about rates of acquisitive and life-threatening crime, gun crime and violent offences per 1,000 population. There was no mention of child abuse in the Delivery Plan. The IMR says: *"The Home Secretary's 'National Policing Plan 2006-2009' guided local priorities particularly in relation to their performance target"* and described some local plans. *"It is also notable that like the National Policing Plan neither child protection nor missing persons featured in the performance data produced for this document, suggesting at this time neither were seen as a specific [local] priority, something reflected across the Force."*

7.4 This does not mean that staff who were working on, for example, missing persons did not work extremely hard at what they were doing, but does indicate the challenge to devote priority time to activity that might prove lengthy – and often fruitless as investigations were unlikely to lead to convictions. There was, however, no evidence of a knowing decision *not* to pay attention to potentially exploited or otherwise vulnerable children because of priorities. Again, not using this as an excuse but to illustrate the context, the County Council showed the SCR how intensive the external performance management culture was with, say, in 2008-9, 115 different targets for children and young people that had to be accounted for – none specifically related to sexual exploitation and one for missing children.

7.5 **Oxfordshire's journey:** This section goes into detail, as local agencies will learn from seeing how the knowledge developed in the uncoordinated way it did. There is no evidence that the overall position of readiness in Oxfordshire differed substantially from that in many other areas, but it is the case that from the mid-2000s there were girls (and more than A-F) who were sexually active with much older men, getting involved with drink and drugs and some associated crime, sometimes hurt, and often missing for substantial periods – so Oxfordshire may have had a greater chance than some areas to identify CSE. As will be seen, what is hard to explain is that, with many professionals very worried about the girls, with considerable resources being used to keep them safe (for example, in distant secure facilities) and 'missing' statistics which were unusually high, why the full picture did not emerge and the issue never percolated through to governing body level such as CEOs, Boards, or Committees. The 'journey' is described firstly by looking at the OSCB, which had a statutory oversight of child protection work, and secondly how things unfolded across the County over time.

7.6 ***The Oxfordshire Safeguarding Children Board (OSCB):*** The 2002 Oxfordshire ACPC (the predecessor body of the OSCB) procedures echoed recent national guidance and included *"Entry into prostitution usually involves a complex set of factors often including a strongly dependent relationship with a coercer or an abuser. Helping a young person to leave prostitution will therefore be complex, involving winning trust and overcoming fear, and may therefore take time… Children and young people living in and leaving care, especially residential care, are particularly vulnerable and those who run away even more so. Joint local authority/police procedures must be followed when young people go missing and when they return."*

7.7 The first reference to young people involved in prostitution in ACPC minutes was in 2005, where it was agreed that police and CSC would work on 'a piece of action research'. At the next meeting, it said that *"a member of the CSC's City team was working with the Police Child*

Protection Unit to identify incidents of 'sexual exploitation' with a view to further analysis", with the action allocated to the interim Head of CSC. The OSCB says there are no subsequent references to this.

7.8 In 2007, there were several mentions at the Board or its subgroups. In March 2007, the minutes of the OSCB (chaired by the CSC Head of Service) referring to its City sub-group noted '*... concerns about 14-15 year old girls in relation to drugs/prostitution/going missing, a problem which seems to be increasing. It was agreed that the Board needs to address this. Action is in hand locally".* (At interview, the then City subgroup chair said that local action meant "*We were dealing with the individual children's cases and managing the risk".*) In May 2007, the OSCB Core Group (a subgroup which monitored OSCB business), chaired by the Head of Service for CSC, agreed to a future agenda item, the "*role of child protection process in protecting young people exhibiting risky behaviour (drug abuse, prostitution etc) for July agenda". (*At the next two meetings of the OSCB Core Group, discussion was postponed twice due to the absence of the Police member, with any references then stopping after August 2007).

7.9 Parallel to this, the OSCB City subgroup met in June 2007 and recorded *"continued concern regarding cases of 14-15 year old girls exhibiting out of control behaviour and possible involvement in prostitution and drug use within Oxford"*. There was a case discussion about two girls, one of whom from initials used was one of A-F. *"… Police are feeling equally as 'stuck' as any other agency in how the negative influences for these cases can be addressed (i.e. Drug Dealing, Possible Prostitution, Missing Persons and high risk out of control behavior). Subgroup members agreed, at last meeting, that this required a wider/ joint response, but issues still appear to be being considered on a case by case basis. There is a serious concern that there is an organised abuse ring within Oxford and that a Complex (organised or multiple) abuse investigation should be considered".*

7.10 The action was for the subgroup chair, a CSC officer, to brief his two senior CSC safeguarding and quality assurance colleagues. There was no mention of this item at the next City subgroup meeting. There is no indication that a *"complex abuse investigation"* was held or actively considered. The Review understands that the County Head of Safeguarding wrote to social workers to try to obtain more evidence about CSE, but had a *"poor response"*, and it was not thought that complex abuse procedures should be implemented. There should have been follow-through to a formal conclusion. The point the subgroup minute made about things being looked at on a case-by-case basis, and it needing a wider, joint response, was exactly right and stayed the position until early 2011.

7.11 The OSCB, a week later in mid-June, had a verbal report of the City subgroup and minuted *'There are concerns about a number of young women coming into contact with statutory agencies who may be victims of organised prostitution. (A CSC service manager) is pulling together what information is known with a view to making a judgment about likely connections and the need for these cases to be addressed other than on a case-by-case basis."* The minutes made no reference to its City subgroup's view that *"there is a serious concern that there is an organised abuse ring within Oxford and that a Complex (organised or multiple) abuse investigation should be considered".* There is nothing in subsequent minutes. The OSCB IMR says that, at the time, there was no process in place to pick up items that dropped off the agenda.

7.12 In September 2007, the OSCB City subgroup met again and, as mentioned earlier, the City Nuisance Officer and a colleague warned about the risks to children from massage parlours and reminded the meeting that his team was continuing to pass to the Police information about 14 and 15 year olds being seen in cars with older men.

7.13 No further reference to the mix of drugs/prostitution/young teenagers has been identified in OSCB and subgroup minutes until the Bullfinch investigation.

7.14 In September 2008, the OSCB's Monitoring and Evaluation subgroup noted the increase in children going missing, and at its March 2009 meeting a member of the Missing Persons Panel said there were *"no specific concerns"*. That year, following a Joint Area Review[34] (a multi-agency external review), an OSCB Business Manager was appointed full-time for the first time to address the deficiencies in business administration. The OSCB says there are several recorded minute entries about insufficiently regular or senior attendance leading to insufficient *"promotion of child protection issues and disseminating information within their agencies".* (The March 2009 review[35] of progress after the Joint Area Review rated the OSCB as good, as has Ofsted since then.)

7.15 The 2009 statutory guidance was not picked up in any meaningful way. The OSCB explained to the SCR, "*From 2008 to 2010 there is an increase in the number of guidance documents raised at Board level, as evidenced by the Board minutes and associated papers. At the time the role of Business Manager… included producing an overview of recently published guidance and proposing recommendations to the Board for further action… this appears to have been left for the Business Manager to assign follow-up actions. There is no evidence these actions were arrived at in conjunction with the Chair… or any Board Member. This reliance on the Business Manager appears to have led to complacency amongst the members in challenging whether these decisions were the most appropriate ones."*

7.16 The Board members were not sent a copy of the guidance but alerted to its existence in a September 2009 agenda paper, which listed another 11 items of guidance from the previous six months. The recommended action in the paper was *"OSCB procedures to be reviewed against guidance. Put on website".* The minutes make no reference to it, so one presumes the fact that it contained much beyond simply 'procedures' was not noticed by members or Board officers. In fact, nothing happened until the January 2010 OSCB meeting, when a 'Sexual Abuse Mapping' paper went to the Board. It said that the Oxfordshire Safer Communities Partnership had set up a Sexual Violence and Abuse Group to *"drive forward the agenda".* Noting that a senior CSC manager had not been able to attend, the paper (which made no reference to CSE in the narrative) recommended that the OSCB *"require that a senior manager from Children's Social Care become an active part of the sexual abuse strategy group to ensure the needs of children are included in this strategy… This member to feedback to the OSCB on a 6 monthly basis the progress to date… ensure this member also pick up the work from the Government's Guidance on Children who are Sexually Exploited…"* A strategy was delivered for July 2010, but did not cover most requirements of the statutory guidance.

7.17 A senior safeguarding nurse on the OSCB told the Review that it was not that there was no consideration of CSE, but that it was *"simply not believed to be a local issue".*

[34] *Joint Area Review – Oxfordshire* (Ofsted, April 2008).
[35] *Final Evaluation of OSCB* (DCSF, March 2009).

7.18 The Sexual Violence and Abuse Group to which the OSCB passed the statutory guidance was not actually part of the OSCB, but was under the Oxfordshire Safer Communities Partnership, another multi-agency partnership, facilitated by the County Council. This was not or not wholly appropriate as the guidance contained statutory requirements for the OSCB itself.

7.19 In January 2011, the OSCB Chair and Business Manager received from the chair of the Board's City subgroup a City Council report on CSE. It was referred on to the Sexual Abuse Strategy Group (see previous paragraph) and seems never to have been put to the Board. The City report, which had been drawn up after surveying agencies' knowledge of the signs of CSE in their work, summarised national guidance, gave the results of the survey, highlighted the shortcomings in local services, referred to the recent major CSE case and SCR in Derby (Operation Retriever), and made many recommendations.

7.20 It came from the City's Drug Strategy Coordinator, but was the sort of report that should (under national guidance) have been prepared by Safeguarding Boards, or certainly given higher-level consideration. It was done because "*In late 2009 concerns were raised in Oxford by a professional that young school girls had disclosed that they were in receipt of high priced gifts in exchange* for *sexual favours",* and it identified that *"No data collection of children & young people who are 'at risk' or who are affected by sexual exploitation, No specific child sexual exploitation training for professionals, care pathways are generic and do not address specific concerns for children & young people who are being sexual exploited, and no specialist service who can offer support to those at risk, victims and/or parents/carer."* It was a useful review of national knowledge, organisational and training needs locally, staff perceptions of local risk from CSE, etc, but it did *not* identify the CSE as it was later understood. At the end of January 2011, the Drug Strategy Coordinator asked the OSCB City Safeguarding subgroup Chair if the report had gone to the OSCB Executive. The response was that it was understood the matter was to be put to an existing sexual violence group and asked whether the Drug Strategy worker knew the Chair of that group. *"I will discuss with [the Business Manager] as you must be linked in!"*

7.21 It was June 2011 before that report's author joined the Sexual Abuse Strategy Group and the minute does not indicate that her report was received. In any case, this was not an OSCB subgroup. By this time, Operation Bullfinch had started, although few people, for reasons of operational secrecy, knew the details. In the summer, as a result of some knowing what was being investigated, the Sexual Abuse Strategy Group was disbanded and replaced by the CSE Task and Finish Group, which, this time, was a subgroup of the OSCB. Invitations were issued in August 2011 and it had met before it was formally approved by the OSCB. The City Drug Strategy Coordinator was a member.

7.22 It is clear that failing to follow or to follow fully the 2009 national guidance was initially widespread in England, and the OSCB did go through a period when it was less than thorough on CSE, with no strategic oversight of the topic. It was not that it was ignoring messages about local concerns, but that, other than in 2007, such messages did not get to the Safeguarding Board itself until 2011.

7.23 Some former top CSC managers were critical of OSCB organisation/proactivity in their interviews with CSC. Before 2008 there was no Independent Chair. Other than the very part-time Independent Chair from 2008, all LSCBs consisted only of the senior representatives

from each agency, and the critics were some of the most senior and influential members. This raises questions about how much members of the OSCB fulfilled their statutory duties as members.

7.24 Safeguarding Board Annual Reports were statutorily required from 2010-11. The first contained no reference to CSE, but did include an article about missing children by the Detective Inspector in charge of the Police CAIU. It did not refer to CSE being a possible cause. This may have been because Operation Bullfinch had just started and great discretion was being used until arrests were made. In contrast, the 2011-12 report has tackling CSE as a priority. There is a CSE subgroup. It identifies there is CSE in the County, reports a July 2011 OSCB conference on CSE, and announces the forthcoming CSE strategy and the introduction on the Kingfisher specialist multiagency CSE team. The then Chair said that *"CSE has become a key focus for the Board…"*

7.25 ***The growing awareness in Oxfordshire:*** This part looks at how awareness grew across the agencies working with the families. The detail here highlights not only great effort in some quarters, but also who knew what, and learning about inter-agency connections. The awareness in the County came from those who worked with these children and families or in their communities and who had a growing sense, despite the girls' frequent denials and lack of cooperation, that there was something really awful happening. Many signs could have been seen, and the girls and families would at times give sufficient information for conclusions to be drawn. The headline milestones in the journey should not be taken to mean that nothing else was happening, as the 3,900 pages of agency chronologies testify. Many entries are the same event described by different agencies, but there would probably be up to 10,000 contacts and events. The momentum grew strongly in 2010 as various groups took the initiative, although not in a coordinated way, and staff who led those strands of discovery should be applauded for their determination and concern.

7.26 The paragraphs above on the OSCB describe some mentions of child prostitution from 2005, with nothing further on this or exploitation until 2007. However, there was growing awareness in 2005-6 of very serious cases and extreme behaviour associated with going missing, drugs, older men and prostitution that do not seem to have been addressed by the OSCB, its local subgroups or top managers – or, more accurately, not brought to their attention. With one of A-F, the following references could be found in her chronology of agency records in one period of less than three weeks in 2005.

- 13 years old
- Drug use – crack
- Symptoms of cannabis dependence
- Delivering cocaine/admits drug dealing
- 'They sprinkle coke on weed'
- Associating with 'older inappropriate males'
- Not eating when missing
- Frequently missing
- Returns home dehydrated and in neglected state
- Emaciated in police station
- Mother complains over 3 weeks is too long to wait for a multi-agency meeting
- Child left a note about 2 rapes – charges followed
- Blood soaked jeans and underwear

- May have been 'prostituting herself'
- Says she will be dead by 20
- Receives phone call with accented black man – she is in debt to men. Number given to police
- Being driven in and driving cars
- At risk of sexual exploitation
- Sexually assaulted by 2 males

7.27 There was very considerable agency activity in this period, but one wonders if this case was typical of many and did not stand out, or was so extreme that it should have warranted very top attention. In the same year, there were concerns about at least three of the other girls around going missing, adult men, drugs, coming back from missing with money, etc. One girl was branded. Despite this, there was no recognition of a Bulfinch-type coordinated and wide-scale abuse.

7.28 In 2006, there was the abandoned trial when a child refused to give further evidence under tough cross-examination. There was also concern about the management of missing children, especially from Care, as seen in the plea from the Police Missing Persons Coordinator to her superiors up to head of Oxfordshire level in September 2006, and there were meetings about individual children with good level multi-agency involvement. This included a Police DCI-led 'Tactical Meeting' (which may in part have been a response to the coordinator's email) with County and City staff present, as well as the private home where the girls were placed. It discussed multiple offenders described as a *"paedophile ring"* being arrested for offences against one of A-F. It was agreed that TVP would consult other forces about the subject in general and the child concerned (which led to the creation of the Missing Persons Panel).

7.29 The minutes show that, as well intentioned as the meeting was, much of what the child was saying was disbelieved, even though the notes showed that many signs of being abused were known. There was a discussion on using ASBOs and other control measures with *"the males".* This indicates an awareness of the possibility of group exploitation in 2006. There was also a very high level of concern for several of the girls across 2006. This is discussed further under 'Missed opportunities' in Section 8.

7.30 In 2007 the OSCB, as described earlier, twice recorded concerns by its City subgroup. In June 2007, after concerns were raised about a possible 'organised abuse ring', the County Head of Safeguarding tried to find supporting evidence and decided not to introduce complex abuse procedures, it is understood because he thought there was insufficient evidence. At the end of 2007 a strategy meeting was held about one child and her involvement with an adult Asian male (referring to violence from a man later convicted in Bullfinch). A few days later, cross-references to other children began to emerge when, at a strategy meeting with at least CSC middle managers present (but no police), others in A-F were mentioned. The notes say: *"Concerns regarding the association between a number of girls LAC/leaving care and adult men from the Asian Community".* Three from A-F were listed. The content of the meeting, although relating to different girls, was very similar to the meeting almost three years to the day later, which led to the first complex abuse meeting being called. It told of groups of men, sex with adults, drugs, drink, named men, and disclosures from a child.

7.31 A CSC chronology comment wondered whether this was the first strategy meeting where multiple victims were discussed. It may have been for three or more girls, but the September

2006 Tactical Meeting was about two girls and multiple men. However, earlier in 2007, the City Drug Strategy Coordinator, part of the City's Community Safety Team, attended the daily morning briefing of the Oxford Police as usual and heard about two of A-F absconding from Care and being with two adult males (later convicted in Bullfinch). She corresponded with a Police managerial colleague: saying "*There are a number of females in social services care and the missing persons who are going missing on a regular basis. Care Plans are in place for some but there seems to be little done about the males involved."* She asked if the care homes could stop the children or test for drugs on return. *"If all else fails note the details of the car, occupants and pass them onto the Police. Letters can be sent to the registered owner advising if found with the females again or in the area of the Home legal proceedings will be considered..."* The Police colleague replied saying she had told a senior officer about "*possible tactics that could be used against perpetrators"* in order to tell more senior staff.

7.32 The City worker forwarded the correspondence to the Missing Persons Coordinator who, in response, reported positive links with residential homes. *"I have spent many an hour with social services at the children's homes with reference to keeping their children safe. They are powerless to prevent them from leaving and are VERY well aware of the risks the children are exposing themselves to. I've a fairly good relationship with the staff and have been given some info re males, vehicles etc, which has all been submitted on 72s."*[36] This suggests that, by spring 2007, there was a degree of knowledge about multiple victims and perpetrators at least amongst those involved in the management of missing persons. This adds to the similar conclusion about 2006.

7.33 Across 2007 and 2008, the City Crime and Nuisance Action Team's (Canact) Nuisance Officer was repeatedly trying to alert CSC (and the Police) to concerns about the vulnerability of one Bulfinch victim. In March 2008, he alerted the senior Police officer in charge of Oxford, copying in a CSC social worker and the safeguarding manager concerned that a 13-year-old was connected to prostitution, was associating with adult Asian males, and was unprotected. (There was indeed very considerable Police and CSC activity around this child, but the gist of his concerns was that protection was not nearly robust enough and specific risks were being tolerated.) The records show he submitted personal sightings of the child in compromising situations with adults, and numerous intelligence reports gathered through his work about her late night contact with adult men despite being in Care.

7.34 In January 2008, a CSC manager told the Missing Persons Panel that one of A-F "*had been disclosing to her social worker her involvement in the past with groups of young Asian males from the [named] area and named other girls involved. [The social worker] described how [the girl] would provide information up to a point but was afraid to stand alone."* CSC says that a *"strategy meeting was to be held on February 5th at Oxfordshire County Council to look at girls with common stories/males for mapping. Details/minutes of meeting not located"*. A few days after that, the County Council Safeguarding Panel (which looked at complaints raised by Looked After children) discussed three of girls A-F. In two cases, the 'complaint against' was logged as *"Asian men' including X"* (a well-known Asian who had allegedly raped one of the girls at 11). The 'Concern' was listed as *"sexual exploitation".* The action was logged as *"strategy meeting held... intelligence being collated… names of other girls… registration of numbers of cars".* At interview for the CSC IMR, the Director of Children's Services at the time had no recollection of this and the Head of Safeguarding was *"not aware"*. The Head of

[36] An internal Police intelligence document on which information is shared and assessed.

Looked After Children services was aware, as was the CSC QA manager for safeguarding who was keeping a list of girls to be followed up at the monthly meetings.

7.35 In 2008, the Police Prostitution Strategy 2008-11 (which had been contributed to by the Drug Strategy and Domestic and Sexual Abuse Coordinators from the City Council) was produced, with good guidance on missing persons, grooming and so on – but it is clear at that point that there was no awareness of abuse on the scale later revealed, as it refers to only *"small pockets"* of prostitution.

7.36 The City Drug Strategy Coordinator chaired the multi-agency Sex Workers Intervention Panel, which began to hear about much younger females being involved. The Detective Inspector who later led the Bullfinch inquiry, on the back of a successful trafficking trial, and was keen to understand more about CSE, also encouraged her to explore further. She decided, in consultation with her manager, to set up a youth version of that Panel and in March 2010 the Prostitution Strategy Youth Group met with representation from 12 staff from the City, County and Health, with apologies from a Police schools officer. The minutes said that *"anecdotal evidence had come to light of young girls who were being groomed by much older men in Oxford. The men were buying expensive gifts for the girls who believed them to be their 'boyfriend'. This has raised concern and this scoping meeting has been set up to determine if other agencies are aware of young people, boys and girls, who are being sexually exploited. If they are then how prevalent is it and how are they responding. If it is agreed that there is an issue then how do we tackle it?"*

7.37 Interestingly, it said that *"all agencies reported cases of young people engaged in some form of exploitation".* (By 'all agencies', it meant the relatively junior staff with whom inquiries had been made.) The minutes say the form of the abuse included the following – a near perfect description of what was described three years later in the Bullfinch trial:

- *Older 'boyfriends' who buy expensive gifts for girls under the age of 16*
- *Girls granting sexual favours in return for somewhere to sleep for the night*
- *Girls selling their bodies to pay for a drug habit*
- *Girls being collected and taken to London*
- *Family member actively facilitating sex with their child*
- *Grooming solely to sexually exploit*
- *Abusive same age relationships, where the females believe that they cannot say no*
- *Young girls actively targeting older men to establish a 'father figure' relationship that is missing from their lives*
- *Young people going through the care system increasing the likelihood of being sexually exploited*
- *Young girls proactively engaging in sexual activity with older men for complex reasons*
- *Rape being used as a punishment within groups*

"In all of the cases reported there is professional involvement but the majority of the females do not see themselves as victims at this point and are not ready to listen to advice… It was agreed that there does appear to be a problem in this area but as there is no formal monitoring the number of girls being sexually exploited is impossible to quantify." The minutes say they needed to continue to develop a strategy to tackle CSE and bring the Police and some other agencies into the group. The pooled information at this meeting suggests considerable awareness of sexual exploitation a year before the Bullfinch investigation started, but the

minutes were not seen in any senior setting.

7.38 The day before this meeting, the Missing Children Panel, with no overlapping membership, had met and noted the 57 missing episodes from Home A in the previous three months. A month later, the OSCB (also with no overlap with those who were working on identifying the problem) appears from its minutes not to have a related item on the agenda.

7.39 The next meeting of the Prostitution group was at the end of April 2010 – this time described as the Youth Sexual Exploitation (YSE) Group, with senior police attendance. The group was working hard on a terms of reference and clearly, and to their personal credit, saw it as *the* setting in which the problem was to be tackled on a strategic basis. A subgroup of the YSE group met in May to map out all the tasks that needed doing, and was concerned how they could demonstrate there really was a problem so they could argue for funding support. A *"risk"* noted gave a view that senior management was *"reluctant"* and was nervous of funding issues – but about what request and which management was not specified. It was from this work that the City Drug Strategy Coordinator did the research and produced the December 2010 CSE Scoping Report, which is discussed above in relation to the OSCB.

7.40 While this was happening, concern was growing in the Police. In February 2010, a CAIU Sergeant was raising concerns about three girls who had gone missing 53 times from Home A in three months and a request was made for this to be discussed at the Missing Children Panel in March. In May, a PC in the East Oxford Neighbourhood Policing Team became aware of several girls being involved with older Asian males regarding prostitution and underage sex, and another PC logged 31 intelligence reports about the same thing. In June, a DC in the CAIU reported attending a meeting about seven girls (two from A-F) called by CSC. No minutes have been located but notes suggest useful exchange about involved places and names of adults. Donnington Doorstep also attended. This was one of three such meetings that were key in piecing the scale of the abuse together

7.41 The meeting above was called and chaired by a CSC specialist practitioner (senior front line worker) who worked in the CSC referral/assessment team, where she was *"seeing all new referrals at the assessment team, talking to colleagues at the office, and especially with the ex Home A colleague... the same names kept cropping up. I also picked up more as locality senior for East Oxford which included Donnington Doorstep, relevant schools and children's centres… There were three girls [two of girls A-F and another]. There was something else – we didn't understand what."*

7.42 Although often referred to in records as strategy meetings (statutory meetings to determine investigative steps on a child), they were not. Rather, they were 'professionals meetings', which are informal information exchange meetings. The chair's team leader was aware of the first and the area manager from the second. Minutes have only been located for one of the first three meetings, although one attendee kept personal notes seen by the Review

7.43 After that first meeting, the CSC Service Manager for Strategy, Performance and Development contacted the Youth Exploitation chair (the City Drug Strategy Coordinator) to ask whether she had any figures on child exploitation to assist with the sexual violence and abuse strategy she was working on with a colleague, also from the City. In a long response, she explained about the Youth Exploitation Group, the impending survey, youth workers' concerns about girls and older men, how youth workers felt they needed more

training, and her thoughts on how she could go about making links to take the work forward. The reply was that the Service Manager would raise this with the Service Manager for Safeguarding and the Chair of the Sexual Violence and Abuse Group: *"However, I agree if this is a growing concern, more strategic action will be needed."* (The CSC head of safeguarding told the CSC IMR he was unaware of concerns until 2011.) The same month, the City ran a conference on human trafficking *"especially women and girls into prostitution"* attended by 100 people.

7.44 The OSCB met at the beginning of July 2010 and approved the Sexual Violence and Abuse Strategy, which had some reference to CSE but was not a CSE strategy. Also in July, whilst conducting inquiries on one of the girls, officers were told by her social worker about four men she was believed to be associated with. Two days later there was a *"child protection (non-crime incident) report"* which said confusingly, *"This crime report has been created to collate information/intelligence/referrals etc in relation to a number of young females [including two of A-F] in the Oxford area who are suspected of being involved in the sex trade. To date there is a number of crime reports in existence. A number of the females concerned are also regular missing persons."*

7.45 A few days later two neighbourhood PCs attended the second professionals meeting chaired by the CSC Senior Practitioner about nine girls who were or might be involved with sexual exploitation, including the same two from A-F. Again, a number of males were named, with at least one later convicted in Bullfinch. The Drug Strategy Coordinator who chaired the youth exploitation meetings was there and recalls feeling concerned that the group was not meeting again until after the holidays and there appeared to be no plan in place to address what was being discussed about the girls. (The concern was not escalated.)

7.46 The Sexual Violence and Abuse Group to which was referred the City CSE report was another stream of meetings, in addition to those led by the City/Youth Exploitation and CSC, and the developing thinking by the Police. In October 2009, a multi-agency meeting of the Sexual Violence and Abuse Strategy Group (SCASG), occurred *"under the auspices"* of the Oxfordshire Domestic Abuse Steering Group (ODASG), itself a subset of the Crime and Disorder Reduction Partnership (CDRP). It said that *"reports will go to the Oxfordshire Safer Communities Partnership and CDRPs via OSDAG".* (The SCR understands that, while Community Safety Partnerships sit statutorily under Districts, the Oxfordshire Safer Communities Partnership sits under the County Council.) One of the Strategy Group's functions was to "*drive the Sexual Violence and Abuse Strategy".* Its place in the structure of meetings was unclear as the minutes say that "*SVASG would be a stand-alone strategic group but will be reviewed in future to determine if it would be better placed in ODASG".* It met again in early 2010 with an OSCB officer present and began to refer to children, noting that the OSCB had no sexual abuse strategy.

7.47 Despite this rather vague positioning, the group did do important work and created the Sexual Violence and Abuse Strategy that was presented to the OSCB on 1 July 2010 by a County Council Strategy Manager who had been part of the process. The strategy did have a children's section. The lack of clarity about structure was shown in the City IMR, which said the SVASG belonged to the Safeguarding Board, while also saying that when the Drug Strategy Manager went to her first meeting of the group in April 2011 it was *"convened as a development group rather than established partnership and will look for a longer strategic 'home' for this work".* This demonstrates that the process was not clearly 'owned'.

7.48 In August 2010, an intelligence PC prepared a report about children running away from care. "*Most were regular missing persons and intelligence suggested that they were being collected from the Oxford area and taken to addresses in the West London/Slough/Reading areas where they were supplied with alcohol and drugs and were then used for sex with groups of older Asian males. This report raises concerns that the males had returned and a 'new generation' of young girls were being involved in the same activity."* In another report, a CAIU Detective Constable told the Detective Inspector that she had visited all four girls (two from A-F) some several times, including *"one last time with their social worker".* Three of them denied any involvement in prostitution, and the fourth subsequently denied it. The Police had been conducting *"high visibility patrols/stop checks",* the PC had researched Facebook, mobile phone records were being examined. It concluded: *"I do not believe we are in a position to progress this investigation further at this time In my opinion, the only way… would be to conduct a covert operation in order to identity possible offenders and gather intelligence".* This shows much work by the Police in association with CSC, even if it concluded they could not act against offenders then.

7.49 In September 2010, the third of the CSC professionals meetings chaired by the Senior Practitioner (now an Assistant Team Manager) was held. The Police reported that all the relevant girls had been seen but there had been no disclosures. Six days later, the fourth youth sexual exploitation meeting took place with a range of City, County and Health staff, and the Detective Inspector for the CAIU. Like the previous meetings, it was chaired by the Drug Strategy Coordinator. Only a City Community Partnership Manager was at both meetings. It discussed the results of the survey the City worker had done. The numbers of cases reported by the respondents was more than had been referred to CSC. It was wondered whether they were referred without use of the word 'exploitation'. It was suggested the group contact the Chair of the OSCB. The Inspector suggested a presentation at the OSCB to include gaps in return interviews of missing children

7.50 In October 2010, at an Oxford City Police meeting, another Detective Inspector discussed one of the children who was missing being involved in prostitution, and the CAIU met with the Children and Families Assessment Team regarding a number of girls. The Police note that there was a *"joint decision that without further actionable intelligence or disclosures this could not be progressed any further".* Later in the month, a CAIU report showed that there had been 204 missing episodes from Home A in the first ten months of 2010.

7.51 In the autumn the Youth Exploitation Chair (and two other City colleagues) joined the National Working Group (NWG) on Child Sexual Exploitation – a network of projects, practitioners and policymakers. *"It gave me a huge amount of knowledge, contacts, resources – and access to the lead of the NWG."* She informed the Oxford DCI of the Leicestershire Police model and *"obtained copies at his request including the policy which was currently being reviewed by the National Police Improvement Agency (NPIA) for adoption of good practice nationally".*

7.52 In November 2010, the CID Detective Inspector who later initiated the Bullfinch plan first *"recognised the potential for wide scale abuse and began work to identify the full details of the offending"*, a view which he further confirmed in January 2011. Also in November, there was a Child Exploitation Project meeting chaired by the City's Drug Strategy Coordinator to discuss how to take forward the findings of the survey and resulting report. This had more senior presence, with the Chair of the OSCB's City subgroup and the Designated Nurse for

Safeguarding (who was to forward the report to the OSCB), the District Council's representative on the OSCB, as well as the County lead on teenage pregnancy. In December 2010, the City CSE report described above was sent to the OSCB, although with little apparent response.

7.53 In December 2010, concerns were mounting, on top of considerable ongoing casework by CSC. Mid-month, the City Drug Strategy Coordinator wrote to CSC, the Police and Donnington Doorstep: *"I have been informed that the two girls are linked to a well-known sex worker… maybe introducing them into the ways of working. It is believed that the girls have been in her company whilst getting into a vehicle. They have also been seen at hanging around a known sex worker's address on the X Road… is believed to be out all night staying at her boyfriend's who is believed to be 21 years old [later found guilty of nine offences at the Bullfinch trial]. Mum seems to know where he lives and the relationship that [the child] has with him, may have been in this relationship for a number of years… You may already have this information but I am very worried about what is happening to these girls. The girls refer to themselves as prostitutes but in reality they are abused children as they cannot give consent. Is there any way that the girls can be removed from Oxford and found a place of safety? I am really scared that something serious will happen to these girls.*

I am trying not to be too dramatic but I really do have concerns and would recommend a case conference with all the agencies who have any contact with the girls to talk, with the girls present and their parents and explain what could, would, will happen if this continues… It would be helpful if the police could, where-ever possible, engage with the girls and give warnings to adults present about their involvement with these children. It maybe that the police consider issuing warning/harbouring notices to these adults."

7.54 It appears that, in response to this, CSC called a strategy meeting for the following day which included City, County, Police and Donnington Doorstep staff. Again, names of victims, perpetrators and addresses were pooled. The chair was the senior practitioner's team manager, and included Police and the CSC area manager who invited her Assistant Director. The notes, discussing one of A-F, said: *"…sex exploitation – discuss with (CSC head of safeguarding) we need to focus on this".* And also, *"Report being prepared for [the Chair of the City OSCB subgroup] to take to the OSCB".*

7.55 As a result of that meeting, and the worrying information being mapped about a number of girls, the CSC Assistant Director immediately wrote a briefing note to the then Deputy DCS (and Head of Service for CSC) referring to the information pulled together by City, County, Police and other professionals saying, *"… there are at least [five] girls known to social care who would appear to sexually expolited by much older men, a network of girls… (some are care leavers) linked to both adult sex workers schedule 1 offenders and half way houses for offenders… This was eye opening and as you can imagine extremely concerning."* It referred to three of the girls associating with Asian/Afghani men. A response is not in the documents provided, and there is no record of a follow-up meeting (given the level of concern) for six weeks, when CSC invited, at the end of January, a large multi-agency group to a 'highly confidential' Complex Abuse meeting on 9 February 2011. (There had been work in CSC on mapping information which had led to calling this meeting.)

7.56 Also in December 2010, the Greater Manchester Police (GMP) came across an Oxford girl in their Rochdale inquiries. She indicated a similar pattern in Oxford. There was communication

between GMP and TVP and the girl's Oxford social worker and the Police. The social worker's notes stated that a GMP email had said there had been *"an email from police in Oxford to say that there is a similar enquiry happening in Oxford… regarding child sexual exploitation".*

7.57 The CSC Assistant Team Manager called a 'planning meeting' around two of the girls for 17 January 2011. No minutes or attendance have been identified, other than a brief note by one attendee. The following day a decision was taken to call a Complex Abuse Strategy meeting.

7.58 On 20 January 2011 the OSCB Executive discussed the annual Missing Children Report. The Chair of the OSCB City subgroup, and the senior manager who had alerted the Deputy DCS in December to the sexual exploitation were there. *"Missing Children – There is more work to do in this area. There appears to be an issue with regard to the approach taken when dealing with frequent runaways. Each instance needs to be as thoroughly looked at as the first. Why they went, where they went and who they were with should be fully explored through return interviews as we need to know more about who they are with when they're gone. Within Oxfordshire most of the missing children reports come from the same few children.The Missing Children Panel is a case discussion panel and does not have sufficient strategic oversight of Missing Children. There needs to be a formal strategy... The Terms of Reference for the Missing Children Panel need to be checked to see if this is a function they could also pick up and if it would be suitable for that group. The Thames Valley guidance on Missing Children has yet to be signed off by all authorities. When it has been Oxfordshire need to ensure they are compliant."* There was no reference at that OSCB Executive to any of the concerns about CSE discussed at professional, strategy, Police or youth expoloitation meetings held over the previous year.

7.59 The same day the local CID Detective Inspector chaired a CSE scoping meeting, which included seven Police staff and the author of the City CSE Report, although the minutes incorrectly say she was from the County Council. This was essentially an operational meeting about tactics and information gathering – largely around girls missing from Home A. The meeting Chair told the Review that this was the point at which he decided that real action now had to be taken.

7.60 As a result of this meeting, the DCI for Intelligence and Protecting Vulnerable People wrote to the Deputy Director of Children's Services at the beginning of February 2011 to say "*There is significant intelligence to suggest that the national trend of local Asian males targeting our most vulnerable girls is occurring in the city. A number of these girls are housed within your institutions and we have particular intelligence relating to (Home A)... There are a number of options and tactics available to (the Oxford DCI) when considering long and short term solutions all of which need careful consideration. As some of these tactics are quite sensitive it is important we consider the appropriate engagement with yourselves as a starting point. This is particularly prudent in light of (the service manager for safeguarding's) work around grooming, prostitution and exploitation… What would be a good start is for the 5 of us to get together to discuss the situation and agree a way forward."* The Vulnerable Persons DCI was informed of the impending Complex Abuse meeting and asked the senior officer who had led the 20 January scoping meeting to attend.

7.61 Eight days later, on 9 February 2011, there was the first strategy meeting held under the 'Potential Complex Abuse Case' heading with a large attendance from CSC, health (the designated nurse) , the City, the voluntary sector and the Police (both the Oxford DCI and

CAIU DIs). The 28 January email invitation from CSC said that *"Family Support Teams in Oxford City have identified some potential links between children… that may indicate a grooming network for CSC."* The meeting discussed a number of girls, including three from A-F. It was chaired by the CSC Service Manager for Safeguarding. The Chair's pre-minutes note of the meeting said, *"During December and Jan 2011 social workers in the family support teams in the city noted continuing concerns relating to [five girls]. On January 18th the area service manager for the city and service manager for safeguarding met, a complex abuse strategy meeting was arranged to continue mapping out the concerns and inform the need for complex abuse investigation."* There was no mention of the 1 February top-level approach from the Police about group CSE being identified in the City, but three of the recipients of the 1 February email were there. It was a very detailed meeting sharing information, including 26 suspect addresses and health concerns.

7.62 The meeting concluded that there were *"some very worrying concerns…* and… *several participants remarked on the worry that this had been going on for some time".* It was also recorded that the police investigation so far had *"met a wall of silence".* The meeting concluded the need for *"absolute confidentiality"* to ensure no possible offenders were alerted. A large range of operational actions were agreed, and the Head of Safeguarding for CSC agreed to brief the DCS, with the intention of setting up a senior management group by 18 February 2011 *"to drive the investigations forward*" as per the Complex Abuse Protocol.

7.63 The Police have described the 9 February meeting as *"a critical meeting where for the first time all agencies involved acknowledged the extent of the potential abuse and in effect identified that child sexual exploitation was occurring".* After this meeting, the CSC Head of Safeguarding discussed it with the Interim Deputy Director who briefed the then DCS. The DCS informed the CEO and Lead Member for Children, and the CEO briefed the Council Leader. The next day, the City IMR says, *"the [Chair of the Youth Exploitation meetings] met with police to discuss issues and allocate tasks".*

7.64 The SCR has seen a helpful briefing note about the analysis and proposed investigatory work from the Interim Deputy DCS (who became DCS in November 2011), which it is believed was sent to the OSCB Chair (and top County officials), again urging confidentiality. For reasons which are not fully understood, the City Council CEO was not briefed for a further year, in March 2012, by either the Police or CSC.

7.65 In March 2011, the CID DI communicated with Oxford staff about the Home A girls being targeted, directed staff to pay particular attention to the males they were with, and provided guidance on Abduction and Harbouring Notices. The Assistant Chief Constable and then the Chief Constable were briefed in April.

7.66 ***Top of the office knowledge:*** A key issue in this Review is how long it took for concerns across the field to be coordinated and then reach the highest reaches of organisations. In the NHS there is no evidence that anything went to a board-level manager until after Operation Bullfinch had started. (One parent in 2004-6 did copy the Social Services Director into several letters to an MP, worried about the care and management of the daughter. One of the six letters did refer to the child being trafficked to London from another area where she was Looked After. The traffickers were not connected to Oxfordshire). At Donnington Doorstep the management was aware of individual cases from 2007, and was part of the meetings across 2010 which began to build the collective picture which Doorstep was itself seeing.

7.67 In the City Council, the Chair of the Community Safety Partnership (a Director, not a member) and the Partnership were aware of the national cases of CSE. It was from the Community Partnership arena that the work done leading to the City's December 2010 CSE Report emanated. The City CEO was not briefed on this work, but was briefed by the County DCS in March 2012 about Operation Bullfinch and recalls that he was shocked to hear what was happening, as was the City Council Leader who the CEO immediately briefed. The City says that *"was [the CEOs] first knowledge of the cases involving the children and also to the prevalence of Child Sexual Exploitation in the city".* This raises issues about inter-agency communication and internal escalation, as City staff were aware of at least the generality of Bullfinch. It is possible that those staff followed the Police request for complete confidentiality and did not even have discussions internally, but the Police, the SCR was told, assumed staff in the know would tell their seniors! The author is surprised that the City CEO was not taken into the inner fold of Bullfinch at the beginning, given that the offences were mainly in the City, its community safety role, and the role played by his staff in raising awareness of CSE.

7.68 At the County Council, there were long periods when concerns did not seem to be escalated above Head of Service level, or even at times to that level. The CEO said that she was first formally informed in writing about CSE in February 2011. She says: *"I was immediately alerted by the then DCS as soon as she herself had been briefed by her Interim Deputy Director... I also have a clear recollection of the deputy... [giving] me a heads up and saying words to the effect that he thought we might have a group operating similar to one of those in the north... Prior to this I had no knowledge of the concerns about CSE in Oxfordshire... I was subsequently made aware of concerns about a number of girls, some of whom were looked after but others who were living at home, who were suspected of being abused by adult Asian males. I was also made aware that there were concerns of historical abuse of a similar nature. At that stage we did not know the extent of the alleged abuse but obviously we quickly began work to identify this and thereafter I was regularly kept informed of progress... No previous Director had ever raised concerns about this issue with me. I had therefore not raised the issue previously with the Leader of the Council, the Lead Member or any other Elected Member."*

7.69 As the Deputy Director overseeing CSC was aware of pretty serious concerns from at least mid-December, it is surprising that neither the DCS nor CEO and Lead Member were briefed until after the Complex Abuse meeting nearly two months later. Escalation also did not happen to very top Police officers for some time after the pattern began to be recognised, which is also surprising.

7.70 The Chief Constable summarised the position for the SCR. *"The first time the issues, that were to become Bullfinch, were taken beyond the Police area occurred was when (the CID DI) highlighted his concerns to the Head of Crime, Detective Chief Superintendent… early 2011. Initial inquiries continued until the matter was taken to the appropriate Assistant Chief Constable who was responsible for both Oxfordshire and Force Crime... who then briefed me on Operation Bullfinch in April 2011."*

7.71 ***Operation Bullfinch***: In May 2011 Operation Bullfinch formally commenced following preparatory work and resource commitment by both the Police and Children's Social Care from Oxfordshire County Council. The joint Police and County investigation team comprised Police officers and staff and two senior social work managers seconded from CSC. This

ensured an aligned approach to the management of victims and eased the ability to share information. The investigation progressed identifying suspects and liaising with potential victims to obtain disclosures of sexual abuse. It proved very challenging to obtain disclosures from the victims as most were, understandably, mistrusting of any form of authority and the relationships were particularly difficult to maintain. Innovative but challenging tactics were used to secure forensic evidence which would prove critical at Court.

7.72 In April 2012, over twenty males were arrested in connection with the disclosures made by the victims and forensic evidence. Nine men were charged with various serious offences. Throughout this period the most challenging part of the investigation remained the ongoing management and support of the victims. Extensive work was undertaken with the CPS to overcome significant legal disclosure issues. The scale of this task required the CPS to employ two dedicated 'disclosure barristers' in addition to the prosecution barristers. The trial began in early 2013 and after several weeks the jury found the majority of the defendants guilty.

7.73 **Comment:** In many respects, organisational knowledge and reaction to guidance in Oxfordshire was similar to elsewhere, as national surveys have shown. There was the same slowness to grasp what was happening, and similar limitations in skill in how to tackle group-related CSE, as has been seen elsewhere – and not just in places with notable trials. What was to some extent different was that in the County, and mainly the City within it, there were more signs pointing in the direction of exploitation than would have been seen somewhere where there was no group-related CSE. In other words, there was an opportunity. In each year from 2005-10, there were discussions in one setting or another in Oxfordshire about sexual exploitation, but hardly any of this was at a level that could have made a strategic difference.

7.74 The author is not sure that the fact that seeing what was happening as prostitution, out-of-control teenagers, the result of home problems or whatever is sufficient to explain how it was so many years before there was concerted action and top leaders became involved. It might not have been understood as CSE, but there was little doubt the girls were suffering badly – even if it was thought to be self-induced. Not knowing the full picture does not explain some of the individual case management. The girls were only 12-15 years old.

7.75 It must raise a question about the culture of escalation in Oxfordshire, where top leaders seem never to have been briefed or consulted about what many of their staff were struggling with, or even interagency disputes. Also, about the effectiveness of the OSCB which appeared fairly peripheral at the time to the growing awareness of CSE. The report about CSE from the City was not put to the Board. It also raises questions about the working relationship between the County Council and the City Council, especially given that most of the abuse was in the City.

7.76 If important information does not reach the very top, it must be a combination of issues which relate to both escalating and receiving escalation. The OSCB and its member agencies will need to be assured that there are, now, more effective systems of escalation for concerns about abuse (both within and between agencies), that the OSCB is managed so it effectively implements national requirements and indeed holds the safeguarding ring in the County, and that there are open effective relationships around safeguarding, especially sexual exploitation between major agencies.

8 APPRAISAL AND LEARNING

8.1 Introduction: This section makes an appraisal of how agencies worked in Oxfordshire, looking at the context and explanations from previous sections, and forms a view on their performance back to 2005. Professional responsibilities for keeping children safe are both agency and collective. It is important to acknowledge the vast amount of work by professionals in all agencies with the girls and their families. Reference has already been made to the nearly 4,000 pages of chronology itemising agency dealings with the six girls, and the author could see evidence of daily work over long periods of time of a very challenging nature. This is not a story about not trying, but the degree to which the effort was effective in preventing or intervening to stop exploitation. Looking back now, even if there was enough information to indicate something very bad was happening, the CSC IMR author, referring to the full horrors of what emerged in Bullfinch, commented that *"It was striking at interview that all the social workers and managers had been shocked when they found out via internal briefings and external media reporting what had actually happened to the girls with whom they worked."*

8.1 As far as CSE is concerned, Oxfordshire has made very significant progress from the time in 2011 it was finally realised there was a pattern of organised CSE and multiple victims (see Section 4). It now uses modern methods of perpetrator-focused intelligence gathering, disruption and prosecution. The old attitude of the victims being responsible for their own plight has gone. Top leaders have shown high levels of personal commitment to tackling CSE, as well as the commitment of their agencies. People now visit Oxfordshire to see how things should be done. Nevertheless, it is right to see what can be learned from the period where arrangements were not nearly as good as they are now.

8.2 Learning points: Some 'learning points' from the SCR are itemised under each heading. Asking in these points for something to be checked against current practice does not be mean that it is necessarily not now in place, but emphasises the importance of agencies assuring themselves that it is. Some learning points may seem bland when compared to the dramatic stories in this Review, but they are about creating the environment within which front line work with the most difficult cases can be nurtured. This Review is being written up to four years after the corner was turned in Oxfordshire, and many learning points itemised below are already subject to work, for example in the OSCB CSE Action Plan. Where that is the case, these points act as further confirmation of their priority. A much more detailed description of the rich learning points for each agency can be seen in the *CSE in Oxfordshire: Agency Responses since 2011* report published alongside this SCR.

8.3 Were mistakes made? This SCR tries to understand why agencies responded as they did in order to learn from it. Although much of the response is understandable in the context of the time, it is clear that mistakes were made. There has been no attempt to deny this and the two most involved agencies have issued clear apologies. The Chief Constable apologised that it took so long to bring the offenders to justice and was sorry that "*we did not identify the systematic nature of the abuse sooner and that we were too reliant on victims supporting criminal proceeding"*. At the time, she wrote to all six victims and apologised, and met with three of the girls to make the apology in person. The County Council CEO was *"deeply sorry we were not able to stop the abuse sooner"* and said, *'We would like to publically apologise for not stopping this abuse sooner."* The DCS met four of the victims personally. It is clear to the author how shocking agencies and professionals have found the full revelation of the abuse,

and that opportunities to intervene were missed or belated. The author has encountered no efforts to deny the scale of abuse or that there were errors. The County Council offered and provided the children with (where accepted) a range of practical and material support in relation to post-trial normalisation of their lives. This recognised that victims lost a lot of normal opportunities earlier during their abuse, for example by not being able to complete their education.

8.4 Section 5 described in some detail the agency-based delays, and a summary of errors is as follows. Some were agency specific, some system wide. Many of the issues have been seen wherever else CSE has come to light, but some were more Oxford specific.

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 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
- 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 in 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 comprising 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

8.5 **Could CSE have been identified or prevented earlier?** The simple answer is yes. In practice, identifying CSE has proved difficult in many parts of the country, and it is likely that there will be more discovered elsewhere. Wherever it has appeared and led to convictions, there seem to have been warning signs not picked up earlier, a difficulty in believing such things could happen, and an attitude that looked more at victims than perpetrators as the source of the problem. This has been regardless of guidance, which has (even if using different terminology) for many years described the signs of child sexual exploitation and offered guidance on action. The issues contributing to the delay are appraised below.

8.6 ***Missed opportunities***: There was a window within which a number opportunities to recognise what was happening were lost. Given the general level of knowledge at the time, the then evidential requirements and the then lack of experience elsewhere, it would be wrong to conclude that Operation Bullfinch would definitely have happened earlier, but it might have done. In 2005-8, there were some significant concerns about multiple victims and abusers to a level very similar to that which, in 2010-11, led to Operation Bullfinch.

8.7 In 2005, there was considerable concern about some girls who we now know were being exploited. A detailed illustration is given in 7.23 above. There was similar knowledge in 2006 with the plea from the Police Missing Persons Coordinator, only a constable, to quite senior colleagues about the need for more action in relation to two girls, the need to go after the perpetrators, and expressing a fear that even death might occur. The same month (September) the police-led, multi-agency 'tactical meeting' discussed multiple offenders using the phrase *"paedophile ring"* and hearing allegations of rape by multiple men.

8.8 The coordinator's concern and the focus of the meeting were two girls in particular, one of from the 2005 example. The purpose of the table below is not to criticise action by front line staff – their work was dominated by these girls daily, and there were investigations, arrests of six men for offences against one child, residential staff out searching, medical care provided, Police visiting other areas to learn more, and very little consistent evidence was given. The purpose is to argue that what was happening was so extreme that it required attention by the highest levels of management, who, with their greater distance, may have been able to bring a more strategic approach to the problem and may have been able to identify patterns. It is also to query why these concerns were not reported to governing level.

8.9 The table shows extracts from agency chronologies of two girls in a period of around six weeks around the time of the tactical meeting, so both Police and CSC staff were aware of the detail (and doing a lot of work around these children). It would be hard not to conclude by this point that there was an organised element to the abuse. However, to put this in context, in 2006 there was little experience anywhere in the country of identifying, let alone getting convictions for, CSE and cases were still being seen as relatively isolated, with little chance of successful prosecution.

First girl, age 14/15	**Second girl, age 14**
Frequently missing from care home	Frequently missing from care home
Gave addresses where abuse happened	Gave same addresses as first girl
Admitted 'underage sex' with a group of Asian males	Advised police that she and the first girl had stayed the previous night in a multi-occupancy dwelling where there was drug taking. She showed police several addresses … described that the occupants at one address had two firearms
Drank a bottle of Jack Daniels	Said she had sex with four men one night, two the next and one the night after – in their 20s and 30s
Admitted to hospital, alcohol poisoning	Reported an oral rape
Tells hospital her friends have sex with her	Found by police with several Asian men who she said she had had sex with. Men later convicted in Bullfinch also arrived
Describes rape by two men convicted in Bullfinch six years later	Multiple arrests of Asian men
Told residential home staff she had sex with at least seven Asian men aged 17-33, with two older	
Told police she had oral sex with eight men in return for alcohol	
'These men are my protectors'	
In a crack den with Asian males	
Strategy meeting planned but did not happen	
Eventual meeting talks of 'paedophile ring'	
Thought to be having sex for drink drugs, lifts	
Tells police she has had sex with several Asian men	
Twice stopped by Police with an Asian male later convicted in Bullfinch. Told Police she was afraid of him, and that he and her friends knew her age	

Found with same man a week later and alleged rape	

8.10 There was a recognition that the management of missing children needed to be better, advice was taken, and the Missing Persons Panel introduced. But it was still not recognised that the prime focus on managing the girls was not the right approach.

8.11 In 2007 the OSCB was twice alerted to concerns from its City subgroup. The Board minutes in March noted, concern about an 'increasing' problem of 14-15 year olds going missing, agreeing the Board needed to deal with it, and action was 'in hand locally. In June, the Board noted its City group's concern that girls could be victims of 'organised prostitution' (the subgroup minutes called it an 'organised abuse ring'). The Board minute did not refer to the subgroup's view that a "*complex abuse investigation"* may be needed, or the "*need for a wider/joint response"* (rather than just tackling it on a case by case basis). The subgroup had agreed these views would be passed to County safeguarding managers. There is no evidence of significant action as a result of these concerns.

8.12 In 2007, the minutes of six OSCB and subgroup meetings refer to risks to young teenagers including from drugs, prostitution, and associated risky behaviour with men. Either attending, or seeing, minutes would be a range of senior managers and safeguarding staff (below director level). However, concerns were never revisited, and did not reappear in minutes for four years. The SCR has seen no evidence of this being in anyway a deliberate suppression, but it is clear that the OSCB and its member agencies should have taken it more seriously and reached minuted conclusions on any necessary action. For context, CSE by Asian groups as it later emerged was an unknown issue in 2007.

8.13 Also in 2007 (and 2008), there was the concern expressed by the City Nuisance Worker around one child aged 13-14, with numerous reports of association whilst in care with adult males late at night. In December 2007 there was a strategy meeting about one child about a missing girl marked by a man later convicted in Bullfinch, and threats from this man's family members. Eight days later, there was a very significant strategy meeting, which noted: *"Concerns regarding the association between a number of girls LAC/leaving care and adult men from the Asian community".* The meeting discussed groups of men, sex with adults, drugs, drink, named men, and disclosures from a child. It also discussed an incident for which there were convictions six years later in the Bullfinch trial.

8.14 The statistics on 'missing' in this period were also worrying. From 2005 to 2007, three of the girls went missing a total of 359 times, with 161 of those occasions being from Council care. In 2006 and 2007, Oxfordshire had almost half the missing from care episodes in the TVP area with only a third of the population. Half of all Oxfordshire missing from Care episodes in 2006 and 2007 were for two girls from A-F, so it is hard to argue that these were not exceptional cases. (The missing from care episodes in Oxfordshire continued to grow in 2007-8 and 2007-9, although the contribution from A-F was much smaller, which suggests the possibility of more girls being trapped by groomers.)

8.15 In 2008 the Missing Persons Panel, the County Safeguarding Panel and the Nuisance Officer's referrals all discussed exploitation by adult Asian males. In 2009, Donnington Doorstep was sharing concerns about girls and adult men. Early in 2010, the junior respondents from 'all agencies' reported to the Youth Exploitation Group a full range of signs

of CSE, and professionals meetings began to put the picture together around specific girls. The first any of this got to Director level was December 2010. The OSCB and agencies must make sure that there are processes in place so this could not happen again

8.16 There were also in 2005-8, for just four of A-F, 12 reported sexual assaults by some of the men later convicted in Bullfinch. Only two led to convictions, mainly due to evidential weaknesses, but this only led to a sense that little could be done, and the sequence did not seem to be discussed in any forum where the pattern could be recognised.

8.17 From what was recorded over these years, at least a partial picture of a group of girls, links with being LAC, multiple Asian abusers and real harm to those girls could have been formed. The component parts of that picture were seen to some extent by operational staff and some more senior staff in the CSC and the Police, but they did not trigger, in their un-joined-up state, a collective high-level managerial and strategic response, as occurred in early 2011. In the author's view, the level of information known by 2007 was not dissimilar to that which was sufficient in 2011 to trigger the discussions that led to Bullfinch, so opportunities were indeed missed.

8.18 The CSC IMR came to a similar conclusion about the depth of knowledge from 2005. It said: *"There can be no doubt that from 2005 onwards there was knowledge of these and other young girls being involved with older Asian males."* It gave many examples of girls being found with men convicted years later in Bullfinch, of events which were not fully investigated, for which there were convictions later in Bullfinch, and of where it would have be possible for staff to make connections. It said that the four older girls being managed in separate CSC area teams *"did not aid social workers to make connections"*.

8.19 It is not just that the bigger picture was not grasped but that the individual cases, which by and large were not linked, were so extreme in their circumstances that greater protection should have been given – regardless of whether there was an abusing group or not. It is important that this is not overlooked by just focusing on the missed bigger picture.

8.20 Ofsted rated CSC only as adequate in 2006, 2007 and 2008, raising issues including too many children placed too far from home, reviews for children that are Looked After need to be done on time, and the lack of placement choice on occasions putting children and young people in less appropriate placements (2006); Weaknesses with the referral, assessment and child protection systems. Increases in children being de-registered and re-register (suggesting hasty de-registration) and a need to improve the timeliness of LAC reviews; and the management of referrals and assessment raised for third time (2007); Rearranging processes had led to 'referrals' doubling (2008). The JAR in early 2008 described Council services saying, *"Oxfordshire's performance is often below that in similar authorities and the track record of improvement in services has been variable."*

8.21 A former DCS in post in 2006 and 2007 said: *"My perception of children's social care was of a service under very considerable pressure, high demand, significant overspends and I suppose in response to that it seemed like it had been constantly reviewed and there was a view that things needed to be different. Pressure points appeared to me to be: – entering care/LAC/Assessments …"* The CSC IMR described supervision as generally poor in these cases. Such cases, which are so hard, create powerful feelings and emotions in staff, and

good case supervision is essential so staff can be as insightful, objective and effective as possible.

8.22 Many authorities were 'adequate' at the time, so there is no necessarily direct correlation between this and CSE-related weaknesses. However, the key weaknesses listed by Ofsted and the JAR are those which may well have made it less likely that trends would be picked up, that risks that needed escalating would be identified, that children's progress would be reviewed well, and that children in Care would have been placed optimally. The tensions (not restricted to Oxfordshire) described above where DCSs did not have a social work background may have contributed (wrongly) to attitudes to escalation in CSC.

8.23 ***What was missing organisationally in Oxfordshire?*** Whilst there was much, looking back, which was not helpful, was ill-informed or even seemed uncaring, the general patterns seen in this Review were not unique, and there is no evidence of top managers or governing bodies failing to respond to what was later subject to many convictions at the Bullfinch trial – they did not know about it. What needs to be learned from locally is the picture (that did not fully emerge until the SCR) of parallel streams of work on what is called, in Section 7, 'Oxfordshire's journey' of discovery about CSE. The local consensus is that there are now substantially better inter-agency connections, joint working arrangements, a well-functioning OSCB, and Bullfinch itself is said to have drawn professions and organisations together in an unprecedented way. But this SCR offers the opportunity to take steps to be sure that what is described under this heading has indeed been addressed or will be.

8.24 What was seen in Oxfordshire was a range of concerns, some very high, about the risks to which a number of girls, mainly LAC, were exposed by their association with much older men, drink/drugs and generally 'difficult' behaviour. For a whole host of reasons described earlier, responses were not what they would be now, the signs of CSE were not recognised or, even if suspected, were not drawn together in a way that led to collective top-level action.

8.25 In 2010 the several parallel strands of discovery began in earnest: the more strategic approach by City staff, the case-focused approach by County staff, and the growing concerns by City Police. And, across the whole period, the most intense work by CSC staff to manage the most difficult of cases. The key question is, why it was not pulled together earlier?

8.26 There are the simple answers about lacking knowledge, the inability to grasp that something so dreadful could be happening in Oxford or the County, and the nationwide attitudes which failed to see such difficult children as victims, and so on. However, there seemed to have been weaknesses in the collective work across the child protection partnership. The author would not want to imply that this was all unique to Oxfordshire, but it is what the OSCB and other strategic partnerships must make really sure has been addressed now.

8.27 The OSCB, although seen as good for some years, was not well developed by the time of the JAR in 2008: *"Underdeveloped operational and monitoring arrangements for the OSCB".* And although improvements were put in place with a new Independent Chair that year, it is clear that reaching a good level of functioning took some time, as evidenced by the non-response to the 2009 statutory guidance or not utilising the 2010 City report on CSE. That new and first Independent Chair reported that she found it hard to get deadlines met and to improve the performance management rigour found wanting earlier. She also felt that

meetings with senior council officers only happened at her instigation. (It would be fair to say that many councils found it hard to adapt to their first Independent Chair.) That Chair says her first priority was to improve the level and commitment of agency membership and develop the governance arrangements of the Board. The DCS appointed in 2010 says she instituted regular meetings with the OSCB Chair, and between the OSCB Chair and the County CEO.

8.28 Also, it has often proved hard for agencies, even senior staff, to appreciate that, other than the Independent Chair, who then would have worked maybe half a day a week, the LSCB does not exist other than as a collective of members. The only 'independent' professional on any Board is that very part-time Chair. This means that, largely, challenge and scrutiny of performance has to be on a peer basis. Indeed, at the time of Bullfinch, national guidance[37] required members to act independently of their agencies. *"The individual members of LSCBs have a duty as members to contribute to the effective work of the LSCB, for example, in making the LSCB's assessment of performance as objective as possible, and in recommending or deciding upon the necessary steps to put right any problems. This should take precedence, if necessary, over their role as a representative of their organisation."* (This was removed from national guidance in 2013, and it is unclear whether government still expects the spirit to be adhered to.) Before Bullfinch, the OSCB was not as proactive as it should have been. Certainly the work the City Drug Strategy Coordinator and colleagues did in 2010 to try to scope CSE and join agencies together to address growing concerns was what the OSCB should have been doing following the 2009 guidance, and doing more thoroughly in a CSE strategy.

8.29 There are indications that, before Bullfinch, the influence on the OSCB from top managers varied. This contributed to the OSCB not operating in a way that was picking up growing levels of concern, or exercising its statutory duty to have led collectively on CSE from 2009. National research would suggest this was not an uncommon picture. This, and the fact that concerns across all agencies never reached the most influential decision-makers, meant that those leaders were not driving a strategic approach and this contributed to the delay in identifying the CSR. The OSCB has been working well on CSE since 2011.

8.30 Secondly, there were also issues across agency boundaries. Oxfordshire has a two-tier local authority arrangement. Districts have community safety responsibilities, whilst the County have the statutory child protection role. It has taken Bullfinch for there to be a realisation of just how related are these two service areas. Without that understanding, the connections between the two in the City (the only District specifically looked at) were not close enough at middle management tier, whilst there is evidence of much closer working at field level. Although there is a much better mutual understanding now, pre-Bullfinch there was a degree to which it appears that in some quarters the City was seen as a rather small player. The correspondence about the Nuisance Officer's concerns did not show due respect for the views being put forward; not taking the City CEO into full confidence about Operation Bullfinch for a year seems remarkable. The only involved major agency not invited to join the overseeing Panel for this SCR when formed in 2012 was the City. City staff did as much as if not more than any to understand and identify responses to CSE when this was actually a collective duty, but this good contribution was not generally known until it emerged during this SCR – which makes the point.

[37] *Working Together to Safeguard Children* (HM Govt, 2010).

8.31 It is clear now that, within the County, CSE is not just in the City. One district used to represent all five on the OSCB. (The previous OSCB Chair told the Review that this was their choice). This has been addressed by the new Independent Chair, who has secured both resource and senior management commitment to the OSCB from all the districts. All districts understand the importance of membership. The need for greater understanding and clarity about the link between various strategic partnerships was confirmed in a 2013 external review[38] of OSCB effectiveness, commissioned by the OSCB, which listed as an area for development: *"Specifically clarify the respective roles and inter-relationships between the OSCB and the Health and Well-Being Board, the Children and Young People's Partnership Board, the Community Safety Partnership and the Safeguarding Vulnerable Adults Group".*

8.32 Thirdly, there is an issue for agency governing bodies. In the evidence received for the SCR, there was almost no reference to governing bodies such as Boards or Council Committees (which in all cases involve lay people). The absence of concerns getting to directors would be the main reason for governing bodies not addressing CSE before Bullfinch. It would be a good exercise for governing bodies to consider whether, in hindsight, there is information, which, looking back, should have got to member/non-executive level – and if so to make such expectations clear now. Related to this, they should consider whether existing performance management processes are identifying significant causes for concern at an early enough stage: for example, the very worrying missing from care figures and what was happening to the young people concerned. If this was a new issue today, are there processes which would ensure governing bodies have the opportunity to contribute to a robust response and determine priority?

8.33 Fourthly (and great credit should go to the mainly junior and middle ranking staff who pursued the implications of what they saw and heard until eventually there was some joined up action), there was something that prevented those concerns being either passed upwards or put into a more strategic arena by those who were aware. It is hard now, many years later, to be clear what that 'something' was. It is known, for example, that in CSC there was a climate of trying to deal with things at a senior operational level rather than at a more corporate County level. TVP is a very large organisation, which, before 2011, had fewer processes in place than it has now to see things on a force-wide basis.

8.34 The minutes of meetings seen by the SCR seem to support the notion of a lack of grip. Most were multi-agency, although 'owned' by one agency. IMR authors and this author found it difficult to find minutes of many meetings (for 2011 and earlier) referred to in the SCR. All except OSCB minutes were devoid of logos or other headings to distinguish the agency responsible for them. A number did not indicate who chaired them. In many, it was hard to follow what happened, and as many of these meetings were subgroups it was hard to see to whom they were accountable. The impression was of informality and a lack of either clarity about or understanding of the importance of 'governance'. This is not to say that the meetings were not doing good work, but that minuting during that period needed to be a much more valued exercise. This comment applies both to agencies preparing them and agencies receiving them.

.

[38] *Independent Review of the Effectiveness of the OSCB* (Paul Burnett, August 2013). Note: the current OSCB Chair told the Review she was 'comfortable' that all the recommendations in this report had been achieved.

8.35 *Learning points:* Rather than trying to be definitive about why inter-agency arrangements did not lead to greater awareness at the top, and why it was left (not consciously) to junior staff to scope and identify the CSE when there were requirements for this be done at a higher level, the relevant learning points below can be used as a guide against which current ways of working can be assessed:

- 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 that 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 be sure that all Districts continue to be represented on the OSCB
- Governing bodies need to be sure they are clear on what they expect 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 is the governance framework for the work

8.36 ***Knowledge:*** In general terms, Oxfordshire would not stand out from many other parts of the country in its amount of accumulated knowledge about the concept of CSE, or in terms of implementing guidance. The Review has described national research in 2011, and even in 2013 (by which time Oxfordshire was doing well), which showed low uptake of national guidance. On the other hand, the OSCB at the time of the major national statutory guidance in 2009 did not have a very robust process in place to ensure that new guidance was always dealt with at the right level. Also, many OSCB member agencies would have known of the guidance but did not raise it with the Board as a shortcoming, so responsibility must be shared. Although there were some concerns over the years, the evidence for the SCR shows only some City staff making determined efforts to learn more about CSE – notably through the Community Safety Team which should be applauded for its efforts – and, associated with this, the Police also began making inquiries elsewhere.

8.37 The Oxfordshire experience (and that of others) shows how long inappropriate views can remain entrenched if there are not good processes of learning from national good practice guidance and robust multi-agency oversight

8.38 *Learning points:*

- 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 ongoing monitoring

8.39 ***Escalation*****:** In this Review, the evidence was of very limited escalation to top decision-makers, so no Directors/Chief Officers or governing bodies were aware of anything akin to organised Asian groups and multiple young victims until very late 2010, 2011 or even 2012. The reasons varied. Some organisations like the Police and County are so large or have such a range of services that the individual cases (as they were seen) might not reach the very top. In other cases, staff were trying to be sure there was something especially unusual before pushing it up the line.

8.40 Whether they should have realised it or not, there is little evidence of anyone having a *clear* picture of group-related CSE and not escalating it, although the IMRs have identified evidence that might have supported such a picture in 2005-8. It took from mid-December 2010, when the Deputy DCS was briefed in writing about growing concerns, to mid-February 2011 before the DCS and then CEO/Lead Member were briefed, a point two weeks after the Police identified to CSC concerns about the group sexual exploitation of children in care of a very significant nature. This should have been done quicker. It was April 2011 before the Assistant Chief Constable, and then Chief Constable, were briefed about awareness of local group CSE. Again this should have been quicker.

8.41 Given how long, due to the complexity, it took Operation Bullfinch to get even to the point of arrest (a year), it is unlikely these delays made much difference but the speedier upward briefings would have been appropriate. By this point, there was some national awareness about Asian-led group abuse of multiple children, and the Directors/Chief Officers should have been given the opportunity to consider the implications both practically and politically and be sure action was at the appropriate level. It is important to emphasise that this was in no sense 'hiding' the issue but staff not seeing the need to brief chief officers (wrongly in the author's opinion).

8.42 It is also important to avoid hindsight when assessing how soon the chief officers needed to know. The Rochdale and Rotherham publicity is now etched on the public consciousness, but the beginning of 2011, when it was realised Oxfordshire had a pattern locally, was over a year before the main Rochdale trial concluded and over three years before Rotherham became news. Only the far less publicised Derby case might have been known by then.

8.43 Over the years, the issue is whether concerns should have been escalated and, had they done so, would there have been more strategic and concerted action. (See also 'Tolerance' below). The Chief Constable, talking to the SCR, was asked about expectations of escalation, and illustrated the above point about hindsight: *"Knowing what I know now about the significance of the operation and the court case for Thames Valley Police I would have wanted to know sooner. However I do not think that my knowing would have affected the outcome of the investigation. The question is whether it is reasonable for the officers involved, knowing what they did at the time, to have begun to deal with the case without escalating it to chief officers. In early 2011 they were establishing the team in partnership with Social Services from within resources they controlled and had no need at that time to seek additional help or permission to begin to develop the intelligence and gather evidence."*

8.44 What is clear is that the pattern of limited escalation of whatever was known at the time was more or less the same across all agencies, despite leaders feeling they were open to hearing staff concerns. To some extent, this was because staff did not know that something uniquely awful was happening, or could not believe it, so thought they were dealing with the difficult end of the spectrum of cases which they were expected to get on with. On the other hand, this Review has shown that there was enough information about the signs (as a opposed to the recognition of the overall pattern) of abuse of linked children by multiple men of mainly Pakistani heritage for many years before Bullfinch began, which would have benefited from the consideration of top managers and governing bodies.

8.45 Chief officers were never told of any of the concerns during 2005-10, neither were Directors of Children's Services. (CSC had its first Escalation Policy in 2010.) Even the City Council did not agenda its own December 2010 CSE scoping report at any internal meeting or even at the Community Safety Partnership where it was lead agency. One former DCS said: *"In previous jobs if a social worker had concerns they would want it to get to the top of it asap and get it dealt with…"* That DCS said that in OCC (Social Work and Education), there was a sense of *"people not wanting to deal with things"* and "*letting it go"* if the manager above was perceived as not being interested.

8.46 The author, in discussions with senior staff and the new independent OSCB Chair about draft findings, has found there is still a degree to which the value of top managers/governing bodies being briefed is not grasped. This suggests a public sector culture within Oxfordshire where middle or even senior management feel a need to solve problems themselves, rather than considering the wider corporate governance issues, and in doing so deny the top the opportunity to have influence. This means that top management/governing bodies must consider how open and welcoming they are to early warning, and indicate their need to know about extreme matters being handled by their staff. Those with whom the author has spoken believe they have always been open, so the cause of the non-escalation will need to be understood, and current improvements tested.

8.47 Agencies and the OSCB need to consider whether, should another 'new' topic emerge now, it *would* find its way up the line more easily and more quickly, so there could be a more corporate response. Agencies should review how clear it is what their staff and junior managers are expected to escalate, and the OSCB should review its committee and other arrangements so that it gets to hear of worrying concerns early enough to use its collective influence well. Many local agencies will have looked at this in recent years as a result of Bullfinch (and CSC has an updated 'Need to Know' policy on escalation) so the task will be to test out new arrangements to make sure they are robust, that the 'top of the office' is indeed told what it would expect to hear, and that staff are quite clear what they need to share.

8.48 Disputes between agencies about case handling may at the time seem unnecessary, but they may well contain issues of real concern that can be submerged in irritation across agencies or professions. The 2007-8 tension described around one child and family, given the nature of concerns expressed, could have been handled much better, and would have benefited from, in both City and County, higher managers considering the childcare implications. In this case, the resolution at the time seemed more tactical than child focused.

When there were concerns about child protection processes (eg case conferences) not being used, there was no sign of disputes processes being used.

8.49 *Learning points:*

- OSCBs 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 regarding resolving differences of opinion about cases or groups of cases both internally and across agencies

8.50 ***Tolerance:*** Other reviews have found it hard to get over to the public how incidents in which children have been hurt or exposed to major risk have not always led to 'something being done' and the whole pattern not recognised. One does not need training in CSE to know that a 12-year-old sleeping with a 25-year-old is not right, or that you don't come back drunk bruised, half naked and bleeding from seeing your 'friends', etc.

8.51 It is not the role of the SCR to examine each individual incident and judge whether a professional acted in a culpable way (that lies with agency processes separate from SCRs), but it can summarise some of the reasons and suggest the impact of national culture. The Police are clear that, where a specific allegation reached investigators, cases were indeed investigated – although success was mostly limited for evidential reasons and insufficient focus on perpetrators. However, the Police review also identified reports of many incidents that were crimes but not regarded as such, and where judgements on future action were coloured by attitudes which saw action as futile due to non-cooperation or self-induced harm. The SCR has also described CSC's reports of incidents that merited, at the least, further thought and at times statutory inquiry, which received neither. There were also times where it seems that confidentiality was put before protection (with the intention of maintaining relationships with staff who could offer ongoing help).

8.52 The result was that inappropriate or illegal sexual activity by children who were clients, patients or looked after children was subject to a higher tolerance threshold than would be the case than, say, the average parent. This may have been because professionals could not find a way to stop the girls going where they were at risk; it may have been from trying to avoid being too 'controlling' and risking more alienation, and from the wide sense that 'nothing could be done'. However, for some, it may also relate to a reluctance to take a moral stance on right and wrong, and seeing being non-judgemental as the overriding principle. What is right and wrong about youthful sexuality is anyway a rather blurred issue. Paragraph 5.43 referred to health guidance which determines a child's ability to consent to sexual health advice and get contraception for an act which the child might be legally unable to consent to. The law regards underage sex between peers over 13 as not something that should have any intervention, and it is not much more of a step to see sex between say a 14-year-old and a young adult as 'one of those things'. And, in this Review, sex with older adults did not always lead to what might colloquially be called bringing in the cavalry to intervene come what may. The benign word 'boyfriend' disguised age-inappropriate relationships.

8.53 This is more than a policy debate. It affected practical steps. Missing children in care were in the main reported missing, but it was some of the parents who scoured the streets trying to find them, not generally the corporate parent (the Council), although there were some notable exceptions of residential staff doing just that. The logistical difficulty in council staff doing what a parent beside themselves with terror about a child might do is understood, but it is interesting to consider the comparison.

8.54 There can be little doubt that the earlier sexualisation of children, the age of perceived self-determination and ability to consent creeping lower, and the reluctance in many places, both political and professional, to have any firm statements about something being 'wrong', creates an environment where it is easier for vulnerable young people/children to be exploited. It also makes it harder for professionals to have the confidence and bravery to be more proactive on prevention and intervention. This is an issue reaching way beyond Oxfordshire and requires a national debate.

8.55 There is also the tolerance that comes from dealing with the extreme ends of human activity, which can happen to any professional. The author has an impression from reading the evidence that because the girls faced so many problems, were missing so often, caused concern so often, that any one incident would be regarded less seriously than a single incident would if it were the only occurrence. This is a natural reaction, but one which can have serious consequences if it results in downplaying the level of harm a child is experiencing. Reading the chronology of events around the child subject to the longstanding concern of the City Nuisance Officer, described earlier, it is disturbing to see how, despite very clear accounts of her late-night lifestyle at 13 with adult men, she was 'protected' by being placed with a relative from where the activity continued, as it did when in residential care.

8.56 Whatever the reasons for the higher professional tolerance levels for these children, it was one of the factors that prevented sufficient weight being given to the key task of stopping the abuse.

8.57 *Learning points:*

- 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 about 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 action 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

8.58 ***Staff attitudes and rigour:*** Although the impact of staff attitudes on the handling of CSE has been written about in guidance and several other SCRs or similar, it is worth repeating here as this is at the heart of messages from victims and their families. A number of illustrations were given in their own words in Section 3. While there is no doubt that the grooming, threats and abuse made the victims unable to support investigations, and unable on most occasions to give what would be good evidence, it is also the case that there were plenty of signs that something serious was wrong. One victim, in a Police training video, has described very lucidly signs that she thought were visible and should have meant more to staff. Extreme stories of sex or violence that 12- or 13-year-olds *"could surely not make up"*, about marks on her that were not pursued, about the ravaging by drugs at such a young age, about being dishevelled and bleeding and not feeling cared for, about no one asking if she was ok, about leaving disturbed pictures around for people to see, and of not being believed. She talked of 'snide comments' and an attitude that it was her fault. She would admit she was very difficult to deal with, but thought there were enough clues. (The context of these remarks was about the police, but the CSC IMR details a number of illustrations where CSC did not pursue signs of harm, and Health staff also heard worrying stories and assumed others were dealing with it.)

8.59 These reactions often stemmed from the belief that the girls were being difficult, badly behaved and putting themselves in harm's way. This in turn made it easier for staff not to be inquisitive, not to pursue every allegation or sign of harm, not to deal with the girls in a way likely to encourage them to be more open, and not to pick up the hints and signs that were there. Whilst in the absence of understanding the grooming process the reactions might be understood, they were not right, fed into the delays, and unintentionally added to the girls' isolation and sense of vulnerability to the abusers

8.60 Although some of the parents were far from easy to deal with, there was insufficient recognition of how *they* were affected by their child's grooming inspired behaviour. Illustrations were given in 5.112. One can see that, in some cases, social work staff became quite exasperated by parents and in these situations staff need the highest level of support and supervision to help tease out what might be an inherent parental reaction, what might be from dealing with the nightmare scenario of a child as a victim of CSE, and what might be a reaction to how they are being treated by staff. Some parents also found the Police at times insufficiently sensitive to their desperation.

8.61 The girls' comments about how they trusted and felt most at ease with unqualified staff (see section 3 and 5.113), finding some professionals hard to relate to and cool/distant/boundaried, is food for thought for those involved with professional training and practitioners. Professionals were no doubt, by and large, acting as they had been trained, and the depth of dysfunction, the risks, and statutory roles all need professionals' skills, but the victims are saying that they would have shown more trust and be more likely to disclose (after some time) if some key staff had been more ordinary. They did not use this word, but it sounded like they meant more like 'friends'. It would seem that to be successful with girls at risk of or suffering CSE that at least one person in the team needs to be like this.

8.62 *Learning points:* Some of the learning points have used words given by victims and parents

- 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

8.63 ***Investigations:*** The Police have been very open in their review for this SCR that, on many occasions and for a host of reasons, incidents which needed to be logged as crimes and investigated as such were not, or that incidents initially classified as crimes were reclassified. The HMIC 2014 report shows that this is still a national issue, and the findings in this SCR may well reflect a national position rather than just local. Also, many of the mistaken classifications reflected the level of understanding and the attitudes about CSE prevalent at the time. Nevertheless, the decisions now seen in retrospect to be wrong did mean that victims were sometimes denied their right to a full investigation of crimes against them (even if they might not have been helpful to that investigation). It also meant that it was less likely that patterns and links would be identified. The Police also identified issues about a lack of clarity around the 'ownership' of investigations, and confusion around consent. The cases were hard enough and any lack of clarity could not have helped.

8.64 It was not only in the Police that processes led to no or inadequate investigations. CSC's own review showed alleged assaults by parents not being investigated, information revealed in strategy meetings not looked at quickly, strategy meetings not being called when Police *were* investigating, and the presence of known offenders with a risk to children in children's lives not being explored. There were also illustrations of multi-agency investigations delayed to await meetings, and the 'moment' when disclosure may have happened was lost.

8.65 In their work for the SCR, both the Police and CSC have emphasised the importance of supervision and review processes in being assured that proper decisions and appropriate action are being taken. In both organisations, there was the involvement, at least at some point, of more senior managers/officers in most of the examples where it is now deemed that an inappropriate decision was taken. This emphasises the importance of a corporate understanding about how processes are working in practice, and of how CSE should be managed.

8.66 Alongside the lack of evidence gathering around offenders until late 2010 and 2011, there was also a lack of disruption activity – which is now a central part of the armoury in tackling CSE. The tools (such as Child Abduction Notices) were available throughout the period under review, and in guidance, but TVP, alongside most other forces, made little to no use of them. The impact was that when the victims were not protected through

prosecution/conviction, they were also not protected through the disruption of offender lifestyles in the way one would be today. As an indication of the newness of disruption techniques, Birmingham City Council gained significant national publicity in November 2014 for using civil injunctions to restrict risky men when prosecutions seemed not possible, even though orders with similar powers have been available since the 1980s.

8.67 There was also the focus on the abused and their evidence, rather than getting evidence about the abusers. Although guidance pointed to the necessary focus on the alleged perpetrators, the need to put in major effort was not grasped, and many offences could not be pursued due to weak victim evidence. Not using this approach delayed both the full identification of this sort of CSE and successful prosecutions. But relying almost solely on victim evidence was not unique to the County, and it is only in the most recent years that more offender-focused approach has been accepted as national good practice. The Police IMR has two summary learning points which make the point well: *"Moving away from victim disclosure led investigations towards the evidence based approach taken in domestic abuse cases. Building the case without the victim generates disruption/enforcement opportunities and ultimately creates a better environment for them to provide their evidence (Example -The investigation may identify other victims, forensic and/or CCTV evidence that corroborates the victim's account and reduces the reliance/pressure on them). Recognising that unlike interfamilial abuse the safeguarding of CSE victims relies more heavily on the police led criminal justice interventions as opposed to the social care led 'Working Together' processes. This is because these traditional safeguarding approaches cannot protect against offenders outside the family setting, particularly as these will often be unidentified."*

8.68 This was echoed by the CPS: *"At the heart of any investigation into child sex or grooming must be a 'what is happening' or 'what happened' to the victim as opposed to simple evaluation of the quality of victim and his/her account as a witness. The CPS has adopted this approach so that the focus rest on the credibility of the allegation rather than the credibility of the complainant… What is required is an investigation both with the co-operation of the victim if the victim is prepared to co-operate and also an investigation independent of the victim, whether or not the victim is prepared to co-operate."* It gives as an example the Oxford Police obtaining forensic evidence from victim's clothing without their knowledge. Also the use of phone evidence, care homes and families keeping contemporaneous records of victims' comings and goings, their appearance, descriptions of those they meet, and vehicle details. The combined effort in Oxfordshire to do all this in the Bullfinch investigation and since is to be applauded, although some family members and care staff did provide information like this years before Bullfinch.

8.69 The CPS also said, *"The investigation team did a remarkably good job in encouraging the victims to give evidence and thereafter, keeping in contact with them in the run up to the trial. That is a lesson well learned and should be repeated. The idea of having a dedicated flat for the use of each victim as she gave her evidence was extremely sensible and worked extremely well."* (This involved Police and CSC working together.)

8.70 The Police think greater emphasis on the wider investigative aspects of CSE could be given in the statutory 'Working Together' guidance. For example, the section beginning *"Professionals should, in particular, be alert to the potential need for early help for a child who…"* does not refer to sexual exploitation (which is not mentioned in the core text of the

guidance). The guidance on assessment is all about the child and their family, when it might be better also to include the key points of dealing with abuse from outside the family.

8.71 In Oxfordshire, it has been clear since 2011 that it is only the combination of disruption, investigation, intelligence gathering, prosecution and safeguarding the children which leads to successful prevention or intervention, and these method have been or are being used since Bullfinch across the whole Thames Valley area.

8.72 *Learning points:*

- 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 vulnerable 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

8.73 ***Going missing:*** The scale of missing episodes was vast. From 2005-10 the six girls were reported missing around 500 times, with around half of the episodes being from Council care. Bearing in mind that no one child was went missing in more than three of those years, one was never in care and several were unable to be missing for long periods as they were in secure accommodation, the intensity of these episodes was high. There was a multi-agency Missing Persons Panel in place from 2007 and the Police's Missing Persons Coordinator is widely seen (by staff and families) as one of those who should be strongly praised for the personal commitment shown. Paragraphs 5.88 onwards describe a number of weaknesses in the overall process and, despite the coordinator escalating concerns upwards, a focus on managing the girls rather than blocking whatever was being done to them.

8.74 Many of the things that should have been done better are covered above – about crime/no crime, not being sufficiently curious, seeing the girls as at fault, and so on. What is striking to this Review is the scale of going missing and the scale for individuals about whom there was particular concern about health and well-being and sexual activity with older men. This is another confirmation that, over a period of years, processes were not in place which might have brought such issues to the highest attention (managerial or political leaders) so that a major, system-wide response or inquiry could be made to address it.

8.75 Care must be taken in making this point. From April 2006 to March 2010 (when the journey of discovery was just beginning to gather pace), there were over 17,000 episodes of being missing in the TVP area, and over 5,800 of these were from Oxfordshire, so going missing was not an unusual occurrence. However, had it been known at the time by higher management or the OSCB that Oxfordshire's missing from Care figures in 2006-9 were disproportionately large in the Thames Valley, or that half their missing from care episodes related to girls with many recorded concerns about adult males, etc, there *may* have been a quicker, higher-level response. For example, the OSCB Monitoring and Evaluation Subgroup received missing statistics twice yearly, with a one-line minute in September 2008 and March 2009 saying, *"Group to note numbers, with significant numbers of episodes and trends and review over time"*, and then *"No specific concerns from [Missing Persons] Panel. Very positive re work of Panel."* In the year ending March 2009, the Police recorded the highest numbers missing in Oxfordshire under 18 years, both overall and from Care. There should have been more challenge at this point. Indeed, the CSCs IMR concluded that their own *"Performance management systems should have picked up the issue of large numbers of incidents of children missing from care and triggered further challenge about what was happening and why".*

8.76 *Learning points:* This Review does not intend to go into detail about how managing missing children is best managed. Recent government statutory guidance covers this well,[39] and more detailed local agency learning is in the associated publication, 'Agency Responses since 2011'.

- 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 required for local authorities to ensure a discussion with the child, the family or both after two or more episodes, and also a requirement to ensure that 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 not only receive the Missing Persons information regularly, but 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

8.77 **The impact of ethnicity:** As noted above, the material submitted to this SCR makes little reference to ethnicity. This Review has considered whether this reflects the deliberate ignoring of the ethnic aspect to protect sensitivities (which has been suggested elsewhere in the country), or any failure to consider it when to do so would be helpful. The answer, within the limits of time and methodology, is that the author has identified neither, and reports and

[39] *Statutory guidance on children who run away or go missing from home or care* and *Flowchart showing roles and responsibilities when a child goes missing from care* (DFE, January 2014).

interviews suggest that the perpetrators were seen as just that, and not treated differently because of their background. The members of the SCR Panel also specifically discussed this in December 2014, and assured the author that no one was aware of evidence of any holding back due to ethnicity.

8.78 This does not mean that investigators might not have found working with tight-knit groups of a different culture, and at times language, hard. But that does not imply any 'going easy' to avoid offending cultural sensitivities or seeming politically incorrect. However, as has been found wherever this type of organised group abuse has been uncovered, the perpetrators have been mainly from an Asian heritage, with some from Africa or south east European countries, and with a mainly Muslim culture. This has continued with the Thames Valley cases post-Bullfinch, and in the very recent convictions in Bristol.

8.79 This SCR, in one county, is not the place to attempt a definitive analysis of why this is, and this needs to be researched and understood at a national level given both its importance and the sensitivities of any conclusions. It cannot be parked as too potentially sensitive or inflammatory to pursue openly at that level.

8.80 The association (not of all CSE, but group-based CSE) with mainly Pakistan heritage is undeniable, and prevention will need both national understanding, communication and debate, and also work with faith groups at a local level. A national recommendation is made below. Section 4 described some of the work around developing community relationships and resilience in Oxfordshire.

8.81 *Learning points:*

- The importance of agencies individually and collectively developing 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

9 CONCLUDING SUMMMARY AND RECOMMENDATIONS

9.1 This conclusion summarises the facts and findings of the Serous Case Review and makes some recommendations. These recommendations do not aim to repeat the agency-specific recommendations contained in IMRs and being worked on by agencies, nor the OSCB's collated Action Plan. These can be seen in the associated 'Agency Responses since 2011'. Rather this Review focuses on overarching, system-wide issues, or those for national consideration.

9.2 A group of approximately 370 girls and young women have been identified as possible victims of sexual exploitation within the last 16 years. Since 2011, there have been a large number of investigations and convictions, the most significant of which was Operation Bullfinch, which culminated in seven men being convicted of around 60 offences against six children. This investigation used a multi-agency approach and innovative tactics to bring together victim statements and intelligence about the lifestyle of the offenders. The core of this SCR is whether this point could have been reached earlier, and if so why.

9.3 The agencies involved have made comprehensive reviews of their own services, and have openly identified many things that could have gone better. The author has been impressed by the candour of agencies (as well as their huge commitment to make things better now). However, there were clearly many things done which are clearly seen now as mistakes or mistaken approaches. The author has seen little that has not been replicated in other SCRs on CSE, or in national reviews which have identified over and again the slow progress in responding to guidance, and a poor understanding of CSE and its wide geographical spread. That slow progress was often related to three things – thinking group based CSE happened somewhere else, an inability to grasp that something as horrible could really be happening, and seeing the victims as placing themselves at risk rather than understanding the grooming process.

9.4 The fact that the most of the patterns of agency and professional response seen in Oxfordshire were not unusual is both true and sad. But the fact that the lack of knowledge and understanding of CSE and attitudes to the most difficult teenagers were common nationally does not mean no one was responsible: all agencies and professionals in the country share the responsibility of protecting children. This is why this Review has gone to some length in describing what happened and the long process to discovery. As most information about what happened has diligently and openly come from agencies, it is also to show that Oxfordshire has recognised what could and should have been different, and is not hiding its own mistakes.

9.5 There were three other attitudes which also lay behind the failure to recognise more quickly that group CSE was occurring to multiple girls. Firstly, the girls' precocious and difficult behaviour was seen to be something that they decided to adopt, with harm coming because of their decisions to place themselves in situations of great risk. The fact that most of the children came from families with other problems enhanced the belief that the problem and the solution lay with the family or the girl concerned. Secondly, there was a failure to recognise that the girls' ability to consent had been eroded by a process of grooming escalating to violent control. These two issues sometimes resulted in responses to the girls or parents which compounded the lack of trust in agencies instilled by the grooming. Thirdly,

there was pessimism about the prospect of criminal investigations being successful. Very strong evidence was needed and, through the impact of the grooming and fear, hardly any evidence was obtained that was not withdrawn or later denied.

9.6 Overlaying this, and partly related to the attitudes in the previous paragraph, were confusions about what should be recorded as a crime and investigated, a lack of curiosity, and a failure to look into worrying events, was seen in several agencies. This in turn was enhanced by weaknesses in supervision. There was also an apparent tolerance of inappropriate sexual activity, which was partly created and partly fuelled by societal ambivalence (and lack of understanding) around consent.

9.7 There was very little use of disruption tactics before Bullfinch; although several such tactics were known and available, these were also not widely used elsewhere. Neither were the covert surveillance and rigorous intelligence gathering now seen to be essential. This meant that taking something forward rested almost wholly on victim evidence – which in CSE can rarely be expected to be forthcoming or maintained. Whilst Oxfordshire now has a nationally renowned level of expertise in how to approach the multi-agency investigation of CSE, the approaches it uses now were not widely known and understood before 2011.

9.8 The patterns seen above are likely to have been seen anywhere where CSE has been a challenge, but there were in addition issues that seemed to be more local to Oxfordshire. Whilst the fact that the OSCB regrettably did not respond adequately to the 2009 statutory guidance on CSE was not uncommon amongst LSCBs, it did seem to reflect a pattern in Oxfordshire in the years leading up to Bullfinch of weaknesses in the way agencies collectively worked together around safeguarding. External inspection showed the OSCB to need improvement in 2008, and the fact that it did not get a grip of CSE until 2011 suggests it took some time to work well, although it was externally rated as good from 2010 so must have been making improvements. The Safeguarding Board consists almost entirely of Oxfordshire agencies. There is no indication that any of them challenged the delay in responding to the statutory guidance, or indeed the earlier dropping off the agenda of concerns expressed in 2007 about girls and 'organised prostitution'.

9.9 Despite there being very worrying case illustrations over a number of years involving more than one girl, multiple alleged perpetrators, usually Pakistani, with a very strong association with children in care, the highest levels of management were not briefed until 2011. This included Directors of Children's Services. Whilst it must be pointed out that, until the end of 2010, there was little knowledge of the CSE that had happened elsewhere in the country, this Review concludes that the circumstances described, regardless of the name given to them, were so extreme that top management and indeed governing bodies should have been given the opportunity to bring their unique perspective to the issue earlier.

9.10 There are, of course, differing cultures of escalation in different agencies, but the fact that there was no exception to this pattern of non-escalation suggests something that leaders in Oxfordshire must make sure is not present now. It is true that the way this Review has tabulated series of events over short periods to illustrate what was known is a type of collation not done until late 2010, so staff never saw the picture as starkly. That in itself provides a learning point about continually taking history into account.

9.11 This lack of overview is regrettable, as the information, for example across 2005-8, was very similar to that which triggered Bullfinch in 2011. The position in Oxfordshire was not therefore of clear warnings to top decision-makers but the absence of such warnings.

9.12 The various strands of thinking about CSE which eventually culminated in the Bullfinch investigation were led by dedicated and enthusiastic staff, some quite junior, in the City and County Councils and the Police (with support from other agencies), and their work must be applauded. It was the combined impact of their work which in the end led to the investigation, convictions and modern ways of tackling CSE. However, the fact that this work was essentially done in a governance vacuum, without strategic oversight, provides a clear lesson for agencies about what was missing, and about what they must be sure is in place now.

9.13 The contribution to the Review by victims and parents has been extensive and hugely valuable. Their perspectives about the grooming process, their interaction with staff, and what they think would have made things better have had a big impact on this Review, for which the author and the OSCB is most grateful.

9.14 **Recommendations:** The recommendations from this Review are aimed at the system. The learning points, set out in collated form in Appendix 1, provide a more detailed set of points for OSCB and agency consideration – for use as a checklist against which to assess current practice. There are three recommendations for national consideration. The local recommendations below are set out for OSCB consideration, either for direct action or to oversee in its assurance role. Such assurance needs to be ongoing. They are worded that the OSCB has flexibility in how it achieves them. Where there is reference to 'member agencies', this should be deemed to include educational establishments that are not actual members, nor under OCC management, and the OSCB will need to be sure how it seeks assurances from them

For national consideration

i. The DfE should review 'Working Together' 2013 to ensure it gives sufficient weight to investigation and disruption aspect of safeguarding children at risk from CSE
ii. Relevant government departments should 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
iii. 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.

For the Oxfordshire Safeguarding Children Board

The Board should (if it has not done so already):

i. Ask each member agency to review its escalation procedures, and provide assurance to the Board that they are understood and complied with

ii. Review the interrelationships with other multi-agency partnerships, such as District Community Safety Partnerships and the County Safer Community Partnership, to ensure there is mutual clarity about each other's roles and appropriate cross-representation
iii. Ask each agency to provide evidence of its supervision policies and how the agencies ensure they are effective
iv. Be assured that the lessons from this Review and IMRs are embedded in OSCB and single agency training
v. Ensure that the messages from victims and their families given to this review are embedded in training
vi. Seek evidence that minutes of multi-agency meetings are clear about ownership, have consistent titles, and can be seen by their content and appearance to be of high value
vii. Seek assurance from TVP about progress on recording crime relating to sexual offences
viii. Seek assurance from OCC that there is appropriate access to the necessary range of LAC placements
ix. Ensure that reports on missing children statistics for the Board are fully interrogated to identify any emerging patterns
x. Seek assurance from Oxfordshire County Council that there are good arrangements for the transfer of information between schools about child vulnerability, and that decisions around exclusion from school and its management (risk assessments and plans) take into account that the behaviour is or may be related to exploitation
xi. Seek assurance from NHS bodies, including general practice, that staff include the consideration that consent has been eroded through exploitation when assessing a child's ability to consent to treatment and that referrals to statutory agencies will be made appropriately
xii. Seek assurance from all member agencies that staff are aware of the guidance around consent to sexual activity, and relationships
xiii. Continue to undertake rigorous multi-agency case audits where CSE is suspected

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 ongoing 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

APPENDIX 2: SCR TERMS OF REFERENCE

Note: The Terms of Reference are those agreed by the SCR Panel on 11.9.14 to update them for revised national expectations following new guidelines published in March 2013, and to guide the production of the final report. They were originally prepared in November 2012.

TERMS OF REFERENCE FOR THE SERIOUS CASE REVIEW OF CHILD SEXUAL EXPLOITATION IN OXFORDSHIRE (CHILDREN A-F)

1. Decision to hold the Serious Case Review

Following the review of circumstances relating to the cases of Children A,B,C,D,E,F from Operation Bulfinch, a decision was made by Oxfordshire Safeguarding Board to convene a Serious Case Review (SCR) on 26 September 2012. The cases met the criteria for a SCR as defined in chapter 8 paragraphs 8.9–8.12 of 'Working Together 2010'.

This draft of the Terms of Reference is a **working document** and will be subject to amendment by the SCR Panel.

2. Background and scope of the review

Background: Concerns were identified about young people in Oxfordshire who were being sexually exploited. The collective picture from local agencies and the intelligence that emerged about those individual young people led to 'Operation Bullfinch'. This complex investigation was led by the Police and involved other OSCB partners. Over 20 young people were identified as victims of serious sexual exploitation. Nine men stood trial at The Old Bailey in January 2013, seven of whom received substantial custodial sentences. The charges related to six individual girls: four cases of historic abuse and two which were current. The abuse was described by Judge Rook as a "series of sexual crimes of the utmost depravity".

Scope: This review is on child sexual exploitation in Oxfordshire and using the cases of the six victims, reviews the work of agencies, the extent to which they were aware of the abuse, and how they responded to it.

The six had suffered abuse over a long period of time and they were a representative group of a wider cohort of known young people. The complexities of their circumstances led to a thematic review in order to build on what was already understood by 2012 and to maximise learning.

The report will describe the background to and experiences of the girls' journey through exploitation. This process will draw out the themes that show the strengths and weaknesses of the safeguarding system and aims to understand not only 'what' happened but 'why'.

The first annual report of the National Panel of Independent Experts on SCRs (which oversees the quality of reviews and that appropriate action is being taken from the learning) comments on SCRs being produced now. It has expressed concern about undue length. It warns against a level of detail that would make publication difficult (and hence learning is limited). It calls for a 'sharp focus' and 'concise accounts'. This SCR will take this into

account by using the case detail to illustrate findings rather than attempt to describe all the very significant history.

3. Key themes for study

Although this review was commence under the national guidance, 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2010', these terms of reference are now also guided by the successor guidance, 'Working Together, 2013'. This guidance captures the purpose: *when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm…*

These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

'Working Together, 2013' goes on to say:

- *reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;*
- *action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and*
- *there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public.*

SCRs... should be conducted in a way which:

- *recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings.*

This Review will explore any avenue necessary to fulfil these statutory requirements, and will look at the following two key questions:

- To what extent was the child sexual exploitation experienced in Oxfordshire preventable?
- What can be learned from the reviews appraisal of the quality of agency work, and the experiences of the victims and their families?

To answer these questions the review will need to explore:

- What was known about child sexual exploitation and how it could be tackled
- If it was not identified quickly enough, why not?
- What, including the quality of agency work, contributed to the vulnerability if the victims to abuse?

- How did agencies respond to the growing awareness of child sexual exploitation?
- What have agencies already learned and done as a result of Operation Bullfinch?
- What still needs to be done?

The Review should identify where agency performance could have been better, but also explain the context in which that performance occurred, so that the contributory factors provide learning for OSCB and its member agencies.

To fulfil these Terms of Reference, the views of the six girls and their families must be sought and reported, and they should have an early opportunity to hear and discuss the findings.

SCR Panel 11.9.14

Report author: The Report author from July 2014 is Alan Bedford, who has a background in child protection social work, senior leadership of NHS Trusts and Health Authorities (13 years as a CEO), as an LSCB Chair and is the author of many SCRs.

APPENDIX 3: CSE NUMBERS – METHODOLOGY

'A group of approximately 370 girls and young women have been identified as possible victims of sexual exploitation within the last 15 years'

This is the method used in reaching the figures as assessed by Children's Social Care and Thames Valley Police

These figures have been derived from TV Police and OCC records. Individual children have been cross-matched to avoid duplication and to ensure that both agencies are agreed as to the appropriate category for the child. Children's Social Care records cover the period 1999-2012. TVP records cover the period from the period subject to the Operation Bullfinch investigation (2005) to date. Kingfisher figures (joint CSC and TVP) cover its referrals since it started November 2012 to December 2014.

From a Children's Social Care perspective, the figures were arrived at following work during Operation Bullfinch. All the girls of interest to Bullfinch were identified with the police team and a search done to identify those with whom CSC had had any contact. A file review was then undertaken looking at each of those girls to identify any issues and concerns which may have been an indicator of CSE, including missing episodes, allegations, and information such as having an older boyfriend or associating with other girls at risk. Some of the girls were active Bullfinch cases and information from the police team was used to prioritise the review work.

That information was collated on a simple pro-forma and then analysed and the girls categorised into the following groups:

- Disclosed to the police, either before or as part of Operation Bullfinch, or possibly a clear disclosure to a social worker or other professional, even where that did not result in a formal statement or charges
- Evidence but no disclosure = strong evidence of grooming/CSE noted by either the Bullfinch investigation or in CSC records, which includes a 'third party' disclosure by a friend or family member but where the girl herself (at the time of writing) had declined to make a disclosure
- Probable = examination of these cases show clear indications of grooming or CSE as would currently be identified in the CSE Screening Tool, including information that the child had been with other victims and/or at addresses where other victims were believed to have been abused
- Possible = less clear than the previous group, but case records indicate some of the signs of CSE/grooming which would currently be identified in the Screening Tool
- No Evidence = these girls names were raised through Bullfinch but analysis of records does not give any clear indications of grooming/CSE
- Girls specifically linked to a (named) case which has since been dropped

An additional four girls were added to the list following a review of a children's residential unit which identified them as likely victims, ie they would have fallen into group two.

In 2013, the police in the Bullfinch Team were provided by CSC's reviewer with a full report setting out details of all the girls where concerns had been identified. A meeting was held with the senior officer within the team, a second police officer, the CSC reviewer, the manager of Kingfisher and the Area Social Care Manager to discuss the report. It is understood that the Bullfinch Team would consider those cases as part of their ongoing investigations.

APPENDIX 4: OFSTED INSPECTION 2014: KEY FINDINGS

Section 1: The local authority

Summary of key findings

This local authority is good because:

1. When agencies are concerned about children, they know how to get the right level of help for them. Thresholds for the different levels of help, including social care, are clear and understood by professionals.

2. Agencies work well together. Early help services are well coordinated and have clear thresholds for support. The Troubled Families programme, Thriving Families, is well targeted and responsive, with good take-up by those families in most need. When children are referred to children's social care they almost always receive a prompt response and the right help. The large majority of social work assessments are good. Children are always seen and asked about their life and what they need to improve it. Assessments analyse risk carefully and what needs to be done to reduce it. Hospital-based social workers complete good assessments that result in effective planning and discharge arrangements for newborn babies who may be in need of help or protection.

3. The large majority of child protection enquiries are carefully planned by children's social care with the police and other agencies and investigated thoroughly. Social work action to protect children when they need it is decisive and proportionate.

4. Consultation and advice are readily available to professionals who are concerned about possible child sexual exploitation. The Kingfisher team provides a consistent service for children identified as at risk of sexual exploitation. Their work is clearly focused on reducing risks as well as on meeting children's and young people's wider needs.

5. A stable workforce in children's social care means that most children experience consistency of social worker and say they have a significant, sustained relationship with them.

6. Decisions about whether children should become or remain looked after are timely and based on evidence about the child's needs. When necessary, care proceedings are initiated quickly to ensure that children are not exposed to harm for extended periods.

7. The Family Placement Support Service is a particular strength. It works effectively with families to prevent the need for children to become looked after. It also supports families when a child returns home after being looked after.

8. Long-term planning to secure stable futures for children is given a high priority. The search for suitable alternative families starts at the earliest possible stage. The contribution made by the adoption service is good. The number of children placed for adoption has increased over the last two years and includes improved adoption rates for older children.

9. Young people are well supported when they leave care. The quality of most pathway plans is good and, whilst some lack detail, most reflect clear and timely actions to help young people make the transition to independence. Most care leavers feel well supported by their

social workers and describe effective and consistent relationships that enable them to develop trusting relationships.

10. A ‘Staying Put’ scheme has enabled a growing number of care leavers to remain with their carers beyond the age of 18. This is bringing demonstrable improvements to the life chances of most care leavers, for example in increased emotional stability as well as a secure base while in education.

11. Services for children and families are given a high priority by senior leaders and elected members. The local authority knows its strengths and weaknesses well. Strategic priorities are identified and informed by feedback from children, young people, parents, carers and staff. Leadership is strong and effective and services make a demonstrable difference in improving the life chances of some of the most vulnerable children in Oxfordshire.

12. Elected members have high aspirations for looked after children and young people in Oxfordshire and have prioritised continued investment, for example in additional social worker and team manager posts. They hold senior officers to account for the quality of services.

13. Management oversight of practice is good. Performance data are used effectively to inform change and drive improvement. This learning culture is further supported by the effective identification and dissemination of lessons from audits and serious case reviews.

APPENDIX 5 ACRONYMS

ACPC	Area Child Protection Committee
ASBO	Anti Social Behaviour Order
BME	Black and Minority Ethnic
CAIU	Child Abuse Investigation Unit
CEOP	Child Exploitation and Online Protection Centre
CID	Criminal Investigation Department
CSC	Children's Social Care
CSE	Child Sexual Exploitation
DC	Detective Constable
DCS	Director of Children's Services
DfE	Department for Education
DI/DCI	Detective Inspector/Detective Chief Inspector
FT	NHS Foundation Trust
GP	General Practitioner
IMR	Individual Management Review
JAR	Joint Area Review
LAC	Looked After Child/ren, ie in Council Care
LSCB	Local Safeguarding Children Board
MP	Member of Parliament
NWG	National Working Group on CSE
OCC	Oxfordshire County Council
OCyC	Oxford City Council
OH	Oxford Health NHS FT
OUH	Oxford University Hospitals NHS Trust
OSCB	Oxfordshire Safeguarding Children Board
PC	Police Constable
PCT	NHS Primary Care Trust
SCR	Serious Case Review

APPENDIX 6: OXFORDSHIRE SAFEGUARDING CHILDREN BOARD MEMBERS

As of 26.2.15 when it accepted this SCR and approved it for publication

Name	Job title	Organisation
Maggie Blyth	Independent Chair	Independent
Jim Leivers	Director for Children's Services	Children Education and Families Oxfordshire County Council
Christian Bunt	Superintendent	Thames Valley Police
Stephen Czajewski	Director	Thames Valley Community Rehabilitation Company
Katy Barrow-Grint	Detective Chief Inspector	Thames Valley Police - Protecting Vulnerable People Unit
Peter Clark	Monitoring Officer and Head of Law & Governance	Legal, Oxfordshire County Council
Clare Robertson	Designated Doctor Safeguarding	Oxfordshire Clinical Commissioning Group
Sula Wiltshire	Director of Quality and Innovation	Oxfordshire Clinical Commissioning Group
Pauline Scully	Director of Children and Families Division	Oxford Health NHS Foundation Trust
Ros Alstead	Director of Nursing and Clinical Standards	Oxford Health NHS Foundation Trust
Lucy Butler	Deputy Director	Children's Social Care & Youth Offending Service Oxfordshire County Council
Rebecca Matthews	Interim Deputy Director for Education and Early Intervention	Children Education and Families Oxfordshire County Council
Seona Douglas	Deputy Director for Social & Community Services (adults)	Social & Community Services Oxfordshire County Council
Clare Edwards	Lay member	
Modupe Adefala	Lay member	
Alison Chapman	Designated Child Protection Nurse Safeguarding	Oxfordshire Clinical Commissioning Group
Julia Grant	Acting Lead Nurse, Safeguarding Children Services	Oxford Health NHS Foundation Trust
Tracy Toohey	Safeguarding Children Lead and Patient Experience	Oxford University Hospitals NHS Trust
Debra White	Senior Probation Officer	Oxford Probation Service
Gareth Davies	Brigade Welfare Support Officer	Army Welfare Service 11Bde

Hannah Farncombe	Safeguarding Manager	Children Education and Families Oxfordshire County Council
Penny Browne	Area Social Care Manager Central Area	Children Education and Families Oxfordshire County Council
Tan Lea	Early Intervention Manager	Children Education and Families Oxfordshire County Council
David Heycock	GM Home and Community Safety Manager	Fire and Rescue – Oxfordshire County Council
Catherine Stoddart	Deputy Chief Nurse	Oxford University Hospitals NHS Trust
Julie Kerry	Thames Valley Area Team Manager	NHS England
Tony McDonald	Divisional General Manager – Children & Women's Division	Oxford University Hospitals Trust
Gerry Stevens	Social Work Team Manager	SSAFA Personal Support and Social Work Service RAF
Amrik Panaser	County Manager Youth Offending Service	Children Education and Families Oxfordshire County Council
Sally Thomas	Service Manager Oxford	CAFCASS
Sally Truman	Shared Policy and Partnerships Manager	South and Vale District Council
Tim Sadler	Executive Director, Community Safety	Oxford City Council
Val Johnson	Partnership Development Manager	Oxford City Council
Nicola Riley	Shared Interim Community, Partnerships and Recreation Manager	Cherwell and Northants District Council
Diana Shelton	Head of Leisure and Tourism	West Oxfordshire District Council
Jo Melling	Head of Commissioning - Drugs & Alcohol Team (DAAT)	Public Health – Oxfordshire County Council
Romy Briant	Voluntary rep	Reducing the Risk of Domestic Abuse
Emma Lawley	Head teacher	Springfield School
Annabel Kay	Head teacher	Warriner School
Lynn Knapp	Head teacher	Windmill School
Melinda Tilley	Councillor and Lead Member for Children	Oxfordshire County Council

Alan Bedford Final. OSCB approved 26.2.15