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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Children's Services Overview and Scrutiny Committee to be held on Wednesday, 6 October 2021 at 4.30 pm in Council Chamber, City Hall - City Hall, Bradford

Members of the Committee – Councillors

LABOUR	CONSERVATIVE	BRADFORD INDEPENDENT GROUP
Alipoor **Choudhry** **Humphreys** **Jamil** **Mohammed**	**Winnard** **Pollard**	**Sajawal**

Alternates:

LABOUR	CONSERVATIVE
Firth **H Khan** **Mir** **Wood**	**K Green** **Felstead**

VOTING CO-OPTED MEMBERS:

Joyce Simpson	Church Representative (CE)
Fauzia Raza	Parent Governor Representative

NON VOTING CO-OPTED MEMBERS

Tom Bright	Teachers Secondary School Representative
Dr Samina Karim	Children's Social Care Representative

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
- The taking of photographs, filming and sound recording of the meeting is allowed except if Councillors vote to exclude the public to discuss confidential matters covered by Schedule 12A of the Local Government Act 1972. Recording activity should be respectful to the conduct of the meeting and behaviour that disrupts the meeting (such as oral commentary) will not be permitted. Anyone attending the meeting who wishes to record or film the meeting's proceedings is advised to liaise with the Agenda Contact who will provide guidance and ensure that any necessary arrangements are in place. Those present who are invited to make spoken contributions to the meeting should be aware that they may be filmed or sound recorded.
- If any further information is required about any item on this agenda, please contact the officer named at the foot of the agenda item.
- Given the restrictions on room capacity, any Councillors and members of the public who wish to make a contribution at the meeting are asked to email mustansir.butt@bradford.gov.uk by

10.30 on Friday 1 October 2021 and request to do so. You will then be advised on how you can participate in the meeting. Access to the meeting cannot be guaranteed if those wishing to attend do not register given the Council must comply with the Covid regulations and guidance in place at the time.

On the day of the meeting you are encouraged to wear a suitable face covering (unless you are medically exempt) and adhere to social distancing. Staff will be at hand to advise accordingly.

From:

Parveen Akhtar
City Solicitor
Agenda Contact: Fatima Butt / Jill Bell
Phone: 01274 432227/434580
E-Mail: fatima.butt@bradford.gov.uk / jill.bell@bradford.gov.uk

To:

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper

should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Fatima Butt/Jill Bell - 01274 01274 432227/434580)

4. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

The following referrals have been made to this Committee up to and including the date of publication of this agenda.

The Committee is asked to note the referrals listed above and decide how it wishes to proceed, for example by incorporating the item into the work programme, requesting that it be subject to more detailed examination, or refer it to an appropriate Working Group/Committee.

B. OVERVIEW AND SCRUTINY ACTIVITIES

5. Child Sexual Exploitation Thematic Review 2021 1 - 136

The Chief Executive will submit a report (**Document "G" which contains Not For Publication Appendix C**)on the CSE Thematic Review was commissioned in 2019 by the Bradford Safeguarding Children Board, subsequently replaced by the Bradford Partnership – Working Together to Safeguard Children. The three statutory partners of the Partnership are the Council, Police and Clinical Commissioning Group (CCG) and also a number of key agencies, designated as "relevant agencies" are also members. It has an independent chair and scrutineer- Jane Booth.

The review was commissioned in accordance with governmental guidance in force at the time and focuses on the response of the agencies in Bradford to Child Sexual Exploitation. Five specific cases formed the basis of the review, two non-recent cases of CSE which have already been in the public domain and the media and three more recent cases. The review also includes a review of three more recent cases. It was led by an independent author Clare Hyde MBE. The review looks in detail at the experiences of five children. It spans a 20-year period from 2001 through a range of political administrations and officers. No individuals are named- the report focuses on children and learning.
The review was published on the 27th of July 2021

Recommended -

(1) The Committee is invited to note the report

(2) That Committee receive a full report in November on current work in relation to exploitation of both children and adults and that this includes updated details of work in relation to the CSE actions in the Thematic review.

(3) That the Committee commit to working closely with partners to deliver on the actions within the developmental action plan and progressing the extensive wider work presently on going in Bradford

(Darren Minton - 01274 434361)

6. Residential Children's Homes & Related Issues

137 - 142

The report of the Strategic Director of Children's Services (**Document "H")** provides an update regarding the current situation regarding the Children's Residential homes in Bradford and related issues.

Recommended that the report be noted.

(Marium Haque – 01274 432955)

7. Children's Services Overview and Scrutiny Committee - Work Programme 2021/22

143 - 152

The report of the Chair of the Overview & Scrutiny Committee (**Document "I"**) includes the Children's Services Overview & Scrutiny Committee work programme for 2021-22.

Recommended -

(1) That members consider and comment on the areas of work included in the work programme.

(2) That members consider any detailed scrutiny reviews that they may wish to conduct.

(Mustansir Butt – 01274 432574)

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Chief Executive Office to the meeting of the Children Services Overview & Scrutiny Committee Meeting to be held on 30th September 2021

Subject: Child Sexual Exploitation Thematic Review 2021

Summary statement: G

The CSE Thematic Review was commissioned in 2019 by the Bradford Safeguarding Children Board, subsequently replaced by the Bradford Partnership – Working Together to Safeguard Children. The three statutory partners of the Partnership are the Council, Police and Clinical Commissioning Group (CCG) and also a number of key agencies, designated as "relevant agencies" are also members. It has an independent chair and scrutineer- Jane Booth.

The review was commissioned in accordance with governmental guidance in force at the time and focuses on the response of the agencies in Bradford to Child Sexual Exploitation. Five specific cases formed the basis of the review, two non-recent cases of CSE which have already been in the public domain and the media and three more recent cases. The review also includes a review of three more recent cases. It was led by an independent author Clare Hyde MBE. The review looks in detail at the experiences of five children. It spans a 20-year period from 2001 through a range of political administrations and officers. No individuals are named- the report focuses on children and learning.
The review was published on the 27th of July 2021

Appendix C – Is exempt under paragraph 7 (Crime Prevention) Schedule 12A of the Local Government Act 1972

EQUALITY & DIVERSITY:
Child Sexual Exploitation (CSE) & Child Criminal Exploitation are crimes committed by predominantly male perpetrators from all different backgrounds. Victims of exploitation also come from all backgrounds. Nevertheless, local experience and national research indicates that recognised victims and perpetrators do not necessarily reflect the gender ethnicity and other characteristics of the district's population.

Kersten England
Chief Executive

Report Contact: Darren Minton Safeguarding Partnership Business Manager / Jane Booth – Independent Scrutineer – The Bradford Partnership
Phone: (01274) 434361
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Portfolio:

Children and Families

Overview & Scrutiny Area:

Children`s Services

1. SUMMARY

1.1 The CSE Thematic Review was commissioned in 2019 by the Bradford Safeguarding Children Board, subsequently replaced by the Bradford Partnership – Working Together to Safeguard Children. The partnership includes the three statutory partners of Council, Police and Clinical Commissioning Group (CCG) and also a number of key agencies. It has an independent chair and scrutineer- Jane Booth.

1.2 The review focuses on the response of the agencies in Bradford to Child Sexual Exploitation in response to two historical cases of CSE which have already been in the public domain and the media. The review also includes a review of three more recent cases. It was led by an independent author Clare Hyde MBE. The review looks in detail at service responses to the experiences of the five children. It spans a 20-year period from 2001 through a range of political administrations and officers. No individuals are named- the report focuses on children and learning.

1.3 The review was published on the 27th of July 2021

1.4 The Partnership and its member agencies have accepted the findings of the review and are working to ensure the recommendations are carried out. A copy of the current developmental action plan is attached. It will be updated monthly, and actions may be amended and or added as required. The Chair and Independent Scrutineer has set a deadline for the completion of action plan by the end of December 2021 which is challenging. Extension of current targets for completion will only be accepted on evidence of justifiable delay.

1.5 A further review of actions is planned for mid-2022 to consider the evidence of outcome/impact and check necessary changes have been embedded in practice.

1.6 The review set out to look at three areas

1. Whether lessons have been learnt from multi-agency responses to non-recent cases of CSE within the Bradford District and beyond and whether these lessons are embedded in current policies and procedures.
2. The extent to which analysis of the responses of all agencies to current cases provide assurance that working practices and responses that exist now are robust, child-centred and effective in protecting children from sexual exploitation and related harms; and
3. To what extent good practice lessons around placement provision for looked after children at high risk of, or experiencing, CSE are embedded in practice.

1.7 All the children's names have been anonymised in the report

2. BACKGROUND

2.1 The issues that emerge in all the cases are distressing to read and the historic cases in particular demonstrate that significant learning was needed, and the children had not been kept safe.

2.2 While the review found that there had been substantial improvements in practice since the response to the non-recent cases, it found that there was also learning for agencies in the more recent sample and that the policy changes were not always embedded in practice.

2.3 None the less the review noted positive progress over the period of the review During the period since 2011 there has been a significant focus on CSE in the Bradford District, with many perpetrators brought to justice; the formation of a multi-agency CSE hub; a systematic trawl of historic cases revisiting data on missing children through Operation Dalesway, and a number of victims have come forward as a result of this. Bradford had one of the first CSE hubs in the country. Current processes are in place to identify children, assess risk and to put services in place.

2.4 National understanding of CSE has improved significantly during this time. In 2002 for example the phrase "child prostitution" was in common usage. Bradford's response to CSE has been recognised nationally and commented on positively in the 2018 ILACS inspection.

2.5 Summary Findings – Terms of reference 1
To what extent have lessons been learnt from the multi-agency responses to non-recent cases of Child Sexual Exploitation within the Bradford & how well is this embedded

2.6 The review process reflected upon the learning from two previous local CSE Serious Case Reviews (SCRs) and asked why, despite improvements, not all learning has been fully embedded into practice. This review also identified the impact of an adverse Ofsted Inspection of Children's Social Care and the consequent instability in the children's social care management and workforce.

2.7 Policy changes had been made in relation to CSE in all agencies, but this was not always seen in sustained practice changes.

2.8 The short-term nature of funding for some CSE and family support services was also evident. This means that staff turnover can be high with experienced practitioners moving on to different roles or different areas. A further consequence of this is likely to be that 'organisational memory' across the system and learning from local SCRs and other reviews is lost too.

2.9 Summary Findings – Terms of reference 2
To what extent does analysis of responses from all agencies to current cases provide assurance that working practices and responses are robust, child centred, and are effective in protecting children from sexual exploitation and related harms?

2.10 While there was evidence of good practice in strategic activity, the evidence of quality of practice was not there in all cases and all agencies.

2.11 A CSE risk assessment tool is used once a possible risk has been identified. There was however evidence that risk was not always recognised even where there were clear signs and indicators suggesting sexual exploitation and there were examples of assessments being very delayed.

2.12 The language used about the children did not always reflect their vulnerability and they were, on occasion, deemed to be making choices.

2.13 At times, the response and attitudes to the male victim was different to that of the female victims.

2.14 Where risk was identified, changing levels of risk were not always responded to quickly and there was variance in how different professionals interpreted risk.

2.15 Good supervision is critical to the quality of practice, particularly with cases where there is constant change and challenge.

2.16 Case load size is also a factor as working with CSE is complex and time consuming. High levels of staff turnover in children's social care have made it difficult to measure the take up and impact of essential training. All three factors were identified as an issue in the Ofsted inspection in 2018 and so it is no surprise that these were found in the review.

2.17 The role of drugs and alcohol in grooming, control and exploitation was identified but not addressed by a referral to specialist services.

2.18 A number of wider issues were evident. These related to the role of drugs and alcohol in grooming, control and exploitation; the response to young people with disabilities and with behavioural problems; recognising and responding to online abuse; and the lack of consideration of any possible grooming/ radicalisation or in the later cases a referral to Prevent.

2.19 Summary Findings – Terms of reference 3
To what extent are good practice lessons around placement provision for looked after children at high risk of experiencing child sexual exploitation embedded in practice?

2.20 In the sample the review found many examples of children at risk of, or being, exploited being placed in expensive placements which could not meet their needs. They experienced many moves and went missing on a regular basis.

2.21 Two of the female children considered in this review became pregnant as a result of their abuse. Two of the babies were placed for adoption and all were subject to child protection arrangements.

2.22 Four of the five children in the case sample experienced being arrested and held in custody and some were convicted of offences in response to their behaviours. There was little contextualising of the offences. Research clearly demonstrates that a trauma informed response works best in these circumstances.

2.23 All the children considered in this review experienced significant disruption to their education causing them to miss out on a basic education, miss out on the protective factors provided by regularly attending school and miss out on social interactions with peers. Their

early histories of abuse, neglect and trauma resulted in them displaying very challenging behaviours.

2.24 The review did identify some good practice, but this was not always sustained. The children struggled to achieve their aspirations, such as attendance at college, and lacked the confidence and skills to engage successfully in the routines of everyday life.

2.25 Summary Recommendations

The report contains a total of 20 recommendations. These recommendations are set out in full in the review but can broadly be grouped into key areas of action.

2.26 That the agencies work closely together to look at local and national learning and to ensure that the pervasive, long term and sustained impacts of CSE on children and then later as adults is understood

2.27 Agencies develop a system wide approach to jointly commissioned, long-term approaches which address the human and financial costs of a child's lifetime exposure to trauma, abuse, neglect and exploitation.

2.28 That the impact and relevance of substance misuse as part of CSE is recognised and understood by all services and professionals and that warning signs are recognised more quickly

2.29 That the additional vulnerability of disabled children is recognised and that services respond appropriately.

2.30 That services are professionally curious in relation to changes of cultural identity in children

2.31 That the impact of placement change is recognised, and the lack of enough suitable local placements is addressed by commissioners

2.32 That the vulnerability of children missing education is recognised as well as the impact on education that this has had.

2.33 What is being done to address these issues?

2.34 The Bradford Partnership has a developmental action plan and is working with all partners to address the issues raised in the review.

2.35 The Bradford Partnership are in the process of establishing a specific monitoring group with external assistance to ensure the developmental action plan recommendations and actions are progressed and completed.

2.36 The Bradford Partnership have established links with the Centre of Expertise – Child Sexual Abuse. The nationally recognised and home office funded team have been supporting the development of processes and assurance / challenge sessions

with Police, Children Social Care, CCG and Health partners on the current response to CSE. Further sessions are being planned with other key partners.

2.37 Earlier this year, (February 21) the district held a virtual CSE conference with nationally recognised speakers including survivors of exploitation. The event had over 300 delegates.

2.38 The Specialist Exploitation Hub is in the process of being developed. The new hub will enhance existing practice and processes. The Hub development is being support by a strategic mobilisation sub group with membership from statutory partners and VCS. Additional resources have been recruited to support the hub, and these include Health worker and Educational Safeguarding Officers.

2.39 Bradford District has a well-established multi -agency child exploitation (MACE) process in place. Partner agencies meet every 6 weeks and is co-chaired by the head of services and a Police Chief Inspector. The meeting considers cases deem to high risk and other cases where progress has stalled.

2.40 The district also holds a daily multi- agency risk assessment meeting (DRAM) to review new and existing cases known to agencies where there is evidence of exploitation. Exploitation and missing strategies are put in place with agreed points of review to mitigate the risk of harm.

2.41 The All-Age Exploitation sub group, chaired by a Police Superintendent are hosting a unique workshop conference on the 10th of September 21 to undertake an assessment of exploitation in its broader sense. The facilitated event will aim to gather feedback from practitioners and community partners to enhance our response to exploitation in Bradford. The event is being supported by colleagues from the National Police Foundation and the National Vulnerability Knowledge and Practice Programme (VKPP)

2.42 Training on CSE has continued to be delivered by partners agencies to frontline practitioners. The Bradford Partnership have also commissioned bespoke training sessions on exploitation in response to this report by a specialist trainer. These will commence in November and early December 21 for frontline practitioners.

2.43 The Bradford Partnership will submit a further report on exploitation in November 2021

3. OTHER CONSIDERATIONS

3.1 There are no other considerations.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 There are no additional financial implications arising from this report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The protection of Children and Vulnerable adults is the highest priority for the Council and its partners when considering the implications of exploitation, as is the provision of services to support those who are victims of this abuse. Failure to protect and provide appropriate services significantly increases the risk to children and vulnerable adults in the district. It would lead to significantly reduced public confidence in Bradford Council, West Yorkshire Police, the Health economy and other partners, as has been demonstrated nationally.

6. LEGAL APPRAISAL

6.1 The Council has a general duty to safeguard children in its area that are at risk of harm and that includes child sexual exploitation pursuant to the Children Act 1989 and in cases of trafficking and abduction, Modern Day Slavery Act 2015.

7. OTHER IMPLICATIONS

7.1 SUSTAINABILITY IMPLICATIONS

7.11 None

7.2 GREENHOUSE GAS EMISSIONS IMPACTS

7.21 None.

7.3 COMMUNITY SAFETY IMPLICATIONS

7.31 Exploitation of children and vulnerable adults is a criminal offence. The consequences of exploitation can be long standing for the victim and there is growing research evidence that victims of criminal exploitation are themselves over represented among young people coming to the attention of police services as potential perpetrators. In addition, exploitation has lasting consequences for families of both victims and perpetrators and has the potential to impact of community relations.

7.32 The Community Safety Partnership (CSP) oversees the commissioning of funding from the passporting of Police and Crime Commissioner and the Violence Reduction Unit funding against key priorities related to exploitation.

7.3.1 HUMAN RIGHTS ACT

7.41 Sexual and Criminal Exploitation is a violation of the rights of the child/adult under the Human Rights Act. The multi-agency partnership arrangements are intended to prevent the rights of the child/adult being violated in this way

7.5.1 TRADE UNION

7.51 None

7.5.2 WARD IMPLICATIONS

An annual report on the Bradford Partnership Response to exploitation will be presented in the Autumn to both Executive, O&S Panel and Area Committees

7.7 AREA COMMITTEE ACTION PLAN IMPLICATIONS (For reports to Area Committees only)

N/A

7.8 IMPLICATIONS FOR CORPORATE PARENTING

7.81 National and local evidence shows that children who are looked after by the local authority are more likely to become victims of Child Exploitation than other groups. This means that in relation to safeguarding and corporate parenting responsibilities, partners have a responsibility to understand the safeguarding risks facing children, and especially in relation to Child Exploitation.

7.9 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

7.10 The nature of Sexual and Criminal Exploitation work requires partners to manage confidential matters and data under GDPR regulations in accordance with individual agency guidelines. There is no sensitive data included in this report that requires a Privacy Impact Assessment None.

8. NOT FOR PUBLICATION DOCUMENTS

8.1 Appendix C – CSE Thematic Action Plan - Is exempt under paragraph 7 (Crime Prevention) Schedule 12A of the Local Government Act 1972

9. OPTIONS

9.1 None

10. RECOMMENDATIONS

10.1 The Committee is invited to note the report

That Committee receive a full report in November on current work in relation to exploitation of both children and adults and that this includes updated details of work in relation to the CSE actions in the Thematic review.

10.2 The Committee commit to working closely with partners to deliver on the actions within the developmental action plan and progressing the extensive wider work presently on going in Bradford

11. APPENDICES

Appendix A – CSE Thematic Review Executive Summary & Main Report
Appendix B – CSE Thematic Review appendices including main report chronology

Child Sexual Exploitation Thematic Child Safeguarding Practice Review

Clare Hyde

July 2021

Thematic Child Sexual Exploitation Child Practice Safeguarding Review

Executive Summary

Part One

This review was commissioned by the Chair of the former Bradford Safeguarding Children Board prior to the establishment of the current Bradford Partnership. In accordance with guidance at the time responsibility for the review transferred to the new Partnership at the conclusion of transitional arrangements in September 2020. It was carried out by an independent person, Clare Hyde of the Foundation for Families. It was overseen by a panel of senior officers representing local agencies in accordance with national guidance.

Five children were included as the main case sample, three now adults, two of whom were abused during the 2000s. The review also considers the impact of learning from two other SCRs carried out locally in 2015 and 2016.

The terms of reference for this review required the independent reviewer, the review panel members, over 40 practitioners and managers from a wide range of agencies and crucially people who are still living with the consequences of child sexual exploitation (CSE) to consider whether or not there had been sustained improvement in the way agencies and individuals respond to CSE in Bradford. The review had three terms of reference and set out to establish:

1. Whether lessons have been learnt from multi-agency responses to non-recent cases of CSE within the Bradford District and beyond and are embedded in current policies and procedures.
2. The extent to which analysis of the responses of all agencies to current cases provides assurance that working practices and responses that exist now are robust, child centred and effective in protecting children from sexual exploitation and related harms; and
3. To what extent good practice lessons around placement provision for looked after children at high risk of, or experiencing, CSE are embedded in practice.

At an early stage in the process of conducting this review it became clear that despite some significant improvements in agency understanding of and responses to CSE between the less recent and current cases, agencies and individuals in Bradford have not always got it right. CSE is a complex crime and continues to be an area of concern and action in Bradford, as it is in many other places in the country and the learning from this review informs this process.

What is Child Sexual Exploitation?

CSE is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. CSE does not always involve physical contact; it can also occur through the use of technology. The term child sexual exploitation sanitises the reality of what that means for children. In several of the cases included in this review this meant being raped, sexually assaulted, physically assaulted, being afraid and anxious, being forced to take drugs and alcohol, being involved in criminal activity, being homeless and being lonely and isolated from family and friends.

Most of the children included in this review have lived with domestic abuse, physical and emotional abuse and neglect for most of their lives and this therefore poses a challenge for commissioners, managers and practitioners as it is the failure of the system to protect children from these harms which *creates* vulnerability to further abuse from CSE and also child criminal exploitation (CCE).

Part Two

The Children included in this review, a summary.

More detailed information about the lives of the children and their experiences of services is included in the overview report with more detailed chronology of multi-agency involvement in Appendix 2.

Cases 1 and 2 are less recent cases covering a period between 2001 up to 2012.

Case 1- Anna

Anna experienced multiple disadvantage and abuse as a child. Her mother first raised concerns about CSE when Anna was 14 and services were put in place including social care and a specialist voluntary sector provider. These services did not keep Anna safe, and the review concludes that they colluded with a situation in which Anna had an older abusive boyfriend, appeared to support a religious marriage with him and set up a foster placement for Anna with his family outside of normal processes. Many reports of abuse and assault were not addressed, and Anna had two children whilst she was still a looked after child.

Multi-agency working and the placements did not keep Anna safe.

Case 2- Fiona

Fiona was a child who came from a home with significant domestic abuse. Fiona's distress resulted in deteriorating mental health and her behaviour become increasingly concerning. Fiona came into care in 2008 but was not referred for CSE support despite assaults which resulted in her attendance at A&E. Fiona did try to tell services about her CSE abuse, but this was not heard or acted upon. Fiona gave birth to a child who was subsequently adopted, which compounded the impact of her sexual exploitation causing lifelong sustained trauma to her. In February 2019 nine offenders were convicted of twenty-two offences against Fiona.

More recent cases 3-5

Case 3 – Samara

Samara was a child who grew up in a home with domestic abuse and where parental mental health issues were a factor. Her parents raised a concern about CSE risk when she was 12. She was referred to social care who did demonstrate some areas of good practice in responding to her. There was a timely police response, and two arrests were made.

Despite this there were delays in responding to Samara. There was professional challenge about the risk she faced. There were also examples of use of language that placed

responsibility on Samara - “putting herself at risk”. This related to Samara creating profiles online where she claimed to be an adult in order to meet men. She was aged 12 at the time.

Case 4- Ruby

Ruby had a disrupted childhood which included the death of her mother when she was a very young child. Ruby was identified as being at risk of CSE aged 13 and came into care aged 15. Ruby suffered from significant mental health issues and a physical condition which impacted on her behaviour and may have impacted upon her understanding of what was happening to her. Ruby experienced 14 different placements including secure placements. Services did respond to Ruby, but the review finds that there was too much emphasis on the impact of Ruby’s behaviour on staff rather than the cause of it. Services did not keep her safe.

Case 5- Ben

Ben is a child with a disability which significantly impacted on his communication. There were concerns during his childhood in relation to domestic, physical and sexual abuse. Concerns were also identified from an early age about Ben’s use of pornography, cocaine and alcohol. Ben had a severely disrupted education and was a victim of CSE from both male and female perpetrators.

He and his siblings were on child protection plans, but there was a difference between the response to Ben and his female siblings in respect of CSE.

Examples of changes in Policy & Practice since 2011.

Since 2011 there has been a significant focus on CSE in the Bradford District, in a non - recent trial of CSE; 9 perpetrators were brought to justice for 21 indictments and sentenced to a total of 132 years; the formation of a multi-agency CSE hub; a systematic trawl of historic cases revisiting data on missing children through Operation Dalesway, and a number of victims have come forward as a result of this. The Police have made over 120 arrests in relation to non-recent cases in Bradford with investigations continuing still. Current processes are in place to identify children, assess risk and to put services in place. The following provide some examples from current practice:

Response to missing incidents and Domestic Abuse

4.2 A report of a child at high risk of CSE going missing now triggers an immediate response and full investigation. Adults who may be involved in high-risk children going missing are considered as suspects, located, arrested and interviewed. A social care referral is made and a CSE assessment follows. At the time of Fiona`s and Anna`s cases many missing incidents were treated as “unauthorised absence” rather than missing, resulting in a lower-level response. This categorisation is no longer used.

4.3 The Philomena Protocol was introduced in Bradford in 2020 and has resulted in improved management of missing children.

4.4 The Philomena Protocol is a scheme that asks carers to record vital information about children in placements which assists with both risk assessment and the response to any

children who may go missing enabling the information to be immediately available to help find them quickly and safely.

4.5 There is a specialist police team dedicated to protecting children vulnerable to exploitation which works closely with other agencies.

4.6 Domestic abuse incidents between those in a relationship when under 16 are now treated as child protection, not domestic abuse cases. Over 16 they are dealt with as domestic abuse, and all are risk assessed. Where there is concern that they are high risk and there may be further abuse they are considered at a MARAC meeting.

4.7 Where children live in households where there is domestic abuse, children's social care (CSC) and the child's school are informed of any incident so they can assess impact and monitor well-being.

4.8 Where perpetrators can be identified new preventative and protective legal provisions are used and the perpetrators arrested where there are sufficient grounds.

Teenage Pregnancy

Specialist nurses/midwives support teenage mothers and pregnant children looked after by the local authority (LAC) and they are more highly trained in safeguarding matters. There is a process for documentation and sharing of concerns with CSC. The Bradford Teaching Hospital and Airedale Hospital Trust's safeguarding teams also review all A&E attendances for self-harm or possible abuse and refer on to CSC as appropriate.

Executive Summary

Part Three

Findings

Terms of reference 1:

To what extent have lessons been learnt from the multi-agency responses to non-recent cases of Child Sexual Exploitation within the Bradford District and beyond and how well is this embedded in current policy?

While the review found that there had been substantial improvements in practice since the response to the non-recent cases, it found that there was also learning for children in the more recent sample. The LCSPR process reflected upon the learning from two previous local CSE SCRs and asked why although there have been improvements, not all learning has been fully embedded into practice. This review also identified the impact of an adverse Ofsted Inspection of Children's Social Care and the consequent instability in the children's social care management and workforce.

- Policy changes had been made in relation to CSE in all agencies, but this was not always seen in sustained practice changes. New standard operating procedures were issued in

2019 and a compliance audit revealed a positive response and high levels of compliance but some continuing issues with the quality of service.

- The short-term nature of funding for some CSE and family support services was also evident. This means that staff turnover can be high with experienced practitioners moving on to different roles or different areas. A further consequence of this is likely to be that 'organisational memory' across the system and learning from local SCRs and other reviews is lost too.

Terms of reference 2:

To what extent does analysis of responses from all agencies to current cases provide assurance that working practices and responses are robust, child centred, and are effective in protecting children from sexual exploitation and related harms?

While there was evidence of good practice in strategic activity, the evidence of quality of practice was not there in all cases and all agencies.
A CSE risk assessment tool is used once a possible risk has been identified. There was however evidence that risk was not always recognised even where there were clear signs and indicators suggesting sexual exploitation and there were examples of assessments being very delayed.
The language used about the children did not always reflect their vulnerability and they were, on occasion, deemed to be making choices.
At times, the response and attitudes to the male victim was different to that of the female victims.
Where risk was identified, changing levels of risk were not always responded to quickly and there was variance in how different professionals interpreted levels of risk.
Good supervision within CSC is critical to the quality of practice, particularly with cases where there is constant change and challenge. Case load size is also a factor as working with CSE is complex and time consuming. High levels of staff turnover in children's social care have made it difficult to measure the take up and impact of essential training. All three factors were identified as an issue in the Ofsted inspection in 2018 and so it is no surprise that these were found in the review.

Several wider issues were evident:

- The role of drugs and alcohol in grooming, control and exploitation was not addressed by a referral to specialist services.
- Response to young people with disabilities and with behavioural problems
- Recognising and responding to online abuse.
- Lack of consideration of any possible grooming/ radicalisation or in the later cases a referral to Prevent.

Terms of reference 3: **To what extent are good practice lessons around placement provision for looked after children at high risk of experiencing child sexual exploitation embedded in practice?**

In the sample the review found many examples of children at risk of, or being, exploited being placed in expensive placements which could not meet their needs. They experienced many moves and went missing on a regular basis.
The review did identify some good practice, but this could not be sustained. The children struggled to achieve their aspirations, such as attendance at college, and lacked the confidence and skills to engage successfully in the routines of everyday life.

Additional analysis and matters identified throughout the review.

- The use of drugs and alcohol as tools of exploitation was present in all cases. None of the children were referred to specialist services.
- The impacts of physical, sensory and learning or cognitive disability on children and young people compounded the risk to them of becoming exploited and abused.
- Half of the female children considered in this review became pregnant as a result of their abuse. Two of the babies were placed for adoption and all were subject to child protection arrangements. Long term impacts of early pregnancy are well-understood but there is little UK research about the impact of bearing a child as a consequence of abuse.
- There is little wider focus on and therefore little understanding of what, if any, common factors, including adverse childhood experiences, perpetrators of CSE share. Understanding how and why people become perpetrators of sexual abuse is important if we hope to reduce the harms caused by them to individuals and communities.
- There is a strong relationship between child sexual abuse and adverse mental health consequences for many victims.
- Four of the five children in the case sample have experienced being arrested and held in custody and some have been convicted of offences in response to their behaviours. There was little contextualising of the offences, and this is also true for cases in the detailed audit. Research clearly demonstrates that a trauma informed response works best in these circumstances.
- All the children considered in this review experienced significant disruption to their education causing them to miss out on a basic education, miss out on the protective factors provided by regularly attending school and miss out on social interactions with peers. Their early histories of abuse, neglect and trauma resulted in them displaying very challenging behaviours.
- The long-term impacts of sexual exploitation on mental health and wellbeing is significant.

Summary of Recommendations

The full recommendations are set out in full in the review but can broadly be grouped into key areas of action.

1. That agencies work closely together to learn from local and national learning and to ensure that the pervasive, long term and sustained impacts of CSE on children and then later as adults is understood and;
2. That there is a system wide approach to jointly commission, long term approaches which address the human and financial costs of a child's lifetime exposure to trauma, abuse, neglect and exploitation.
3. That services should recognise that drugs and alcohol are used as part of the grooming coercion and control of victims by perpetrators and that responses need to be developed to reflect this. All services and professionals should understand the warning signs and act quickly.
4. That the additional vulnerability of disabled children is recognised and that services respond appropriately.
5. Those practitioners are professionally curious in relation to changes of cultural identify in children.
6. That the impact of placement change is recognised, and the lack of suitable local placements is addressed by commissioners.
7. That action is taken to ensure school placements are available for children such as those considered in this review and steps taken to improve school l attendance of those who are missing out on education.
8. That the long-term mental health and wellbeing needs of children and adults who experience CSE, and coexisting traumas is prioritised and understood by commissioners and practitioners.
9. That the outcome for children (and their children) who become pregnant as a result of sexual exploitation or abuse is better understood and responded to.
10. That more is learnt and understood about the perpetrators of child sexual exploitation

An executive summary can never fully reflect the information and events that these children suffered. The full details are contained in the substantive review and appendices.

Contents

Thematic Child Exploitation Serious Case Review

Foreword

Jane Booth, Independent Chair and Scrutineer

The Bradford Partnership – Working Together to Safeguard Children

In March 2019 nine out of 10 men were sentenced to a total of 132 years' and 8 months' imprisonment following sexual exploitation of a child who had been in the care of the Local Authority. Now an adult, she had shown considerable courage in coming forward and speaking about her experiences as a child during the years between 2006 and 2011.

Following the trial, a second woman who had suffered similar abuse came forward and criminal investigations have been carried out in respect of alleged sexual offences she suffered when also in the care of the local authority in the years between 2001 and 2006.

In April 2019 I commissioned a serious case review, this was passed to the Bradford Partnership following changes in legislation and the development of new safeguarding arrangements. The work to complete the review was conducted under their auspices as a Local Child Safeguarding Practice review (LCSPR), I recognised that it was important to understand the experiences these two young women had suffered and to ensure that steps had been taken to improve the way agencies work together with children today to better protect them from exploitation. I felt it was equally important to understand the issues around more current practice and concerns that had been raised in respect of more recent cases. These cases are therefore also included in this review.

The review therefore considered multi-agency responses to five people who were children at the time of their abuse, enabling more recent development in multi-agency practice to be included.

The Bradford Safeguarding Children Board had previously completed two other SCRs following sexual exploitation of children, one in 2015 and the other in 2016 and I asked that the review consider the extent to which learning from these reviews had been actioned and embedded in current work with children and their families.

Alongside this LCSPR, a number of audits have been undertaken both by the Partnership and by single agencies which are relevant to the review. These were shared with the independent author to inform the review.

The review makes difficult and, at times, distressing reading. The children suffered abuse that no child should have to experience and, in most cases, had suffered other traumas and abuse long before they were sexually exploited. We must do all we can to ensure support for children at risk of or experiencing sexual exploitation is as good as it can be, includes preventative work, protects those at risk and pursues those who commit such crimes. We can always identify things that could have been done better and in looking at these cases we can see many occasions where opportunities to protect children were missed and, in some of the most heart-rending situations, where children were left at risk and subsequently abused.

We must also recognise that work to protect those at risk of exploitation is complex, requires resources and is very reliant on the commitment of staff who are entitled to good supervision, support and appropriate training.

A further challenge exists in identifying and prosecuting the offenders who prey on these vulnerable children. Our work inevitably focuses on victims, but the perpetrators must be made to take responsibility for their actions and the success of a number of prosecutions in Bradford is very welcome.

The Partnership and local agencies are committed to continued development and delivery of good quality services. They have welcomed this report and are actively pursuing improvements in the ways they work, singly and together, to reduce the risk of children being abused, to better support those who are and to deal with perpetrators.

I hope this review will be widely read and will help to inform the development of services elsewhere. Both the young women who shared their experiences want the analysis of what happened to them to lead to change and reduce the risk to others. We owe it to them to make sure it does.

Acknowledgements

The author of this report and the Chair of the Bradford Partnership and the Serious Case Review Panel members would like to thank the practitioners who shared their views, insight and experiences for this review. Also, thanks to Jaci Quenelle for her expertise in designing and delivering the practitioners learning events.

Most importantly, thanks go to the survivors of child sexual exploitation who contributed to this review often reliving difficult and traumatic experiences.

Although not all the children in the case sample, and their families made a direct contribution to the review, all wish to see the complete review. If any further learning comes from their responses, then this will be built into action plans and plans are in place to develop learning tools based on victim and family experiences of exploitation.

1.0 The Review

Part One

1.1 Bradford Safeguarding Children Board (BSCB), replaced in September 2019 by the Bradford Partnership – Working Together to Safeguard Children, commissioned this thematic serious case review (SCR) of child sexual exploitation (CSE) in April 2019.

1.2 The review was agreed following concerns regarding historical multi-agency responses to CSE. In addition to information held within agencies, the victim of a non-recent CSE enquiry had waived her right to anonymity following a successful criminal court case and had spoken openly about her experiences and the nature of the engagement agencies had with her.

1.3 It was agreed that a thematic SCR would be commissioned looking at both non-recent and current CSE cases to link lessons from the past with current practice across the agencies. Responsibility for the review was passed to the new Safeguarding Partnership in September 2019 and work continued as a Local Safeguarding Child Practice Review.

1.4 The review had three terms of reference and set out to establish:

I. Whether lessons have been learnt from multi-agency responses to non-recent cases of CSE within the Bradford District and beyond and are embedded in current policies and procedures.

II. The extent to which analysis of the responses of all agencies to current cases provides assurance that working practices and responses that exist now are robust, child-centred and effective in protecting children from sexual exploitation and related harms; and

III. To what extent good practice lessons around placement provision for looked after children at high risk of or experiencing CSE are embedded in practice.

2.0 Methodology

Working Together to Safeguard Children (2018) provides guidance for undertaking a LCPSR.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

2.1 The Thematic LCPSR was designed and led by Clare Hyde MBE from The Foundation for Families (a not-for-profit Community Interest Company). Ms. Hyde developed a review model that would enable participants and stakeholders to consider Bradford's responses to CSE. Ms. Hyde is also the author of this report and the methodology included elements of the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

https://gov.wales/sites/default/files/publications/2019-05/guidance-for-arrangements-formulti-agency-child-practice-reviews.pdf

3.0 Case Selection

3.1 Five cases were selected for inclusion in the scope of the review by the Panel members in consultation with the independent reviewer. The decision regarding which children and adults should be the focus of the review included a number already identified as likely to meet criteria for review with the sample selected to ensure a cross section of cases (age, ethnicity, disability and sex).

3.2 In two of the three more recent cases key front-line practitioners and their managers participated in learning events which aimed to understand the context of current practice and involve practitioners in identifying improvements and good practice.

3. 3 The outcome of a more recent procedural compliance audit has also informed this review.

4.0 Independence

4.1 The independent reviewer, Clare Hyde, was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody.

4.2 Ms Hyde has also designed and facilitated a number of multi-agency reviews including a CSE review in Rochdale in 2012 and is currently the Independent Chair of several SCRs and Domestic Homicide Reviews and has designed and led several Learning Reviews on behalf of Local Safeguarding Children and Adults Boards Serious Case Review Panel

4.3 The review panel comprised senior and specialist representatives from partner agencies, (see Appendix 1), to provide oversight and assist the independent reviewer in considering the evidence, formulating the recommendations and quality assuring this report.

4.4 The panel met on a number of occasions between July 2019 and July 2021. The overview report was ratified at the Bradford Partnership meeting on 15th July 2021. The COVID-19 pandemic and the additional pressures this placed on agencies impacted upon the expected timescales of the review and caused a significant delay in completion.

4.5 Two learning events were held with over 40 practitioners and managers who were involved of the lives of Ruby and Ben (the two most recent cases). The events were designed to.

- Share research and theory
- Consider current practice and work together in 'imagining what a good life' would look like for Ruby and Ben and how that differed from what was currently happening to them.
- Identify what needed to change at an individual and system wide level to achieve this.

4.6 During the course of the review the independent reviewer met with two of the subjects of this review. Their views are reflected throughout this report. The other 3 children and families have been made aware of the report and plans are in place to enable them to share their views if they choose to do so in the future.

5.0 Backgrounds of the children in the review

5.1 The children included in this thematic review are from a variety of backgrounds. One child is of Asian heritage and four children are white British. Three of the children had a combination of learning, physical disabilities and communication difficulties.

5.2 The following is a list of conditions considered to be disabilities from the NSPCC.

- Autistic spectrum / ADHD
- Learning disability
- Deafness
- Physical disability
- Visual impairment
- Long-term illness

https://learning.nspcc.org.uk/safeguarding-child-protection/deaf-and-disabled-children

6.0 Parallel Processes

6.1 There were ongoing police investigations in one of the non-recent cases. In addition, the National Independent Inquiry into Child Sexual Abuse (IICSA), which was established to examine how the country's institutions handled their duty of care to protect children from sexual abuse was in dialogue with the Bradford Partnership during 2020. They engaged with a range of agencies across the district and offered the local population the opportunity to engage with the Truth Project to inform the outcome of the National Enquiry.

7.0 Non-recent Cases and the national context

7.1 The two less recent cases included in this review relate to two women who are now in their late 20's and early 30's. The timelines for their individual experiences of CSE cover the period 2002 up to 2012. It is, therefore, useful to consider the national 'picture' regarding CSE during that period and how this was reflected in public and professional attitude, policy and practice.

7.2 As a previous Bradford SCR notes *"Any systemic failure has a complex and particular causality. Some of it, as the Serious Case Review into CSE in Oxfordshire (2015) concludes, relates to a general context and moment in the wider coming to terms with sexual exploitation as a society and as a culture*". 'Autumn' Serious Case Review Bradford 2015

8.0 National CSE Timeline

8.1 In 2000/01 Guidance was issued by the Home Office as a supplement to Working Together to Safeguard Children. It was called '*Safeguarding Children involved in Prostitution*' and was aimed at police, CSC and education and recommended that children involved in prostitution be treated as victims of crime.

8.2 In 2003 the Sexual Offences Act closed a loophole which prevented an adult from being prosecuted for sexually abusing a child if they could prove it was consensual.

8.3 In 2009 the Government published '*Safeguarding Children from Sexual Exploitation'*. This followed years of public campaigning by Barnardo's (who were the major provider of CSE related services at the time), the Children's Society and others about the sexual exploitation of children. The term 'child sexual exploitation' and acronym 'CSE' was adopted into common usage around this time reframing the child as a victim.

9.0 CSE Services in Bradford

9.1 Specialist services working with children at risk or victims of CSE have been operating in Bradford for over 25 years. The practice landscape for these services has been shaped by a range of activity at local and national level. Bradford was one of the first areas to set up a multi-agency CSE Hub in 2011. Despite reductions in public finances, national and local agencies have been expected to invest in and improve their response to CSE. CSE continues to be recognised as a national and local threat and can manifest in many different ways and has clear links to other forms of abuse and exploitation. The Home Office and the Department for Education are the government departments leading on the response to CSE.

9.2 Additional local context for Bradford is that the Ofsted inspection of children's services in December 2018 found that, while CSE support was seen as good, services for children overall were inadequate. This led to a focus on those areas which had been identified as most in need of improvement but also resulted in a period of very significant instability in service management which has been described as impacting on all areas of service. The service has seen some increasing stability since the establishment of the new leadership team consisting of the Director of Children's Services who came into post in July 2019 followed by the Deputy Director in October 2019. In addition to their posts, increased capacity and resource have been created by recruiting a senior leadership team which aims to bring stability, vision and clarity to the workforce and partnerships.

9.3 An Innovation and Improvement Programme is supporting the development of the 'foundations' which are required to consistently improve the quality of CSC practice in Bradford.

10.0 Local CSE Data and Safeguarding Arrangements

10.1 Data is collected in respect of both CSE and child criminal exploitation (CCE). Sexual exploitation is the most prevalent exploitation risk category for children in Bradford, shortly followed by children who are at risk of criminal exploitation. Over 50% of children with an 'Exploitation marker' are aged between 13 and 15.

10.2 The Ofsted Inspection of Children's Services in 2018 identified the departmental response to exploitation as effective, bound by multi-agency interventions and achieving positive outcomes for young people. This was largely delivered through the Multi Agency Safeguarding Hub (MASH) which was a co-located team of professionals from statutory and non-statutory services. The team complement in the MASH consisted of social workers, police, health and the third sector. After comments by Ofsted about police led decision making, the colocation arrangements were reconfigured although the overall resource remained the same.

10.3 At the time of writing this report, though still referred to as the MASH, the initial response to CSE referrals is managed by a team which consists of CSC staff who liaise with other agencies on a regular basis. There is also a separate multi-agency police and social care team which responds to non-recent sexual abuse investigations although staffing has been depleted significantly over time. The police team that investigates non-recent CSE - such as the cases of Anna and Fiona referred to in this report - still exists and has not diminished in role. In 2019 the police team was re-located to police premises to continue its work. The police CSE team was renamed as the 'Children Vulnerable to Exploitation Team' (CVET) to encompass child criminal exploitation as well as CSE.

10.4 Within the MASH a daily multi-agency risk assessment meeting (RAM) is held to consider the vulnerabilities and safety plans for children at risk of Exploitation.

10.5 Any children who are considered to be 'significant risk and stuck' are discussed at a six weekly multi-agency child exploitation (MACE) panel. The MACE panel has a strategic lead from all agencies and voluntary providers in attendance, which provide relevant updates from their respective areas for example 'hot spots` and key perpetrator information. On the same day, social workers and managers attend and provide an update on specific children deemed at high risk, or that may have been deemed to be drifting without a clear plan of action. These cases are reviewed, and agencies provide information to ensure all aspects of safety planning are in place and to determine what further action is required at a strategic level to assist progress or provide solutions. The allocated social workers for children who are open to CSC are invited to contribute and attend the above meetings. For children who do not have a social worker, consideration is given to whether they need one and appropriate referrals are progressed.

10.6 In spite of no longer being co-located, communication between agencies is regular and decisions are generally made collectively. Audit activity has identified that the response often 'starts off strong' but the intensity of interventions can tail off and on too many occasions, services (statutory and non-statutory) are not working in synergy. This is largely due to the logistics of working in different sites and a pressure to close cases to make way for new referrals due to rising demand.

Part Two

11.0 Case 1 Anna

11.1 Anna was known to CSC from a very young age and suffered multiple adverse childhood experiences including severe abuse and neglect. Anna also had caring responsibilities for her mother who had severe mental health problems and for her sibling who had complex needs. She was the subject of Child Protection Plans several times during her childhood. She moved between different households, mother, father, grandparents, family friends, as relationships broke down and her mother became increasingly unable to provide safe care.

11.2 In 2002, when Anna was aged 14 her mother expressed concerns about possible CSE. Anna was referred to a specialist project "Streets and Lanes" (SALS) which was a service for children abused through prostitution. In December 2002 Anna was placed in residential care and frequently went missing from the placement. In January 2003 Anna is recorded as having an Asian "boyfriend" who is variously recorded as being aged between 18 and 27. At this time Anna was said to have begun following the Islamic religion.

11.3 Throughout the time Anna was being supported by the SALS project she made frequent disclosures of sexual abuse and coercion, including rapes, when missing from the residential unit (she went missing on more than 70 occasions). At that time, SALS' policies offered service users complete confidentiality, and this meant none of this information was shared with police or CSC. She also told SALS that she was being subjected to assaults which were referred to as domestic abuse though she was still a child under the age of 16.

11.4 In June 2003, a LAC review took place, and it is recorded that Anna is "engaged" to her boyfriend and has converted to Islam. Her boyfriend attended the review. The IRO records that his being invited to the review "is an acknowledgment of the significance of the relationship".

11.5 In July 2003 Anna (now aged 15) told the SALS worker that she had married her Asian "boyfriend" in an Islamic ceremony. It appears that there was collusion with this by her CSC social worker who allegedly attended the ceremony and assessed that her marriage was likely to reduce the risks incurred when Anna was missing.

11.6 In the December 2003 Looked After Child Care Review, it is recorded that Anna is pregnant and wishing to be fostered with the family of the man referred to as her "husband". The review records this as unacceptable but within days she was placed with the family as a foster child, and they were paid a fostering allowance though there is no record of any assessment or approval process. It is hard to understand how this decision can have been made and it resulted in Anna being entirely reliant on her abuser and his family. Anna reported significant restriction of her freedoms by the family which would today be seen as coercive control. She also reported further assaults from her "husband". These were not passed on to CSC.

11.7 Anna moved to a flat, rented by her "husband" in 2004 and her baby was born while she was living there, although her "foster mother" is recorded as having been present at the

birth. Shortly after this Anna reported that her “husband” had forged papers in order to get a passport for the baby and was threatening to take the baby abroad. In the following months, her residence is unclear from records, and she seems to have moved in and out of placements as the nature of her relationships fluctuated.

11.8 In December 2004 Anna was taken to a refuge following an assault by her “husband”. At this point she was still a looked after child. By February 2005 Anna was pregnant with her second child.

11.9 What we do not see in the agency chronologies is that, during the time Anna was in care, she was being sexually abused and exploited by dozens of adult males, some of whom were known to her “boyfriend/husband”. More than 20 arrests have been made connected to the investigation of Anna’s abuse and investigations continue.

12.0 Key Themes Anna

12.1 Anna experienced severe neglect and abuse from a very young age. She was affected by severe parental mental illness and significant domestic abuse. She was subject to child protection arrangements on several occasions and finally came into the care of the local authority when she was aged 14.

12.2 As she came into care it is likely that Anna was already being sexually exploited. This escalated very rapidly and within a very short period of time she was being groomed, exploited and sexually abused by adult males.

12.3 Anna’s placement at the residential children’s home in Bradford did not keep her safe. She went missing frequently (over seventy times) and the staff there were aware that she was getting into cars with males including the male they referred to as her ‘boyfriend’. (This male was referred to as her ‘boyfriend’ and then later as her ‘husband’ by other professionals CSC, police, and health agencies).

12.4 It is apparent from conversations with Anna and from information contained in agency chronologies that the local authority did not reflect what was happening to her in terms of sexual abuse and exploitation.

12.5 It was whilst she was still living in the residential placement that Anna began to wear full Muslim dress, adopted a Muslim name and told CSC that she had been married to the adult male ‘boyfriend’ in a Nikah ceremony. (Nikah is a Muslim wedding at which the bride does not have to be present as long as she sends two witnesses to the drawn-up agreement). Anna was aged 15.

12.6 The willingness of some professionals to legitimise this wedding is clear from agency records. The adult male was thereafter referred to by professionals as her ‘husband’ and his parents as her ‘mother-in-law’ and ‘father-in-law’. The ‘Nikah’ marriage far from being challenged and perceived as coercive or exploitative was accepted and Anna’s social worker at that time attended the ceremony.

12.7 The decision to consider and approve a fostering placement with the adult male's parents is difficult to understand. The adult male was her abuser. It was also clear that she was not regarded with respect and affection by her abuser's family. In fact, they were also controlling and abusing her.

12.8 The Panel members discussed the placement of Anna with her abuser's family at length. This placement did not protect Anna from harm but did in fact place her at greater risk and made her entirely dependent on them. Whilst in the 'care' of these adults she was subjected to further sexual abuse and exploitation, domestic abuse including assaults and coercion and what we would now recognise as domestic slavery during the time she lived there.

12.9 Anna told the SALs project about her difficulties concerning her male social worker when she was living in her abuser's home. Although the SALs worker attempted to contact a SW manager about this her attempts were unsuccessful, and she did not formally escalate her concerns and Anna's situation did not improve.

12.10 Once she had become a mother herself Anna continued to be subjected to several further assaults and abuse by the adult male 'husband'. The way in which agencies; including CSC, the police and the SALs project responded to this was poor and did not protect Anna or her very young children from further harm. Anna was still a looked after child herself at this point in time.

12.11 What we do not see recorded in agency chronologies is that during the time she was in the care of the Local Authority Anna has described to the independent reviewer that she was being sexually abused and exploited by dozens of adult males some of whom were known to her 'boyfriend'.

12.12 Anna who was described as a bright child by her primary school did not receive any consistent education after the age of thirteen and there is little information in agency records to suggest that plans were put in place to address this.

12.13 In conversation with the independent reviewer, Anna was able to describe the ongoing impact of the trauma and abuse she experienced and the effect that this continues to have on her mental health and emotional wellbeing. She says:

"*Numerous social services assessments were carried out throughout my very early years from the authorities with a "being at risk" noted but nothing ever acted on, and I was failed for more than two decades. My needs as a child were not met my education was non-existent throughout my teenage years. From around 12 years old it was apparent to social services I was absconding from home and was being trafficked all-over west Yorkshire. I was at great harm however they allowed me to continually be subject to sexual, physical, and emotional abuse and psychological abuse and harm. Safeguarding risk assessments were carried out and acknowledged that I was being sexually abused by grooming on a large scale. Recommendations were put forward at various strategy meetings to remove myself as I was at escalated risk from sexual perpetrators and to be place into a secure unit or foster carers away from the area, but recommendations were ignored time and time*

again. I was regularly missing for numerous weeks at a time with no sightings, and no contact from myself. Social services and the police did nothing to locate me this could have ended in a homicide case as I was suffering from severe domestic violence. I was co-dependent from being 13 I was psychologically suffering throughout my teenage years, but no intervention was offered. I was a minor, unstable as well as unable, as any child is to make the correct choices which were life changing decisions these have had a major impact on my life. I was 15, but the authorities thought it was in the best interest and to minimise the severity of my absconding and placed me in a foster care placement while being fully aware with the parents of my abuser. We had no similarities in race, religion or culture and I continued be subject to domestic violence and was subject to a coercive controlling sexual relationship with a known perpetrator. I was frightened to leave, in fear of an honour-based killing. At 14 years old I was engaged to be married, taking on the role of an Islamic wife fulfilling the needs of my husband and the extended family somewhat like a maid. I was identified as a vulnerable and naïve child converting to Islam wasn't a case of wanting to embrace Islam for my own individual choices. I was manipulated and controlled while I was on a local authority care order the authorities should have protected me however they allowed abuse to occur for numerous years. Resulting in living a life of dual identity despite only being 15. The local the authorities allowed and witnessed a sharia law Nikah wedding to take place allowing a man to carry out sexual activity on a child to occur on a daily basis which is illegal.

If only the authorities had done what was recommend for me, the secure unit or accommodation. I wouldn't have been subject to sexually and physical abuse for many years. And because I wasn't looked after as a child should have been under a local authority care order. Contact arrangements with parents was minimal bonds were damaged with close family which can now never be rectified. I'm left with my adult years to educate and work on my mental health state of mind and coming to terms with the realisation I will always be in recovery. I'm not in control of my anxiety and only feel at ease with my nerves, when I'm in another county living a life that nobody knows who I am or what I've been subject too. Throughout my late adult years, I've had a significant number of disturbing dysfunctional relationships as I've not healed as a victim of child sexual exploitation and physical abuse.

I've found courage and been courageous in coming forward and I sincerely hope other victims will speak out about their child sexual abuse".

13.0 Case 2 Fiona

13.1 In February 2019, nine offenders were convicted of 22 offences against Fiona, including rape and inciting child prostitution.

13.2 Records of domestic abuse between Fiona's mother and her partner go back eight years prior to the first contact with CSC. In 2006 Fiona's relationship with her mother became very volatile with an incident of Fiona assaulting her. She moved initially to her grandmother's and later to friends and was frequently missing from home. Her behaviour in school deteriorated and she was excluded. Records reflect concern about her being in contact with males but the possibility of her being groomed and abused was not explored at this time.

13.3 Throughout her involvement with services Fiona expressed her distress and was clearly seeking help. Police powers were used to protect Fiona in 2008 and a CAMHS

assessment recorded that her low mood and distress were due to her home circumstances (domestic abuse) and that if returned there she would likely self-harm. Three placements with crisis carers were used but Fiona would not stay. There were differing agency views about the suitability of placements and CSC had no care order in respect of Fiona – her mother retaining the decision-making power. She was eventually admitted to care in March 2008.

13.4 Fiona continued to express her distress, to self-harm, to struggle to care for her own wellbeing and to go missing. A placement move did not bring about positive improvement and Fiona's behaviour had become more aggressive resulting in her being arrested on a number of occasions. Missing episodes escalated and there were clear concerns about CSE, however no risk assessment appears to have been in place.

13.5 In June 2008, a strategy meeting took place (very delayed). Warning letters were sent to potential harbourers and hotels but there is no record of Fiona being referred to CSE services or taken for a sexual health check and a risk assessment had still not been carried out.

13.6 On more than one occasion Fiona attended A&E with significant physical injuries but would not give information about who had assaulted her.

13.7 In December 2008 Fiona told her CAMHS worker and the Looked after Child nurse that she was pregnant. There is no record of discussion about the father. Fiona continued to go missing and her mother told the police she believed her "boyfriend was a paedophile". There is no record of follow up action.

13.8 A number of placements moves followed, including bed and breakfast and periods back at home, and in this period, Fiona was convicted of battery.

13.9 Fiona's baby was born in July 2009, and they were placed in a mother and baby home but were asked to leave due to her "boyfriend" being there outside permitted hours – again there is no evidence that any enquiries were made about this person. She returned to her mother's but assaulted her and was arrested – the baby remained with her mother.

13.10 In the months that followed (Fiona was still only 16) her accommodation changed frequently, her mental health deteriorated, she went missing, she was physically assaulted, and she alleged rape by a former boyfriend.

13.11 In the August specific concerns about CSE were raised by a support worker, a number of other reports followed. Fiona was removed from the premises of a 44-year-old man and recognised as being very vulnerable and in contact with a number of men. Fiona stopped engaging with CAMHS and was reported to be using drugs and "fragile" and likely to self-harm.

13.12 Fiona continued to be described as at high risk of CSE but was clearly being abused. She moved into independent accommodation (still under 18) but reported visits from men who assaulted her. Police records report concerns from a neighbour that the property was "being used as a brothel and smelt of Cannabis".

13.13 Similar circumstances continued and in 2012, when Fiona was 18, her child was made subject of a care order and subsequently adopted.

13.14 There was little stability for Fiona both before and after she came into care. There was clear recognition that she was being sexually exploited but none of the actions taken, nor the placements made resulted in her being safe. She was also physically assaulted numerous times and criminalised for behaviours that were a likely response to her own abuse and distress. An assessment that she could not safely care for her child led to adoption which has caused her ongoing grief and she continues to have mental health issues as an adult including Complex PTSD.

14.0 Key Themes Fiona

14.1 Fiona's early life was characterised by serious domestic abuse and her mother's poor mental health. Agencies were aware of the domestic abuse including physical abuse and Fiona was explicit about how this impacted upon her. Despite this nothing changed for her, and the outcome was that she left the family home and the perpetrator continued to live there.

14.2 Fiona's mother expressed concerns about CSE as early as January 2008 and there was evidence that Fiona was in contact with adult males. This was not acted upon by the police or CSC.

14.3 There was little stability for Fiona before and after she became a looked after child and she experienced frequent moves. She went missing on an almost daily basis and the police (and other agencies) response to this was, at times, poor. Fiona was described by the police, more than once, as 'street wise' and this implied that she could look after herself. Her missing from home/ care episodes were also graded as 'unauthorised absences' which resulted in a 'downgraded' response compared to a grading of 'missing'. This also meant. that missing from home interviews did not take place with Fiona and there was no missing strategy plan in place to help manage the risk to her.

14.4 There appeared to be agreement by all agencies that Fiona was either at risk of CSE or was actively being sexually abused and exploited (including by a known 44-year-old abuser) but this was not addressed by any single agency until the Turnaround service worked with her (with sporadic engagement; from November 2011).

14.5 When Fiona became pregnant at the age of 15 there was little curiosity or enquiry about who the father was and whether or not Fiona was safe. Similarly, when Fiona reported that she had a boyfriend there was little consideration of how safe this 'relationship' was for Fiona.

14.6 During the timescale considered by this review Fiona was assaulted at least seven times (beginning when she was aged eight or nine). There is nothing in any agency records to describe how this would have affected Fiona or how it might contextualise her own aggressive behaviour. The assaults included rape and sexual assault and these allegations were not given the same credence and response as had they been made by an adult or even by a different child and a medical was not undertaken.

14.7 Fiona ended up with several convictions for behaviours some of which may well have been a symptom of the levels of fear and distress she was experiencing (see also the Criminalisation of Sexually Exploited Children below).

14.8 The language used by CSC and the police to describe what was happening to Fiona between 2008 and 2011 was striking. She was described as *exchanging sexual favours for alcohol and drugs* (aged 14 or 15) and *soliciting and operating a brothel* (aged 17). She was a looked after child during these periods.

14.9 An assessment that she could not provide her child with a safe environment meant that her child was adopted against Fiona's wishes. This decision was made after many years of Fiona herself being unsafe and experiencing significant harm whilst in the care of the local authority. The trauma and loss from the adoption of her baby will have lifelong implications for Fiona (and for the adopted child and siblings).

14.10 Fiona, as an adult, suffers from ongoing mental health issues including a diagnosis of Complex PTSD.

14.11 In conversation with the independent reviewer Fiona described the impact of how she was treated by professionals as being as "*bad as the abuse*" and exploitation.

14.12 Fiona asks, "*Why was my child removed from me because of concerns over me being a victim of CSE but I, still under the age of 18, was left to carry on being abused"?*

14.13 In summary Fiona was not kept safe by agencies who had responsibility for her wellbeing and the abuse, assaults, exploitation and other harms she experienced were not acknowledged or addressed.

15.0 Case 3- Samara

15.1 Samara's family were known to CSC and health agencies throughout her life due to domestic abuse within the household and to her parents' mental health difficulties. When she was aged 12 her parents contacted the police reporting that she was in contact with several adult males she had met initially online. She was sexually exploited both when living in the Bradford District but also when she moved to another area.

15.2 A striking difference in Samara's case was the involvement with her family who identified possible CSE. Following her parent's contact with the police, the case was immediately picked up by the relevant services and dealt with in accordance with procedures and, with the exception of some medical interventions, there was evidence of good practice. A suspected perpetrator was arrested and charged with rape.

15.3 Despite her young age and the timely response to concerns, it is of note that the Specialist Health Practitioner (SHP) and police described Samara as "putting herself at risk" and encouraging men. Her brothers blamed her for her abuse and felt she had brought shame on the family.

15.4 Samara suffered considerable distress in the following months and was particularly anxious about the court case and possible approaches from her alleged abuser or his contacts. She

was provided with consistent support by the SHP throughout. She was also distressed by her brothers' response to the abuse and blame being levelled at her. The trial resulted in a finding of not guilty.

15.5 There were significant delays in planned work with Samara to help her to understand grooming and exploitation and professional disagreements about the continuing level of risk of further exploitation. Nor had any therapeutic work been completed though the CAMHS were planning to do some desensitisation work to treat her PTSD.

15.6 When Samara subsequently moved to another area to live with a family member she went missing and her CSE risk rating was increased too high. She was 14 at this point. Two men were arrested, one for abduction. The police response was timely and effective with steps being taken to protect Samara using Police Powers of Protection and to arrest the suspects. However, records indicate that the out of area CSC failed to carry out a child protection investigation. This was noted in Bradford and a follow up investigation completed but clearly not within required timescales. There were issues with the health responses, but the forensic health profession did identify Samara as being at high risk of CSE.

15.7 Over time the required work did take place with Samara and by 2019 she appeared to be much more settled, back in school most of the time and no longer subject to a Child Protection Plan. In 2019 her CSE risk assessment was recorded as low risk.

15.8 The evidence in relation to continuing challenges in developing good practice mirrored the findings in the case sample itself.

16.0 Key Themes Samara

16.1 A striking difference between Samara and the other children's cases was the involvement of her family with agencies at a very early stage. Her parents had recognised the warning. signs for CSE, such as changes in Samara's behaviour; staying out late and being evasive about who she was meeting and her use of a mobile phone to contact a number of men and they reported their concerns to the police.

16.2 What is also documented is the impact of this on Samara's parent's already troubled mental health. It was also apparent that they and Samara's brothers believed that she was responsible for the CSE. This understandably caused Samara further distress.

16.3 A further striking difference between Samara and the other children's cases is the consistent relationship Samara and her family had with the Sexual Health Practitioner (SHP) whose commitment and holistic understanding of the issues Samara was coping with (especially those within her own family) meant that Samara's voice was heard and understood. The Sexual Health Practitioner was able to use professional challenge effectively and did so on three occasions. Of particular note was the occasion in September 2018 upon which the SHP challenged agencies who had been tasked with actions in Samara's CPP and had not started/ progressed these.

16.4 The SHP's excellent record keeping enabled the independent reviewer and author of this report to understand Samara's vulnerabilities and the ongoing distress caused by her family's response to the CSE.

16.5 Samara also received a speedy and pro-active response from the police and consistent. support from the police officer allocated to her leading up to the trial of the first suspect. The officer demonstrated similar understanding of Samara's needs and her family context and responded accordingly.

16.6 Similarly, Samara's first school provided sensitive support and valuable information to the police and other agencies when Samara went missing in Cambridgeshire.

16.7 There were, however, some instances when Samara was not supported well, and her experiences of forensic medicals followed by STI screening was one of these. The record keeping by the company providing this service was incomplete and therefore fell below expected standards.

16.8 It is also of note that professionals including the SHP and a police officer described. Samara's behaviour as 'putting herself at risk' or 'putting herself in risky scenarios. Samara was quite clearly an extremely vulnerable 12-year-old child whose understanding of sex, relationships, exploitation and risk was appropriate to her age. She could not therefore assess risk to herself and continued to believe that one of the men 'had been nice to her' because he had brought her food and drink. The SHP identified that Samara felt unloved and was seeking affection from the adult males. This was exploited by the older men, and it was this that led to Samara being sexually and physically abused.

16.9 The judgement made and shared by a police officer that Samara had not been sexually exploited but had encouraged the men and lied about her age had a direct impact on Samara as it influenced what services she was referred to by healthcare providers in 2018. Whilst Samara had lied about her age and this would have impacted on the possibility of a successful prosecution, the phrases used by the police officer to relate this could have influenced how Samara was responded to or to imply that she was to blame for what happened to her.

16.10 The confusion regarding who would undertake S47 enquiries between WYP and Cambridgeshire police led to a delay in these being carried out and it is unclear why this confusion occurred.

16.11 In summary, whilst there were no significant or prolific concerns about how agencies worked together to safeguard Samara the author of this report considers that without the challenge of the SHP this might not always have been the case.

16.12 Despite the examples of good practice and swift agency responses described above, there was a delay in providing Samara with therapeutic interventions which may have contributed to her going missing in Cambridgeshire as, at that stage, she did not recognise that she was being exploited. Samara suffered significant harm and was trafficked, raped and sexually exploited. This was compounded by the not guilty verdict and her family's response caused her further distress.

16.13 There may well still be learning from Samara's case about the 'cultural' response of family and community to CSE and TBP and partners may wish to focus upon this in their plans following this review.

17.0 Case 4- Ruby

17.1 Ruby had a disrupted childhood following separation from, and the subsequent death of her mother. From a very early age, her behaviour was described as problematic, leading to school moves and exclusions. As she became a teenager her father asked for support from CSC.

17.2 She was first identified as being at risk of sexual exploitation in 2014 at age 13 and became a looked after child at age 15. She had been diagnosed with a disorder affecting learning ability when aged 14, giving some context to her behavioural problems. Over time she had 14 placement moves with all but three being out of the authority boundaries. She frequently went missing and had two secure placements one in a secure children's home and one in a mental health hospital. Ruby prolifically self-harmed, requiring hospital admissions, the most serious self-harm incidents focussing on her genitals.

17.3 There were numerous incidents where Ruby went missing and was believed to have been sexually exploited, including allegations of abduction and rape.

17.4 The information provided by agencies shows an almost exclusive focus on Ruby's behaviour and the impact of this on placement staff rather than as a possible manifestation of her distress or symptom of sexual exploitation. Not all professionals recognised her level of risk and there were professional disagreements about how best to respond to her needs with concerns from the police being escalated at the highest level and there were examples of very poor practice. Agency interventions with Ruby did not keep her safe.

17.5 When Ruby began to dress in "Muslim clothing" and talk of getting married and moving to Afghanistan this was not responded to as possible grooming and no referral into the prevent programmes were made.

18.0 Key Themes Ruby

18.1 The root cause of Ruby's early behavioural and emotional difficulties may well be a combination of the separation from and subsequent sudden loss of her mother, the physical and cognitive impacts of a chromosomal disorder, a diagnosis of ADHD, and the fractured relationship with her father, stepmother and half sibling.

18.2 There was an almost exclusive focus by CSC and the placement staff on Ruby's behaviour and the impact of this on residential placement staff at critical time for Ruby (huge escalation in risk and harm from CSE) rather than a focus on Ruby's behaviour as a manifestation of distress or as a symptom of sexual exploitation.

18.3 Despite evidence of increasing risk there was no assessment or recognition of Ruby's vulnerability to CSE by her SW who perceived Ruby as low risk. (September 2018)

18.4 There were professional disputes between Police and CSC in respect of the risk to Ruby and the ability of her placement to keep her safe and these were not resolved.

18.5 Ruby moved placements 14 times and the scarcity of suitable placements locally was noted by practitioners. Her move out of the area did not keep her safe and in fact, the area to which she moved has higher than average reported CSE rates than the rest of the county.

18.6 Ruby had a number of fixed term and a final permanent exclusion from school and suffered a disruptive education journey which further compounded her vulnerability and isolation.

18.7 Ruby began to dress in 'Muslim clothing' in January 2019 and talked about getting married and moving to Afghanistan. It is not clear from agency records at that point in time how this was responded to. This does not appear to have been assessed as a sign of grooming or exploitation or to have triggered Prevent: Protecting children from radicalisation strategies.

18.8 At this point in time Ruby has a diagnosis of ADHD, a chromosomal disorder and specific learning difficulties. Her understanding of her world and her life experiences are not always consistent with her age. "*She is an eight-year-old in an 18-year old's body*" (Reflections from a practitioner who attended the learning event), meaning that assumptions cannot be made about her understanding of consent, healthy relationships and what constitutes abuse.

19.0 Case 5 - Ben

19.1 Ben has a severe disability and needs support with communication. Interpreters were not always used by professionals and family members were often allowed to interpret for Ben, running the risk that they mediated his views.

19.2 Throughout his childhood there were concerns about physical abuse, neglect, domestic abuse when he was aged six. There were physical and behavioural indications that Ben may have been sexually abused.

19.3 Agencies became aware of concerns about sexual exploitation in respect of Ben's extended family when he was aged ten and it was known he had been exposed to pornography. Aged 12 Ben was known to be using cannabis, alcohol and cocaine. Records described him as being "sexually active" with an older 'girlfriend' and there was concern that he might pose a risk to siblings. The children, including Ben, were subject of child protection plans several times but agency interventions did not meet Ben's needs or keep him safe.

19.4 There was a marked difference in how agencies responded to Ben's abuse and to that of his female siblings.

19.5 Ben's behaviour was at times violent within the home and at school and he went missing several times. He was also subject to physical assaults by both parents. When 13, he was assessed as being at risk of sexual abuse by older males connected to the family, from both within and outside the district.

19.6 When 15, he was “found in bed” with an older female but police investigations did not proceed to charge due to evidential difficulties.

19.7 Finding appropriate education for Ben has been a challenge and there have been significant periods when he has had no school place.

Key Themes Ben

20.1 Ben experienced neglect and physical, emotional abuse and was exposed to domestic abuse from a very young age. It is also possible that Ben was sexually abused at the age of 6 however this was not explored by professionals at the time. His disability meant that he was isolated and the use of family members as interpreters meant his voice was mediated by them and his own voice was rarely heard. Ben’s father in particular was regularly relied upon to interpret for Ben and other family members. This was unsafe and further compounded Ben’s isolation and lack of voice. Professionals noted that Ben’s father was extremely controlling and that he accompanied Ben and his siblings to medical and other appointments.

20.2 The focus of interventions and assessments in respect of Ben was his behaviour and aggression. Ben’s distress and vulnerability was not always seen as an indicator that he was possibly being sexually exploited or abused or of the issues he faced at home.

20.3 The difference in how risk and need was ‘framed’ in relation to Ben and his female sibling was stark. For example, at a core group meeting in October 2018 it is recorded that “*Ben has been involved in sexual incidents and is hanging around with those involved in drugs, whilst his sibling has been sexually abused.*” “*For sibling, we are worried about the impact of the sexual abuse she has suffered upon her emotional health and understanding. Sibling will often show her emotional difficulties through behaviour before expressing this verbally”. “For Ben, we are worried about his ability to manage his emotions when things become very difficult, his choice to smoke cannabis to help him sleep and his relationship with his parents, friends and sisters*”.

20.4 The language used by other agencies in respect of the sexual exploitation of Ben was also of note. For example, there were references to ‘*underage sexual activity’* and *‘sexual relationships*` and that Ben was ‘*sexually active and had been in a relationship with a 16year-old girl’*. Ben was, at that point aged 12. In UK law a child under 13 does not, in any circumstances, have the legal capacity to consent to any form of sexual activity. These are offences of strict liability as regards to age, and there is no defence of reasonable belief in relation to the age of the complainant.

20.5 The panel members and independent reviewer considered how different agency and individual practitioner responses may have been if Ben was a girl. Would, for example a 12-year-old girl have been described as having a sexual relationship with a 15 or 16-yearold boy?

20.6 The number of time Ben’s parents called the police in respect of Ben’s aggression is also notable. WYP appropriately identified that Ben was a vulnerable child and shared information with agencies after each incident (with a few exceptions). However, this pattern of Ben’s father calling the police and/ or throwing Ben out of the family home after an allegation of assault was

not analysed and was taken at face value by professionals as a consequence of Ben's aggressive behaviour.

20.7 Furthermore, throughout the entire period of time included in this review Ben's parents were physically assaulting their children. Ben's father presented an unchallenged version of events after each incident involving Ben as alleged perpetrator. Ben remained voiceless and/ or his father interpreted for him. There was no analysis of how the incidents were triggered and what the frequency of incidents meant in terms of risk and harm to Ben.

20.8 None of the children called the police when they were assaulted (they told other adults) and it does not appear that prosecution of the parents for assault was considered apart from one occasion in 2014 when a police investigation, including interview of Ben's father as a suspect, took place. Consideration of prosecution concluded that there was insufficient evidence to proceed. Ben was a very young child when the police were first called to an incident involving him as the 'perpetrator' and the number of further such incidents is of concern.

20.9 The failure to make consistent use of suitably experienced and qualified interpreters in this case is of immediate and urgent concern. Ben has remained largely voiceless and incredibly isolated. This has compounded the neglect and the physical and emotional abuse he has experienced and has also compounded his vulnerability to CSE and criminal exploitation.

20.10 The difficulty for any child with profound communication difficulties to disclose sexual abuse cannot be understated. This difficulty, in part, relates to how children 'frame' what is happening to them because of the 'abstract' nature of abuse and the subtlety of language needed to communicate very distressing and sensitive information and feelings.

20.11 Ben was not in education for significant periods of time covered by this review which was an additional risk factor and compounded his vulnerability and isolation.

Responses to issues raised in the review.

Missing from Home episodes

21. 1 Non recent cases were often assessed as "unauthorised absence". This grading is no longer used. A missing person can be graded as 'absent' for up to 18 hrs with Inspector reviews every 8 hours. The absent grading can be used only when the risk is 'negligible', so would not apply to a child missing from care in these circumstances. Otherwise, they will be graded as low, medium or high. (For example, Ruby was never graded as absent, and consistently graded as high risk once graded as high risk of CSE).

21.2 Current practice is that missing incidents linked to a child considered to be at high risk of CSE immediately trigger a high-risk missing person response and a full investigation to

follow with investigative direction from a Detective Inspector. The awareness of CSE has changed radically. Instances where Anna or Fiona were found in the company of adult males would be responded to differently now. There is a high likelihood that this would result in the arrest of the males, with far greater emphasis on evidence gathering opportunities (digital media, forensic opportunities). A social care referral and a CSE risk assessment would follow. The contrast and better practice are evidenced in Ruby's case.

21.3 In the non-recent cases there was little evidence of follow up. Currently a return interview is always attempted even if the missing child refuses to engage. Investigative opportunities, such as seizing of underwear and examination of digital devices are considered. Any offences disclosed are recorded and investigated from the outset.

21.4 The police child missing from home coordinator sends a list of children reported missing over the previous 24hrs (48hrs at weekends) to the CSC missing coordinator each weekday so there is a regular exchange of missing child information. The top 10 missing people for the district are discussed at a weekly missing meeting.

21.5 Current policies and practice involve regular multi-agency review of incidents, follow up by way of independent return interview by a voluntary sector agency and adoption of the Philomena protocol for children in residential setting which has resulted in a significant drop in the numbers of looked after children going missing.

21.6 The Philomena Protocol was adopted in Bradford in 2019.

21.7 The Philomena Protocol is a scheme that asks carers to identify children and young people who are at risk of going missing, and to record vital information about them that can be used to help find them quickly and safely.

Investigating CSE Allegations

21.0 Police officers are far more proactive in investigation and their use of powers (which have also been widened). If a child is found in circumstances suggesting they are at risk, they are likely to be taken in to police protection. If they are found with other people in circumstances that suggest the other people may have committed an offence, those people are likely to be arrested. Where there are sufficient grounds, positive action is taken even in the absence of a disclosure from the child.

21.1 There is dedicated police 'Children Vulnerable to Exploitation Team' (CVET) with a clear remit to support children at risk of exploitation and investigate offences against them. The team includes accredited Detectives and Specialist Child Abuse Investigators.

Domestic Abuse incidents involving a child.

22.0 Now, when a victim is under the age of 16, this is addressed as 'Child Protection' rather than domestic abuse. A MARF is submitted to share information. Once over 16, this is considered

as a domestic abuse incident. A DASH assessment is completed and all DA incidents where a child or children are involved are shared with CSC. DA incidents are discussed at a daily risk assessment meeting. Where cases are high risk and there is concern those victims may be exposed to further abuse, they are referred in to the MARAC process.

22.1 The majority of the children considered in the report experienced domestic abuse in the family home prior to being exploited. As above, whenever a child is present at a domestic abuse incident, information is now shared with CSC. If the child is in education, their school is also informed so that they can monitor the impact of domestic abuse on the child (Operation Encompass).

Teenage pregnancy and looked after children.

23.0 Currently, BTHFT and Airedale have named midwifes, an associate safeguarding midwife and also has a specialist teenage pregnancy midwife who all work closely together. Midwives are also taught as part of their required training that any looked after child who presents as pregnant needs to be referred to the safeguarding midwife and that a referral to CSC should be completed for a pre-birth assessment. A safeguarding families document is initiated which contains all the safeguarding information relating to the young person and any safeguarding concerns.

Mental health assessments

25.0 Current practice is that every child who attends the Emergency Department (ED) has their ED attendances reviewed by the Safeguarding team to ensure safeguarding concerns are not missed. Details of any child attending ED with signs of self-harm, mental health issues including anxiety and panic attacks (so not always sign of physical injuries) are shared with relevant agencies. All are shared with the 0-19 service and some of them are also shared with other agencies such as CSC. It would be expected that a discussion with CAMHS would be had prior to discharge as often CAMHS will agree to see a child in the community rather than having to wait in the hospital.

Part Three

26.0 Summary Analysis of Key Findings and Associated Learning and Recommendations

26.1 This section of the report sets out an analysis of key findings and associated learning points and recommendations against the terms of reference for this Thematic Serious Case Review. The analysis also draws upon relevant research and findings from other serious case reviews. The Terms of Reference provide the headings for the following sections of the report.

Terms of Reference 1 "Policy and Procedures: To what extent have lessons been learnt from the multi-agency responses to non-recent cases of CSE within the Bradford District and beyond and how well is this learning embedded in current policy and procedures".

26.2 Examination of local reviews and those published more widely, demonstrates that lessons for policy and practice are identified, but the very nature of a complex review process and report can mitigate against some of that learning being disseminated and successfully embedded. Lengthy and complex reports can of themselves be inaccessible to many.

26.3 This review found more evidence of lessons in respect of policy being successfully implemented than of sustained practice change. National research shows this to be a widespread systemic issue and offers some insights into why this may be and how it might be overcome. The review process reflected upon the learning from two previous local CSE SCRs and asks why not all of this had been fully embedded into practice (see more detail below). It also reflected on relevant learning about the impact of neglect, physical and domestic abuse.

26.4 In line with the research findings, this review has, as described, highlighted that there are still instances where outcomes for children are not as good as they should be although it is not possible to quantify this i.e., the number of 'good practice or poor practice' cases.

26.5 This review has taken a view across the complex health, social care, VCS and criminal justice 'system' and it is obvious that responding to and working with children who are sexually exploited is difficult and nuanced work. For all of the children included in this review, that work pre-dated their sexual exploitation, often from the child's infancy. We cannot ignore that earlier work in assessing how learning is embedded into policy and practice. For example, if we know that failing to protect a child from neglect and domestic abuse and parental mental illness contribute to a child's vulnerability to CSE (and other abuse) then we must also urgently look at the system's response to those issues too.

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26.6 The research reminds us that learning lessons and implementing actions are not the same thing – indeed in this review we have seen that action plans from earlier reviews have largely been implemented but can see less impact on practice than was anticipated when those actions were planned.

26.7 A compounding factor may be that this work is often taking place in a context of shrinking resources which in some cases has caused organisational upheaval. This review also identified the impact of an adverse Ofsted Inspection and the consequent instability in the Children's Social Care management and workforce.

26.8 The precarious nature of funding for some CSE and family support services is also evident with well used and well regarded third sector and statutory services funded only for short periods of time or funding being lost altogether. This means that staff turnover can be high with experienced practitioners moving on to different roles or different areas. A consequence of this is likely to be that 'organisational memory' across the system and learning from local LCSPRs, SCRs and other reviews is lost too.

27.0 Learning from the Thematic Review cases

27.1 The two audits of recent cases recognised that the Ofsted improvement activity resulted in more regular formalised supervision by CSC.

27.2 The importance of education in supporting children and families is recognised in the current Exploitation Strategy and TBP has developed effective working relationships with the Local Authority Safeguarding Education Team to enable monitoring of children not in school.

27.3 Raising awareness with communities has been achieved through the work of Trusted Relationships, Breaking the Cycles and Youth Services and the Bradford Police Cyber Team. Trusted Relationships, Breaking the Cycles and Youth Services also provide valuable support around therapeutic services, but this is not set within an overall strategic approach to commissioning therapeutic services across the district and is insufficient against the overall demands.

27.4 The Partnership's Communications and Engagement Group is a positive function to engage with key stakeholders. Using a dedicated group reduces confusion over the source of messaging, avoids multiple messaging and provides opportunities to link with national key events/days. This brings together the key strategic boards with wider partners.

27.5 It is clear that the complexity of the cases and the scale of the challenges involved in the work risks that the cases 'run the worker' rather than the other way round.

28.0 Learning from previous Serious Case Reviews

28.1 Prior to the completion of this Thematic Review the former Safeguarding Board had completed two previous SCRs involving CSE. The SCRs for 'Jack' 2015 and 'Autumn' 2016 produced a number of recommendations for the LSCB, and partners also identified single agency learning which led to multi-agency and single agency action plans. This thematic review has considered those action plans and also the district's overarching CSE action plan. Additionally, the author has had access to an annual report to the Bradford Council Executive `Protecting Children and Vulnerable Adults at Risk of Exploitation` (2020) which provides a summary of current arrangements which is summarised in Appendix 3- Update on CSE Progress November 2020)

28.2 The following section provides an overview summary of how well learning has been embedded in current policy and procedures.

28.3 "Jack" Serious Case Review. BSCB Action Plan and Combined Single Agency Action Plans July 2017.

28.4 This review was signed off by the Case Review Sub-Group in November 2018, (although the offences it related to took place in 2012) with all actions shown as completed. The review made three key recommendations, firstly around technology assisted abuse;

secondly that assurance be provided by police and CSC that child protection processes are fit for purpose and are being applied; and lastly a challenge to CSC around an internal review relating to practice and staff. The report had wider learning that is used for analysis in this section. The issue raised in the review included the Police response to Jack's contact with an offender; the fact that a strategy meeting and section 47 were not held after a number of referrals; the fact that Jack was not protected by the police and social care; and management oversight and support to front line workers.

28.5 Autumn Serious Case Review. BSCB Action Plan and Combined Single Agency Action Plans 2016

28.6 This review was completed in 2016, again relating to offences in 2012. A number of recommendations were made regarding practice improvement in the following areas:

- Assessment and Care Planning
- Decision Making
- Supervision
- Multi-agency working and resourcing.
- Professional curiosity
- Support to and preventative work with parents and siblings
- Engagement with children at risk of CSE
- Health and Therapeutic Services
- Placements and education

28.7 The Partnership recognised the wider emergence of criminal exploitation resulting in the widening of the CSE/Missing sub-group into a Risk & Vulnerabilities in Complex Safeguarding sub-group (now the 'all age' exploitation group).

28.8 Although many of these areas of work were still found to need improvement in the Social Care Ofsted Inspection, actions to address them have been built into the Council's Improvement Plan. One incomplete action was the need to seek assurance that appropriate therapeutic services were available for victims of CSE. Despite the issue being raised with the Health and Well-being Board and with Public Health Commissioners, this remains unresolved. Further work was reported to be underway under the auspices of the Partnership`s All Age Exploitation group to currently mapping services in order to assess capacity against need.

28.9 The CSE action plan was also extended, recognising these changes and including the ongoing work (Red and Amber actions) into the new action plan.

29.0 Recommendations from Term of Reference 1

"Whether lessons have been learnt from multi-agency responses to non-recent cases of Child Sexual Exploitation within the Bradford District and beyond and are embedded in current policies and procedures".

Recommendations

R1. That TBP seek assurance that current arrangements and practice for supporting professionals with such complex cases reflects best practice and addresses the issue of specialist versus generic expertise and the time demands in doing this work well (learning from "What works" research).

R2. TBP should reflect on the evidence regarding enablers and barriers to learning and ensure it effectively disseminates the lessons from this review and that they are embedded.

30.0 Recommendations from Term of Reference 2:

"**To what extent does analysis of the responses from all agencies to current cases provide assurance that working practices and responses are robust, child centred and are effective in protecting children from sexual exploitation and related harms."**

30.1 Whilst there was evidence of some good practice in strategic activity, analysis of responses from all agencies *did not* provide assurance in all cases that working practices and responses are sufficiently child centred and protect children from sexual exploitation and related harms.

30.2 The following paragraphs provide examples, grouped into themes, which relate to some, or all of the cases reviewed during the review.

30.3 Recognising and responding to CSE.

Bradford's agencies currently use a CSE risk assessment tool to identify the level of risk in cases where there are concerns about possible CSE. However, before the risk assessment is used there is a reliance upon practitioners recognising that CSE *may* be a risk for an individual child thus triggering use of the tool. In some cases, even when there were signs that a child *was* being sexually exploited practitioners did not always recognise this. For example:

- In 2018 Ruby's SW did not believe or recognise that Ruby was being sexually exploited
- When CSE was recognised, it was not always responded to appropriately and in a timely manner.
- See examples in respect of Ben, Anna and Fiona which demonstrate use of language minimising risk.
- The detailed case audit supports this view, whilst these cases highlight obvious risks to children; the changing levels of risk and particularly increases in risk are not as well assessed, analysed or responded to.

30.4 A number of tools and checklists have been developed over the last 10 years, and are now widely used, to identify young people at risk of CSE. Research in 2016 (Brown et al) identified many issues with CSE risk assessment tools, including a lack of consistency in the risk indicators featured in different tools, and varying thresholds for being identified as a potential victim of CSE.

30.5 In 2017, the Centre of Expertise in Child Sex Abuse commissioned an exploratory study to build on this research, exploring the purposes for which tools and checklists are used and the

ways in which they do or do not support good practice in the developing field of CSE prevention. In short risk assessments are seen as ineffective in identifying true CSE risk. The study identified that there is sometimes confusion as to whether screening or risk assessment is being carried out, with debate amongst professionals as to whether one tool for both these purposes is required, or different tools for different purposes.

30.6 In summary the CSE risk assessment process is not always used appropriately or in a timely manner and the outcomes of the risk assessment process i.e., an assessment of low or medium risk of CSE did not always reflect the reality for the subject of the assessment.

Recommendations

R3. Considering the learning from this review and evidence from research TBP should consider the recommendations made by the Centre of Expertise in Child Sex Abuse in respect of the effective use of screening and risk assessment tools.

https://www.csacentre.org.uk/documents/infographic-seven-principles-recommendation/

30.7 Good supervision is vital in helping practitioners consider, recognise and respond to CSE.

30.8 In each of the review cases considered by this review, and within the two case audits, the children had a wide range of needs, and both historic and ongoing risks and harm. Often SW, education and police practice was reactive in response to fast moving incidents (for example several missing episodes in one day, several allegations of assault/ rape within a short timescale). In this context the role of good supervision is vital and can ensure that practitioners are challenged and supported to recognise and respond well to CSE. It is vital that supervision is well resourced in terms of time, space, and opportunity and that supervisors are also offered developmental and supervisory support and oversight themselves. It is clear from the cases included in the review that supervision was not always effective at providing oversight and challenge and TBP may wish to explore what can support supervisors in their roles. The case load of staff working with children with such complex needs and risks should reflect the intensity and time-consuming nature of the work and the need for regular supervision: i.e., caseloads should be small.

30.9 TBP may wish to use existing quality assurance methodologies e.g., *S11 and *S175 Audits to assure themselves that partner services, training, awareness raising, practitioner experience and supervision are of the standard required to provide a good response to children who are being sexually exploited.

30.10 The high turnover of staff from some disciplines, e.g., social work, means that it is difficult to measure the impact and uptake of CSE and associated training. Investment in a learning system which enables this to be measured and evaluated may help to assess this.

30.11 Existing training programmes may not always be mandatory and TBP may wish to review which elements of training need to be so. Minimum requirements could be built into future Section 175 and Section 11 audits that are undertaken by partners including schools. **Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.*

**Section 175 of the 2002 Education Act requires local education authorities and the governing bodies of maintained schools and FE colleges to make arrangements to ensure that their* functions are carried out with a view to safeguarding and promoting the welfare of children.

30.12 To what extent are other signs of exploitation and coercion, and the religious conversion of the children responded to?

30.13 A striking feature of Ruby and Anna's histories is that they suddenly began to wear Muslim dress and talk about becoming Muslim, marrying Muslims and in Ruby's case she discussed getting a passport and moving to Afghanistan. For both Ruby and Anna this sudden change occurred when it was known by agencies that they were being sexually exploited by adult males. It does not appear from agency records that this sudden and dramatic change was considered as a possible sign of grooming or coercion.

30.14 In Anna's case this change was described as '*confusion about her identity'*. In Ruby's case the change was recorded but not analysed or explored in the context of CSE. This change in behaviour and dress was not responded to as possible radicalisation and Prevent Strategies were not used. The NSPCC guidance 'Protecting Children from Radicalisation' states 'Children who are at risk of radicalisation may have low self-esteem. They may feel:

- Isolated and lonely or wanting to belong.
- Unhappy about themselves and what others might think of them.
- Embarrassed or judged about their culture, gender, religion or race.
- Stressed or depressed
- Fed up with being bullied or treated badly by other people or by society.
- Angry at other people or the government
- Confused about what they are doing.

30.15 In Anna and Ruby's case more professional curiosity should have been exercised in respect of any potential risk of radicalisation.

30.16 Recommendations

R4. TBP should seek assurance that practitioners and managers are aware that changes in cultural identity may be a sign of coercion, exploitation and/or radicalisation and:

- ***Display appropriate professional curiosity to recognise any potential risks.***
- ***Would have the confidence to challenge.***
- ***Would know how to respond.***
- ***Would know who else to inform if they suspected this.***

R5. TBP should seek assurance that grooming and radicalisation of girls within the context of CSE is understood and considered by the Prevent Panel (Channel Panel) in Bradford

30.17 The role of drugs and alcohol in sexual exploitation

For each of the children and young people included in this review and in the detailed case audit, drugs and alcohol were used by their abusers as tools of exploitation. Ruby, Ben,

Anna and Fiona were exploited by adult males who were dealing drugs and who used alcohol and different drugs as part of the grooming and abuse process. Ben was using cannabis at the age of 12 or earlier. This may have been supplied to him by a family member. By 2018 concerns were being expressed about 'county lines', criminality and Ben's drug use. He was aged 14 at this point. (There are similarities between different forms of exploitation and the criminal and sexual exploitation of children may overlap. Victims of child exploitation may, at any one time, be subject to both. Perpetrators of CSE and child criminal exploitation (CCE) can share patterns of behaviour in respect of coercion, violence, intimidation and the power imbalance inherent in them and many other offences).

30.18 Agencies did not appear to respond to the drug and alcohol use by the children and young people in the ***context of their sexual exploitation*** and no direct work was therefore done with the children and young people in respect of this or in respect of any potential / future substance misuse issues.

30.19 Referrals to substance misuse services or work done in respect of the harms of alcohol and drug consumption were not made in the cases included in this review.

30.20 Recommendations

R6. TBP should seek assurance that:

- ***practitioners have the understanding that drugs and alcohol are being used by abusers within the CSE context.***
- ***appropriate safeguarding leads and relevant practitioners in partner agencies know how to respond to children who have been coerced and groomed using alcohol and drugs including referral to appropriate services.***
- ***relevant practitioners working in substance misuse services and those involved in direct CSE work have regular opportunities to share information, expertise and knowledge and ensure that a holistic response to children who are being coerced and exploited is developed and maintained.***

30.21 Children and Young People with Disabilities

Both Ruby and Ben had significant diagnosed conditions / disabilities which impacted upon the way in which they processed information and were able to communicate their distress. Evidence that working practices are not always child centred, robust and effective in protecting children from sexual exploitation is found in the way in which their behaviours were interpreted and responded to. Their behaviours included significant self-harm, suicide threats (and attempts) and aggression and were the focus of many discussions and interventions. This was also apparent in the detailed case audits.

30.22 'Unprotected, overprotected: Meeting the needs of young people with learning disabilities who experience, or are at risk of, sexual exploitation' was published by The Children's Society in 2015 and makes the point that "***Professionals described how a lack of knowledge and understanding of CSE & learning disabilities can lead professionals to view some young people with these impairments who experience CSE as 'challenging,' as a 'management problem', rather than recognising that this masks***

their vulnerability, or is an outward sign that sexual exploitation is occurring". This is evident in respect of both Ben and Ruby.

30.23 The impacts of physical, sensory and learning or cognitive disability on children and young people compounded the risk to them of becoming exploited and abused.

30.24 Practitioners who contributed to the learning events in respect of Ruby and Ben expressed willingness (and also had the experience and skills) to work with managers and commissioners in order to re-imagine the response available to children with additional vulnerabilities.

30.25 Recommendations

R7. TBP should seek assurance that the training which was developed in response to the 2015 report (Under-protected/Over-protected) which is now provided in Bradford is effective and reaching all relevant practitioners who come into contact with children with disabilities and additional needs.
R8. TBP should seek assurance that relevant practitioners recognise that children with disabilities are at increased risk of sexual abuse.

30.26 Pregnancy and CSE

30.27 A long-term impact of CSE on health and wellbeing is pregnancy. This is discussed in more detail below.

30.28 Of the five review cases and five cases in the detailed audit included in this review, five of the girls became pregnant as a result of their abuse. Of these, two babies were placed for adoption and all children born to the girls were/ are subject to child protection arrangements.

30.29 The long-term negative impacts of becoming pregnant as a child are well known. However, less is known about the long-term impacts on mother and child if that child was born as a result of rape and/ or sexual abuse. Rape-related pregnancy is recognised as a public health problem (especially in the U.S.) and is where sexual violence and reproductive health connect.

30.30 In UK law a child is defined as any person under the age of 18 and child sexual abuse involves "*forcing or inciting a child to take part in sexual activity, whether or not the child is aware of what is happening and not necessarily involving a high level of violence. This may involve physical contact including rape or oral sex, or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing*". Crown Prosecution Service

30.31 Typically, the victims of CSE do not recognise themselves as victims and if they do become pregnant it may be many years before they consider their pregnancies within the context of their sexual exploitation.

30.32 There is also evidence (including from Anna) that children born as a result of CSE may be used by the perpetrator as a further means of control and coercion.

30.33 The author of this report has found very little research which has considered the long-term impacts on both mother and children of having become pregnant or being born as a result of CSE.

30.34 However, what we do already know from research, from other SCRs and from the 5 review cases and 5 cases in the detailed audit is that the outcomes for *some* children born to very young mothers who were themselves looked after children is very poor. It is not currently known if outcomes worsen for the children of children who are taken into care because of CSE and who then give birth.

30.35 For example, one study found that adults who were taken into care when they were children are 66 times more likely than their peers to have their own children taken in to care (Jackson and Smith, 2005).

30.36 For the girls included in this review the issues associated with becoming a very young mother will undoubtedly be further compounded by the fact that their children were born as a result of sexual exploitation.

30.37 Recommendations

R9. TBP should take steps towards understanding the scope of the issue of pregnancy of girls who are at risk of or who have been exploited in the district, and develop responses which provide long-term, highly personalised support to the girls (and their children).

30.38 Recognising and responding to Online Grooming and Exploitation

30.39 The use of the internet and mobile phones to groom and commit offences against the children and young people was a feature in *all* of the cases included in this review.

39.40 Ben was involved in several online incidents where he was either filmed or shared 'pornographic' films of other young people. It is not clear from agency records how this aspect of his exploitation was specifically responded to. (*Devices seized have been examined and no indecent content of children found. However, that does not mean that it wasn't on the Cloud or social media platforms, just that no evidence was found*).

39.41 In each of the other cases mobile phones were used by abusers to contact and control the children and young people. In some cases, phones were given to the victims for exclusive contact with the abusers. Similarly, the internet was used to contact and coerce children and young people in some cases to arrange to meet with them.

39.42 Agencies do not currently know whether or not the other children and young people included in this review were filmed or photographed by their abusers and this would not routinely be identified in other cases. It is not always possible to establish this.

39.43 Online grooming, exploitation and abuse feature in practitioners training and awareness raising and Bradford have the Police Cyber Team, a group of (CEOP) trained PCSOs who can give one to one online safety advice to victims. There is a 'police online investigations team' (POLIT) with the sole remit of investigation of online CSEA. They have also run proactive investigations working with specialist regional resources. This is recognised as a growing crime area, and resourcing has been increased with planned significant investment in digital forensic capability.

30.44 Recommendations

R10. TBP should seek assurance that the training described above is taken up by practitioners who have relevant contact with children, and opportunities to engage with hard-to-reach communities are maximised through the work in schools.

R11. TBP should ensure that online exploitation and abuse feature strongly in training, strategy and planning.

31.0 Term of Reference 3

"Good practice lessons around placement provision for looked after children at high risk of or experiencing CSE are embedded in practice".

31.1 Safe and high-quality placement provision for children and young people who are experiencing CSE is ***not*** readily available in Bradford.

31.2 A 2016 study 'Child sexual exploitation: support in children's residential homes research report' (Ivana La Valle and Berni Graham with Di Hart) showed that children affected by CSE placed in residential care were very vulnerable and had a range of complex, high level needs. These children were typically highly traumatised due to CSE, compounded in some cases by other traumatic experiences common among children in residential care, Traumatic experiences meant that these children were very vulnerable, with substance abuse, self-harm, depression, violent behaviour, low self-esteem, and sleep and eating disorders being common.

31.3 This early childhood experience of multiple traumas and loss is reflected in four out of the five review cases included in this review and all five of the cases included in a detailed case audit exercise which has been shared with the author. What this means for children and young people is that they experience many moves, often out of the area away from family and friends and the placements do not keep them safe. The standard in placement provision for children with histories of significant trauma, loss, neglect and abuse is that they are long term, stable, relationally secure and therapeutic. The placement should be

able to offer highly personalised, trauma informed packages of care to such children and also focus on the child's strengths and aspirations.

31.4 The current provision in Bradford (and often elsewhere) does not meet this standard and the challenge of developing services which meet these standards is significant.

31.5 Recommendations

R12. TBP should call on commissioners and senior decision makers to rise to the challenge and reinvest the considerable costs attached to current provision and move towards developing appropriate standard residential placements in Bradford.

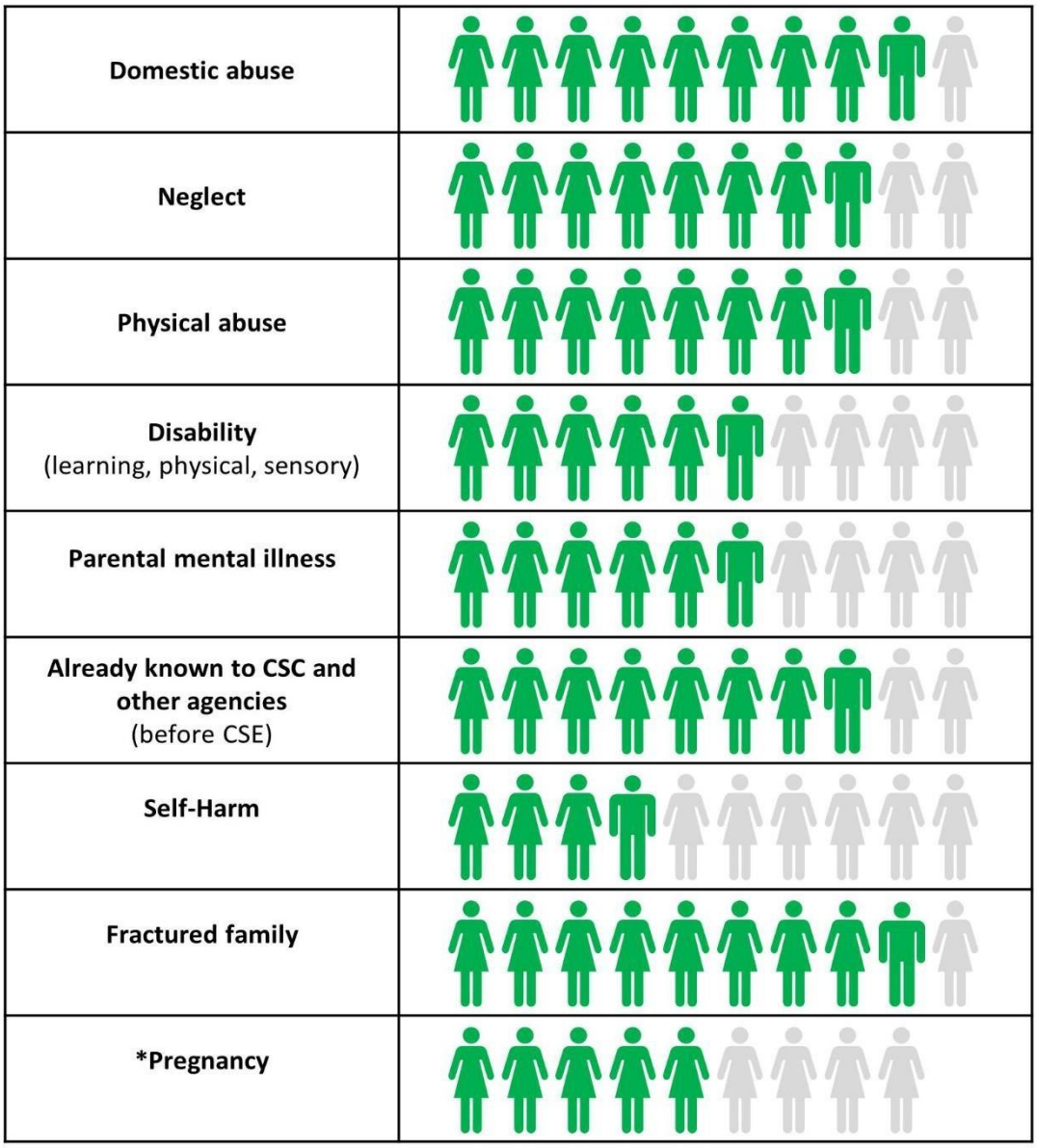
32.0 Additional Analysis and Learning

32.1 This section of the report details further key themes and analysis which emerged during the review.

32.2 Reframing Vulnerability

32.3 The graphic below shows the shared experiences of each of the five children included in the review and the five children who were the subjects of the detailed case audit. As is shown each of the children is living with or has experienced multiple traumas and disadvantages. This has significant implications for safeguarding policy and practice.

Shared experiences of the children and young people



*All CLA when they became pregnant 4 out of the 5 children born are subject to child protection arrangements and 1 adopted

32.4 As is clear, all but two of the children were known to CSC and other agencies *before* their sexual exploitation was known to have begun.

32.5 A March 2020 publication Child Sexual Exploitation Practice: Innovation and Moving Forward (Dr Jessica Taylor) makes the point that:
"*One of the most common methods of identifying and responding to children who are, or are suspected of, being sexually exploited is to measure factors known as 'risk indicators' and by changing or reducing the 'risk level' of the child by changing their behaviours in some way. Professionals in multi-agency teams measure the risk of CSE happening to the child using a matrix of 'CSE risk indicators' on a toolkit adopted by each local authority,*

police force or larger strategy area. Note, that they do not measure the risk of the offender, but the risk of the child."

32.6 The report then goes on to say:

"*Lists of vulnerabilities to CSE are widely used in practice, with many lists of vulnerabilities attached to the previously discussed CSE risk toolkit. The lists of vulnerabilities vary widely from toolkit to toolkit and have not been validated or evaluated to show causation or correlation as yet. Vulnerabilities include having a learning disability, being a looked after child and witnessing domestic abuse at home. Generally, the lists of vulnerabilities include adverse experiences from throughout the lifespan of the child, however, some are vaguer and include moving to secondary school, illness of a family member and having lowered self-esteem. It is thought that the more vulnerabilities the child has, the more likely they are to be sexually exploited. This approach to working with children represents a deficit model of children, rather than a strengths-based model of understanding their lives and potential*."

32.7 This was borne out by the practitioners who attended the two learning events in respect of Ruby and Ben. When asked to discuss and consider what 'good would look like' for Ruby and Ben their responses focused on positive aspirational outcomes and included the following.

- Consistency of relationships with key workers
- Aspirational; focus on positives not just disabilities or 'problems. Focus on self-esteem building.
- Positive peer supports in place.
- Access to appropriate interpreters
- Long term therapy which addresses multiple layers of trauma and loss
- Long term holistic plans which include opportunities for volunteering, work experience, education

32.8 A reframing of vulnerability might be helpful in tackling CSE in Bradford and the reality that children who are exploited have often experienced a wide range of traumas and disadvantages for many years *before* they are exploited.

32.9 Much direct preventative work in CSE involves efforts to 'reduce vulnerabilities' of children in order to protect them from a sex offender, who is assumed to only target children with vulnerabilities. This framing of vulnerability and risk seems peculiar to children (the majority of whom are girls) with pre-existing vulnerabilities who are being sexually exploited and there are no similar narratives, for example, in respect of the sex offender Barry Bennell a football coach who was convicted in 2018 of over 50 child sex offences. None of the commentators or experts in child sex abuse or offending behaviour discussed the risky behaviour of the boys who had been sexually abused. Nor did they discuss the boys' vulnerabilities other than in general terms. Barry Bennell was recognised universally as a predatory sex offender and the boys as 'straightforward victims`.

32.10 We also know from the Bennell case and others (clergy and teachers) that child sex offenders place themselves where they have access to children. There is evidence that perpetrators of sex offences we describe as CSE place themselves outside schools, outside

children's homes and in public places like parks and shopping centres where they can 'spot a likely looking' victim.

32.11 The efforts of many agencies working with children who are being sexually exploited is focused on teaching children how to protect themselves with an emphasis on them not taking risks. The perception that children 'put themselves at risk' of CSE is still widely held.

32.12 In light of this the next chapter of this report considers how a different focus on perpetrators of child sex offences may be required. This review presents TBP with an opportunity and a challenge to reframe how victims and perpetrators of CSE are currently perceived and responded to by the multi-agency system.

32.13 Recommendations

R13. TBP should seek assurance that.

- ***the current work taking place to develop a Bradford wide strategy in respect of Adverse Childhood Experiences (ACEs) reflects the learning from this review.***
- ***specifically, that CSE is, for many children, a consequence and a continuum of early trauma, and abuse and that CSE does not happen in isolation.***

32.13 Perpetrators of Sex Offences

32.14 The current focus of most agencies (with the obvious exclusion of the police and probation) is on victims of CSE and their families and agency efforts are focused on keeping children and young people safe from sexual exploitation.

32.15 There is little wider focus on and therefore little understanding of what, if any, common factors, including adverse childhood experiences, perpetrators share. Understanding how and why people become perpetrators of sexual abuse is important if we hope to reduce the harms caused by them to individuals and communities.

32.16 For example, a key study* carried out in 2009 by Colin Hawkes of the National Clinical Assessment Treatment Service (NCATS) into sexually harmful behaviour noted that "*neglect and maltreatment (often including sexual abuse) experienced within the family is a core influence on child development, in particular on closely linked relational faculties of attachment and sexuality. Genetic predisposition and unresolved trauma suffered by a parent, in particular the mother, tend to erode resilience to maltreatment in boys. This results in disorganised/disoriented attachment in infancy, and a diminished capacity to contain emotions and to reflect on them. Subsequently, in childhood they adopt externalised coercive strategies to manage relationships. After an experience of sexual victimisation, these strategies take on a sexual character*."

32.17 Hawkes' study findings relate to a sample of 27 boys who began to cause sexual harm before the age of 10. All the boys in the sample were known or suspected to have been victims of child sexual abuse – on average by the time they were five years old. This may

be particularly relevant in Ben's case as he has been both a victim and a perpetrator of sexual harm.

32.18 Research also demonstrates that the accessibility of on-line pornography plays a role in sexual offences and the Deputy Children's Commissioner in her foreword of the 2013 report '*Basically… porn is everywhere'* states:

> "*The use of and children's access to pornography emerged as a key theme during the first year of the Inquiry. It was mentioned by boys in witness statements after being apprehended for the rape of a child, one of whom said it was "like being in a porn movie"; we had frequent accounts of both girls' and boys' expectations of sex being drawn from pornography they had seen; and professionals told us troubling stories of the extent to which teenagers and younger children routinely access pornography, including extreme and violent images. We also found compelling evidence that too many boys believe that they have an absolute entitlement to sex at any time, in any place, in any way and with whomever they wish. Equally worryingly, we heard that too often girls feel they have no alternative but to submit to boys' demands, regardless of their own wishes*."

32.19 There is much to learn about the 'pathway' to becoming a sex offender and whilst data is currently collected by the police, Youth Offending Service and Probation Service this information, on the whole, is collected after an offence has or is suspected to have taken place. This is particularly relevant for Ben whose own possible childhood sexual abuse and exposure to pornography was never addressed and who is suspected to have become both a victim and a perpetrator of sexual offences.

32.20 In the 'here and now' there should be a change in risk assessments to firstly consider perpetrator behaviour, then contextual issues, risks posed by failure to protect and impact of under-resourced services. This should lead to a decrease in locating the 'risk' in the child; a decrease in 'score' based risk assessments; a decrease in tools that conflate predicted and actual risk and a decrease in using 'risk factors' that have no evidence base.

32.21 What we would expect to see is an increase in evidence-based risk assessment, participatory risk assessment, in peer and situation/location risk assessment, in assessment of risk posed by families or services failing to protect and an increase in recording and escalating situations where the required service does not exist or is not being funded.

32.22 Without this 'reframing' of how we respond to both victim ***and*** perpetrator we continue the narrative that sexual exploitation and abuse is inevitable for some children.

32.23 Recommendations

R14. TBP should ensure that data collected about the perpetrators of CSE, and research is effectively used to inform practice and strategy.

R15. TBP should seek assurance that general preventative multi-agency activity is effective; particularly within the night time economy and around CSE hot-spots and locations of risk.

32.24 The Long-Term Impacts of CSE on Health and Wellbeing

Research has long established a strong, albeit complex relationship between child sexual abuse and adverse mental health consequences for many victims.

32.25 Negative mental health effects that have been consistently associated in the research with child sexual abuse include post-traumatic symptoms (Canton-Cortes & Canton, 2010; O'Leary & Gould, 2009; Ullman, Filipas, Townsend, & Starzynski, 2007); depression (Fergusson et al., 2008; Nelson et al., 2002); substance abuse (Lynskey & Fergusson, 1997; O'Leary & Gould, 2009); helplessness, negative attributions, aggressive behaviours and conduct problems; eating disorders (Jonas et al., 2011); and anxiety (Banyard, Williams, & Siegel, 2001; Nelson et al., 2002).

32.26 More recently child sexual abuse has also been linked to psychotic disorders including schizophrenia and delusional disorder (Bendall, Jackson, Hulbert, & McGorry 2011; Lataster et al., 2006; Wurr & Partridge, 1996) as well as personality disorders (Cutajar, 2010b). Child sexual abuse involving penetration has, in particular, been identified as a risk factor for developing psychotic and schizophrenic syndromes (Cutajar et al., 2010a).

32.27 Anna and Fiona's stories bear out much of this research and in discussion with the independent reviewer both adults were able to describe their symptoms of Complex PTSD and other mental health diagnosis, fluctuating mental health, the ongoing threat of retaliation from perpetrators and the anxiety this causes.

32.28 As discussed elsewhere throughout this report the disruption of a child's education because of CSE and the co-existence of other issues also has a long-term impact on children and can have a further negative impact on their wellbeing and life chances.

32.29 Recommendations

R16. TBP should seek assurance that current interventions and responses recognise and address the potential long-term impacts of CSE on health and wellbeing.

32.30 The Criminalisation of Sexually Exploited Children

Four of the five young people who are the subjects of this review have experienced being arrested, spending time in custody and in some cases convicted of offences. Each of the offences was dealt with as it occurred sometimes with little contextualising of the extreme distress of the child. There is a similar picture for the children from the detailed case audit.

32.31 The criminalisation of traumatised children and young people is well researched and the 2018 National Protocol for Reducing Unnecessary Criminalisation of Looked After Children and Care Leavers makes the point "*However, although the vast majority of looked-after children and care leavers do not get involved with the justice system, they remain overrepresented compared with others in the criminal justice system."*

32.32 The protocol and other guidance and research are clear that trauma informed approaches work best with children and young people who share similar experiences with the subjects of this review. There was, however, little evidence that trauma informed approaches were consistently used or considered or that the child's challenging behaviour was understood to be a symptom of distress and fear and, in some cases, a lifetime of trauma.

32.33 It was of note however, that in Ben's case, officers responding to one or two of the incidents at the family home where Ben was the alleged aggressor did recognise and respond to him as a traumatised child.

32.34 Recommendations

R17. It is recommended that TBP engages with the Home Office seeking to promote that the good progress made in decriminalising children who offend in the context of CCE should be extended to CSE.

32.35 Missing out on Education.

All of the children and young people considered in this review experienced significant disruption to their education. In some cases, the children did not receive any education (including sex and relationships education) for several months or years. The impact of this is threefold.

32.36 Firstly, their basic human right to receive an 'effective education' was not met and this has long-term impacts on their life chances and makes seeking further education or employment more difficult. It also results in a lack of routine and structure which again impacts on their ability to manage further education and employment.

32.37 Secondly, the protective factors provided by regularly attending school are well known and come from teaching and non-teaching staff getting to know a child (and often their families) very well. They understand the community context in which the child lives and are well placed to identify any changes in a child's wellbeing. Crucially, if a child is in school and not therefore 'wandering the streets' they are less vulnerable to being targeted by organised and/or opportunistic sexual predators.

32.38 Thirdly the 'normal' social interactions with peers are denied to children not in education. This interaction and the friendships and wider community connections formed through these friendships are also important for a child or child's sense of identity, wellbeing and safety.

32.39 The majority of the children included in this review had significant and multiple disadvantages and were living with domestic abuse, parental mental illness, neglect, poverty and other issues. This means that school was even more important as a place of potential stability and safety.

32.40 These multiple disadvantages and ongoing traumas also meant that the children displayed a range of behaviours which were 'difficult' or 'challenging'. Trauma informed education would recognise that these behaviours were as a result of a child's lived experiences and

would put plans in place, including extra-curricular interventions, to support the child to remain in education.

32.41 This review has identified some good practice; for example, Ruby's relationship with one of her schools was very good, however she moved to an out of area placement and this relationship was lost.

32.42 The difficulties of providing safe and effective education were, in Ben's case, compounded by his communication disabilities. His absence from education for many months left him vulnerable to criminal and sexual exploitation.

32.43 The case audit also identified the challenges in further education. Children struggled with following their aspirations in successfully pursuing courses and attendance at college. Children felt intimidated by the "busy" lifestyle of colleges and lacked confidence with new environments.

32.44 Recommendations

R18 TBP should assure themselves that there is sufficient provision planned within the SEND sufficiency plan and the School Sufficiency Plan to enable the delivery of adequate special and mainstream education places for pupils of a statutory school age.

R19. TBP should seek assurance that appropriate action is being taken to improve the attendance of children who are persistently absent who are known to children social care.

32.45 Joined Up Service Responses, the System.

This section of the report describes some of the current service response in Bradford and reflects the conversations held by the independent reviewer with practitioners and review panel members.

32.46 The practitioners who attended the learning events described feeling frustrated by a shortage of good residential and education placements for some children and young people in Bradford, a view supported by Social Workers spoken to during the detailed case audit.

32.47 A further very important issue was the scarcity of therapeutic services which could be highly personalised and tailored to meet the children and young people's needs. (Therapeutic services need to work with the child in the context of their very unsettled lives and be able to work more imaginatively than through rigid appointments).

32.48 Therapeutic services could provide a range of responses which do not have a 'mental health' label for example mentoring, safe space to relax and talk, and peer support through to structured and intensive trauma informed therapy which recognises that children and young people may very well still be experiencing trauma.

32.49 The work with children and young people experiencing sexual exploitation is very demanding and requires a well-supported, highly trained and experienced workforce.

32.50 The various practitioners currently providing the response to at risk and exploited children describe the short-term nature of funding for some services and initiatives. This creates further frustration in the system and a perpetual effort to retain funding or apply for new funds.

32.51 In summary the issues described above result in a 'system' that can feel fractured and one that works against itself. An example of this came from the case of Ben and the difficulties his CSC workers had in securing funding for a residential school placement which resulted in him being badly let down, confused and frustrated.

32.52 Learning event participants, Panel members and stakeholders described what an improved future response for the children and young people of Bradford who are at risk from or already experiencing CSE could look like. This improved response would be consistent but flexible, child-centred and trauma-informed.

32.53 Much discussion took place about the transition points in children's lives; in particular, reaching the age of 16 and 18 and what that means for children and young people who are experiencing CSE. The ideal response would be consistent services which could provide support and advice without a cut -off point when a child reaches 16 or 18 years of age.

32.54 A child centred, holistic system which recognises the pre-existing disadvantages and complexities in the lives of children and young people experiencing CSE would require the commitment of health, social care and police commissioners to work together with service and support providers in a different way using systems learning and improvement approaches.

32.55 The graphic below summarises the key system issues which impacted upon practice and outcomes for the 5 children who were the subjects of the review and the 5 children who were the subjects of the case file audits.

System issues

32.56 Recommendations

R20. Involving front line practitioners in system wide and single agency CSE improvement and development work is recommended. TBP and partners should also consider how children and adults who have experienced CSE can contribute to this work.

R21TBP should challenge agency partners to demonstrate that there is a system wide approach to jointly commissioned, long term approaches which address the human and financial costs of a child's lifetime exposure to trauma, abuse, neglect and exploitation.

33.0 Operational Learning Perspectives

33.1 The review and case audits highlighted a number of areas of learning from an operational perspective. Partners should consider these in future planning, processes, quality assurance and training and ensure:

33.2 Practice and Procedure

- Consistent approach to how risk is assessed, analysed, responded to and also recorded.
- Recognition and assessment of cumulative harm and wider holistic assessments, particularly reflecting on the impact and influence of parents and siblings, changes to cultural identities in a trauma-based approach.
- Consistent approach in the production and recording of care plans, around structure, detail, approach and use of signs of safety model. Plans should be forward thinking and not reacting to incidents.
- Timeliness in moving to formal statutory processes at an earlier stage, recognising increases in complexity and risks.
- Quality assurance of assessments and care plans to recognise over optimism, prevent drift and delay and allow partners an opportunity to challenge the effectiveness and escalate concerns where necessary.

- Section 175 Schools Audit and Section 11 organisational audit to seek assurance based upon the learning from this review.
- Good practice – plans separating out areas of risk, providing a detailed balance of expectations for the child, prompts and partner responsibilities.
- Good practice – use of trigger plans for missing episodes and use of dedicated resource to provide one-to-one support and the use of a specialist services in developing positive pathways.

33.3 Information, Disruption and Prevention

- CSE profiles that utilise information from all available sources and partners to fully inform the threats and risks around CSE (Note: The West Yorkshire Risk and Vulnerability Group have set up a task and finish group to look at information sharing and threat profiles).
- Effective information sharing with front line partners and practitioners, including those in non-safeguarding roles, to identify CSE hot spots and locations of risk and contribute to preventative opportunities. TBP may wish to consider the reintroduction of dedicated resource for the Night Time Economy.
- Preventative plans based upon locations of risk /perpetrators particularly around alcohol/substance misuse.
- Technology-based abuse – continued education and preventative activity.
- Further awareness raising campaigns through the Communications and Engagement Group, with a focus on hard-to-reach groups.

33.4 People

- Complex cases should be allocated to suitably qualified and experienced staff in social care and caseloads recognise that complex cases are often more time consuming.
- Front Door expertise should support practitioners dealing with CSE to understand what specialist support provision is available and share good practice, including care planning.
- Regular supervision should take place across the partnership, across all partners and particularly where risk escalates, and the existing plan cannot mitigate the risks or is not effective.
- Training requirements set and agreed for practitioners working with children.
- TBP may wish to review the current multiagency training offer to include learning from this review.

33.5 Parents

- Support and guidance for parents who are unable to adequately care for children at times of increased complexity and vulnerability.
- Good Practice – increased support for parents of preventative approaches, the use of the Police Cyber Team, Trusted Relationship and other similar initiatives are recognised as valuable methods.

33.6 Engagement with children at risk of CSE

- Capturing the voice of the child for specific periods or interventions and placements would provide a more specific and informed method of feedback for particular decisions and parts of a plan.

- Review the use of the Viewpoint letter and consider a more user-friendly method to capture the voice of the child.
- Support for children seeking further education.
- Partners should display professional curiosity in the use of alcohol and drugs, frequenting CSE hot spots, sources of money and lifestyles.
- Adequate provision of therapeutic services and continued use of initiatives such as Trusted Relationship, Breaking the Cycles and the Youth Provision.
- Professionals would welcome more opportunities around psychiatric assessments in understanding why children were at risk and also in assessing mental health.
- Effectiveness of contraception and relationships and sex education may be an area of learning.

34.0 Summary and Conclusions

34.1 The terms of reference for this Serious Case required the independent reviewer, the Serious Case Review Panel members, over 40 practitioners and managers from a wide range of agencies and crucially women who are still living with the consequences of CSE, to consider whether or not there had been sustained improvement in the way agencies and individuals respond to CSE in Bradford.

34.2 During the process of conducting this review it became clear at an early stage that agencies and individuals in Bradford do not always get it right and some children remain unprotected while some perpetrators remain unknown and unchallenged. This is despite some significant improvements in agency understanding of and responses to CSE between the less recent and current cases.

34.3 The Panel members and other stakeholders were beginning to consider what an improved future response to the perpetrators of sexual abuse and exploitation might look like. This might involve working with academic partners and others to begin the process of understanding how people (overwhelmingly males) of all ages and all backgrounds become perpetrators. Only by doing this will communities and agencies be able to focus on preventing abuse happening in the first place.

34.3 The term ‘at risk of Child Sexual Exploitation’ is used in cases where children and young people are actively - here and now - being exploited and abused. The term Child Sexual Exploitation sanitises the reality of what that means for children. In several of the cases included in this review this meant being raped, sexually assaulted, physically assaulted, being afraid and anxious, being forced to take drugs and alcohol, being homeless and being lonely and isolated from family and friends.

34.4 The multiple disadvantages and the traumas experienced by the majority of the children included in this review pre-dated their sexual exploitation and abuse. Sexual exploitation and abuse should not, therefore be viewed as a single ‘new’ issue but as an important part of a continuum of trauma and/or abuse.

34.5 As described, most of the children included in this review have lived with domestic abuse, physical and emotional abuse and neglect for most of their lives and this therefore poses a

challenge for commissioners, managers and practitioners as it is the failure of the system to protect children from these harms which creates vulnerability to further abuse from CSE (and CCE).

34.6 Abuse does not occur because of a child's vulnerability. It occurs because there is someone who is willing to take advantage of this vulnerability and because there are inadequate protective structures (around the child and their family) in place to prevent this.

34.7 The thematic review has looked in detail at both non recent responses to CSE and more recent practice. Through the lens of children some of whom are now adults, the review has shone a light on responses to CSE in Bradford over a 17-year period. The stories of the children are difficult to hear. It is also clear that while there has been considerable work in the district in relation to CSE there are still lessons that need to be learned and the responses to victims of this complex crime is not yet good enough in all cases.

Glossary

ADHD	Attention Deficit Hypertension Disorder
AIM	Assessment Intervention and Moving On
CAMHS	Child Adolescent Mental Health Service
BPP	Be Positive Pathways
TBP	The Bradford Partnership (formerly the Local Safeguarding Children Board)
YOS	Youth Offending Service
CIN	Child in Need
CAWN	Child Abduction Warning Notice
CAF	Common Assessment Framework
CPP	Child Protection Process
CPS	Crown Prosecution Service
CSA	Child Sexual Abuse
CSC	Children's Social Care
CSE	Child Sexual Exploitation
ICPC	Initial Child Protection Conference
IRO	Independent Reviewing Officer
LCSPR	Local Child Safeguarding Practice Review
MARAC	Multi -Agency Risk Assessment Conference
MACE	Multi- Agency Child Exploitation
MASH	Multi -Agency Safeguarding Hub
NICHE	Police Records Management System
OFSTED	The Office for Standards in Education, Children's Services and Skills
RAM	Risk Assessment Meeting
RCPC	Review Child Protection Conference
RSPCA	Royal Society for Protection of Animals
SCR	Serious Case Review
SNSC	Senior Nurse Safeguarding Children
SNS	School Nursing Service
SHP	Specialist Health Practitioner
TAF	Team Around the Family
Misper	Missing Person

References

Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., et al. (2012) New Learning from Serious Case Reviews: A Two-Year Report for 2009–2011. London: Department for Education.

Chase, E., Maxwell, C., Knight, A and Aggleton, P. (2006) Pregnancy and Parenthood Among Young People in and Leaving Care: What are the Influencing Factors, and what Makes a

Difference in Providing Support? Journal of Adolescence 29: 3 437-451

Child sexual exploitation: support in children's residential homes Research report December 2016 Ivana La Valle and Berni Graham with Di Hart DfE

Eaton, J. (2019) 'Critical Perspectives: Child Sexual Exploitation Approaches and Practice', Victim Focus Publications, UK

Jackson, S. and Simon, A. (2005) The Costs and Benefits of Educating Children in Care

Chase, E., Simon, A., & Jackson, S. (Eds.) In Care and After: A Positive Perspective (pp.44–62) London: Routledge

OFSTED (2012) Protecting disabled children: thematic inspection (PDF). Manchester: Ofsted.

OFSTED (2009) Learning lessons from serious case reviews: year 2 (PDF). Manchester: OFSTED.

May 2016 Children's Rights along the Journey from Victims to Survivors: A Review of the UK Literature; Helen Codd, Nigel Thomas & Dianne Scullion

March 2020 publication Child Sexual Exploitation Practice: Innovation and Moving Forward (Dr Jessica Taylor)

A Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify ways of Overcoming these Barriers Research July 2014 Anne Rawlings, Paty Paliokosta, Daryl Maisey, Jessica Johnson, Jenny Capstick & Professor Ray Jones - Kingston University Institute for Child Centred Interprofessional Practice (ICCIP) DFE,

Taylor, J. et al (2014) An Investigation into the Relationship between Professional Practice, Child Protection and Disability. Edinburgh: The Scottish Government.

Jones, L et al. (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. The Lancet July 2012.

Hawkes, C (unpublished) 2009 A UK study of onset of sexually harmful behaviour before the age of ten years in boys referred to a specialist assessment and treatment service. Working Together to Safeguard Children 2018

Appendices

1. Panel Members
2. Detailed multi- agency responses to the review
3. Recommendations
4. Summary of progress

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Appendices Child Exploitation Thematic Review

Appendices

1. **Panel Members**
2. **Detailed Multi Agency Responses to the Review of Cases**
3. **Recommendations**
4. **Summary of Progress**

Appendix 1: Panel Members

Clare Hyde	Chair / Independent Reviewer	
Alan Weekes	Chief Inspector	WYP
Amanda Fisher	Senior Probation Officer	Nation Probation Services
Anne Chester-Walsh	Interim Assistant Director	Children's Services
Dawn Lee	Head of Safeguarding	BDC FT
Deborah Buxton	Service Manager	Barnardo's
Jane Booth	Independent Chair & Scrutiny Lead	TBP
Jo Newman	Named Nurse, Safeguarding	Airedale NHS FT
Jude MacDonald	Designated Nurse	CCGs
Lyn Sowray	Assistant Director, Operational Services	Health & Wellbeing
Mark Griffin	Manager	BSCB
Naz Kazmi	Centre Manager	KAWACC
Rachel Davis	Service Manager	YOT
Vicky Cotter	Named Nurse, Safeguarding	BTH FT
Amanda Robinson	Head of Safeguarding	BDCFT
Danielle Wilson	Strategic Manager,	Education Safeguarding
Irfan Alam	Deputy Director, Children's Social Care,	Children's Services
Janice Hawkes	Assistant Director, Children's Services	Barnardo's
Jemma Tesseyman	Named Nurse, Safeguarding,	BTH FT
Lyndsey Brown	Headteacher	
Ruth Skelton	Designated Doctor	CCG

It should be noted due to the length of time of the review panel members have changed during the course of the review.

Appendix 2: Detailed Multi Agency Responses to the Review of Cases

Contents

Case 1 – Anna

1.0 Brief Background

1.1 Anna was known to CSC from a very young age and suffered severe abuse and neglect and multiple adverse childhood experiences. She also had caring responsibilities for her mother who had severe mental health problems and for her sibling who had complex needs. She was the subject of Child Protection Plans several times during her childhood. She moved between different households, mother, father, grandparents, family friends, as relationships broke down and her mother became increasingly unable to provide safe care.

1.2 In 2002, when Anna was aged 14 her mother expressed concerns about possible CSE. Anna was referred to a specialist project "Streets and Lanes" (SALS) which was a service for children abused through prostitution. In December 2002 Anna was placed in residential care and frequently went missing from the placement. In January 2003 Anna is recorded as having an Asian "boyfriend" who is variously recorded as between being 18 and 27. At this time Anna was said to have begun following the Islamic religion.

1.3 Throughout the time Anna was being supported by the SALS project she made frequent disclosures of sexual abuse and coercion, including rape, when missing from the residential unit (she went missing on more than 70 occasions). At that time, SALS' policies offered service users complete confidentiality, and this meant none of this information was shared with police or CSC. She also told SALS that she was being subjected to assaults which were referred to as domestic abuse though she was still a child under the age of 16.

1.4 In June 2003 a looked after children (LAC) review took place and it is recorded that Anna "is "engaged" to her boyfriend and has converted to Islam. Her boyfriend attends the review. IRO records that his being invited to the review "is an acknowledgment of the significance of the relationship".

1.5 In July 2003 Anna (now aged 15) told the SALS worker that she had married her Asian "boyfriend" in an Islamic ceremony. It appears that there was collusion with this by her Children's Social Care (CSC) social worker who allegedly attended the ceremony and assessed that her marriage was likely to reduce the risks incurred when Anna was missing.

1.6 In the December 2003 Looked After Child Care Review, it is recorded that Anna is pregnant and wishing to be fostered with the family of the man referred to as her "husband ". The review records this as unacceptable but within days she was "placed" with the family as a foster child, and they were paid a fostering allowance though there is no record of any assessment or approval process. It is hard to understand how this decision can have been made and it resulted in Anna being entirely reliant on her abuser and his family. Anna reported significant restriction of her freedoms by the family which would today be seen as coercive control. She also reported further assaults from her "husband". These were not passed on to CSC.

1.7 Anna moved to a bedsit and then to a rented house in 2004 and her baby was born while she was living there, although her "foster mother" is recorded as having been

present at the birth. Shortly after this Anna reported that her “husband” had forged papers in order to get a passport for the baby and was threatening to take the baby abroad. In the following months her residence is unclear from records, and she seems to have moved in and out of placements as the nature of her relationships fluctuated.

1.8 In December 2004 Anna was taken to a refuge following an assault by her “husband” – at this point she was still a looked after child. By February 2005 Anna was pregnant again.

1.9 What we do not see in the agency chronologies is, that during the time Anna was in care, she was being sexually abused and exploited by dozens of adult males, some of whom were known to her “boyfriend/husband”. More than 20 arrests have been made connected to the investigation of Anna’s abuse and investigations continue.

1.10 multi-agency working, and the placements provided did not keep her safe.

2.0 Key practice episodes and other events

2.1 In 2000 Anna and her sibling were made subject of Child Protection Plans (CPPs). By 2002 the children had been on a CPP for two years and in June 2002 a new Social Worker (SW) was allocated to the family and Anna was extremely hostile towards her. The root cause of this hostility was not explored, and a decision was made at a Child Protection (CP) review conference to remove Anna from the CPP because the SW could not work with her. This was recorded as Anna “refused to work or cooperate with Social Care and on a number of occasions has or attempted to assault the Social Worker. Anna does not however, seem to have such a problem with other workers”.

2.2 In July 2002 Anna’s mother reported to CSC that her daughter was getting into cars with boys and staying out all night. And in August 2002 a CSC recording states, “Concerns that Anna is getting involved in prostitution, and this is with the encouragement of Mother”. There is no information describing what happened as a result of this, but it did not trigger S47 enquiries. Anna was aged 14 at this point.

2.3 The decision made in June 2002 to remove Anna from the CPP was challenged by Education Bradford and the Safeguarding Unit and overturned at a CP Review Conference in September 2002. It was noted at the review that Anna was “at risk of third-party abuse”.

2.4 It was also recorded that Anna and her sibling were living in appalling and unsafe conditions with their mother. Animals were removed from the home by the RSPCC as they were not being fed and cared for.

2.5 Also, in September 2002 the case was allocated to a new social worker and the transfer notes state that a referral to CAMHS is to be made for Anna and a referral to the Streets and Lanes Project’ (SALS) because Anna was ‘placing herself at risk of 3rd party abuse’. SALS began to support Anna in November 2002. The SALS project was established in 1994 as a partnership between the local authority, education, health and Barnardo’s, initially with staff seconded in to the Barnardo’s team. This was one of the first, if not the first, specialist projects of its type in the country.

However, it would appear from reviewing the record that in reality much of the project's work at that time was undertaken in isolation from social workers and police.

2.6 By December 2002 CSC were seeking a long-term placement for Anna. It is not clear from the records why this was not considered earlier and on 18th December she was subject of an Interim Care. A placement was available at **** which is where Anna was placed.

2.7 Anna frequently went missing from the placement.

2.8 Anna engaged with SALS and told them that she was having unprotected sex and that she might be pregnant. SALS noted that she was vulnerable to being abused through prostitution.

2.9 Throughout the significant engagement with SALS Anna made frequent disclosures about the sexual abuse, coercion and control she was experiencing. At that time SALS policy, which had been developed in partnership with the local authority, was that they did not share information with other agencies as they offered young people total confidentiality.

2.10 By January 2003 it was noted by SALS and CSC that Anna "has been following the Islamic religion and has an Asian boyfriend. So, whilst Anna is comfortable with her own ethnic and racial background, she is leaning towards the Asian culture, due to her Asian boyfriend and the community in which she is living".

2.11 It was also recorded by CSC that Anna "likes to take herself off to Keighley and Haworth regularly. Staff (at the placement) not sure who she is mixing with whilst at either the above-mentioned places in Bradford".

2.12 On 12th February 2003 a police record made in response to a missing from home report states "Anna and (one other) went off in a taxi -maybe at ***** taxi (company). Her boyfriend a 27yr old works there". Anna was aged 14.

2.13 On 13th February 2003 Anna returned to the placement and reported that someone had tried to rape her. She told the police at that time that "*she has a boyfriend who she says is 18 years old, works as a taxi controller and has a child to a previous relationship, and which Anna describes the mother of the child as a prostitute"* It was also recorded that the 'boyfriend' was a suspected crack cocaine user/ dealer. WYP records do not show what investigations into the allegation of attempted rape took place beyond the initial interview with Anna.

2.14 On 27th February 2003 a decision was made to find an out of area foster placement for Anna. By this point she had gone missing from the placement at least 16 times.

2.15 On 11th March 2003 a WYP intelligence log following Anna going missing records that "Anna and second 14-year-old girl, residents of the placement were picked up outside their home by three youths driving (deleted). They were driven to an unoccupied semi derelict house at (deleted). Inside the house which is undecorated and unfurnished but has old arm chairs and settees on the ground floor living room they met up with a further group of males. Alcohol was consumed by all present whereupon part of the group attempted to undress Anna and 2nd girl against their will. They fought their way out of the house whereupon Anna called the police.

Although Anna is 14, she appears younger, in contrast 2nd girl who looks older. There are concerns about the girl's sexual activities and in particular that they are being groomed for prostitution. The girls have refused to give any formal account of the above to police. Anna knows a male believed to be called (deleted) who is a co-owner with his uncle of (deleted taxi firm). (Deleted) is believed to be about 30 years of age and Anna refers to him as her boyfriend, but it is believed that he is her 'pimp'". This information was not shared with CSC or other partners.

2.16 Throughout April and May 2003 Anna, who was then aged 15, went missing; on one occasion for several days at a time. She told her support worker at SALS that she had "got a house with her boyfriend but had left him when he beat her up".

2.17 On 22nd May 2003 Anna told her SALS worker that her "*boyfriend was now in prison and that his brother now had responsibility for looking after her*". The worker noted that Anna was still very dependent on boyfriend's family and had informed her that she wanted to cease taking contraception as she would like a baby when she is 16.

2.18 In June 2003 a LAC Review took place and it is recorded that Anna "is "engaged" to the boyfriend and has converted to Islam. The boyfriend attends the review. The IRO records that his being invited to the review "is an acknowledgment of the significance of the relationship".

2.19 On 10th July 2003 Anna told staff at the placement and a SALS worker that she was now married to her Asian boyfriend. SALS records state "Discussed her "Muslim marriage" to her boyfriend who she said was in Pakistan for a month. She said that he was invited to her review and that his mother was being considered as a foster carer although the boyfriend would not be allowed to live at the same address. Discussed what living there would be like – Anna said she knew she would be expected to clean up all day, and that this "wasn't her." It was noted that her 'boyfriend' was aged 22. It was at this time that Anna was recorded as wearing "full Muslim dress".

2.20 On 29th August 2003 Anna had been missing from the placement for 18 days and is recorded by CSC as having "telephoned a helpline claiming that she has been held against her will. Anna would not provide an address". There is no further detail provided about the helpline.

2.21 On 19th September Anna returned briefly to the placement but left in her 'boyfriend's' car. WYP logged this information and knew who the adult 'boyfriend' was, but the information was not shared or used to safeguard Anna.

2.22 On 3rd October 2003 when Anna was still aged 15, a strategy meeting was held and attended by WYP and CSC. The meeting was held because Anna had, at that time, been missing from the placement for 8 weeks and was refusing to return stating that she wanted to move in with her 'boyfriend'.

2.23 The strategy meeting discussed that Anna has "advised that she has had a Nikah" (marriage ceremony). The Nikah is said to have taken place at the end of June/beginning of July this year. There are concerns around Anna's confused identity. Social Care are not of the view that they can promote the placement with her 'boyfriend' However Anna had also stated that she would like to live with her

'boyfriend`s` parents' The strategy meeting records state "This could possibly be given some further consideration/assessment. Anna stated that she would like to live with Foster Carers, but if made to return to ***** House, she will continue to abscond".

2.24 On 6th October a CSC 'contact' recording states Anna "wants to go and live with 21-year-old boyfriend. Arguably will be less at risk there than being 'missing' or resident at **** House - but is subject to care order. Senior management view needs to be sought - difficult to see how SS could 'approve' of the arrangement - but may be possible not to try too hard to return her to **** House (but placement may need to be kept nominally open)".

2.25 In November 2003 two SALs workers visited Anna at the placement (she had, by this point been reported as missing over seventy times) Anna informed them that she had just found out she was pregnant and that she had been trying to get pregnant for four months. Anna said that her boyfriend did not like her accessing SALS as it was for "prostitutes." Anna gave staff her 'boyfriend's' mobile number so they could contact her on that number to arrange individual sessions.

2.26 At a LAC Review in December 2003 the attendees noted that "It has not been possible to achieve Anna's view of being placed with foster carers. Respite carers were offered but she has refused this. It is known that Anna regards herself as married and wishes to live with him. She is aware that this is not acceptable as she is only 15 years old and too young for such an arrangement. Anna is expecting a child in August and clearly will have to be regarded not only as a looked after child but a young parent. Anna has taken an overdose since the last review and was discharged without any significant harm. She was offered an appointment with CAMHS but declined this. Anna's placement with ***** House to continue. A further placement to be found for where she can remain until her 16th Birthday and be able to make clear choices about her future".

2.27 There is nothing in CSC records to show what assessment of Anna's 'boyfriend's' parents took place. However, within days of the placement which commenced in December 2003, SALs workers recorded their concerns that Anna was not allowed out of the house unaccompanied and sometimes not at all. It is of note that a condition of the placement was that Anna had her own bedroom and no sexual contact was to take place between her and the 'boyfriend' however Anna was already pregnant. When she was in the first trimester of her pregnancy Anna was badly assaulted by her 'husband' and suffered a severe head injury. She was taken to the ED by paramedics. Anna later reported the assault to the police as a hate related crime as she was too afraid of the consequences to report that it was her 'husband' who had injured her.

2.28 In January 2004 at a placement review CSC record that "Anna (now known as ****) moved in with her boyfriend and his family in early December 2003. Father-in-Law has advised that the placement was difficult at first as there was a lot of cultural and behavioural differences. There was a great deal of confrontation between his son and Anna. The placement is more settled that they are both aware of the expectations. The consent was provided by the boyfriends' parents for the marriage ceremony. Social Care have not given consent for this due to Anna's age. Anna to remain the

current placement. Student social worker will undertake a family and friend's assessment and present to Fostering Panel" Anna's SW however attended the Nikah wedding ceremony and referred thereafter to her 'husband' and 'mother and father-in-law'.

2.29 Also in January 2004 Anna booked for her maternity care. She was 15 years old, and her maternity records show that she described herself as married and living in foster care/ with her 'in-laws'. This did not trigger any safeguarding concerns from maternity staff.

2.30 In February 2004 Anna contacted SALS and described that she was unhappy. She was not allowed to go out; was made to cook and clean, was not allowed to attend the GP or an education placement. Anna also said that she had no confidence in her male social worker who talked in Urdu to her 'father-in-law' and excluded her from the conversation. Anna also stated several times that she would not be able to speak openly in front of her 'husband' or her 'father-in law'. The SAL's worker attempted to speak to SW1 who was on leave and then to a manager (no-one was available). She then spoke to the duty social worker SW2 and expressed concerns about Anna`s allegations. The SALs worker did not escalate her concerns about this or about SW1.

2.31 In March 2004 Anna twice told a SAL's worker that her 'husband' had hit her on several occasions. This did not trigger a safeguarding response in respect of Anna who was still a child or in respect of her unborn baby.

2.32 Throughout the period of time Anna lived with her 'boyfriend's' family (they were paid as foster carers) she reported mal-treatment, extremely controlling and isolating behaviour and domestic abuse. This was observed by practitioners from SALs and by CSC. SALs practitioners attempted to raise concerns about the safety of the placement with CSC however when these attempts were unsuccessful, they did not formally escalate their concerns. By April 2004 the placement had begun to break down and Anna was 'thrown out' by her 'boyfriend's' parents.

2.33 Anna stayed in contact with the SALs service and on 20th April 2004 they informed CSC that the placement had broken down and that Anna was now living in a bedsit.

2.34 A professionals meeting was held on 27th April, and it appears that Anna was by then believed to have returned to the placement (she had not) and discussions focused on her pregnancy. Information was not shared by SALs about the domestic abuse.

2.35 Throughout the rest of Anna's pregnancy and whilst she was still a looked after child she lived in a bedsit (which had shared bathroom facilities). The news that her unborn baby would be subject to a pre-birth assessment prompted Anna to find alternative accommodation suitable for herself and the unborn child. Funding was provided by CSC however no assessment of the property took place and Anna described to the independent reviewer that the bedsit was infested with mice and was not suitable for a pregnant 15-year-old child. Anna found a suitable house within weeks. Funds were provided by CSC and whilst no initial vetting of the property took place the independent living service intervened and provided Anna with help with her tenancy and vetting was carried out and the property was deemed suitable.

2.36 In late June 2004 Anna gave birth prematurely at 35 weeks. She was isolated and very anxious and her 'foster mother' was present when she gave birth. Following the baby's birth Anna remained very anxious that CSC would remove the baby or that her 'boyfriend' would take the baby from her and leave the baby with his parents. Anna also informed the SALs worker that her 'boyfriend' was threatening to get a passport for the baby and take the child abroad.

2.37 Anna remained in contact with the SALs workers throughout this postnatal period.

2.38 CSC carried out a home visit in September 2004 and recorded that Anna and baby were doing well and there were no concerns. At a home visit in December 2004 Anna told her SW that she and her 'boyfriend' had split up.

2.39 Later in December 2004 Anna was assaulted by her 'boyfriend' and her social worker took her and the baby to a women's refuge. At this point in time Anna was still a looked after child and there is no information in CSC records to explain why she was taken to a refuge rather than more appropriate accommodation.

2.40 On 29th December CSC record that Anna has returned 'home' and that the 'boyfriend' is visiting the baby but Anna states that they are not back together. There is no information to suggest that an assessment of risk to Anna and the baby took place.

2.41 On 4th February 2005 Anna attended a GP appointment. She was pregnant again. At this point in time, she was 16 years old and still a looked after child.

2.42 On 3rd March at 16 weeks pregnant Anna attended the hospital to book her maternity care.

2.43 On 22nd March Anna told a SALs worker that she had not yet disclosed her pregnancy to SW3 and that she had denied to her midwife that she had a social worker.

2.44 Later in March 2005 there are conflicting notes in CSC records indicating that Anna has her own tenancy and 'is doing well' but then referring to a foster placement and Anna wanting to change foster carers. It is not clear if the foster placement was her 'boyfriends' parents.

2.45 In May 2005 Anna contacted the SALs project in a distressed state. She had found a letter indicating that her 'boyfriend' was applying for a passport for the baby to take him out of the country. Anna stated that she was frightened of her 'boyfriend' but did not wish to leave the house, so options were discussed with her regarding support via a domestic abuse project and gaining an injunction. Anna had contacted the police regarding her boyfriend's forgery of her signature on the passport application but had decided not to take it further as she was frightened about how he would react. Anna was still a looked after child at this point in time and it is not clear from the records that the SALs worker shared this information with CSC.

2.46 Throughout this period CSC records indicate that Anna and the baby were doing well and there were no concerns about the unborn baby or concerns following the birth.

2.47 On 13th November 2005 Anna called the police as her 'boyfriend' had assaulted her. The police logged the incident as a domestic abuse incident but did not share information with CSC.

2.48 In November 2005 Anna attended her GP practice with concerns that she had postnatal depression. She told the Advanced Nurse Practitioner (ANP) that she has 'problems at home, separated from husband', 'living alone' and 'loss of contact with her own family'. Eldest child being cared for by husband who has gone back to live with his family. Appointment made with counsellor, follow up as needed at 3 weeks and advised to also contact Health visitor." It is not clear from agency records that the ANP knew that Anna was a looked after child.

2.50 On 3rd May 2006 the police were called to a further domestic abuse incident by Anna. Again, no referral to CSC was made in respect of Anna who was under the age of 18 or in respect of her two children.

2.51 Anna reached 18 years of age in July 2006.

2.52 Following her courageous decision to come forward more than 20 arrests have been made in connection to the investigation of Anna's abuse.

3.0 Key Themes Anna

3.1 Anna experienced severe neglect and abuse from a very young age. She was affected by severe parental mental illness and significant domestic abuse. She was subject to child protection arrangements on several occasions and finally came into the care of the local authority when she was aged 14.

3.2 As she came into care it is likely that Anna was already being sexually exploited. This escalated very rapidly and within a very short period of time she was being groomed, exploited and sexually abused by adult males.

3.3 Anna's placement at the residential children's home in Bradford did not keep her safe. She went missing frequently (over seventy times) and the staff there were aware that she was getting into cars with males including the male they referred to as her 'boyfriend'. (This male was referred to as her 'boyfriend' and then later as her 'husband' by other professionals CSC, police, and health agencies).

3.4 It is apparent from conversations with Anna and from information contained in agency chronologies that the local authority did not reflect what was happening to her in terms of sexual abuse and exploitation.

3.5 It was whilst she was still living in the residential placement that Anna began to wear full Muslim dress and told CSC that she had been married to the adult male 'boyfriend' in a Nikah ceremony. (Nikah is a Muslim wedding at which the bride does not have to be present as long as she sends two witnesses to the drawn-up agreement). Anna was aged 15.

3.6 The willingness of some professionals to legitimise this wedding is clear from agency records. The adult male was thereafter referred to by professionals as her 'husband' and his parents as her 'mother-in-law' and 'father in law'. The 'Nikah' marriage far from being challenged and perceived as coercive or exploitative was accepted and Anna's social worker at that time attended the ceremony.

3.7 The decision to consider and approve a fostering placement with the adult male's parents is difficult to understand. The adult male was her abuser. It was also clear that she was not regarded with respect and affection by her abuser's family. In fact, they were also controlling and abusing her.

3.8 The review Panel members discussed the placement of Anna with her abuser's family at length. This placement did not protect Anna from harm but did in fact place her at greater risk and made her entirely dependent on them. Whilst in the 'care' of these adults she was subjected to further sexual abuse and exploitation, domestic abuse including assaults and coercion and what we would now recognise as domestic slavery during the time she lived there.

3.9 Anna told the SALs project about her difficulties concerning her Asian male social worker when she was living in her abuser's home. Although the SALs worker attempted to contact a SW manager about this her attempts were unsuccessful, and she did not formally escalate her concerns and Anna's situation did not improve.

3.10 Once she had become a mother herself Anna she continued to be subjected to several further assaults and abuse by the adult male. The way in which agencies; including CSC, the police and the SALs project responded to this was poor and did not protect Anna or her very young children from further harm. Anna was still a looked after child herself at this point in time.

3.11 In summary, when Anna came into the care of the local authority, she had already suffered neglect and abuse and lived with the impact of domestic abuse and parental mental illness. As Anna came into care she was already being sexually exploited and within weeks this had escalated. Anna experienced ongoing sexual abuse, sexual exploitation, domestic abuse and possible domestic slavery whilst in the care of the local authority.

3.12 What we do not see recorded in agency chronologies is that during the time she was in the care of the Local Authority Anna has described to the independent reviewer that she was being sexually abused and exploited by dozens of adult males some of whom were known to her 'boyfriend'.

3.13 Anna was described as a bright child by her primary school but did not receive any consistent education after the age of thirteen. There is little information in agency records to suggest that plans were put in place to address this.

3.14 In conversation with the independent reviewer, Anna was able to describe the ongoing impact of the trauma and abuse she experienced and the effect that this continues to have on her mental health and emotional wellbeing. She says:

3.15 "*Numerous social services assessments were carried out throughout my very early years from the authorities with a "being at risk" noted but nothing ever acted on, and I was failed for more than two decades. My needs as a child were not met my education was non-existent throughout my teenage years. From around 12 years old it was apparent to social services I was absconding from home and was being trafficked all-over west Yorkshire. I was at great harm however they allowed me to continually be subject to sexual, physical, and emotional abuse and psychological abuse and harm. Safeguarding risk assessments were carried out and acknowledged*

that I was being sexually abused by grooming on a large scale. Recommendations were put forward at various strategy meetings to remove myself as I was at escalated risk from sexual perpetrators and to be placed into a secure unit or foster carers away from the area, but recommendations were ignored time and time again. I was regularly missing for numerous weeks at a time with no sightings, and no contact from myself. Social services and the police did nothing to locate me this could have ended in a homicide case as I was suffering from severe domestic violence. I was co-dependent from being 13 and I was psychologically suffering throughout my teenage years, but no intervention was offered. I was a minor, unstable as well as unable, as any child is to make the correct choices which were life changing decisions these have had a major impact on my life. I was 15, but the authorities thought it was in the best interest and to minimise the severity of my absconding and placed me in a foster care placement while being fully aware with the parents of my abuser. We had no similarities in race, religion or culture and I continued be subject to domestic violence and was subject to a coercive controlling sexual relationship with a known perpetrator. I was frightened to leave, in fear of an honour-based killing. At 14 years old I was engaged to be married, taking on the role of an Islamic wife fulfilling the needs of my husband and the extended family somewhat like a maid. I was identified as a vulnerable and naïve child converting to Islam wasn't a case of wanting to embrace Islam for my own individual choices. I was manipulated and controlled while I was on a local authority care order the authorities should have protected me however they allowed abuse to occur for numerous years. Resulting in living a life of dual identity despite only being 15. The local the authorities allowed and witnessed a sharia law Nikah wedding to take place allowing a man to carry out sexual activity on a child to occur on a daily basis which is illegal.

If only the authorities had done what was recommend for me, the secure unit or accommodation. I wouldn't have been subject to sexually and physical abuse for many years. And because I wasn't looked after as a child should have been under a local authority care order. Contact arrangements with parents was minimal bonds were damaged with close family which can now never be rectified. I'm left with my adult years to educate and work on my mental health state of mind and coming to terms with the realisation I will always be in recovery. I'm not in control of my anxiety and only feel at ease with my nerves, when I'm in another county living a life that nobody knows who I am or what I've been subject too. Throughout my late adult years, I've had a significant number of disturbing dysfunctional relationships as I've not healed as a victim of child sexual exploitation and physical abuse.

I've found courage and been courageous in coming forward and I sincerely hope other victims will speak out about their child sexual abuse".

Case 2- Fiona

4.0 Brief Background

4.1 Fiona has waived her anonymity for the purposes of this review and has made several public statements about her experiences. In February 2019 nine perpetrators in Fiona's case were convicted of 22 offences including rape and inciting child prostitution.

4.2 Early records include references to concerns about possible abuse of Fiona as a very young child. Though raised by a health professional at the time these do not appear to have been followed up.

4.3 From around 2006, when Fiona was aged 12 Fiona began to show significant levels of distress at her home circumstances and relationships. There was domestic abuse (mostly verbal) between her and her mother and between mother and mother's partner. Fiona frequently went missing and in the early days stayed with her grandparents, but they came to a point where they felt they could not continue. She also went to friends who were subsequently described by the police as "unsuitable". Family expressed concern about possible sexual exploitation, but this was not investigated at the time.

4.4 In 2008 Fiona was admitted to care. She had numerous placement moves, including some in unregulated settings, and was clearly expressing her distress, both explicitly and through self-harm. Her behaviour was, at times aggressive and she was convicted of an assault on a member of staff. In all her placements she went missing.

4.5 Fiona gave birth in 2009 and she was placed with the baby in a mother and baby home. The placement broke down, she returned to her mother's, but this also broke down and she left, leaving the baby with her mother. Her baby was subsequently adopted.

4.6 There were frequent indicators that Fiona was being sexually exploited and often also physically assaulted but it was not until 2010/11 that she was referred to the Barnardo's Turnaround project. Fiona continued to be sexually exploited and abused throughout the remainder of her childhood.

5.0 Key events and other issues

5.1 In 2006 Fiona, aged 12, was assaulted by her mother who described Fiona's behaviour as 'difficult'. Fiona went to stay with her grandmother. There was no exploration of the 'difficult' behaviour and when this had started. Her mother had been formally diagnosed with depression and sleep deprivation but there is no record of what support was put in place. Later in the year Fiona was excluded from school for threatening behaviour. There appears to have been no exploration of why Fiona's behaviour was threatening.

5.2 Although her family were expressing concerns about possible sexual exploitation these were not investigated and Fiona frequently went missing. There were incidents of verbal domestic abuse between Fiona and her mother and of Fiona refusing to return home. It is of note that a verbal domestic abuse incident was recorded between Fiona's mother and her partner in March 2007. By this point in time agencies knew that Fiona and her sibling had been experiencing domestic abuse for at least eight years.

5.3 Fiona went missing again in January 2008 and the police records for this state "*Missing person is a rather bright student who up until the past few months has been getting good grades and was expected to do well. The missing person fell out with her mum and went to live with her grandma, this was because the missing person found her parents looking at her diary as they were concerned about her. The parents have frequently found telephone numbers of Asian males on scraps of paper in the missing person's bedroom. They have grave concerns after recent media attention to the grooming of young girls*".

5.4 The entry also notes that a friend of Fiona's had stated that Fiona may not have gone home as she had been permanently excluded from school.

5.5 The possibility that Fiona was being groomed or sexually exploited and abused was not investigated or explored by agencies at this point.

5.6 Fiona again went missing in February 2008 and would not say where she had been. She was also admitted to Bradford Royal Infirmary with superficial scratches to both wrists but was discharged. There is no record of any CAMHS assessment.

5.7 Throughout the first three weeks of February 2008 Fiona stayed at the home of a friend. Fiona's mother tried to persuade Fiona to return home. Eventually the friend asked Fiona to leave, and Fiona again went missing.

5.8 On 19th February she was made subject of a Public Protection Order (PPO) on the grounds that she was going missing repeatedly. At this point Fiona stated that she did not want to return to her mother's as she did not get on with her stepfather. Fiona was placed in crisis care.

5.9 On 20th February 2008 a multi-agency meeting took place at Fiona's school. It is recorded that "*Fiona refused to return to mum's care saying no-one was listening to her, she refused to return home as she reports she could not sleep She spoke of being stressed - losing weight and hair falling out and that she could not return home as she cannot sleep as all she can think about is her mum slitting her wrists, blood over the television and fighting. Fiona agreed to speak with Dr *** from CAMHS who had just arrived. Fiona then said that her step father had hit her a couple of weeks ago on her arms at her friend's house when her mum and him tried to make her come home. She showed us her arms and there were faint marks on them. She said she could not go back to the house because he would do it again".*

5.10 Dr **** from CAMHS confirmed that Fiona's low mood and distress were due to her home circumstances, and she would be likely to self-harm if made to return home.

5.11 Because of her disclosure about physical abuse a S47 enquiry was deemed appropriate however there are no records available to confirm whether or not this took place.

5.12 On 22nd February 2008 Fiona went missing again. A crisis carer was identified for over the weekend when she was located.

5.13 Fiona was found at her friend's house. Fiona was getting distressed as she had been to three crisis carer's in the matter of a few days. The friend was willing to keep Fiona on a temporary basis. Fiona advised if she was taken to another crisis carer's she would just run off.

5.14 The PPO had now come to end, and CSC had no legal orders in place or accommodation agreement, therefore Fiona's mother still had full parental responsibility and she was refusing to allow Fiona to stay at the friends.

5.15 On 25th February Fiona was arrested for breach of the peace after refusing to return to her mother's address from the friend's house.

5.16 Also on 25th February Fiona was seen in school by a CAMHS worker who shared information with CSC that Fiona presented as very distressed and tearful due to her home environment.

5.17 On 4th March 2008 a meeting took place between Fiona's allocated social worker and a police officer. The police insisted that Fiona must not be at the property of her friends as it wasn't appropriate due to the environment and the concerns the police had about the family. It was recorded that if Fiona is found to be at **** she must be removed by the police and returned home. There is no information in CSC records to detail what the concerns about Fiona's friend's family were or how these informed risk assessments and other plans for Fiona.

5.18 On 4th March 2008 Fiona was admitted to hospital having self- harmed as a reaction being told she had to return to her mother's home. Two days later Fiona moved into a children's residential home under Section 20 of the Children Act.

5.19 On 7th March Fiona was visited at the children's home by a CAMHS worker. Fiona was unwell with a throat infection and a broken rib. The CAMHS worker noted that Fiona did not seem to care about her health. There was no record of a discussion about how Fiona had broken her rib and any possible assault or abuse.

5.20 On 9th March a police record indicates that a reviewing officer described Fiona as '*street wise'*.

5.21 Throughout March 2008 Fiona again went missing from the children's home and was distressed and agitated when she returned. She talked to a member of staff about using drugs.

5.22 On 21st March Fiona was again arrested. She was on the street and was very drunk. She spat at a special constable and admitted that she had drunk 1.5 litres of vodka before the police arrived. Fiona was aged 14 at this point. Fiona continued to go missing from the children's home. No formal 'missing from home' interviews and no CSE risk assessment took place.

5.23 On 29th March 2008 Fiona's mother rang CSC to say she wanted her daughter to return home. She stated that she feels Fiona is at more risk at the residential home than she would be at home as there are no restriction on Fiona leaving the establishment.

5.24 On 3rd April 2008 a LAC review took place, and it was recorded that Fiona would move to a different children's home (still under Section 20 arrangements). By this time Fiona had experienced several moves between her mother`s, her friend`s, crisis placements and residential children's homes.

5.25 Fiona wrote a letter to be read by the professionals at the review meeting. It was a clear and very powerful description of how the trauma and loss Fiona had experienced continued to impact upon her. In the letter she states that everything changed for her family when her stepfather began to abuse her mother.

5.26 Fiona said that "*she worries about being sent home, people thinking she is pregnant, not seeing her sister, who her real dad is, not being able to sleep properly, worrying about returning to school and failing her GCSE's, feeling unwell, remembering things that have happened to her at home not having clothes or make up, worrying about being moved anywhere different and cutting herself and not knowing any other way round it".*

5.27 Fiona was arrested for a public order offence in April and also went missing from the children's home.

5.28 On 8th April Fiona's mother raised concerns about the suitability of the placement for Fiona. Two days later Fiona was arrested at the children's home where she had damaged her room. She was taken into custody to '*calm her down'* and was later charged with criminal damage and bailed and a court date of 18th April was set, and she was subsequently received a 3-month referral order.

5.29 Fiona was arrested again after assaulting another child at the children's home. Police officers noted self-harm scars on her arms.

5.30 She was moved to a permanent placement at a children's home on 15th April 2008 and went missing on the first night.

5.31 On 23rd April CSC completed a core assessment which listed the following:

- CAMHS to continue to work with Fiona around feeling low.
- CSC work with Education to get Fiona back in to school.
- CSC to work with Fiona and mum around improving their relationship.
- YOT to work with Fiona around her criminal activity.

5.32 The assessment did not consider the risk to Fiona from CSE or her frequently being missing.

5.33 Throughout April and May 2008 Fiona engaged with CAMHS and said that the support would help her not to self-harm.

5.34 In May 2008 she was convicted at court of assault (March 2008 incident detailed above)

5.35 Throughout May Fiona went missing several times and on 31st May she and another resident from the children's home were found in the company of 2 males who were in their 20's. This met threshold for a strategy discussion as there were clear CSE concerns however there appears to be no CSE risk assessment in place for Fiona and no evidence to say that she had been discussed at a CSE meeting.

5.36 On 6th June 2008 a multi-agency meeting was held in respect of Fiona and the other girl she had gone missing with. The girls were going missing every evening and returning at about 5am the following morning. Staff were concerned about the girls being at risk of CSE. Another child from the home had informed the staff that Fiona and her friend were involved with a number of adult males who were supplying them with alcohol and drugs. The outcome of the meeting was for CSC to arrange a CSE meeting. This was five months after Fiona's mother had raised concerns about CSE.

5.37 On 12th June Fiona who had been missing for 36 hours returned to the children's home and stated that she had been camping out in the garden of an older male and his friend. It does not appear from CSC records that this was reported to the police.

5.38 On 23rd June a CSE multi-agency strategy meeting was held in respect of Fiona's continued missing episodes.

5.39 The police record of the meeting shows that identified risk factors are:

- Believed to be associating with adult males.
- Goes missing with ** (more vulnerable when together)
- At risk of sexual exploitation (low to med risk)
- History of self-harming last incident approx. Three weeks ago…. not serious
- Other residents believe she is being groomed.
- Missing episodes are becoming longer (two-three days)
- Believe she now has regular boyfriend.
- Known to drink alcohol.
- A preventative action plan shown as:
- To be referred to 'turnaround', with assistance of YOT as she is doing reparation work with them.
- care plan to be agreed at children's home.
- plans to be put in place to separate the girls.
- Persistent 'unauthorised absence' marker requested on PNC.

5.40 There is no corresponding record of this meeting available from CSC.
On 23rd June 2008 a LAC review was held which noted that Fiona had initially settled well when she moved to **** Children's Home on 15th April and continued to develop good relationships for the first few weeks. Within 6 weeks however another

girl moved into the placement and she and Fiona developed a strong relationship resulting in them absconding and reported as missing 23 times since 24th May 2008.

5.41 It was noted that:

- Fiona has a three-month referral order since she assaulted a member of staff now increased to six months as she breached this.
- Concerns that Fiona is using alcohol and possibly other harmful substances.
- Fiona has not been attending CAMHS appointments".

5.42 It was also noted that a Strategy meeting was to follow the review (same afternoon) to discuss safeguarding Fiona from sexual exploitation and the placement at **** Children's Home. There is, however, no record of a strategy meeting taking place, who attended or minutes in the CAMHS /LAC records.

5.43 On 28th June a CSE Strategy meeting took place as there were further concerns around Fiona being at risk of CSE. Warning letters were sent to any potential harbourers and hotels. There is no record in the CSE strategy meeting minutes of Fiona being referred to CSE services or whether she had been taken for a sexual health check.

5.44 A CSE risk assessment had still not been carried out with Fiona.

5.45 On 1st July 2008 Fiona and another girl went missing. The police log of this incident states: "*05.26: Both mispers are believed to be in the Bradford Area with an unknown Asian male who is supplying them with drugs in return for sexual favours. Requests have been sent to Bradford to carry out address checks. Both mispers were spoken to by an officer at around 0330hrs on their mobile phones, they would not give their location but did confirm that they are together at this time. Log endorsed that information received from care staff that FG was spoken with in the early hours by them and was at ***** Bradford. Return interview report attached to occurrence. This detailed that Fiona had been found at the above address at 07.40 that day by officers. She did not want to return, and police liaised with a family support worker who advised them that if Fiona was safe and well she could remain at the address. Fiona declined to say how she got there*".

5.46 Throughout June and July 2008 Fiona continued to go missing from the children's home. On 22nd July Fiona was allocated a new social worker.

5.47 On 22nd August Fiona was convicted at Bradford Magistrates of criminal damage and given a Conditional Discharge for 12 months.

5.48 Throughout August and September Fiona continued to go missing and on 11th September Fiona reported that she had been assaulted by a male and had a black eye and two lumps on her eye, bruises on her chest and that she had received hospital treatment for her injuries. Fiona would not give any information about who had assaulted her. During this period of time Fiona disengaged with CAMHS and partially re-engaged in October 2008

5.49 In November 2008 Fiona became pregnant. She was aged 15.

5.50 In December 2008 Fiona was convicted of battery at Bradford Juvenile Court and received a three-month Action Plan Order and three months electronic tagging with a curfew. She was also found guilty of breach of the Attendance Centre Order.

5.51 Fiona told her CAMHS worker that she was pregnant and asked to be discharged from CAMHS in December 2008. The LAC nurse visited Fiona in December 2008 and Fiona discussed her pregnancy and her fears and hopes for the future. Neither the CAMHS worker nor the LAC nurse record that they discussed who the father of the baby was and whether or not it was an age appropriate and safe relationship.

5.52 In early January 2009 Fiona went missing on several occasions and she was again described by the police as '*extremely streetwise'*. Fiona's mother reported to the police that she believed Fiona's 'boyfriend' and father of the baby was a paedophile. No agency had any information about him at that point.

5.53 On 22nd January 2009 a CSE meeting took place, and it was decided that Fiona required a CSE risk assessment which was to be completed by allocated social worker.

5.54 On 23rd January 2009 Fiona was treated in A & E for a broken nose, two black eyes and other facial injuries. She stated that she had been assaulted by her boyfriend's friend and named him (he was arrested, charged and convicted of the assault). This met the threshold for a strategy discussion. Fiona was pregnant and subject to a significant assault. However, it does not appear that a strategy discussion took place.

5.55 On 26th January a CLA review noted concerns that Fiona was still going missing and was still using alcohol and drugs.

5.56 At the end of January following a court appearance Fiona had a change of placement following her telling the court that she was being bullied at her existing home. This led to her being placed in a crisis placement.

5.57 On 12th February following weeks of Fiona moving between houses CSC carried out an assessment of her friend's suitability as a placement. This was the same friend who had previously been assessed as unsafe. However, on this occasion CSC decided that Fiona would be 'least at risk' staying there. By 9th March this arrangement had broken down as the friend of Fiona's said that Fiona's behaviour was inappropriate and causing problems for the family. Fiona returned to live with her mother. At this point in time CSC had not sought legal advice and the Section 20 arrangements had not changed.

5.58 By 13th March Fiona had been placed in a bed and breakfast as her return to live with her mother had also broken down. This 'placement' lasted one night as the proprietors said they would not accommodate Fiona as she had spent the night in

bed with a male who was also staying there. This did not trigger any discussion with Fiona or consideration of CSE.

5.59 On 26th June the Section 20 arrangement ended.

5.60 Fiona gave birth to her baby in July 2009 and following a positive pre-birth assessment she and the baby returned to live with her mother.

5.61 On 5th October Fiona and the baby were placed in a mother and baby placement but on 1st November she was asked to leave as she had not stuck to the terms of her placement and had allowed her boyfriend in after the 11pm deadline. Again, there is no record of who this boyfriend was.

5.62 Fiona returned to her mother's house whilst another placement was found however Fiona assaulted her mother on 19th December. The baby who was present became distressed and Fiona was arrested. Following this incident Fiona went to live at her grandmother's and the baby remained with Fiona's mother.

5.63 On 12th January 2010 a leaving care worker made a referral to CAMHS for Fiona following an incident in which Fiona threatened to harm herself with a knife. The referral detailed that "*Fiona sometimes disappears for days at a time with male friends. When asked to sort out her utilities Fiona picked up a knife and threatened to kill herself. Abrasions and a bite mark also noted on her lower arms by a worker from Foundation Housing*" The referral also detailed concerns that Fiona was not feeding her baby and that the flat was cold. There was no consideration that the '*male friends'* may in fact have been abusers.

5.64 The following day Fiona assaulted her social worker and housing support worker as they informed her that they felt she should not be in a flat on her own and should either return to her mother's or go to a hostel.

5.65 Fiona was arrested again following a further assault of her mother on 26th January 2010.

5.66 On 27th January Fiona reported to CSC that she was homeless; she was put in a B&B for the night. The following day Fiona went to Leeds to stay with a friend and failed to get in touch with her social worker as planned. There is no detail on record to say who this friend was.

5.67 There are no further agency records until April 2010 when Fiona was admitted to hospital following an overdose. She was seen by adult mental health staff and deemed fit to be discharged.

5.68 On 7th May Fiona was moved to an out of area placement in West Yorkshire.

5.69 On 27th May Fiona's GP made a referral to adult mental health services.

5.70 On 10th June 2010 Fiona's mother contacted CSC to say she was struggling to care for Fiona's baby. She was not receiving any support and requested respite.

5.71 On 18th June Fiona was reported missing from her placement and returned after a week and a half. She had been to Scotland with a friend. There is nothing on record to say who the friend was and whether or not Fiona had been safe. (It later transpired that this trip to Scotland had been made with adult males)

5.72 Throughout July 2010 Fiona was again arrested for assaulting her mother and sister.

5.73 A referral to the Barnardo's Turnaround service was made on 12th July by Fiona's careers worker. (Missing in Yorkshire was a service delivered at that time across Kirklees and the referral was shared with Turnaround as Fiona was a Bradford child and was going missing).

5.74 On 16th July Fiona was seen by an adult mental health worker with her support worker in attendance at her home. Fiona presented with a black eye and when asked how it had happened refused to discuss it.

5.75 On 19th July 2010 Fiona alleged that she had been raped by an ex-boyfriend. There is a police report on the electronic system which provides details of the incident, however there are no further details recorded providing the outcome of the investigation by the police and CSC.

5.76 On 6th August a support worker called the police to report that Fiona and another 16-year-old had got into a car with a male who was under the influence of drugs. The support worker also stated that Fiona and the other child had been on a drinking and drugs spree for two days.

5.77 On 11th August 2010 a staff member from Fiona's residential unit called the police and reported that Fiona and other girls from the home were being sexually groomed by a 44-year-old male. This staff member also stated that Fiona and others from the home have reported that the male washes her clothes, provides crack cocaine, alcohol, cigarettes and food. Although the girls deny this the caller felt that the girls were being sexually groomed. The police record states "*The girls have said that young Asian males call frequently at the house, and it has been suggested that the girls are sleeping with some of these males. The organisation does not have the power to make these girls come back to the home as a consequence can only report them as under age. Caller is saying that this is a repetitive problem that issues surrounding this have to be addressed as these girls keep going back to this Asian male. She would like to talk with the duty Inspector on her mobile phone on this log as a secondary number, in the next couple of hours to discuss the options available to bring this to a positive conclusion*". This information was shared with CSC.

5.78 On 17th August the police found Fiona and another child at the adult male's house and returned them to the residential unit.

5.79 On 19th August Fiona was seen by the adult mental health worker who had persisted in trying to meet with and support Fiona, however Fiona's missing from home episodes had made this difficult. Fiona said that she did not want mental health involvement. At this time Fiona also declined support from the Barnado's Turnaround service.

5.80 Throughout the rest of August and September Fiona continued to go missing from the residential unit including travelling to Birmingham with "*unknown Asian males to celebrate Eid".* A CSE meeting took place on 13th September, and it was noted that there was "*Evidence to suggest consistent grooming by the Asian male *** and Fiona seems to be one of the dominant figures in supporting him to entice other girls to the address*". The outcome was that a harbouring notice was given to the suspect.

5.81 On 16th September a strategy meeting was held in respect of Fiona and three other girls who were all being sexually exploited by the same 44-year-old and several other males. There is no record of what the outcome of the strategy meeting was.

5.82 Throughout September Fiona was frequently missing from the residential unit and made it clear that she did not want to stay there. Also during this period of time, the adult mental health worker attempted to meet with Fiona but was unable to as she was missing.

5.83 On 24th September Fiona was arrested at the residential unit for criminal damage. The police log notes "*Fiona has claimed to have phoned 'some Asians' to come to the home and help her. She is vulnerable to sexual exploitation and is heavily involved with males in the Bradford area*" The police note also record that Fiona is "*using cocaine and has depression and a personality disorder".* It is not clear where this information came from. Fiona did not have a diagnosis of a personality disorder or depression.

5.84 On 26th September, Fiona had been reported missing again. The police log states "*Misper is a 17yr old in supported housing living alone but with supported visits, spoken to by staff since missing believed with male friends who she often visits whilst 'Missing'. I do not see any imminent danger this evening, she does this on a very regular basis, I therefore grade this as a Low risk misper*". This was reviewed by a supervising officer and the log indicates "*case discussed with officer in charge who raised valid concerns about sexual exploitation with this girl. Misper officer aware of this girl. In view of this upgraded to medium risk. Misper has been laughing down phone this eve so is clearly not in any distress or immediate danger*" The grading was then changed to medium risk.

5.85 On 29th September the adult mental health worker recorded that "*Fiona has failed to engage and has DNA several appointments. When she has been seen she doesn't exhibit any signs or symptoms suggestive of depression or any other mental illness. Fiona uses illicit substances regularly and doesn't accept at present that this may have a negative effect on her mood and functioning in life. She is currently living in a non-statutory residential unit in Dewsbury but often is absent from there for days and returns to Bradford to be with her friends*".

5.86 On 4th October 2010 Fiona told staff at the residential placement that she had been sexually assaulted on 2nd October and had grazes on her legs. Fiona refused to tell the police or speak to her social worker. Fiona said only that it was a guy called ** but would not say more. She told her support worker at her placement that she had "*a little argument with her friend and then had met these guys who said they would take her home but instead took her to a house. She said the three males tried to touch her and that she had sex with one of them in an empty bath. Fiona said that she did not say no to him and just wanted to get it over and done with*". There is no evidence that S47 enquiries were carried out and no information from the police to suggest the assault was reported to them.

5.87 On 6th October the manager of the residential unit telephoned Barnardo's Turnaround service, at this point the service had not met with Fiona, were very concerned that Fiona "*needs advice following possible miscarriage, including sexual health advice. Noted that Fiona's uncle had just died*". It was agreed that the manager would take Fiona to the Turnaround Service.

5.88 On 8th October 2010 a Harbourers Notice was sent by post to a second adult male in respect of Fiona. There is no information recorded to show that he was spoken to in person by the police.

5.89 During October Fiona continued to go missing and told staff that she had a new boyfriend. The boyfriend was 19 years old and had just been released from prison. Fiona said that he was violent. She also stated that he was the father of her baby who was by this time 16-month-old. It was also recorded that Fiona owed the 45-year-old male money for drugs. Also, during October Fiona's mother stated that she was seeking a residential order in respect of Fiona's baby.

5.90 In addition, the Barnardo's Turnaround service worker liaised with the residential unit manager about Fiona however she did not manage to meet with Fiona as she was missing.

5.91 On 23rd October at a return from missing interview Fiona told the police that she had been with "*friends one of which is a drug dealer called *** who gave her 3 Valium tablets after which she fell asleep. **** is an Asian male 28-30 years old, muscular build, 6ft tall".*

5.92 On 25th October Fiona called the police to report that she had been stalked by her ex-boyfriend for the past six months. Fiona had received a call from him threatening to burn her house down with her daughter in the house. He had rung her about 12 times that night.

5.93 On 29th October 2010 a police log in response to Fiona going missing recorded that Fiona's social worker had given permission for her to stay out all weekends and therefore would not be reported missing at those times.

5.94 On 1st November 2010 a support worker at the residential unit contacted the adult mental health worker to say that Fiona was struggling and had said that she wished she had engaged with the service. The adult mental health worker agreed to discuss and to identify if a worker could offer an appointment. There is no further documentation regarding the outcome.

5.95 On 2nd November staff at the residential unit relayed their concerns to the police and to CSC that Fiona was very fragile and had asked staff to remove razor blades and pills from her room to prevent her harming herself.

5.96 On 10th November CSC recorded that Fiona was regularly using drugs.

5.97 On 17th November the Barnardo's Turnaround worker spotted Fiona leaving her grandparent's house at 7.00pm and getting into a car, parked nearby, with three men. The driver was dressed in a business suit and looked to be in his forties. There is nothing recorded to show that this information was shared with CSC.

5.98 On 24th November Fiona moved property at her request. This was a planned move to a supported tenancy. The staff from the residential unit would offer three hours support a day to Fiona. This was on the understanding that Fiona would engage with support services and education.

5.99 On 20th December it was noted by CSC that Fiona was requesting overnight contact with her child at Christmas. This was not agreed as Fiona had not had any contact with her child for a long time. It was agreed that Fiona could have supervised contact with the child on Christmas day. (Fiona's child at this point in time was living with Fiona's mother)

5.100 On 24th January 2011 CSC record that Fiona's neighbour reported concerns that she is "*using the property for solicitation. The neighbour sees numerous men visiting the flat during the night. The men stay between 30mins and 1hour. Some of the men are very well dressed (business men like)*. *The neighbour also been informed by the landlady that Fiona meets Asians in cars on the main road. These people don't come into the flat but stay in their vehicles providing Fiona with substances. It is suspected that Fiona is soliciting herself for alcohol and drugs to meet her addiction*".

5.101 On 27th January a worker from the Barnardo's Turnaround service attempted to contact the residential unit manager to discuss concerns about Fiona. It is of note that there was an attempt to arrange a visit in mid-November 2010. The last contact with Fiona was by a worker other than the allocated worker on 29th October informing her that someone would be in contact within the next few weeks this had now stretched to several months.

5.102 In late January 2011 Fiona sought legal advice in respect of contact with her child. The subsequent court process resulted in Fiona's child being taken into foster care under a Section 20 arrangement in February 2011 and an Interim Care Order was granted to Bradford CSC on 7th March 2011.

5.103 In March 2011 Fiona moved to a new flat in a different town within the borough.

5.104 On 29th March Fiona was injured when a male she had met when visiting someone in prison threw a glass bottle at her feet. This happened outside Fiona's new home.

5.105 On 6th April 2011 a meeting took place between Fiona's social worker, Fiona's support worker and Fiona's child's social worker. Concerns were raised around Fiona not engaging with services and not attending contact with her child, drug and alcohol issues and not meeting her own care needs. Fiona was not brought to the meeting, therefore the workers tried to visit Fiona and she was verbally abusive towards them, so they had to leave.

5.106 On 12th April Fiona was admitted to hospital after self-harming.

5.107 On 15th April the police were called about a disturbance at Fiona's property. "*A group of 5 Asian males, approx. 20 -25yrs old turned up and began shouting at the occupants to come out and meet them. The group made off in a large vehicle towards the bus station. Officers attended and spoke to the female occupant of ***** who advised officers that nothing had happened*". The police log then states "*This will be Fiona previously of ******. Storm logs from her previous address suggest while she was resident it was being used as a brothel and frequently smelt of cannabis. Many Asian men were seen to visit the premises at all hours of the night"*.

5.108 On 10th May 2011 Fiona returned to live with her grandmother.

5.109 On 8th June Fiona moved into a new flat. This was her fourth move in eight months.

5.110 On 23rd June 2011 Fiona was seen by a worker from the Barnardo's Turnaround Service. Fiona was reluctant to engage and said that she was seeing too many professionals and wanted to focus on getting her child back. The worker's assessment was that Fiona remained at high risk of CSE owing to her contact with individuals involved in CSE, her drinking and drug taking, her depression and self-harming and the stress of the court case in relation to her child.

5.111 On 25th July Fiona reported to CSC that she had been attacked twice over the weekend within her home.

5.112 On 9th August a parenting assessment was completed by CSC. Fiona was informed that the local authority would not be recommending that her child was returned to her care and the care plan would be adoption.

5.113 Throughout October and November 2011 Fiona engaged sporadically with the Turnaround service.

5.114 In November she was again attacked within her own home and went to live with her mother whilst waiting to be re-housed.

5.115 On 9th January 2012 the Final Court Hearing took place in respect of Fiona's child and a Care Order and Placement Order granted to the local authority.

5.116 Fiona was aged 18 at this point.

6.0 Key Themes Fiona

6.1 Fiona's early life was characterised by serious domestic abuse and her mother's poor mental health. Agencies were aware of the domestic abuse including physical abuse and Fiona was explicit about how this impacted upon her. Despite this nothing changed for her, and the outcome was that she left the family home and the perpetrator continued to live there.

6.2 Fiona's mother expressed concerns about CSE as early as January 2008 and there was evidence that Fiona was in contact with males. This wasn't acted upon by the police or CSC.

6.3 There was little stability for Fiona before and after she became a looked after child and she experienced frequent moves. She went missing on an almost daily basis and the police (and other agencies) response to this was, at times, poor. Fiona was described by the police, more than once, as 'street wise' and this implied that she could look after herself. Her missing from home/ care episodes were also described as 'unauthorised absences' which resulted in a 'downgraded' response than would a description of 'missing'. This also meant that missing from home interviews did not take place with Fiona and there was no missing strategy plan in place to help manage the risk to her.

6.4 There appeared to be agreement by all agencies that Fiona was either at risk of CSE or was actively being sexually abused and exploited (including by a known 44-year-old abuser) but this was not addressed by any single agency until the Turnaround service worked with her (with sporadic engagement; from November 2011)

6.5 When Fiona became pregnant at the age of 15 there was little curiosity or enquiry about who the father was and whether or not Fiona was safe. Similarly, when Fiona reported that she had a boyfriend there was little consideration of how safe this 'relationship' was for Fiona.

6.6 During the timescale considered by this review Fiona was assaulted at least seven times (beginning when she was aged eight or nine). There is nothing in any agency records to describe how this would have affected Fiona or how it might contextualise her own aggressive behaviour. The assaults included rape and sexual assault and these allegations were not given the same credence and response had they been made by an adult or even by a different child.

6.7 Fiona ended up with several convictions for behaviours, some of which may well have been a symptom of the levels of fear and distress she was experiencing (see also the Criminalisation of Sexually Exploited Children in the overview report).

6.8 The language used by CSC and the police to describe what was happening to Fiona between 2008 and 2011 was striking. She was described as *exchanging sexual favours for alcohol and drugs* (aged 14 or 15) and *soliciting and operating a brothel* (aged 17). She was a looked after child during these periods.

6.9 An assessment that she could not provide her child with a safe environment meant that her child was adopted against Fiona's wishes. This decision was made after many years of Fiona herself being unsafe and experiencing significant harm whilst in the care of the local authority. The trauma and loss from the adoption of her baby will have lifelong implications for Fiona (and for the adopted child and siblings).

6.10 Fiona, as an adult suffers from ongoing mental health issues including a diagnosis of Complex PTSD.

6.11 In conversation with the independent reviewer Fiona described the impact of how she was treated by professionals as being as "*bad as the abuse*" and exploitation.

6.12 Fiona asks, "*Why was my child removed from me because of concerns over me being a victim of CSE but I, still under the age of 18, was left to carry on being abused"?*

6.13 In summary Fiona was not kept safe by agencies who had responsibility for her wellbeing and the abuse, assaults, exploitation and other harms she experienced were not acknowledged or addressed.

Case 3 – Samara

7.0 Brief background

7.1 The review considered events between March 2014 and July 2019

7.2 Samara is now aged 15. Samara's family were known to CSC and health agencies from 2004 onwards because of domestic abuse. Her mother and father both had mental health difficulties.

7.3 In January 2017 when Samara was aged 12 her family contacted the police to report that Samara was in contact with several adult males. The contacts had initially been on-line and had led to face-to-face meetings and abuse.

7.4 At one stage Samara had moved out of area and was being sexually exploited there. This required three police forces and two Local Authorities to work together.

8.0 Key Practice and other Events

8.1 When Samara's family contacted the police in January 2017 the police made an immediate referral to the MASH and a strategy meeting was convened. The meeting was led by the police as it was likely that crimes had been committed against Samara

(the suspect was a man in his 20's from a neighbouring borough). At that point in time Samara was assessed as at high risk of CSE.

8.2 Samara said that she had been using a mobile app and had been messaged by the suspect and she later met with him. Her phone and clothing that she had worn were seized by the police. Enquiries with social care in the suspect's home area were directed to ensure safeguarding of other children he may be in contact with.

8.3 Samara was admitted to hospital via the emergency department with abdominal pain the same day. This pain does not seem to have been assessed as a potential impact of an assault.

8.4 The following day in late January a further strategy discussion was convened as Samara had presented at the hospital with vaginal bleeding and abdominal pains. She confirmed she was taken to a hotel by a male, and they had sexual intercourse. She stated she was scared. CSC carried out S47 enquires, and the outcome was that concerns were substantiated however Samara was judged not to be at continuing risk of significant harm as this was an isolated incident and her parents were deemed to be protective.

8.5 Information was shared with the hospital about the possible assault and a forensic medical was agreed via a strategy discussion between the police and a paediatric consultant. However, there was no longer an 'out of hours' service available who could carry out the medical, so arrangements were made with West Yorkshire Sexual Assault Referral Centre (SARC) to carry it out the following day. This meant that there was a 48-hour delay in gathering forensic evidence.

8.6 The forensic examination took place as planned however there was no STI screening carried out which meant that Samara had to undergo a further invasive medical procedure at a later date. The forensic medical records were incomplete and stated that a referral had been made for STI screening. This referral was not within the records and there is no documentation of the results of the STI screening, although the paediatrician has confirmed it did take place. The records also state that a safeguarding referral has been completed but this is also not available in the paper records. In addition, a CSE risk assessment was not completed. A GP notification letter was completed however there is no evidence that this was sent to or received by the GP surgery.

8.7 On the same day the suspect was arrested by GMP officers and brought to a Bradford police station where he was interviewed in the presence of a solicitor. Samara positively identified him via video, and he was then charged with rape. He was remanded in custody.

8.8 Later in January a multi-agency decision was made to reduce Samara's CSE risk from high to medium although there is no information to detail the rationale for this decision.

8.9 Throughout January and February 2017 the police investigation progressed. Samara underwent the STI screening in the first week in February and was given Hepatitis B immunisation. It was noted that Samara was overweight. A specialist health practitioner (SHP) agreed to work with Samara and her mother to offer support in respect of the rape and for weight management.

8.10 At a home visit with Samara the SHP recorded Samara "*reports worsening nightmares more frequently- bedwetting is more frequent with the build up to the court appearance Not attending school this week. Feels increasingly scared that perpetrator or someone else will come and get her or do something to her increasing. General anxiousness within family that Samara will be taken into care. Dad and brothers telling mum not to talk to us as it will make it worse. Spoke to family to ensure they understood process of CSC assessment and what all police statements were and that it is important to talk to professionals and to support not blame one another*". Samara was not attending school during this period.

8.11 CSC carried out a single agency assessment at this time. There was no mention of the outcome off the medical, Visual Recorded Interview (VRI) or the on-going police investigation in the single assessment. There appeared to be a support plan in place for Samara but there was no timescale as to when the work would take place and when it should be completed. It was also unclear as to who is responsible for carrying out some of the tasks.

8.12 In late February the SHP carried out a further home visit and recorded that Samara had returned to school and her anxiety was lessening. Samara's father requested help with some forms and went on to discuss difficulties and deterioration with his own mood and sleeping. The SHP also noted that she would speak to Samara's mother's GP about her low mood.

8.13 On the same day Samara's mother reported that father had visited (they lived in separate houses) swearing and being very aggressive towards her waking up Samara. He blamed Samara's mother 'for everything'. She denied any physical violence but agreed that this was domestic abuse and agreed to a referral to Staying Put for support.

8.14 Father disclosed that 'things had got too much for him' and was found at home by his sons to be incoherent and confused, he attended A&E and was admitted overnight for observation.

8.15 In the first week of March a CSE risk assessment was completed and discussed at the MASH CSE meeting. It was agreed by all professionals that Samara's risk had been reduced from high to medium too soon (4 days after the incident) based on the serious nature of the incident and because CSE work had not been started at the time of the initial professional planning meeting. Information was also shared by the police that Samara was or had been in contact with other older men therefore her risk assessment was returned to 'high'.

8.16 On the same day the suspect had his first appearance in court and the police informed Samara and her family.

8.17 Throughout March the police kept Samara and her family updated about the court proceedings and in the third week in March the suspect was known to intend to plead not guilty.

8.18 During the same time period the SHP continued to offer support to Samara and noted that she felt that Samara was 'holding back' and 'reluctant to talk about her feelings'. She also noted that her mother was waiting for counselling. By the last week in March, she recorded "*Home Situation unchanged, Samara and mum concerned about the trial, Samara still not talking openly about feelings. Still having nightmares and wetting the bed. Mum has asked dad to give her some space spending less time at house but still sees his children*".

8.19 In early April the SHP during a visit to Samara at school recorded that Samara was concerned about trial and upset as her brothers were constantly questioning and blaming her for what happened. A police officer was also present at the visit and agreed to take Samara to court a few weeks before the trial in order to try and lessen her anxiety. The officer also visited the family home and spoke to Samara's brothers and asked them to stop asking her questions and to support her. Her school had allocated a member of staff to support Samara.

8.20 Throughout April 2017 Samara continued to receive support from a social worker and the SHP. It was noted that she was on the waiting list for the Alma Project (now the CALM project).

8.21 In May 2017 a CIN meeting took place, and it was agreed that Samara should remain on a CIN plan.

8.22 In June 2017 a multi-agency pre-trial planning meeting took place, and it was agreed that the Alma Project and CAMHS would provide support to Samara after the trial.

8.23 In late June Samara's school recorded that she was stressed and suffering from nightmares as the trial date neared and they emailed the MASH to ask what additional support was available for her. In response to this the CSE police officer who had supported Samara since the incident spoke to Samara and co-ordinated support for her from CAMHS and the SHP.

8.24 During July the trial took place and Samara, and her mother gave evidence. Three days later the defendant was found not guilty. The SHP records that "*Samara was distraught the outcome of court case today and very tearful She feels that no one will believe anything she says now and is scared the suspect will "come and get her" Reassured that a sexual harm prevention order was granted- denied any thoughts to harm herself, no previous history of self-harm. Agreed to contact Alma Street project to arrange starting the work with them*".

8.25 Later in July Samara sustained an injury to her hand after punching a wall. She explained that this was as a result of her emotional distress. The SHP continued to support her and monitor her emotional health. The SHP offered and Samara agreed to education work around CSE, grooming and internet safety. Samara stated that she missed her phone. The SHP discussed the conversations with other males online. Samara stated that she was only chatting and in general conversation, never anything sexual and it wasn't until she had phone contact with the perpetrator that it changed to a threatening nature resulting in her agreeing to meeting up as she was scared of what would happen if she refused.

8.26 Later in July Samara informed the SHP that she had told the defendant where she and her mother lived, and she was now scared to go home (she was staying with a brother at this point). She had not told her family what she had done and was also afraid of their reaction. The SHP passed this information on to the police who visited Samara's mother at her home. Samara's mother and brothers stated that they felt safe and there was no information to suggest that the defendant would try and contact them.

8.27 During the last week of July, the SHP visited Samara and noted that Samara "*is feeling a little more accepting of events. Upset by comments in the local newspaper reassured. Police have discussed a panic alarm being fitted; Samara felt she would feel safe enough to return home once this was in place to liaise with police*".

8.28 Also during that week, a High Risk CSE meeting took place it was noted that Samara was about to start work with Alma Street project and possibly individual work with CAMHS. It was also noted that Samara "*continues to exhibit trauma response symptoms".*

8.29 In August Samara reported that she was still too afraid to return home.

8.30 Also in August following a CSE risk assessment a multi-agency decision was made to reduce Samara's risk of CSE to medium.

8.31 Throughout August the SHP continued to support Samara and her family. Samara had returned home and stated that her nightmares had returned, and she felt unsafe. She also said that she did not want to return to school as everyone would be talking about her.

8.32 During the second week in September Samara's school raised concerns about her wellbeing with the SHP will refer for EHDR (desensitisation therapy for PTSD). School advised by the SHP that pupil's behaviour is entirely normal.

8.33 In mid -September a further CIN meeting took place, and it was agreed that Samara should remain on a CIN plan.

8.34 In early October 2017 Samara attended the accident and emergency department with an injury to her wrist which she said had been caused by being pushed accidentally into a wall at school. AED staff explored bullying with Samara and family

but were assured that the incident was accidental and contacted CSC EDT at time of admission. A child protection flag and CSE flag in place on electronic patient record prompted AED staff to alert safeguarding children's team of Samara's attendance and the safeguarding team liaised with the social worker, MASH and school nurses.

8.35 In mid-October a further CSE risk assessment was completed, and Samara's risk was reduced to low after discussion at a MASH CSE meeting. A day later during a case discussion meeting the SHP who was not present at the MASH meeting stated her disagreement with the reduction in risk. She summarised that Samara had not completed any work to enable her to understand grooming and exploitation and how to keep herself safe. The Alma Street Project had closed the case as they felt that it was not the right time to complete the therapeutic work and suggested some work for the SHP to complete with her. CAMHS were about to start EMDR. In other words, no therapeutic or CSE specific work had yet been completed.

8.36 Furthermore, the SHP stated that "*whilst Samara's parents were acting protectively Samara did not associate with any friends outside of school, she did not go anywhere on her own as she was scared of being alone, she was still sleeping in her mother's bedroom for the same reason. The defendant was back in the community and knew where she lived. She has no access to a phone or the internet and feels socially isolated as she used to have contact via phone and messaging with her friends outside of school. Her parents had disengaged from direct work with CAMHS in respect of the exploitation following the outcome of the court case as they did not feel it was worth doing anymore. Samara's mother had reluctantly agreed to look at completing that work which entails understanding the recovery process and how to support Samara appropriately".*

8.37 The SHP summarised that "*In order to reduce her risk Samara needed to complete direct work around CSE and grooming and keeping safe from a specialist CSE service, complete therapeutic work to aid recovery from the sexual abuse experienced and parents to complete the education and awareness work with CAMHS in order to effectively protect and support Samara. Clear Safety plans need to be agreed with the family and Samara to support and protect her in all situations and enable her to live a fulfilling life like other 13-year-olds".*

8.38 In mid- November 2017 CSC records indicate that the case was closed however no case closing meeting took place and there is no information detailing the rationale for the decision. It is therefore not clear what direct work had taken place with Samara in respect of CSE.

8.39 On the same day a police entry records that "*The case of the above-named individual has been carefully considered by the Modern Slavery and Human Trafficking Unit (MSHTU) Competent Authority. As a result of further investigations into the case, the MSHTU Competent Authority has concluded that the above individual is a victim of modern slavery".* There is no record of how or if Samara was informed of this or of her reaction to it.

8.40 In mid- February 2018 Samara's mother contacted the SHP to say the family were in Cambridgeshire visiting family and Samara went missing at 10pm the night before. This had been reported to the police. Samara had cleared her wardrobe and taken bags with her. Her brother found that she had downloaded Instagram a couple of weeks earlier. A strategy discussion was convened, and a decision made to increase Samara's CSE risk to high immediately. Samara was aged 13 at this point.

8.41 Contact was made with Cambridgeshire police and a police Joint Investigation Team officer and a CSE SW were to be allocated to update risk assessment and complete any actions from section 47 investigation completed by Cambridgeshire CSC.

8.42 Samara's school were informed that Samara was missing (during school holidays) a member of staff accessed information about pupil's friendship groups securely from home and shared Information with the SHP, Cambridgeshire Police and the MASH. Police conducted home visits using information provided and liaised with **** until Samara was located.

8.43 Over the next few days it transpired that Samara had been in contact with two males; one of whom was a friend of her brothers and known to the police as being involved in CSE. Samara had been asking for money from her parents and friend and had been using a mobile phone taken from her grandmother's house. This phone had been locked since the previous year. Samara's diary was found and contained further details including phone numbers of the two males. The diary and mobile phone were seized by WYP and collected by Cambridgeshire police who had arrested one of the males.

8.44 By the third week in February it was believed that Samara was in the Bradford area and a second male was arrested on suspicion of abduction.

8.45 On 21st February 2018, a CSC record indicates that a strategy discussion was held with Cambridgeshire CSC & Cambridgeshire Police. Samara had been found in a hotel room in Birmingham in bed with an adult male. There was another male who has collected her and brought her to Birmingham. Both of these males have been arrested and were being held for questioning. Samara was made subject of a PPO.

8.46 The outcome of strategy discussion was that Cambridgeshire police were to continue their investigations. Samara was to be accompanied to ****** Cambridgeshire SARC for a medical by the allocated police officer and her mother. It was agreed that there was no necessity for a Cambridgeshire SW to attend. Bradford CSC were happy for Samara to return home and the PPO to be removed unless she disclosed something during the investigation which would give rise to concerns about parenting capacity to safeguard.

8.47 It was agreed that the allocated SW in Bradford would forward all relevant contact details for professionals in Bradford to professionals in Cambridgeshire. Cambridgeshire police and CSC would give updates to Bradford as and when necessary, in relation to the investigation and any significant changes such as when

the family are returning to Bradford. It was also agreed that Cambridgeshire police would carry out S47 enquiries.

8.48 The ***** Cambridgeshire SARC medical records are incomplete in respect of Samara's attendance for a forensic medical. The medical was not carried out fully and there is no record of why this was the case. There also appears to have been confusion and delay caused by the medical examiner running late and asking a colleague to carry out the medical. The medical examiner telephoned a consultant to ask for advice as Samara had stated that she was too exhausted to have the medical. Again, the records were incomplete and there was no detail of the outcome of the discussion. However, a second appointment was made for Samara the following day.

8.49 Also the following day the SHP recorded that "*Mum said she understood Samara feeling like that she didn't want to return as she would be scared of what family will say to her now as she was like this last year after January incident and after the court case*."

8.50 Over the course of 4 days in late February the SHP recorded her contacts with Samara and her family. She records that Samara's mother was "*Very distressed and clearly confused by Samara's actions. She doesn't understand the process of grooming and impact on victims and is struggling to take on some of the things that Samara is saying. Happy for Samara to be at brothers but feels it is a lot of pressure on them*".

8.51 Samara was recorded as "*Confused about the whole situation and didn't really understand how she felt or what she thought about it all. She talked about the male that was arrested and that she didn't see him as a bad guy and that he looked after her, came and saw her and brought her food until he did what he wanted to do with her. I asked how her sleep had been in relation to previous nightmares and bedwetting and she said she had had nightmares the night before she was interviewed and during the interview, she had flashbacks".*

8.52 A further SHP record states *"Saw Samara at brother's house, she looked well and was pleased to see me. She remains hesitant to share information about the events and what led up to her going missing. She talked about difficult relationships at home with her brothers constant questioning of her and her sister not really talking to her at all. She has thought about running away for a while but didn't give any information about the contact with the males. Her account does contradict to some extent what the police have discovered through their investigations. She said she had only had a phone since the day they broke up for half term and denied accessing the internet/websites or any apps. Mum is doing ok and is pleased Samara is safe. She is still struggling to understand why Samara did what she did and to deal with her own thoughts and feelings regarding this*"?

8.53 On 28th February, a CS note records that a follow up strategy meeting took place. Cambridgeshire CSC failed to undertake S47 enquiries as agreed in their strategy

discussion, Bradford CSC therefore carried out the enquiries. This was obviously not within timescales.

8.54 Also on 28th February a police officer emailed the healthcare provider to advise that this was a suspected CSE case but following an investigation it does not appear so. The email stated that Samara had "*put herself in risky scenarios, contacting men through dating sites, purporting to be 20+ years old. She does not appear to have been groomed or offered drugs/alcohol to gain compliance. She has then been offended against sexually once she has met them by virtue of her age*". This meant that Samara did not meet the criteria for referral to NSPCC or Link to Change as the case must involve CSE. It is of note that the Forensic Nurse Examiner had identified Samara as being at high risk of CSE.

8.55 During the second week in March 2018 the Section 47 enquiries were completed by Bradford CSC, and it was found that concerns were substantiated, and Samara was judged to be at continued risk of significant harm. It was noted that Samara had decided she was not going to return to Bradford, and she stayed with her brother and sister-in law in Cambridgeshire with her parent's consent. A decision was made for Cambridgeshire and Bradford CSC to complete a Child and Family assessment. The assessment was completed by the first week in April it was recorded that Samara was a victim of Human Trafficking for the purpose of sexual exploitation. Samara disclosed that she had been in contact with 6 different males whilst she was missing for a period of 6 days.

8.56 In the second week of April WYP removed Samara's CSE 'flag' which did not reflect the possibility that she might return to Bradford. (When an officer creates a CSE flag on the local WYP computer system, the officer also requests a marker to be put on the Police National Computer).

8.57 Also during that week the SHP transferred Samara's care to the Cambridgeshire health provider. The provider contacted the SHP two weeks later to report a missing episode which had happened in February and also Samara's 'substance misuse'.

8.58 In the second week of May 2018 Samara had invited a male over to her brother's house at 2 am when her brother was at work. An ICPCC was held in Cambridgeshire and Samara was made subject of a Child Protection Plan under the category of sexual abuse.

8.59 Samara returned to her father's house in Bradford 4 days later as this was felt by her parents to be the safest place for her.

8.60 During the first week in June the SHP visited Samara at her father's home. She recorded that "*Samara seen alone and was honest and open about the time she was missing from Cambridgeshire. Whilst in the hotels with the males she talked about not eating food very much but drinking juice and pop and that when she was with the last male for the 3-day period before she was found, his friend (an adult Asian male) came in a car and into the room. She does not know his name but said she remembers what he looked like. She said he gave her a clear drink to drink which*

she did, she didn't know what it was but believes it was vodka from discussion she had with her sister-in-law later. She said it burnt the back of her throat. She said she was also given a white powder which she sniffed, she believed this to be cocaine. She then can't really remember what happened after that but remembers waking up. I asked if she had told anyone this information before and she said she hadn't, she said the police had asked in interview about drugs and alcohol but couldn't tell them "Stuff like that". She said she has never had alcohol or drugs before. She talked about family relationships and how she feels they are disowning her because of what she has done. She became upset and tearful whilst talking. She said her brothers will not speak to her".

8.61 On 12th June 2018 a transfer of case took place and Samara was made subject to a CPP in Bradford under the category of sexual abuse. Present were a SW from Cambridgeshire, SW Bradford, a teacher from School 2, a school nurse, CAMHS, Samara's mother and Samara. Information was shared that Samara had sought the company of males on line by using her brother's smart phone. This had happened a few times the last being the day before the ICPCC and it was believed that Samara would continue this behaviour in Bradford. It was felt that she did not fully understand the implications of her behaviour and the risks she was placing herself in. A full cognitive assessment was to be carried out by CAMHS to determine Samara's understanding of what had happened to her.

8.62 The SHP continued to support Samara and her case records indicate Samara's openness and willingness to confide in her. She also documents her growing concerns about the family relationships. Samara's brothers in particular held Samara responsible for what had happened to her. Samara was spending most of her time in her room at her father's house. The SHP felt that Samara was beginning to show insight into why she had sought out the males. She was keen to get back to school but was worried as she had missed six months. The SHP shared information regarding the missing episode in relation to drug and alcohol given by the males with the police. She also referred her to the trafficking group at Turnaround (Barnado's service).

8.63 The SHP planned a sexual health education session and arranged follow up sexual health appointment for Samara. She noted that Samara did not have a lot of knowledge about sexual health.

8.64 In late August a CP review took place and it was agreed that Samara should remain on a CPP. There were no further core group recorded on the CSC system since June 2018 and only two home visits took place in July and August 2018 - both out of timescales.

8.65 During the last week in September the SHP emailed the SW to raise her concerns about a break down in family relationships; "*She is left alone most of the time in her room and is not being constantly watched, challenged or asked to do things like she felt was happening at mum's home. Concerns that dad does not talk about what has happened and has no understanding of CSE and grooming and feels that locking the door and keeping her in the house is keeping her safe and allowing her to build trust*

again. Samara currently has no access to the internet or a phone unless she uses mum or dads' phone with them watching her. She has stated that if she is made to go back to live at mums' home she will run away again. Schools offered for Samara, but dad seemed reluctant to agree to her choice because of her previous Instagram account. Samara became hysterical screaming and shouting and crying saying they were lying and that they just didn't want her to go to school, Dad basically asked me to go and see the brothers and find out what the problem was.

8.66 The brothers talked very openly with me about how they feel about everything that has gone on. They believe Samara is responsible for everything and she has made contact with the males asking for sex and that she will do it again if she has the opportunity. Tried to discuss the impact of grooming and CSE on a young person but they were still of the opinion that Samara was to blame. They said she was obsessed with males, and she shouldn't be anywhere near them.
They admitted they had called her a slag and "all the names under the sun" they said they do not want any contact with her and she is not allowed in the house if they are there. They spoke about incidents last year that had not been reported to us".

8.67 The incidents included Samara stealing her mother's mobile phone and meeting with a male outside a park. The SHP reviewed the CPP "*I can see no evidence of any work that has been completed by BPP or any progress towards completing actions identified in the CP plan. I feel that other agencies are not working with this family as agreed in the CP review meeting and core group. It feels at the moment as though the approach to risk management is not joined up and that I am raising concerns that are not being heard and responded to appropriately"*.

8.68 The SHP then outlined what she believed needed to happen "*Strategy discussion to be completed regarding historic incident of meeting and talking to an adult male in the park are outside the home. Work to be completed with the family ASAP in particular with dad to address breakdown of relationships and negative language and behaviour towards Samara and improve understanding of CSE & grooming and the impact of sexual abuse. Further assessment of parent's ability to protect Samara. Samara to be in education as soon as possible*".

8.69 A single agency assessment was completed by the allocated SW in late November and the outcome was that Be Positive Pathways (BPP) were to undertake one to one work with brother and parents and the SW would have one to one session with Samara. Core group meetings were to be held every four weeks and the CSE risk assessment was to be updated.

8.70 In early January 2019 a multi-agency CSE planning meeting took place and the CSE risk to Samara was reduced to medium. It was reported that she was engaging in therapeutic work and had settled well into her new school.

8.71 By February Samara had been given a mobile phone by her father who was monitoring her use of it. The SHP recorded continuing concerns about Samara's relationship with her brother. By mid-March the SHP recorded "*Concerns that Samara has talked about a male who allegedly goes to ** school that she has been*

talking to; she knows him through her friend. Mum is worried and believes she is deleting things from her phone. Dad up until now has not really been checking her phone as was agreed, mum has told him he must check it. Agreed to discuss with colleagues re management.

8.72 The SHP also recorded that "*BPP have completed work around CSE with mum, dad and Samara all said it has been useful and they feel they now have a better understanding of CSE and grooming. Concern raised by me that the brothers have not completed any work yet, and although they are now ok with Samara going to the house it is not clear that they have changed their opinion that Samara is responsible Clear plan agreed with parents that dad must check her phone randomly to ensure there is nothing concerning on it and Samara should leave her door open when having conversations on the phone so as not to hide anything from dad or mum. SHP to try and complete work with the brothers as there is already a relatively good relationship with them*".

8.73 In early May 2019 Samara's CPP ended and CIN arrangements were agreed. It was noted that "*BPP ended their involvement before completing all work. An updated report of work completed had not been provided. Most work has been completed with Samara and the family. Work is still outstanding with her brothers on their understanding of CSE, their relationship with Samara and them blaming her. It is unclear if they will engage with this work. It was noted that regular core groups and Social Work visits have been taking place. There have been no incidents of Samara putting herself at risk during the review period. The CSE risk assessment has been reviewed and Samara remains at medium risk. This will continue to be reviewed regularly*".

8.74 In July 2019 Samara's CSE risk was reduced to low as there had been no further concerns and the case was closed.

9.0 Key Themes Samara

9.1 A striking difference between Samara and the other children's cases was the involvement of her family with agencies at a very early stage. Her parents had recognised the warning signs for CSE, such as changes in Samara's behaviour; staying out late and being evasive about who she was meeting and her use of a mobile phone to contact a number of men and they reported their concerns to the police.

9.2 What is also documented is the impact of this on Samara's parent's already troubled mental health. It was also apparent that they and Samara's brothers initially believed that she was responsible for the CSE. This understandably caused Samara further distress.

9.3 A further striking difference between Samara and the other children's cases is the consistent relationship Samara and her family had with the SHP whose commitment and holistic understanding of the issues Samara was coping with (especially those within her own family) meant that Samara's voice was heard and understood. The

SHP was able to use professional challenge effectively and did so on three occasions. Of particular note was the occasion in September 2018 upon which the SHP challenged agencies who had been tasked with actions in Samara's CPP and had not started/ progressed these.

9.4 The SHP's excellent record keeping enabled the independent reviewer and author of this report to understand Samara's vulnerabilities and the ongoing distress caused by her family's response to the CSE.

9.5 Samara also received a speedy and pro-active response from the police and consistent support from the police officer allocated to her leading up to the trial of the first suspect. The officer demonstrated similar understanding of Samara's needs and her family context and responded accordingly.

9.6 Similarly, Samara's first school provided sensitive support and valuable information to the police and other agencies when Samara went missing in Cambridgeshire.

9.7 There were, however, some instances when Samara was not supported well and her experiences of undergoing forensic medicals followed by STI screening was one of these. The record keeping by the company providing this service was incomplete and therefore fell below expected standards.

9.8 It is also of note that professionals including the SHP and a police officer described Samara's behaviour as 'putting herself at risk' or 'putting herself in risky scenarios. Samara was quite clearly an extremely vulnerable 12-year-old child whose understanding of sex, relationships, exploitation and risk was appropriate to her age. She could not therefore assess risk to herself and continued to believe that one of the men 'had been nice to her' because he had brought her food and drink. The SHP identified that Samara felt unloved and was seeking affection from the adult males. This was exploited by the older men, and it was this that led to Samara being sexually and physically abused.

9.9 The judgement made and shared by a police officer that Samara had not been sexually exploited but had encouraged the men and lied about her age had a direct impact on Samara as it influenced what services she was referred to by ***** healthcare providers in 2018. Whilst Samara had lied about her age, and this would have impacted on the possibility of a successful prosecution the phrases used by the police officer to relate this could have influenced how Samara was responded to or imply that she was to blame for what happened to her.

9.10 The confusion regarding who would undertake S47 enquiries between WYP and Cambridgeshire police led to a delay in these being carried out and it is unclear why this confusion occurred.

9.11 In summary, whilst there were no significant or prolific concerns about how agencies worked together to safeguard Samara the author of this report considers that without the challenge of the SHP this might not always have been the case.

9.12 Despite the examples of good practice and swift agency responses described above there was a delay in providing Samara with therapeutic interventions which may have contributed to her going missing in Cambridgeshire as, at that stage, she did not recognise that she was being exploited. Samara suffered significant harm and was trafficked, raped and sexually exploited. This was compounded by the not guilty verdict and her family's response caused her further distress.

9.13 There may well still be learning from Samara's case about the 'cultural' response of family and community to CSE and TBP and partners may wish to focus upon this in their plans following this review.

Case 4 -Ruby

10.0 Brief Background

10.1 The review considered events between May 2001 and May 2019

10.2 Ruby is now aged 18 and is a 'care leaver'. Her parents separated when she was aged three and at the age of five, when living with her father and stepmother, Ruby experienced the sudden death of her mother.

10.3 Records indicate that Ruby experienced difficulties in reception class and at primary school where her behaviour was described as difficult and this was thought, at the time, to be due to her bereavement. She moved schools but her behaviours continued, becoming more apparent in secondary school and leading to a number of fixed term exclusions. Concerns related to her behaviour but there were also concerns about possible sexual exploitation and she was linked to two different known sex offenders.

10.4 In 2014 Ruby was diagnosed as having a disorder which gave context to some of her behavioural difficulties. Ruby was also assessed as having a borderline learning difficulty and ADHD.

10.5 She became a looked after child in 2015 after her father and stepmother said they could no longer cope with her behaviour. After becoming looked after Ruby was placed in 14 different placements and all but 3 of these have been out of the Bradford area. In all her placements, other than those that provided a secure environment, there have been significant issues regarding Ruby going missing and her vulnerability to exploitation. Ruby was placed in 2 different 'Secure' placements, 8 months in a Secure Children's Home under Secure (welfare) criteria, and 6 months in a Mental Health Hospital under Mental Health criteria.

10.6 Ruby has also prolifically self-harmed and has required hospital admissions and general anaesthesia on occasions. The most serious incidents of self-harm have been focused on her genitals.

10.7 Ruby has also been described as threatening and aggressive towards staff within her placements at times.

11.0 Key Practice and other Events

11.1 Ruby's vulnerability to CSE was first recorded in October 2014 when she was linked to a suspected sex offender. It is not clear from agency records that this led to a CSE assessment or what work was done with Ruby in respect of this. WYP records show a police CSE occurrence was recorded and that she was working with 'Turnaround' and an allocated social worker after this. She was linked to a different suspected sex offender in January 2015. Nine missing from home episodes were recorded between March 2013 and May 2015.

11.2 Ruby became a child looked after in March 2015.

11.3 Ruby experienced an unsettled school life and was permanently excluded from her secondary school in 2014. In May 2014 she joined a Special School (SEMH) in Bradford where she remained for 12 months.

11.4 In July 2015 a CSE Risk assessment was completed. Ruby was assessed as at 'medium risk.' This was 9 months after the first recording of a link to a suspected sex offender. This assessment was reduced to 'low risk' in December 2017.

11.5 In August 2018 Ruby returned to Bradford from an out of area placement and was placed in a local supported accommodation placement. Within days there were episodes when Ruby went missing and there was also an increasing number of self-harm incidents which required hospital admissions. Throughout August 2018 her distress continued and she frequently self-harmed and went missing.

11.6 Staff at the placement told the police following one incident where Ruby had threatened a staff member that Ruby was not getting the help she needed and that they were not able to meet her needs.

11.7 Concerns were raised by hospital staff about the appropriateness of the placement staff's behaviour when they accompanied Ruby to hospital when she was admitted for an infection, and they refused to sit with her in case they caught her infection.

11.8 In August 2018 a strategy meeting was held, and the placement gave seven days' notice to end Ruby's placement due to her behaviour. The strategy meeting focused on Ruby's difficult behaviours and the issue of finding a placement for her rather than her distress. There was no discussion of the CSE risk to Ruby or her increasing levels of distress and the nature of her self-harming.

11.9 Over the next three days Ruby went missing a further three times and the police recorded concerns that she was at risk of CSE as she reported having met 'friends' from Northampton and Leeds but would not say who these people were.

11.10 In early September Ruby met with a 47-year-old man that she had met online. She described being abducted and sexually assaulted by the man who also threatened to kill her. The police issued the suspect with a Child Abduction Warning Notice (CAWN) and informed CSC and the CSE MASH for consideration of a 'CSE Flag'

against Ruby's name. The offence was investigated but there was insufficient evidence to charge.

11.11 Throughout September 2018 it is recorded in agency chronologies that:

- Ruby met with a 32-year-old male with whom she shared alcohol and cigarettes,
- She was admitted to hospital after taking medications given to her by a male,
- Had pregnancy tests (negative) following unprotected sex,
- Had said she will travel to Afghanistan on a false passport to enter into a marriage.
- Numerous missing episodes.

11.12 In late September 2018 Ruby's social worker responded to an email contact from WYP which highlighted concerns about CSE, and the response was that the SW was not aware of Ruby meeting with a 47-year-old male and that it was her belief that Ruby was not at risk of CSE.

11.13 In early October the manager of the placement in Bradford told a police officer that Ruby had been raped but she was 'not sure if she should mention it'. The police recorded a crime and investigated but Ruby was unwilling to provide an evidential account. A suspect was interviewed, but there was insufficient evidence to charge.

11.14 Later in October Ruby was discussed at the CSE meeting as the police had received an Information Report that she was being picked up by a male who had just been released from prison, on licence managed by Probation and flagged as a MARAC Offender with a history of befriending vulnerable young people and engaging in abusive behaviour.

11.15 In mid-October the police located Ruby who had been reported missing by the placement. She was described as being very quiet and stated that she had been in car with two males and that they had dropped her off at a shopping centre.

11.16 On the same day a Strategy Discussion initiated by the police took place. The Strategy Discussion recorded that the risks to Ruby "*are escalating. She is said to be getting into cars with unknown males and has recently reported a rape by one of her peers. Her mental health remains un-assessed and she continues to place herself at risk of injury by serious self-ham. There are no new lines of enquiry which would warrant triggering S47 enquiries however, the evidence suggests that Ruby is actively being sexually exploited by person or persons unknown. We do not feel confident that she always has the ability to give informed consent to sexual activity as her mental health fluctuates*."

11.17 The following day WYP placed a 'High Risk CSE' flag against Ruby's name. Within three days WYP received information that Ruby had been taken to a different area for the purposes of sexual exploitation.

11.18 In late October 2018 Ruby, whilst having a medical in respect of an alleged rape, disclosed a further rape. The following day Ruby was reassessed by CSC as being at high risk of CSE using a formal CSE Risk Assessment.

11.19 Also in late October 2018 WYP used the West Yorkshire Safeguarding Consortium Escalation procedure to resolve professional disagreement about safeguarding Ruby between Police and CSC. This involved a Safeguarding Review of Ruby's case by a Detective Inspector (DI). The DI records "*I have recommended that the current care plan is insufficient for Ruby, *** the private provider is not keeping her safe, CAHMS intervention is not working and BD social care are not keeping her safe effectively and consistently and due to her mental health concerns there are serious concerns that she may self-harm. She has complex mental health problems, learning disabilities and has been previously sectioned and placed in secure accommodation. Firm and positive action is requested from social care, and this has been reviewed at professional planning meetings and a further meeting requested to escalate the risk with CSC has been delayed by them. This case has now been escalated for urgent review and intervention by senior BD CSC management. Current CSE investigations are ongoing also at this time stemming from missing occurrences, The CSE team are managing this young person as a high risk CSE victim with a firm risk management and plan in place. My firm recommendation to CSC is that she is placed into a secure unit or at the very least removed from **** placement and put into a 2-1 therapeutic placement to protect her and effectively safeguard this is being escalated and previously requests have been declined, escalation of this to senior management from BD social care on 26/10.*

She was missing 12 times in the last 3 weeks but there have been over 22 calls for service for Ruby in October alone. This has been raised and taken up with the home. A professionals meeting was held last week with SW, CAHMS and the home, further one was requested this week and has been put back by CSC to next Monday."

11.20 During a week in late October Ruby went missing four times and reported to the police that she had been raped (this was her third allegation of rape). She also reported having got into a car with a male who told her he would buy some cannabis. Ruby reported that she left the car and did not return.

11.21 On a date in late October 2018 Ruby was detained by WYP under S136 of the Mental Health Act having been found with shards of glass and tin in her possession. Ruby was later discharged from hospital.

11.22 In early November 2018, following a Team around the Child (TAC) meeting, Ruby was referred by CSC to the Barnardo's CSE Service.

11.23 Also in early November Ruby was found by the police after going missing and she reported that she had been met by older males who brought her alcohol and drove her around in their vehicles. Ruby had broken glass, a condom, a lighter and £10 cash in her pocket. Within two days Ruby was again found by the police and was intoxicated and stated that she had been given drugs by people whose cars she had got into.

11.24 In mid- November 2018 Ruby disclosed to health practitioners that she had been raped after being picked up by two males in a car outside the placement address.

11.25 Also in mid-November 2018 the Barnardo's CSE Worker met with Ruby for the first time and reported that Ruby engaged well. Throughout the rest of November 2018 Ruby:

- went missing ten times.
- was picked up by men in cars.
- was found to have £750 cash in her possession and told different stories about how she had acquired it.
- was taken to a flat with three men.
- was found semi-conscious and drunk in the street.
- was admitted to hospital with an acute infection. (Whilst Ruby was an inpatient the placement staff reported that she had been visited by a male who was supplying her with drugs and 'prostituting her'. This information was not shared with CSC).
- Missed two cognitive assessment appointments with CAMHS (possibly as she was an inpatient at that time)

11.26 In late November 2018 the police took Ruby in to police protection for her own safety.

11.27 Practitioners attended TAC meetings and a new out of area placement for Ruby was discussed as was cognitive testing in relation to Ruby's learning difficulties.

11.28 In early December 2018 WYP record that they had again raised concerns about Ruby's safety and specifically the suitability of her placement with CSC.

11.29 Throughout December 2018 Ruby continued to go missing, continued to self-harm, was taking various drugs, and reported having sex with men in exchange for drugs and money.

11.30 By late December the police issued CAWNS to four men suspected of harbouring Ruby.

11.31 In the last week in December 2018 Ruby reported that she had been sexually assaulted by a man in a car. She later denied this.

11.32 In late December 2018 Ruby was arrested and charged with causing criminal damage at the placement. She was held in custody where she reported that she had been sexually assaulted the evening before.

11.33 On 1st January 2019 WYP escalated their concerns to Senior Management at CSC for the second time using the West Yorkshire Safeguarding Consortium Escalation procedures.

11.34 In the second week in January 2019 a TAC meeting was held, and it was recorded that Ruby was now dressing in Muslim clothing and talking of getting married and

going to Afghanistan. It was noted that CSC planned to move her out of area by the end of the month and planned to remove her mobile phone. Due to the level of concern an urgent strategy meeting was convened.

11.35 By mid-January 2019 it was recognised that the grooming and exploitation Ruby was subject to also met the definitions of *Modern Slavery as it was believed that she was being groomed and trafficked by unknown / unidentified persons for the purpose of sexual abuse.
* The Modern Slavery Act 2015 is designed to tackle slavery in the UK and consolidates previous offences relating to trafficking and slavery. Slavery/Trafficking involves the exploitation of people/children who are coerced, deceived, forced into, or expected to accept, a life of abuse, servitude or inhumane and degrading treatment.

11.36 In the third week in January Ruby was moved out of area to a different placement where she remained until March 2019. It was noted that she continued to self-harm, go missing, be aggressive towards staff and be sexually exploited and abused.

11.37 In March 2019 Ruby returned to Bradford where she was placed in three different placements within 6 days. Throughout March 2019 Ruby continued to self-harm and was further sexually assaulted and exploited.

11.38 In Ruby's case every allegation was recorded and investigated by WYP.

11.39 In April 2019 Ruby reached the age of 18.

12.0 Key Themes Ruby

12.1 The root cause of Ruby's early behavioural and emotional difficulties may well be a combination of the separation from and subsequent sudden loss of her mother, the physical and cognitive impacts of a chromosomal disorder, a diagnosis of ADHD, and the fractured relationship with her father, stepmother and half sibling.

12.2 There was an almost exclusive focus by CSC and the placement staff on Ruby's behaviour and the impact of this on residential placement staff at a critical time for Ruby (huge escalation in risk and harm from CSE) rather than a focus on Ruby's behaviour as a manifestation of distress or as a symptom of sexual exploitation.

12.3 Despite evidence of increasing risk there was no assessment or recognition of Ruby's vulnerability to CSE by her SW who perceived Ruby as low risk. (September 2018)

12.4 There were professional disputes between the police and CSC in respect of the risk to Ruby and the ability of her placement to keep her safe. The police recognised the risk to her and also the unsuitability of her placement.

12.5 Ruby moved placements 14 times and the scarcity of suitable placements locally was noted by practitioners. Her move out of area did not keep her safe and in fact, the area to which she moved has higher than average reported CSE rates than the rest of the country.

12.6 Ruby had a number of fixed term and a final permanent exclusion from school and suffered a disruptive education journey which further compounded her vulnerability and isolation.

12.7 Ruby began to dress in 'Muslim clothing' in January 2019 and talked about getting married and moving to Afghanistan. It is not clear from agency records at that point in time how this was responded to. This does not appear to have been assessed as a sign of grooming or exploitation or to have triggered Prevent: Protecting children from radicalisation strategies.

12.8 At this point in time Ruby has a diagnosis of ADHD, a chromosomal disorder and specific learning difficulties and her understanding of her world and her life experiences are not always consistent with her age. "***She is an eight-year-old in an 18-year-olds body***" (Reflections from a practitioner who attended the learning event), meaning that assumptions cannot be made about her understanding of consent, healthy relationships and what constitutes abuse.

Case 5 Ben

13.0 Brief Background

13.1 The review considered events between early 2004 and the summer of 2019.

13.2 There were concerns throughout Ben's childhood about physical abuse, neglect, and domestic abuse when he was aged six there were physical indications that Ben may have been sexually abused.

13.3 Agencies became aware in 2014 that there were concerns about sexual exploitation in respect of Ben's wider family in another area. Ben exhibited sexualised behaviour from the age of ten and it was known that he had watched pornography. In 2012 it was noted that he was a potential risk to his sisters if 'boundaries' were not put into place. There is nothing in agency records which describes what this risk may have been.

13.4 In November 2016 Ben was first assessed as being at 'low' risk of CSE after having disclosed being 'sexually active' with an older girl. He was aged 12 at this point in time.

13.5 Ben and his siblings were made subjects of child protection arrangements several times. In 2017, when he was 13, Ben's child protection plan was in place because of sexual abuse. He suffered sexual harm throughout 2016 and 2017 and was also using cannabis, alcohol and cocaine during this time. Ben's behaviour was, on occasion, violent within the family home and at school and he went missing several times. Ben was permanently excluded from three schools and spent long periods of time not in education. He was known to be at risk of sexual exploitation from older males and an older female, and in 2018 and 2019 made threats and attempts to take his own life.

14.0 Key Practice and other Events

14.1 Ben and his siblings were made subjects of a Child Protection Plan in 2010 because of neglect. There were also concerns about non-accidental injuries and signs of potential sexual abuse of Ben and one of his siblings.

14.2 In 2012 the family moved to another area prior to which the children had been removed from Child Protection arrangements and CAF arrangements were agreed. CSC shared this information with CSC in the family's new area. In March 2013 S47 Enquiries were instigated by the new area's CSC following an injury to Ben caused by his father. The family were subject to Child in Need arrangements at that time.

14.3 In 2014 Ben's parents separated and he, his mother and siblings returned to live in Bradford. Bradford CSC assessed the family's needs and issues with Ben's behaviour were noted. Ben went to live with his father, who had also returned to Bradford in 2014 and back to his mother's address shortly afterwards.

14.4 In 2014 Ben underwent a Child Protection medical for an injury caused by his father kicking him. He underwent a further Child Protection medical later in 2014 for an injury to his arm caused by his father.

14.5 By the end of 2014 Ben's mother and father signed a contract of expectation that father would not have unsupervised contact with the children.

14.6 Early in 2015 a referral to CAMHS was made for Ben. His behaviour was problematic.

14.7 In spring 2015, Ben underwent a child protection medical after his mother assaulted him. Ben was made subject of child protection arrangements because of physical abuse. The other children were subject to Child in Need (CIN) arrangements. This assault was recorded by WYP, but CSC were the lead agency and no further action was taken by WYP.

14.8 By summer 2015 Ben had moved to live with his father in another area as his mother was struggling to cope with his behaviours. Early in 2016 Ben returned to Bradford to live with his mother. He had remained on a CPP throughout the time he lived with his father and these arrangements continued when he returned to Bradford.

14.09 It was noted at the time he returned to Bradford that he was not registered with a GP or with a dentist. Ben's dental care had been an issue before he moved out of the area when his dental health had begun to deteriorate.

14.10 Ben's behaviour issues and distress increased during this time and the police were called following Ben becoming violent and causing damage in the family home.

14.11 In 2016 following a report by his mother that Ben was searching the internet for methods to kill himself a specialist National CAMHS became involved but could not provide crisis support to Ben.

14.12 In 2016 it was known that Ben's father and mother were planning a reconciliation and that his father would move into the family home. Ben stated that he did not want his father to move in with them and that he hit him and that he was afraid of him. At this time another of Ben's siblings underwent a child protection medical for a cigarette burn to her arm which she said had been caused by her father. Several injuries were noted including the burn.

14.13 During 2016 the police were called on a number of occasions when Ben was aggressive and distressed. It was reported that a family member was supplying Ben with cannabis. Ben was aged 12 at this point.

14.14 In 2016 Ben attempted to seriously injure or kill himself at school. He received a 5-day fixed term exclusion.

14.15 Also in late summer 2016 CSC record that a family member of Ben's who lives in a different area is a violent ex-offender. Ben had a close attachment to his uncle. It was also recorded by CSC that "*There have been unconfirmed reports that members of Ben's family have been involved in CSE, the parents do appear to be very protective of their children in this area, so it is expected that they would be open an honest with professionals if they became aware of further information*". It was also recorded that "*Ben's sexualised behaviour may become a problem for his sisters if the parents do not work together to support him by creating appropriate boundaries*". There is no indication that Ben was considered as a potential victim of sexual abuse at this time.

14.16 In late 2016 Ben disclosed that he had had sex with an older girl. His father had supplied him with condoms on his request. He was aged 12 at this point in time. A Niche CSE occurrence was created and a Risk Assessment document indicating that Ben was at Low Risk of CSE was attached by WYP.

14.17 A CSC record "*There is no direct evidence to suggest that Ben is being actively groomed or at risk of CSE. However, he is a very vulnerable young person who can easily be led in an attempt to get accepted and subsequently gets exploited. From conversations with the specialist national CAMHS, who are currently involved in some therapeutic work with Ben, he appears to be craving intimacy and a connection, leaving him even more vulnerable to possible exploitation. He is a sad little boy with a lot of frustrations about his disabled identity. If Ben were to start an intimate relationship, he could not cope with the rejection when this finished as he does not have the emotional coping mechanisms to deal with this.*

14.18 *School raised concerns that 'another child' and Ben have recently been frequenting a certain man`s flat, the man is believed to be in his 40s, lives alone and a close associate of Ben's relative who is currently serving a jail term in prison.*

14.19 *Ben is sexually active, he is only 12 years old and has been in a relationship with an older girl, he is known to ask for condoms from various sources but refuses to disclose who his sexual partner is which raises more concerns*".

14.20 In late 2016 a strategy discussion took place as Ben was visited by his social worker who recorded that Ben informed her that he had had sex with a girl who was a few years older. The social worker noted that this could be statutory rape as Ben was only 12 years old.

14.21 WYP note in early 2017 that "*The victims do not support a prosecution; the evidential threshold is not met to approach CPS, and it is clearly not in the public interest. Therefore, no further investigation is required in relation to this offence*".

14.22 In early February the Child Protection Review Conference minutes note that "*The focus of this meeting has mainly been on Ben, and it is understandable that people are worried about his past and present behaviour. There is a worry about the risk he poses to those around him, and school have had to make a difficult decision regarding Ben's academic future. Ben has displayed troubling behaviour and it has been reported that he is involved in what has been described as a 'sexual relationship' with an older girl – which is an on-going police investigation. There are worries that Ben is not emotionally mature enough to deal with the relationship or how he would react should the relationship end, regardless of the legal view. There are concerns about the level of distress that Ben is feeling. Ben's needs must be assessed and addressed in order for the situation to improve"*.

14.23 Ben was subject to child protection arrangements at that point in time because of sexual abuse with emotional harm also highlighted.

14.24 At the end of February 2017 CSC recorded that the CSE MASH had completed their assessment of Ben and had closed the case.

14.25 In spring 2017 the police were called to Ben's home as he was causing damage and out of control.

14.26 At the April 2017 Child Protection Review Conference it was noted that there were still concerns about Ben's vulnerability to CSE and that he was not in education at that time. The child protection arrangements were ended, and Child in Need arrangements agreed.

14.27 In late spring 2017 Ben witnessed a sexual offence which took place at Ben's home. Ben was discussed at the daily CSE Meeting and was thought to be at low risk of CSE as there was no information to suggest that he was being exploited or trafficked.

14.28 Again in late spring 2017 a ** year old girl reported to the police that she had had sex with Ben this led to a strategy meeting and the outcome was that support around sexual health would be offered to Ben (he was at this point attending a residential school in another area).

14.29 In late spring 2017 one of Ben's younger siblings disclosed serious sexual abuse. It was noted by CSC that other victims were 'coming forward'.

14.30 In summer 2017 Ben was excluded from the residential school and returned home the same day. The police were later called to the family home as he was in possession of a knife and was causing damage to the property and neighbour's gardens. The police were called again two days later as Ben was breaking windows and brandishing a metal bar. He was arrested (now aged 13) and taken into custody. He was released without charge the following day.

14.31 Throughout summer of 2017 Ben continued to be in extreme distress and the police were called on further occasions. CSC attempted to place Ben in residential care, but he caused damage to one placement and ran away from another.

14.32 In mid- summer CAMHS received an assessment from the specialist national CAMHS which stated that Ben is "*not considered to have mental health disorder. He struggles with emotional regulation but without the security of a permanent placement both educationally and at home therapeutic work has made little difference. The home situation exposes Ben to ongoing trauma and feeling of isolation and rejection*".

14.33 Later that month the police seized devices from Ben who had disclosed that he and other friends had been taking indecent photographs of themselves and sharing them online.

14.34 Also later that month Ben's father called the police to report Ben missing and believed that he was going to see an 18-year-old male who had been issued with a Child Abduction Warning Notice (CAWN) and had been encouraging Ben to abscond.

14.35 In late summer Ben's father reported that the 18-year-old male had uploaded a video to social media of Ben masturbating. Also, in late summer Ben was discussed at a CSE meeting and was assessed as at low risk of CSE. Throughout the following days the police received intelligence that the 18-year-old male was also supplying Ben with cannabis. The police records indicate that there were difficulties in obtaining appropriate interpretation for Ben during their investigations.

14.36 In early autumn 2017 CSC carried out a single agency assessment. The issues highlighted included:

- Boundaries and routine
- Expectations
- Drug misuse
- Peer Group
- Underage Sexual Activity
- Challenging Behaviour – home & school
- Physical Assault of Mother – punch to face.
- Threats to shoot family.

- Intimidation of parents/ siblings – Ben's younger sister believed he had a gun.
- Damage to property – trashed bedroom
- Verbal outbursts – swearing.

14.37 It was also recorded that "*There are CSE concerns for Ben while in the community and concerns about his friendship with an 18-year-old who has a harbouring notice against another child. CSC are worried that if Ben is not adequately monitored, he will be at risk of being exploited"*.

14.38 In late November a strategy discussion took place following Ben's father raising concerns about Ben's association with older males, one of whom was an older family member and also some communication with an unidentified male approximately 30 years old online. It was noted that "*Ben's family member is apparently associating with adult Asian males who are regularly having sex with young boys. Ben's online 'chats' are linked to his mother's tablet, so they are getting to see what he is doing. Recently, Ben's behaviour has significantly deteriorated. Father stated that he has made a weapon by hammering nails into a broom handle, but it is not known why.*

14.39 *Assessed as low risk of CSE and no actual disclosures have been made as yet in term of sexual contact or inappropriate messages / pictures*".

14.40 Later in 2017 the police were informed by Ben's father that an indecent image of a man had been found on Ben's device and that the male had indecent images of Ben. It was noted that there was a link to an investigation being undertaken by South Yorkshire Police.

14.41 At the end of 2017 Ben went missing from home and returned at 5am. The police had intelligence that contact may have been made by an adult male with Ben via social media. The adult male had previously been arrested for meeting a child. Again, there were problems in accessing appropriate interpretation throughout this period and Ben's father often acted as interpreter.

14.42 In early 2018 Ben went missing from home and on one occasion was found at a house party and admitted smoking cannabis. He was aged 13 at this point.

14.43 Following a visit to the GP by Ben's father Ben's GP records show an entry from community pharmacist CP1: Plan: To book Ben in for a 20-minute appointment slot with clinician to do PHQ9, GAD score and general assessment of mental wellbeing. To decide next steps how to proceed with Ben based on the outcome of this consultation:

- Re-refer to CAMHS but Ben may refuse.
- To speak to father and ask him about the input from the specialist national CAMHS.
- Refer to paediatrics.
- To chase up and ask social services to discuss how we can assist with this boy.

14.44 Ben was not taken to the appointment with a GP which was subsequently made for him.

14.45 In early summer 2018 Ben went missing from home. He returned a day later and told WYP who conducted a 'return home interview' who he had been with and that he had taken cannabis and cocaine.

14.46 In summer 2018 Ben was admitted to hospital following an incident at home during which he dropped a TV onto his foot. His father interpreted throughout the initial attendance at the A & E department and said that Ben had also threatened to jump from a window. Ben was admitted to a children's ward and staff did attempt to book an interpreter but were unable to do so. Ben was discharged the following day having been seen by CAMHS.

14.47 In mid- summer 2018 a strategy meeting was held, and a decision made to hold an ICPC. The ICPC was held, and Ben and his siblings were made subject to CP arrangements for emotional and physical harm. It was noted that Ben was "*at risk of CSE, use of cannabis, cocaine and alcohol, deliberate self-harm and violent"*.

14.48 At a core group meeting in autumn 2018 there was significant focus on the sexual abuse of Ben's sibling and how this was impacting upon her wellbeing and behaviour. In contrast the focus on Ben was on his "*ability to manage his emotions when things become very difficult, his choice to smoke cannabis to help him sleep and his relationship with his parents, friends and sisters*".

14.49 In late 2018 CSC carried out a Case Audit of their involvement with Ben's family. The Auditor notes "*The case has been judged as inadequate as the child cannot be assessed as safe. Although subject to a CP plan and a safety plan being put in place following a recent case review the case focusses on Ben's behaviour as the problem and seen as a naughty child rather than an abused child. There are multiple risk factors for Ben which increases his level of vulnerability to be exploited. Missing episodes have not been followed through, the CSE risk assessment is not updated. The case notes and assessments and CP plans indicates that Ben is subjected to physical chastisement when this is physical abuse as defined in the NSPCC definition. Consideration has not been given to Ben's response and behaviours are attributed to his abuse*".

14.50 Also in late 2018 WYP reviewed Ben's 'CSE Status' and record that Ben has been "*Flagged as Low Risk CSE since 11.05.2017. The report endorsed that an updated CSE Risk Assessment requested on 13.11.2018 was still awaited, notes last CSE related information was December 2017. The review agreed to close the occurrence and remove CSE flags*".

14.51 In early 2019 a professionals meeting was held. The meeting had been arranged by specialist national CAMHS who explained "*Towards the end of 2018 Leeds and York Partnership Foundation Trust (LYPFT) CAMHS practitioners contacted the safeguarding team for advice regarding concerns for a number of disabled children*

who were all related. Specialist CAMHS staff were working with two children in two of the families which placed them in a unique position to identify safeguarding concerns. Staff were concerned they did not have a full picture of the children's circumstances".

14.52 The safeguarding concerns raised at the professionals meeting included:

- Previous and ongoing potential CSE
- Young person engaging in drug use.
- Potential financial exploitation of a young person from extended adult family members.
-

14.53 There were also a number of unknown suspected risks:

- Alleged extended adult family members encouraging young persons to become involved with the selling of drugs, potential coercion.
- Previous allegations of cannabis cultivation
- Teenage pregnancy
- Extra familial threats to a young person
- Potential criminal activity amongst adults including drug use/selling and sexual offences, risks were unknown, intelligence unknown.
- Younger children in the household without a voice
- Members of the family interpreting for agencies
- Children not having the opportunity to be seen alone.
- Potential disguised compliance

14.54 Concerns were also raised about the availability and reliability of interpreters.

14.55 It was agreed that the meeting had been useful and had enabled professionals to share information and concerns. Actions were agreed for individual professionals, and it was agreed that a further meeting would be held.

14.56 However, it appears that the social worker who attended the meeting left his/ her post shortly after the meeting and there is no record of what actions he or she agreed to take or that information was shared at a hand –over of the case to a new social worker.

14.57 In essence nothing changed for Ben or the other children in the family as a consequence of the professionals meeting.

14.58 When he was fifteen, Ben was 'found in bed' with an older female friend from another area. Following a full police investigation, there was no further action in relation to the sexual activity with a child as there was insufficient evidence and Ben, and a witness were unwilling to provide evidence. The suspect denied that any sexual activity took place and Ben was placed in an emergency foster care placement but returned home a day later.

14.59 There followed a distressing number of incidents for Ben including a video recording of him 'having a sexual relationship' being sent to his mother.

15.0 Key Themes Ben

15.1 Ben experienced neglect and physical, emotional abuse and was exposed to domestic abuse from a very young age. It is also possible that Ben was sexually abused at the age of 6 however this was not explored by professionals at the time. His disability meant that he was isolated and the use of family members as interpreters meant his voice was mediated by them and ran the risk that his own voice was rarely heard.

15.2 Ben's father in particular was regularly relied upon to interpret for Ben and other family members. This was unsafe and further compounded Ben's isolation and lack of voice. Professionals noted that Ben's father was extremely controlling and that he accompanied Ben and his siblings to medical and other appointments.

15.3 The focus of interventions and assessments in respect of Ben was his behaviour and aggression. Ben's distress and vulnerability was not always seen as an indicator that he was possibly being sexually exploited or abused.

15.4 The difference in how risk and need was 'framed' in relation to Ben and his female sibling was stark. For example, at a core group meeting in October 2018 it is recorded that.

> "*Ben has been involved in sexual incidents and is hanging around with those involved in drugs, whilst his sibling has been sexually abused*".
>
> "*For sibling, we are worried about the impact of the sexual abuse she has suffered upon her emotional health and understanding. Sibling will often show her emotional difficulties through behaviour before expressing this verbally".*
>
> *"For Ben, we are worried about his ability to manage his emotions when things become very difficult, his choice to smoke cannabis to help him sleep and his relationship with his parents, friends and sisters*".

15.5 The language used by other agencies in respect of the sexual exploitation of Ben was also of note. For example, there were references to '*underage sexual activity'* and *'sexual relationships* and that Ben was '*sexually active and had been in a relationship with a 16-year-old girl'*. Ben was, at that point aged 12. In UK law a child under 13 does not, in any circumstances, have the legal capacity to consent to any form of sexual activity. These are offences of strict liability as regards to age, and there is no defence of reasonable belief in relation to the age of the complainant.

15.6 The review panel members and independent reviewer considered how different agency and individual practitioner responses may have been if Ben was a girl. Would, for example a 12-year-old girl have been described as having a sexual relationship with a 15 or 16-year-old boy?

15.7 The number of time Ben's parents called the police in respect of Ben's aggression is also notable. WYP appropriately identified that Ben was a vulnerable child and shared information with agencies after each incident (with a few exceptions). However, this pattern of Ben's father calling the police and/ or throwing Ben out of the family home after an allegation of assault was not analysed and was taken at face value by professionals as a consequence of Ben's aggressive behaviour.

15.8 Furthermore, throughout the entire period of time included in this review Ben's parents were physically assaulting their children. Ben's father presented an unchallenged version of events after each incident involving Ben as alleged perpetrator. Ben remained voiceless and/ or his father interpreted for him. There was no analysis of how the incidents were triggered and what the frequency of incidents meant in terms of risk and harm to Ben.

15.9 None of the children called the police when they were assaulted (they told other adults) and it does not appear that prosecution of the parents for assault was considered apart from one occasion in 2014 when a police investigation, including interview of Ben's father as a suspect, took place. Consideration of prosecution concluded that there was insufficient evidence to proceed. Ben was a very young child when the police were first called to an incident involving him as the 'perpetrator' and the number of further such incidents is of concern.

15.10 The failure to make consistent use of suitably experienced and qualified interpreters in this case is of immediate and urgent concern. Ben has remained largely voiceless and incredibly isolated. This has compounded the neglect and the physical and emotional abuse he has experienced and has also compounded his vulnerability to CSE and criminal exploitation.

15.11 The difficulty for any child with severe communication difficulties to disclose sexual abuse cannot be understated. This difficulty, in part, relates to how such children 'frame' what is happening to them because of the 'abstract' nature of abuse and the subtlety of language needed to communicate very distressing and sensitive information and feelings.

15.12 Ben was not in education for significant periods of time covered by this review which was an additional risk factor and compounded his vulnerability and isolation.

16.0 Case File Audit

16.1 This report was also informed by the findings from an of five cases which were selected at random to provide insight into much more recent practice. The period reviewed in the cases audited is at least two years and ends in 2020. The methodology involved a set of questions based upon emerging learning themes from this review, previous case audits and JTAI inspection criteria. The audit involved extensive case auditing of CSC records and telephone interviews with a sample of the social workers. These audits have all been followed up internally within CSC.

16.2 All five of the CSC cases evidenced high levels of complexity both within the family but also from a contextual perspective. The children had all experienced adverse childhood experiences, drug/alcohol misuse, domestic abuse, including violence within the home and all were known to CSC *before* the time period of the audits. All the children are female, with three of the children being from a BAME family. Of the five children 2 have since given birth and a third is pregnant (she became pregnant after her 18th birthday). The police conducted research in support of this audit in relation to five separate children at risk of CSE and also in relation to a number of perpetrators.

16.3 There was some evidence of good practice.

a) Vulnerabilities were recognised and referred in a timely manner to Children Social Care.
b) Contextual risk factors were identified.
c) Disruption activity and investigations were consistently undertaken (but non-engagement impacts on successful outcomes).
d) Good practice seen in plans–
    - separating out areas of risk, providing a detailed balance of expectations for the child, prompts and partner responsibilities.
    - use of trigger plans for missing episodes.
    - use of dedicated resource to provide 1-1 support.
    - use of a charity in developing positive pathways.
    - Effective working practices between partners in sharing information and diagnosing complex health conditions which are affecting vulnerability and the child's progress.

17.0 Police Audit

17.1 Bradford District Police also conducted an analysis of case records of five victims of CSE and 10 perpetrators of CSE. The police analysis found that.

a) In a two-year period five victims of CSE suffered a total of 89 sexual offences, 18 violent offences and 269 missing occurrences, across all 5 of the children.
b) All five victims of CSE were recorded as suspects in crimes and violent offences featured the most (four of the five children)
c) Seven of the ten perpetrators were victims in crimes. Violent offences featured the most (four out of five children)
d) Across the ten male perpetrators, a total of 44 sexual offences for all ten; 61 violent offences in 8/10 me; drugs cases 6/10 men and domestic abuse in 5/10

18.0 Learning

18.1 The 2014 publication "A Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify ways of Overcoming these Barriers Research" (Rawlings et al) examined why the lessons from SCRs across England have not been embedded in policy and practice. The report which can be read in full here link makes the point that:

"*Working in the complex area of safeguarding requires all practitioners to have exceptional skills that are quite often 'hidden' in that they are the results of an individual's values, experiences, training and problem solving attributes that will affect the way they interpret a particular child, young person or family's circumstances as harmful and whether they perceive referral to be the end of further involvement or a step towards protecting the child and safeguarding the welfare of children and families. The focus group discussions demonstrate how inter-professional, interpersonal and organisational factors in the system are complex and influential on frontline practitioners when making crucial judgements and decisions. Who listens and who acts? Further research is necessary to explore in more detail how decisions are made under pressure, particularly at the point of decision making, and why".*

18.2 The 2014 study referred to above identifies three key *enablers* to embedding learning. These are:

- Instigate a learning culture that recognises clear lines of responsibility and accountability with acknowledgement of professional expertise when making judgements enabling flexibility within complex systems.
- SCR national reports to be refined to 'learning themes' with opportunities for practitioners to discuss and reflect upon cases in a 'safe' environment.
- Regular and multi-levelled training, (specific to disciplines, across disciplines and focussed on key practitioners where appropriate that acknowledges the emotional impact on practitioners).

18.3 Useful learning also comes from a 2010 report "Learning from serious case reviews: Report of a research study on the methods of learning lessons nationally from serious case reviews" (Sidebotham P et al) which states that many SCRs and inquiries seem to draw similar conclusions about the systemic and professional shortcomings that fail to protect children.

The authors identified that a number of factors may contribute to this including:

- The emphasis on learning lessons rather than apportioning blame, whilst important, may result in avoidance of serious issues when they do contribute.
- Professional "blindness" to deeper seated systemic failings;
- A failure to translate findings into specific, achievable goals.
- A failure to follow up on implementation of recommendations.
- Poorly focused reviews.
- The inevitable timeframe involved in completing reviews and in conducting national reviews so that lessons learnt do not lead to timely action.

18.4 The report made a number of recommendations including the following which are of relevance to this review:

- Design and develop evidence-based learning 'tools' applicable nationally to facilitate collective but also targeted and tiered learning.
- Learning together - with a strong focus on multi professionalism.
- Learning for action and in action.

- Learning to challenge - learning to ‘think the unthinkable’ including working with non-compliant parents/carers; confidence to challenge apparent compliance and to ensure all the ‘unseen and unheard’ have been investigated for example the ‘hidden man of the household’; child and young person; other voices not in the system such as grandparents and neighbours; and other underestimated sources.
- Learning together with and from front line practitioners, strategic managers and the third sector
- Learning through supervision.

Appendix 3

Recommendations

1. ***That TBP consider current arrangements and practice for supporting professionals with such complex cases and to address the issue of specialist versus generic expertise and the time demands in doing this work well (learning from "What works" research)***

2. ***TBP should reflect on the evidence regarding enablers and barriers to learning and ensure if effectively disseminates the lessons from this review and that they are embedded.***

3. ***Considering the learning from this review and evidence research TBP should consider the recommendations made by the Centre of Expertise in Child Sex Abuse in respect of the effective use of screening and risk assessment tools. https://www.csacentre.org.uk/documents/infographic-seven-principles-recommendation/***

4. ***TBP should seek assurance that practitioners and managers are aware that changes in cultural identity may be a sign of coercion, exploitation and/or radicalisation and:***
    - ***Display appropriate professional curiosity to recognise any potential risks.***
    - ***Would have the confidence to challenge.***
    - ***Would know how to respond.***
    - ***Would know who else to inform if they suspected this.***

5. ***TBP should seek assurance that the grooming and radicalisation of girls within the context of CSE is understood and considered by the Prevent panel (Channel Panel) in Bradford.***

6. ***TBP should seek assurance that:***
    - ***practitioners have the understanding that drugs and alcohol are being used by abusers within the CSE context.***

    - ***appropriate safeguarding leads and relevant practitioners in partner agencies know how to respond to children who have been coerced and groomed using alcohol and drugs.***

    - ***relevant practitioners working in substance misuse services and those involved in direct CSE work have regular opportunities to share information, expertise and knowledge and ensure a holistic response to children who are being coerced and exploited is developed and maintained.***

7. ***TBP should seek assurance that the training which was developed in response to the 2015 report (Under-protected/Over-protected) which is now provided in***

Bradford is effective and reaching all relevant practitioners who come into contact with children with disabilities and additional needs.

8. ***TBP should seek assurance that relevant practitioners recognise that children with a disability are at increased risk of sexual abuse.***

9. ***TBP should take steps towards understanding the scope of the issue of pregnancy in the district and towards developing responses which provide long term high personalised support for the girls (and their children)***

10. ***TBP should seek assurance that the training described in (recommendation 7) is taken up by relevant practitioners who have contact with children, and opportunities to engage with hard-to-reach communities are maximised through schools.***

11. ***TBP should ensure that online exploitation and abuse feature sufficiently in training, strategy and planning.***

12. ***TBP should call on commissioners and senior decision makers to rise to this challenge and reinvest the considerable costs attached to current provision and move towards developing appropriate standard residential placements in Bradford District.***

13. ***TBP should seek assurance that:***
    - ***current work taking place to develop a Bradford wide strategy in respect of adverse childhood experiences reflects the learning from this review.***
    - ***specifically recognises that CSE is, for many children, a consequence and a continuum of early trauma and abuse and that CSE does not happen in isolation.***

14. ***TBP should ensure the data collected by agencies about the perpetrators of CSE, and research is effectively used to inform practice and strategy.***

15. ***TBP should seek assurance how general preventative multi-agency activity can be undertaken, particularly within the night time economy and around CSE hot-spots and locations of risk.***

16. ***TBP should seek assurance that current interventions and responses recognise and address the potential long-term impacts of CSE and health and well-being.***

17. ***It is recommended that TBP engages with the Home Office seeking to promote that the good progress made in decriminalising children who offend in the context of CCE should be extended to CSE.***

18. ***TBP should assure themselves that there is sufficient provision planned within the SEND sufficiency plan and the School Sufficiency Plan to enable the delivery of adequate special and mainstream education places for pupils of a statutory school age.***

19. ***TBP should seek assurance that appropriate action is being taken to improve the attendance of children who are persistently absent who are known to children social care.***

20. ***TBP challenge partner agencies to demonstrate that there is a system wide approach to jointly commissioned, long term provision which ensures effective holistic and therapeutic support to those subject to exploitation.***

Appendix 4

Summary of CSE progress in 2020

In November 2020 the Safeguarding Partnership presented a summary of progress to the Council Executive

This annual report is presented to the Council Executive, Overview & Scrutiny Committee and to the District's Area Committees regarding the issue of Child Exploitation (CE). It focuses on the strategic response to all forms of exploitation in children and adults and how partners work to drive improvements across the district and how the TBP holds agencies to account for their work in their area. The report outlines how partners have changed practice, against learning and local and national best practice.

https://bradford.moderngov.co.uk/ieListDocuments.aspx?MId=7339&EVT=105

The report sets out the multi-agency arrangements which are outlined earlier in the review.

The action plans for 'Autumn', 'Jack' and a further action plan from the MASH Review were amalgamated into a single plan, which initially totalled over 50 pages with oversight through the CSE & Missing Sub-Group of the BSCB. The plan was subsequently refined and streamlined into the 2021/2023 CSE Action Plan. TBP recognised the wider emergence of criminal exploitation resulting in the widening of the CSE/Missing sub group into a Risk & Vulnerabilities in Complex Safeguarding sub-group and now is a joint group linked also to the Safeguarding Adults Board and the Community Safety Partnership. (This sub group is now called the All – Age Exploitation sub group and is chaired by a senior Police Officer)

The 2018/19 CSE action plan was also extended, recognising these changes.

Communication and awareness raising is a focus across 'Autumn', CSE Action Plan (2018/19) and Council Executive report (2020). The creation of district's Communications and Engagement Group is a positive function to engage with key stakeholders. Whilst it is not clear if the work with localities is embedded, there is evidence that the work of Trusted Relationships, Breaking the Cycles and Youth Services is well established in providing a valuable link with children, parents and communities. Of note, since 2015, the Bradford Police Cyber Team has delivered training to 153, 000 children, 22,000 members of the community and 9,000 parents. This work also provides strong evidence of progress against the recommendation in 'Jack' SCR of technology-based abuse. Elected Members receive awareness training around CSE, this is mandatory and takes place internally.

There is recognition of the importance of engaging with hard to reach and emerging communities, and whilst the positive work in Keighley is evidenced, the links with other ongoing strategies and work-streams does not appear to have materialised and has been hampered by the challenges of the Covid pandemic which required agency partners to focus on these urgent demands and resulted in the Partnership Sub-groups being suspended

between March and September 2020. Given the diverse nature within Bradford further work would be of value.

Multi-agency training for practitioners' complements awareness raising with parents and children. As expected, training threads through all the reports and the Safer Bradford website outlines the training offer, which is an established service. The CSE action plan also recognises the importance of training parents and children, and this has been achieved through the awareness raising, Police Cyber Team and other initiatives such as Trusted Relationships.

In a similar way the plans identify the importance of practice and procedures. All plans include this principle and there has been positive progress around information sharing and linked consent and thresholds (now Continuum of Need). The Council Executive Report (2020) describes the use of the most recent Child Exploitation Protocol and Risk Assessment Tool. Scrutiny and auditing are recognised within the action plans, but the detailed case audit found that while there were high levels of compliance with policy and procedures there were inconsistencies in assessments and care plans which indicates that whilst the procedures have been developed, the quality of practice requires further work.

The action plans recognise the importance of Education and the actions in 'Autumn', CSE Action Plan and Council Executive Report evidence strong links with Education, mainly through the Local Authority Safeguarding Education Team. The Section 175 Schools audit provides a tool to retain oversight and assurance around CSE training and on-line threats. The development of preventative work through the Trusted Relationship initiative again brings the focus into schools.

Improvement in the availability of therapeutic services and remains incomplete in the CSE action plan 2018/19. The sustainability of a long-term provision is recognised as a risk. The Local Authority were identified in the action plan as responsible for progressing work, but there is no positive outcome to date. The work of Trusted Relationships does provide therapeutic support and the Council Executive report evidences positive outcomes but it does appear limited against the demand and is an isolated response within a commissioned service whose future is uncertain. Moving forward there needs to be strategic oversight of the required services and how these will be provided, i.e., through established services or commissioned services. The challenge has been the sustainability of this type of service and in light of the emergence of wider exploitation and increases in demands this will be an ongoing challenge. * Mapping existing therapeutic services has commenced with the All-Age Exploitation Sub Group (February 2021).

Partners recognise the importance of information sharing to inform assessments and profiles and aspired to develop multi-agency activity through the established processes with wider locality-based model. Work around multi-agency assessments and profiles was progressed through the CSE group but was based around police and CSC data. The MASH evidences good partnership working and information sharing but it is not clear if the locality approach is embedded within community teams, who understand CSE, hot spots and contribute to prevention work and information sharing. The plan recognises the loss of resource around night time economy and linked businesses albeit the Police have undertaken initiatives. Profiles would benefit greatly from wider partner information in addition to the Police and

Children Services, although the Council Executive Report reflects that education information is now shared to inform thinking. Building upon existing structures is logical and national best practice recognises assessments should include as many sources as possible. Partners may wish to consider current effectiveness and what more can be done to progress.

In summary, policies reflect national standards and are reviewed by the safeguarding partnership regularly. A specific Partnership Sub Group focusses on multi-agency policy and practice in respect of sexual exploitation and revised standard operating procedures were put in place across agencies during 2019. The BSCB coordinated CSE activity through the CSE sub-group for a number of years. In 2017 partners recognised the need to separate operational from strategic activity and an operational group was formed to focus on multi-agency policy and practice in respect of sexual exploitation and revised standard operating procedures were put in place across agencies during 2019. The group also links with national and regional standards and best practice. The group progressed work from the strategic CSE group which later became the risk and vulnerabilities group. The group has now been mainstreamed into the MACE meeting. Data is monitored quarterly and audits of practice completed to ensure compliance with practice standards (the latest being in October 2020).

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director Children's Services to the meeting of the Children's Services Overview & Scrutiny Committee to be held on 6 October 2021

Subject:

Residential Children's Homes & Related Issues **H**

Summary statement:

This report provides an update regarding the current situation regarding the Children's Residential homes in Bradford and related issues.

EQUALITY & DIVERSITY:

Mark Douglas
Strategic Director

Report Contact: Marium Haque
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Portfolio: Children & Families

Overview & Scrutiny Area:

Children' s Services

1. SUMMARY

This report provides an update regarding the current situation regarding the Children's Residential homes in Bradford and related issues.

2. BACKGROUND

In recent weeks several of our children's homes have been inspected and the outcome is that a number have dropped one or more grade.

Since June 2021, 7 homes have been inspected. Three have retained their "Good" judgement. The outcome for the other 4 homes are as follows:

- **Valley View (including BEST)** – Inadequate (previously RI). Included a suspension of registration and a compliance notice.
- **Owlthorpe** – Inadequate (previously Good). Included a suspension of registration & a compliance notice
- **The Willows** – Inadequate (previously Good). Included a compliance notice
- **Wedgewood** – Requires Improvement (previously Good)

The following actions have been undertaken to improve outcomes:

- A decision notice is being prepared for the future of Valley View. An Action Plan is being drawn up to address the areas outlined in the compliance notice.
- Ofsted have recently revisited Valley View and have lifted the suspension notice and have re-instigated the registration for Valley View. An extension has been given to provide additional time to address the revised compliance notice, following the recent visit.
- Options are being explored to separate BEST and Valley View from the same URN to provide more options for the use of BEST.
- Ofsted have revisited Owlthorpe and lifted the suspension and the compliance notice. An Action Plan is being progressed to begin reintroducing children back into Owlthorpe and to move it rapidly out of an Inadequate category.
- Ofsted have revisited the Willows and have determined that all aspects have met within the compliance notice. All restrictions have therefore now been lifted at the Willows.
- Work is underway to put in place action plans to rapidly improve the outcomes at Valley View, Owlthorpe and The Willows to support all three homes to move out of the inadequate Ofsted rating.
- An Action Plan specific to the issues identified at Wedgewood is in place to enable it to improve quickly to achieve a Good or better rating at its next inspection.
- A re-introduction plan is being carefully drawn up to safely and gradually enable The Willows and Owlthorpe to begin to have children placed in the homes.

STAFFING

There have been a number of challenges at all levels regarding staffing, which have occurred in the past few weeks.

- Two senior managers, including one who was also the Responsible Individual for Children's Homes, have both resigned and now have left their posts.
- Several middle managers with responsibility for some of the homes are on long-term sickness absence.
- A significant number of residential staff operating out of Valley View (including BEST) and The Willows are on long-term sickness absence
- There is a very high reliance on agency staff across a number of the Children's Homes

A number of changes have taken place to begin to address these issues:

- On the 2nd August, the Deputy Director for Education & Learning, has stepped across to provide senior leadership support and to also, for the interim, take over as the Responsible Individual for all 11 Children's Homes.
- An experienced interim Head of Service took up post on the 12th August. The Head of Service will also take over the Responsible Individual role as soon as the registration transfer is completed.
- An experienced interim Assistant Director took up post on the 16th August 2021.
- The Deputy Director will continue to retain oversight for the short-medium term to ensure that there is continuity in the work that has already been started and a continued line of sight for residential managers into senior leaders.
- Approval has been given to recruit interim middle Managers to ensure adequate management oversight across all the children's homes.
- Staff who are on long-term sick leave have been contacted to ensure that appropriate referrals have been made to Occupational Health and to discuss how we can support them to safely and confidently return to work.
- A system has been developed to ensure that appropriate checks are in place to ensure that where agency staff are required, that they have the appropriate checks and qualifications provided to Residential Managers so that this can be recorded correctly.
- Work is underway to provide opportunities for casual and bank residential staff to consider moving onto permanent contracts.

REGULATION 44 REPORTS

- Following the outcome of recent judgements, it is clear that we need to have assurances that our current children's homes are offering a high quality of care for our children/young people. Where issues are known, it is important that we have robust action plans in place that are scrutinised and secure rapid improvement.

- Concerns have been identified regarding the Regulation 44 reports which do not always reflect the concerns identified by Ofsted in their inspection

outcomes. A quick review (led by the School Improvement Service) of all the regulation 44 reports submitted in June would concur with this position.

- In addition, it has been noted that the Action Plan section at the back of the regulation 44 reports are not completed or reviewed in such a way as to be able to track and record the progress against identified areas.

    - A quick review of the Action Plans for individual homes has shown an inconsistency in the quality of the plans and there is no set format or template for action planning in our Children's Homes.

The following action has been taken:

- An experienced external organisation has been identified to undertake a review of the quality of provision across each of the children's homes to identify areas for improvement, as well as to provide clarity on the quality of the care provided to children/young people. It is anticipated this will begin week beginning 13th September and will be for a contracted period of 23 days. A report will be produced which will inform further and future planning for children's homes.

- The interim Head of Service is putting in place a standardised template which will be used across all Children's Homes so that there is a consistent approach in action planning with clarity on expected outcomes that will need to be evidenced.

3. OTHER CONSIDERATIONS

The physical condition of the homes has been an area that has been recently identified as needed a very different and more responsive approach. Positive discussions have taken place between the Deputy Director and colleagues in Facilities Management to put in place arrangements to ensure that we have a quick response when repairs are needed in our children's homes.

Plans are being put in place to enable children to decorate their own bedrooms and also be involved in choosing furniture and other aspects in shared areas in the homes.

In addition, work is underway to set out a clear plan to ensure that all homes are part of a regular condition survey with planned upgrades for longer-term and larger aspects, such as fire alarms, boiler upgrades, etc.

4. FINANCIAL & RESOURCE APPRAISAL

Capital funding is being identified to support the maintenance of children's homes.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

6. LEGAL APPRAISAL

7. OTHER IMPLICATIONS

7.1 SUSTAINABILITY IMPLICATIONS

7.2 GREENHOUSE GAS EMISSIONS IMPACTS

7.3 COMMUNITY SAFETY IMPLICATIONS

7.4 HUMAN RIGHTS ACT

All children and young people are entitled to have their basic needs met and the provision in our Children's Homes must ensure that children in our care have access to good quality care and support to enable them to thrive.

7.5 TRADE UNION

Trade Unions have been engaged with and further meetings are planned.

7.6 WARD IMPLICATIONS

7.7 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

7.8 IMPLICATIONS FOR CORPORATE PARENTING

Children's Homes are a critical part of the care provision in the District for our Children Looked After. The Corporate Parenting Panel receive reports on the Children's Homes in the District and work is underway to further strengthen and develop the role of the Corporate Parenting Panel.

7.9 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

In order to protect the rights of individuals, including staff and children/young people, the contents of this report have been written in such a way as to provide information to enable the Committee to consider the information contained in this report. However, specific details on individual issues in the homes may not be able to be disclosed for the purposes of protecting the identities of individuals.

8. NOT FOR PUBLICATION DOCUMENTS

9. OPTIONS

10. RECOMMENDATIONS

10.1 That the report is noted.

11. APPENDICES

None.

12. BACKGROUND DOCUMENTS

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Chair of the Children's Services Overview and Scrutiny Committee to be held on 6 October 2021

Subject:

Children's Services Overview and Scrutiny Committee – Work Programme 2021/22

Summary statement:

This report includes the Children's Services Overview and Scrutiny Committee work programme for 2021/22.

EQUALITY & DIVERSITY

Community Cohesion and Equalities related issues are part of the work remit for this Committee.

Cllr Geoff Winnard
Chair – Children's Services Overview and Scrutiny Committee

Portfolio:

Children and Families

Report Contact: Mustansir Butt
Overview and Scrutiny Lead
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E-mail: mustansir.butt@bradford.gov.uk

Overview & Scrutiny Area:

Children's Services

1. SUMMARY

1.1 This report includes the Children's Services Overview and Scrutiny Committee work programme for 2021/22, which is attached as appendix 1 to this report.

1.2 Also attached as appendix to this report is a list of unscheduled topics for 2021/22.

2. BACKGROUND

2.1 The Council constitution requires all Overview and Scrutiny Committees to produce a work programme.

3. OTHER CONSIDERATIONS

3.1 The Children's Services Overview and Scrutiny Committee has the responsibility for "the strategies, plans, policies, functions and services directly relevant to the corporate priority about services to children and young people." (Council Constitution, Part 2, 6.3.1).

3.2 Best practice published by the Centre for Public Scrutiny suggests that "work programming should be a continuous process". It is important to review work programmes, so that important or urgent issues that arise during the year are able to be scrutinised. Furthermore, at a time of limited resources, it should also be possible to remove areas of work which have become less relevant or timely. For this reason, it is proposed that the Committee's work programme be regularly reviewed by members of the committee throughout the municipal year.

3.3 The work programme as agreed by the Committee will form the basis for the Committee's work during the year, but will be amended as issues arise during the year.

3.4 This Committee has agreed to undertake a programme of detailed scrutiny reviews, with the Committee already having started the Alternative School Provision Scrutiny Review. The other scrutiny reviews include:

- Looked after Children.
- Children's Homes.
- Fostering.
- Children's Mental Health.
- Recruitment and retention of Social Workers.
- SEND, (Special Educational Needs and Disabilities).
- YOT, (Youth Offending Team).

4. FINANCIAL & RESOURCE APPRAISAL

4.1 None.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 None.

6. LEGAL APPRAISAL

6.1 None.

7. OTHER IMPLICATIONS

7.1 SUSTAINABILITY IMPLICATIONS

None.

7.2 GREENHOUSE GAS EMISSIONS IMPACTS

None.

7.3 COMMUNITY SAFETY IMPLICATIONS

None.

7.4 HUMAN RIGHTS ACT

None.

7.5 TRADE UNION

None.

7.6 WARD IMPLICATIONS

Work of this Overview and Scrutiny Committee has ward implications, but this depends on that nature of the topic.

7.7 IMPLICATIONS FOR CORPORATE PARENTING

This will be a key area of work for the Committee.

7.8 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

None.

8. NOT FOR PUBLICATION DOCUMENTS

None.

9. OPTIONS

9.1 The Committee may choose to add to or amend the topics included in the 2021-22

work programme for the committee.

9.2 Members may wish to consider any detailed scrutiny reviews that it may wish to conduct.

10. RECOMMENDATIONS

10.1 That members consider and comment on the areas of work included in the work programme.

10.2 That members consider any detailed scrutiny reviews that they may wish to conduct.

11. APPENDICES

Appendix One – 2021-22 Work Programme for the Children's Services Overview and Scrutiny Committee.

Appendix Two – Unscheduled Topics.

12. BACKGROUND DOCUMENTS

Council Constitution.
2020-21 Children's Services Overview and Scrutiny Committee Work Programme.

Democratic Services - Overview and Scrutiny

Childrens Services O&S Committee

Scrutiny Lead: Mustansir Butt tel - 43 2574

Work Programme

Agenda Items	Description	Report Author	Comments
Thursday, 29th July 2021 at City Hall, Bradford.			
Chair's briefing 30/06/21. Report deadline 15/07/21.			
1) Ofsted inspection of LACS - Improvement		Mark Douglas/Irfan Alam/Stuart Smith.	
2) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt	Also including Resolution Tracking.
Wednesday, 22nd September 2021 at City Hall, Bradford.			
Chair's briefing 01/09/21. Report deadline 09/09/21.			
1) Ofsted inspection of LACS - Improvement.	To also include Vital Signs, as recommended by the Committee on Thursday 29 July 2021.	Mark Douglas/Irfan Alam.	
2) Workforce development aspect of the Children's Services Improvement Programme.		Mark Douglas/Irfan Alam/Claire Threpleton.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 11 March 2021. Deferred from Children's Services Overview & Scrutiny Committee from Wednesday 7 April 2021.
3) School organisation including, school expansion programme, education capital funding and academy conversations.	That a report be presented to the Committee in 12 months, which also includes a breakdown of capital and ethnic mix of schools.	Marium Haque.	Chidlren's Services Overview and Scrutiny recommendation from Wednesday 5 August 2020.
4) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt.	
Thursday, 30th September 2021 at City Hall, Bradford.			
Chair's briefing 08/09/21. Report deadline 16/09/21.			
1) Child Sexual Exploitation Child Thematic Safeguarding Practice Review.		Lawrence Bone/Jane Booth/Darren Minton.	Children's Services Overview & Scrutiny Committee recommednation from Thursday 29 July 2021.

Childrens Services O&S Committee

Scrutiny Lead: Mustansir Butt tel - 43 2574

Work Programme

Agenda Items	Description	Report Author	Comments
Thursday, 30th September 2021 at City Hall, Bradford.			
Chair's briefing 08/09/21. Report deadline 16/09/21.			
2) Valley View Home Closure/Bradfords Care Homes.		Mark Douglas/Irfan Alam.	Children's Services Overview & Scrutiny Committee recommendation from Thusrady 29 July 2021.
3) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt.	
Wednesday, 20th October 2021 at City Hall, Bradford.			
Chair's briefing 30/09/21. Report deadline 07/10/21.			
1) Health Care issues relating to Children's Social Care.		Mark Douglas/Irfan Alam/Sasha Bhatt.	Councillor request.
2) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt.	
Wednesday, 17th November 2021 at City Hall, Bradford.			
Chair's briefing 28/10/21. Report deadline 04/11/21.			
1) Working together to safeguard children - The Bradford Partnership Annual Report 2019-20.	That a report be presented in 12 months time and in preparation, discussions to take place with officers, the Children's Services Overview and Scrutiny Chair and Deputy Chair to agreed on the key areas to be included in the report at the earliest opport	Mark Douglas.	Children's Services Overview and Scrutiny Committee recommendation from Wednesday 4 November 2020.
2) Troubled Families Programme.		Chad Thompson.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 6 January 2021. Deferred from Wednesday 7 April 2021 meeting.
3) In-house Fostering Service.	Demand/supply/quality/sufficiency/recruitment.	Richard Fawcett.	Request from Childrens Services Overview & Scrutiny Committee Chair and Deputy Chair.

Childrens Services O&S Committee

Scrutiny Lead: Mustansir Butt tel - 43 2574

Work Programme

Agenda Items	Description	Report Author	Comments
Wednesday, 17th November 2021 at City Hall, Bradford.			
Chair's briefing 28/10/21. Report deadline 04/11/21.			
4) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt.	
Wednesday, 15th December 2021 at City Hall, Bradford.			
Chair's briefing 25/11/21. Report deadline 02/12/21.			
1) Review of the School Appeals process.		Mark Douglas/Guy Close.	Children's Services Overview & Scrutiny Committee recommendation from Thursday 11 March 2021.
2) Youth Offending Team.		Lisa Brett/Sarah Griffin.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 6 January 2021. Deferred from Wednesday 7 April 2021 meeting.
3) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt.	
Wednesday, 19th January 2022 at City Hall, Bradford.			
Chair's briefing 23/12/21. Report deadline 06/01/22.			
1) Ofsted inspection of LACS - Improvement		Mark Douglas/Irfan Alam.	
2) Budget for Children's Services.		Mark Douglas.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 3 February 2021.
3) Educational Standards - Early Years to Key Stage 4.	Future reports to contain details of key areas of improvement and actions being taken to continue to address them, focusing on the approaches being taken to improve Bradford Council's ranking in this area.	Marium Haque.	Children's Services Overview and Scrutiny Committee recommendation from Wednesday 15 January 2020.
4) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt.	

Childrens Services O&S Committee

Scrutiny Lead: Mustansir Butt tel - 43 2574

Work Programme

Agenda Items	Description	Report Author	Comments
Wednesday, 9th February 2022 at City Hall, Bradford.			
Chair's briefing 19/01/22. Report deadline 27/01/22.			
1) Audit findings relating to the quality of Social Work Practice.		Richard Fawcett.	Children's Services Overview & Scrutiny Recommendation from Wednesday 11 March 2021.
2) Raising Attainment Strategy.	That the Raising Attainment Strategy to be presented to this Committee in the New Year.	Marium Haque.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 2 December 2020.
3) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt.	
Wednesday, 23rd March 2022 at City Hall, Bradford.			
Chair's briefing 03/03/22. Report deadline 10/03/22.			
1) Special Educational Needs and Disability Reforms.	That a further report be presented to the Committee in January 2021also focusing on compliance.	Mark Douglas.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 2 September 2020.
2) Young Carers.	Specifiaclly focusing on performance targets and standards.	Cath Dew.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 11 March 2021.
3) Work Planning.	There is a need to regulalrly review the work programme, in order to prioritise and manage the work.	Mustansir Butt.	

Democratic Services - Overview and Scrutiny
Scrutiny Committees Forward Plan
Unscheduled Items

Childrens Services O&S Committee

Agenda item	Item description	Author	Comments
1 Performance Outturn report		Phil Witcherley.	
2 Schools Forum.	An update on the work of the Schools Forum.	Andrew Redding.	Monthly Electronic briefing to members.
3 Child Friendly City.	The Committee will receive a report detailing the progress towrads Bradford becoming a "Child Friendly City".	Sue Woolmore.	Stuart Smith suggested the report be presented to Children's Services Overview and Scrutiny, rather than the Improvement Board.Need re-scheduling from cancelled meeting on Wednesday 15 April 2020.
4 Informal information gathering sessions relating to the Alternative School Provision Scrutiny Review.		Mustansir Butt.	
5 Children's Services Overview and Scrutiny - Programme of Scrutiny Reviews.	That a programme of Scrutiny Reviews be undertaken across key areas within Children's Services which include: (a) Alternative School Provision, (including Home Schooled Children). (b) Looked after Children. ©Children's Homes. (d)Fostering. €Children's Mental Health. (f)Recruitment and retention of Social Workers. (g)SEND, (Special Educational Needs and Disabilities). (h)YOT, (Youth Offending Team).	Mustansir Butt.	Children's Services Overview and Scrutiny recommendation from Wednesday 9 October 2019.
6 School Organisation including school expansion programme, educational capital funding and academy converstaions.		Marium Haque.	Children's Services Overview and Scrutiny recommendation from Wednesday 5 August 2020.

Childrens Services O&S Committee

Agenda item	Item description	Author	Comments
7 This Committee requests that the Children's Services Overview &Scrutiny Committee considers aspects of the Impower Contract that relate specifically to Children's Services.		Mark Douglas/Chris Chapman/Parveen Akhtar.	Recommendation from Corporate Overview & Scrutiny Committee on Thursday 23 July 2020.
8 Sepcial Educational Needs and Disability Reforms, (SEND).		Jane Hall.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 2 September 2020.
9 Opportunity Area.	For the more up-to-date information relating to the Bradford Opportunity Area to be circulated to members within three months. Also for a progress against the porgramme to be presented to the Committee spcifically focusing on outcomes for children, in 12	Kathryn Loftus/Lee Turner.	Children's Services Overview and Scrutiny Committee recommendation from Wednesday 15 January 2020.
10 Impower.	This Committee requests that the Children's Services Overview & Scrutiny Committee considers aspects of the Impower Contract that relate specifically to Children's Services.	Mark Douglas/Joanne Hyde.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 2 September 2020.
11 Early Help and Prevention Service.	That the next report to this Committee should include targets and measures of performance, which demonstrate the effectiveness of the Family Hubs, as well as qualitative measures.	Lisa Brett.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 2 December 2020.
12 That the Committee keeps an overview of the Council's plans for remote learning taking place across the District and requests that officers present new information when it is available to the Committee.		Marium Haque/Sharon Sanders.	Children's Services Overview & Scrutiny Committee recommendation from Wednesday 6 January 2021.
13 Private Fostering.			Children's Services Overview & Scrutiny Committee recommednation from Thursday 29 July 2021.
14 Better Start Bradford			Children's Services Overview & Scrutiny Committee recommednation from Thursday 29 July 2021.
15 Young Carers.	That an Annual Report on Young Carers be presented to the Committee in June 2021, which would include the full year activity.	Cath Dew.	Briefing to be circulated to members.