CHILD SEXUAL EXPLOITATION 'MAKING A DIFFERENCE'

The impact of the multi-agency approach to tackling CSE in Oxfordshire

MAGGIE BLYTH

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OXFORDSHIRE SAFEGUARDING CHILDREN BOARD

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FOREWORD

This report pulls together collective work by Oxfordshire agencies to tackle the perpetrators of child sexual exploitation (CSE) and protect children. It headlines the progress that has been made since 2011 when Operation Bullfinch commenced, in the identification and analysis of CSE and in the provision of clear pathways for children at risk through the Kingfisher team and the work of the CSE sub-group of the Oxfordshire Safeguarding Children Board (OSCB). The report concludes that services and interventions across all agencies in Oxfordshire are making a difference to children because of changes made since 2011. The overall conclusion is that there has been good progress in setting up specialist interventions for children at risk of CSE and robust measures used to identify perpetrators and bring them to justice. A parent of a child victim of Operation Bullfinch told me in April 2015;

> ***'I have no doubt the Kingfisher team would have been very helpful to us if they had existed 12 years ago.'***

The partnership in Oxfordshire has moved a long way together to address the problem of CSE, identify collective solutions and produce some tangible evidence of impact. This has led to other improvements to help children, such as tackling self-harm, neglect within families, and Female Genital Mutilation (FGM). There is much stronger engagement from NHS organisations, schools and the faith, community and voluntary sectors working with parents and children and with district authorities and the county council to provide solutions. This report outlines the impact of these changes and describes a professional culture that has adapted and is changing.

While this is positive the findings also show the continuing need for *strategic co-ordination* of activity across organisations. It is vital that the county council's children's services department, the body tasked with lead statutory oversight responds to safeguarding concerns swiftly, and is also perceived by all to be in that leadership role for safeguarding. Changing the culture of how all professionals work together takes time and this report concludes that while agencies know where the gaps remain, there can be no room for complacency. There are two areas in particular that require further work involving the regulation and use of taxi drivers and the commissioning of services to provide help and

therapy for children into adulthood. Oxfordshire county council has set a high bar for ensuring the children it is responsible for are transported safely, but maintaining such standards requires robust *strategic co-ordination* across different departments within the county council. Oxfordshire licensing authorities (district councils) need to improve how they share information about drivers, delegate enforcement powers and require taxi drivers to complete safeguarding training as part of any knowledge test.

Overall this report demonstrates that while positive progress has been made in Oxfordshire since Operation Bullfinch, strategic drive is required in the areas outlined below. The partnership must also remain vigilant about where the next pressure points could appear. The role of the Director of Children's Services (DCS), the statutory position empowered with operational lead responsibility for education and children's social care, continues to be vital in this regard. Safeguarding concerns must be routinely escalated to the OSCB to provide challenge and solution. Organisations have to work together to keep children safe not just from CSE but from all forms of abuse and neglect.

The report makes five important observations about where Oxfordshire agencies must focus:

A) Tackling CSE means getting the basics of frontline child protection right and relies on strong and persistent leadership that can change culture and attitudes towards the most vulnerable children. Chief officers, with an example set by the DCS, must take responsibility to ensure that all serious safeguarding matters are escalated to the Board for challenge by the partnership.

B) The perpetrators of CSE in all its forms, like other forms of child abuse are very clever at targeting vulnerable children and in disguising their activity. More understanding is needed of perpetrator profiles.

C) The success of Oxfordshire's work with CSE has been the impact of specialist services for child victims of CSE through its Kingfisher team. Similar specialist interventions are needed for those adults who may only disclose the abuse they experienced as children some years later.

D) The regulation of the contracts to transport vulnerable children across Oxfordshire and the licensing of taxi drivers should be more robust.

E) Working with and engaging communities is key to effectively tackling CSE. The CSE sub-group of the OSCB must hold to account the co-ordination of district council community safety partnerships in this area.

To conclude, Oxfordshire organisations have identified what is working well and where more needs to be done there is a clear and coherent strategy in place. In keeping up the pace of change required, the OSCB will continue to hold services to account to make sure that the impact of the investment over the last three years continues to lead to positive outcomes for children.

Maggie Blyth
Independent Chair
Oxfordshire Safeguarding Children Board

BACKGROUND AND METHODOLOGY

On the 3rd March 2015 the Independent Chair of the Oxfordshire Safeguarding Children Board (OSCB) received a letter from the Parliamentary Under Secretary of State for Children and Families, the Minister of State for Crime and Prevention and the Parliamentary Under Secretary of State for Health. This was in response to the publication of the Serious Case Review into Child Sexual Exploitation in Oxfordshire (Children A-F).

The OSCB agreed to lead on a specific piece of work into the impact of the multi-agency approach to tackling CSE in Oxfordshire. Sophie Humphreys was appointed by the Children's Minister to work alongside and support the OSCB to gather evidence of the impact of the reforms to frontline practice. This stocktake offers Government and the public in Oxfordshire additional assurance, and should be a valuable contribution to the establishment of a national centre of professional expertise on what works in effectively tackling CSE.

The OSCB and its partners have looked at services as they are now and has considered how they may be further improved in the future. It examines the root causes of earlier failings and whether they have been addressed in current arrangements. Most importantly the report identifies the impact that the new way of working in Oxfordshire is having on improving outcomes for children and families.

In answering five key questions agencies have not shied away from identifying where further improvements may be needed. Facts, data and qualitative and quantitative information have been gathered and at the heart of this has been the experiences of children and their families alongside the wider community of Oxfordshire affected by the abuse inflicted on their area's most vulnerable children. Oxfordshire has asked itself:

1. Has our **culture** changed?
2. Has our **attitude** to vulnerable children and parents changed?
3. Has our **response** changed and are we keeping vulnerable children safe?
4. Are **strategic leaders** working to safeguard children from CSE?
5. What are our **risks and gaps** and are plans in place to address them?

The information that follows describes what Oxfordshire was previously like for children and their families, how services respond now and what difference this is making to their lives presently and in the future.

All organisations and individuals have responded openly and candidly and acknowledged that they are on a journey of improvement. The techniques used throughout this stocktake have drawn on 'real time' information from children's social care, adult services, district authorities, NHS organisations, schools, police, probation, courts and community and voluntary sector activity supplied through 'business as usual' meetings, deep dives and evaluations, as well as on-the spot audits, interviews and focus groups to check the validity and robustness of service responses and user experiences.

A multi-agency audit examining 13 randomly selected cases was specifically used to identify findings for this stocktake report. Quotes from the case audit are used to support evidence. Interviews were carried out with 6 children and 7 parents from the audit sample and information from those interviews is used throughout the report. A full list of evidence is available at Appendix 1.

This information was analysed by a project team of staff from all agencies represented on the OSCB and provided to the Independent Chair, supported by an independent Safeguarding Board Manager from outside Oxfordshire, Julie Davies. That is a strong audit approach but inevitably less evidentially robust than a full inspection. The report was written by Maggie Blyth with support from Julie Davies.

We are grateful to all the frontline staff, managers, families and children who have provided us with their observations between March and June 2015.

WHAT HAPPENED IN OXFORDSHIRE

The serious case review (SCR) published by OSCB in March 2015 describes in graphic detail the experiences of six girls who were the victims of child sexual exploitation between 2004 and 2012. The girls were aged between 12 and 16 years at the time of their abuse. Nine men were convicted in May 2013. Work is on-going to identify other victims and perpetrators. There have been further arrests and convictions through Operation Reportage, March 2015 and Operation Sabaton, June 2015.

The language used by professionals saw them as the source not the victims of their extreme behaviour, and this profoundly affected the response from all professionals who encountered them. They were seen as troublesome and making bad choices of their own volition. Many of their families had complex problems, which deflected attention from who was drawing the girls away from their homes.

The girls lost the ability to consent or make their own decisions due to grooming. The law around consent was not properly understood, and this was compounded by contraception being prescribed (albeit legally) long before the law states children are legally able to have sex. There was a professional tolerance to knowing young teenagers were having sex with adults.

The victims almost never co-operated with investigations and this led to a sense that nothing could be done as evidence was weak. The need for disruption, covert surveillance and comprehensive intelligence gathering, despite no formal evidence from victims, was not understood.

There was a lack of curiosity across agencies about the visible suffering of the children and the information that emerged from girls, parents, or carers, or staff. There was also a failure to recognise the extreme circumstances around the victims were of such concern that information should be escalated and a strategic response be developed. Instead, the cases were seen in isolation, with the focus mainly on protecting and containing the girls rather than tackling the perpetrators.

It is clear, unlike Rotherham, that the ethnic origin of the perpetrators did not delay the identification of the group CSE.

The endeavours of frontline staff using their own initiative eventually led to a shared recognition that there was group-related exploitation of multiple girls in Oxfordshire. Action then became co-ordinated and successfully led to the Bullfinch inquiry and trial 2011-2013. This could and should have happened much sooner. Information had been known but not appropriately acted on in the period 2005-2010.

This stocktake report provides evidence that the root causes of failings in Oxfordshire are being remedied and that there are now in place effective multi-agency systems to identify early and address all child protection issues as they arise, with clear strategic management and oversight so that children are confident they will be heard and communities are assured that swift action will always be taken. The agencies have an understanding of where further improvement is needed and demonstrate a strong commitment to continue to address those areas.

HOW OXFORDSHIRE RESPONDED

1. Has our culture changed?

Oxfordshire then

Many professionals from numerous disciplines, and several organisations took a long time to recognise CSE. They used language that appeared to blame victims and see them as adults, and had a view that little could be done in the face of 'no co-operation'. The language used contributed to delaying the protection needed by the girls and asked for by their parents. It had the effect of judging the behaviour of the victims and deflected away from the groomers. There was a perception of children consenting to sexual activity and a very unreasonable excuse of uncertainty about age as the reason for not taking further action.

The patterns of abuse uncovered in Oxfordshire mirrored those seen in other places such as Rochdale, Derby, Bristol and Rotherham. Organisational weaknesses prevented the true picture from being seen.

Staff did not act with appropriate sensitivity, rigour, imagination or common sense. Processes and procedures were not implemented correctly, and the multi-agency work around safeguarding was not strong enough or apparently evident. Concerns were not escalated to senior managers, and the work done was not good enough. This meant the abuse continued for longer than it should have.

The value of top managers and governing bodies needing to know and be involved was not grasped. The culture within Oxfordshire was for middle managers and practitioners to solve problems themselves rather than considering the wider corporate governance issues. This denied those at the top of the office any influence over what was happening and created a culture of them not being open to early warning and wanting to know about the most challenging and risky issues being handled by their staff.

Oxfordshire now and the difference this is making for children and their families

The creation of the ground-breaking multi-agency Kingfisher team in 2012 introduced real-time sharing of 'soft' and 'hard' information from a wide variety of sources including police intelligence. This creates opportunities to identify county-wide patterns of children at risk of CSE very quickly and enables the team to see links between individual children and potential perpetrators and this has been instrumental in recent and current investigations. The team gathers intelligence and information about children and suspects of concern. As of 1st April 2015 they were working intensively with 70 children and identified over 100 potential offenders. 373 children have been identified at risk in total[1],[2],[3].

The recent Operation Reportage (March 2015) is an example of using experience from Operation Bullfinch to inform new investigations. Action was taken following concerns raised by family members even though the child was not making disclosures to the professionals. Small pieces of information about one child led to talking to other children and linking them with the perpetrators. The police investigation team and the Kingfisher team understood that some victims were unlikely to feel safe to disclose until the perpetrators had been arrested and that the victims will tell their story in small installments as they 'test out' the police and social workers and look to see whether they will really be helped. The ability to stick with the child, even when they were non co-operative and abusive was a critical factor in gaining their trust. At the conclusion of the trial guilty verdicts were returned on 23 out of 26 indictments and the perpetrators received custodial sentences.

The Kingfisher Team also provides consultancy and support to other professionals working with children at risk of CSE and co-ordinates locality based information sharing through 'extended team meetings'. They have supported the roll out of Chelsea's Choice, attending sessions in schools and have taken disclosures from children as a result.

The implementation of the CSE screening tool across all agencies has raised awareness and ensured that key partners take responsibility for early identification. A recent report highlights the range of partners completing the screening tool. There has been a 104%

[1] Summary of Kingfisher work and outcomes
[2] Kingfisher Intelligence
[3] Letter from Louise Casey following a visit to the Kingfisher Team

increase in the number of tools completed in January to March 2015 compared to the same period in 2014. The multi-agency case audit for this stocktake indicated that they were completed to a high standard and in cases where there were concerns, but not evidence of grooming or CSE, support was in place through schools, School Nurses and early intervention workers, including voluntary sector providers to work with children. Where appropriate, the screening tools had been updated as new information came to light[4].

Evidence provided for this report demonstrates that agencies across Oxfordshire have increased awareness of the risk and indicators of CSE. There were examples of CSE screening tools being completed by schools, health services, the youth offending service, early intervention service and social care. They were completed in a timely and thorough way to enable the Kingfisher Team to consider risk and create a full picture of the situation the child was in.

Children's social care has employed an Analyst who is working within the Multi-Agency Safeguarding Hub (MASH), the first point of contact for most CSE referrals. The Analyst is developing a Social Network Analysis approach at this first point of contact considering multi-agency data including missing children data and CSE screening tools to enhance understanding and early identification of children at risk and their links with other children and potential perpetrators.

Anyone under 18 is now referred to as a child and not as a young person so their status as a vulnerable child is never overlooked or misunderstood. The Senior Investigating Officer in Operation Reportage reinforced the importance of this in presenting the case to the court and in enabling the Jury to see that the victim was a vulnerable child. He commented that prosecution barristers needed to be reminded of the importance of this in presenting the case. Children understand that police, social care and health work together and share information. This enables openness and reduces the need to repeat their story which children and parents find frustrating.

Parents and carers are recognised as pivotal players in keeping children safe. This is shown in the case records audited[5] for this stocktake, and the pledges published in the

[4] Analysis of completed CSE screening tools from January 2013 - March 2015
[5] Multi-agency case file audit, May 2015

Oxfordshire CSE [6] promise following Operation Bullfinch. Social workers and other professionals work closely with them to support and protect their child and provide appropriate challenge and intervention when parents are not protective. Almost all the children and parents spoke positively about being involved in planning for the child although some felt that some agencies could do better[7].

Many parents interviewed for the case audits spoke positively about the support they had received and commented on how this had improved in recent years –
'They've got better – the professionals'

Foster carers (some of whom had previously cared for a few of the A-F children) told us that it is like ***'being in a different world now'*** and that when they **'talk *to social workers about concerns now they jump'*.**

Some parents still felt that the professionals could share information with them earlier or that sometimes the professionals could work together with schools better.

'It mattered that she stuck with it. I had 4 social workers before I got my social worker, I was a pain and just told them all to f off, but my social worker wouldn't f*** off!'***

Children's social care 'Need to Know' policy sets out the types of situations that need to be escalated to senior managers. Following the findings of the SCR A-F a workshop was held for senior and middle managers to reinforce the policy and expectations. Analysis of the use of this policy shows that cases are being escalated from social care teams across the County and directors are confident middle managers are contacting them appropriately about cases causing concern.

This is supported by the multi-agency audit where cases were swiftly followed up when one agency failed to act on a concern or pursue it in a timely way. One practitioner told us

[6] Oxfordshire CSE promise
[7] Engagement Report

during a frontline visit that she is confident that 'it feels there is enough people to take an issue forward to if we were not happy with an initial response'.

Escalation in social care in the 12 months up to March 2015[8] identified themes around teenage self-harm incidents, an emerging gang culture in one area and a growing awareness of perpetrator profiles linked to asylum seekers. This change in culture has resulted in the review of historic records and cases re-referred for further investigation as well as the setting up of specific groups to tackle new and emerging themes.

Peer violence amongst older children has been identified as a priority for the OSCB in 2015/16 through feedback from cases. A visit to the team working with children in care and those leaving care showed us the importance of continuing support beyond 18 for some children at risk of CSE. Training is extended to housing providers and personal advisers working with care leavers.

Children's social care has secured funding for children in care, to increase children's residential units increase from 12 to 32[9]. A core aspect of the strategy is to keep the most vulnerable children closest to home and reduce the use of out-of-county placements[10]. This case study below shows why this is important:

A child was admitted into care in crisis. She was known to be engaging in sexual relationships with older teenage males and males up to the age of 26 years. A multi-agency risk management action plan (MARAMP) allowed the home to provide high level safeguarding responses. For example tracking the child's movements on the buses to provide the Kingfisher team and police with addresses and areas frequented. This resulted in the older teenage males being remanded on police bail under the abduction act and drug offences and other abduction notices being served to disrupt unsafe behaviours. The child is beginning to form trusting relationships with her social worker and the team at the home.

Thames Valley Police (TVP) have robust systems in place[11] to ensure senior officers are aware of emerging issues and concerns including daily management meetings and weekly

[8] Evidence of escalation in Children's Services
[9] Oxfordshire's Placement Strategy for children in and on the edge of care, July 2013
[10] Update on progress of Placement Strategy April 2015
[11] Evidence of escalation in Thames Valley Police

tasking and co-ordination meetings. These enable senior officers in leadership roles to quickly respond to changing needs and to deploy resources accordingly.

For CSE, TVP have a force-wide CSE oversight group that meets monthly and is chaired by a Superintendent who holds the CSE strategic lead. This tends to cover larger CSE investigations and themes across the force. For example, an issue of “trap parties” was raised recently in this forum but subsequently found to be involving over 18s.

A force CSE Gold group is the final overview and escalation process. This is chaired by the Assistant Chief Constable for crime and provides chief officer oversight on all CSE issues and concerns.

The Superintendent briefs all district Chief Executives quarterly and local Commanders extend these briefings where there are serious issues and investigations. Reports are added to tactical assessments and joint work with taxi licensing is identifying potential suspects.

In 2014 the early intervention service, police, social care and the missing person’s panel were sufficiently curious to share concerns they had about a group of children in the south of the County. They were worried about the risk of CSE because of the children’s substance misuse, sexually risky behaviour and the number of times they were going missing. Agencies mapped the connections between these children and the services they were known to. This confirmed there was no organised or prevalent CSE issue. They continue to share information to monitor the situation and keep the children safe[12]

Our observations are that escalation from the frontline to management is more robust and this is reported through section 11 returns to the OSCB[13]. This is supported by the proactive approach taken by district councils through their youth engagement activities and training their staff on the ground to be the ‘eyes and ears’ of safeguarding. Moving forward, the partnership, through OSCB, must collectively evidence that it is sufficiently equipped through its membership to highlight any new pressure points emerging within child protection.

[12] Practice example
[13] OSCB Section 11 report and peer review

A school Nurse at one Oxford city secondary school told us that any child missing from school was immediately sought out and found by a bespoke minibus service operating from the school. This stocktake has shown that schools are compliant with reporting missing children swiftly and robustly and this is reported to the OSCB. A focus group of foster carers who were contributing to the refresh of the OSCB CSE strategy gave very positive feedback about schools engagement with missing children and those at risk through CSE and analysis of the missing children data confirms that schools are now very proactive[14].

'We tested them, the social workers and everybody; we didn't know who we could trust it was important that they kept coming back.'

Extensive awareness raising activity and training, and reviewing and re-writing of operational and strategic policies has resulted in an increase in the completion of screening tools and referrals to the Kingfisher Team 2012-14. The pervading acceptances of the risks that CSE presents to children has permeated the language and tone of the conversations between professionals and their confidence to challenge through escalation if they are not happy with, or are unsure about, the action being taken. This is matched by the senior management response to confronting the nature of CSE and taking action against it by working in partnership, hearing the safeguarding issues and never giving up.

CSE is now evidently seen as child abuse and responded to as a crime. It is a community safety issue and the district community safety partnerships are well embedded into the county-wide approach to tackling CSE[15]. Local police commanders are expected to keep district council chief executives apprised of risks and threats in their area and they in turn are expected to work in partnership with the OSCB to tackle and disrupt perpetrators[16], [17].

[14] Foster carer focus group
[15] Minutes of meetings with district councils
[16] Local Police Area disruption plans
[17] Thames Valley Police Prevalence Report

'It wasn't good before Kingfisher. People did not know about CSE and grooming.'

'We are going to university and train to be social workers and then we are going to work in Kingfisher and help girls like us.'

2. Has our attitude changed towards vulnerable children and parents?

Oxfordshire then

The views of families about police and social care were not positive. They saw staff as not taking their concerns seriously enough, not believing the girls, and not picking up the hints that they were giving about their abuse. As one parent put it;

> ***"no service or individual has been able to engage with her at all, most have not even tried. She is absolutely alone in the world apart from me and she refuses to allow me to have any influence on her".***

To some agencies, certain parents were seen as unco-operative, collusive and even obstructive. The girls held similar views about police and children's social care. They said people were not being inquisitive enough about what was happening to them. They saw staff as critical and unable to make a meaningful connection with them. Their bewilderment at not being seen as a child and never being asked 'why' is graphically expressed in the SCR.

The girls were not always seen as children nor were they seen as victims. Their verbal and non-verbal actions were ignored and professionals did not understand these as signs of grooming and CSE and so agencies did not intervene. Agencies did not respond robustly to their resistance to support and were unable to handle the frequent withdrawal of allegations or refusal to give details of what happened.

The language used by professionals demonstrated the lack of full understanding of CSE at the time. It described the girls getting themselves 'into trouble'. Other examples were a child missing being recorded as:

> ***'Believed to be prostituting herself... to pay for drugs', 'putting themselves at risk"***

This unsuitable language had the consequence of delaying the protection needed that the

"She is a streetwise girl who is wilful...'

girls secretly wanted, and the parents very clearly desired. This was because the words were judgemental and created a sense of the child as a criminal rather than a victim, and deflected attention away from the perpetrator and the role they were playing.

There was a poor relationship with the sexual health clinics as they focused on maintaining confidential relationships rather than considering if children were safe. This heightened the dearth of professional curiosity. Information sharing was poor and the issue of consent in a sexual relationship under the age of 16 was not widely understood or consistently recognised.

Police investigations looked at the presenting issue and did not progress unless the girls were prepared to make a statement or provide a Video Recorded Interview. Potential evidence was not pursued beyond intelligence or missing persons reports, and investigators did not make the connection. This meant the chances of a successful prosecution were much lower and little disruption activity was undertaken.

Oxfordshire now and the difference this is making for children and their families

Proactive work has been instigated around the issue of consent. This started in 2013 and was repeated in 2015. A dedicated website has been developed (www.checkconsent.com) alongside campaign materials[18]. Posters were distributed to Pub Watch Co-ordinators across the Thames Valley area and to every secondary school and university. The OSCB has re-commissioned its training on working with vulnerable children and risky behaviours to include more information on consent.

Thames valley police collate and store evidence and information regardless of the child's current attitude towards progressing the investigation[2]. This means it can be retrieved and is valid should the child decide to make a statement at a later stage or other evidence comes to light which could lead to a prosecution.

'Before Kingfisher the police just used to find me, take me home and push me through the door saying there you are she's home.'

The Crown Court Trial of Operation Bullfinch made consistent and important decisions

'The police since Kingfisher are different. They understand it and they tell you like it is'.

about how vulnerable victims should be treated when giving evidence. Operation Reportage 2015 benefitted from this approach and Oxfordshire has put together detailed support packages for all victims giving evidence, working closely with family members.

A more understanding and robust attitude towards children involved with CSE is clearly evident not just in the courts but within policing and in particular with the officers working within Kingfisher. Comments made by parents and children during the audit interviews confirmed that professionals in the key agencies were alert to the signs of CSE and that they were 'curious'. Several children and some parents described professionals as 'being nosey' and one child spoke about a police officer not giving up when worried about her[7]:

'They kept on asking what it was all about and in the end I had to tell them'

Additionally the review heard of some noteworthy practice in understanding the child's needs from those who led Operation Reportage. The approach is child-centred, welfare issues are considered and the pace of the work is matched to the child's needs[5].

The social worker spent time talking to a child and listening to them. They also spoke to the child's parents and extended family, and the school. This led the child to quickly disclose he was gay and to explore his gender identity issues with the social worker and later with a nurse. Discussions unpicked issues such as the child saying he was looking for a father figure when searching for males on line.

The child was unco-operative throughout the prosecution because of the feelings he had towards his abuser. The social worker, police, nurse, and placement maintained a very clear approach with him that he had been abused. They worked with him to develop his understanding about this and to address the on-going risks he faced when attempting to contact his abuser and possibly other adult males.

As a result of this work the child is now safer. He gradually understood the risks of meeting males on-line and has stopped doing this.[5]

Operation Reportage, March 2015 and Operation Sabaton, June 2015, show on-going commitment to never giving up on children, allowing the time they need to build trusting relationships and to disclose their abuse and a determination to hold perpetrators to account for their actions. Following publication of the SCR two of the Bullfinch victims spoke to over 450 frontline staff and managers in March and May 2015 about their experiences and this had a significant impact on those who heard their input.

Police and social workers jointly visit and patrol locations where CSE is suspected to ensure that welfare issues are incorporated into any police-led activity[19]. Hotspot locations are identified through surveillance reports and disruption actions identified in each local command area CSE disruption plan[20]. The case audit illustrated how children are given time to tell their stories and be believed. Children spoke positively about those professionals who gave them time and who understood they needed to build trust. They were less positive about those they saw as asking too many personal questions too soon. Sexual health services work with children, explore the issues of consent and are inquisitive about their home life and support they are receiving.[7]

Social workers openly discuss issues, such as religious beliefs and sex, with parents and their children. Honesty about the impact of individual actions is at the forefront of these conversations. Parents and children spoke about the importance of social workers setting boundaries and of the professionals being friendly and welcoming. Parental behaviour is challenged and change supported so they are better able to support and protect their child. This example was included in the case audit[5].

A teenage boy told his social worker he wanted to be called by a girl's name to wear girl's clothes. The social worker accepted what the child was saying. In discussing what had changed for them the child said – 'I now feel safe'.

The social worker was uncertain whether the gender identity issues were a reaction to the sexual abuse the child had experienced or something that would have happened anyway.

[19] Case example of disruption work
[20] Multi-agency disruption examples

They recognised the need for specialist advice and support for the child and for themself in working with them on this.

The child was supported by the social worker to talk to his parents about his sexuality and work was undertaken to help them understand and accept this.

Children are no longer considered in isolation. The involvement and impact of other children is considered. For example, the behaviour patterns of children in one part of Oxfordshire were linked through the sharing of information at the district community safety partnerships and the problem profiling report compiled for the safeguarding board CSE sub-group[17].

A 13 year old girl's friends raised concerns with school about her being sexually exploited by a relative. The children were believed and a strategy meeting was held with the Kingfisher team in June 2014. The child and her mother initially lied about her contact with the relative. The child insisted their relationship was not sexual and she denied their relationship and tried to stop professionals talking about what had happened with the adult concerned. The social worker saw how well the child responded to the child abuse investigation officer and it was agreed the police would take the lead role with the girl.

Agencies are working with children on protective behaviours, which has led to the development of a consent checklist for sexual relationships used by School Nurses. All secondary schools have a School Nurse. Children can self-refer to this service. Some School Nurses are available all year round and not just in term time.

Each year School Nurses compile school health improvement plans with input from head teachers. These provide an opportunity to highlight the strategic safeguarding needs of the school. The specialist nurse working in Kingfisher has provided CSE training for School Nurses and offers support and advice on cases where early concerns have been identified. One city school reported that emotional wellbeing, self-harm and sexual health were priorities, triggering questions around CSE[21].

Oxfordshire has an effective response to CSE, which has been in place for 3 years. However, this should not and cannot distort the single- and multi-agency response to other

[21] Good practice examples from School Nursing Service

known pressures in the child protection system such as the impact of domestic abuse, substance misuse, and neglect. There is good evidence of this wider safeguarding work being prioritised, for example though a 'neglect pilot', a multi-agency project for schools and colleges in responding to and reducing self-harm in the north of the county and a new pathway to tackle FGM[22], [23], [24], [25]. It is essential that children's social care continues to evidence to itself and the OSCB that the top of the office is aware of safeguarding pressures.

It is recognised that these factors can be linked to an increased vulnerability to grooming and CSE and a reduced resilience. This understanding is being used to target interventions, particularly in the faith, community and voluntary sectors and often in partnership with schools, the police, social care and early intervention services. There is evidence through this review of good practice with work being done with children on raising their self-esteem, recognising unsafe and safe relationships and encouraging children to provide positive support to each other[26], [27], [28], [29], [30], [31]. The district councils have used funding via their community safety partnerships to support local projects undertaking this work.

'It's like a different world now – nothing like it was when I cared for my girl in 2009/10'

'The police response has definitely changed. They now respond to all missing children and take it seriously – even if the child is over 16. Before they would tell us the child was making their own decisions, now they look for them and bring them home'

'Schools are better at sharing information now and they come to the strategy meetings which is good'.

[22] Complex case planning report
[23] FGM training GP impact quotes
[24] Development of the MASH
[25] Impact of work on FGM
[26] Practice example
[27] Early Intervention Service feedback fortnight
[28] Values verses violence evaluation
[29] Residential care case example
[30] Oxford Pastors Forum October and December 2014
[31] Early Intervention Hub case example

3. Has our response changed and are we keeping vulnerable children safe?

Oxfordshire then

There was little co-ordination of the services being offered to the girls and their families, professionals struggled when they met with resistance and staff were not adequately trained about the signs of CSE and in understanding why the victims and their families behaved as they did. This lack of knowledge also affected the therapeutic care given to the girls as risks were not identified, clues not picked up, and the presenting issue was the only focus.

Disrupting the activity of individuals and groups that were exploiting the girls was not a core part of practice. The police did not use the range of legal orders that had been available since the mid-1980s (child abduction warning notices introduced in 1984 for under-16s, and in 1989 for under-18s and risk of sexual harm orders introduced in 2003). Also, the police did not involve other agencies in tactical meetings, such as the district councils who issue licences for taxis or the county council who have a range of other regulatory powers.

In some cases there was a lack of determination and persistence from staff, which meant there was little chance of the girls building trust with a dedicated worker. Victims were not confident to disclose and give evidence, and there was little or no support for victims and their families.

Prosecution was perceived as difficult and investigations did not always occur. The girls therefore did not disclose, or they made a partial disclosure, because they could not see how the police would keep them safe from their perpetrators. In their eyes nothing happened as a result and this reinforced their sense of isolation and lack of choice.

There was pessimism about whether cases could successfully get to court due to the lack of evidence from victims, and this was a disincentive to further investigation without victim support. Attention was focused on a strategic approach to *managing* missing children rather than bringing adult perpetrators to justice.

Children's social care tried to manage the times the girls went missing rather than focussing on understanding why they were going missing and so did not understand the need to

weaken the perpetrators 'pull' on these very vulnerable children. Added to this, there was a total disconnect between the missing children's panel and specific CSE issues.

Overall the co-ordination of work and sharing of information around the safety of these children was poor. This meant that a wider picture on CSE could not be gained to enable effective multi- and single-agency interventions to be deployed to safeguard children who were incapable of protecting themselves.

Oxfordshire now and the difference this is making for children and their families

At the heart of the change in structures and culture is the Kingfisher team formed in autumn 2012. It is a joint team comprising of social care, police and health professionals working solely on child sexual exploitation issues in a single office. Those children whose cases were audited, and their parents, were all positive about the Kingfisher team[7] valuing their skilled approach and that the workers had the time to build relationships. Parents appreciated social workers who were responsive and being able to call and text if they were worried.

Kingfisher's remit is to help and protect children who have been or who it is thought may have been subject to child sexual exploitation, and to disrupt criminal activity with the aim of bringing court proceedings against perpetrators[32].

The team has been fundamental to supporting Operation Bullfinch, bringing forward other prosecutions, including the convictions in March 2015 of six individuals in Banbury. In addition to the group-based convictions in the period to March 2015, a further six lone offenders and another group of three offenders have been convicted of offences including on-line grooming and abuse of both boys and girls. Convictions have been secured in relation to offences against 35 children in total. The most recent arrests took place on 2nd June 2015 and at the time of writing a number of males have been charged.

Every child that is referred to the specialist nurse in Kingfisher is offered a health assessment. There has been a 60% uptake of these[33]. The other children have chosen to receive this support from someone they are already working with. A small number choose

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32 Independent Reviewing Officers Report May 2015
33 Report from specialist nurse in Kingfisher

not to engage with health.The Kingfisher nurse offers emergency contraception, pregnancy testing and chlamydia screening. They work closely with the School Nurses and can refer to sexual health clinics.

Engagement with schools and education was an area where further improvements were needed and it is evident attending school is seen as a significant safeguarding indicator. Some parents and children still spoke about school not understanding their particular issues.

The case audit highlighted how this is now being addressed through partnership work and engaging with the child and family[5].

Initially supported in her local secondary school, it was quickly noted that one girl's unsafe behaviour led to the need for an individual educational package, mostly away from the school site.

Assessing her needs and listening to the child's views, the child was placed in an appropriate full-time school provision. This took account of her wishes for the future and was mindful of the risks regarding placement highlighted by multi- agency work.

She has been able to re-take one academic year and is on track to attain her GCSEs. She is happy and feels that she belongs in her new school.

Refresher training has been provided on the use of the multi-agency risk assessment and management plan (MARAMP) tool[34]. This tool has improved the approach to evidence-based and outcome-focused multi-agency working with high-risk children. Professionals are identifying risk factors and thinking about how to build children's resilience. They ask 'why' and focus on what is triggering the risky behaviour. The children and their families work with services and take responsibility for some of the agreed actions. One parent commented positively on the use of a child protection plan and how it served to bring all the professionals together, although she had found the conference itself quite intimidating.

The youth offending service is contributing towards the emerging proactive approach and early intervention work around CSE. The Oxford Child on Parent Violence Project started

34 Audit of Multi-agency risk assessment and management plan (MARAMP)

in April 2015 and a pilot called ‘Building Respectful Families[35]’. These projects are for teenagers and families experiencing child-on-parent violence and are being delivered through partnership with the voluntary sector using funding from the Police and Crime Commissioner. This potential indicator of child abuse was a feature in several of the A-F girls and shows the significance services place on supporting parents and children together.

We found evidence that services recognise the vulnerabilities of older children and there is consideration of their housing and accommodation needs. It is the norm in Oxfordshire for looked after children to remain looked after and in placement until at least they reach 18 years old. In all cases the Deputy Director or Director have to agree a discharge from care before 18 and no cases have been put to them for agreement in the last year.

Prior to the Staying Put legislation (2013/14) the county council had a policy which allowed young people to remain in foster care post-18 for the remainder of the academic year in which they turned 18 providing they remained in full time education. Between 2009 and 2013 sixty children aged 18 remained with their carers to complete education. Since the Staying Put legislation was implemented Oxfordshire has actively promoted the scheme although the transition to financial support through housing benefit as opposed to fostering allowances has not been without difficulty for some carers. Since the Staying Put scheme was introduced 24 young people have remained with their foster carers.

Young people who are Looked After or Leaving Care aged 16 and 17 are able to access the full range of LAC accommodation provision. Those not looked after but in need of supported accommodation can access the Supported Housing Pathway. The Pathway is an intervention based on multi-agency needs and risk assessment through the MARAMP (multi-agency risk assessment and management plan). All supported housing providers, as well as children's social care teams, have received training in the function of this framework and its implementation. Every supported housing provider within the Pathway has adopted this framework as their primary risk management tool and have given very positive feedback around its impact on improving accurate risk information and shared management strategies.

The Early Intervention Hubs play a key role in supporting teenagers in the community and their role includes return interviews with some children who have been missing from home.

[35] Building Respectful Families Project

Providing long term support for young people abused through CSE is placing additional demands on services and the county council has commissioned a review of the needs of vulnerable young people aged 16 to 25 years to consider best practice and recommend future servcie models. Other partners, including health, are also reviewing their transition services.

The Missing Person's Co-ordinator is part of the Kingfisher team. They share information immediately with the team. This has increased knowledge on potential perpetrators or venues where CSE may be taking place. It has also strengthened the approach to gathering evidence used for arrests and prosecution. The OSCB CSE sub-group has responsibility for monitoring practice in relation to missing children and has recently followed up concerns about the timeliness of return interviews in some cases. Many parents spoke positively about police and social work responses when their child was missing[36].

The role of community safety alongside the civil remedies available to the police has led to a number of successful disruptions and new operations to bring perpetrators to justice[20]. Over the previous 15 months 29 child abduction notices have been issued by the police and 6 sexual harm prevention orders have been issued by the courts at the request of the crown prosecution service and the police. To date no civil orders have been used but the county council legal team has been in contact with Birmingham to consider how they have been used there and the childcare team is briefed to advise social workers should there be a case where such an order would be appropriate. Local police teams carry out joint disruption patrols with the Kingfisher team using data and intelligence that identifies CSE hot spots where young people are congregating or it is known have been approached.

The district councils and the county council have been involved in joint intelligence sharing and joint operations which have served to safeguard children, including a case where intelligence suggested that girls were being given free alcohol from an off-license in exchange to then performing sexual acts on staff members. Test purchasing operations were organised, together with licensing officers from the local council, but no further concerns were evidenced. This was accompanied by a covert police operation which again raised no further concerns in terms of the location, but additional intelligence work is being completed regarding the males.

[36] Report on Missing Children

In another case a number of individuals had been frequenting a public house and conducting their business of dealing controlled substances and engaging in CSE offences. A large-scale operation involving fire, licensing, council, health and safety resulted in the premises being closed down. The closure of the public house has shown the community that the activity was unacceptable. It was well known that young girls were being groomed by males, who believed they were in a relationship with some of these men. The management of the establishment was telling staff not to report outbreaks of violence.

In 2013 a number of multi-agency warrants were executed at a guest house in Oxford which was historically linked and frequented by perpetrators of CSE. Police co-ordinated the warrants working with Fire and Rescue, Health and Safety, Licensing and HMRC. As a result of these warrants two of properties were closed.

In 2014 a warrant was executed at a guest house believed to be linked to CSE and trafficking. This was an extended multi-agency warrant involving the National Crime Agency, City Council, County Council, Police, Operation Bullfinch, and the Police lead for human trafficking. Two suspects were arrested. Prosecutions are on-going by the council for numerous environmental breaches. Two females were removed from the property and have been assisted to return to their home country.

The district councils are committed to sharing information to improve the regulation of taxi licensing across Oxfordshire and deal with safeguarding issues in a pro-active way[37]. However, collaboration across all the district councils is needed, with monitoring of this, to overcome the challenge presented by licensing rules that make it increasingly common for a driver to be licensed in one area but drive a private hire vehicle in another area. This has the effect of cancelling out any council's attempt to protect the public by raising the bar for its licensing criteria. Information exchange between licensing authorities needs to be set on a formal footing to enable the effective assessment of whether a driver passes the 'Fit and Proper Person' test. This determines whether a license is refused or revoked due to conduct.

Oxfordshire county council's changed its procurement arrangements in 2015, meaning that it will only issue contracts to providers who meet a new higher standard. However,

[37] Taxi licensing information from City and district councils

challenges remain in regulating drivers of vulnerable children and adults and during this stocktake it has become apparent that the system requires robust overview. Remedial action has been taken and new face-to-face vetting procedures will be introduced from June 2015[38],[39].

The county council has set high standards relating to the regulation and transporting of vulnerable children but information provided to us showed there have been on-going challenges to monitoring these across different county council departments and between county and district authorities. An internal audit was undertaken in early 2015 as children's social care recognised that progress had been too slow in completing risk assessments on providers. The county council acknowledges the need to connect their assurance mechanisms around transport to the wider issue of risks to CSE in partnership with the district councils and that concerns like this must be escalated to the OSCB more swiftly in future as part of the drive for continuing improvement. Safeguarding children in transport was identified as a priority for the OSCB at its extended meeting in April 2015 and the OSCB is monitoring progress both within the county council and across the districts. The OSCB section 11 requirement has been extended to the county council department with oversight of transport contracts for its 2015 return as it is clear that reporting from children's social care alone was insufficient.

A huge amount of training and awareness-raising has been and continues to be delivered to a wide range of professionals across the county[40]. This includes staff in schools and GPs. In 2014 over 7,500 practitioners who have contact with children received training on CSE. The impact from this can be seen in the significant increase in the number of CSE screening tools completed and the range of agencies referring into the Kingfisher team. However, in this report we noted the difficulty in mandating safeguarding training to wider sectors of the community. Although training has been provided to hoteliers, for example, only 12 out of 800 Oxford city licensed drivers took up the offer of training from Oxford city council in the last 12 months and no safeguarding training is offered in the other districts. We recommend that licensing of taxi drivers should be linked to mandatory safeguarding training across Oxfordshire and the rest of the country. Work has begun to co-ordinate practice across the district council areas and local police area command areas on the roll

[38] Allegations management - taxi providers
[39] Action plan, safeguarding in transport
[40] Partnership training information

out of ‘Say Something If You See Something’[41] training to hotels, guest houses, door staff, parks and street scene staff and others who can act as ‘eyes and ears’ on the ground.

Following a visit to Kingfisher, one of the A-F girls is quoted in a BBC news article as saying she believes the police are **"*well on their way*"** to improving their methods in dealing with child sex exploitation. "*They're more vigilant*," she said. **"*There's more police out looking for older men with younger girls, or young girls looking distressed.*"**

This view was expressed by practitioners at a learning lessons event run by the safeguarding board in March 2015. In 2014 the Kingfisher team secured support from BLAST, an organisation with specialist expertise in work with boys based in the north of England who provided training and support to the team. Two cases audited for the stock take were boys and both demonstrated evidence of practice to a high standard and sensitivity to their needs. The boys were involved in on-line grooming and had met adult males who abused them. The proportion of males in the Kingfisher caseload has gradually increased over the life of the team and by March 2015, made up 17% (1 in 6) of the open caseload.

[41] Say something if you see something update

4. Are strategic leaders working to safeguard children from CSE?

Oxfordshire then

Top-level commitment from agencies to the OSCB was variable, and board members did not follow things through. Crucial national guidance in 2009 on CSE was overlooked, and there was no strategic overview.

Before Bullfinch, the influence on the OSCB from top managers varied. This contributed to the OSCB not operating in a way that was picking up growing levels of concern, or exercising its statutory duty to collectively lead on CSE from 2009. Concerns across all agencies never reached the most influential decision-makers, and therefore those leaders were not driving a strategic approach.

There were issues across agency boundaries. There was limited understanding of the relationship between the community safety responsibilities held by the districts and the statutory child protection role of the county. Performance management processes did not identify significant causes for concern at an early enough stage. Governing bodies therefore did not have the opportunity to contribute to a robust response and determine priorities.

It took a long time for concerns to be co-ordinated and reach the highest level of organisations. In each year from 2005-10, there were discussions in one setting or another in Oxfordshire about sexual exploitation, but hardly any of this was at a level that could have made a strategic difference.

Oxfordshire now and the difference this is making for children and their families

Following an internal review in August 2013 the OSCB has recognised it must have a strong strategic profile of child protection across Oxfordshire and all organisations are now properly represented at the right level on the safeguarding board with regular formal meetings.

The Oxfordshire Safeguarding Children Board has had a CSE sub-group in place since 2011 and produced a CSE strategy and action plan, a CSE Screening Tool and

Professionals Handbook in 2012. The strategy and action plan is currently being refreshed and includes input from children, parents and carers. The refreshed strategy is written to reflect Oxfordshire's involvement as one of three national pilot sites for the office of the children's commissioner 'See Me, Hear Me' framework. The CSE sub-group brings together all key partners, including the district councils and voluntary sector, and is driving forward the local response to CSE. The sub-group connects with other key partnerships and groups for example the missing person panel, the district community safety partnerships and the children in care council. The CSE sub-group has oversight of the work of Kingfisher, the missing person panel and the police prevalence report and provides support and challenge to ensure the work of partner agencies is robust. The sub-group has started to use a multi-agency performance dataset and is working closely with the OSCB Performance and Quality Assurance sub-group to ensure data and analysis informs their work plan. The CSE sub-group will include the learning from this stocktake in the action plan. The CSE sub-group chair reports to the OSCB to ensure effective oversight and the OSCB CSE co-ordinator supports the sub-group.

CSE as a strategic priority is reflected in all major partnership plans across the County[42] and the Independent Chair has instigated chief officer safeguarding summits. CSE is a priority of the safeguarding board, the county council, district community safety partnerships, the health and well-being board, the children in care council, school health plans, and policing plans. Oxfordshire county council has invested additional resources to tackling CSE, including recruiting more social workers. The Kingfisher Team, which was initially established using short term funding, is now incorporated into the base budget. In real terms children's services budgets increased by 80% between 2007 and 2014. The Chief Executive of the county council describes CSE as her "*number one personal priority*". The police have recruited a number of specialist posts to tackle CSE. Oxfordshire's funding of School Nurses in schools demonstrates new public health investment and the district councils have contributed through the safer communities budget, including a contribution towards a specialist BME worker in the Kingfisher Team.

[42] Review of Oxfordshire's strategic partnerships

Leaders in Oxfordshire have shown their commitment to tackling CSE and disrupting and bringing to justice perpetrators across the county. This report concludes that current and future strategic planning needs to reflect a more dynamic understanding of the area's diverse communities, both in terms of locally agreed priorities and the workforce employed to deliver services to these communities. Data provided for this stocktake shows that the population of Oxfordshire includes 9.2% of people from various minority ethnic communities whilst Oxfordshire county council has a workforce (excluding schools) of 6.5% from minority ethnic communities and Oxford universities hospitals trust 19%. Some partners were unable to provide useful workforce data. Examples of the apprenticeship scheme into children's social care are promising where 147 young people have been provided with opportunities including 9 care leavers and 27 young carers.

District community safety partnerships are directly engaged with the safeguarding board and in disrupting CSE. They are all now represented on the CSE sub-group. Through the intelligence they receive they take direct action from training frontline staff so that they know what to look out for and how to report what they see to closing down public houses. They have commissioned specialist services to work with children at risk through CSE, including risk as victims or as potential perpetrators, on a local level with some good examples of engagement with the faith, community and voluntary sectors[43].

All schools, including independent schools, across Oxfordshire completed a safeguarding audit in 2014, the first time a 100% return rate has been achieved. 47 of these reports were from the independent sector under section 157, with a further 285 returned from maintained, free schools and academies under section 175. Since 2014, the audit captures a wide range of information on safeguarding practice within each educational setting. In addition to the annual report and those schools who self-audited, during the 13/14 academic year, the safeguarding team at the county council undertook a total of 91 audits in schools across the county. This included audits in 12 independent schools[44].

Head teachers and their management teams have risen to the challenge of showing their commitment to working in partnership to safeguard children. More than 18,000 children have seen Chelsea's Choice, a drama that tours Oxfordshire schools to raise awareness of child sexual exploitation. Thousands more children have viewed the drama this year. In the

[43] Faith and Community Sector Focus group, May 2015
[44] Schools' safeguarding audits

autumn term 2015 secondary schools will be involved in the production Somebody's Sister, Somebody's Daughter, aimed at older students. This will reinforce and strengthen the messages they received from Chelsea's Choice. Oxford primary schools have been involved in piloting the Values Versus Violence programme which aims to develop children's core values, self-esteem and resilience and as such is seen as a very early preventive measure in terms of children becoming victims or perpetrators [28].

Prevalence reports which the police provide for Oxfordshire, detailing the current risks, hot spots and planned disruptions and operations are routinely shared with the community safety partnerships. The impact of operations and interventions and outcomes from prosecutions is monitored by the safeguarding board[17]. They use this information to inform their CSE strategy and action plan and to challenge how agencies are working together. The missing link in this report is the profile of perpetrators so that a better understanding can be derived locally and more sophisticated disruption techniques and prevention activities used. A force wide 'problem profile' has recently been developed which includes perpetrator information to be shared with partners (within which the OSCB will require the inclusion of ethnicity/cultural identity). This has been recognised by the CSE sub-group as an area for further development.

The CSE work led to a similar model being put in place in response to the emerging theme of female genital mutilation (FGM). The safeguarding board identified the significant impact that FGM has on the safety and wellbeing of girls and women[24]. A strategy outlines how the safeguarding board aims to prevent FGM from happening, improve services and professionals' responses to women and girls who have undergone or are at risk of FGM, and ensures sensitive specialist support, information and advice is available to them. Learning from work on CSE includes the use of a screening tool and the need for professionals to be curious and ask questions. One young mother, recently giving birth to her 3rd child said:

'*this is the first time anyone has asked about what happened to me.*'

The safeguarding board has mapped the community activity underway or planned throughout Oxfordshire during 2014[45]. This is extensive and some examples are given below:

- Parents groups in schools offering support to help them identify signs of abuse, and practical advice on how to manage risky behaviours and keep their children safe.
- Joint visits by the Kingfisher Team and the Community and Diversity Officer in Thames Valley Police to women's groups in the community.
- Developing and delivering in partnership with mosques child protection training to Imams and committee members in the City.
- Organising a safeguarding event and follow up training with the Oxford Pastor's Forum to raise awareness of abuse.
- City council community development team engaging faith and ethnic minority groups to build resilient and more cohesive communities as part of its CSE community development and engagement strategy[46].

A specialist family support worker in the Kingfisher team works with secondary schools to raise awareness of CSE, deliver protective behaviours work and address sexual health issues.

This is a snap shot of what is going on across the county and there is evidence to show a lot of activity and raised awareness. However, our conclusions are that because this is not overseen or co-ordinated the volume and breadth of activity is not fully understood and this remains a risk. The benefit of greater co-ordination through the community safety partnerships would be the joining up of efforts so there is no duplication, enabling targeting of scarce resources, sharing expertise and resources as well as making sure all diverse communities in Oxfordshire are reached. There needs to be a tight grip on district activity and reported progress from district authorities through the CSE sub-group of the OSCB, tasked with monitoring the CSE action plan.

Oxfordshire county council's adult commissioning team is piloting a project with adult services to provide bespoke support to young adults who disclose abuse or exploitation that took place when they were children but are not able to engage with statutory services. This

[45] OSCB CSE mapping
[46] Community Engagement, Oxford City Council

is being delivered in conjunction with the voluntary sector but at time of completion of this report it is not possible to comment on impact. The CSE sub-group has reported gaps in the amount of help and therapy that is available for adults. Recent discussions have been held with the organisation NAPAC (National Association for People Abused in Childhood) and one young survivor is being supported to participate in their programme. NAPAC are working on a plan to offer a bespoke group within Oxfordshire for adult victims identified through the on-going Bullfinch operation. Again, progress in this area must be sustained. CAMHS services provide intensive interventions to young people past their 18th birthday where this is appropriate and work is underway in Oxford health NHS foundation trust to ensure that other victims of CSE who need on-going mental health support can transition effectively into adult services. The importance of this must not be underestimated.

The stocktake found a good understanding within adult services and OCCG in how such interventions could work and they have been responsive to the findings of the SCR but progress is slow. Adult social care services have dedicated social workers who are based within the multi-agency team working on the follow up to Bullfinch and they will provide support to the (now) adult victims as well as brokering access to mental health, substance misuse and other services[47].

[47] Case study

5. What are our risks and gaps and are plans in place to address them?

The many and varied examples of new ways of working, innovative approaches to service delivery and the evident commitment to tackling CSE head on shows how far Oxfordshire has come since Operation Bullfinch. Services are listening, understanding, taking action, and never giving up; and they are making a difference to children who have suffered from or are at risk of sexual exploitation. Systemic weaknesses have been rigorously addressed and are reported to the OSCB in a more transparent way. Everyone knows the part they have to play in keeping children safe.

There is still work to do and there are five key areas for improvement. These have been widely acknowledged by the safeguarding board and its strategic partners. **As Oxfordshire continues to make progress and build upon the undoubted improvements, the need for consistent strategic grip of services and partnerships remains of paramount importance now and in future.**

i. Tackling CSE means getting the basics of frontline child protection right and children's social care must provide strong and persistent leadership working within the wider partnership. Chief officers of all organisations must take responsibility to ensure that serious safeguarding matters are escalated to the safeguarding board for challenge by the wider partnership.

ii. The safeguarding board and individual agencies (particularly the police) have a good oversight of who the perpetrators are in Oxfordshire. A better understanding of the link to ethnicity/cultural identity is required so that the right tools are used to target prevention work, disrupt individuals and bring them to justice.

iii. NHS and local authority commissioners need to work together to ensure that there are therapeutic services available for adults who disclose abuse and exploitation from their childhood. A huge focus of the work to date has been on the children currently at risk or being exploited and there is a gap in services for them as they move into adulthood and beyond. This includes ensuring that adult services are able to respond in an appropriate and timely way.

iv. Oxfordshire county council and all district councils must work more closely together to ensure that the regulation of the contracts to transport vulnerable children and taxi licensing across Oxfordshire is more robust.

v. Engaging and working with communities is key to effectively tackling CSE. The work of the district community safety partnerships across Oxfordshire must be more effectively organised in relation to safeguarding.

Appendix 1 - References

1.	Summary of Kingfisher work and outcomes
2.	Kingfisher Intelligence
3.	Letter from Louise Casey following a visit to the Kingfisher Team
4.	Analysis of completed CSE screening tools., January 2013 - March 2015
5.	Multi-agency case file audit, May 2015
6.	Oxfordshire CSE promise
7.	Engagement Report - parents, carers and young people, May 2015
8.	Evidence of escalation in Children's Services
9.	Oxfordshire's Placement Strategy for children in and on the edge of care, July 2013
10.	Update on the progress of the Placement Strategy for children in and on the edge of care, April 2015
11.	Evidence of escalation within Thames Valley Police
12.	Practice example
13.	OSCB section 11 report and peer review
14.	Foster carer focus group
15.	Minutes from meetings with district councils, including: - Cherwell Community Engagement, December 2014 - Oxford City Community Engagement, October 2014 - West Oxfordshire, Community Engagement, April 2015 - South Oxfordshire and Vale of White Horse, Community Engagement, March 2015
16.	Local Police Area CSE disruption plans: - Oxford City - South Oxfordshire and Vale of White Horse Districts - Cherwell and West Oxfordshire Districts
17.	Thames Valley Police CSE Prevalence Report, April 2015
18.	Check Consent Resources
19.	Case example of disruption work
20.	Multi-agency disruption examples
21.	Good practice examples from School Nursing Service, May2015
22.	Complex Case planning
23.	FGM training, GP impact quotes
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25.	Impact of work on FGM
26.	Practice example
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30.	Oxford Pastors Forum: - Abuse Awareness Conference, October 2014 - Training, December 2014
31.	Early Intervention Hub case example
32.	Independent Reviewing Officers Report on Kingfisher, May 2015
33.	Report from specialist nurse in Kingfisher
34.	Audit of multi-agency risk assessment and management plans (MARAMP): - MARAMP Audit, February 2014

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35.	Building Respectful Families Project
36.	Report on Missing Children
37.	Taxi and private hire licensing information from City and district councils: - Data analysis, City and district councils - Cherwell District Council, CEO response to Rotherham report on CSE
38.	Allegations management - taxi providers, Local Authority Designated Officer
39.	Children's Services action plan, safeguarding in transport
40.	Partnership CSE training information: - Oxford Health - Children's Services - OSCB
41.	Say something if you hear something update
42.	Review of Oxfordshire's strategic partnerships, May 2015, including - Health and Wellbeing Board - Children's Trust - District Community Safety Partnerships - Oxfordshire Safer Communities Partnership - Children in Care Council
43.	Faith and community sector focus group, May 2015
44.	Schools' safeguarding audits, including: - 2014 Audit - Local Authority Designated Officer work with independent schools and tutorial colleges - OSCB education sub-group - Local Authority Designated Officer work with language schools
45.	OSCB CSE mapping - work within faith and community groups
46.	Community Engagement, Oxford City Council
47.	Case study

Appendix 2

Summary of Risks and Gaps

Work undertaken for this stocktake has confirmed the areas where further work is required to continue the improvements made to date. A learning event is planned for September 2015 to ensure all organisations are informed of the findings of the stocktake.

These include areas for local agencies to address strategic and operational improvements and two matters for national consideration:

For National Consideration

• There should be core national standards for the licensing of taxis and private hire vehicles which include safeguarding factors. This would help to eliminate risks because of differential standards across neighbouring licensing authorities. The standards should include mandatory safeguarding training and the requirement for a driver to prove that the majority of their work is in the area in which they are licensed.
• There should be national research to identify perpetrator profiles linked to the different models of abuse through child sexual exploitation including gangs and groups, on-line and 'boyfriend' models. This should also include peer on peer child sexual exploitation.
• The lack of therapeutic interventions for young adults requires a national response in relation to an evidence based approach

For local agencies

• **For Oxfordshire County Council, with district councils, to** develop a single joint operator framework covering all aspects of transportation of children and taxi licensing arrangements to ensure the highest standards of practice are in place to safeguard children
• **For Oxfordshire Children's services** to continue to work with schools to prioritise safeguarding, and ensure schools respond appropriately, including to attendance issues
• **Oxfordshire Children's Services** to incorporate learning from the feedback from parents and children into the professionals handbook
• **Oxfordshire Children's Services** to ensure a briefing is held by County Council legal services department on the use of Civil Orders
• **For district councils** to include mandatory safeguarding training in their licensing requirements for taxi drivers.
• **For district councils** to report on outcomes of community engagement work to the OSCB.
• **For district councils to** closer align licensing standards and adopt the OSCB information sharing protocol
• **For Thames Valley Police** to ensure that information about perpetrators of CSE is collated to inform a perpetrator profile and help preventative work
• **For Oxfordshire Clinical Commissioning Group** to develop a response to children who are at risk through CSE and in need of CAMHS support and other

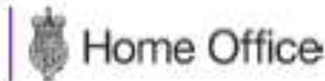
therapeutic interventions to ensure their needs are assessed and services provided in a timescale which meets the child's needs.
• **For Oxford Health NHS Foundation Trust** to ensure that there is smooth transition between CAMHS and adult mental health services especially for the group of victims who experience difficult engaging with mainstream services.
• **For Oxford Health NHS Foundation Trust** to implement and evaluate the impact of the new model for the Sexual Abuse pathway to ensure that children receive appropriate and effective assessment and treatment in line with national best practice.
• **For Oxfordshire Clinical Commissioning Group** and the local authority to develop a response to adult survivors of CSE and ensure they are able to access therapeutic services in a timescale which meets their needs.

For the OSCB – to revise its CSE Strategy to include

• the commissioning of prevention work with potential victims and perpetrators and services to support families where a child is identified as being at risk of CSE
• a CSE dataset to ensure all strategic partnerships have appropriate data and can monitor the incidence of CSE and response in their area.
• the impact of community safety partnerships on community engagement activity
• a recommendation in relation to transitional arrangements between a child victim and adult services when they leave child social care responsibility.

The above actions have been included in the OSCB CSE Action Plan and progress will be monitored through the CSE sub-group and reported to the safeguarding board.

Appendix 3 – Letter from Ministers dated 03.03.15



Maggie Blyth,
Chair of Oxfordshire Safeguarding Children Board
By email

Copied to: Ian Hudspeth (leader of Oxfordshire County Council), Anthony Stansfeld (Thames Valley Police, Police and Crime Commissioner), and Joe McManners (Clinical Chair of Oxfordshire Clinical Commissioning Group).

3rd March 2015

Dear Maggie,

PUBLICATION OF THE SCR INTO OPERATION BULLFINCH

We welcome your decision to publish this serious case review in full and to make no effort to hide the extent of serious, organised child sexual exploitation which occurred in Oxfordshire over a number of years. It is only by publishing in-depth accounts of what happened, what went wrong, and why, that children's social care systems locally and nationally can address the failings which have betrayed some of our most vulnerable children. That is why this government has insisted that serious case reviews be published and in full.

The account of what happened to children in Oxfordshire over a number of years is, as you acknowledge, deeply disturbing. The experiences of these girls, and the complete failure of public services to protect them, is appalling, sickening and truly saddening.

We would like to pay tribute publicly to the victims of child sexual exploitation in Oxfordshire and to their families who co-operated with this serious case review. The review makes clear the bravery required for them to speak out, as they have done, and we thank them.

It is clear from the serious case review that there was knowledge of the sexual exploitation of children in Oxfordshire from as early as 2005. But repeatedly, social workers, the police and health workers failed to look past the 'troubled teenager' to the abuse beyond. As a result they failed to act on clear evidence of sexual abuse, to protect the girls or even to pass on concerns to a sufficiently senior level.

The depth of failure is at times hard to fathom and we do not accept explanations that child sexual exploitation (CSE) was not 'widely recognised' nationally at the time. As the serious case review notes, 'One does not need

training in CSE to know that a 12-year-old sleeping with a 25-year-old is not right, or that you don't come back drunk, bruised, half naked and bleeding from seeing your "friends".' (para 8.50).

As ministers it is not for us to apportion individual blame but to assure ourselves that any local or national systemic weaknesses have been addressed. We acknowledge that improvements have been made in Oxfordshire both collectively and individually in the local authority, police and health services, and welcome the fact that the Local Safeguarding Children Board has taken a lead role in coordinating the improvements. It is, however, important that you are able to demonstrate, with evidence, just how these improvements are making a difference to frontline practice; and which services and interventions are making the biggest difference to children who have suffered from, or are at risk of, sexual exploitation.

We therefore propose that the Local Safeguarding Children Board leads a specific piece of work into the impact of the multi-agency approach to tackling CSE in Oxfordshire. To support you in this, we have appointed Sophie Humphreys to work alongside you, in order to gather evidence of the effect of your reforms to frontline practice. This will offer us and the public in Oxfordshire additional reassurance, and will be a valuable contribution to the work we are doing nationally to establish a centre of professional expertise to consolidate and share evidence on what works. We will expect this report back by the end of June 2015.

Today the Government has published a report into the action we are taking to tackle CSE, in light of the findings of the Professor Alexis Jay review into failures identified in Rotherham. In that report, we have announced a national whistleblowing helpline, new duties on the police to co-operate across force boundaries, and more support for victims of CSE. The revised 'Working Together' guidance will also introduce an expectation that Local Safeguarding Children Boards undertake regular assessments of local responses to CSE.

The experiences of the children set out in this serious case review should never have happened. We all owe it to them now to do everything within our power to stamp out this horrific abuse and to bring perpetrators to justice.

Edward Timpson MP	**Lynne Featherstone MP**	**Dr Dan Poulter MP**
Parliamentary Under Secretary of State for Children and Families	Minister of State for Crime and Prevention	Parliamentary Under Secretary of State for Health