

**Report of the
Independent Inquiry
Telford Child Sexual Exploitation**

Chaired by Tom Crowther QC

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Independent Inquiry

Telford Child Sexual Exploitation

Chapter 6: Other Organisations

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6. Other Organisations

Introduction

- 6.1 I have considered it necessary in order to fulfil my Terms of Reference to examine the role of certain other agencies within the policing and prosecution of Child Sexual Exploitation ("CSE"). As a result in this chapter I consider the roles and influence of the following:
- 6.1.1 National Policing Bodies;
 - 6.1.2 The Office of the Police and Crime Commissioner (the "OPCC"); and
 - 6.1.3 The Crown Prosecution Service (the "CPS").
- 6.2 As with the previous chapter, this chapter is dense and contains numerous acronyms, for which it may be useful to have the Glossary to hand.

National Policing Bodies and CSE

Introduction

- 6.3 The Inquiry has examined, as part of its remit, how West Mercia Police ("WMP") has sought to investigate CSE over the timeframe relevant to the Inquiry's Terms of Reference. In doing so, it is for the Inquiry to consider how police forces in England and Wales have been enabled in this endeavour by way of national policies, procedures and guidance, including where information has been shared with the local force relevant to the investigation or management of CSE offences, or related offences.
- 6.4 I have considered above the separate requirements locally as part of the obligations placed upon WMP to allocate resources in a way that addresses the objectives of the Police and Crime Plan, set by the Police and Crime Commissioner ("PCC") with assistance from Chief Constables, and as noted in that section of this chapter, the Inquiry has had access to material prepared by both the PCC for West Mercia and WMP in this regard.
- 6.5 This section looks specifically at the role of other national policing organisations, past and present, insofar as such bodies have played a part in setting parameters for dealing with the issue of CSE, as defined in the Inquiry's Terms of Reference. It is beyond the scope of this section to consider the wider role, effectiveness or work of those bodies individually, however.

CSE as a National Threat

- 6.6 On a national level, all police forces must have regard to the Strategic Policing Requirement ("SPR") first issued by the Home Secretary in 2012.¹

¹ In accordance with s37A Police Act 1996 as amended by section 77 Police Reform and Social Responsibility Act 2011.

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The SPR sets out the Home Secretary's view on national threats and the appropriate policing capabilities required to address them.²

- 6.7 It should be noted that the SPR was updated in 2015 to include child sexual abuse ("CSA") as a stand-alone national threat, with the aim of assisting forces to build a collective understanding of what is required to counter the threat and work in partnership to ensure the most vulnerable in our society are protected.
- 6.8 I have set out in Chapter 5: The Policing of CSE in Telford how police forces in England and Wales - and in particular WMP - use a national approach to intelligence handling, as well as Regional Organised Crime Units ("ROCUs") to share information and intelligence and support one another across a spectrum of policing capabilities. However, in addition to ROCUs and in line with the SPR, there are a number of key national policing bodies that assist police forces to adopt a consistent approach nationally to CSE.

Association of Chief Police Officers ("ACPO")

- 6.9 ACPO (covering England, Wales and Northern Ireland) was established in 1948 and replaced in 2015 by the National Police Chiefs' Council ("NPCC"). The association was a method by which chief police officers could evolve policing practices and share information in a national forum. Policing practices would be developed by ACPO who released Authorised Professional Practice ("APP"), publications that provided guidance to all officers on best practice in various aspects of policing. APP later became the responsibility of the College of Policing ("COP") after ACPO was dissolved.
- 6.10 In addition to APP, ACPO agreed upon guidance for police forces in collaboration with the Association of Directors of Social Services ("ADSS"). These guidelines included Home Office Circular 52/1988 (as discussed in Chapter 5: The Policing of CSE in Telford), which established the procedures that should be adopted in the investigation of allegations of CSA.
- 6.11 In response to campaigns highlighting the extent of 'child prostitution' in the United Kingdom, ACPO became involved in a national steering group in Spring 1997, alongside the ADSS, government departments and Barnardo's. This steering group was tasked with developing guidelines for third party organisations (police, health, social services, education) for safeguarding children involved in 'child prostitution'. As discussed in Chapter 5: The Policing of CSE in Telford, this guidance was successfully piloted in Wolverhampton and Nottingham, and became the ACPO national policy.
- 6.12 Taking place over 12 months, the pilots resulted in the prosecution of 22 men and 3 women for a variety of serious offences, including rape and unlawful sexual intercourse with a child under 16 years of age. These pilots demonstrated the effectiveness of strategic response to CSE via information sharing and inter-agency working between statutory and voluntary sectors, and thus still inform policing strategies in both Wolverhampton and Nottingham.
- 6.13 In 1998, the ACPO guidance set out alternatives to prosecution and diversion strategies for child victims/survivors. The guidance promoted what was then considered the appropriate

² The PCC and the Chief Constable must have regard to the SPR when developing the regional PCP.

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use of terminology, identifying children as 'victims', as well as collaboration between the key local agencies, and encouraging careful examination of the causes of CSE rather than symptoms.

- 6.14 The ACPO published additional guidelines in 2004 with an emphasis on tackling exploitation and abuse where children were exposed as 'victims' through 'child prostitution'. This document promotes an approach to the policing of 'child prostitution', which targets the individual, community and those who exploit and abuse simultaneously. This guidance was updated in 2011.³

National Police Chiefs' Council ("NPCC")

- 6.15 The NPCC is a national policing co-ordination body that replaced ACPO in 2015. The NPCC is not a legal entity and has no legal powers, but a collaborative agreement exists⁴ between all Chief Constables, PCCs and fifteen other organisations relevant to policing,⁵ that allows the NPCC to carry out its functions. The NPCC is not a law enforcement agency and does not investigate crime.
- 6.16 The NPCC's functions include the coordination of national operations and the national implementation of standards and policy as set by the COP and the Government. The NPCC has a Chief Constables Council, where operationally independent Chief Constables act as the decision making body and agree common approaches and national coordination.

NPCC Coordination Committees/Portfolios and National Action Plans

- 6.17 The NPCC has 11 coordination committees, each led by a Chief Constable. The coordination committees consist of portfolios which have working groups attached. In February 2019, a separate 'Group Based CSE' portfolio was formed which had previously been contained within a Child Abuse and Investigation Portfolio.
- 6.18 An initial national CSE action plan was developed in 2012⁶ and was drafted based upon recommendations from a review of high profile investigations.⁷ The action plan was refined and republished in 2014 and again in 2016 as the National CSE Action Plan.⁸ The national action plan addressed all aspects of policing CSE including training, prevention and intelligence gathering.
- 6.19 In 2015, the regional CSE coordinators employed by ROCUs used learning from the national plan to assist in the implementation of consistent regional plans. I have included within Chapter 5: The Policing of CSE in Telford, a section on regional intelligence management, which explains what happened to these coordination posts after the funding concluded and

³ ACPO Strategy & Supporting Operational Guidance for Policing Prostitution and Sexual Exploitation -- https://www.npcc.police.uk/documents/crime/2011/20111102%20CBA%20Policing%20Prostitution%20and%20%20Sexual%20Exploitation%20Strategy_Website_October%202011.pdf

⁴ Pursuant to section 22A of the Police Act 1996.

⁵ Including the British Transport Police, the Civil Nuclear Constabulary and the Ministry of Defence Police.

⁶ By ACPO.

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⁸

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how ROCUs seek to assist police forces in their region and beyond to share important information concerning CSE.

- 6.20 The 2016 National CSE Action Plan was replaced in 2017 by the National Vulnerability Action Plan ("NVAP"). The current NVAP was published in January 2018 and is aimed at supporting forces to deliver key themes such as effective investigation/outcomes and early intervention/prevention. This plan contains 13 strands of vulnerability, of which CSE is one. The plan provides strategic direction to chief officers in implementing regional plans and benchmarking exercises are conducted to assess regional force performance against the national plan. In these exercises, forces respond to a range of questions, the response to which are assessed by an analytical team who provides feedback highlighting areas of good practice and improvement. The implementation of the NVAP is an example of how the NPCC as a national policing body seeks to achieve a common approach between forces in respect of CSE.

Operation Hydrant ("Hydrant")

- 6.21 In 2014, following the death of Jimmy Savile and the disclosures of CSA and exploitation that followed, Chief Constable Simon Bailey⁹ designed and instigated Hydrant on behalf of the NPCC to coordinate a national policing response to allegations of non-recent CSA, including CSE. This national operation is in existence today and was in direct response to the growing number of complex investigations in this area, and the need for the police to understand the scale of the threat to children. The operation also aims to develop a consistent approach to investigations based on best practice with particular focus on investigations involving large institutions and Persons of Public Prominence ("PPPs"). Hydrant is funded by a Home Office Special Policing Grant requiring application on an annual basis.
- 6.22 Hydrant was also founded with a view to reducing the risk of police forces investigating the same individuals or organisations. Whilst the operation does not conduct any active investigations itself (as this role remains with individual police forces), it receives information which is then disseminated amongst all forces, and regional and national units, to prevent duplication. This process is termed 'deconfliction'.
- 6.23 Hydrant receives referrals from a range of different organisations, including individual police forces, the NSPCC and the Independent Inquiry into Child Sexual Abuse ("IICSA"). Upon receipt of relevant information falling within Hydrant's scope, it cross references accounts from victims/survivors and witnesses and identifies where police forces have different allegations against particular offenders. Each investigation is registered and indexed on a HOLMES database, which assists the linking and de-conflicting process. Hydrant relays this information and brings police forces together to agree primacy; appropriate terms of reference; and collaborative working practices. This allows for the sharing of intelligence and information.
- 6.24 Where multiple forces are involved in 'cross-border' investigations, Operation Hydrant uses two models to ensure that policing remains effective. The first model, 'lead force', is where a single force takes the lead and investigates a number of cross-border allegations involving

⁹ The NPCC National Policing Lead for Child Protection and Abuse Investigation and Public Protection.

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the same victim(s)/survivor(s) or perpetrator(s). An initial strategy meeting is held to agree this. The second model, 'coordinated', is where there are a number of established investigations and a coordinated strategy is implemented by each force, for example, timing of arrests, searches or media releases.

- 6.25 Statistics released by Hydrant¹⁰ in the period up to and including 31 March 2022, indicate that the total number of suspects brought to its attention was 9,369,¹¹ of which 8,038 cases are now closed.¹² This figure is broken down into 8,570 males, 643 females and 156 of unknown gender. There are a total of 1,331 ongoing police investigations. The statistics state that PPPs account for 250 of the investigations open to Hydrant.
- 6.26 In January 2016, the Alliance¹³ began to submit referrals to Hydrant, where relevant incidents or crimes are reported via a monthly return containing relevant data for Hydrant's deconfliction process. Such returns are the responsibility of WMP's Serious Case Analysis Section officer. WMP has a single point of contact who monitors the compliance of returns to Hydrant, and provides advice and guidance to officers and SIOs.¹⁴
- 6.27 Referrals from Hydrant are contained within a central e-mail that is checked by staff in WMP's crime bureau. A crime record is then created and the case allocated to the relevant team for investigation. In circumstances where the referrals do not contain sufficient information to record a crime, an intelligence record is created.
- 6.28 The Inquiry has received evidence from Hydrant that details its involvement in Telford CSE cases.¹⁵ The records indicate that details of two cases were referred to Hydrant from IICSA, and these were then passed onto WMP, as the relevant police force, for action. In addition, the details of ten cases have been submitted to Hydrant by the Alliance to assist in the deconfliction process. These cases include non-recent allegations made against PPPs and which fit squarely within the Hydrant remit; those cases do not, from my review of the information, fall to be categorised as CSE as defined by this Inquiry's Terms of Reference, and do not, therefore, merit individual consideration here.
- 6.29 The Inquiry notes that Hydrant is also responsible for the administration and management of the Child Sexual Abuse Review Panel ("CSARP"), and for reviewing those relevant cases where the victim's/survivor's right to review has been engaged. The CSARP is discussed within the CPS section of this chapter, below.

The Tackling Organised Exploitation Programme ("TOEX")

- 6.30 This is a national programme between the NPCC and the National Crime Agency ("NCA") aimed at enhancing the regional and national response to organised exploitation, including CSE. Home Office funding for the current financial year has led to the development of three

¹⁰<https://www.npcc.police.uk/Hydrant/Hydrant%202021/OFFICIAL%20Op%20Hydrant%20Quarterly%20Stats%20Apr%20Jun%202021.pdf>

¹¹ This figure includes 1,465 suspects who are deceased.

¹² A closed investigation is where the police or CPS have taken NFA or there has been a caution, acquittal or conviction.

¹³ The policing alliance entered into between West Mercia Police force and Warwickshire Police force, as discussed in Chapter 5: The Policing of CSE in Telford.

¹⁴ [REDACTED], pg 214

¹⁵ [REDACTED]

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pilot regional 'exploitation hubs' from April 2021. These hubs sit within regional ROCUs and I understand that the ROCU West Midlands ("ROCUWM") has a pilot hub.

- 6.31 The programme's stated intentions are to enhance the regional and national response to exploitation by improving intelligence sharing; informing operational tasking, co-ordination and capability development; and prioritising resources in high harm threats. The programme aims to do this by working in collaboration with the NCA's National Data Exploitation Capability and National Assessment Capability to improve information sharing around vulnerabilities and identifying patterns in offending and new opportunities for criminality, including underpinning assessments of exploitation threats.
- 6.32 The Inquiry understands that experienced regional TOEX teams are led by a Detective Inspector who acts as a Senior Investigating Officer ("SIO") and participates in Strategic Governance Groups. The Detective Inspector reports into existing ROCU leadership teams. Each regional team has a Senior Intelligence Analyst who has responsibility for the triage of referrals into the team and management of analysis. To support this regional team management, it is envisaged that regional teams will have an Intelligence Analyst, a Data Analyst, a Financial Intelligence Officer and an Intelligence Officer.¹⁶
- 6.33 Evidence provided to the Inquiry by Hydrant indicates that the TOEX teams are currently supporting a number of investigations including those with a focus on group-based CSE and grooming.
- 6.34 At this stage, the Inquiry cannot meaningfully assess how the TOEX project will assist WMP tackle the specific issue of CSE, but this project forms part of the current policing framework for all forces, as the programme of three yearly funding cycles to support the programme is currently in existence until 2025.

COP and its predecessors

- 6.35 A national curriculum for police probationer training was implemented in 1989. This curriculum had a modular approach with most training taking place at national training centres supported by local force training and delivery. In 1998, a parliamentary review of police training uncovered a lack of consistency in the knowledge and understanding of probationary police officers and recommended that police training should continue through national training centres. Notwithstanding this, all initial police training was moved from national training centres to local force training centres. In order to support this, the Central Police Training and Development Authority was established as the primary means of police training in the UK. This was replaced by the National Policing Improvement Agency ("NPIA") on 1 April 2007.
- 6.36 The COP was established on 1 December 2012 and replaced the NPIA. It is a limited company owned by the Secretary of State for the Home Department, but operating at arm's length from the Home Office. It has no operational policing role.

¹⁶ https://www.norfolk.police.uk/sites/norfolk/files/page/downloads/toex_-_recruitment_brochure_rocuwm.pdf

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- 6.37 The COP works alongside experts from other law enforcement and non-law enforcement agencies to develop expert knowledge and products designed to support the delivery of policing services to the public. Products include APPs, as referenced above, which act as the official source of professional practice on policing. The APP on 'Major Investigations and Public Protection' has sections addressing CSA/CSE investigations. This guidance was written in 2012/2013 following a series of high profile cases that highlighted the requirement for a consistent police approach to identifying risks and safeguarding in cases of CSE.¹⁷ The CSE section provides advice and guidance on issues such as warning signs, and within this provides guidance on emotional and behavioural development; education; identity; family; social relationships; and health. It also provides guidance on locations of concern and types of exploitation including the methods used to coerce victims.¹⁸
- 6.38 The COP has also developed training and learning products to assist the policing response to CSA/CSE. These products include SIO development programmes; CSE training for officers; new joiner curriculums with content on CSA/CSE; vulnerability training; and more specialist training for investigators in child sexual abuse. This specialist training is delivered locally using COP training products and requires the completion of a portfolio known as 'SCAIDP'.¹⁹ I discuss this training and WMP's implementation of it in Chapter 5: The Policing of CSE in Telford.

NCA and its predecessors

National Criminal Intelligence Service ("NCIS") and National Crime Squad ("NCS")

- 6.39 Since 1989, there have been numerous changes to the structure and organisation of national law enforcement agencies. NCIS was established in 1992 to assist UK police forces with intelligence pictures by the collection and analysis of data. The NCIS had regional offices throughout the UK and had child sexual offending under its remit.
- 6.40 The NCS was established in 1998 and existed alongside the NCIS to deal with organised and major crime at a regional and national level. Prior to the NCS, there were Regional Crime Squads with minimal focus on localised crime.

Serious Organised Crime Agency ("SOCA")

- 6.41 SOCA was established in 2006 and the NCIS and NCS were merged and amalgamated into SOCA, in addition to other national policing units. SOCA was the direct predecessor to the NCA. SOCA had a national remit, with regional units that also supported police forces to investigate crime, with particular focus on serious and organised criminality. The Inquiry notes that the Child Exploitation and Online Protection ("CEOP") centre (or 'command', as it later became known) was staffed by SOCA officers but operated independently of it.

¹⁷ Operation Span, Operation Retriever and Operation Bullfinch.

¹⁸ <https://www.app.college.police.uk/app-content/major-investigation-and-public-protection> The APP – Major Investigations and Public Protection can be accessed on the College of Policing website.

¹⁹ <https://www.iicsa.org.uk/key-documents/24657/view/CPO000031.pdf>

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CEOP

- 6.42 In the same year SOCA was established, CEOP was created to address the serious, organised and growing threat to children from offenders online - both nationally and internationally. CEOP works with national and international child protection partners to identify the main threats to children and coordinates activity against these threats to bring offenders to account. CEOP was amalgamated into SOCA and exists today as part of the NCA; due to its area of focus, CEOP is staffed with police officers, social workers and other individuals who specialise in locating and gathering evidence against online offenders.
- 6.43 In broad terms, anybody can make an online report to CEOP including children who suspect they have been or are being groomed and/or sexually abused online. Once a report is received, a child protection advisor reviews the information and where necessary considers further action required to keep a child safe, liaising with the appropriate authority or third party. CEOP also makes onward referrals to police forces including WMP, with the force then taking on responsibility for acting on the information and carrying out a localised criminal investigation if required, based on the evidence/intelligence received. I discuss this in the context of WMP below.

NCA

- 6.44 Established in 2013, the NCA is a national law enforcement agency created to provide a national approach to UK policing with specialisms in areas such as organised crime, human trafficking and CSA/CSE. The NCA has a strategic role whereby it uses evidence and intelligence to analyse how criminals are operating on a national scale and how such national threats can be disrupted.
- 6.45 The NCA brings together intelligence from a range of sources in order to maximise analysis, assessment and tactical opportunities. For example, publicly available information (such as social media); information from members of the public; covert/overt surveillance operations; and private sector reporting, are all used to develop a national intelligence picture. The NCA then develops and coordinates a national intelligence picture of serious organised crime (including CSE) and disseminates this to partners in the UK and overseas. This can also be shared with partners who use it to complement their own intelligence or to take action, such as ROCUs, Border Force, police, and HMRC. The basis of the relationship between the NCA and UK police forces is one of voluntary agreement and mutual assistance, although it does also have the power to direct regional forces, where the NCA requires operational assistance.
- 6.46 The Inquiry notes that prior to the creation of the NCA and ROCUWM, WMP would liaise with NCIS, NCS and the SOCA to gain information about national CSE threat assessments and intelligence.
- 6.47 The Inquiry approached WMP to request confirmation of what referrals or intelligence it had received from the NCA/CEOP, and the position was explained as follows:

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WMP and NCA-CEOP

- 6.48 Prior to the CEOP being established, WMP would receive intelligence referrals from agencies such as NCIS. WMP told the Inquiry that between 2006 and 2008 51 Online Child Sexual Exploitation referrals from CEOP were received.²⁰ Using these referrals, WMP generated intelligence packages that were sent out to LPAs for enforcement action. I am told that in 2006, packages were checked by a supervisor and a hard copy document taken to a Detective Inspector who would be briefed on its contents.
- 6.49 WMP's Corporate Submissions to the Inquiry have explained that WMP created a CEOP single point of contact ("SPOC") in 2008, who was attached to the Force Intelligence Bureau ("FIB"). This SPOC coordinated the force response to referrals from CEOP and other connected agencies. The Inquiry understands the process of receiving referrals in 2008 is very similar to the one used today.²¹ The SPOC will review and act upon information provided by NCA-CEOP. Referrals may be triggered by, for example, evidence of individuals accessing indecent images of children.
- 6.50 An example of how the NCA-CEOP referral process has worked on a large and international stage, and which is relevant to WMP as well as other national forces, is demonstrated by a 2015 Toronto Police investigation.²² This was an investigation into a particular website that hosted films with CSE content. Intelligence from this investigation was passed to NCA-CEOP who made 60 connected referrals to WMP due to the geographical location of offenders who had accessed illegal material. Statistics provided to the Inquiry indicate that from the 60 referrals to WMP, 29 cases were actionable and resulted in action being taken in respect of identified suspects.
- 6.51 In April 2015, proposals were presented to the Chief Constables Council of the NPCC (the senior decision making body within the NPCC) who agreed a national, regional and local response to the threat posed by online CSE. In line with this, and as discussed in more detail in the earlier Chapter 2: Nature, Patterns and Prevalence of CSE in Telford, in January 2016 the Alliance formed an Online Child Sexual Exploitation Team ("OCSET"), whose remit was to investigate external referrals relating to online CSE which emanated from CEOP and other agencies. The team comprised of one Detective Sergeant and nine Detective Constables who were spread across the Alliance and managed by an Inspector.
- 6.52 The way in which WMP disseminated intelligence packages from the FIB for enforcement action changed post January 2016, to ensure that relevant information was shared with the OCSET. As I have noted in Chapter 2: Nature, Patterns and Prevalence of CSE in Telford, from January 2016 to 30 June 2020, 896 CSE intelligence packages were generated and allocated for enforcement or safeguarding by WMP.²³
- 6.53 The Inquiry understands that a new risk assessment tool has also been implemented which takes the form of a questionnaire template, which asks a number of questions to assess the risk of a 'contact' offence taking place. However, the Inquiry has been informed that this tool is currently under review due to inaccuracies discovered in the information

²⁰ [REDACTED], pg 210

²¹ [REDACTED]

²² Operation Spade.

²³ [REDACTED], pg 212

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provided. The conclusions of this review are not known to the Inquiry, and therefore I am unable to make any comment as to the efficacy of this particular tool in tackling CSE.

- 6.54 In 2018 the WMP SPOC for CEOP referrals was placed within the Specialist Operations Cyber Crime Unit. In 2019 a database was created to manage all referrals received by the SPOC. From 1 January 2019 to 30 June 2020, the database had recorded 616 cases received from the NCA-CEOP and other enforcement agencies.²⁴ Again, the Inquiry is unable to say what proportion of these cases related to CSE, rather than other forms of online abuse that sit outside of this Inquiry's Terms of Reference.
- 6.55 The Inquiry notes that this system changed with the separation of the Alliance and in October 2019 WMP moved to a smaller OCSET of one Detective Sergeant and six Detective Constables. WMP indicated that the SPOC remained a dual function until 1 April 2020.
- 6.56 In the first six months of 2020, WMP received 172 referrals from NCA-CEOP and other agencies. This marks a 54% increase from the same period in 2019; I have not heard an explanation for that significant change. Again, the Inquiry is not able to say what proportion of these referrals related to CSE, but it does serve to demonstrate the unrelenting trend of these types of offences – as I discuss in more detail in Chapter 2: Nature, Patterns and Prevalence of CSE in Telford, when discussing the prevalence of CSE in Telford.
- 6.57 WMP has indicated that it has recently enhanced its OCSET. The team now comprises of two Detective Sergeants and 14 Detective Constables in the investigative team, and one Detective Sergeant (SPOC) and three Detective Constables in the intelligence team. WMP has also indicated its intention to increase the intelligence development capability which will incorporate a SPOC function, suggesting this was lost to WMP post 1 April 2020 when the dual function ceased to exist. The Inquiry has not been provided with evidence to confirm the SPOC function has been incorporated moving forward, or indeed why it was removed.

Anti Human Trafficking Organisations

Modern Slavery Human Trafficking Unit ("MSHTU") and its predecessor

- 6.58 The MSHTU is a command of the NCA and was formerly known as the UK Human Trafficking Centre ("UKHTC"), based in Sheffield and affiliated to SOCA. The UKHTC was established in 2006 as the central point for the development of expertise and operational coordination concerning the trafficking of human beings. The UKHTC commissioned the film 'My Dangerous Loverboy' as mentioned earlier in Chapter 2: Nature, Patterns and Prevalence of CSE in Telford, which was intended as a key intervention to alert children and young persons to the potential of sexual exploitation and trafficking, and involved face to face interviews with frontline workers and victims/survivors, in order to try to increase awareness of the grooming models used by CSE offenders.
- 6.59 In September 2016, UKHTC changed its name to MSHTU. Its aims were said to be to give advice on how a human trafficking case might play out; to set out investigative options;

²⁴ [REDACTED], pg 213

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explain the risks and duty of care to victims/survivors; and to set out best practice for interviewing and linking in with the National Referral Mechanism ("NRM") - a framework for identifying victims/survivors of human trafficking or modern slavery and ensuring they receive the appropriate support.

- 6.60 On 29 April 2019 the Home Office assumed responsibility for all areas of the NRM, including referrals, decision making and data collection. Prior to that date the NCA was responsible for collecting data on the NRM.²⁵
- 6.61 The Inquiry was told that WMP officers and staff are provided with training packages that include guidance on the NRM process – as discussed in Chapter 5: The Policing of CSE in Telford. I have also seen evidence that confirms an expert from UKHTC was consulted at the earliest stage of Chalice, due to the mounting evidence of children having been trafficked out of Telford to other areas of the country for CSE, and with a view to exploring whether trafficking offences could be considered for prosecution of the offenders under investigation as part of Chalice (as discussed in the dedicated section on Chalice, included within Chapter 5: The Policing of CSE in Telford).

National Referral Mechanism Single Competent Authority ("NRM SCA")

- 6.62 In 2000, the United Nations General Assembly adopted The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children ("Trafficking Protocol") which entered into force in December 2003. This was one of three protocols created by The United Nations Convention against Transnational Organized Crime (Palermo Convention). The Trafficking Protocol defined the trafficking of human beings and prohibited the trafficking of children for the purposes of commercial sexual exploitation of children ("CSEC"). The Inquiry has seen how this convention was used by WMP in Chalice, as 'Palermo' status letters were prepared and trafficked status sought to afford the victims/survivors more protection from other agencies within the criminal justice system.
- 6.63 In addition to the Trafficking Protocol, the NRM was introduced by the UK Government in April 2009 to identify and support victims/survivors of trafficking in the UK. It was born out of the Government's obligation to identify victims/survivors under the Council of Europe Convention on Action against Human Trafficking, which came into force on 1 February 2008.
- 6.64 The NRM is designed to make it easier for all agencies involved in trafficking cases to cooperate; share information about potential victims/survivors; and facilitate victim/survivor access to advice, accommodation and support. It is important to note that the NRM applies to trafficking for any purpose, not solely CSE.
- 6.65 The framework for the NRM is intended to help build a clearer picture about the scope of human trafficking, by identifying victims/survivors of human trafficking and ensuring they receive the appropriate protection and support; and by collecting statistical data for the volume of victims/survivors or potential victims/survivors of trafficking.

²⁵ <https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/modern-slavery-and-human-trafficking>

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- 6.66 In November 2014, the Home Office conducted a review of the NRM, where recommendations were made to extend the NRM to all victims/survivors of modern slavery in England and Wales, following the implementation of the Modern Slavery Act 2015. At this time, to be referred to the NRM, a 'Designated First Responder' (which includes the police) must refer potential victims/survivors of trafficking using a paper-based referral to one of the UK's two Competent Authorities, namely:
- 6.66.1 The MSHTU; and/or, if relevant
 - 6.66.2 Home Office Visas and Immigration ("UKVI") – for the purposes of considering perpetrators who may be in the country illegally and/or potentially subject to deportation.
- 6.67 In August 2019, the referrals moved to online referrals and there was an amalgamation of the MSHTU and the UKVI into the NRM SCA. First responders have been required to make such referrals since the NRM was introduced in 2009.

Referrals and the Duty to Notify

- 6.68 Since 1 November 2015, specified public authorities (including the police and local authorities) have had a formal 'Duty to Notify' the Home Office about all potential victims/survivors of trafficking and slavery. Where an individual is being referred to the NRM, then the existing NRM referral process can be used to satisfy this duty. The Government's direction is that all victims/survivors who are or may be under the age 18 must be referred to the NRM. Child victims/survivors do not have to consent to the referral.
- 6.69 I have noted that WMP (as part of the Alliance) introduced its own policy and procedure in November 2014 entitled Modern Slavery and Human Trafficking, however this pre-dated the implementation of the Modern Slavery Act 2015, and the policy does not therefore make direct mention of the NRM referral process and the Duty to Notify, although it does include a NRM referral form.
- 6.70 I have also noted evidence that suggests WMP adopted the NRM referral process when it first commenced in April 2009, and as mentioned above there is evidence of NRM referrals in Chalice. The Inquiry has also seen evidence of two further NRM referrals relating to other CSE victims in 2009 and 2016.²⁶
- 6.71 A further guidance document was produced in 2017 (*Modern Slavery and Human Trafficking Guidance*) to assist police officers with the NRM process. The document provides officers with a more detailed insight into the NRM, how to refer an individual and the 'Duty to Notify' procedure, including access to specialist support.
- 6.72 The Inquiry has reviewed its witness evidence to analyse comments made about the NRM and its impact upon the handling of CSE cases in Telford. In total, only six witnesses made a comment about the NRM. Of these, four were victims/survivors, or supporters of victims/survivors; one worked for the Council and one for WMP.

²⁶ [REDACTED]

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- 6.73 Victim/survivor evidence tended to suggest that those individuals were told either that NRM referral was pointless, or something that they personally needed to take responsibility for:

*"I was told there was no point in completing an NRM form as it would 'just be closed' without further investigation."*²⁷

*"I was aware that a person can self-refer for support or seek advice from this service."*²⁸

*"I referred myself to the NRM for guidance and support."*²⁹

- 6.74 The views of professionals, whilst limited, suggested to the Inquiry that the referral may be considered where required, but in my view based upon the evidence I have seen, this had no impact upon the way cases of CSE were dealt with in practice:

*"Every young person that we're allocated, an NRM referral is considered... NRM referrals are considered at the risk assessment stage as a matter of course. I attended an NWG training course which was about the NRM."*³⁰

*"There was no difference in how cases were dealt with if there was an NRM referral. The twofold premise of NRM was helping people who are illegally coming into the country and preventing them from being trafficked; and then a support mechanism such as prevention of deportation."*³¹

Conclusions – Human Trafficking

- 6.75 It is evident to me that knowledge and practice around trafficking for the purposes of CSE has increased and improved in later years, as one would have expected following the Modern Slavery Act 2015; and agencies within Telford appear to have kept up with developments nationally since that time. However, it is relevant to note that trafficking for the purposes of sexual offences (including CSE) has existed as a statutory offence since 2004, following the implementation of the 2003 Act.

- 6.76 In my view, WMP did have the understanding and foresight at the time of Chalice to investigate trafficking offences for the purposes of CSE – and I have seen evidence that prosecution for such offences was considered and indeed sought in respect of some offenders, with one offender ultimately being convicted for two counts of human trafficking as part of the Chalice prosecutions in 2012, as I have explained in Chapter 5: The Policing of CSE in Telford.

- 6.77 As regards the NRM specifically, I do have some reservations as to whether this has historically been used to its optimum value, in terms of offering support to victims and survivors: one victim/survivor expressed to me that they *"would like every case which has evidence of some form of trafficking to be referred to the NRM... but it doesn't happen."*³²

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- 6.78 As I have noted above, referral of potential victims/survivors of sexual trafficking is compulsory under the Duty to Notify, and I am concerned that there may not have been referrals by WMP in every qualifying case. I do not know if that is because one agency leaves it to another; but if there is not an accord between the police and the local authority as to who takes responsibility for referral in a joint working case, I would expect that to be resolved as a matter of urgency. It is for this reason that I have made a specific recommendation to this effect within my Recommendations section at the beginning of this Report, with a view to improving the referral pathway for victims.
- 6.79 However, I have not seen any evidence to suggest that this has negatively impacted upon how cases of CSE and, specifically, trafficking for the purposes for CSE, have been handled and considered by WMP insofar as the approach to investigation and prosecution of those offences is concerned.

The OPCC

Introduction

- 6.80 Before Police and Crime Commissioners, there were Police Authorities. Police Authorities were public authorities responsible for overseeing police forces in England and Wales. Each of the 43 police forces of England and Wales had its own authority. West Mercia Police Authority comprised 17 members, both councillors and selected independent members. The Inquiry has heard evidence which would suggest that a driver for change away from the Police Authority model came from concerns that Police Authorities found it difficult to effect change or provide in depth scrutiny.³³
- 6.81 The 2010 coalition Government set out to *"make the police more accountable through oversight by a directly elected individual, who will be subject to strict checks and balances by locally elected representatives."*³⁴
- 6.82 A Government consultation published later that year set out the proposal to introduce PCCs. The Police Reform and Social Responsibility Act 2011 (the "2011 Act") transferred the control of police forces from the existing Police Authorities to elected PCCs. As a result of this legislation, the first PCC elections took place in November 2012 and were set to occur every four years thereafter.
- 6.83 The 2011 Act also created Police and Crime Panels in each police area ("P&C Panel(s)"),³⁵ responsible for scrutinising the PCC. Each P&C Panel comprises of one representative from each regional local authority within the force area and at least two independent members.
- 6.84 PCCs must produce a Police and Crime Plan ("PCP") that sets out their objectives for policing; details on the allocation of resources; and how forces will be measured. Both the PCC and the Chief Constable must have regard to the PCP when performing their duties.

³³ [REDACTED]

³⁴ The Conservative-Liberal Democrat coalition agreement 2010 – *'The Coalition: our programme for government'* UK Cabinet Office Website. <https://publications.parliament.uk/pa/cm201011/cmselect/cmhaff/511/51103.htm>

³⁵ Section 28 of the Police Reform and Social Responsibility Act 2011.

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- 6.85 The 2011 Act required the Secretary of State to issue a Policing Protocol.³⁶ The Policing Protocol Order 2011 (“PPO”) came into force on 16 January 2012 and applied to all PCCs, Chief Constables and P&C Panels (with the exception of some London areas). In broad terms, this order sets out the nature of the relationship between the PCC and the Chief Constable of each force area and all staff within the relevant organisations are expected to have regard to it.
- 6.86 PCCs marked a distinct change from the Police Authority structure. As well as setting overarching strategy suggested by the police, determining the policing budget and holding Chief Constables to account for their strategic actions, PCCs were also given the power to commission services and examine police performance in detail. For example, from April 2015, PCCs have been able to commission victims’ services. The PCC has a commissioning manager and team who are responsible for commissioning services to support the PCC. This means that funded services are now provided through the commissioning team who can ensure a proper procurement process. In addition, the creation of PCCs meant the existence of one identifiable individual who could engage with the public in a process of holding Chief Constables and their force to account.
- 6.87 I set out in more detail below the nature of the relationship between the PCC for West Mercia, and WMP.

Legal powers and duties of the PCC

- 6.88 The PPO outlines the scope of the relationship between the PCC and the Chief Constable of each force. The PPO states:
- “The establishment and maintenance of effective working relationships by these parties is fundamental. It is expected that the principles of goodwill, professionalism, openness and trust will underpin the relationship between them and all parties will do their utmost to make the relationship work.”³⁷*
- 6.89 Through the PPO, the PCC has the responsibility for the totality of policing in their area and a statutory duty to hold the police to account on behalf of the public. The PCC is also responsible for receiving and distributing all funding related to policing and crime reduction matters to their forces. Whilst the Chief Constable can provide the PCC with professional advice on the allocation of funding, the allocation is ultimately at the discretion of the PCC.
- 6.90 Paragraph 17 of the PPO states that the PCC has the legal power and duty to, amongst other things:
- 6.90.1 Set the strategic direction and objectives of the force through the PCP. In doing this the PCC must have regard to the SPR set by the Home Secretary;
 - 6.90.2 Scrutinise, support and challenge the performance of the force against the PCP;
 - 6.90.3 Hold the Chief Constable to account for the force’s performance;

³⁶ Section 79 of the Police Reform and Social Responsibility Act 2011.

³⁷ The Policing Protocol Order 2011, para 8

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- 6.90.4 Decide the budget and allocate assets and funds to the Chief Constable;
 - 6.90.5 Appoint, or if appropriate remove the Chief Constable; and
 - 6.90.6 Monitor all complaints against the force and have responsibility for those relating to the Chief Constable.
- 6.91 Importantly, the PPO also provides that the PCC has overall responsibility for the delivery of community safety and crime reduction.³⁸
- 6.92 However, the PCC is not permitted to *"fetter the operational independence of the police force and the Chief Constable who leads it."*³⁹ The PPO makes clear that:
- "At all times the Chief Constable, their constables and staff, remain operationally independent in the service of the communities that they serve."*⁴⁰
- 6.93 As stated above, the PCC has no formal role in operational policing arrangements and therefore has no involvement in police CSE investigations or case reviews, although the Inquiry understands that a representative from the OPCC may attend operational meetings as an observer/stakeholder only.⁴¹

PCC for West Mercia

- 6.94 There have been two West Mercia PCCs to date. From November 2012 to May 2016 Bill Longmore held the role; he was succeeded by John Campion, who served his first four year term as PCC until 2021, and he has since been re-elected for a second term.
- 6.95 As an elected official, the PCC is accountable to the public for the performance of the WMP force area. The PCC - together with input from the Chief Constable for WMP - shapes the strategic objectives for West Mercia and the Chief Constable is accountable to the PCC for operational delivery. The performance of the PCC is scrutinised by the West Mercia P&C Panel.

Disclosure Request to the PCC

- 6.96 At an early stage of the process, the Inquiry contacted the OPCC for West Mercia to request a Corporate Submission on behalf of the PCC, to address a number of areas including:
- 6.96.1 The relationship between PCC and WMP;
 - 6.96.2 The PCC's decisions in relation to CSE in Telford;
 - 6.96.3 The Safer West Mercia Plan;

³⁸ The Policing Protocol Order 2011, para 20

³⁹ The Policing Protocol Order 2011, para 18

⁴⁰ The Policing Protocol Order 2011, para 22

⁴¹ [REDACTED], pg 4

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- 6.96.4 Liaison with other organisations; and
- 6.96.5 Complaints or concerns raised with the PCC (as are relevant to the Inquiry's Terms of Reference).
- 6.97 Given the fairly recent introduction of the OPCC, the Inquiry also sought confirmation from the PCC as to whether any historic material was held from the predecessor West Mercia Police Authority. It was confirmed that whilst the OPCC for West Mercia does hold some material, none is relevant to the Inquiry's Terms of Reference.

PCC Funding, Budgets and Decisions relating to CSE⁴²

- 6.98 As noted above, all PCCs are responsible for setting the annual budget for local policing. The PCC has indicated that whilst the PCC sets the budget, it is for the Chief Constable to determine how to best use that resource to address operational policing needs within West Mercia. For example, in its Corporate Submission to the Inquiry the PCC explained that whilst there is no record of dedicated funding allocated to CSE training for West Mercia police officers, this is because the allocation of funds for officer training would be a matter for the Chief Constable to consider and delegate as part of their budget spend for each year.⁴³
- 6.99 However, the PCC provided the Inquiry with a list of any relevant references to CSE⁴⁴ in the final budget papers used to set the annual budget for West Mercia. The following is a summary of the relevant references within the budget across the years:
- 6.99.1 2016/2017: CSE was referenced with regard to the "*Deployment of additional police officers and staff to investigate Child Sexual Exploitation (CSE)*".⁴⁵
- 6.99.2 2017/2018: In relation to the strategic objective of delivering a more secure West Mercia, the budget papers referenced additional officers and staff allocated to investigate CSE. CSE is also mentioned in the context of changing demands in policing; and the PCC's intention to strengthen resources dedicated to the prevention and investigation of CSE.
- 6.99.3 2018/2019: CSE was mentioned as part of a demand on policing that is complex and has grown. Additionally, CSE was mentioned in relation to the strategic objective of reassuring West Mercia's communities, raising awareness in schools and protecting children against cyber crime.
- 6.99.4 2019/2020: When noting an increase in recorded incidents of certain crime types as a context for budget priorities, a table was referenced that showed a staggering 288% increase in recorded CSE crimes in West Mercia when compared with the same period four years previously. Additionally, CSE was mentioned in relation to the strategic objective of reassuring West Mercia's communities, supporting community projects to raise awareness in schools and protecting children against cyber crime. There was also reference to West

42 [REDACTED] pg 20
43 [REDACTED] pg 20
44 [REDACTED] pg 20
45 [REDACTED] pg 20

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Mercia's protective policing portfolio continuing to work alongside local policing dedicated to investigating areas such as vulnerability or CSE.

- 6.99.5 2020/2021: CSE was mentioned in relation to the strategic objective of reassuring West Mercia's communities; the continuation of support for community projects to raise awareness in schools; and protecting children against cyber crime. There was also reference to West Mercia's Crime and Vulnerability policing portfolio continuing to work alongside local policing dedicated to investigating areas such as vulnerability or CSE.
- 6.100 I note from the above budget papers between 2018/19 to 2020/21, the similarity in the CSE issues flagged, and the fact that CSE is noted consistently as a growing trend across the years.
- 6.101 There is no specific mention of CSE in the budget papers between 2012/13 to 2016 when the previous PCC, Bill Longmore, was in office. Reference has been made by the PCC to statistics relating to his predecessor in other areas (i.e. not in relation to CSE), and the absence of statistics in this particular analysis is notable, and not explained; I am driven to the view that CSE simply did not feature during that time.

PCC Decision Notices⁴⁶

- 6.102 In its disclosure to the Inquiry, the OPCC for West Mercia provided a list of "significant" formal decisions taken by the current and former PCC that "are or may be" relevant to the Inquiry. These decisions are captured within a decision notice and are published on the PCC's website.
- 6.103 The Inquiry has reviewed the 12 decision notices provided that have a date range of between December 2014 and March 2020. Of these notices and from the information provided, I have been able to identify five that I conclude are broadly relevant to CSE for the purposes of the Inquiry:
- 6.103.1 Victims' Services Contract Award: December 2014 – the PCC assumed responsibility for commissioning victims' services from 1 April 2015.
- 6.103.2 Community Safety Funding: November 2015 – the PCC used funds from the community safety budget to provide the Community Safety Partnership with funds designed to support the local community. £155,000 was allocated to Telford & Wrekin, however I note that only £5,000 of that was awarded specifically to tackle CSE.⁴⁷
- 6.103.3 Purchase of a vehicle for Joint Use by Safer Neighbourhood Team and Street Pastors in Telford & Wrekin: June 2018 – the PCC provided funding of £20,000 for the purchase of a vehicle to be used by the Street Pastors.
- 6.103.4 Resources for Additional Officers: September 2018 – Proposal for the PCC to provide funding for 100 additional police officers in West Mercia as a result of

⁴⁶ [REDACTED] pg 24
⁴⁷ [REDACTED] pg 66

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the changing patterns of crime and complex nature of investigating allegations of crimes such as child abuse. It is also acknowledged that expectations are placed on officers to safeguard the vulnerable. This is not directly related to CSE, but goes to the resourcing of officers available to tackle complex crimes such as CSE.

6.103.5 Victims' Services Funding Contract Award: December 2018 – A new victim support service is made available and a three year contract in place. The service takes advice from Victim Advice Line and provides longer term support for victims/survivors.

6.104 I have seen decision notices in 2014 and 2018 that relate to victim services contract awards. Whilst these clearly may have benefitted victims/survivors of CSE, I am unable to assess the extent of any focus as the evidence is not CSE specific.

PCC grants and commissioning activity⁴⁸

The PCC has provided the Inquiry with a list of grants that were deemed as relevant to the Inquiry. These have been separated into grants funded for over one year and grants funded for one year only.

6.105 There are 23 grants listed as funded for over a one year period. The details provided of each project are brief, but from the information provided I have identified the following nine as potentially relevant and/or directly focused on CSE:

6.105.1 Telford & Wrekin Community Safety Partnership: Taxi Marshalling Project: Funding period 2013 to 2020: Total funding amount £107,000 - this is funding for taxi marshals working out of two locations from 1am to 4am Friday to Sunday.

6.105.2 Telford & Wrekin Community Safety Partnership: Street Pastors: Funding period 2013 to 2020: Total funding amount £46,789 - this funding is for the Street Pastors working in the night-time economy between Friday evening and Sunday morning. I have set out the work of the Street Pastors in Chapter 4: Taxi Licensing and the Night-Time Economy.

6.105.3 Telford & Wrekin Community Safety Partnership: Crucial Crew: Funding period 2013 to 2020: Total funding £85,000 - this funding is for the Crucial Crew who deliver an educational safety awareness package for all year six primary school children. Their work seeks to raise awareness around personal relationships, consequences of crime and domestic abuse, including CSE.

6.105.4 Telford & Wrekin Community Safety Partnership: CSE Awareness and Education Project: Funding period 2017 to 2019: Total funding £62,296 - this project aims to develop and coordinate a prevention package around CSE, missing children and online safety. The aim is to take a proactive not reactive stance.

⁴⁸ [REDACTED], pg 5

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- 6.105.5 Telford & Wrekin Council: Children Abused Through Exploitation ("CATE"):
Funding period 2018 to 2020: Total funding £70,000.
- 6.105.6 NHS England: Children and Young Persons SARC: Funding period: 2016 – 2020:
Total funding £192,766 - this funding was a contribution towards a jointly
commissioned regional children and young persons' sexual assault service
covering all of West Mercia.
- 6.105.7 AXIS: Independent Sexual Violence Advisor Service ("ISVA"): Funding period
2013 to 2014 and 2016 to 2020: Total funding £1,105,057 - this project works
with victims/survivors of sexual abuse aged 11 and over to assist them with
accessing the services they need in the aftermath of the abuse they have
experienced. They aim to ensure that victims/survivors are aware of all the
services available to them to address their needs. These include services such
as counselling, SARC, housing and sexual health. The service also aims to
facilitate or support the victim/survivor access to the services they require.
- 6.105.8 Mentor Link: Feeling Safe Project: Funding period 2015 to 2018: Total funding
£63,508 - this project provided training to vulnerable children aged 5 to 10 years
old about their right to feel safe at all times and recognise, understand and
inform others about possible ill treatment, abuse or neglect.
- 6.105.9 Young Solutions Worcestershire: CSE Awareness: Funding Period 2017 to 2019:
Total funding £44,570 - this funding was to coordinate and implement CSE
awareness raising in West Mercia by communicating with hoteliers, bed and
breakfast proprietors, taxi drivers, the night-time economy and wider
community groups.
- 6.106 I acknowledge that the taxi marshalling project, the Telford Street Pastors funding and the ISVA funding commenced in 2013. However the first significant and ongoing project funding that appears directly focused on CSE education/prevention began in 2017 with the CSE Awareness and Education Project. This project looked to educate and prevent CSE rather than assist victims/survivors. Whilst the taxi marshalling project and the street pastors may have contributed to CSE prevention, that was not their sole focus.
- 6.107 There was CATE Team funding in 2018 and other significant funding thereafter. Notwithstanding this, there appears to be an absence of CATE Team funding prior to 2018, which I find surprising given that, by that point, the impact CSE was having on victims/survivors and the awareness of the issue had long been recognised by the authorities in Telford.
- 6.108 There are 40 grants listed as funded for one year only between the years 2013 and 2020. The details provided of each project are brief, but from the information provided the following five have been identified by the Inquiry as potentially relevant to, or directly focused on CSE:

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2015/2016

- 6.108.1 AXIS: Pilot of an Independent Sexual Violence Parent Advisor Service: Total funding £40,000 - this service was designed to provide a parent advisor service, with these advisors being present in primary schools to facilitate early parental contact. Coffee mornings with topics such as childhood sexual abuse awareness and internet safety were available.
- 6.108.2 Telford & Wrekin Community Safety Partnership: Child Sexual Exploitation: Total funding £5,000 - this funding purchased four laptops to work with children.

2016/2017

- 6.108.3 Young Solutions: 'Something's Not Right': Total funding £39,250 - Young Solutions were contracted to implement the 'Something's Not Right' programme in West Mercia, securing actions to meet the WMP and Local Safeguarding Children Board ("LSCB") strategic requirement for CSE awareness amongst hoteliers, B&B proprietors and taxi drivers.
- 6.108.4 Telford & Wrekin Community Safety Partnership: Tackling CSE: Total funding £2,500 - this funded the purchase of four laptops to work with children open to CATE; the grant was controversial, with a witness telling the Inquiry that they regarded it as inappropriate for the PCC to fund a Council initiative.⁴⁹

2019/2020

- 6.108.5 WMP: Exploitation and Vulnerability Trainers: Total funding £63,825 - these Trainers were put in place to coordinate and deliver a training package concerning child exploitation, to professionals and community groups delivering services to children.
- 6.108.6 AXIS: ISVA – Child ISVA: Total funding £73,750 - this service provided support to any child aged five to ten who has experienced sexual abuse regardless of whether there are ongoing criminal justice processes. This funding also provided introductory sessions for four year olds to familiarise them with ISVA with a view to their one-to-one support commencing when they are five.
- 6.109 I note that there were no one-year funded projects that appear directly relevant to, or focused on, CSE until 2015/2016. Additionally, I note there were no projects of this nature between 2017/18 to 2018/19, but this may be due to the existence of the ongoing CSE awareness projects funded over this period (projects funded for more than one year).
- 6.110 In my Recommendations, and alongside the conclusions I make in Chapter 4: Taxi Licensing and the Night-Time Economy, I refer to the role of the PCC in funding initiatives such as the taxi marshalling project and the Telford Street Pastors, and I recommend that these should be continued in Telford, given the part they have played in tackling CSE (amongst other night-time economy issues) to date.

⁴⁹ [REDACTED], pg 32

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The Safer West Mercia Plan⁵⁰ ("**SWMP**")

- 6.111 As noted above, the PCC has a statutory obligation to produce a PCP, which is an important way to communicate the PCC's intentions and crime objectives for the area. The SWMP represents the PCP for West Mercia.
- 6.112 The SWMP was subject to a two-stage consultation before it was finalised. The final version is available to the public and published on the PCC's website – the most recent version being released in December 2021 following the PCC's re-election.⁵¹
- 6.113 A PCP can take any format but usually encompasses issues highlighted in manifesto commitments. The SWMP has four 'key pillars':
- 6.113.1 Putting Victims and Survivors First;
 - 6.113.2 Building a more secure West Mercia;
 - 6.113.3 Reforming West Mercia; and
 - 6.113.4 Reassuring West Mercia's communities.
- 6.114 'Putting Victims and Survivors First' is intended to focus on working to support victims/survivors of crime recover from their experience. There is therefore the existence of objectives that relate directly to addressing the issue of CSE. The SWMP outlines the commitments of the PCC as follows:⁵²
- Work hard to put victims and survivors first;
 - Set out commitments in a new Victims Charter which will clarify what services victims/survivors can expect and what services must be delivered;
 - Complete a victim's/survivor's needs assessment;
 - Bring together and help lead a new Victims' Board to ensure better results and consistency;
 - Make sure victims and survivors get effective services;
 - Work with government to enhance services for victims/survivors; and
 - Support the use of restorative justice.
- 6.115 The previous PCP for West Mercia which was in place between 1 April 2013 and 21 March 2017 consisted of four strategic aims, one of which was "*to provide a strong and powerful*

⁵⁰ [REDACTED] pg 30

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⁵² [REDACTED] pg 5

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voice for the people and victims of crime". This plan also contained the objective "to work in partnership to protect the most vulnerable people in our society".⁵³

- 6.116 Witness evidence indicates it was a conscious decision not to include specific reference to CSE in both PCPs, on the basis that the PCC is required to represent the entire force area, whilst CSE was seen as a specific concern in Telford.⁵⁴ Notably, the 2021 SWMP makes no specific reference to CSE either. I regard that decision as short sighted and evidencing a view that CSE is not a potentially universal issue. The previous PCP, whilst not including a pillar of 'putting victims and survivors first', did include a commitment to vulnerable victims/survivors. Whilst both plans speak about victims/survivors, I note there is little focus on preventative measures.
- 6.117 As explained above all PCCs and Chief Constables must carry out their functions with the pillars and objectives of the PCP in mind. The PCC told the Inquiry that how the PCP is implemented must be considered at a local level due to the differing needs of every community. This means that how the SWMP is implemented in Telford should be considered at a local level by WMP – not within the SWMP itself. To allow local variation is in my view sensible providing that there is an expectation that there will be proper local consideration of implementation, and satisfaction of that expectation is monitored.
- 6.118 To monitor the objectives and performance of the SWMP, I understand that a delivery plan is in place that tracks the progress of activities and is monitored by the PCC on a monthly basis. This delivery plan is submitted to the P&C Panel in a quarterly report,⁵⁵ for the P&C Panel to, in turn, scrutinise the performance of the PCC.
- 6.119 The Inquiry has been provided with such a report for October to December 2020.⁵⁶ The report outlines the actions taken by the PCC against the pillar of '*putting victims and survivors first*'. The delivery plan tracks the commitment by the PCC against the supporting activity and overall progress. CSE action forms part of the delivery plan and update: one activity within the pillar was to develop a commissioning strategy for CSE, and the plan identifies that formal commissioning intentions are now finalised.⁵⁷
- 6.120 In addition to the delivery plan, the PCC has a statutory obligation to publish an annual report. This report must outline progress against the SWMP and is scrutinised by the P&C Panel. The annual report is published on the PCC's website.
- 6.121 I have noted that the current SWMP makes no mention at all of CSE, or the wider exploitation of children, though it speaks more generically of protecting those who are vulnerable to exploitation.⁵⁸

⁵³ [REDACTED] pg 31

⁵⁴ [REDACTED] pg 10

⁵⁵ [REDACTED] pg 32

⁵⁶ [REDACTED] pg 98

⁵⁷ [REDACTED] pg 107

⁵⁸ Safer West Mercia Plan - West Mercia Police Crime Commissioner (westmercia-pcc.gov.uk)

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SWMP and multi-agency working with Telford & Wrekin Council

- 6.122 The PCC accepts there are limited examples of multi-agency working between the OPCC for West Mercia and the Council in the early years of the role, although he states that links have developed more recently as the scale of CSE has been better understood.⁵⁹
- 6.123 The PCC states that this relationship improved in April 2015 when the PCC was given responsibility for commissioning victims'/survivors' services.
- 6.124 As the PCC has oversight of the police, and not the Council, he also has no formal role in, for example, the LSCB and is not represented at any scrutiny panels.⁶⁰

Victim services

The Victims' Board⁶¹

- 6.125 In broad terms, the Victims' Board is a multi-agency board designed to assist victims and survivors of CSE. The PCC's Commissioning Manager sits on the Victims' Board and provides a report linked to commissioned services (including paediatric sexual assault services). The Victims' Board works with partners with a view to ensuring victims/survivors of CSE receive the support available to them, in addition to ensuring their needs are also met as cases progress through the criminal justice system.
- 6.126 The Victims' Board is responsible for ensuring compliance with the Code of Practice for Victims of Crime ("Victims' Code") and works with a West Mercia Criminal Justice Board to review pathways and access to services for victims/survivors of crime.
- 6.127 With specific reference to CSE, the Victims' Board's aim is to ensure that victim/survivor needs assessments are being completed by partner agencies and referrals are being made to the most appropriate service. Services include referral to the AXIS/ISVA and service providers are invited to flag concerns to the Victims' Board. The Victims' Board also ensures vulnerable victims/survivors are provided with an enhanced service as required under the Victims' Code and that cases proceed through the criminal justice system correctly. The Inquiry has heard evidence of a rape case that was facing unacceptable delays, and where concerns were raised with the Victims' Board who encouraged the courts to expedite the judicial process.⁶²
- 6.128 Additionally, the chair of the West Mercia Serious Sexual Offences Coordinating Group ("SSOCG") is a standing member of the Board. I understand that this group reviews cases of CSE, and any relevant matters that it cannot resolve are taken to the Victims' Board.

The PCC's Victims' Charter

- 6.129 This charter was part of the PCC's manifesto commitment in 2016 and part of the pillar of 'putting victims first' in the SWMP. Its aim is to improve the experience and service

⁵⁹ [REDACTED] pg 35
⁶⁰ [REDACTED] pg 11
⁶¹ [REDACTED] pg 33
⁶² [REDACTED] pgs 12-13

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pathways for victims of crime. The document was subject to six weeks' public consultation before publication and was created in further consultation with victims/survivors of crime and service providers.

- 6.130 The Inquiry notes that this charter is essentially a set of nine standards that the PCC will seek to uphold. In general terms, the Victims' Charter aligns with the Victims' Code and states "*West Mercia Police will treat victims of crime with respect, without prejudice and acknowledging individual vulnerability.*"⁶³
- 6.131 The Inquiry understands that performance against this charter and partner compliance is measured through contract management meetings and monitoring reports. Contracts with services and grant applications are aligned to conform with the Victims' Charter. Additionally, performance data is used in contract management meetings including referrals rates and repeat victimisation data to monitor the effectiveness of a service.
- 6.132 I note that the PCC's performance against this charter will also be scrutinised by the P&C Panel, although I have not been provided with sufficient information to be able to comment upon whether the P&C Panel considered the PCC to have delivered in this regard.

Scrutiny of WMP by the PCC⁶⁴

- 6.133 Whilst it is the duty of the PCC to hold the Chief Constable to account, the 2011 Act does not mandate how this should be done.
- 6.134 I have reviewed evidence provided by the PCC that indicates the first PCC for West Mercia held weekly meetings with the then Chief Constable, and for the last nine months of his tenure, one meeting a month was a dedicated 'holding to account' ("HTA") meeting.⁶⁵
- 6.135 The PCC has provided the Inquiry with a summary of the meetings where CSE was raised during the first PCC's tenure. The record of these meetings dates from June 2014 to September 2015.⁶⁶ There were 11 relevant meetings in total where CSE was discussed. The discussions include the PCC asking whether more resources should be invested into tackling CSE and the rise of reporting non-recent allegations of CSE in 2014. The discussions also include questions from the PCC as to whether schools were sufficiently trained to deal with CSE and detail the implementation of training for police officers/PCSOs to deal with CSE in 2015.⁶⁷
- 6.136 It is clear, therefore, that CSE issues were being discussed in these meetings in 2014 and 2015, prior to the current PCC's tenure, and after Chalice. It was therefore an issue known to the OPCC in West Mercia from inception. It is acknowledged that the PCC made funding grants for projects such as the taxi marshalling project, the Street Pastors funding and ISVA service from 2013 to 2020. Notwithstanding this, the first significant project funding that appears directly focused on CSE prevention began in 2017 with the CSE Awareness and

⁶³ [REDACTED], pg 34

<https://www.westmercia-pcc.gov.uk/app/uploads/2016/09/PCC-Victims-Charter.pdf?x81642>

⁶⁴ [REDACTED], pg 4

⁶⁵ [REDACTED], pg 4

⁶⁶ [REDACTED], pg 45

⁶⁷ [REDACTED], pg 46

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Education Project. Given that CSE and issues were being discussed, it is surprising that no such projects were developed before 2017.

- 6.137 From the evidence provided by the PCC, I have not seen any evidence of HTA meetings concerning CSE before 2014, which I regard as surprising; plainly the PCC should have been kept apprised formally of important trends in offending and of significant CSE investigations.

Holding to Account (“HTA”) Meetings

- 6.138 It has been explained to me that the PCC informally meets the Chief Constable on a weekly basis. No formal records or minutes are held from these meetings, however. Additionally, the PCC conducts a monthly HTA meeting and the notes from these meetings are published on the PCC’s website.⁶⁸ However, the Inquiry understands that CSE is not a standing agenda item at these meetings.⁶⁹ Witness evidence collated by the Inquiry indicates that whilst the Chief Constable is given a broad understanding of what will be discussed in advance of each meeting, the PCC does not provide specific questions in advance of the HTA sessions.⁷⁰
- 6.139 The PCC has provided the Inquiry with a summary of the HTA meetings where CSE was raised. The records of these meetings date from September 2016 to March 2019.⁷¹ There were ten relevant meetings in total where CSE was discussed. There was a bespoke CSE assurance meeting in September 2016, specially focused on the area of Telford. This meeting took the form of a formal question and answer session. It recognised a range of issues including training, staffing, the identification of perpetrators and the general threat and intelligence assessments. This meeting specifically focused on the force approach in Telford as it was deemed a particular concern for the local community. The Chief Constable was asked where he would like the *“quality of intelligence assessment to be”* in relation to CSE. I note that his response was *“to be in a position where it is possible to be confident that the force is getting it right.”*⁷² Additionally, in response to a question about the low number of flagged incidents and crimes, the Chief Constable replied:
- “CSE falls into a wider category of child abuse so it is not always easy to separate CSE out for reporting. It is recognised nationally that a growing number of our young people are likely to be a victim of CSE and under reporting remains an issue.”*⁷³
- 6.140 I am aware that by 2016, CSE markers could be utilised and I have examined in Chapter 5: The Policing of CSE in Telford, evidence to suggest the accuracy of data was dependant on officers applying the marker to the correct offences.
- 6.141 In respect of HTA meetings where CSE is raised, there is then a six month gap until the next meeting in March 2017, and a further five month gap to August 2017. There is also a further five month gap between a meeting in October 2017 and March 2018.

68 [REDACTED] pg 4
69 [REDACTED] para 44
70 [REDACTED] pg 14
71 [REDACTED] pg 50
72 [REDACTED] pg 51
73 [REDACTED] pg 53

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- 6.142 I regard it as surprising that given the continued prevalence of CSE offending, and the upheavals in WMP's policing provision with respect to CSE at this time, that only ten HTA meetings in a two and a half year period raise the issue of CSE. I am unable to assess the frequency that CSE was discussed in the weekly meetings, as there is no formal record taken of these meetings and no evidence of their content provided to the Inquiry.
- 6.143 It is right to recognise that I have seen correspondence from 2016 in which the PCC expresses concern to the Chief Constable about the need for "*continued upskilling of our staff to recognise and effectively deal with CSE in our community*" and, continuing, he states:
- "I fully recognise the very good work that has been done in developing the vulnerability training and I hope that in the coming weeks you will be able to appraise me of when all staff will benefit from it."*⁷⁴
- 6.144 Although not expressly mentioned, this was the time that the Pathfinder programme, to which I have made reference in Chapter 5: The Policing of CSE in Telford, was underway; this may be a reference to the difficulties being experienced in the roll-out.
- 6.145 The Inquiry is aware that, in addition to the Victims' Board, there are other meetings that take place that are attended by both the PCC and WMP, where CSE may be discussed. These meetings include:⁷⁵
- 6.145.1 Strategy meetings in Autumn every year. These meetings are attended by several individuals including the PCC and his deputy; the Chief Constable, and the Deputy and Assistant Chief Constables. In these meetings, the budget and financial priorities for the year are discussed.
- 6.145.2 Critical Incident Management Meetings (CIMMs) and Gold Command meetings. These are meetings arranged by WMP and a representative from the PCC attends as an observer only. If a CSE incident is declared a critical incident, a representative from the PCC would be entitled to attend, listen to the information presented and ask questions if required. As regards the key CIMMs relevant to this Inquiry, I have made reference to the Gold Group formulated after Chalice, which represented WMP's force-wide response to national and local coverage of CSE issues in West Mercia,⁷⁶ and I note that a representative of the PCC has been recorded as present at some of these meetings.⁷⁷ I have seen minutes of CIMMs relating to other CSE investigations which tend to suggest that the PCC was not present; it is not clear whether an invitation had been issued. It seems to me that the PCC should be invited to, and be represented at, any CSE related CIMM.
- 6.145.3 Community Safety Partnership meetings (CSPs). These meetings are held at a local level and CSE in Telford would be considered by the Telford CSP.

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- 6.146 I have not been provided with sufficient material in relation to any of the above meetings to be able to assess the degree to which CSE featured within these meetings and, therefore, the effectiveness of any such scrutiny that is purported to have taken place. I have, however, sought to make specific recommendations in the Recommendations section at the beginning of this Report, around the HTA process and the information to be provided to the PCC by the Chief Constable of WMP, with a view to improving the accountability meetings held by the PCC.

Implications of the Alliance on scrutiny by the OPCC

- 6.147 The Alliance between Warwickshire and WMP commenced in 2012 and ended in April 2020, notice having been given by WMP in 2018. This meant that the formation of the Alliance fell into the same timeframe as the formation of the OPCC. The Alliance therefore had one PCC for each respective force area.

- 6.148 An independent review by the Police Foundation was commissioned into the formation of the Alliance. The final report of this review was published in September 2014. The report stated:

*"[In] order to maintain momentum, the PCCs should consider an initiative or gesture to help 'kick start' the next phase. An example would be agreement that the two offices of the PCCs – led by chief executives – share resources or merge particular functions such as communications/PR. This would have the advantage of unifying the key messages of the two PCCs as well as sending a clear message to officers, staff and the public that the two PCCs are integrating some of their resources too."*⁷⁸

- 6.149 The Inquiry has obtained witness evidence that indicates the suggestion of shared resourcing between the two offices caused some difficulty. A suggestion that PCPs were coordinated was also not felt to be the correct approach.⁷⁹ There may have been a difficulty with expectations; the Warwickshire OPCC has responded to the Inquiry to note that a merger of the two offices of the police commissioners - or indeed, the two forces - had never been intended.

- 6.150 In relation to the issue of governance and accountability, the final published report of the independent review stated:

*"Accountability is weakened by the ad hoc nature of meetings between PCCs and chief officers. Not all meetings between the two PCCs and two Chief Constables occur on a regular, formal, minuted basis, with consequent risks that decisions may be made on the basis of informal understanding and will lack transparency. The two PCC and Deputy PCCs would benefit from meeting more regularly with their respective Chief Executives present, enabling the latter in bringing coherence to the work of the two offices and ensuring effective delivery of PCC decisions."*⁸⁰

- 6.151 Witness evidence obtained by the Inquiry accepts that meetings often took place informally which helped build relationships but, it was felt, left room for complacency and the risk of

⁷⁸ [REDACTED] pg 20
⁷⁹ [REDACTED] pg 20
⁸⁰ [REDACTED] pg 5

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becoming “*too friendly*”.⁸¹ Informal meetings also took place between the PCC and the Chief Constable which I have discussed in this section.

- 6.152 So far as the P&C Panel in West Mercia was concerned, the independent review stated it was:

*“... not effective in attracting and engaging members of the public; their task of holding PCCs to account is undermined by constant churn in membership, with attendant problems of poor understanding of the Panel’s role ... The West Mercia PCC has created the role of ‘community ambassador’ to extend his network of ‘eyes and ears’ on the ground but the role seems neither well defined or understood. They are described as having a ‘roving brief’ with the attendant risks that they confuse answerability – SNT managers are not answerable to the ambassadors but are accountable only up the policing chain. On occasions the ambassadors’ enthusiasm has led them to interfere in local policing matters, or attempt to explain publicly about an operational incident but get the explanation wrong”.*⁸²

- 6.153 Evidence gathered by the Inquiry indicates that the transparency of HTA meetings improved in 2016 with the publication of minutes on the PCC’s website. Notwithstanding the observations of the report, I note that the informal weekly meetings still exist. I was told no minutes are taken. This gives the impression that the only truly informal thing about this recurring weekly meeting is the fact that minutes are not taken. I confess that I am of the view that for the sake of accountability and transparency, the meetings should be minuted – and this also appears in my Recommendations.

- 6.154 Additionally, witness evidence indicates that P&C Panel numbers frequently change and panellists are substituted on a regular basis. I heard evidence that because the P&C Panel is not a committee that carries a monetary allowance, the councils did not always give P&C Panels the attention they deserved.⁸³ I assume this to mean that elected members are not paid expenses for attendance and as a result attendance is poor.

- 6.155 The Inquiry understands that community ambassadors exist today but do not prepare formal feedback documents or reports. Instead, their information is used to inform the HTA meetings. No evidence has been made available to me that indicates community ambassadors for Telford have identified any new issues in how the force deals with cases of CSE, however.

- 6.156 In relation to protective services, the report from the independent review stated:

*“Both PCCs articulate a clear vision about ‘protecting the front line’ and preserving local identities. But despite the adoption of protecting people from harm, as a principal aim, a worrying chasm exists around how protective services operate and why their work will rarely be mentioned by members of the public, who tend to see only visible, accessing policing (i.e. bobbies on beats) as important.”*⁸⁴

81 [REDACTED] pg 21
82 [REDACTED] pgs 5-6
83 [REDACTED] pg 22
84 [REDACTED] pg 11

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- 6.157 I have not been provided with any evidence to indicate what, or if any, action was taken by the PCC following this criticism. The public should be credited with a greater capacity to understand modern policing techniques than I believe the PCC allowed: if the public only tend to see the benefit of 'bobbies on beats' then it is my view that the PCC should explain why and how alternative provision was effective.

Complaints received by the PCC concerning CSE

Complaints received by the PCC concerning how WMP addressed CSE in Telford

- 6.158 In response to the Inquiry's disclosure request, the PCC provided a table detailing the complaints raised with it regarding WMP and the handling of CSE in Telford. The details of ten complaints have been provided, ranging from police inaction/inability to keep Telford safe; to criticism of the force's comments on identity of perpetrators; and the requirement for an independent inquiry.
- 6.159 The PCC or a member of his office appears to have responded directly to the complainant in all cases where a response was possible. In cases where an operational policing update was needed, I have noted that the PCC consulted WMP and then responded to the complainant to provide a position.
- 6.160 I have viewed all of the complaints and responses and conclude that these have been detailed and attempted to answer the questions raised. It is beyond the remit of this Inquiry to investigate those individual complaints, however from the information provided to me, I consider that these have generally been appropriately handled by the PCC; although I did note one failure adequately to record a concern raised verbally, and, some unfortunate use of terminology in describing CSE, albeit by a now departed member of the PCC's office staff.

Complaints received by the PCC concerning the PCC's role in responding to CSE in Telford

- 6.161 The details of five complaints have been provided. The details of these complaints range from calls to review or provide a view on CSE in Telford, to the PCC's position on an independent inquiry.
- 6.162 The PCC or a member of his office appears to have responded directly to the complainant in all cases where a response was possible, and I consider the response to have been appropriate in each case.
- 6.163 That said, I do believe that more transparency is required regarding complaints in relation to CSE, and that the Chief Constable should also share details of any such complaints or concerns reported to WMP with the PCC, to ensure that these cases are highlighted and discussed as part of the HTA process.

Conclusions - OPCC

- 6.164 Since 2012, the OPCC has held an important role in police oversight. Whilst the Chief Constable retains operational independence from the PCC, they are ultimately answerable to the PCC for the performance of their force. The importance of the PCC's role to scrutinise the actions of the police should therefore not be underestimated.

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- 6.165 In West Mercia, the PCC has also been responsible for commissioning victim/survivor services since 2015 and the PCC's commissioning manager sits on the Victims' Board. As a consequence, the PCC plays an essential role in seeking to ensure victims/survivors receive the right service at the right time, and in maintaining public confidence in such services.
- 6.166 Despite this, I have read evidence that indicates there was a lack of multi-agency working between the Council and the OPCC in the early years, and this has only developed more recently under the current PCC.
- 6.167 I consider it relevant that the PCC roles commenced in 2012, approximately the same time as the conclusion of Chalice, and consequently the scale of CSE should have been understood by the PCC at that time, and, in my view, there should have been a greater focus on multi-agency working as a priority.
- 6.168 I also believe that the HTA process is essential to the PCC's role in scrutinising the performance of the Chief Constable, and that this process should be robust and transparent. It is, therefore, surprising that the 2011 Act does not mandate how the HTA should be conducted. The HTA function is, in my view, crucial to ensuring matters of enormous public importance, such as CSE, are being dealt with appropriately by the police. I have read evidence that tends to show the HTA process in West Mercia was lacking in firm structure until 2016, as a designated monthly HTA meeting was only established in the last nine months of the first PCC's tenure. This is surprising given the need for transparency in this area.
- 6.169 I believe that the decision to make the record of HTA meetings public in 2016 was a positive step. Whilst I understand there may have been meetings where CSE was discussed before 2014, it is surprising that, on the evidence made available to me, the issue has not been recorded in any formal meeting note of either the PCC or Chief Constable given the profile of the issue at the time.
- 6.170 I have also noted the concerns raised by the independent report into the Alliance about the lack of effective scrutiny and transparency by the P&C Panel, in addition to witness evidence suggesting there may still be issues in consistency of attendance and enthusiasm from participating members. As they directly relate to scrutiny, these factors inherently have the potential to impact the effectiveness and efficiency of how CSE has been approached by WMP.
- 6.171 Whilst I have seen no direct evidence to indicate the Alliance affected the scrutiny of CSE, the evidence suggests the Alliance presented difficulties in the operation of the two OPCCs at the time it was introduced, and certainly by 2014 when the independent report was published. There appears to have been a reluctance to share and/or amalgamate resources which may have impacted upon levels of scrutiny at the time.
- 6.172 Notwithstanding this, there appears to be the absence of CATE Team funding prior to 2018. I am told this was because the Council had not previously asked for funding, and I accept that: it is entirely consistent with the Council's long-standing aversion to third-party funding, with which I have dealt in Chapter 3: The Council Response to CSE in Telford.

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- 6.173 In short, I consider that earlier consideration should have been given by the PCC for West Mercia to what funding could and should have been directed at tackling the issue of CSE in Telford.
- 6.174 As mentioned throughout the above section, I have made certain recommendations in the overall Recommendations of this Report, with a view to improving the scrutiny of WMP via the PCC, specifically via the HTA process and the information to be shared with the PCC; in relation to the PCC's handling of complaints; and with regard to ensuring ongoing funding of support services for the night time economy and for victims/survivors of CSE in Telford.

CPS and its role in prosecuting allegations of CSE

The CPS role and structure

- 6.175 The CPS was established in 1986 by the Prosecution of Offences Act 1985 and is responsible for the prosecution of criminal cases in England and Wales. It is led by the most senior public prosecutor, the Director of Public Prosecutions ("DPP") who is appointed by the Attorney General.
- 6.176 The CPS has responsibility for advising the police in certain types of criminal investigations and reviewing cases submitted and/or investigated by the police to make the final decision on what, if any, criminal charges should be brought in all but minor cases. It also has the responsibility for preparing criminal cases and presenting them at court.
- 6.177 The Inquiry notes that the CPS has not always had the responsibility for making the final charging decision in criminal cases. The CPS acquired this responsibility in 2004⁸⁵ for all but minor cases, and prior to that decision making rested with the police who would simply take advice from the CPS when the police deemed it necessary. This is also known as 'statutory charging'.
- 6.178 The structure of the CPS has changed throughout the years, alternating between a differing number of prosecution areas. The CPS informed the Inquiry that it currently operates under a 13 area structure following the 2010 Government spending review. CPS lawyers who were previously based in police stations to determine, charge and advise on investigations were removed and replaced by a CPS telephone consultation service known as 'daytime direct'.⁸⁶ Information published on its website indicates the current structure consists of 14 CPS areas (London being split into two areas, North and South) and a 'virtual' fifteenth area named CPS Direct that "*provides charging decisions on priority cases 24 hours a day.*"⁸⁷

⁸⁵ The implementation of this responsibility stemmed from Lord Justice Auld's 2001 review and the subsequent Criminal Justice Act 2003.

⁸⁶ [REDACTED] pg 2

⁸⁷ <https://www.cps.gov.uk/about-cps/cps-areas-cps-direct-cps-central-casework-divisions-and-cps-proceeds-crime>

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CPS West Midlands

- 6.179 The CPS West Midlands prosecution area services West Midlands, Staffordshire, Warwickshire and WMP force areas; the CPS West Midlands is therefore the relevant CPS area for the purposes of this Inquiry.
- 6.180 CPS West Midlands is one of the stakeholders who was approached by the Inquiry early in the evidence gathering phase. I attended an initial meeting with senior representatives of the CPS to discuss access to records and historical case papers, and parameters for disclosure. It was clear during the course of that meeting that due both to the passage of time and the restrictions imposed by legal privilege, limited information would be available from the CPS in relation to the prosecution of CSE cases in Telford – but that all such information should be available via disclosure requests of WMP. The Inquiry therefore ensured that CPS papers formed part of the disclosure requests made to WMP, and I am satisfied that the Inquiry was provided with the relevant material where requested.
- 6.181 The CPS West Midlands also provided the Inquiry with a Corporate Submission in response to a number of direct areas of questioning, including covering the following areas:
- 6.181.1 The role of the CPS in the prosecution of CSE cases;
 - 6.181.2 Relevant statutory regimes and guidance;
 - 6.181.3 Thresholds and targets for the prosecution of sexual offence cases;
 - 6.181.4 The approach to the prosecution of CSE cases, and in particular historic offences; and
 - 6.181.5 The role of Victim Liaison Units.
- 6.182 Copies of specific documentation were also requested, and I refer to these throughout this section.

The CPS decision making process

The Code for Crown Prosecutors

- 6.183 The Code for Crown Prosecutors (“the Code”) is a public document and is central to how crown prosecutors make charging decisions in all criminal cases, including those concerning CSE. It provides guidance on general prosecution principles and sets out the threshold for when an individual can be charged with a criminal offence. The section of the Code which sets out the threshold for charging is known as the ‘Full Code Test’ (“FCT”), and, with very limited exceptions, prosecutors may only start or continue a prosecution when the case has passed the FCT.

The 2018 FCT

- 6.184 The most recent Code was published in October 2018 following a period of public consultation. There are two stages to the FCT: the evidence stage (Stage 1) and the public interest stage (Stage 2).

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Stage 1 – The Evidential Test

- 6.185 Stage 1 requires the following:
- 6.185.1 A prosecutor must be satisfied that there is sufficient evidence to provide a realistic prospect of conviction; and
 - 6.185.2 To pass this stage, a prosecutor needs to consider whether an objective, impartial and reasonable jury, properly directed and acting in accordance with the law, would be more likely than not to convict the defendant. This test is based on the prosecutor's objective assessment of the evidence, rather than based on a predictive approach informed by their experience of juries.⁸⁸
- 6.186 If a case does not pass Stage 1, it cannot move on to Stage 2 and no charges/criminal prosecution can be brought.
- 6.187 The Code further requires:
- 6.187.1 When assessing the evidence, prosecutors must consider a number of factors including whether there are any reasons to question the reliability and credibility of the evidence, its accuracy or integrity; and
 - 6.187.2 Prosecutors must be satisfied that all reasonable lines of enquiry have been pursued, or that further evidence/material is unlikely to affect the application of the FCT, before making a decision at Stage 1.
- 6.188 In some criminal investigations, and with particular reference to CSE, these requirements have the potential to cause significant delay in initiating criminal proceedings as investigations are often complex and involve many different lines of enquiry. Such delay can be particularly distressing for complainants and can result in a protracted passage of time between the gathering of evidence and any potential trial.
- 6.189 A 'threshold' test also exists for certain cases and provides an exception to the sufficiency of evidence test and its application (the "Threshold Test"). In such cases there is a lower threshold for the evidence required to charge in certain types of criminal cases. To apply the Threshold Test, the following conditions must all be satisfied:
- 6.189.1 There must be reasonable grounds to suspect the perpetrator committed the offence;
 - 6.189.2 Further evidence, such as to provide a realistic prospect of conviction, can be obtained within a reasonable period of time (so that the FCT can be applied);
 - 6.189.3 The immediate charging decision is justified by the seriousness or circumstances of the case; and

⁸⁸ R v FB, ex.p. DPP [2009] EWHC 106 (Admin)

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- 6.189.4 On a proper risk assessment, the suspect is not suitable to be bailed, even with substantial conditions.
- 6.190 The Code only permits the use of this Threshold Test in exceptional cases and prosecutors are directed to keep these cases under constant review. Cases of CSE can be charged using the Threshold Test but the facts and circumstances must meet the criteria, which will be a matter for the prosecutor to assess in each individual case.
- 6.191 Only cases that pass the Stage 1 of the FCT or pass the Threshold Test may move onto Stage 2.

Stage 2 - The public interest stage

- 6.192 Stage 2 of the FCT requires prosecutors to decide whether a prosecution is required in the public interest. A prosecution will usually take place unless public interest factors against prosecution override those in favour.
- 6.193 To make a decision at Stage 2, a prosecutor must consider a whole range of factors set out in the Code and consider each case on its own facts, circumstances and merits. The listed factors include the seriousness of the offending; the level of the culpability of the perpetrator; and the circumstances of the victim/survivor.
- 6.194 Importantly for complainants in CSE cases, the Code explains that the decision not to initiate criminal proceedings in any given case, does not mean that the complainants are not believed, or are considered not to have been the victims/survivors of crime.

The Code throughout the years: specific factors relevant to cases of CSE

- 6.195 There have been a number of iterations of the Code over the years. Given the time period applicable to this Inquiry's Terms of Reference, I have set out briefly below the key changes in the Code, as it has developed over time, insofar as I consider those changes may be relevant to the consideration of CSE offences.
- 6.196 The 1986 version had similarities to today's Code in the applicable standards used to decide whether there should be a criminal prosecution. It contained one sufficiency of evidence test with relevant public interest factors for the prosecutor to consider. In evaluating the evidence, a prosecutor was directed towards factors including whether a child witness would be able to give sworn evidence. In relation to sexual offences the 1986 version of the code stated:
- "Sexual assaults upon children should always be regarded seriously, as should offences against adults, such as rape, which amounts to gross personal violation. In such cases, where the Crown Prosecutor is satisfied as to the sufficiency of evidence there will seldom be any doubt that prosecution will be in the public interest."*
- "Should doubt still remain, the scales will normally be tipped in favour of prosecution as if the balance is so even, it could properly be said that the final arbiter must be the court."*
- 6.197 The 1992 Code contained few changes, but the 1994 Code introduced the two stage type of test that we see today, with a distinct public interest test to be satisfied.

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- 6.198 Unlike the codes before it, the 1994 Code identified separate factors to be considered, both for and against a prosecution. Relevant factors in favour of prosecution that may have been relevant to CSE cases included whether:
- 6.198.1 There is evidence that the offence was premeditated or carried out by a group;
 - 6.198.2 The victim was vulnerable, put in fear or suffered personal attack damage or disturbance; or
 - 6.198.3 There are grounds for believing that the offence is likely to be continued or repeated.
- 6.199 The 2000 Code may be considered more victim/survivor focused. In the public interest section it highlighted the need to take into account the consequences for the victim/survivor in deciding when to prosecute; the views of the victim's/survivor's family; and the need to keep the victim/survivor informed.
- 6.200 The 2004 Code contained some significant changes as the responsibility for charging decisions was taken from the hands of the police and placed with the CPS. As well as the responsibility for charging, it was the first time a code included guidance on the CPS role as police advisors in the investigative process:
- "Prosecutors should provide guidance and advice to investigators throughout the investigative and prosecuting process. This may include lines of Inquiry, evidential requirements and assistance in any pre-charge procedures. Crown Prosecutors will be proactive in identifying and, where possible, rectifying evidential deficiencies and bringing to an early conclusion those cases that cannot be strengthened by further investigation."*⁸⁹
- 6.201 Despite this guidance, the investigating police officers maintained control of the investigative steps to be taken. The CPS advise upon an investigation but technically do not have the power to direct police action. This may be difficult to rationalise, as the CPS may be reluctant to authorise a charge in cases where the investigating officers have not obtained the evidence requested by the CPS as part of its statutory charging duty.
- 6.202 The 2004 Code also contained important additions to the public interest factors relevant to CSE investigations. A prosecution was now deemed more likely if the offence was committed in the presence of, or in close proximity to a child. A prosecution was also more likely if it would have a significant positive impact on maintaining community confidence.
- 6.203 The 2010 Code allowed prosecutors to make a decision as to whether a case would pass the public interest test prior to all evidence being collated. The codes before it did not allow for an early public interest decision in this way. Meanwhile the test as to whether there was a realistic prospect of conviction was expanded. The code stated that this test was:
- "... an objective test based solely upon the prosecutor's assessment of the evidence and any information that he or she has about the defence that might be put forward."*

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- 6.204 The 2010 Code included new factors for a prosecutor to consider when reviewing the reliability of evidence, in that prosecutors were now directed to consider whether there was further evidence which the police should be asked to find that may undermine or assist the account of a witness. Additionally, they were directed to consider whether further evidence could be obtained that would support the integrity of the evidence.
- 6.205 The 2013 Code was the seventh edition to be revised. The role of the CPS in criminal investigations was clarified, with specific reference to its inability to investigate and/or formally direct a criminal investigation.
- 6.206 Prosecutors were no longer asked to consider factors for and against a prosecution when assessing the public interest. The 2013 Code introduced a set of questions for prosecutors to consider including the circumstances and harm caused to the victim/survivor; the impact on the community; and whether sources of information require protecting.
- 6.207 Considerations relating to victims and survivors have therefore remained central to the Code throughout the various iterations over the years.

The CPS approach to rape and serious sexual offences

- 6.208 The manner in which the CPS has dealt with rape cases has evolved significantly since 2002, when Her Majesty's Inspectorate of Constabulary ("HMIC") and Her Majesty's Crown Prosecution Service Inspectorate ("HMCPISI") published a joint inspection report concerning the investigation and prosecution of rape cases (whether of a child or adult).
- 6.209 The report made recommendations with a view to improving the investigation and prosecution of rape cases. These recommendations focused on more guidance and training for prosecutors and the police when dealing with rape allegations, including decision making and the treatment of victims/survivors and/or other witnesses. In particular, this report made a recommendation that rape cases should be prosecuted by specialists with a lead lawyer in each of the prosecution areas, which included the West Midlands.
- 6.210 In July 2002, the Government published a '*Rape Action Plan*' which accepted the joint inspection's recommendations.⁹⁰
- 6.211 As a consequence of this report, the CPS introduced specialist rape coordinators and ensured that all rape cases were dealt with by 'rape specialists'. Whilst there was no prescript standard of competence, the Inquiry understands these specialists had to attend a mandatory sexual offences training course.⁹¹
- 6.212 In 2007, HMCPISI published its '*Without Consent*' report, which recommended a set standard of competence for rape specialists. The CPS responded by implementing a standard for rape specialists including a requirement to undertake specialist national and local training. Rape specialists had to be senior crown prosecutors with a prescribed degree of experience in prosecuting sexual offences.

⁹⁰ [REDACTED] pg 11

⁹¹ [REDACTED] pg 11

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- 6.213 The CPS told the Inquiry that the concept of specialist lawyers in the area of CSE did not exist, and rape cases would have been dealt with in volume crime teams as part of a mixed caseload.⁹² It follows that CSE cases, whether or not charged as rape, would also have been dealt with by these teams, with no required specialism in the area of sexual offences.
- 6.214 From 2002, the Inquiry understands that specialist lawyers were focused on rape cases only and child sexual abuse/exploitation cases (not charged as rape) remained within the remit of volume crime teams.⁹³

CSE and the Rape and Serious Sexual Offences team ("RASSO")

- 6.215 In 2008, some CPS areas moved their casework into specialist teams. The approach in the West Midlands was to create a Public Protection Unit. In this unit, experienced lawyers were allocated a range of cases including rape, honour crime, serious domestic abuse and other serious sexual offences including child sexual abuse/exploitation. This move was followed by other CPS areas, the South West forming a similar unit in 2009, Wessex in 2010 and the South East in 2012.⁹⁴
- 6.216 There was, however, still no requirement for a specialist prosecutor to deal with child sexual abuse and/or exploitation cases whilst rape allegations retained the benefit of such specialism.
- 6.217 In 2012/2013 the number of rape and sexual offences reported to the CPS by the police nationally fell, and as a consequence each CPS area was instructed to establish a RASSO in order to promote better reporting of offences for prosecution. These teams were staffed with specialist prosecutors to deal exclusively with rape and serious sexual offences such as child sexual abuse and exploitation. RASSO teams remain the responsible CPS unit for dealing with cases that fall within this definition. However, cases of this nature that are particularly large and/or complex would fall within the remit of the CPS's Complex Case Unit ("CCU"), but would still be handled by RASSO specialists in the same way.⁹⁵
- 6.218 I have noted from the material made available to me that it was the formation of RASSO as a prosecution specialism in 2012-2013 which resulted in child sexual abuse and exploitation cases being dealt with in the same way as rape and other serious sexual offences. It bears comment, however, that there are no separately trained specialist CSE prosecutors, only specialist RASSO prosecutors who are experienced in a broad range of sexual offences.
- 6.219 The RASSO unit within the CPS West Midlands currently deals with all CSE cases and specialist prosecutors without CSE experience are supervised by a District Crown Prosecutor.⁹⁶

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RASSO and CPS charging⁹⁷

- 6.220 After the CPS was given the responsibility for charging cases in 2004, the CPS provided charging advice at the police stations from Monday to Friday 9.00am to 5.00pm with a telephone advice service for out of hours requests. In 2010 this changed, and CPS prosecutors were removed from police stations and a stand-alone telephone consultation service provided for volume crime. Offences falling within the RASSO category still benefitted from face to face advice on a rota basis.
- 6.221 RASSO cases received within office hours from Monday to Friday are reviewed by an allocated RASSO prosecutor. RASSO cases submitted after this time are dealt with by the CPS out of hours service and not specialist RASSO prosecutors. A decision to charge by this service is re-reviewed by a RASSO lawyer within five working days. A conference is also arranged with the police officer in charge of the case within two weeks of the charging decision being made.
- 6.222 The Inquiry was told that the CPS tries to maintain consistency in the RASSO prosecutors dealing with cases, and where possible cases remain with the charging lawyer throughout the criminal proceedings. Indeed, from the CPS paperwork made available to me via WMP and upon the evidence I have seen from a number of police witnesses, I have noted that there was consistency in the CPS lawyers who were approached for, and provided advice.
- 6.223 The charging decision is a matter for the individual judgement of the allocated prosecutor based on the evidence before them. The allocated lawyer has reference to the Code and the Director's Guidance on Charging. The Director's Guidance on Charging is a public document providing additional guidance to prosecutors when making a charging decision and is supplemental to the Code. The guidance sets out the obligations and responsibilities of the prosecutor but is not specific to offence type.⁹⁸ The same standards and thresholds therefore apply to cases of CSE as apply to other types of criminal offence. Prosecutors can escalate issues or seek assistance from colleagues on an informal basis. Non-recent cases in particular are often technically difficult due to changes in legislation over the years. In the case of offences relevant to CSE and the prosecution of historic offences, I have noted at the beginning of Chapter 5: The Policing of CSE in Telford, those relevant offences over the years, and the fact that the 2003 Act does not apply to offences that pre-date it and so legislation in existence at the time of the offence (e.g. the Sexual Offences Act 1956 (the "1956 Act")) should be identified and applied.

Staffing - RASSO

- 6.224 In its submission to the Inquiry the CPS explained that its staffing requirements are calculated using the National Resourcing Model. This model applies a formula to identify several factors including the average time to complete operational steps, the grade of staff member and the projected volumes of cases.⁹⁹
- 6.225 The RASSO units were not separately funded until 2016, and formed part of the budget for management of all CPS work. This was changed in 2016/17 and separate calculations were

⁹⁷ [REDACTED], pg 13

⁹⁸ The most recent Directors Guidance on Charging was issued in 2020 - Sixth Edition.

⁹⁹ [REDACTED], pg 16

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used for the RASSO units that acknowledge the specific requirements of prosecuting these types of case.

- 6.226 At the time of its Corporate Submission the CPS had 209 full-time equivalent RASSO specialist prosecutors nationally. The CPS West Midlands is apportioned 23.14 of these posts. The Inquiry understands from the National Resourcing Model figures that the team should have 27.75 and that the RASSO unit within the CPS West Midlands is therefore currently understaffed; however the Inquiry was told that this is being addressed through recruitment.

Supervision of CPS casework

- 6.227 It was explained to me that the quality of CPS decision making and casework is supervised in a number of ways. There are Individual Quality Assessments ("IQA") where managers answer a series of questions against information from a dip sample of cases on a monthly basis, to ensure cases are being handled correctly. There are also Local Case Management Panels ("LCMP") in some cases, where the CPS casework team and managers discuss the pertinent issues in individual cases.¹⁰⁰
- 6.228 The Chief Crown Prosecutor ("CCP") also chairs a quality casework board and is accountable for all casework in their area. Information from IQAs and LCMPs is discussed at the board to inform management action.
- 6.229 The CPS also manages the quality of its performance by analysing data including the time taken to provide advice. There is an aspiration that all cases referred by the police are reviewed within 28 days, and cases that fall outside this timeframe are investigated internally.
- 6.230 Finally, the HMCPSI conducts regular inspections of the CPS and its departments, including its RASSO units. In December 2019, the report of its most recent inspection of RASSO units made the following key findings:¹⁰¹

"Since 2016, the number of cases prosecuted by the CPS has fallen by 52%. This is despite the fact that there has been a 43% rise in the number of rape allegations to the police.

But there has been a 23% fall in the number of cases referred to the CPS for a decision by the police. This reduction means that while reports of rape to the police have nearly doubled, a significant number of these cases have not been referred to the CPS.

Nearly a third of all the cases which the CPS received from the police were 'admin finalised'. These are cases which are sent back by the CPS to the police for further investigation.

There have been concerns that the CPS were only charging easy cases where a conviction was more likely, rather than applying the appropriate legal test (known as the Code for Crown Prosecutors). That view is not supported by the findings from this inspection.

¹⁰⁰ [REDACTED], pg 15

¹⁰¹https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2014/04/ARC_20020401.pdf
HM Crown Prosecution Service Inspectorate - Thematic inspection - RASSO units - 17 December 2019

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CPS has improved its application of the Code for Crown Prosecutors – the test for prosecutions: in the 2016 inspection there was a 10% failure rate but in this inspection there was a 2% failure rate”.

- 6.231 I have not seen material which gives comparable figures for Telford – and indeed I am of the view that to interrogate this would be beyond my Terms of Reference – so I am unable to comment on any such failure rate in West Mercia.

Early Investigative Advice (“EIA”)

- 6.232 The CPS is also able to provide the police with EIA during a police investigation, prior to any decision being made on charge. The Inquiry notes that this service has only been available since 2004.¹⁰²

- 6.233 Whilst EIA is available for any case, the current guidance indicates that cases involving death, rape or other serious sexual offences should always be referred for EIA. Paragraph 7.3 of the guidance states:

*“Investigators must consider seeking early advice in serious, sensitive, or complex cases. Cases involving a death, rape, or other serious sexual offences should always be considered for early referral, particularly once a victim has been identified and it appears that continuing the investigation will provide evidence upon which a charging decision may be made”.*¹⁰³

- 6.234 The rationale behind this decision is to develop a joint strategy for the prosecution and to assist the investigating officers in collating the necessary evidence. Since EIA has been available, indictable only offences (i.e. one that can only be tried in the Crown Court) and offences under the 2003 Act committed by or upon persons under the age of 18 years of age have attracted the positive requirement for EIA to be considered. It follows that CSE cases would almost always attract the requirement for EIA to be considered.

- 6.235 However, as explained above, the CPS cannot direct a criminal investigation and therefore cannot mandate the police to seek EIA. The seeking of EIA therefore remains at the discretion of the individual police officer.

- 6.236 In the West Midlands RASSO unit, I understand from evidence provided to the Inquiry that when a case is referred for EIA the officer responsible for the investigation will discuss the case with the District Crown Prosecutor so the appropriate lawyer can be allocated to provide EIA and a timescale agreed for its provision.¹⁰⁴

- 6.237 As CSE cases now fall within the remit of the RASSO team, I understand they also form part of the monthly discussions between the CPS RASSO unit head and the police RASSO Superintendent. The Inquiry was told that these meetings discuss significant investigations to ensure the CPS RASSO team is aware of those cases that will require EIA and the appropriate resources identified, including a barrister where appropriate. I have noted from

¹⁰² [REDACTED]

¹⁰³ Charging (The Directors Guidance) – Sixth edition - December 2020

¹⁰⁴ [REDACTED], pg 15

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the evidence made available to me that in recent meetings of this nature, the WMP Superintendent would always include a discussion on CSE investigations.¹⁰⁵

- 6.238 In cases involving multiple victims/survivors, complaints and suspects, the CPS can take a bespoke approach to EIA and charging, and where there are linked suspects and potential prosecutions, cases can be allocated to a small team of lawyers. I have seen indications that EIA was sought in the Chalice series of cases, as I have discussed in Chapter 5: The Policing of CSE in Telford. Further, cases may be directed to the CCU if they are judged to be sufficiently complex.¹⁰⁶

Relevant Legislation, Policies and Guidance

- 6.239 In addition to the Code and the Directors Guidance on Charging, prosecutors must apply relevant policies and guidance to their decision making process.
- 6.240 The legal principles and attitudes that apply to the evidence of children has changed significantly over time. Barriers to the admission of the evidence of children have been removed, and protections put in place for children giving evidence. Given that any prosecutor considering a case based on the evidence of a child will need to consider the rules of evidence concerning the admission of that testimony, I have set out below what I consider to be relevant landmarks in this respect:
- 6.240.1 Section 38(1) of the Children and Young Persons Act 1933 (the "1933 Act") provided that a "*child of tender years*" (under 14), who, in the opinion of the court, did not understand the nature of the oath might give evidence unsworn; though it was not possible to convict a defendant on such unsworn evidence without corroboration.
- 6.240.2 The 1933 Act also made provision for reporting restrictions in relation to proceedings involving children.
- 6.240.3 This requirement for corroboration of the unsworn evidence of children was revoked by section 34 of the Criminal Justice Act 1988. The requirement for corroboration in other circumstances for certain sexual offences, including 'causing prostitution' and; 'procuration' under the 1956 Act¹⁰⁷ remained.
- 6.240.4 The same Act provided¹⁰⁸ for children under 14 to give evidence, in relation to specified offences, including sexual offences, with the leave of the court by way of television link.
- 6.240.5 Section 52 of the Criminal Justice Act 1991 directed that children under the age of 14 should give evidence unsworn. A child's competence to give evidence – where the issue arose – was to be determined by the ordinary rules applicable to an adult witness. This provision came into force 1 October 1992.

¹⁰⁵ [REDACTED] pg 15

¹⁰⁶ [REDACTED] pg 26

¹⁰⁷ Sections 22, 23 Sexual Offences Act 1956

¹⁰⁸ Section 32 Criminal Justice Act 1988

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- 6.240.6 The Sexual Offences (Amendment) Act 1992 granted automatic lifetime anonymity to victims/survivors of sexual offences.
- 6.240.7 Section 32 of the Criminal Justice and Public Order Act 1994 revoked the corroboration rules in respect of sexual offences. This provision came into force on 3 February 1995.
- 6.240.8 Section 53 of the Youth Justice and Criminal Evidence Act 1999 provided that all persons, whatever their age, were competent to give evidence in criminal proceedings save in specified circumstances. The same Act made provision for the extension of the circumstances in which evidence could be given unsworn and for video recording of testimony of eligible witnesses. The provisions for video-recorded evidence in chief were quickly adopted; adoption of the matching provisions for cross-examination took nearly 20 years.
- 6.241 In addition to the above, the CPS has provided the Inquiry with a chronological breakdown of relevant CPS policy and guidance throughout the period of time relevant to this Inquiry, noting that CSE has always been approached as a subset of CSA.¹⁰⁹

The CPS Policy Manual (1988 -1992)¹¹⁰ (with reference to sexual offences)

- 6.242 In a section headed sexual offences involving children the manual notes:

"The credibility and credit of the child will often be of limited value and, in the case of very young children, may be nil. In cases involving young victims.....it will always be necessary to consider whether the child is likely to be permitted to give evidence on oath or, alternatively, give unsworn evidence having regard to the court's duties and discretions in these respects."¹¹¹

- 6.243 Notwithstanding this, the manual does make clear that the:

"... welfare of the child must not be overlooked [and that] more trauma may be produced by requiring the child to recount the incident in court, but equally the public interest may require that such difficulties are confronted and proceedings commenced."

- 6.244 The manual also recognises that:

"... the attitude of the child's parents should be taken into account... [and] all cases involving children should be handled with the utmost care and sensitivity, and every effort should be made to have the proceedings heard at the earliest opportunity."

¹⁰⁹ [REDACTED] pg 17

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¹¹¹ Policy Manual D.1.2 (i)

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- 6.245 The main offences against children considered in the manual were unlawful sexual intercourse with a girl under the age of 13/16;¹¹² indecency with children;¹¹³ and causing or encouraging prostitution of a girl under the age of 16.¹¹⁴
- 6.246 Whilst the section makes reference to sexual offences against children, it makes no distinct reference to cases involving child sexual exploitation – which was in keeping with other legislation and guidance of the time, as I have set out at the beginning of Chapter 5: The Policing of CSE in Telford.

The CPS Prosecution Manual (January 1995 – July 2001)¹¹⁵

- 6.247 This manual had seven volumes and was marked 'restricted'. Chapter 7 of the manual is dedicated to guidance on child abuse and child witnesses and is dated 4 January 1995. It was updated to take into account the changes made by the Criminal Justice and Public Order Act 1994. The introduction states:

*"A child victim or witness deserves special care and attention from the Crown Prosecution Service in the conduct of his or her case. That is particularly so where the child is the victim of, or witness to, child abuse."*¹¹⁶

- 6.248 The chapter outlines Article 3.1 of the United Nation's Convention on the Rights of the Child and the requirement for the best interests of the child to be the primary consideration.
- 6.249 The guidance gives priority to child abuse cases and adopts the definition of CSA from the 'Working Together' guidance.
- 6.250 The definition of CSA is:

*"Actual or likely sexual exploitation of a child or adolescent. The child may be dependant and/or developmentally immature."*¹¹⁷

- 6.251 I have emphasised here the inclusion of 'exploitation' within the definition of CSA in 1995.

- 6.252 The chapter states that *"it will be rare that a prosecution will not be needed in the public interest if the evidence provides a realistic prospect of conviction"*¹¹⁸ and goes on to say:

*"You should always bear in mind the needs of the child witnesses. They are vulnerable and may often be intimidated by court proceedings. Consider what steps you can properly take to shield them, wherever possible, from unnecessary or unfair attack."*¹¹⁹

¹¹² Section 5 and 6 of the Sexual Offences Act 1956

¹¹³ Section 1 Indecency with Children Act 1960

¹¹⁴ Section 29 of the Sexual Offences Act 1956

¹¹⁵ [REDACTED]

¹¹⁶ CPS Prosecution Manual 1995 – Chapter 7.1

¹¹⁷ CPS Prosecution Manual 1995 – Chapter 7.10

¹¹⁸ CPS Prosecution Manual 1995 – Chapter 7.37

¹¹⁹ CPS Prosecution Manual 1995 – Chapter 7.112

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- 6.253 The manual also stipulates that "*child abuse cases are given preferential treatment in the review process*"¹²⁰ and "*areas will ensure that child abuse cases are dealt with by lawyers and caseworkers with the appropriate experience.*"¹²¹
- 6.254 Chapter 5 of the manual¹²² provides dedicated guidance on offences of child abuse and child abduction, as well as a number of other child cruelty and indecency offences set out under various statutes (including, for example, the 1993 Act and the Protection of Children Act 1960) thus covering a broader range of offences than outlined in previous guidance.
- 6.255 Nevertheless, there is no bespoke commentary on how these offences may relate to CSE as a recognised form of child abuse notwithstanding the increased awareness of CSE as shown in official publications to which I have already referred – for example, the Home Office Circulars released in the late 1990s and the Safeguarding Children involved in Prostitution: Supplementary Guidance published in 2000. This tends to suggest that national guidance published for different agencies was not yet speaking with one voice about CSE.

CPS Policy statement on rape – 2004¹²³

- 6.256 This statement followed the 2002 joint inspection report by HMIC and HMCSI into the investigation and prosecution of rape. The CPS committed specialist prosecutors to rape cases. I have noted that this did not include specialist prosecutors for cases of CSA/CSE where rape was not the offence prosecuted. While the policy statement has little focus on child victims/survivors or sexual exploitation, it is important to note this as the beginning of sexual offences being regarded as a specialist area for prosecutors.

The Victims' Code – Legal Guidance

- 6.257 This is a criminal justice system publication. The Victims' Code sets out the services provided to victims/survivors in England and Wales by listed organisations, including the CPS. The Victims' Code was originally published in 2006 and revised in 2013 and 2015. The 2006 version included a section on vulnerable victims, including people under the age of 17 at the time of the offence.¹²⁴ This category of victim/survivor is entitled to an enhanced service under the code, which includes an obligation on service providers to pass victim/survivor information to certain other service providers, and mandates shorter timescales for certain obligations.
- 6.258 The 2006¹²⁵ version also included a requirement for the CPS to offer face to face meetings with victims/survivors of child sexual abuse/sexual offences to explain their prosecution decision.¹²⁶ It also directed the CPS to the range of special measures available for vulnerable witnesses in the provision of the enhanced service.¹²⁷

¹²⁰ CPS Prosecution Manual 1995 – Chapter 7.123

¹²¹ CPS Prosecution Manual 1995 – Chapter 7.125

¹²² [REDACTED], pg 25

¹²³

¹²⁴ The Code of Practice for Victims of Crime – Legal Guidance – 2006 Para 4.1

¹²⁵

¹²⁶ The Code of Practice for Victims of Crime – Legal Guidance – 2006 Para 7.1

¹²⁷ The Youth Justice and Criminal Evidence Act 1999 – The provisions of measures such as screens and video link evidence

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- 6.259 The revised 2013¹²⁸ Victims' Code was significantly more detailed than its predecessor, with a separate detailed chapter concerning children.¹²⁹ In a similar way to the 2006 version, the 2013 version explains the entitlement of child sexual abuse victims/survivors to be offered a meeting with the CPS at key points in a case. It also explains the entitlements of child witnesses to be informed of important events during a criminal prosecution with a timeframe for communication (usually 1 working day from the event).
- 6.260 A Victim Contact Scheme was also made available for victims of violent and sexual offences where the offender received a custodial sentence of 12 months or more. However, in the 2013 Victims' Code there is no mention of CSE or sexual exploitation.
- 6.261 The 2015¹³⁰ version of the Victims' Code is extremely similar to its predecessor, but CSE is mentioned - albeit briefly - for the first time in a section concerning restorative justice.
- 6.262 I have noted that a new Victims' Code came into force on 1 April 2021.¹³¹ This version establishes 12 well-defined victims'/survivors' rights. The obligations and minimum standards of service to victims/survivors apply to the CPS. Victims/survivors of child abuse and sexual offences still retain the right to be offered a meeting with the CPS following a decision not to charge the suspect. Whilst child abuse and sexual offences are mentioned in this new guidance, CSE is not separately defined or discussed. Notwithstanding this, I have seen evidence that as long as a decade before this, the CPS were involved (as were instructed counsel) in meetings with victims/survivors where a decision had been taken not to charge.¹³² Indeed, I have noted in Chapter 5: The Policing of CSE in Telford of this Report that such an approach was taken in the case of Operation Beta.

CPS Sexual Offences Legal Guidance 2006¹³³

- 6.263 As I have noted in Chapter 5: The Policing of CSE in Telford, the 2003 Act came into force on 1 May 2004 and repealed the majority of existing legislation in relation to sexual offences, and created a new range of sexual offences available for prosecution, including three categories of sexual offences against children of different age. This CPS legal guidance was released in 2006 and outlined these new sexual offences for prosecutors. This guidance was available to prosecutors and the public; it was available online and amended frequently between 2006 and 2012.
- 6.264 I have already set out at the beginning of Chapter 5: The Policing of CSE in Telford the relevant child sexual offences under the 2003 Act. In relation to the new offences in sections 47 to 50 of the 2003 Act concerning child exploitation, consent was not an issue and the guidance made clear that the act of exploiting children is of itself sufficient to commit the stated offences.
- 6.265 This guidance contained a section highlighting considerations for prosecutors. The section stated:

¹²⁸ [REDACTED]
¹²⁹ The Code of Practice for Victims of Crime – Legal Guidance – 2013 - Chapter 3
¹³⁰ [REDACTED]
¹³¹ The Code of Practice for Victims of Crime in England And Wales – November 2020
¹³² [REDACTED], pg 31
¹³³ [REDACTED]

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"Although the legal age of consent is 16, Parliament considered that persons should be protected from sexual exploitation up until the age of 18. The intention behind these provisions is to provide maximum protection for children from those who seek to exploit them for the purposes of prostitution or pornography. A prosecution usually takes place unless there are public interest factors tending against prosecuting which clearly outweigh those tending in favour. These are very serious offences in which the public interest will normally require a prosecution."

- 6.266 The acknowledgement of CSE as a separate issue distinct from CSA and other offences was, in my view, a positive one. It is disappointing that the language of 'prostitution' and 'pornography' was retained.

The Rape Manual of Guidance – 2008¹³⁴

- 6.267 This guidance was introduced to supplement the CPS legal guidance with particular reference to rape prosecutions. The guidance has specific reference to relevant sexual offences against children created by the 2003 Act, including those which relate specifically to exploitation. The issue of societal myths is addressed in the guidance for the first time, but none of the examples raised relate specifically to the issue of CSE or CSA or ostensible consent in exploitation cases. The guidance also highlights the fact that victims/survivors may not provide full details of the incident due to feelings of shame, cultural or family concerns, or for other (unspecified) other reasons.

Safeguarding Children: Guidance as Victims and Vulnerable Witnesses - 2009

- 6.268 The first iteration of this guidance was issued in 2009,¹³⁵ and was, I am led to believe, the first CPS guidance to focus exclusively on safeguarding children as victims/survivors. Under a heading "*Cases involving children*" the guidance states:

*"Children can be victims in relation to any offence. For example, as victims they may be abused sexually or physically by adults or, much more commonly, they may be assaulted by other children or have their possessions damaged or stolen."*¹³⁶

- 6.269 It contains guidance that makes reference to 'child prostitution' and trafficked children but is limited in content about other offences of CSA or CSE. With reference to 'child prostitution', the guidance acknowledges that children can be lured, persuaded or forced into 'prostitution' and should be treated as abused and in need of help. This guidance has a separate section concerning historical and institutional cases which states:

*"Allegations arising from incidents (from several to many) years earlier are a common feature of prosecutions involving child victims, particularly allegations of sexual offences. In some cases, the child victims will now be adults."*¹³⁷

"There are good reasons why such cases do not come to light at the time of the incidents, beyond the possibility that they are untrue. For example, children are used to being

¹³⁴ [REDACTED]

¹³⁵ [REDACTED]

¹³⁶ Safeguarding Children: Guidance as Victims and Vulnerable Witnesses – 2009 – para 13

¹³⁷ Safeguarding Children: Guidance as Victims and Vulnerable Witnesses – 2009 – para 75

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*controlled by adults and offenders can be expert at exercising control; they may not even realise until they are older that they have been subject to abuse; they may only be prompted to reveal what happened to them when they see the pattern being repeated with younger relatives.*¹³⁸

*"One of the difficulties that emerged some years ago was a result of 'trawling' for witnesses when an allegation was made against (for example) an employee in a children's home. This led to suggestions to witnesses in court that they had manufactured their allegations in response to the police approach, in order to secure compensation."*¹³⁹

*"'Trawling' is not prohibited. The police have a statutory duty to investigate allegations of child abuse, regardless of whether they relate to contemporary or past events. Prosecutors should certainly enquire as to whether and how it has been done and consider the implication for any evidence that arises."*¹⁴⁰

6.270 While care in respect of 'trawling' is plainly necessary, I do not consider the decisions not to pursue possible victims/survivors towards the end of Chalice to have been made on this basis; if they had been, that reason would surely have been recorded. Nor would I consider the pursuit of identified victims/survivors to be 'trawling'.

6.271 The 2012 edition¹⁴¹ of this guidance contained updates mainly concerning the competence of young witnesses. Further updated editions were published in 2015¹⁴² and 2019.¹⁴³ The 2019 edition changes its approach to "Cases involving children" and states:

*"Children can be victims of offences and can also be affected by crime even if they are not themselves victims or witnesses. A child may be seriously affected by, for example, domestic violence, even if not present in the same room as the offence is committed."*¹⁴⁴

6.272 The reference to children as the victim of sexual offending has therefore been removed. I also note, with surprise, that the term 'child prostitution' is still used within the 2019 guidance, despite the changes made to the Sexual Offences Act in 2015 that removed this terminology from the criminal offences. The 2019 guidance has little other reference to CSE, which I find to be a surprising omission in guidance of this nature.

Guidelines on Prosecuting Cases of Child Sexual Abuse - 2009 and 2013

6.273 As noted above, the generic CPS Sexual Offences Legal Guidance existed since 2006, but the first guidance exclusively focused on prosecuting cases of child abuse was published in 2009.¹⁴⁵ The guidance was called 'Child Abuse: Guidelines on Prosecuting Cases of Child Abuse' and included child sexual abuse within its remit. It provided guidance to prosecutors on most of the evidential and procedural aspects of prosecutions.

¹³⁸ Safeguarding Children: Guidance as Victims and Vulnerable Witnesses – 2009 – para 76

¹³⁹ Safeguarding Children: Guidance as Victims and Vulnerable Witnesses – 2009 – para 77

¹⁴⁰ Safeguarding Children: Guidance as Victims and Vulnerable Witnesses – 2009 – para 81

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¹⁴²

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¹⁴⁴ Safeguarding Children: Guidance as Victims and Vulnerable Witnesses – 2019

¹⁴⁵

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- 6.274 The guidance outlined the statutory and common law sexual offences against children. The definition of CSA was outlined as follows:

*"Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may not involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities or encouraging children to behave in sexually inappropriate ways."*¹⁴⁶

- 6.275 Whilst the criminal offences that relate to CSA, and the trafficking offences from the 2003 Act were outlined, there was no reference to broader CSE.¹⁴⁷

- 6.276 In October 2013,¹⁴⁸ the DPP issued an update to this guidance called '*Guidelines on Prosecuting Cases of Child Sexual Abuse*'. These guidelines were published as a result of interim guidance issued in June 2013¹⁴⁹ that was subject to a three month consultation period. Before the consultation, roundtable meetings were attended by all key stakeholders including police, lawyers, the judiciary and victims'/survivors' representatives.

- 6.277 The 2013 guidelines were the first to focus exclusively on the prosecution of child sexual abuse and exploitation cases. CSE was independently defined and the guidelines included an annex setting out for the first time common myths and stereotypes in relation to child sexual abuse and exploitation cases. Prosecutors were informed that some factors which had previously been seen to undermine a complainant's credibility should no] longer automatically be seen as doing so. These factors included not reporting the offence immediately, returning to the alleged perpetrator and inconsistent witness accounts – factors which I have noted elsewhere have featured heavily in a number of CSE cases I have reviewed in this Inquiry.¹⁵⁰

- 6.278 Within the introductory section CSE is specifically referenced in this way:

"These guidelines are designed to set out the approach that prosecutors should take when dealing with child sexual abuse cases. Experience has shown that these cases bring with them particular issues that differentiate them from other types of case particularly in terms of, for example, a victim's response both to the sexual abuse and the subsequent intervention by the police. These guidelines are intended to cover the range of child sexual abuse, including the abuse referred to as 'child sexual exploitation'..."

- 6.279 For the first time these guidelines outlined the context and circumstances of CSA with detailed reference to CSE:

"Child sexual abuse comes in a number of different forms. Sexual abuse by coordinated networks is a form of child sexual abuse that has become more prominent recently and is referred to as child sexual exploitation. These networks may be informal clusters of people linked through a set of victims or 'friendship' groups or they can be more organised criminal

¹⁴⁶ Child Abuse: Guidelines on Prosecuting Cases of Child Abuse – 2009 – Annex A

¹⁴⁷ [REDACTED] pg 12

¹⁴⁸ [REDACTED]

¹⁴⁹ [REDACTED]

¹⁵⁰ Guidelines on Prosecuting Cases of Child Sexual Abuse – 2013 – para 49

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*groups or gangs. Children and young people may be groomed into 'party' lifestyles where they go to houses, flats, hotels and bed and breakfast accommodation with numerous men and other child victims. Sometimes a single relationship may be formed, but in some cases, there is no single relationship and instead a general network exists. The 'parties' are usually organised by adults with young people sometimes being coerced into bringing friends along.*¹⁵¹

- 6.280 The guidelines also contained a section which includes how to identify children who may be at risk of exploitation; typical vulnerabilities in children prior to exploitation; and behaviours that may be exhibited in children being sexually exploited. They also identified the 'duty' of prosecutors to identify potential CSE cases even where the police have neglected to do so.¹⁵²
- 6.281 The guidelines were reviewed in 2017¹⁵³ and 2020 but the Inquiry notes the marked change in approach to highlight CSE stems from those published in October 2013.

RASSO legal guidance – 2012 (and current)

- 6.282 The 2012 Rape and Sexual Offences guidance¹⁵⁴ replaced the 2008 Rape Manual and reflects the changes made when the RASSO units were established. It identifies the specific sexual offences against children created by the 2003 Act, yet (still) there are no specific references to CSE, how CSE manifests itself or examples of CSE for prosecutors to consider. Notwithstanding this, from 2012, the CPS told the Inquiry that the RASSO units dealt with CSE as a serious sexual offence.¹⁵⁵
- 6.283 The 2012 guidance was updated in 2021.¹⁵⁶ The current guidance has a chapter on '*Issues relevant to particular groups of people*',¹⁵⁷ which does include sections on victims of child sexual abuse and exploitation and gang-associated sexual exploitation and violence.
- 6.284 The 2021 guidance also provides the prosecutor with guidance on the issue of consent in child sexual exploitation cases, providing useful references to case law and commentary. It also identifies some factors prosecutors must consider when reviewing cases of CSE, including:¹⁵⁸
- *"The age and maturity of the complainant especially in relation to the suspect;*
 - *The history of the relationship between complainant and suspect;*
 - *The presence of any other vulnerability of the complainant such as a learning disability;*

¹⁵¹ Guidelines on Prosecuting Cases of Child Sexual Abuse – 2013 – para 13

¹⁵² Guidelines on Prosecuting Cases of Child Sexual Abuse – 2013 – Annex B

¹⁵³

¹⁵⁴ [REDACTED] pg 12

¹⁵⁵ [REDACTED]

¹⁵⁶ [REDACTED] Rape and Serious Sexual Offences legal guidance updated 2021 – Chapter 5

¹⁵⁷ [REDACTED] pg 56

¹⁵⁸

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- *The existence of grooming through the provision of gifts, alcohol, insincere compliments, apparent security, a more exciting way of life, attention and false promises;*
- *The provision of alcohol and drugs and the effect on the complainant;*
- *The use and/or threat of violence and intimidation; and*
- *The use of other means of control such as emotional or situation control.”*

6.285 When addressing the child exploitation offences created by sections 47-50 of the 2003 Act, the guidance defines CSE and highlights the issues of coercion, manipulation and grooming. It also directs these offences to be used in cases of children exploited by way of 'child prostitution':

"Coercion and manipulation often feature in abusive situations so that the child or young person does not understand what is happening. Offenders may groom the child or young person and their family and friends, gaining their trust or they may make threats. Sometimes, the offender may exert control but implicating the victim in other criminal activity (e.g. possession of illegal drugs or shoplifting). Some offenders may claim that the victim has brought shame on their family. Prosecutors should be aware of cultural barriers to reporting such abuse.

Offenders may avoid suspicion by taking victims to be abused for a short time or during school hours so their absence is not noticed. The fact that a victim is maintaining a seemingly normal routine does not mean they have not been victims of sexual abuse.

'Grooming' is not a specific form of child sexual exploitation but should be seen as a way in which perpetrators target children and manipulate their environments. It is an approach to exploitation and may be the beginning of a complex process adopted by abusers. Grooming can be defined as developing the trust of a young person or his or her family in order to engage in illegal sexual activity or for others to engage in illegal sexual activity with that child or young person.

Sections 47 - 50 provide offences specifically to tackle the use of children in the sex industry who are victims of abuse and sexual exploitation.”¹⁵⁹

6.286 It is clear, therefore, that despite decades of increasing knowledge on the subject, and the introduction of the offences under the 2003 Act, specific legal guidance on how to approach the prosecution of CSE offences has only been available to RASSO prosecutors since 2013, and arguably, only in sufficient detail to understand the complex issues to be considered in CSE cases, even more recently than that.

¹⁵⁹ [REDACTED], pg 74

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Training of Crown Prosecutors

- 6.287 It has been explained to me that the CPS requires new prosecutors to undertake induction training which includes training on the Code, decision making, and the general criminal offences they will be expected to prosecute.¹⁶⁰
- 6.288 Further, a RASSO training programme is mandatory for prosecutors who wish to work within these units. This training must be completed before work can be undertaken on a RASSO case. The Inquiry was told that frequent refresher training exists but this is optional;¹⁶¹ that is a surprise. RASSO specific training also includes crown advocacy, disclosure management, victim communication and liaison scheme, and 'youth RASSO'.
- 6.289 The CPS told the Inquiry in its Corporate Submission:
- "Whenever substantial changes are made to guidance, or new guidance published, it is often accompanied by some form of training to embed that learning. Smaller changes are notified to prosecutors through email bulletins, currently known as 'gateway' communications. Locally, unit heads will ensure staff are aware of new developments during team meetings."*¹⁶²
- 6.290 I note the word 'often' and therefore must assume that training is not mandatory upon any change in guidance and practice. Again, I regard that as an oddity, and one which could usefully be resolved. I have not, however, been provided with direct evidence of when, or how this occurred within the CPS West Midlands in relation to the above developments in legislation and guidance.
- 6.291 The CPS told the Inquiry:
- "CPS training has been delivered centrally by our Central Legal Training Team (CLTT) since 2019. Prior to this it was developed by a central Learning & Development (L&D) team but cascaded to Area trainers to deliver the products locally. We have very limited, incomplete details around localised delivery of training and so we are unable to say specifically what training was delivered within West Midlands."*¹⁶³
- 6.292 In light of this, I am unable to assess the exact training provided locally to those prosecutors dealing with CSE cases prior to their inclusion within RASSO units in 2012, nor am I able to consider how many members of the West Midlands unit participated in any training offered. I was also told that CPS areas had access to national training products and that *"periodically training is mandated and checks are made to ensure all areas comply with that direction."*¹⁶⁴
- 6.293 The CPS did identify some relevant training courses which were delivered, dating back to 1997. Prior to 2012, the names of these courses indicate they were focused on sexual offences generally or child abuse, rather than anything directly intended to address CSE.

160 [REDACTED] pg 21
161 [REDACTED] pg 22
162 [REDACTED] pg 21-22
163 [REDACTED] pg 22
164 [REDACTED] pg 22

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October 2012 saw the delivery of a CSE seminar, however the title of later training suggests there was more focus on CSA than exploitation.¹⁶⁵

- 6.294 I have seen evidence that the CPS Central Legal Training Team has delivered central training since 2019. CPS prosecutors also have access to e-learning products¹⁶⁶ that they can access at any time.¹⁶⁷

Charging Decisions

Targets for charging decisions

- 6.295 I have set out above the tests to be applied by the CPS when making a charging decision, and the process of EIA which is available to the police and which is encouraged in particularly complex cases, such as CSE. Charging decisions made by the CPS can, however, be challenged by the police. In these cases the initial CPS decision will be reviewed by a more senior prosecutor, who will take a view on the decision and advice given and the correct action to be taken. It is worth noting here that I have seen evidence of senior prosecutor review of decisions and advice as having been provided throughout Chalice.
- 6.296 It is also relevant to comment upon the fact that, for some years (since 2005/2006), the CPS has been given targets to measure conviction rates. Until 2009/2010 these were called 'Attrition Rate Targets', and therefore measured the rate of prosecutions that did not result in conviction – i.e. unsuccessful prosecutions.¹⁶⁸ From 2010/2011 to 2012/2013 no targets were in place, but the performance of prosecution areas was assessed against the overall national rate and trends in charging rates and conviction.
- 6.297 The position changed again in 2013/2014 and targets were re-introduced. These were no longer referred to as 'Attrition Rate Targets' but were instead called 'Levels of Ambition'; it is not clear why the terminology changed. These 'Levels of Ambition' continued until 2017/2018 and were based on the percentage of charged cases that resulted in conviction.
- 6.298 'Levels of Ambition' targets were replaced with High Performing Benchmarks ("HPBs") in 2017 and all targets based on conviction rates were removed. No HPBs were implemented for magistrates and crown court cases but conviction rates and case volume were monitored.
- 6.299 In terms of any relevant targets applicable to child sexual offences or CSE, the CPS confirmed that, first, in relation to offences of rape:
- 6.299.1 From the years 2005/2006 to 2006/2007 there were no attrition rate targets for rape or 'Violence Against Women and Girls' offences (as they are referred to).
- 6.299.2 In 2007/2008 a rape target was introduced for the first time. It took the form of quality flagging on the Case Management System and attrition rate. The flagging relates to a tick box on the Case Management System that indicates the case is

¹⁶⁵ [REDACTED], pg 22

¹⁶⁶ These are provided via their intranet site 'Prosecution College'

¹⁶⁷ [REDACTED], pg 22

¹⁶⁸ [REDACTED], pg 24

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one of rape. The target was 95% flagging and 45% attrition (i.e. only 45% of rape prosecutions not to result in conviction).

- 6.299.3 In 2008/2009 an attrition rate target was implemented for rape and sexual offences. Rape had a target of 41% and other sexual offences a target of 29%.
- 6.299.4 In 2009/2010 an attrition rate target was implemented for rape at 39%, sexual offences at 23% and 'Violence Against Women and Girls' at 26%.
- 6.300 No annual targets were then implemented until 2013/2014. This year the level of ambition for 'Violence Against Women and Girls' conviction rate, which included rape and sexual offences, was set at 75%. This level of ambition remained the same for 2014/2015.
- 6.301 In the years 2015/2016 to 2017/2018 a single level of ambition conviction rate for rape was set at 60%.
- 6.302 I am aware of negative commentary on the subject of the CPS Level of Ambition targets; it is important to state I have not seen any evidence that charging decisions were influenced at all, let alone improperly, by targets – however those targets were described.

Charging of cases involving multiple victims/survivors, and the grouping or separating of cases for prosecution

- 6.303 The CPS must take into account the Code and guidance relevant to the type of offences charged. There is no bespoke code of practice or charging guidance in relation to cases involving multiple victims/survivors, nor in relation to CSE.
- 6.304 The Inquiry understands that there can be no standard approach, as the facts of every case will be different. Chapter 7 of the most recent RASSO legal guidance¹⁶⁹ states that counts on the indictment must:
- *"Reflect the seriousness and extent of the offending supported by the evidence;*
 - *Give the court adequate powers to sentence and impose appropriate post-conviction orders; and*
 - *Enable the case to be presented in a clear and simple way."*
- 6.305 The CPS states that decisions about grouping of offences are often made at the investigation stage and can depend on how such cases are presented by the police. Should cases be presented and charged separately, it is possible that they can be joined at a later stage in the criminal proceedings by applying to the court to join the indictments. Equally, applications can also be made to sever indictments.
- 6.306 The CPS has general legal guidance on 'drafting the indictment' published in 2018 and updated in September 2021, which includes the matters which should be taken into account when considering the shape of a trial and whether to prosecute multiple offenders/offences

¹⁶⁹ Rape and Serious Sexual Offences legal guidance updated 2021

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together or separately. This was an issue in Chalice, as I have already discussed in Chapter 5: The Policing of CSE in Telford.

- 6.307 The shape of a trial has never been simply a matter of prosecutorial discretion; the Criminal Procedure Rules, reflecting longstanding principle, now provide an express role for the court:

"It is generally undesirable for a large number of counts to be tried at the same time and the prosecutor may be required to identify a selection of counts on which the trial should proceed, leaving a decision to be taken later whether to try any of the remainder."¹⁷⁰

- 6.308 As I have noted with regard to Chalice, I regard the CPS advice as being consistent with a sensible eye to the manageability of the cases being considered from the outset.

Re-examination of cases previously submitted for a charging decision

- 6.309 A Victims' Right to Review Scheme ("VRR") exists to allow victims/survivors to seek a review of decisions not to start or to stop criminal prosecutions.¹⁷¹
- 6.310 The VRR was launched in 2013. It has been explained to me that requests under this scheme are usually dealt with by the local area CPS office where the decision was originally made. The Inquiry notes this scheme is not retrospective and does not apply to charging decisions before the scheme was launched, with the exception of CSA.
- 6.311 In CSA cases, a CSA Review Panel looks at allegations made when a person has made previous allegations of a sexual offence when they were under the age of 18, and the connected police or CPS decision.
- 6.312 It is important to note further that the VRR scheme only applies to charging decisions. It does not apply, for example, where the police choose not to pursue a case after receiving EIA from the CPS, though a separate right to seek review of the police decision exists.
- 6.313 I have seen no suggestion that a VRR has been requested in any case the Inquiry has considered, or that any Telford victim/survivor of CSE has requested a VRR; nor am I aware of any evidence of victims/survivors seeking review of a police decision not to charge following EIA.

The Child Sexual Abuse Review Panel ("CSARP")

- 6.314 The CSARP is a joint enterprise between the CPS and the NPCC. The panel reviews the case and decides whether the original decision to take no further action in respect of an allegation was correct, or whether further action should be taken. It was established in June 2013 to look at cases that were pre the VRR scheme.

¹⁷⁰ [REDACTED]

¹⁷¹ <https://www.cps.gov.uk/legal-guidance/victims-right-review-scheme>

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- 6.315 The CSARP can refer a case back to the police or CPS area from where the case originated for appropriate action to be taken, such as initiating criminal proceedings or requesting further investigation.
- 6.316 The CPS legal guidance was updated in October 2020¹⁷² and states that since the CSARP was established in 2013, 184 cases have been referred to CSARP. Of these cases:
- 143 cases were reinvestigated by police or reconsidered by CPS (78%);
 - 20 cases were agreed NFA by the panel (11%); and
 - 21 cases where the victim/survivor disengaged with the panel (11%).
- 6.317 Of the 143 cases that were reinvestigated or reconsidered:
- 44 cases resulted in NFA by the police or CPS (31%);
 - 29 cases resulted in a charging decision (20%);
 - 21 cases resulted in a conviction (15%); and
 - 14 cases remain live investigations (10%).
- 6.318 The CSARP consists of a chief police officer, chief crown prosecutor, specialist prosecutor, an experienced child abuse police investigator and an independent representative.
- 6.319 I have not been provided with data specific to CSE cases referred to the CSARP, so am unable to comment upon the number or percentage of cases that led to a change in decision for any such CSE cases that were referred. I would hope that, had such data been available, it would have been made available to me as part of the CPS's Corporate Submission.

Victim Liaison Units ("VLUs")

- 6.320 The Victims' Code placed a duty on the CPS to provide victims/survivors with information about key decisions or outcomes in their case. The CPS do this through letters within a prescribed timescale. These letters were known as 'Direct Communication with Victims' and were completed by the relevant prosecutor.
- 6.321 VLUs were established in 2014 and exist in all CPS areas. The units manage the liaison with victims/survivors, local resolution of VRR and feedback/complaints policy.
- 6.322 VLUs are a point of contact for victims/survivors after a case has been concluded and are responsible for drafting most communications to victims/survivors. In sensitive cases like RASSO, prosecutors will retain responsibility for drafting correspondence. Regardless of who drafts the correspondence, the VLU is responsible for assuring all communications are sent to the victims/survivors in accordance with the Victims' Code.

¹⁷² Child Sexual Abuse Review Panel | The Crown Prosecution Service (cps.gov.uk)

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- 6.323 I have not been provided with any specific information relevant to the work of the VLU or any communications sent to victims/survivors in cases of CSE in Telford – it is not clear if any such material exists.

The CPS role in achieving best evidence (“ABE”)

- 6.324 As mentioned above, the CPS has a number of obligations to victims/survivors set out by the Victims’ Code.¹⁷³ These include:¹⁷⁴
- 6.324.1 Informing the victim/survivor of a decision not to prosecute/discontinue proceedings or to substantially alter a charge, providing reasons for the decision and details of the VRR scheme.
 - 6.324.2 Offering the victim/survivor a meeting to discuss the decision not to prosecute certain cases (including cases of CSE).
 - 6.324.3 Ensuring the trial advocate meets the witnesses in the criminal proceedings to answer any questions before giving evidence.
 - 6.324.4 Ensuring victims/survivors and witnesses are treated with respect and seek the courts intervention where questioning becomes inappropriate.
 - 6.324.5 Ensuring the victim’s personal statement is served on the court. This is a statement that allows the victim/survivor to provide evidence about the impact of the offence.
- 6.325 The investigating police officers should assess the needs of the victim/survivor and communicate this in a formal assessment for the CPS. This assessment will include information about the potential for measures that might assist the victim/survivor to give evidence in court. These are known as ‘special measures’ and are set out in the Youth Justice and Criminal Evidence Act 1999.¹⁷⁵ These measures include:
- 6.325.1 Screens;
 - 6.325.2 Live TV Link;
 - 6.325.3 For sexual offences, the option for witnesses to give evidence in private;
 - 6.325.4 Removal of wigs and gowns by advocates;
 - 6.325.5 The use of video recorded interviews as evidence-in-chief and cross-examination;
 - 6.325.6 Examination of witness through intermediaries (where witnesses are eligible due to particular vulnerability); and

¹⁷³ [REDACTED] pg 27

¹⁷⁴ <https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime/code-of-practice-for-victims-of-crime-in-england-and-wales-victims-code>

¹⁷⁵ Sections 23 to 30 of the Youth Justice and Criminal Evidence Act 1999

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6.325.7 Aids to communication - giving evidence through an interpreter (where witnesses are eligible due to particular vulnerability).

6.326 The measures are available for vulnerable¹⁷⁶ witnesses and those in fear or distress about testifying.¹⁷⁷ A child witness (since 2011, anyone under 18)¹⁷⁸ is automatically deemed vulnerable. The Inquiry notes that complainants in sexual offences are also automatically deemed as being in fear or distress for the purposes of this legislation, and accordingly deemed suitable for special measures.

Examples of CPS Decisions in cases of CSE in Telford

6.327 In the course of the Inquiry's work I have seen a number of CPS charging decisions. I have extracted examples and consider them below. The first two are post-Chalice; the two that follow are Chalice-era decisions.

Case 1

6.328 The first case¹⁷⁹ involved a child under the age of 16. She had been lured into what she thought was a sexual 'relationship' by a perpetrator with whom she spent a great deal of time before he introduced her to other men who repeatedly raped her. What I consider to be a careful charging advice immediately addressed the question of the victim's/survivor's apparent willingness to be with her exploiter. There was no hint of what is known as the 'bookmaker's approach' – i.e. assessing the likelihood that a jury might consider the child unworthy of belief because of her apparent consenting to the 'relationship' by reference to what had happened in past cases, rather than, as here by a strict focus on the evidence.

6.329 The prosecutors in this case considered an offence of child abduction. The advice noted that consent is irrelevant to the offence of child abduction, and the exploiter was accordingly charged with this offence. As to the allegations against the other men, the lawyer expressed the view that the child's evidence could be relied upon to establish lack of consent; and there were rape charges as a result. This analysis was in no way risk-averse. The CPS lawyer – a specialist rape prosecutor - applied the FCT, recognised the difficulties in the case, but considered offences which were appropriate, including non-sexual offences in relation to the initial perpetrator (who went on to introduce other offenders), in light of evidential difficulties around the apparent consent of the victim, which prevented charges relating to sexual offending. Despite the evidential difficulties the prosecutor concluded there was a reasonable prospect of conviction. This approach was in my view careful, measured and unimpeachable.

Case 2

6.330 In the second case,¹⁸⁰ the documents revealed an informal discussion between the officer in the case and a specialist CPS prosecutor. The police sought a meeting for EIA in respect of a case in which a fresh complaint had come to light regarding a perpetrator whose case

¹⁷⁶ Defined by section 16 of the Youth Justice and Criminal Evidence Act 1999

¹⁷⁷ Defined by section 17 of the Youth Justice and Criminal Evidence Act 1999

¹⁷⁸ Coroners and Justice Act 2009 section 98(2)

¹⁷⁹ [REDACTED]

¹⁸⁰ [REDACTED]

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had previously been discontinued. The officer in the case had, the decision records, had a certain view but sought confirmation of it. There was concern about the strength of the new material and whether other victims/survivors whose cases had not been pursued should be approached again to provide further support. In the interim the new complainant withdrew her complaint. The CPS advice noted that the other victim/survivor's case had ended when a formal retraction statement, taken by a solicitor, indicated that the victim/survivor could not be sure what had happened. The lawyer offered the opinion that:

*"... weak cases cannot be used to bolster any prosecution... Any offences charged that clearly did not have a realistic prospect of conviction would be subject of a dismissal application or, failing that, a half time submission. Criticism would inevitably follow of any such prosecution involving wasted public money and the false hope given to vulnerable complainants. Cases that do not meet the full code test cannot be joined together in the hope that they would satisfy the test in these circumstances."*¹⁸¹

- 6.331 This document shows a CPS willingness to engage with and assist the police even on an informal level, recognising the sensitivity of the case, the interests of the complainants, and the understandable desire of the officer to have their decision reviewed. It seems to me that both the police and the CPS were obviously correct in their assessment of the merits of this case: a prosecution founded on two retracted complaints would, without more, be doomed to early failure.

Case 3

- 6.332 The third case¹⁸² was subject to an appeal by the police against an initial decision that there were no reasonable prospects of conviction. The complainant had made an early disclosure of rape to the police and to a friend. She went to hospital but did not consent to samples being taken. She had not wished to pursue her complaint immediately for what the CPS regarded as "*credible reasons*";¹⁸³ an ABE interview took place after some months. The victim/survivor identified her assailant by a single name; she later identified him via identification procedures. It was noted that the victim/survivor had made previous false complaints, and other complaints which she had later withdrawn. The friend to whom disclosure was made was also unwilling to assist in making a statement in support, and her account gave a very different account as to the circumstances of the rape. The first prosecutor took the view that "*the weaknesses of this case far outweigh the strengths and are not capable of remedy. In such circumstances I am minded to advise NFA.*"¹⁸⁴ This case was reviewed by a specialist rape prosecutor who set out the stark truth: that in the absence of other evidence, the victim/survivor's understandable decision not to undergo medical examination had unfortunately deprived the prosecution of potentially crucial, reliable evidence which would have sufficiently bolstered the case. The lawyer noted:

"... although it is possible in the right circumstances to run a case on the basis of one against one evidence, I do not consider that this is a suitable case. If we were to proceed on this basis, the credibility of the complainant would be absolutely vital. With this in mind, we simply cannot ignore that [she] has a previous criminal conviction... the facts of this relate

181 [redacted] pgs 5-6
182 [redacted]
183 [redacted] pg 3
184 [redacted] pg 6

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to the making of a false complaint to the police and then fabricating evidence to support it. I cannot conceive of a more damaging or undermining factor.”¹⁸⁵

- 6.333 This case illustrates the agony of every prosecutor: if they are faithfully to apply the FCT, there will be cases that fail because although a complaint is credible in isolation, the evidence as a whole will not support a prosecution. The sequence here was sensible: the prosecutors considered the case was bolstered by an immediate complaint and did not place undue weight upon the fact that it was not immediately pursued. Importantly, no weight was placed on the fact that the victim/survivor had previously made other complaints which she did not pursue: this underlines the recognition that such complaints are hard to make and often difficult to pursue.
- 6.334 It should be noted that the victim/survivor’s account was not dismissed because she had not consented to samples at the hospital. The fact that there was no scientific evidence to support the allegation was one feature to be taken into account, as was the significantly inconsistent evidence of her friend. Similarly, it was not suggested that she would be unworthy of belief because of her previously false accounts, but that conviction was a factor properly brought into consideration in the overall assessment of the merits of this case. This was a difficult decision, questioned by the police but in my view subject to careful and ultimately correct analysis by both lawyers.

Case 4

- 6.335 In the final case I wish to address,¹⁸⁶ the CPS was asked to consider another complaint of rape. It was subject to review because of the nature of the offence. The victim/survivor was an extremely vulnerable child who had “*clearly been groomed by others*”. There were images and videos showing her in apparently ‘consensual’ sexual activity with other men. There had been a delay of some years in reporting the offence which meant that no forensic material was available to assist. A suspect had been named; he denied any knowledge of the child. The child had given a detailed description of the offender largely consistent with the suspect’s appearance but she failed to identify the suspect at identity procedures.
- 6.336 The analysis by the lawyers in this case, particularly the second reviewer, was painstaking. Each was cautious not only to note that the approach was ‘merits based’ but also to identify the ‘myth’ factors that should play no part in the decision: the mere fact of delay in complaint, the images and videos of sexual activity with others. Their assessment of the victim/survivor was that she would be a credible witness, but that she could offer no evidence on the crucial element of identification; the question was not whether she had been exploited, but whether the suspect could be shown to be the man who committed the offence. That was the basis on which the case was determined ‘NFA’ – no further action; and it was undoubtedly the only proper decision on the facts.

¹⁸⁵ [REDACTED], pg 10
¹⁸⁶ [REDACTED], pg 24

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Conclusions - CPS

- 6.337 The Code and the FCT within it, apply to all criminal cases and are therefore not specific to offences relating to CSE. The Inquiry has seen that from as early as 1986, the Code included reference to factors such as child victims/witnesses and sexual assaults upon children as part of the thought process relevant to whether an individual should be charged with a criminal offence.
- 6.338 I doubt whether the changes in the Code and the approach to it throughout the years have made a significant impact on whether cases of alleged CSE were prosecuted in Telford. The Code has focused on the strength of the evidence, and the public interest in the prosecution of those who sexually offend against children is not in question.
- 6.339 The CPS involvement in the cases I have seen was wider than simply decisions to prosecute. There was early engagement and careful advice. That advice considered not only evidential matters but strategic considerations – including, later, the shape and size of the trials. I regard the advice given in Chalice, for example, with which I dealt in the Chapter 5: The Policing of CSE in Telford, as entirely sensible, particularly with regard to keeping focus on a manageable first trial.
- 6.340 Furthermore, the charging decisions that I have seen have been rational and objective; where cases have not been pursued I can detect no hint of lack of objectivity, nor of the improper taking into account of irrelevant matters, such as the effect of rape myths on juries.
- 6.341 As to other changes, while the Inquiry understands that although specialist CPS ‘rape prosecutors’ existed in 2002, cases of CSE (not charged as rape) would have simply been dealt with by non-specialist volume crime teams with no guarantee that the individual prosecutors involved had any experience or expertise in the complex issues involved in cases of CSE. Nevertheless, in the cases I have examined and most notably in respect of Chalice, the police sought early engagement with a specialist prosecutor whose subsequent presence was consistent and who was plainly engaged with the case. The service provided by the CPS was, in my view, appropriately expert.
- 6.342 Further, it seems to me that the introduction of CSE specific prosecution guidance in 2013 and of RASSO units in 2012/2013, with the consequent guarantee that cases of CSE (not charged as rape) fell within the remit of specialist prosecutors, was a significant and positive change, clearly demonstrating a growing institutional awareness of CSE within the CPS.
- 6.343 There have been significant changes in practice, policy, legislation and above all societal attitude over the Inquiry’s time frame of reference. The approach of the CPS over time has reflected those changes and has, in my judgment, led to more effective pursuit of CSE offences. This is, of course, not simply about the CPS; it is about every feature of a potential witness’s journey through the system and in particular the trial process. It is sobering to note that until as recently as the 1980s, the first step to a child giving evidence was an assessment of whether they were intellectually robust enough to understand an oath; if they failed that test, their evidence could not convict a perpetrator unless it was corroborated. Sexual offences, notoriously, are more often than not uncorroborated; they

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are committed in private and kept secret, and this has always presented understandable evidential challenges for prosecutors to consider, and attempt to overcome.

- 6.344 Equally, it was not until 1989 that children under 14 were allowed to give evidence in relation to sexual offences by way of video link¹⁸⁷ (and not until 1999 that children under 17 were given the unfettered right to give evidence by link), and only ten years ago were judges properly enjoined to ensure that the trial process properly catered for the needs of child witnesses.¹⁸⁸ In a situation where a CPS lawyer is determining whether it is in the public interest to bring a prosecution, the circumstances of the victim/survivor and their likely experience as a witness are proper considerations; and the courts' increased sensitivity to the needs of children has undoubtedly tipped that balance in favour of prosecution as time has passed. General observations aside, however, I have seen no evidence in this Inquiry that any CSE prosecution was denied on public interest grounds – and rightly so.
- 6.345 While I have spoken of societal changes and growing institutional awareness, it is important to remember that the very existence of a case like Chalice contributes to those trends; for it must be less troubling to authorise a prosecution involving relatively new trafficking offences when one is not the first lawyer to do so, just as it must be not to be the first police officer to authorise arrests in CSE cases without willing complainants, or the first youth worker to attempt a new method at engagement with children for whom social workers had no solutions.
- 6.346 I have reviewed witness evidence encouraging me to recommend that the police “*should prosecute all known perpetrators, regardless of a lack of evidence.*”¹⁸⁹ I understand the emotion that drives people to want such things, but a moment's reflection is enough to understand that the consequence of such an approach would be chaos; it would also be illegal. The CPS is designed to ensure that the power of the state to prosecute individuals is only used in appropriate cases; on the evidence I have seen during the course of this Inquiry it is a role that it has performed successfully and with obvious care.

¹⁸⁷ Criminal Justice Act 1988 s.32(1)(b)

¹⁸⁸ R v Barker [2010] EWCA Crim 4

¹⁸⁹ [REDACTED]

“

Victim/Survivor Voice

"I can't sleep at night because it's on my mind. When I eat I feel like I'm just going to throw it back up. I thought I was actually going to commit suicide at one point I got that sick of all of the shit, I felt like I couldn't do it anymore.

1 [REDACTED] pg 2

He shared me like a slice of cake, and I didn't realise, for that whole time I didn't realise that really I was just a piece of poo off the floor to him and really he only wanted me for one thing and one thing only."¹

”

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Chapter 7: Health Agencies

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7. Health Agencies

Introduction

- 7.1 Organisations responsible for and/or for delivering healthcare have always had a vital role to play in the protection and safeguarding of children. Sexually exploited children may access a broad range of healthcare in different settings.
- 7.2 These organisations and the staff within them therefore play an important role in identifying and preventing child sexual exploitation (“CSE”), and being professionally curious – whether they are A&E professionals, GPs, drug and alcohol services, pharmacists or those involved in mental and sexual health.
- 7.3 By virtue of section 11 of the Children Act 2004 (“2004 Act”), it is a statutory responsibility of all NHS bodies to make arrangements to safeguard and promote the welfare of children. Under section 10 of the 2004 Act, there is also a responsibility to make arrangements to promote co-operation between NHS bodies and the local authority in order to protect individual children from harm.
- 7.4 Prior to 2004, the obligation was less explicit, but health organisations were still required to cooperate with the local authority, under section 27 of the Children Act 1989, if the local authority requested help in respect of the exercise of any of its functions, to include safeguarding and promoting the welfare of the child.¹
- 7.5 This means that those organisations planning and contracting services (for example Clinical Commissioning Groups (“CCGs”)) do have a legal duty to ensure that their staff, and those in services contracted by the organisation, are competent and trained to be alert to potential indicators of abuse and neglect in children, and that they know how to act on those concerns. To fulfil these responsibilities, it is the duty of healthcare organisations to ensure that all health staff clearly understand their contractual obligations within the employing organisation, have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing.
- 7.6 These duties form an explicit part of NHS employment contracts, with chief executives holding responsibility to have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children within organisations.
- 7.7 It also remains the responsibility of organisations to develop and maintain quality standards and quality assurance, to ensure appropriate systems and processes are in place within the organisation in order to ensure a safeguarding culture is embedded throughout.
- 7.8 NHS bodies are also statutory members of the Local Safeguarding Children’s Boards (“LSCBs”) under section 13 of the 2004 Act, now re-cast as Safeguarding Partnerships.

¹ Section 22(3) Children Act 1989

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Compliance with section 11 obligations to safeguard and promote the welfare of children was, and is, monitored via the relevant safeguarding board/partnership.

- 7.9 The way in which this section 11 obligation has been, and is, met in practice will be different for each component part of the health economy. By way of example:
- 7.9.1 Primary Care Groups ("PCGs"), Primary Care Trusts ("PCTs") and CCGs - in their various forms, these organisations have taken the strategic lead for health service planning and provision, ensuring the provision of appropriate services for children and quality assuring safeguarding through contractual arrangements with all provider organisations. They also provide health service representation on safeguarding issues, such as involvement in the local area child protection committee groups/LSCBs, in its various forms, and coordinating the health component of case reviews.
 - 7.9.2 NHS England – since its inception in 2013, it has been responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children. It is also accountable for the services it directly commissions. NHS England also leads and defines improvement in safeguarding practice and outcomes.
 - 7.9.3 Hospitals and community trusts - Staff in hospitals will come into contact with children in the course of their everyday work and therefore should be trained to be alert to potential indicators of abuse and refer when appropriate, with that training being continually refreshed, with professional leads appointed to provide advice and guidance.
 - 7.9.4 GPs, midwives, nurses, health visitors and school nurses - Community services are likely to have the most contact with children and families and be best placed to identify those in need of support or safeguarding. As with all health service staff, GPs and those working within surgeries should be trained to know how to identify potential indicators of abuse, contact colleagues who are designated safeguarding professionals and refer a child to the local authority and share information. All these staff need appropriate training and regular updates on child protection issues.
 - 7.9.5 Other services and health professionals - A number of other services also have a role to play – mental health services, child and adolescent mental health services ("CAMHS"), ambulance staff, clinical psychologists, sexual health services, pregnancy and advisory service staff, pharmacists, drugs and alcohol services - to name a few. Along with all clinic and reception staff in outpatient departments, these professionals should receive the training and supervision needed to recognise and act on child welfare concerns and to respond to children in need of support or safeguarding.
- 7.10 The communication between health professionals and other organisations that have a statutory responsibility for safeguarding - the local authority and the police, as well as education providers - is also of vital importance. Nearly all failures of child safeguarding involve some element of failures of communication between these partners.

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- 7.11 Therefore, while their role is less central than that of the police in tackling CSE, and of the local authority in the ongoing management of protecting a child from harm, it has been an important part of my Terms of Reference to consider the role that health agencies have played, and continue to play, in responding to CSE in Telford.

Structural Framework of Health Agencies

- 7.12 In examining the role of health agencies, an inevitable part of that has been gaining an understanding of the structural framework under which health services were, and are, delivered and the various changes that have taken place over the relevant period. It is fair to say that the changing landscape of the NHS from 1989 to the present day is a very complex picture, which could be a report in and of itself. Therefore, this Report is not in any way intended to set out a detailed analysis of what is an incredibly complex changing structural framework of the NHS over this period. It is however important to highlight some of the major changes that have happened in order to illustrate how this has affected how health services have been purchased and delivered in Telford.

DATE	DEVELOPMENT
1989	<p>In 1989, in England there were 14 regional health authorities ("RHAs"). These RHAs were responsible for planning local health services. Prior to 1982, at the next tier down there had been 90 area health authorities ("AHAs") whose boundaries were intended to closely align with those of local authorities providing social services, with whom these bodies were expected to liaise. The political intention at the time was to create better coordination between health and local authorities and to unify the delivery of health services, rather than these being delivered by separate hospital boards and local health authorities. Most areas were then further divided into health districts, administered by district management teams. The Health Services Act 1980 however disbanded AHAs, with 192 district health authorities ("DHAs") being established from 1 April 1982, which combined the functions of AHAs and the health districts; this was intended to strengthen management at a local level.</p> <p>A wide-ranging review took place during the 1980s, resulting in the White Paper, <i>Working for Patients in 1988</i>, which proposed major changes to the management of the NHS, creating a split between purchasers (e.g. DHAs) and providers of care (hospitals, ambulance services etc), in order to create a competitive environment and drive service efficiency. This became known as the "commissioning" process. The concept was that providers would have to compete for business, thereby encouraging efficiencies and improving quality of care, and purchasers were to focus on assessing local need and planning of services. Hospitals were also encouraged to apply for self-governing status as NHS trusts, giving them managerial independence from DHAs.</p>
1993	The next major structural change happened in 1993, when RHAs were reduced from 14 to eight.

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1996	RHAs were then abolished in the Health Authorities Act 1995, which came into force on 1 April 1996. This Act also merged DHAs into a single tier of 100 health authorities, which then existed until 2002.
1999	' <i>Working Together to Safeguard Children 1999</i> ' introduced the concept of "designated" and "named professionals", these being individuals with specific roles and responsibilities for safeguarding children within their organisation, including the provision of strategic advice and guidance in relation to safeguarding to organisational boards across the health community.
1999 - 2002	DHAs were then replaced by Strategic Health Authorities ("SHAs") and PCGs, then moving to PCTs over a period of a few years. The primary responsibility for commissioning healthcare transferred to the new local commissioning bodies (PCGs/PCTs) and the role of SHAs was to provide strategic leadership in assessing and addressing community needs and overseeing commissioning activities.
2006	A further reorganisation resulted in the number of SHAs reducing from 28 to ten and the number of PCTs from 303 to 152.
2012	NHS Commissioning Board formed ("NHSCB"), latterly known as NHS England from April 2013. Nationally, NHS England had five regions, of which Midlands and East (where Telford fell) was one. Each region, at this point, was divided into Local Area Teams ("LATs").
2013	<p>There is further significant structural change under the Health and Social Care Act 2012, creating the most wide-ranging reforms of the NHS since it was established. In 2013 this resulted in SHAs and PCTs being abolished. CCGs were established, and were responsible for organising the delivery of local services. Their role is to look at commissioning local services in line with national recommendations and best practice. GPs are both part of the CCG and following NHS reorganisation are monitored by the CCG from 2016. NHS England was established during this major NHS reform, and it holds commissioning responsibility for services that need to be organised nationally and holds the CCGs to account.</p> <p>Health and Wellbeing Boards were also created in each upper-tier local authority, in order to encourage providers of health and social care to work in an integrated manner.</p>
2016	NHS England reorganised the geographical division of England into Sustainability and Transformation Plan areas ("STPs").
2018	It was announced that STP organisations were, in future, to be called Integrated Care Systems ("ICS").

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2019	NHS England and NHS Improvement merged. Regional divisions increased from five to seven regions. Midlands and East Regions became the Midlands Region.
2021	On 1 April 2021, 38 CCGs were merged into nine CCGs; this included NHS Telford & Wrekin CCG merging with NHS Shropshire CCG, creating NHS Shropshire, Telford and Wrekin CCG. The total number of CCGs in England now stands at 106.

7.13 These structural changes have been reflected in Telford & Wrekin, with the diagram overleaf representing the picture in June 2020:

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NHS Commissioning History

This chart shows the history of local NHS clinical commissioning groups and how they have changed over the relevant period.

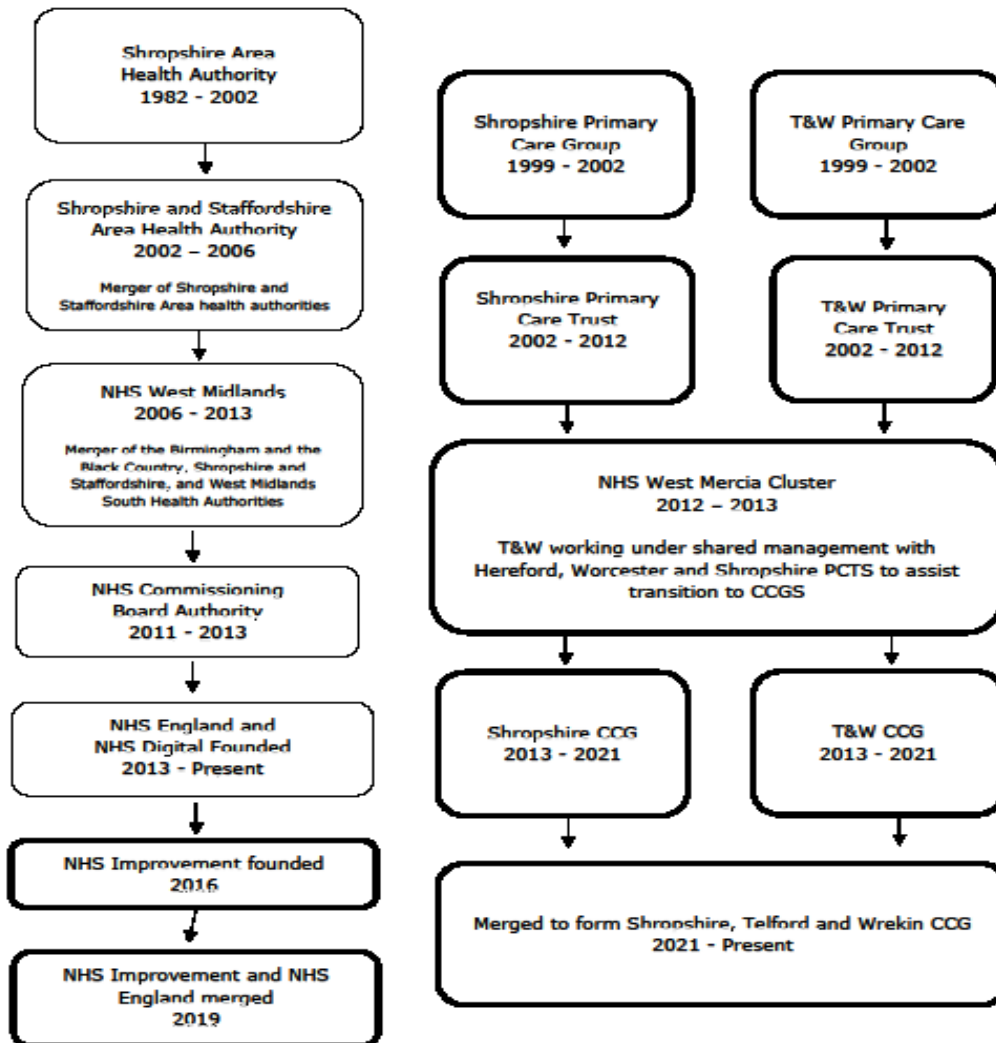


Figure 1²

² As approved by Telford & Wrekin CCG in June 2020

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7.14 As regards an overview of the service provision from NHS local health commissioners and key NHS Providers for the Telford area, below sets out the position in June 2020.

NHS Commissioning Structure

Below is an overview of the service provision from NHS local health commissioners and NHS Providers for the Telford area.

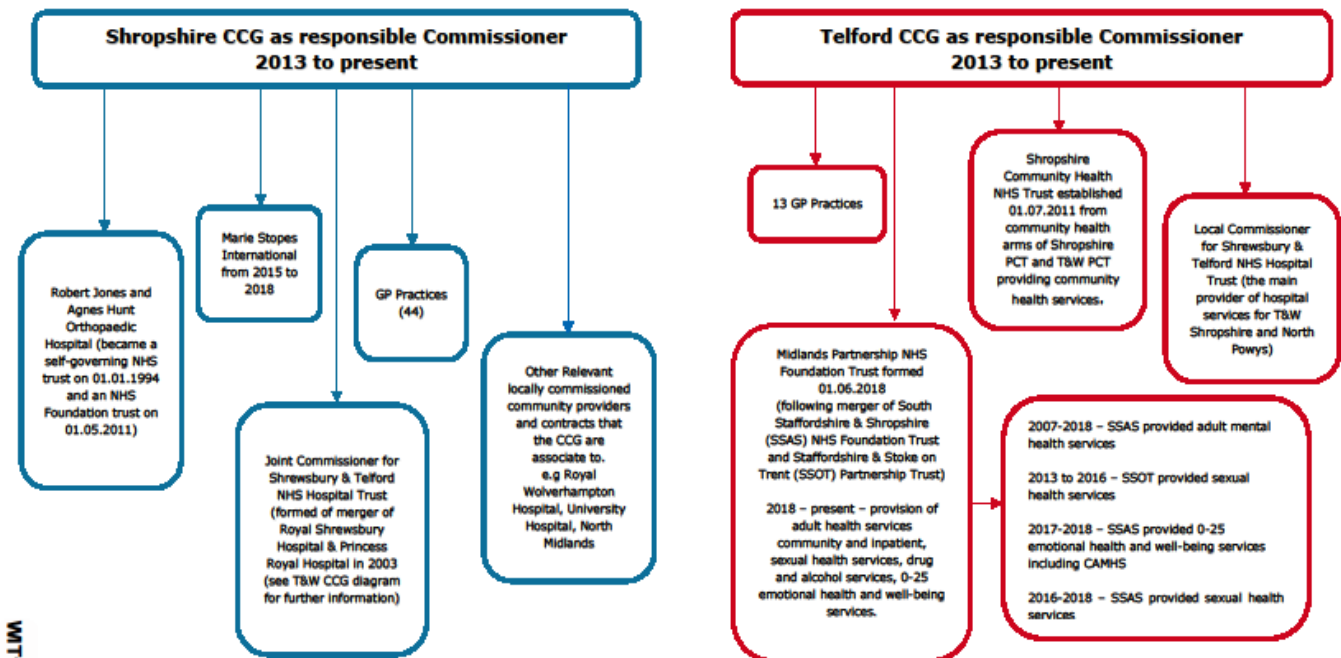


Figure 2³

7.15 It is important to highlight the impact these NHS re-organisations has had on the provision of evidence, both witness and documentary, and therefore the difficulties that has created in examining the operation of health agencies during the earlier period of my Terms of Reference.

7.16 From an early stage of my work, Telford & Wrekin CCG explained to me that the availability of documentation was limited to anything from 1 April 2013 onwards, this being when the CCG became a statutory organisation, and the point at which the PCT re-formed as the CCG. I was told that any records prior to that date will have been held by NHS Telford & Wrekin PCT and on the dissolution of the PCT these will have been transferred to NHS England. I was told that the CCG never had access to the PCT's files that went to NHS

³ As approved by Telford and Wrekin CCG in June 2020, [REDACTED]

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England, as there was never a need. The NHS England Corporate Records Retention Schedule⁴ provides further detail as to how long documents would be retained.

- 7.17 It is also important to stress that the CCG does not hold documents about patients or individual cases; rather the potentially relevant documentation related to safeguarding policies and procedures, minutes of meetings, LSCB material, audits and assurance documentation concerning statutory obligations related to safeguarding, and related material. In general, the document retention schedule referred to above suggests these types of documents would be retained for between six and 20 years, depending on the category of document.
- 7.18 Given the absence of documentation prior to 1 April 2013 available via the CCG, I approached NHS England to assist. They undertook electronic searches for any relevant documents, which included searching current documents, as well as archived documents in long term storage. Documents searched included regional focused work and work undertaken by the local NHS England team, using key words relevant to the Inquiry's Terms of Reference. Together with the search of potential electronic documents, a manual search of archived documents was undertaken; again a list of key words was used to determine which boxes of archived material needed to be retrieved from storage, as well as for searching any documents that were listed as handover documents or organisational transition documents, and anything related to the Telford area and children's safeguarding.
- 7.19 The evidence available for the earlier part of my Terms of Reference was not only limited by documentation, but also the availability of witnesses. The constant re-organisation of the NHS has meant many people that were involved prior to 1 April 2013 are no longer around, and the corporate memory does not exist. I know that this lack of corporate memory due to constant NHS re-organisation is something that other inquiries have suffered.⁵
- 7.20 In relation to NHS providers, for example hospitals and GP practices, without exception all provided documentation to the Inquiry, although some of that disclosure was very delayed, seemingly as a result of the impact of Covid-19, which meant attentions were elsewhere. A handful of the GP practices did however require extensive chasing before any documentation was received.
- 7.21 In relation to the disclosure that was made, I was told that very few providers have electronic records and therefore again there were issues with historical information being provided. The providers themselves have also suffered from re-organisation, for example a number of mergers, and this may also be part of the reason for limited documentation being available. In respect of the relevant hospital trusts, no documents pre-dating 2008 were provided. In respect of GP practices, no documents pre-dating 2014 were provided.
- 7.22 The documentation disclosed by providers tended to be general safeguarding information, including policies and procedures, annual reports, minutes of safeguarding meetings and safeguarding training material; with a limited amount of CSE-specific training material also provided.

⁴ <https://www.england.nhs.uk/publication/corporate-records-retention-disposal-schedule-guidance/>

⁵ For example, Sir Robert Francis QC when he chaired the Mid-Staffordshire NHS Foundation Trust Public Inquiry.

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- 7.23 In terms of patient specific information, providers do not file or record patient details by reference to any abuse or sexual exploitation suffered. I only requested patient-specific information in a small number of cases, for example in relation to the case studies that were adopted, or where a query arose in relation to a particular case. In some cases, records were provided. In others, records were not available. In terms of document retention, I was told that child health records are only retained for 21 years, then it was up to the individual organisation when/whether they were destroyed.
- 7.24 It is my view that the gaps in evidence have not however been due to a reluctance or unwillingness to assist, but rather due to the availability of documentation as a result of the constant re-organisation and the document retention policies in place.
- 7.25 In order to consider the role that health agencies have played, I have set out in the remainder of this chapter a chronological review of the role health agencies have played in responding to CSE and safeguarding children in Telford and key reviews that have taken place during that time. This has been derived from evidence contained in documents disclosed, publicly available reports, evidence from survivors who have experienced health agency response, as well as evidence provided by those who work, or have worked, within the health economy. As will become apparent, the evidence from the earlier period of my Terms of Reference is much more limited; for the reasons explained above, there is far less information available.

1989 to 2000

- 7.26 As set out in other sections of this Report, children have been suffering CSE for a long time; long before professionals became aware of this type of abuse and long before the period that my Terms of Reference cover; sadly it was just not recognised as a form of abuse in the way it is today.
- 7.27 This lack of awareness and understanding is reflected in the evidence that I heard from one former health professional. They explained that although it was recognised that there were very difficult situations occurring for children, there was not a name attached to it, and it was not recognised as a form of abuse; there was no tool or mechanism available for managing when a child presented in this way. The witness found it very difficult to articulate what that meant, but there was a sense that during this earlier period there was "chatter" among children about locations, or generally about what children were doing:
- "I think, there was a sense that something wasn't right but people didn't know how to manage that and how to put their finger on it."*⁶
- 7.28 Notwithstanding the fact that there was no professional awareness, those suffering CSE at the time would still have been displaying concerning signs.
- 7.29 One witness who suffered exploitation in the early part of the 1990s said that she repeatedly visited the same GP practice for the morning after pill. She would however try and see a locum doctor each time to actively ensure that no one became suspicious about the number of times she was taking the morning after pill. No one ever asked any questions about her

⁶ [REDACTED], pg 4

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age or why she needed the morning after pill; the witness said it felt like no one really cared. She was 14 years old.⁷

- 7.30 I have frequently heard evidence from witnesses that, during this earlier period, medical support was sought by under-aged children for abortions and sexually transmitted infections, from GPs and sexual health clinics, and no questions were asked.⁸
- 7.31 As referred to above, in 1999, the '*Working Together to Safeguard Children*' guidance introduced the concept of "designated" and "named professionals", these being individuals with specific roles and responsibilities for safeguarding children within their organisation. Within provider organisations, the health professionals holding these roles would provide advice and expertise for other staff and promote good practice within their organisation. At the commissioner level, these named and designated roles would advise on strategic planning and commissioning, and hold health organisations in their area to account for the quality of the safeguarding services, ensuring that they are meeting their safeguarding responsibilities. They also provided advice for monitoring contracts and commissioned services, as well as providing expert advice.
- 7.32 At the turn of the 21st century, there was therefore this ever-increasing focus on the role that health organisations played in safeguarding and ensuring there were specialists that could advise and provide guidance.

2000 to 2004

- 7.33 It was during these first few years of the 21st century that professionals began to pick up on signs of CSE and began to consider that there could be a wider problem. I have heard that it was around 2000/2001 when these concerns first started to be explored and discussed at the Telford & Wrekin Area Child Protection Committee ("ACPC").⁹ One witness recalls completing a questionnaire for the ACPC about their own experience of CSE as a professional, and a lot of the information was rumours and gossip, but recalls that information was starting to be pooled together.¹⁰
- 7.34 Sadly we know that there was a significant number of children in the grips of CSE at this time:
- 7.34.1 I heard about one individual regularly going to the local sexual health clinic to get the morning after pill; at one stage several times a week; no questions were asked. An account would have to be opened, but this was frequently done in different names. However the same reception and nursing staff were seen on each occasion. No one ever asked any questions or checked to see if they were ok.¹¹ The impression was that the nurses and reception staff knew something was going on, but did not do anything about it.¹²

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- 7.34.2 I have seen evidence that perpetrators would at times drop their victim off at the sexual health clinic.¹³
- 7.34.3 The evidence shows that when one child fell pregnant she went to see her GP for an abortion; she was 15 years old. The GP asked about continuing with the pregnancy, but did not ask about the circumstances of getting pregnant.¹⁴
- 7.34.4 Other evidence also shows one child visiting her GP for the morning after pill at 15 years old, and being asked whether she was "*a lady of the night*". This appears to never have been followed up.¹⁵
- 7.34.5 Another witness however told the Inquiry that when her daughter attended the GPs with injuries that suggested abuse, the doctor was very good at trying to engage with her and understand what was going on.¹⁶
- 7.34.6 There were other occasions when children would lie to sexual health nurses about their circumstances.¹⁷
- 7.35 Following the increased awareness at the ACPC level, in around 2003/2004, I have been told that the one training package for raising awareness of child protection began to be updated to include an element that relates to raising awareness of CSE. The CSE element formed part of a Level 2 course; a Level 1 course was for general awareness and was provided to all staff that came into contact with children; a Level 2 course was more specialised and limited in roll-out.¹⁸
- 7.36 While this was clearly a positive step, I was told that some people were:

*"... very frustrated by the lack of co-ordination and response to what was happening to young people, because it was a bigger issue than that... there was no structures to actually address that..."*¹⁹
- 7.37 At this time, only four hours per week was dedicated to raising awareness about CSE.
- 7.38 Although safeguarding professionals were starting to recognise CSE and understand how it manifested itself in the behaviour of children, with early training beginning, this had not yet developed into any formal pathway, and there was still no widespread awareness amongst health professionals.

2004 to 2008

- 7.39 It was at this time that LSCBs were established, by virtue of the 2004 Act. The legislation placed a duty on all local authorities to establish LSCBs to replace the non-statutory ACPCs, with the transition to LSCBs happening on 1 April 2006. This marked a shift from child

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protection – responding to concerns about children’s welfare once they had been identified at risk of harm – to safeguarding more broadly; with the focus being on prevention, as well as intervention.

- 7.40 I know from LSCB documentation that the PCT (and latterly the CCG) in Telford played an active role in the LSCB, promoting safeguarding at a strategic level. This was recognised by other safeguarding partners:

*"... we had a commitment from Health right from the beginning... Ensuring that the desire for joint working became a reality was, was easier... Right from the beginning with the Children and Young People’s Partnership, to the Children’s Trust, through to the clusters where we had one of the Chief Nursing Officers as heading one of the clusters, we had that commitment from health in its various forms."*²⁰

- 7.41 While that multi-agency engagement was clearly in place at a strategic level, it appears that this was not filtering down to the lower tiers of organisations. I have heard from a number of witnesses that sexual health services in particular were struggling with capacity at this time and there was not this sense of services and agencies working together:

7.41.1 Sexual health clinics often had temporary staff, or bank nurses, so staff would not always see the same children attending. Evidence says that during this period there were no mechanisms in place to log the frequency of visits or the advice/treatment being sought, which would help identify patterns of those attending – *"...it was very disjointed and different services all together."* This meant that children could be accessing sexual services at the various access points (e.g. Risq, Outreach, STI Community, GUM Clinic at Princess Royal), and there was no communication between the different services: this would not have been permitted unless there were safeguarding concerns. I am told those mechanisms do now exist, from around 2015, by way of a sexual health representative attending regular multi-disciplinary meetings with the CATE Team and other agencies;²¹and

7.41.2 The Risq sexual health clinics were always very busy, with over 30 patients coming through a day; it was described as *"overwhelming"*. I was told there was rarely a supervising clinician on site, and decisions were made without proper supervision and guidance. I was also told that only a lead nurse could share information, due to the confidentiality clauses concerning sexual health information.²²

- 7.42 This meant that during this period children were suffering CSE and were regularly accessing sexual health services, which may have been under-staffed, not allowing professionals the time and capacity to address potential areas of concern with individual patients. This was coupled with a limited state of awareness of CSE in the health economy.

²⁰ [REDACTED]
²¹ [REDACTED], pg 18
²² [REDACTED]

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2009 to 2012

- 7.43 The continued lack of awareness of CSE amongst health professionals was acknowledged at this time. Minutes for what is described as a 'CATE Group meeting' on 29 July 2009 record one attendee commenting on *"his frustration at the lack of awareness from health professionals who fail to identify sexual exploitation as an issue."*²³
- 7.44 I have seen evidence from sexual health services which said:
- "... yes, we weren't made aware of CSE as much as we should have been... through training, through communication... there must have been information out there about what was going on in CSE... it was never cascaded down to us... we didn't have the training and the tools to do the job to actually identify."*²⁴
- 7.45 There appeared to be this gap between knowledge at a strategic level, or within a certain group of professionals that were dealing with it on a day to day basis, and a broader knowledge amongst all staff who played a role in safeguarding. The information and knowledge was not being cascading down.
- 7.46 In fact safeguarding training of health professionals was identified as a general issue at this time, particularly for GPs. A review of arrangements in the NHS for safeguarding children undertaken by the Care Quality Commission ("CQC") in 2009 found that on average only 35% of GPs had received appropriate safeguarding children training.²⁵
- 7.47 I have heard that the first CSE specific training one health professional recalls attending was training delivered by Telford & Wrekin Council (the "Council") in 2011.²⁶

2012 to 2015

Transition to CCG

- 7.48 The Health and Social Care Act 2012 set out significant changes for the NHS that were scheduled to come into effect in April 2013. Of local significance was the end of Telford & Wrekin PCT and its replacement by Telford & Wrekin CCG, which took on the responsibility for commissioning most health services for the local population. The responsibility for commissioning some health services were however retained by the newly formed NHS England, notably in-patient (Tier 4) CAMHS provision, Sexual Assault Referral Centres ("SARCs"), and a role in quality oversight of aspects of local health delivery. The legislation also placed new responsibilities on local authorities with the transfer of many public health functions to local government; including school health services (e.g. school nurses), community sexual health services and drug and alcohol treatment services.

²³ [REDACTED]

²⁴ [REDACTED], pg 27

²⁵ https://www.cqc.org.uk/sites/default/files/documents/safeguarding_children_review.pdf

²⁶ [REDACTED]

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- 7.49 While the formal transfer of responsibilities to the new NHS structures took place on 1 April 2013, during 2012/2013 there was a period of transition and shadow working, to plan for and effect a smooth transition.
- 7.50 I have been told that this period of significant re-organisation was recognised as an area of risk in relation to safeguarding children, given the turmoil and the untested nature of the changes that were being introduced. Therefore, a Healthcare Governance Safeguarding Children Committee (“HGSCC”) was established to provide leadership during the NHS structural changes across the health economy. I understand the HGSCC was responsible for providing assurance to the CQC that safeguarding children remained a key agenda item for the local health economy.
- 7.51 The HGSCC was initially set up to bring all NHS trusts across both Shropshire and Telford & Wrekin health economies together formally on a quarterly basis to share safeguarding information, improve safeguarding performance and monitoring of risk within their own organisations.²⁷ Its quarterly performance reporting template mechanism monitored safeguarding activity and arrangements across both health economies. HGSCC then subsequently became a sub group to the LSCB in Telford.
- 7.52 The Designated Nurse and Named Nurses for Safeguarding Children across the health economy were members of the HGSCC. I have seen limited minutes from this group and this is in part due to the issues of document availability due to constant reorganisation of the NHS bodies. I have however been told that the HGSCC was updated in relation to the Operation Chalice investigation and prosecutions.²⁸ The documents I have seen suggest that safeguarding issues were being considered at a high level at this group and they were considering compliance with statutory obligations, as opposed to looking at safeguarding trends in any detail, including CSE.

CQC/Ofsted Inspection 2012

- 7.53 In Summer 2012, Ofsted and the CQC conducted an integrated inspection of safeguarding and Looked After Children’s Services in Telford & Wrekin. The inspection was conducted from 25 June to 6 July 2012, with the report being issued on 10 August 2012.²⁹ The CQC’s role was to assess the contribution of health services to safeguarding and the care of Looked After Children related to the Council.
- 7.54 The conclusions reached during that inspection relevant to health services were as follows:
- 7.54.1 The contribution of health agencies to keeping children safe was considered to be adequate;
 - 7.54.2 Executive leaders and senior managers effectively prioritised and were well engaged with safeguarding activities and the LSCB. There were robust governance and scrutiny arrangements in place for all safeguarding reports, across the health economy;

²⁷ [REDACTED]

²⁸ [REDACTED], pg 12

²⁹ <https://files.api.beta.ofsted.gov.uk/v1/file/50004181>

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- 7.54.3 There had been a dedicated focus on improving GP engagement;
- 7.54.4 There was very good partnership and multi-agency working through the Children Abused Through Exploitation (CATE) project;
- 7.54.5 The quality of supervision was too variable. Midwives access to safeguarding supervision was not yet fully implemented and a lack of capacity within health visiting and community school nursing services was adversely affecting the quality and frequency of safeguarding supervision;
- 7.54.6 Safeguarding training compliance rates were too variable at The Shrewsbury and Telford Hospitals, Princess Royal Hospital site, with 100% staff trained at Level 1, only 47% trained at Level 2 (of which 52% were nurses) but only 18% of medical staff, and 78% at Level 3, although midwife compliance was lower at 68%. There were 89.3% of GPs trained to safeguarding Level 3, sexual exploitation and e-safety. Staff reported a greater awareness of safeguarding, especially emotional neglect and the cultural influences that impact on child health and welfare. However, not all staff were aware of safeguarding escalation policies and challenges remained in relation to some referrals being accepted where physical signs of abuse are lacking;
- 7.54.7 There was good attendance of front line practitioners at child protection meetings and case conferences and/or submission of reports, with the exception of GP attendance which was inadequate. However, staff reported feeling frustrated by the frequent changes to child protection chairs, the lack of consistency with social care representation and the frequent changes in social worker, all of which hinders progress and clarity in planning. Health professionals said that minutes of core group meetings were not frequently circulated, and meetings were cancelled at very short notice, often due to lack of social care staff availability; and
- 7.54.8 There was good representation by health staff at the LSCB and the sub groups.
- 7.55 The findings of this report reflected the general context at the time; that at a strategic level, there was active and positive multi-agency working, but on the ground the experience was not the same.
- 7.56 Other national developments were also happening at this time to increase information sharing between agencies and professionals. In 2013, the health economy in England introduced a Child Protection Information Sharing system, commonly known as 'CP-IS'. The CP-IS project sought to link IT systems used across health and social care and help organisations securely share information about which children are Looked After by the local authority or subject to a child protection plan. The idea was that if a child falls into either of these categories and attends an NHS unscheduled care setting, such as an emergency department or a minor injury unit, the health teams are alerted and have access to the contact details for the social care team. The social care team was also to be automatically notified that the child had attended and both parties could see details of the child's previous 25 visits to unscheduled care settings in England. The objective was that health and social care staff could have a more complete picture of a child's interactions with health and social

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care services to enable them to provide better care and make earlier interventions for children who are considered vulnerable and at risk.

- 7.57 The CP-IS system however took some time to implement and it was a complex undertaking to link the various systems. It was developed nationally in 2013, and was intended to be rolled out in a series of phases, with it being 80% complete by 2018, and I have seen a suggestion in documents that it was intended to be implemented within the Telford & Wrekin health economy in 2015. The project did however experience a series of delays, but I believe has now been implemented cross the Telford health economy.

2013 – CSE Reports

- 7.58 Aligned with this increasing focus on CSE and agency response, on 10 July 2013, the LSCB in Telford held its annual conference which was titled: *'Your Child, My Child, Any Child'*. There were two areas of focus of the conference - CSE and children who are missing. This was perhaps to be expected, following the highly publicised CSE prosecutions in Telford in 2012, as a result of Operation Chalice. The conference brought together 150 delegates representative of a diagonal slice of strategic leaders and operational staff in a forum to consider and review key areas of development in relation to these areas. This would have included strategic leaders in the health agencies.
- 7.59 CSE featured as a topic at the conference despite the fact that during 2013/2014 the LSCB reviewed its key priorities, and decided that two sub groups, CSE and Children Feeling Safe, would be stepped down as it was felt that the work that each group had done since initiation had been embedded in practice.
- 7.60 During the remainder of 2013, there were then a series of reports published relating to CSE and agency response. Some of these were Telford specific and others were national reports; 2013 seems to mark a real shift in terms of the spotlight being on CSE.
- 7.61 On 30 October 2013, the NewStart Networks Report was published.³⁰ This was an LSCB commissioned report, its purpose being to look back on the experiences for all stakeholders of CSE in Telford, focusing on those children known to the CATE Team from December 2008 to March 2013. The report assessed the quality of support offered to the children, families and staff affected by CSE and to determine if the right support was available. This report was undertaken after the Operation Chalice prosecutions as part of a learning exercise.
- 7.62 The report made a number of conclusions that related to health agencies:
- 7.62.1 *"Individual workers from different agencies were identified as most helpful during this time when their child was involved in CSE (Police, CATE, Social Care). No parent identified Health as supportive and one parent identified Health as supportive only when her daughter became pregnant. Agencies as a whole did not feature as helpful, rather an individual worker who was involved and built up a relationship...";³¹*

³⁰ <https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MjA5MDY%3D>

³¹ <https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MjA5MDY%3D>, pgs 18-19

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- 7.62.2 *"No parents identified Health... as agencies that listened";³²*
- 7.62.3 *"There was a consensus that Police, Social Care, Health and Education did not share information appropriately";³³*
- 7.62.4 *"There were examples of good professional support across all agencies but no single agency emerged as consistently supportive of parents. Health and Education services were cited as being the least helpful by the majority of respondents";³⁴ and*
- 7.62.5 *"There was also concern that knowledge, expertise and networks linked with various staff members had, or would be lost through the reorganisation. Risk was highlighted as one organisation that agencies believed is no longer available and not everyone was clear how they now accessed advice regarding sexual health."³⁵*
- 7.63 The conclusions from this report again suggested that while there was an awareness at a strategic level, this was not filtering down the organisations, and those coming into contact with health staff were having poor experiences in respect of CSE support or understanding.
- 7.64 Then in November 2013, the Children's Commissioner published her national report titled *'If only Someone Had Listened'*.³⁶ The report examined CSE in gangs and groups, highlighting the scale of CSE, focusing on what can, and should, be done to protect children from sexual exploitation, how to support those who have been victims/survivors, and how to reduce the prevalence of sexual violence perpetrated by gangs and groups.
- 7.65 The Children's Commissioner was critical of safeguarding agencies in her report. Although her report was not focused on health, she did make the following findings:
- 7.65.1 *"Of health agencies queried, 91% believed that they had come into contact with victims, typically every one to six months. Despite this, only 28% of agencies had processes in place to record and track how many children and young people they had identified as being at risk of CSE. Only 18% could provide actual data for 2012";*
- 7.65.2 *"As the age of a potential victim increases, the likelihood that health services will share information with other safeguarding agencies decreases. Of the agencies responding, 78% said they would share info when approached around a potential victim who was aged 10 to 13, 9% of those said that their decision to share would be different if the individual was aged 13 to 15 years old and 19% said it would be different if they were aged 16 to 18"; and*
- 7.65.3 *"Just over half (53%) of health agencies we contacted told us they had provided staff training on how to identify children and young people at risk of sexual*

³² <https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MjA5MDY%3D>, pg 19

³³ <https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MjA5MDY%3D>, pg 19

³⁴ <https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MjA5MDY%3D>, pg 21

³⁵ <https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MjA5MDY%3D>, pg 33

³⁶ https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/07/If_only_someone_had_listened.pdf

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exploitation... Of the health agencies that we questioned, 90% said that they had measures in place to identify sexually exploited children and young people, although only 25% of these measures were specific to CSE."

- 7.66 This report again highlighted this gap between the awareness at a strategic level, and that on the frontline.
- 7.67 In June 2014, one of NHS England's Regional Safeguarding Leads established an NHS England Child Sexual Exploitation Group, which was a sub group to its National Safeguarding Steering Group. The sub group was designed to provide national leadership, support and advice in CSE and to ensure that NHS England delivers on its responsibilities, including its direct commissioning responsibilities and working closely with the Department of Health to implement policy on CSE through the commissioning system.³⁷ This demonstrated a national focus on CSE across the health service.
- 7.68 At a local level, in 2014, the LSCB conducted a multi-agency case file audit (a "MACFA") on files related to CSE. The LSCB had a statutory function to assess the effectiveness of help being provided by safeguarding agencies to children and families and quality assure practice, and this took the form of these MACFAs, with the audits taking place three times a year, and being based on themes which were national priorities or LSCB priorities.
- 7.69 The second MACFA carried out by the LSCB, in Autumn 2014, was on the theme of CSE, and the CCG, as a safeguarding partner, took part in the MACFA; this was known as 'MACFA 2'. I have seen a copy of MACFA 2, which explains that: *"This specific theme was chosen as it has been a priority area of safeguarding work locally since the Chalice operation and due to the high profile nature of the concerns nationally."*
- 7.70 I understand that four files were reviewed as part of the audit; these files related to *"children where there were concerns about risk of abuse through exploitation (CATE)."*
- 7.71 There were a series of findings made during the MACFA 2, and those related to health were as follows:³⁸
- 7.71.1 *"School Health Nurses (SHN) had no records on child 2A. As it is an active CATE case there should be an active file. Child's issues only known to the SHN who has attended CATE panel, this was not communicated back to the relevant SHN";*
- 7.71.2 *"No note regarding CATE concerns for child 2B on school health nurse (SHN) records";*
- 7.71.3 *"There was nothing in the GP notes to show the GP was aware that child 2A was thought to be at risk of CATE";*
- 7.71.4 *"There is no SCHAT (Shropshire Community Health Trust) safeguarding involvement with Child 2D until her LAC medical, despite serious CATE concerns and her CP plan. This has rightly been graded as inadequate by the auditor";*

³⁷ [REDACTED]

³⁸ [REDACTED]

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- 7.71.5 *"Child 2A's records from the previous authority do not appear to have requested by any agency other than the GP (including school and SHN)";*
- 7.71.6 *"The GP recorded that then 14 year old child 2A was sexually active with a boyfriend but did not record the age of the boyfriend";*
- 7.71.7 *"The GP records for child 2B were good, with it clearly stating she was a child at risk. There was also evidence of liaison between the GP and the social worker involved in January 2013"; and*
- 7.71.8 *"The GP records show they were aware of the CP plan and CSE concerns in relation to child 2C. There was no record of any sexual health advice being given however."*
- 7.72 Good practice was also identified, which included as follows:
- "A good relationship is reported between the CATE workers and sexual health. The sexual health service did not contribute to this MACFA. If the theme is repeated this should be considered. It is also noted that a new contract has been awarded for sexual health, so this may bring risks and will need work to ensure good communications and joint work continues."*
- 7.73 The audit also made a series of recommendations, and again those relevant to health agencies were as follows:³⁹
- 7.73.1 *"That all professionals should be encouraged to record facts rather than using terms such as 'sexualised behaviour' 'sexually inappropriate' and so on. Exact details are required and recording should be explicit";*
- 7.73.2 *"When stating that a child is thought to be involved with an adult, it is good practice to state the age, if known, of the adult";*
- 7.73.3 *"GPs need to be informed of concerns that child might be at risk of CATE. Information should also be sought from them about contact with the child";*
- 7.73.4 *"Recording of CATE concerns in SHN records was particularly poor, and involvement was very limited. With child 2D it was non-existent, which is very poor in such a high risk case. Issues with a lack of school nurse involvement with older children was identified in MACFA 1. There is a plan in place for an improved system in CATE cases however. A specialist SHN will attend the monthly CATE panel and implement a system for consistently updating the child's specific SHN. There is also an expectation that SHNs will engage with the CATE team regarding specific children"; and*

³⁹ [REDACTED]

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7.73.5 *"It is important that all local health professionals are involved in plans for CATE. They are crucial in regards to early identification and in providing services to this vulnerable group."*

7.74 The MACFA 2 also recommended that a further MACFA audit on CSE be conducted within 24 months, and that sexual health services and CAMHS contribute to the audit, as they had not been involved on this occasion.

2015 to 2017

7.75 This further MACFA on CSE, known as MACFA 5, was then conducted in November 2015.⁴⁰ Again four cases were chosen and reviewed. Some of the findings of the audit included concerns that GP records suggested they were not aware of existing CSE concerns as information was not always being shared with GPs or school nurses, and in some of the files there was limited evidence within health records of multi-agency working.

7.76 The audit also looked at the recommendations from MACFA 2, to see what progress had been made. In respect of health, this comparison identified that:

"There remained concerns about information sharing, particularly with GPs. In this MACFA it was noted that there was evidence consent had been given to information sharing with the GP, but it did not happen."

7.77 Following the MACFA 5 audit, I have seen evidence that a series of actions were taken away by the various agencies to address the findings made. In respect of health, this included an action to identify how to ensure GPs were notified when one of their patients was identified as being at risk of CSE. I have been told that this resulted in a process being put in place whereby a letter should be sent to a child's GP where they are identified by the CATE Team as being at risk of CSE; the intention being this would then allow the GP surgery to put a mark on their electronic system to identify this individual as being at risk of CSE.⁴¹ While this will undoubtedly have improved information sharing practices, I am told that a gap still exists, in that if a child moves out of the area, or moves practice, surgeries do not always call up the new surgery to alert them of this, and the information does not always carry over.⁴²

7.78 By 2015, the evidence I have seen does however suggest that there started to be a shift in awareness at all levels of the health economy. For example, minutes from the Safeguarding Children's Committee at The Robert Jones and Agnes Hunt Orthopaedic Hospital in January 2015 notes that *"Concerns regarding Child Sexual Exploitation remain high on the agenda."*⁴³ Evidence from the sexual health service also suggests that by 2015 things had moved on; that there was more training on CSE and other safeguarding topics, with dedicated contacts at the police and a lot more joined up working with other agencies, for example the multi-agency meetings that were then happening monthly. I understand that by this stage the sexual health files were electronic, which meant that flags could be added to a child's notes, for example if they were known to CATE. There were however still

40 [REDACTED]
41 [REDACTED], pg 14, [REDACTED], pg 65
42 [REDACTED], pg 14
43 [REDACTED], pg 4

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limitations, as those records would only contain records from the sexual health service; the system was not integrated with, for example, GP records.⁴⁴

- 7.79 The evidence from this time is also not universally positive; interactions with GPs was still a challenge:

"...as part of the assessment (CATE risk assessment), we'd gone through quite a number of years of writing to GPs as part of the risk panel process. Not always getting a response... In terms of individuals contacting GPs, over the years I've had quite good responses in terms of, accompanying young people and taking them to see their doctor for whatever reason, but in terms of a buy-in to the CATE service, we haven't really had that from GPs, no."⁴⁵

The Council's Scrutiny Review

- 7.80 During 2015 and 2016, the Council conducted a scrutiny review of multi-agency working against CSE in Telford. The review took 18 months and was published in May 2016.⁴⁶ Telford & Wrekin CCG's Accountable Officer, Executive Nurse, Named GP Safeguarding Lead and Designated Professionals for Safeguarding all participated in the review and contributed to the content of the report.

- 7.81 Findings of the report in respect of health agencies included as follows:

7.81.1 *"Victims and survivors were also critical about how easy it can be to obtain emergency contraception or abortion services without appropriate questions being asked. Concern was raised that these services can be obtained from a range of providers (sexual health clinics, GPs and pharmacies) without any questions being raised of familiar faces.";*

7.81.2 *"In order to improve the way agencies work to prevent CSE, victims and survivors feel that more education would enable early identification of potential and actual victims. Victims and survivors feel that organisations and local businesses need targeted training to relate CSE to the work that they do, rather than simply repeating the indicators of abuse which key agencies are looking for.";*

7.81.3 *"The CATE Team told us that good links exist between them and the School Nurse Service, health workers and with CAMHS.";*

7.81.4 *"Although Family Connect told us that GPs make appropriate referrals, the CATE Team told us that obtaining information from GPs can be difficult.";*

⁴⁴

⁴⁵

⁴⁶ ; https://www.telford.gov.uk/downloads/file/4499/final_report_scrutiny_review_of_multi-agency_working_against_cse

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- 7.81.5 *"We understand that the availability of therapeutic support for victims and survivors is not just a local issue.";*
- 7.81.6 *"The Sexual Health Service told us that patient records follow an individual which allows safeguarding concerns flagged in the record to be raised with them when they present at clinic... Additionally, we were reassured that professionals have a lot of tools available to them to overcome issues with people using a false identity and to work with a patient to try to find the truth. Despite this, the most important thing is that the patient walks away having received the service and is not scared off.";*
- 7.81.7 *"The GP representative we spoke to told us that learning from Operation Chalice has resulted in significant improvement in awareness among GPs who are now primed to at least highlight risky behaviour, offer regular contraception and prompt a visit to the sexual health clinic.";*
- 7.81.8 *"Public Health Commissioners told us that extensive training has taken place with pharmacies on emergency contraception and screening/testing, which has included information regarding referral to Family Connect for safeguarding issues. There are also safeguards in place if C-Cards are used too frequently. We were given assurances that local mainstream agencies providing sexual health services (eg Terence Higgins Trust, Community Pharmacies, GPs) are similarly aware of Family Connect and referral mechanisms.";*
- 7.81.9 *"Some gaps in service have been created by the complex new arrangements for the commissioning of sexual health services, which is fragmented between Local Authority, CCG and NHS England responsible components.";* and
- 7.81.10 *"However, victims and survivors of CSE told us that it was difficult for them to access counselling or therapeutic support due to long waiting lists."*
- 7.82 One of the main themes arising from the report was that all agencies, including health agencies, needed to raise professionals' awareness of CSE, the scale of it, and how to play a role in preventing it, and referring appropriately to the Council's Family Connect team and the police.

Further Ofsted and CQC Reviews


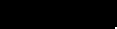
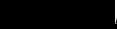
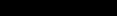
- 7.83 Further reviews followed this, with Ofsted carrying out an inspection of children services and a review of the effectiveness of the LSCB in June to July 2016, reporting in August 2016.⁴⁷ In relation to agency response to CSE, the regulator commented that:
- 7.83.1 *"Work with children and young people at risk of sexual exploitation is good. It is well coordinated with partner agencies and this is improving outcomes for children."⁴⁸; and*

⁴⁷ <https://files.ofsted.gov.uk/v1/file/50004335>

⁴⁸ [REDACTED] pg 9

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- 7.83.2 *"There is a strong commitment from the local authority and its partners to tackle child sexual exploitation... Recently, sexual health services have been recommissioned to support young people to access support. This is a positive improvement that young people are benefiting from."*
- 7.84 The CQC also undertook a review of health services for children Looked After and safeguarding in Telford & Wrekin. The review took place from 26 September 2016 to 30 September 2016, with the review published on 10 January 2017.⁴⁹ The review looked at the effectiveness of health services for Looked After children and the effectiveness of safeguarding arrangements within health for all children.
- 7.85 Key conclusions from the review included:
- 7.85.1 *"Good practice example - The strong sexual health offer from the Telford and Wrekin school nursing service enables effective identification of risks of child sexual exploitation (CSE). All children attending the sexual health drop-in service are routinely screened for risk of CSE using a trust-wide tool. School nurses provide information and receive updates from the safeguarding nurse for all children being discussed at the Children Abused Through Exploitation (CATE) meetings. This helps to guide their practice and monitor risks with young people they see regularly and we saw evidence of this in records we looked at."⁵⁰;*
- 7.85.2 *"In the ED at PRH there are alerts on the electronic patient records system for children subject of a child protection plan, vulnerable children (generally used for CSE), looked-after children and children who are missing from home. Information from alerts is entered by the receptionist onto the paper record referred to as the 'cas-card'. This enables practitioners to be aware of historical or current concerns prior to examination."⁵¹;*
- 7.85.3 *"Risk assessments for CSE in the CAMHS are of a good standard and are detailed. However, in one case we reviewed there was an appreciable delay of about two months between the initial risk being identified and the referral being made to the CATE process. Even though it was clear police and Family Connect were already involved the referral ought to have been made straight away to ensure that those who need to make decisions about risks are fully apprised of all current information."⁵²;*
- 7.85.4 *"In common with the CAMHS and the community child health services, the sexual health service report that they are not routinely informed of the outcomes of referrals they make to children's social care. This is a gap because it means that practitioners are not supported with information that would help them to manage any risks to their clients.";*
- 7.85.5 *"At first contact, sexual health practitioners complete a holistic, child-centred assessment, including a detailed description of the child's presentation and*

⁴⁹  https://www.cqc.org.uk/sites/default/files/20170110_clas-telford-wrekin-final.pdf
⁵⁰  pg 24
⁵¹  , pg 25
⁵²  pg 27

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demeanour and the full name and relationship of the person they attend with. This is good practice as it helps build a clear picture of the child's situation, which supports decision making.”;

- 7.85.6 *“We saw that the sexual health service are generally effective at identifying potential abuse and are timely in their response to concerns.”;*
- 7.85.7 *“There are, however, inconsistencies in practice in identifying specific risks of CSE. In one record we reviewed for another young person aged 14, we noted a number of significant risk areas that had not been explored or identified when she presented for her first consultation. A CSE risk screening tool was not used to assess the risk to the young person and a safeguarding referral was not made, although this has since been rectified. We are aware that the service has recently undertaken some additional training in CSE which was ongoing just prior to and at the time of our visit and this training programme may address these inconsistencies.”;*
- 7.85.8 *“The sexual health services have a positive working relationship with the CATE team. We consistently saw evidence of the CATE team making appointments and attending sexual health services with young people. This is encouraged by the sexual health workers as it aids them in understanding the risks to the young person and supports partnership working. However, although sexual health services are invited to attend the CATE meetings they have, as yet, not had sufficient staff capacity to attend. This is a missed opportunity to add specialist knowledge and insight to the multi-agency processes to protect young people from CSE.”;*
- 7.85.9 *“The sexual health service do not consistently use alerts on young people's records to inform their practice with individual clients. This means practitioners are not immediately alerted to known risks when young people attend for follow-up appointments.”;*
- 7.85.10 *“Child protection practice in GPs is variable in the three different practices we visited.”;*
- 7.85.11 *“The CCG has a highly visible safeguarding presence within the health economy in Telford and Wrekin and the local authority. For example, as we have outlined below in 'Governance', the senior nursing team are actively engaged with the TWSCB and its sub-groups.”;*
- 7.85.12 *“The executive lead nurse for safeguarding in the CCG and the named GP carry out joint annual visits to GPs. This is part of a quality monitoring approach where various attributes of safeguarding performance in practices are measured... Ostensibly, this is a strong arrangement as it enables the CCG to have first-hand knowledge of safeguarding performance within GP practices as opposed to being over reliant on audit reports. It also helps to promote with GPs the availability and accessibility of the CCG for safeguarding advice and guidance. However, the variability in practice we found in the GPs we visited, and which we have reported*

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under 'Child Protection' above, would suggest that this monitoring process is not yet as effective as intended.”;

- 7.85.13 *“Capacity within the school nursing team is also a concern. The band-six nurses are each allocated two secondary schools and six to eight primary schools. Whilst this enables each school to have an identified nurse, the corresponding high number of child protection cases increases risk and limits their capacity to carry out their core functions. This is recognised by SCHT and is currently on the trust risk register. Despite this, school nurses attend all child protection conferences and core groups where there is a defined health need.”; and*
- 7.85.14 *“The design of the risk assessment template in use in the sexual health service does not promote effective questioning of clients to establish risk. For instance, there is confusion about a question that asks clients whether they have had unwanted or unprotected sex and where either the 'Y' and 'N' response is checked without clarifying which question of the two questions it applies to. This is not helpful to establishing risk of exploitation.”⁵³*
- 7.86 The report also acknowledged that school nurses had attended training on a range of topics including neglect, sexual abuse, child on child abuse and CSE, and that sexual health had also received CSE training, although in one example practice had fallen short, and therefore the report concluded that *“the service cannot be assured that the training has had an impact on practice”*.
- 7.87 This increase in training was apparent from other evidence I have seen. For example, I have seen evidence that shows that primary care training figures continued to be increased with the introduction of e-learning resources and further face to face Level 3 safeguarding training sessions to GP medical practices. In 2015/2016 figures were increased to 87% and then 2017/2018 to 91% and reported to the Telford & Wrekin CCG Board. These reviews began to be reflected in activity.
- 7.88 What however appears to have been lacking from the reviews and reports conducted at this time was the voice of those impacted – the victims and survivors. The Council’s scrutiny review did involve some contribution from victims and survivors, but this was very limited – the report suggested one survivor spoke to those conducting the review, and there were 19 other anonymous questionnaires completed, of family members or victims/survivors.
- 7.89 Clearly the multi-agency partners, including health agencies, were alive to the issue of CSE and certainly appeared committed to making improvements. Again, this was not however translating to the services being received by those accessing them:
- 7.89.1 In 2016, following one episode of abuse when she was 13 years old, a child visited a sexual health clinic as she was concerned about pregnancy and sexually transmitted disease. Other than to ask her age, which she was truthful about, staff at the clinic did not ask any other questions.⁵⁴

⁵³ [REDACTED] pg 38
⁵⁴ [REDACTED] pg 3

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- 7.89.2 Other evidence suggests a survivor experienced that their GP did not know anything about CSE and dealt insensitively with issues concerning sexually transmitted diseases.⁵⁵
- 7.89.3 I have seen evidence that shows that at this time professionals were raising concerns about the difficulties vulnerable women were experiencing in accessing sexual health services, with clinics being too busy and some GP surgeries no longer providing contraception in practices.⁵⁶

2018 to Present

- 7.90 In June 2018, LSCBs were abolished by the Children and Social Work Act 2017, which significantly amended the Children Act 2004. The LSCBs were to be replaced with 'local safeguarding partners', which required the three statutory safeguarding partners (local authorities, police and CCGs) to join forces with relevant agencies, as they consider appropriate, to co-ordinate their safeguarding services. This safeguarding partners group was to provide strategic leadership, and implement local and national learning, including from serious safeguarding incidents. The change meant that all three safeguarding partners had equal and joint responsibility for local safeguarding arrangements rather than operating through an independent chair of an LSCB. The transition from LSCBs to safeguarding partners began in June 2018, with arrangements being published in June 2019 and implemented by September 2019.
- 7.91 During this time, I have been told that CSE training for health professionals was continuing, and other positive changes were taking place. For example, I was told that in 2018/2019 a process was developed whereby, if a child became involved with the CATE Team, they would write to the child's GP to make them aware.⁵⁷ This appears to have been as a result of the MACFA 5 audit referred to above.
- 7.92 At an operational level, evidence also suggests that interactions with the sexual health services supporting children had been really positive; with clear lines of communication to set up screenings at clinics and supporting individuals through the process.⁵⁸
- 7.93 Evidence also suggests that the process in place between the CATE Team and seeking sexual health support for children is very streamlined and works well. If a child needs to access sexual health services, the CATE Team are able to book 'SOS' slots, which are safeguarded for the CATE Team. The clinics will also locate a different waiting area if a child is concerned about being recognised. The relationship between sexual health services and CATE was described as being "*really good*".⁵⁹
- 7.94 In 2018, the national CSE group that had been established by NHS England in June 2014, ceased being active, following the departure of the NHS England Regional Safeguarding Lead that had set up the group. I have been told by NHS England that during the ensuing three months there were several messages from cross-governments that child sexual abuse

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and child sexual exploitation were going to merge into a single programme of work across all government departments and so the National Head of Safeguarding agreed a watching brief before recommending the assurance governance structure for NHS England and NHS Improvement. I understand that operationally the focus of government and NHS governance then shifted to Brexit planning and later to COVID emergency planning and so to date, no new or revised group has been convened.⁶⁰

- 7.95 I was told that despite the work of the group ceasing, that child sexual abuse and exploitation is still a critical programme of work for NHS England:

"When Regional Safeguarding Leads raise a specific case of child sexual exploitation, NHS Safeguarding reviews this for regional or national thematic contextual safeguarding. NHS Safeguarding then collaborate with our partners in the justice arenas and peer advocacy services to ascertain how best to support populations from child sexual exploitation in their own services and communities."⁶¹

- 7.96 It is right to note that NHS England has indicated that whilst there has been no formal national CSE Group since 2018, local safeguarding teams within CCGs have continued to monitor cases on an individual basis, but also on a thematic basis for all children within the locality; and that if any of these triggers a serious case review or child safeguarding practice review, these cases would be added by the CCG to the regional/national safeguarding tracker. Further, themes and trends are raised with the National Safeguarding Steering Group which meets on a quarterly basis.⁶²
- 7.97 While CSE is clearly an issue that NHS England is alive to and addresses when cases arise, it is a concern that there is no longer a proactive group monitoring developments of this issue.

Information Sharing

- 7.98 One issue that has consistently come up during my work in respect of health agencies and health professionals has been the sharing of information.
- 7.99 During the period under consideration by this Inquiry, there has always been an understanding that where a child is at risk of significant harm, the overriding consideration is to safeguard the child (introduced under the Children Act 1989), and that may include the sharing of otherwise confidential information, including health information.
- 7.100 Since that point, there has been a range of legislation and accompanying guidance introduced to try and guide professionals about when and how confidential information can be shared. For example, guidance by the Department of Health in 2003 said:

"Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of

⁶⁰ [REDACTED]

⁶¹ [REDACTED], pg 2

⁶² NHS England's response to Maxwellisation.

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*confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service... Each case must be considered on its merits. Decisions will sometimes be finely balanced and staff may find it difficult to make a judgement.*⁶³

- 7.101 The guidance provided to different health professionals can however also differ. Although the Department of Health will provide policies that apply to all health professionals, predicated on law, the guidance on how those policies should be implemented into every day practice are sometimes provided by others, including bodies of royal colleges which represent different health professionals. The royal colleges will take the policy and then create guidance for its members. That guidance may differ between the royal colleges about how a disclosure should be dealt with and what information should be shared, and when.
- 7.102 By way of an example, one witness told me that in the period around 2006-2012, the British Medical Association ("BMA") made it clear to those affiliated to them (for example GPs), that they should be careful about what information is shared in relation to alleged abuse or trauma, as this could implicate somebody else within the family; and some of the BMA's advisory notes explicitly said do not share information unless you are certain.⁶⁴
- 7.103 The journey to understanding clearly how and when information should be shared has therefore not been straightforward. That journey has also been impacted by the introduction of legislation that has sought to protect personal data (the Data Protection Act 1998, and latterly, the General Data Protection Regulation and Data Protection Act 2018), creating an even more complex picture of when information should be protected, and there being serious implications if it is not. The evidence I have heard is that throughout this period there has been an increased level of nervousness and confusion on the part of some health professionals about the sharing of information and when it can be done.
- 7.104 Therefore, there is a complex decision mapping around the sharing of information: the clinician must listen to see whether they can obtain informed consent, judge that response, judge if the individual has the ability to consent (Gillick competency) and then decide with whom it needs to be shared, for example a sexual abuse therapist, a mental health worker, a parent/social worker. The clinician will need to decide who best to share the information with and to decide what level of information to give them so that the information sharing is reasonable and proportionate. I accept that these are difficult decisions for a clinician to be taking, in a context where there is already anxiety around sharing personal data.
- 7.105 There was then a period when a series of death reviews took place in the first decade of the 21st century, including Victoria Climbié, and then in 2010 the investigation into Baby P's death, which highlighted the importance of data sharing, and the tragic consequences that can arise when this does not happen.
- 7.106 This led to updated *Working Together* guidance being introduced from 2013 that said clinicians should believe allegations that are made and should securely share that information – the message was clear that the NHS had to get better at this:

⁶³ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf

⁶⁴ [REDACTED]

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"Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children, which must always be the paramount concern."

- 7.107 In 2018, the revised *Working Together* guidance then brought another level of information sharing expectations again.
- 7.108 The evidence I have heard was that historically, the lack of information being shared was an issue but that it is better now, which mirrors the developing legislative picture and guidance becoming clearer over that period:
- 7.108.1 *"I think back in 2000 there was a fear of the disclosures, so if a child told me something I wouldn't have been able to tell anyone else outside. It's moved on from there now, so it's much better in that, but we do need to make sure that everybody knows."*⁶⁵;
- 7.108.2 Evidence suggests that back in the early 2000s, generally there were concerns about the involvement of GPs and the lack of information being shared, and this being a national challenge at the time: *"...while some GPs were absolutely brilliant and were really involved and engaged, others didn't want anything to do with a child protection team at all."*⁶⁶;
- 7.108.3 *"I mean sharing of information amongst was is [sic] a lot better now as before [2005/2006] you were quite worried about sharing information because of the confidentiality clause and nobody knew really whether they could share it..."*⁶⁷;
- 7.108.4 *"That [There] will always be a small minority or cohort of people who will never ever think of sharing any information because they don't want to get into any further, any aspects of their life, but the majority of them once it's safeguarding and they know it's in the best public interest that they are sharing for the betterment of the child and family. I haven't found that much friction, honestly speaking. So there is no barrier for CSE. If they recognise it as a CSE because as I told you the definition of CSE is not a straight forward thing but if they recognise anything to do with sexual exploitation query they will definitely ask for help..."*⁶⁸;
- 7.108.5 *"It is absolutely true that, that patient confidentiality is always an issue with GPs but... The GPs were very clear about... safeguarding and, and how best to refer, but they also could see the point of services working together. Would I say that every GP was convinced? Probably not, but by and large there was not an issue with GPs."*⁶⁹;

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- 7.108.6 Minutes from an HGSCC meeting on 1 July 2013 also referred to the fact that the CATE Team were receiving very few referrals related to CSE from health organisations;⁷⁰ and
- 7.108.7 One police witness told the Inquiry that the public health bodies worked well with the police and that information was shared appropriately, where necessary, without breaching confidentiality.⁷¹
- 7.109 From the evidence I have seen and heard I do not believe that there existed a culture where health professionals, particularly GPs, did not believe what they were being told by children, or did not care, and therefore deliberately did not share information; rather there appears to have been a concern and confusion about what they were legally permitted to do.
- 7.110 The other challenge that was highlighted to me was one of terminology. I was told that the professional safeguarding language of a GP or nurse, for example, does not accord with that of social services; there is no universal definition of a child who is 'vulnerable'.⁷² This can mean that cases and data sharing across organisations is not always considered in the same way and thresholds may be different/not so easily interpreted. I am aware that NHS England has sought for the Government to develop a legal, mandated, statutory definition of 'vulnerable' and this proposal is one I would endorse.
- 7.111 I understand that the adoption across the NHS of the '*Making Every Contact Count*' initiative in the past few years is designed to encourage health professionals to use every contact and day to day interactions with a patient as an opportunity to support them in making positive changes in their physical and mental health and well-being, and this includes reporting of child sexual abuse and exploitation, and considering this at every contact.⁷³

Training of Health Professionals

- 7.112 Health commissioners have a legal duty under section 11 of the Children Act 2004 to ensure that their staff and those in services contracted by the organisation are trained and competent to be alert to potential indicators of abuse and neglect in children, and know how to act on those concerns in line with the relevant procedures.
- 7.113 Different staff groups require different levels of competence depending on their role and degree of contact with children and families, the nature of their work, and their level of responsibility. All staff working in a health care setting must however know what to do if there is a child protection concern involving a child or family, and know the referral procedure, which includes knowing whom to contact within their organisation to communicate their concerns.

⁷⁰ [REDACTED], pg 2-3

⁷¹ [REDACTED]

⁷² Although not all victims of CSE are considered vulnerable, a high proportion are, and therefore how 'vulnerable' is defined can be very important in this context.

⁷³ [REDACTED]

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- 7.114 In order to understand what constitutes a child protection concern, health professionals also require regular and updated training on the types of child protection issues and indicators displayed by those suffering.
- 7.115 In response to the Laming Report in 2003, and other evidence arising out of serious case reviews at this time, there became a recognition of the importance of the level of competence of some practitioner groups, for example GPs and paediatricians. Recommendation 34 of the Laming Report contained specific actions to ensure all GP providers comply with child protection legislation and to ensure all individual GPs have the necessary skills and training.
- 7.116 This prompted a drive to ensure that GP training and competencies were complete. The revised *Working Together to Safeguard Children 2010* was also updated to clarify that:
- "All GPs have a duty to maintain their skills in the recognition of abuse and neglect, and to be familiar with the procedures to be followed if abuse or neglect is suspected."*
- 7.117 The PCT Designated Nurses were to assist GP practices to access training and improve their existing safeguarding arrangements.
- 7.118 This also led to an intercollegiate document being produced in 2010, which set out the different roles and competences required for healthcare staff.⁷⁴ This framework identifies five levels of competence, gives examples of groups that fall within each of these, and training is then designed depending on each level of competence required. For example:
- 7.118.1 Level 1: All staff including non-clinical managers and staff working in health care settings;
 - 7.118.2 Level 2: Minimum level required for non-clinical and clinical staff who have some degree of contact with children and/or parents/carers;
 - 7.118.3 Level 3: Clinical staff working with children and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns;
 - 7.118.4 Level 4: Named professionals; and
 - 7.118.5 Level 5: Designated professionals.
- 7.119 Annual appraisal was also crucial to determine individuals' attainment and maintenance of the required knowledge, skills and competence.
- 7.120 The implementation and updating of safeguarding training is no mean feat. It is a complex exercise to ensure all healthcare staff are trained at the appropriate level according to their role, and that the materials are comprehensive, updated and compliance achieved.

⁷⁴ Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (intercollegiate Document 2010) - https://www.doncasterlmc.co.uk/wp-content/uploads/2020/07/Safeguarding_Children_and_Young_people_2010.pdf

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- 7.121 In relation to how this translated to the local health economy in Telford, I have seen a variety of material pertaining to safeguarding training. This has shown as follows:
- 7.121.1 A review of arrangements in the NHS for safeguarding children undertaken by the CQC in 2009 found that on average only 35% of GP's had received appropriate safeguarding children training;⁷⁵
- 7.121.2 A CCG safeguarding children annual report from 2013/2014 confirmed that:⁷⁶
- 7.121.2.1 *"There are 79% of GPs and 82% of Practice Nurses now trained in Telford and Wrekin. The National requirement currently stands at 80%. The figures do not include any e-learning undertaken by practice staff and these figures would be difficult to collate."; and*
- 7.121.2.2 *"The figures... does not include basic awareness (level 1), which is distributed in the form of a written update from the Designated Team on an annual basis and access via e learning. Level one compliance is therefore 100%."*
- 7.121.3 A CCG training plan for 2014 to 2019 recorded the current training levels, which included as follows:⁷⁷
- 7.121.3.1 Level 1 basic awareness – GPs – 100%;
- 7.121.3.2 Level 2 – GPs – 77%; Admin staff – 58%; health visitors – 80%; CCG Boards received training; and
- 7.121.3.3 Others trained, including pharmacists, dental staff, optometrists, but percentage figures were not recorded.
- 7.122 I am aware that CSE awareness training was being delivered at quite an early stage, during the first decade of the 21st century, to smaller groups of professionals; but as mentioned above this appears to have been somewhat ad hoc and was not compulsory.
- 7.123 In terms of mandatory CSE specific training forming part of safeguarding training, I have again seen a variety of materials that were delivered as part of training for healthcare staff. This includes CSE materials included in training delivered from 2014 onwards. In particular, I have seen an example of level 3 safeguarding training that was delivered in 2017, which included an update on the CSE pathway. I have also seen a 'One Minute Brief' on CSE that was inserted into GP conference packs in 2016.⁷⁸ One witness told me that GPs started receiving CSE awareness training in approximately 2009/2010.⁷⁹
- 7.124 I have been told that despite the disruption caused by organisational changes in the NHS, the transition from PCT to CCG in 2012/2013 did not negatively affect the PCT's/CCG's

⁷⁵ https://www.cqc.org.uk/sites/default/files/documents/safeguarding_children_review.pdf

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statutory obligations concerning safeguarding and the delivery of safeguarding training continued in the same way.⁸⁰

- 7.125 I have also been told that every NHS trust in Telford & Wrekin now has a CSE champion.⁸¹
- 7.126 I have heard that GPs across the county were able to access level 3 safeguarding training via virtual means during Autumn 2021 and a session dedicated to exploitation was amongst those delivered. A recording of each of the sessions was also provided to each GP whether they were in attendance or not.⁸² I have however also been told by a professional about recent concerns as to the extent and quality of the training since the Covid-19 pandemic and that professionals are less engaged than was previously the case.⁸³ Given that children are likely to be even more vulnerable to CSE at this time, this needs careful attention.
- 7.127 I have also been told that nationally there has also been work done around increasing professional curiosity too when it comes to CSE. With CSE, a child does not explicitly say that they are being exploited, but their reaction to questions asked of them can be an indicator, particularly if those responses are strange. This requires clinicians to be coached into not only recognising these signs and indicators, but how this could be displayed in responding to questions, and developing techniques for eliciting further information and asking carefully phrased questions. I am told that can be very difficult to get to grips with, and I believe would require careful training.⁸⁴
- 7.128 Other evidence also highlighted the fact that a GP's caseload may mean that the number of potential CSE cases that they come across are very low; which would be different from a professional working within sexual health services. For example, a GP may only have five cases of under 15 years old, and therefore their eyes and ears may not be as tuned into the relevant issues and indicators. This means it is even more important that they are trained on devising trigger questions to ask children, using the right language for the right ages of the child, to build in a check and challenge to ensure children's safety.
- 7.129 In addition to coordinating the safeguarding training, the CCG was also responsible for ensuring that it was completed and providing assurance that the statutory obligations of health providers were being adhered to. I have heard that this consisted of regular audits of GP practices and NHS care providers, examining their training records and also asking questions. I have been told this would include asking questions about CSE awareness to ensure understanding. I was told the assurance about whether CSE training was embedded within practice was gained from examining "*patterns of engagement*" with professionals and whether or not relevant issues were being discussed and understood, for example whether issues were being discussed at GP forums.⁸⁵
- 7.130 I have also been told that Practice Managers in GP surgeries monitor to ensure that all their staff are up to date with their safeguarding training and know how to refer to Safeguarding.⁸⁶ The GP practices from whom I requested disclosure did not however

⁸⁰ [REDACTED]

⁸¹ [REDACTED], pg 9

⁸² Telford & Wrekin CCG's response to Maxwellisation.

⁸³ [REDACTED], pg 23

⁸⁴ [REDACTED]

⁸⁵ [REDACTED]
⁸⁶ Telford & Wrekin CCG's response to Maxwellisation.

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provide any documents of this nature, despite requests for any documents related to CSE training, and therefore I have not seen evidence of this monitoring activity.

- 7.131 My attention has also been drawn to the latest CQC reports for the four providers within Telford & Wrekin CCG's boundaries (Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust, Midlands Partnership NHS Foundation Trust and The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust) and the assurances provided within those reports around training.⁸⁷ These reports suggest that "most staff" receive safeguarding training appropriate to their role on how to recognise and report abuse, and most training targets for safeguarding children had been met.

Conclusions

- 7.132 One witness put succinctly the concerns that I had when reviewing the health-related evidence:

"So at one point I think Health, we were, I would have expected more from Health [referrals] to be coming through, sexual health in particular... I think the difficulty I would say with Health is it's massive. It's even worse than the Police in terms of size and organisation and departments. So at one time it was the PCT, now you've got the CCG and then you've got acute and then you've got, you know, there's the health visitors, the school nurses, so sometimes, I think, it's hard to know, to have everybody who you need to be able to address things with."⁸⁸

- 7.133 I do recognise that the constant re-organisation of the NHS by successive governments has been a real challenge. This was accepted by a number of witnesses.⁸⁹

- 7.134 The fragmentation of sexual health services is also a real concern. For example:

7.134.1 Local authorities are responsible for commissioning the majority of sexual health services, including sexually transmitted infection testing and treatment, long acting contraception and outreach and prevention work;

7.134.2 CCGs are responsible for commissioning GPs for general medical services e.g. contraception and also termination of pregnancy and sterilisation services;

7.134.3 NHS England is responsible for commissioning HIV treatment and care, Sexual Assault Referral Centres and cervical screening; and

7.134.4 There is formal system-wide governance and oversight in place to assure the local quality of sexual health services through the Director of Public Health Protection, Quality Assurance Group for Shropshire, Telford & Wrekin.

- 7.135 It is not just the constant re-organisation and fragmentation of services that is a concern; the structural complexity of the NHS means that there are numerous organisations all with

⁸⁷ Telford & Wrekin CCG's response to Maxwellisation.

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⁸⁹ [REDACTED] pg 10

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safeguarding obligations, and holding them to account becomes a challenge. This was something recognised by Alexis Jay in her report on CSE in Rotherham:⁹⁰

"A number of those interviewed, including health professionals, commented on the complexity of the current health structure and its implications for accountability. There are several 'health organisations' within the NHS, who are represented at the Safeguarding Board and in other multi agency forums. These included Clinical Commissioning Groups, NHS (England), the Rotherham Hospital Trust, the RDASH Mental Health Trust, as well as the Director of Public Health located within the Council, and Public Health (England). This made it difficult to establish a single point of contact or a single representative, who could report back and consult with other parts of the service. Similarly, commissioning new services was complicated by the fragmentation of the various health bodies." I found the same problems in Telford.

- 7.136 The structural complexities and re-organisations during this period has however been a symptom of decisions taken by successive governments, and those at a local level would have played the cards they were dealt.
- 7.137 In fact, what I have seen from the health service at a commissioning level is that there was real commitment and passion to meet their safeguarding obligations. The health service has been well represented at meetings of the multi-agency safeguarding boards, in its various forms. The commissioning organisation, and lead and named safeguarding professionals have been active and engaged partners, and clearly motivated to address CSE in Telford. At a strategic level this has been really positive.
- 7.138 That engagement however has not been reflected at a delivery level within provider organisations. That is not due to unwillingness, but because the providers were not engaged quickly enough, and consistently enough. This has then resulted in poor experiences by victims and survivors who have felt that health professionals did not help recognise when they were suffering. At a strategic level, awareness of CSE began as early as 2000/2001; it took many years for this to be translated into a consistent awareness at a delivery level; possibly as long as 15 years. I consider this to be an unnecessarily long time.
- 7.139 I have heard that some health professionals were extremely supportive to victims and survivors, and can see much work has been done to build the relationship and communication between the Council's CATE Team and sexual health services. Witness evidence has made clear that individual professionals feel a weight of responsibility now, and historically, and in some cases it has been hard for them to re-live these experiences. The response of providers to instances of CSE has however not been consistent. It should not be "pot luck" as to whether these children are responded to appropriately.
- 7.140 Training alone is not enough; it needs to be more than a tick box exercise. Simply because CSE training is included on an e-learning course, or a page is included in a handout, this should not be considered 100% compliance. While audits are conducted to check the attendance at training, the real test should be not whether the training has been undertaken, but rather ensuring it has been implemented into practice. For example, the

⁹⁰ Independent Inquiry Into Child Sexual Exploitation In Rotherham (1997 - 2013)

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CQC review in 2016 recognised that even though training had been undertaken by sexual health staff, a gap in practice was still identified.

- 7.141 I address these issues in the Recommendations section that appears at the beginning of this Report.

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Victim/Survivor Voice

"When you are a victim it can take a very long time to actually realise that you were a victim in the first place. For me a large part of the abuse was mental abuse,

manipulating the way I thought, the beliefs I had, it felt as though I had been sort of brainwashed to believe what was happening was not wrong."¹

1 [REDACTED] pg 4

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Chapter 8: Case Studies

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8. Case Studies

Introduction

- 8.1 During the course of my work, I have carefully considered every incident of CSE that has been revealed by the Inquiry's investigation. There are a great many such cases and each is unique. I have given anxious thought to how best to present findings and conclusions in a way that does justice to the victims and survivors of CSE in Telford. I concluded that it is not possible – or proper, not least for reasons of privacy - for this Report to set out the facts of every individual case. As a result, I decided that the most appropriate way to proceed was to select a number of case studies.
- 8.2 Those cases that I have not selected to be case studies have nevertheless been taken into consideration and have helped shape and influence the conclusions found more broadly in this Report.
- 8.3 In this chapter, I consider six specific cases. This is not to suggest that these cases are in any way more significant or important than any other. Nor does it mean that other cases were not considered; what it does mean is that these cases were examined in greater detail, with key documents and evidence relating to these case studies being collated and reviewed to build a chronology and detailed understanding of what happened in each case. In terms of the selection criteria, the case studies were selected due to the distinct involvement of relevant organisations over a broad period of time, spanning different police operations and local authority processes; the selection of case studies was also based on what evidence was available, to enable me to make clear, evidence-based findings.
- 8.4 The case studies have been based on witness and documentary evidence provided to the Inquiry. While I have tried to select case studies that span the timeframe of the Terms of Reference, this has not been possible for the earlier period, due to the lack of availability of historical documentation for all aspects of a case, and the consequent inability to build up a clear picture in order to reach reliable findings.
- 8.5 In four of the case studies, the identity of the children involved has been protected by removing their names and any facts or details, including their ethnicity, that could lead to their identification. Information has also been changed or removed in order to protect police intelligence, to ensure there is no prejudice caused to ongoing police investigations, or to surveillance or other intelligence tactics used by the police. I am also obliged to protect the identities of alleged perpetrators, save where they have been convicted of the crimes of which they were accused.
- 8.6 In some cases this also means that details and facts have been deliberately changed, so as to avoid identification, or I have described the evidence in bland, or non-specific terms. In this, my most important objective has been to protect the identity of the victims and survivors involved. While this does mean that in some cases particular detail is missing and some evidence has been restructured, I consider that what remains is a useful analysis of how key agencies involved in each case responded.

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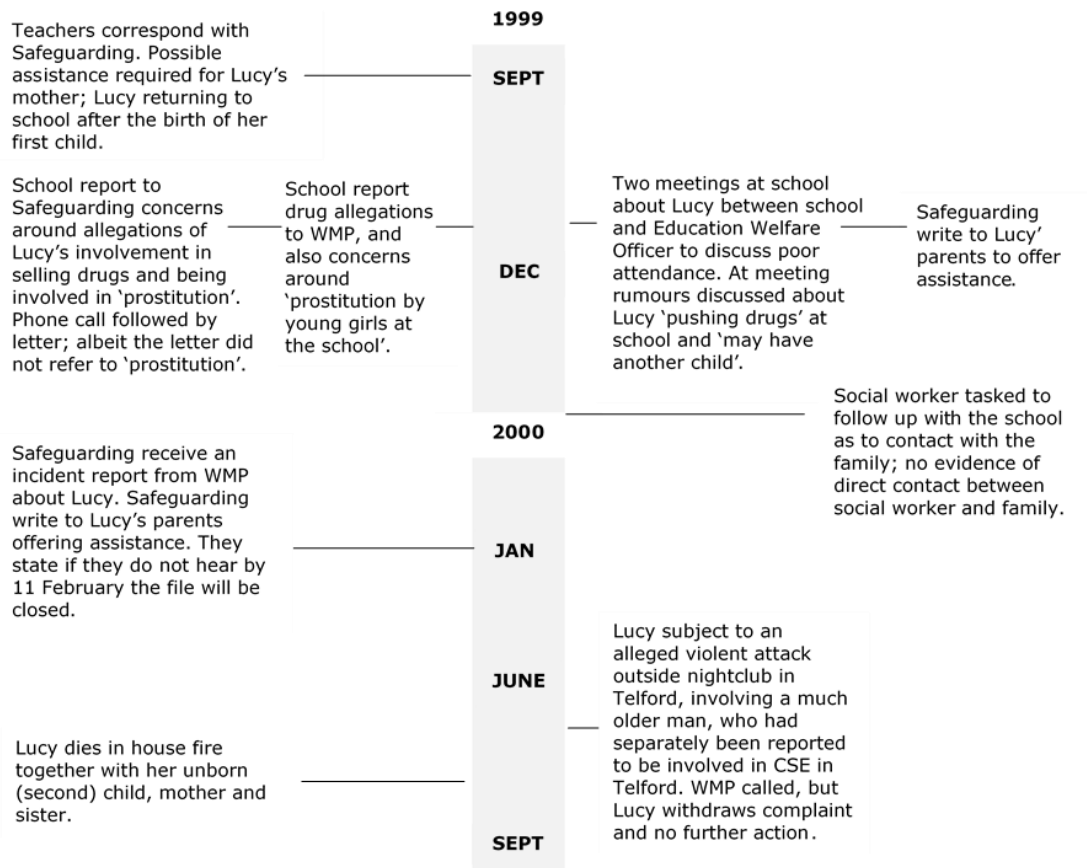
- 8.7 In two of the case studies, the identities of the children have been revealed. This is because both of these individuals are deceased. Each of their cases is well known in the media, both local and national press, and information concerning their cases is in the public domain. It would have been impossible to describe their cases without revealing their identities. Having said that, although those individuals are tragically no longer alive, their family members are, and I have kept that in mind throughout. Therefore, in such cases, I have withheld information which I have regarded as particularly sensitive or distressing, and only included that which I believe helps illustrate the circumstances of these cases and which allows me to draw the conclusions that I need to, in order to do right by those individuals themselves within my Terms of Reference.
- 8.8 It is also of note that terminology used to describe Telford & Wrekin Council's ("the Council's") Children's Services provision has changed over the period under review; for example it is described, almost interchangeably, as 'social services', 'Children & Family Services', 'Children's Services'. For the purposes of this chapter, and indeed elsewhere in this Report, I have however sought to use a consistent term for ease of understanding, and the Council's social work child protection response will be described as 'Safeguarding'.
- 8.9 What follows is a section on each case study; a description of the facts of each case, and a recount of the response from organisations. The case studies selected aim to demonstrate the response of organisations to CSE, or suspected CSE, including the nature, adequacy and timeliness of any response, and any missed opportunities. In the analysis of these cases, I have been ably assisted by the Inquiry's social work expert, Jane Wiffin, and the police expert, Andre Baker.
- 8.10 The cases have been described in chronological order.

Case Study – Lucy Lowe (1999 to 2000)

- 8.11 The case of Lucy Lowe has received significant media attention in the past. Lucy was murdered in a house fire in Telford in August 2000, together with her mother, sister and unborn child. She was 16 years of age at the time of her death. Lucy also had a young child at the time she died. The father of the child - Lucy's 'boyfriend' - was convicted of three counts of murder and sentenced to life imprisonment in 2001.
- 8.12 Following Lucy's death, the Council's Safeguarding team carried out an internal review to understand the Council's previous interaction with Lucy and to consider any lessons learned. The findings of this review are discussed below.
- 8.13 There has also since been a review of the police investigation into Lucy's death; again this identified failures. As a result of these failings, I consider that Lucy's case is a critical one to be considered by this Inquiry as a case study.

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Timeline



Overview

- 8.14 I have not seen any records which indicate that Lucy was on the radar of the Council's Safeguarding team or West Mercia Police ("WMP") when she was pregnant, at the age of 14, nor when she had given birth. Given Lucy's age, as a minimum, I would have expected there to have been a referral to Safeguarding, either from Lucy's school or from the antenatal/maternity unit where she received care and gave birth, and a pre-birth assessment process carried out; although I have been told that pre-birth assessments were not considered normal practice in 1999.¹ There is no evidence to suggest that there was any referral to WMP regarding underage sexual activity despite Lucy's 'boyfriend' being in his mid-20s.
- 8.15 Lucy appears to have first come to the attention of agencies in late 1999 following an exchange of correspondence between teachers at her school and Safeguarding in September 1999, requesting assistance for Lucy's mother who was reported to have been

¹ [REDACTED]

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struggling with Lucy's 'behaviour'. At this point, Lucy was in the process of returning to school after having had her baby. At this time, the school wrote to the Behaviour Support Team at the Council requesting advice and assistance with the *"reintegration of teenaged mothers into mainstream education"*, citing a lack of contact or support from the Council in this regard.² The correspondence that followed showed that several requests were made by the school to the Council in an attempt to assist with reintegrating Lucy back into education and to obtain help for the Lowe family.

- 8.16 Lucy did return to school, and a couple of months after her return, two meetings were held with Lucy's teachers and an Education Welfare Officer ("EWO") from the Council over the course of a month. It does not appear that WMP was present or invited to these meetings.³ The purpose of the meetings was to discuss Lucy's *"poor record of attendance before the pregnancy"* and over *"several years"*.⁴ Evidence suggests that further concerns were raised about her mother's ability to cope with Lucy.
- 8.17 During the meetings, strategies to engage Lucy in education were discussed, but the documents reveal a reluctance on the part of school staff for Lucy to return to school and there was no discussion about support for Lucy to reintegrate into school life; Lucy was not attending school regularly, and the documents suggest that the school staff did not think that the school was a suitable environment for Lucy and believed that Lucy should instead be home schooled. The minutes from the meetings also note *"rumours"* that Lucy *"might have another child"* and refer to allegations that Lucy had been *"pushing drugs in school the previous day"*.⁵ Again, concerns seem to be confined to Lucy not attending school, rather than questioning the reasons for her non-attendance over such a prolonged period, or the fact that she was 15 years of age and pregnant with her second child.
- 8.18 On the same day as the second of these meetings, the school also made a report to WMP notifying them of the allegation that Lucy was *"attempting to sell drugs to pupils"*.⁶ In the same report, further information and wider concerns were shared with WMP about drugs and *"prostitution by young girls from the school"*.⁷ The WMP records note an action to contact the Pupil Referral Unit ("PRU") and the Child Protection Unit ("CPU") to share this information.⁸ Documents also show that WMP considered whether there were any other reports of Lucy being involved with selling drugs, and none were found. They also interviewed school staff, who could not provide evidence of Lucy selling drugs, other than the reports from another pupil.⁹ It is not clear whether there was any consideration by CPU or others in relation to the 'child prostitution' claims, or that Lucy may be linked to these reports from the school.
- 8.19 The day following the second meeting, the school made a referral to the Council's Safeguarding team in relation to Lucy via a telephone call, in which it is recorded that the

2 [REDACTED] pg 1
3 [REDACTED] pg 5
4 [REDACTED] pg 2
5 [REDACTED]
6 [REDACTED] pg 1
7 [REDACTED] pg 1
8 [REDACTED] pg 1
9 [REDACTED] pgs 2-3

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school said "*Lucy – believed to be selling drugs (was selling in school) and involved in prostitution,*" and seeking support for Lucy's family.¹⁰ The school then confirmed the referral in writing a few days later, although the letter did not refer to Lucy being "*involved in prostitution*".¹¹

- 8.20 The Council responded to the referral by writing to Lucy's family to offer assistance.¹² The evidence shows that Safeguarding took a non-interventionist role, and waited for the family to request help or actively seek intervention, rather than proactively exploring the reasons why Lucy was finding it difficult to attend school, allegedly involved in selling drugs, and possibly involved in the rumours of being subjected to 'child prostitution', given she was pregnant for a second time at the age of 15.
- 8.21 Almost a month passed before another social worker was tasked with following up with the school to enquire as to the engagement between the school and the family, suggesting that Safeguarding had not themselves had direct engagement with Lucy (or with her family).¹³
- 8.22 In January 2000, Safeguarding received a copy of a WMP report concerning an incident unrelated to CSE.¹⁴ By way of follow up, Safeguarding wrote to Lucy's parents, inviting them to contact them in relation to any "*concerns or difficulties*" they were experiencing with Lucy. The letter indicated that Safeguarding would assume that if they did not hear back by 11 February 2000, then the file would be closed.¹⁵ It does not appear there was any further follow up or plan to continue to engage with the family; no attempt was made to visit the family home. It is also of note that none of the contact from Safeguarding refers to the welfare of Lucy's child, or the welfare of Lucy, who was also a child, or seeks to engage with Lucy herself. This ran contrary to existing national and local safeguarding procedures.
- 8.23 It is also notable that in all correspondence, the requests for support appear to be focused on supporting Lucy's wider family, rather than Lucy herself or her child; professionals were sympathetic to Lucy's parents, but do not appear to be concerned for, or supportive of, Lucy. They appear to have forgotten that she was a child. I have not seen any reference within the evidence which notes professionals raising questions about how a girl of Lucy's age was pregnant twice; I have not seen any evidence that there were discussions, or referrals or enquiries with sexual health/GP/maternity services, nor any follow up with those agencies.
- 8.24 Despite the referral from the school and police involvement, at this stage no formal assessment had been conducted on Lucy or her child by the Council's Safeguarding team.
- 8.25 Approximately six months later Lucy came to the attention of WMP again; on this occasion she was the victim of an alleged violent attack outside a nightclub in Telford, involving a much older man who had separately been reported to WMP as allegedly involved in 'child

¹⁰ [REDACTED] pgs 19-21
¹¹ [REDACTED] pg 31
¹² [REDACTED] pg 33
¹³ [REDACTED] pg 35
¹⁴ [REDACTED] pg 37
¹⁵ [REDACTED] pg 43

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prostitution' and offences associated with CSE in Telford.¹⁶ Lucy withdrew her complaint later the same morning¹⁷ and no further action appears to have been taken, despite corroborative evidence from another witness of there having been an incident between Lucy and this man.¹⁸ This was a clear opportunity for WMP to investigate the link between Lucy and her potential exposure to CSE. WMP should also have alerted the Council's Safeguarding team to the incident. The failure to share information between agencies was a missed opportunity to identify patterns which may have helped to detect and prevent the exploitation of Lucy and to identify a child who appeared to be being significantly harmed.

- 8.26 Shortly after this incident, Lucy was murdered in a house fire in August 2000, aged 16, along with two other family members and her unborn child. Lucy's father and her child survived the fire.
- 8.27 The police investigation following Lucy's death focused solely on the house fire; it failed to consider the evidence that suggested CSE and possible rape allegations. The fact that Lucy had become pregnant at 14 years of age by a much older man was also not considered to be a red flag from a safeguarding perspective and appears to have been ignored by those investigating Lucy's murder. This is discussed in more detail below.
- 8.28 In November 2000, three social workers, two officers from WMP and a teacher from Lucy's school attended a multi-agency strategy meeting, at which the issue of CSE involving other girls at Lucy's school was discussed.¹⁹ While this meeting did not relate to Lucy herself, she was mentioned and it is clear that at this time the Council did possess knowledge about potential CSE and children being at risk, including current and former pupils at the school.
- 8.29 In 2001, the Council commenced an internal review into Lucy's case to identify *"if there is anything ... that gives rise for concern in relation to the departments handling of the case"*.²⁰
- 8.30 Following Lucy's death, the Council should have referred her circumstances to the local Area Child Protection Committee ("ACPC") to decide whether a 'Part 8 Review' should be commissioned, which was a multi-agency review conducted to help understand all agencies' involvement with a case and to consider any lessons learned. The Part 8 Review should have been completed in accordance with the 1999 iteration of *Working Together to Safeguard Children* ("Working Together").²¹ The criteria for commissioning a Part 8 Review was:

¹⁶ [REDACTED] pg 8
¹⁷ [REDACTED] pg 9
¹⁸ [REDACTED] pg 2
¹⁹ [REDACTED] pgs 60-63
²⁰ [REDACTED] pg 17

²¹ The purpose of a Part 8 review was to establish whether there were lessons to be learned about the way in which local professionals and agencies worked together to safeguard children; to identify clearly what those lessons were, how they would be acted upon and what was expected to change as a result; and to improve inter-agency working and better safeguard children. Part 8 reviews were required to be considered following the death of a child where abuse or neglect were known or suspected to be a factor in the death. They are now known as Serious Case Reviews.

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- 8.30.1 when a child dies and abuse or neglect are known or suspected to be a factor in the death, local agencies should consider immediately whether there are other children at risk of harm who need safeguarding; and
- 8.30.2 whether there are any lessons to be learned from the circumstances about the ways in which local professionals and agencies worked together to safeguard children.
- 8.31 Lucy's circumstances clearly met the criteria for a Part 8 Review. Instead, the Council carried out a single agency review to learn lessons, which they described in the paperwork as a 'Management Review'; this consisted of a review of the records by a manager within Safeguarding; no staff were interviewed and there was no multi-agency engagement.
- 8.32 I was told that the decision to conduct a review outside of the Part 8 process was due to the serious concerns held at the time about Safeguarding and the fragility of services, impacted in part by a number of other outstanding Part 8 reviews which had been left incomplete by the previous managers. I am told that a view was taken that conducting another formal review some time after the relevant incidents and well beyond the conclusion of the criminal case would have provided limited additional outcomes and placed undue additional pressure upon staff who were struggling. I was told that the decision to conduct the review in this way would have been taken with the knowledge of the ACPC, and is also likely to have been discussed with the Social Services Inspectorate, which was working closely with the service at that time;²² although I have not seen any documents confirming this.
- 8.33 The Management Review conducted by the Council resulted in a number of findings, including the following:
- 8.33.1 Council staff relied on letter contact with Lucy's family inappropriately when concerns were raised;
- 8.33.2 There were inconsistencies in information received from the school which were not followed up;
- 8.33.3 There is no evidence that the relevant Council staff considered the needs of Lucy's baby despite the fact that issues had been raised about Lucy. An appraisal of the child's needs should have been undertaken. This includes checks with other agencies;
- 8.33.4 There is no evidence that even fundamental child protection procedures were followed; and
- 8.33.5 There is no entry from a manager, so it is unclear whether or not anyone in management was consulted on, or agreed with, the proposed action taken.²³

²² [REDACTED]
²³ [REDACTED], pg 5

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- 8.34 The findings of the Management Review focused on the staff involved and concluded they did not follow the child protection procedures; the plan was to address this with the relevant staff directly and ensure the appropriate teams were made aware of the procedures; there was no reflection on why this gap existed, as would be expected from such a review. The review and minimal plan of action were endorsed by a senior manager.²⁴
- 8.35 The review noted that child 'prostitution' was "*not specifically mentioned in the CP [child protection] procedures in force at the time*" when Safeguarding were involved with the family.²⁵ 'Child Prostitution' was however introduced into the procedures in April 2000 – which was before Lucy's death, although after the Safeguarding team had ceased its involvement with the family. The review also says that "*no specific procedure was in place about Child Exploitation*"; this suggests that there was an understanding that there were possible unanswered questions regarding Lucy and exploitation, yet the review does not address these. Nevertheless, if there are concerns about a child suffering harm, the fact that the specific 'type' of harm suffered, in this case 'child prostitution', is not laid down in child protection procedures should not prevent or influence whether or not action is taken. If there is evidence of significant harm there were clear criteria in place to take action and in this case there were significant concerns.
- 8.36 There was agreement to take the outcome of this review to the ACPC. However, I have not seen evidence that this happened, or that the concerns were discussed with the CSE subgroup at the time.

Summary

The Council

- 8.37 There is limited evidence of the Council having been involved in Lucy's case, despite a referral having been made and concerns raised by her school in two letters and one telephone call. It is also evident that the Council was made aware of Lucy having given birth at such a young age and that she was pregnant for a second time and still under 16 years of age. However, none of these reports demonstrate concern for Lucy's own welfare or that of her child; instead they all appear to centre around the family's ability to cope with Lucy and the baby. There appears to have been a lack of professional curiosity as to the welfare of either child.
- 8.38 The Council simply wrote (twice) to the family offering assistance. There was no investigation, no visits and no further follow up. No formal assessments (Child in Need/Child at Risk) were ever made by the Council in respect of Lucy or her child, and it appears there was no involvement with her in the months leading up to her death. One witness said that, reflecting back, they cannot understand why it was not referred immediately when there was reference to 'prostitution'.²⁶
- 8.39 The management review that was conducted in relation to the actions of the Council was damning in its conclusion that there was "*no evidence that even fundamental Child*

²⁴

²⁵ [REDACTED] pg 13

²⁶

[REDACTED] pg 111

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Protection procedures were followed". While the review recommended that the case needed to be followed up with the professionals concerned, it is not clear from the evidence disclosed (including the witness statements taken from the individuals concerned) whether or not any such performance reviews or retraining of these staff members took place.

- 8.40 The review undertaken was also a single agency review and was not conducted as a Part 8 Review, in accordance with Working Together 1999. This was an incident where a child and an unborn child lost their lives and were known to services; the review undertaken was superficial in approach and outcome. A Part 8 Review would have been an opportunity to consider the case from a multi-agency perspective and would have been led by someone outside the line management of those making decisions. The review mentions "*child exploitation*" but does not explore this further. Information from the multi-agency network, including the school, could have led to wider strategy meetings, such as the November 2000 meeting at Lucy's school, being incorporated into the review leading to an understanding that other children were at risk of harm. The concerns about CSE that were being discussed at this time make it clear that others were indeed at risk.

West Mercia Police

- 8.41 It appears that WMP had little knowledge of the Lowe family or the fact that Lucy had become pregnant at age 14 and was therefore a possible victim of unlawful sexual intercourse, or even rape. As mentioned previously, neither the school, health services nor the Council appear to have informed WMP of any concerns relating to Lucy until later in 1999. I would have expected that a pregnancy at such a young age, with a much older male, would have prompted at least one of the agencies to conduct some form of follow up, including holding a multi-agency meeting to discuss the risk to Lucy, particularly given the ongoing concerns raised by the school at that time.
- 8.42 In November 1999, the school did provide a report to WMP which suggested that Lucy was "*at the school... attempting to sell drugs to pupils*", and other concerns about drugs and 'prostitution' involving children from the school were also shared. WMP also had direct engagement with Lucy prior to her death in relation to both the incident unrelated to CSE, and the alleged assault by an older male outside the nightclub shortly before her death.
- 8.43 The failure to identify patterns and tie together intelligence reports relating to Lucy, including the drugs and 'prostitution' at the school and the report of violence against Lucy by an older male suspected to be involved with CSE, which were all known prior to Lucy's death, is also concerning – particularly in light of the fact that WMP had been aware of ongoing concerns regarding child 'prostitution' in Telford at least 18 months prior to Lucy's death. Had the links been identified, a further investigation, or at the very least a meeting to discuss concerns, should have been arranged; unfortunately this came too late, only taking place in the November following Lucy's death. Had such a meeting taken place earlier, I believe that WMP would have been forced into asking questions about how Lucy became pregnant at such a tender age; and it is difficult to see how this would not have then led them to investigate further and protect Lucy in the meantime.
- 8.44 It is possible that, from the one report received, WMP may not have considered that there were any overt indicators at that stage that Lucy may have been at risk; however, the incident that took place in July 2000, involving the attack against Lucy by the older male

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outside a nightclub, does in my view signify a point at which a link could, and should, have been made by WMP. Only two days later, a subsequent intelligence report connected individuals involved with Lucy during the July attack to concerns about 'prostitution'; even in the absence of any clear disclosures being made, this should have raised questions that required further investigation.²⁷

- 8.45 In addition, wider evidence disclosed to the Inquiry from this time period indicates that some steps were being taken by WMP to investigate the child 'prostitution' claims being made by Lucy's school, and that a police constable was tasked with following up these enquiries; however this did not happen until after Lucy's death, when a multi-agency strategy meeting took place in November 2000 and officers visited the school. Crucially, it was acknowledged during that multi-strategy meeting that there were links between Lucy and other children, and that they believed Lucy was also the victim of CSE.²⁸
- 8.46 This begs the question of whether action could or should have been taken more swiftly by WMP and CPU in relation to Lucy herself and whether it might have prevented her death. I have also considered whether the reality of Lucy's exploitation only became truly clear following her death when information was gathered from the various witness statements taken from family, friends and neighbours. This must however be balanced against the clear fact that Lucy had already given birth to one child at a very young age, fathered by an older male, and had become pregnant for a second time while still under the age of 16. I find that there were missed opportunities by WMP in failing to take a holistic view of Lucy's case, and in not considering whether any steps should be taken to investigate CSE prior to Lucy's murder.
- 8.47 I have also looked at whether sexual offences charges should have been brought after Lucy's death. The evidence from the police investigation into Lucy's murder shows that even before charges had been laid, WMP had uncovered more evidence which corroborated the earlier concerns about 'child prostitution.' This included direct disclosures of child sexual offences and rape, made by individuals who were interviewed after Lucy's death, as well as a number of corroborated accounts from Lucy's friends and neighbours indicating that she had been involved in the same circle of Asian men and was being coerced and controlled.²⁹ Crucially, there was also evidence from multiple sources that Lucy had complained publicly (albeit not to WMP) of being raped shortly before her death.³⁰ There was also a plethora of other concerning evidence, including letters that were found, a list written by Lucy, and a copy of Lucy's diary, all of which indicated exploitation and underage sexual activity.
- 8.48 Importantly, evidence was disclosed to the Inquiry which showed that a senior officer involved in the murder investigation had been made aware of, and had himself received or reviewed, some of this material.³¹ Further, direct allegations of Lucy's involvement in CSE were raised in a letter sent to WMP the day after Lucy's death; this letter was also sent to the Council.³² The letter referenced her exploitation, and urged WMP to investigate this

²⁷ [REDACTED] pg 9
²⁸ [REDACTED] pgs 61-62
²⁹ [REDACTED] pg 8, [REDACTED] pgs 4-5, [REDACTED] pg 1
³⁰ [REDACTED] pg 8, [REDACTED] pg 3, [REDACTED] pg 3
³¹ [REDACTED]
³² [REDACTED] pgs 4-5

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aspect of the case. It appears no formal response to this letter was sent, although it was suggested that officers should make contact with the author of the letter directly – but I have not been able to confirm whether or not this ever happened. The WMP investigation papers show that a Detective Inspector did consider the letter, and there is then a manuscript note suggesting no further action be taken in relation to the letter.³³

- 8.49 There is tangential reference within the documents, and from evidence gathered by the Inquiry, that during the investigation there was some consideration given to bringing sexual offence charges. I heard that the various intelligence reports/material were likely to have been considered with the CPS as part of the disclosure process: *"I've got a feeling we talked about that issue about the USI [unlawful sexual intercourse] stuff but the overriding factor was... [the] murder..."*.³⁴
- 8.50 I have however not seen any evidence that formal advice was ever sought by WMP from the CPS on the merits or otherwise of pursuing any such charges. The clear fact is that no charges for sexual offences committed against Lucy were ever brought.
- 8.51 Evidence suggests that the focus on the investigation was entirely on the murder charge, and that the other potential offences against Lucy were, in effect, put to one side: *"murder trump[s] all"* and this was the entire focus.³⁵ I also heard that the investigation was *"blinkered"* and focused solely on the murders; officers were never asked to consider sexual offences.³⁶
- 8.52 I also heard that during the course of the investigation there were *"shocking disclosures"* made about exploitation at local premises, including restaurants, as well as links with local taxi firms and that some *"the girls ... were clearly frightened of continuing to be raped"*.³⁷ This information was put back into the incident room and there was a *"very non-committal"* response about whether further action would be taken.³⁸
- 8.53 Other evidence shows that it was *"self-evident"* that Lucy was a victim of USI³⁹ and WMP could have pursued offences, but they *"just couldn't see the point in doing that"*.⁴⁰
- 8.54 I also heard that there was not an appreciation of this being *"exploitation"* at the time; WMP considered it *"improper"*, but as the children were not making complaints, it was just considered to be *"unwise and inappropriate"* relationships and they were *"disappointed"* with their 'choices'.⁴¹
- 8.55 In fact, a later review of the police investigation in 2018 – 17/18 years after the WMP investigation had concluded - found that there had potentially been sufficient evidence to

³³ [REDACTED] pg 2

³⁴ [REDACTED] pg 51

³⁵ [REDACTED] pg 19

³⁶ [REDACTED] pg 8

³⁷ [REDACTED] pgs 10-11

³⁸ [REDACTED] pg 12

³⁹ Unlawful Sexual Intercourse

⁴⁰ [REDACTED] pg 15

⁴¹ [REDACTED] pgs 19-20

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consider offences under section 6 of the Sexual Offences Act 1956 at the time of the original investigation into Lucy's death.⁴²

- 8.56 Unlike the Council, who undertook a review the year following Lucy's death, WMP does not appear to have carried out any contemporaneous review of its handling of Lucy's case until 2018; presumably because it was considered a successful investigation and prosecution, resulting in a conviction for triple murder, as was confirmed by some witnesses.⁴³
- 8.57 The internal review of the police investigation was carried out by two officers in March 2018, and authored by a Detective Sergeant in April 2018. The impetus for the review appears to have been questions raised by the Lowe family in relation to the case.
- 8.58 The review found as follows:
- 8.58.1 *"... I can find no recorded policy decision, action or report to suggest that wider offences... were considered...."*⁴⁴
- 8.58.2 *"[i]t is speculative as to what may have happened with earlier action... my subjective view is that there was potentially sufficient evidence to prepare a case file for CPS consideration [for child sexual offences]".* The report however highlights that WMP was not informed by other agencies about Lucy's first pregnancy, at the time of or prior to birth.⁴⁵
- 8.59 Despite the 2018 findings, no consideration appears to have been given to whether or not the actions of the officers themselves were in line with procedure, or whether any performance management or retraining should have been considered. It is not clear to me what happened with this 2018 review report, other than to confirm to senior officers the fact of past failings within the force, which were now the subject of media scrutiny.
- 8.60 I heard that Lucy Lowe's murder *"does seem to be an opportunity lost to have got into that child sexual exploitation grooming type of sexual offence"* because the fact of her young age and existing child was always known.⁴⁶

Education and Health Services

- 8.61 As set out above, early concerns were raised by staff at Lucy's school, both in relation to Lucy herself as well as a potentially wider issue of 'prostitution'. Lucy was mentioned as being subjected to such exploitation within the telephone referral from the school to the Council, however the primary focus of the concerns in Lucy's case appeared to be around her reintegration into school as a teenage mother and her difficulties in attending school. As has been seen in relation to Safeguarding, in terms of support, the concerns were focused more on the support required for Lucy's family, rather than for Lucy herself.

⁴² [REDACTED] pg 4
⁴³ [REDACTED] pg 50; [REDACTED] pg 38
⁴⁴ [REDACTED] pg 2
⁴⁵ [REDACTED] pg 4; [REDACTED]
⁴⁶ [REDACTED] pg 27

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- 8.62 Given the wider reports of 'child prostitution' being discussed and raised by the school at the time, it is not clear why these concerns were not being voiced more strongly in relation to Lucy, particularly given her having had a child at such a young age, and being pregnant again. Whether this is because there had been more indicators of CSE with other pupils, or whether this was indicative of the staff's own attitude towards Lucy, is unclear. A child of 14 years old becoming pregnant is clear evidence of underage sexual activity, but this was not recognised for what it was - or if it was, it was not followed up, referred or reported.
- 8.63 I consider that in Lucy's case there were serious concerns which should have been voiced more strongly by the school and pursued more rigorously with other agencies – particularly in the context of what else was known. Ultimately, the wider concerns that the school raised were missed by those involved in Lucy's case, but professional curiosity on all sides would have made links between Lucy and CSE. It is highly regrettable that this did not happen until after Lucy's death – perhaps because the severity of her case served as a wake up call to those agencies.
- 8.64 I have seen little evidence from health agencies in relation to Lucy, but it is clear that, together with the school and the Safeguarding team, Lucy's GP practice was aware of her first pregnancy/birth, as well as her second pregnancy. The medical records confirm her positive pregnancy test, but also record a flippant approach to the fact that Lucy was pregnant again under the age of 16, saying "HCG +ve... [forgot?] *from pill surprise surprise!!*".⁴⁷
- 8.65 There does not appear to be any evidence of a referral being made by the GP, or a midwife, to WMP or Safeguarding in relation to underage sexual offences, so that a full and proper assessment could have been undertaken. This lack of information sharing was a failure.

Conclusions

- 8.66 In this case, there is clear evidence that agencies failed to engage with Lucy during her first pregnancy or after the birth of her child, despite the fact that Lucy was 'in a relationship' with a much older man. The lack of professional curiosity on behalf of the agencies involved meant that Lucy and her family were not appropriately supported during her first pregnancy, nor upon her return to education following an extended absence. Further, when concerns were raised by the school about drugs and 'prostitution', aside from sending two letters to Lucy's family (which went unanswered) there were no further attempts to ensure that the welfare of Lucy and her child were protected. The review completed by the Council following Lucy's death found there was no evidence that even fundamental child protection procedures were followed. A formal assessment of Lucy could have been transformative in this case.
- 8.67 The failure by any agencies to recognise that questions should be asked about a teenager who was pregnant to a much older male is surprising, and is perhaps indicative of the attitudes of the relevant agencies at the time. I also consider that Lucy was failed by the police investigation following her death, which focused solely on achieving a murder conviction and neglected to consider any offences related to CSE, despite a raft of evidence.

⁴⁷ [REDACTED] pg 2

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- 8.68 I have been mindful of the fact that these conclusions have been reached in hindsight; in full knowledge of the facts of what happened and what Lucy was suffering at the time. Some might argue that the picture surrounding Lucy and her circumstances was not clear until after her death, and therefore while more proactive steps could have been taken, the circumstances did not suggest these were strictly necessary. I do not agree with that. It is not that agencies should have known what was going on; plainly the evidence was not there to make such a clear judgment. But there were signs that warranted further follow up to ensure the welfare of Lucy, who was just a child. Proactively protecting children should not be a choice; it is an obligation.

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Case Study – Rebecca (“Becky”) Watson (1999 to 2002)

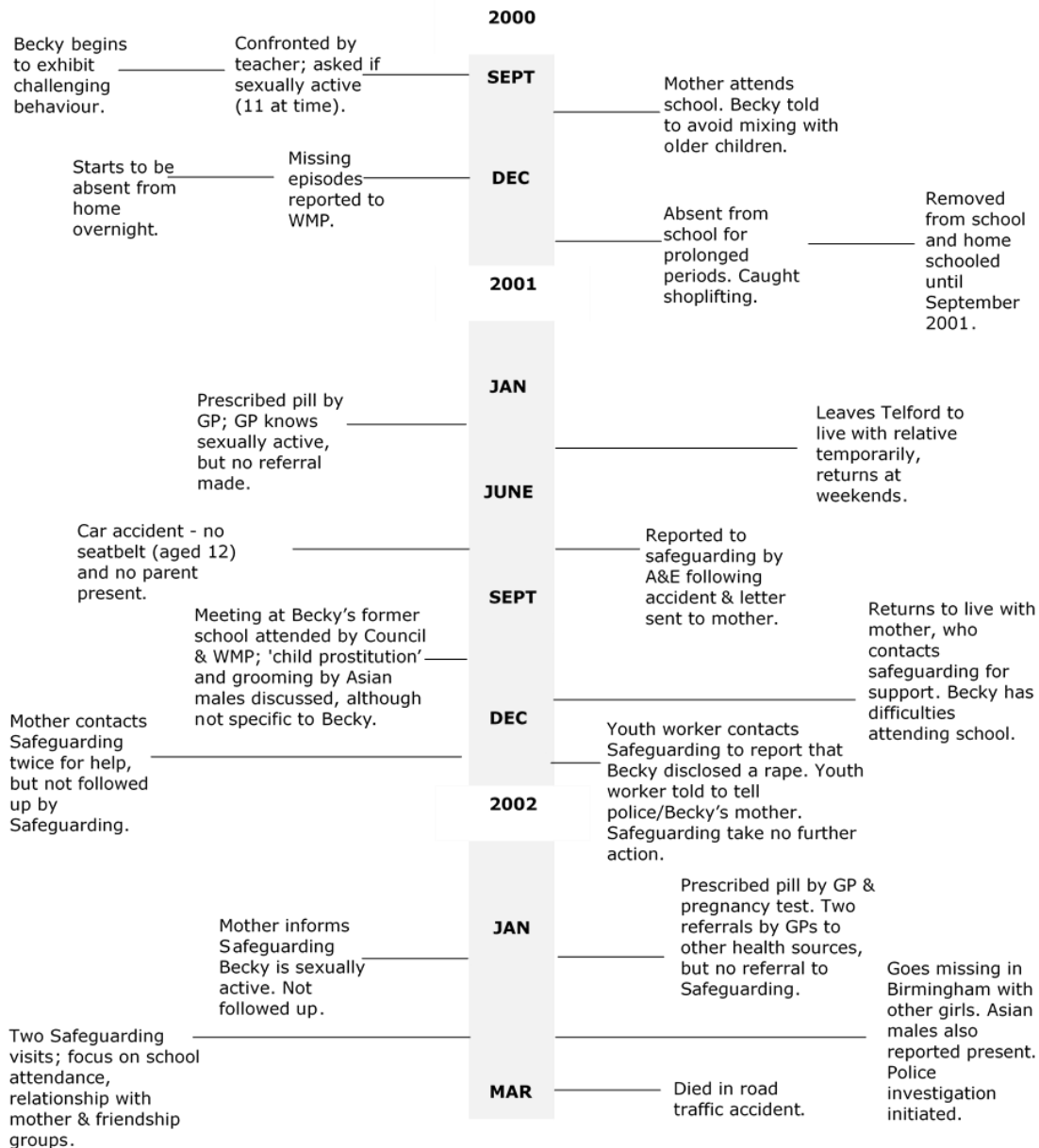
- 8.69 The case of Becky Watson is another that has received media attention in the past, following her death in a road traffic incident in 2002. She was 13 years of age at the time of her death. The driver of the car pleaded guilty to causing her death by dangerous driving and was sentenced to three years’ imprisonment. More than a decade after Becky’s death, and in the wake of disclosures made by other victims in Operation Chalice, WMP carried out a review of Becky’s death, with a view to confirming whether or not there was evidence that Becky had been subjected to CSE during her short life. Those findings are discussed below, and, as a result, I find that Becky’s case is also a crucial one to be considered by this Inquiry as a case study.
- 8.70 The evidence considered in this case includes documents provided by WMP and health services, as well as from witness evidence. The Council was asked for a copy of any case files related to Becky Watson, but none could be located. Given the passage of time, it may be that her file is no longer available, as the Council’s document retention policy requires a file to be retained for ten years, unless it relates to a child protection case, in which case it is 35 years.⁴⁸ Therefore, I have had to rely on copies of Council records that were provided to the Inquiry by WMP.

Timeline

[See over page]

⁴⁸ As can be seen from a review of this case, this did not fall within child protection procedures.

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Overview

8.71 Becky had a stable home environment without any engagement with agencies until she started secondary school in 2000, at which time Becky's mother noticed that she was mixing with an older group of girls and beginning to exhibit challenging behaviours, such as testing boundaries and staying out later than agreed.⁴⁹ At the same time, Becky was confronted by a teacher at school who asked if she was sexually active. Becky was 11 years of age at

⁴⁹ [REDACTED] pg 3

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the time and reported this conversation to her mother, who arranged a meeting with the school to understand the reason for this question. At the meeting, Becky was advised by the teacher to avoid mixing with some of the older girls, but no further explanation was given for this advice. At this meeting it also became apparent that Becky had not been regularly attending school and Becky's mother was unaware of the unauthorised absences.⁵⁰ Becky's mother maintained that Becky was "*too young to be involved in any sexual activity*" and was confused by the suggestion.⁵¹ There are no records of any follow up meetings regarding Becky's unauthorised absences or any referrals to WMP and/or the Council's Safeguarding team regarding the teacher's clear suspicion that Becky was sexually active at such a young age, when legally she could not consent.

- 8.72 In 2001, Becky started to go missing from home overnight, which coincided with her being absent from school for more prolonged periods. Becky would be reported missing to WMP.⁵² In an attempt to address the concerns arising, Becky was removed from school by her mother and was tutored at home until the end of the school year.⁵³
- 8.73 During this period, Becky was prescribed the emergency contraceptive pill. Becky was aged 12.⁵⁴ The evidence demonstrates that the GP knew that she was sexually active but, based on the available evidence, does not appear to have taken any action to raise concerns with Becky's mother, the Council's Safeguarding team and/or WMP, or make a referral, despite the fact that Becky was 12 years old and legally could not consent to any sexual activity.
- 8.74 Over the next few months, Becky started to go missing more frequently and she was reported to have been associating with older girls who "*mixed with Asian men*".⁵⁵ Becky's mother was keen to try to support Becky by removing her from what she perceived to be an older friendship group who were a bad influence, so Becky was temporarily moved out of Telford to live with a relative.⁵⁶ Becky however continued to return to Telford at weekends and to associate with the same group of older girls, and the same patterns continued.
- 8.75 Becky was first referred to the Council's Safeguarding team in August 2001, after attending the A&E department of a local hospital following a car accident, without an adult present. Becky was 12 years of age at the time and the doctor who treated her was concerned that she had seemingly been permitted to travel in a car without a seatbelt, been involved in a road traffic incident and stayed out overnight without her mother being aware.⁵⁷ When the doctor contacted Becky's GP, the GP did not have contact details for her mother.
- 8.76 As a result of the referral from the A&E doctor, a duty social worker from Safeguarding wrote to Becky's mother twice in mid-August 2001 to confirm the need to ensure that Becky was "*receiving appropriate care*".⁵⁸ Becky's mother called the relevant social worker in

50 [REDACTED] pg 11
 51 [REDACTED] pg 12
 52 [REDACTED] pg 6
 53 [REDACTED] pgs 6-7
 54 [REDACTED] pgs 4-6
 55 [REDACTED] pg 8
 56 [REDACTED] pg 8
 57 [REDACTED] pgs 20-23
 58 [REDACTED] pgs 11 and 13

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response to the letter and confirmed that she would ensure that the GP had her emergency contact number and that she would "*ensure [the] supervision and whereabouts*" of Becky.⁵⁹ The doctor who made the referral was informed in writing of this outcome.⁶⁰ There is no evidence of further follow up from the Safeguarding team.

- 8.77 Over the following seven months, Becky was referred to the Council's Safeguarding team a further three times.
- 8.78 It is important to put this case into context of what else was known at the time. The Council and WMP were already aware of a possible local CSE issue, described at the time as 'child prostitution'. In November 2000, officers from WMP had attended meetings at Becky's former school, together with representatives from the Council, where concerns about "*child prostitution*" and suspicions of grooming of female pupils by older Asian males were discussed. Becky was not specifically discussed, but it is clear that at this time there was a growing understanding between professionals that children were potentially at risk.⁶¹
- 8.79 In respect of Becky, after a short spell living with a relative, Becky returned to live with her family in Telford in December 2001, and was enrolled in a new school, but again found it difficult to attend.⁶²
- 8.80 In December 2001, Becky's mother contacted the Safeguarding team to request support. She shared her concerns that Becky (who had recently turned 13) was drinking alcohol, smoking and going missing from home, the latter issue of which had required WMP attendance twice over the previous weekend. Becky's mother advised Safeguarding that Becky had been sexually active since the age of 12 and she was going out without permission.⁶³
- 8.81 In the late evening of the same day, Becky's mother contacted the emergency duty social work team to report that Becky was missing again and that she, as Becky's mother, was desperate. This message was shared with Safeguarding's Referral and Assessment team in the form of a referral and a social worker spoke with Becky's mother the following day, and Becky's mother again asked for help.⁶⁴ The duty team manager agreed an assessment was needed and that Becky and her mother should be visited. A call was made to Becky's mother and a note made on the file that she would "*contact us tomorrow to inform us of movements*". The records of this conversation also suggest that when the social worker explained the "*priority of work*" to Becky's mother, she told the social worker that she was "*close to hitting*" Becky in an attempt to try to escalate the matter and ensure that it was considered a priority. Becky's mother was left to make contact if she agreed that an assessment was necessary. When the team did not hear back after two days, the relevant social worker sent a letter to Becky's mother saying that, as they had not heard any further, they assumed she no longer required assistance. Becky's mother had in fact called and left a message, which she referred to when she next contacted the Council in February 2002.⁶⁵

59 [REDACTED] pg 25
 60 [REDACTED] pg 12
 61 [REDACTED] pgs 60-63
 62 [REDACTED] pg 15
 63 [REDACTED] pgs 26-29
 64 [REDACTED] pgs 8, 9 and 29
 65 [REDACTED] pgs 10, 30 and 31

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During this period, Becky continued to go missing from home and was known to be sexually active. But there was still no formal engagement from Safeguarding; instead Becky's mother was left to attempt to protect her daughter without any support.

- 8.82 The same day that the letter was sent to Becky's mother a youth worker contacted the Council's Safeguarding team to report that Becky, who attended a youth club, was sexually active and had disclosed to her that she had been raped, but had not told anyone else "as *she does not feel she will be believed*". The youth worker was advised by Safeguarding to discuss with Becky "*the need to tell someone Police/mum*".⁶⁶ It does not appear that the Safeguarding team themselves reported this crime to WMP.
- 8.83 Ten days after the report from the youth worker, there is then a record on the file that confirms a team manager at the Council was advised of the rape disclosure, but worryingly the notes state that, as "*mother has not responded to our offer of help*", there was to be "NFA" – no further action.⁶⁷
- 8.84 Records indicate that Becky's mother also informed Safeguarding on two separate occasions, firstly in December 2001 and again in February 2002, that she knew that Becky was sexually active and had been since the age of 12.⁶⁸ There is no evidence that this disclosure to the Safeguarding team was followed up or probed by anyone involved in Becky's case or that the information was passed on to WMP for investigation, bearing in mind Becky's age. It is unclear whether Becky's mother made similar disclosures to the WMP officers who attended the family home to return Becky after she had been missing.
- 8.85 During this period, Becky was also referred for support by two separate doctors, had been prescribed the contraceptive pill and had taken a pregnancy test at her GP surgery. She was 13 years old. I have seen a referral letter from a GP dated February 2002, which describes Becky as: "*... running wild, staying out very late, running away from home, playing truant, in trouble for stealing a mobile phone, she has been on drugs and has been on the contraceptive pill, this was of great concern*". There is no reference to CSE but the GP concludes, "*She is obviously in great danger, and I hope she can be seen urgently*".⁶⁹ It is unclear from records whether the support referrals were being progressed or whether the requirement for this additional support had been shared with Safeguarding. The reason for the second support referral has not been documented so it is not possible to understand whether Becky had made further serious disclosures regarding rape or CSE to the doctors who were treating her. I have however not seen any evidence that her GP referred Becky to the Council's Safeguarding team or WMP, bearing in mind her age, sexual activity and obvious vulnerability. This should have led to a referral.
- 8.86 In February 2002, Becky's mother made another referral to Safeguarding where she reported that Becky was not attending school, was still going missing and that she was sexually active. Evidence shows that Becky's mother was distressed by the situation. She explained that she had responded to the Council's offer of help in December 2001 and had called the social worker at the time. The duty team suggested that a referral be made and

⁶⁶ [REDACTED] pg 30
⁶⁷ [REDACTED] pg 30
⁶⁸ [REDACTED] pgs 29 and 31
⁶⁹ [REDACTED], pgs 6 and 9

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an initial assessment undertaken, and that an EWO would become involved due to Becky's difficulties with attending school. No attempt appears to have been made to investigate the underlying reasons for Becky's inability to attend school or her frequent missing episodes. Becky's mother was however advised that the EWO could help but "*only when child in school*".⁷⁰ There was then a delay of almost two weeks before the EWO engaged with Becky, due to half term and an Ofsted inspection.

- 8.87 As part of the initial assessment, two home visits were carried out in late February 2002 by Safeguarding. These both focused on school attendance, friendship groups and family relationships.⁷¹ The initial assessment concluded that Becky was being influenced by a group of older girls and was refusing to listen to her mother. The assessment confirmed that Becky was "*... not attending school, staying out at night... Mother is unable to cope...*". Becky was said to be refusing to listen to adults telling her what to do. It was felt that as her friends were "*more mature for their years*", Becky was being encouraged to behave this way and was being influenced by an older peer group.⁷² Again, there was no reference to the concerns about sexual activity, nor to the very serious rape disclosure from late 2001; the focus was on Becky's behaviour and not on her welfare and protection. The recommendation was that a support worker from the Council's community support team could offer help with building appropriate friendships, maintaining good behaviour at home and working on improving family relationships.⁷³
- 8.88 On the day that the initial assessment was being completed, the Safeguarding team were alerted by a child protection referral from a school that a significant incident had occurred where Becky was one of a group of girls who had absconded from school and were missing in Birmingham with Asian males; disclosures of CSE had been made in relation to this incident. At the time of the incident, Becky's mother had contacted WMP to inform them that Becky was not in Telford "*and ha[s] no intentions of coming home tonight*".⁷⁴ Becky's mother later reported to WMP that an Asian male had attended the family home late at night and used threatening language when apparently looking for Becky.⁷⁵ Becky was returned home by WMP late that evening. Given the passage of time, documents are not available to confirm the reasons given by Becky to WMP, if any, as to the reasons she was out overnight or why an Asian male had been looking for her during the night and behaving in a threatening manner.
- 8.89 A further home visit with Becky had already been organised by the social worker who had completed the initial assessment to introduce the support worker from the community team. The social worker asked if the child protection referral from the school should be shared with Becky and her mother, as she "*needs to know child at risk*", which indicates there were clearly concerns around Becky's safety.⁷⁶ The home visit took place at the end of February 2002. During the visit Becky denied that she had visited Birmingham with the group of girls, but the social worker's notes of the meeting record that Becky agreed to be

70 [REDACTED] pg 31
 71 [REDACTED] pg 32
 72 [REDACTED] pgs 28-34
 73 [REDACTED] pg 38
 74 [REDACTED] pgs 3-7, pg 38
 75 [REDACTED] pg 15, [REDACTED] pg 14
 76 [REDACTED] pg 33

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interviewed by WMP the following week. It is unclear if Becky's mother was informed of the CSE risk, but the records indicate that she expressed to the social worker that she hoped that the police would prosecute if the allegations were true and that she "*is desperate for this to stop*".⁷⁷ It remains unclear why this child protection referral, which indicated considerable concern, was not actioned with regard to Becky. It should have been.

- 8.90 Four days later, in March 2002, Becky died following a road traffic incident when she fell from the bonnet of a car. The driver was convicted of causing her death by dangerous driving and was sentenced to a three year term of imprisonment.
- 8.91 The day following Becky's death, the youth worker to whom Becky made the disclosure of rape, which was referred on to Safeguarding, was interviewed by WMP. In the youth worker's statement to WMP there was however no record of evidence being taken relating to the fact that Becky was sexually active, any other concerns the youth worker had noticed, or concerns regarding other children who were suspected of being groomed by older Asian males.⁷⁸ There is no evidence that WMP considered widening the investigation to include potential child sexual offences or CSE.
- 8.92 No action was taken by the Council regarding Becky's death - a child being harmed and dying who was known to them. As in the case of Lucy Lowe, a Part 8 Review should have been considered - the Council should have referred this to the local ACPC to make the decision and, if a Part 8 Review had not been commissioned, the Council should have undertaken their own review.
- 8.93 The circumstances surrounding Becky's death was the subject of one review by WMP in 2010 and one further investigation by WMP, which spanned from 2012 to 2015 and produced a number of reports.

2010

- 8.94 The first review was in 2010, when an officer at WMP was tasked with completing a review into Becky's death to identify any possible links to Operation Chalice, which was ongoing at the time. This review concluded that there was a very slim link to Operation Chalice and that an approach to Becky's family was not warranted at that time.⁷⁹

2012 to 2014

- 8.95 There was then a further investigation that commenced in November 2012, when WMP reviewed the circumstances surrounding Becky's death to identify whether she may have been subjected to "*any sexual exploitation*". This was because of disclosures from another victim and the subsequent investigation into those allegations, which had identified possible links to Becky. The initial investigation review was completed in November 2012 (the "November 2012 Review").⁸⁰

77 [REDACTED] pg 34
78 [REDACTED] pgs 39-41
79 [REDACTED] pg 6
80 [REDACTED]

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- 8.96 The November 2012 Review found that obvious lines of enquiry were not followed by those investigating Becky's death, including:
- 8.96.1 A forensic examination of clothes worn by Becky on the night she died;
 - 8.96.2 An examination of Becky's diary, which was handed back to the family; and
 - 8.96.3 An examination of Becky's mobile 'phone.
- 8.97 The November 2012 Review also found inadequacies in the original 2002 investigation concerning the evidence taken from the youth worker to whom Becky had disclosed she had been raped in December 2001.⁸¹ The youth worker's WMP statement failed to include the following:
- 8.97.1 Important disclosures of rape/CSE made by Becky and other children;
 - 8.97.2 The fact that Becky had disclosed to the youth worker that she had three 'boyfriends' that were Asian taxi drivers, one of them being in his 40s;
 - 8.97.3 The youth worker's views on what was happening at the time with Asian males and CSE;
 - 8.97.4 Direct evidence of children being picked up by older Asian men; and
 - 8.97.5 A detailed recollection of what had happened moments prior to the incident which caused Becky's death, including sexualised comments having been made.⁸²
- 8.98 In 2013, as part of the ongoing investigation into the circumstances surrounding Becky's death, the youth worker stated that they tried to provide further evidence concerning potential CSE when the first statement was taken by WMP in 2002, *"but the police taking the statement would whenever I talked about it would say 'can I stop you there can we come back to that' and then would draw me back to the events on the night she died and we never did come back to it"*.⁸³
- 8.99 In their 2013 statement, the youth worker confirmed that they tried to report a rape to WMP in 2010, which had been disclosed by another child who also attended a youth group. The youth worker stated that WMP were reluctant to investigate the matter and indicated they could not *"walk into a mosque and arrest a child [-] can you imagine the consequences on the police"*.⁸⁴ During this investigation in 2013, the youth worker told investigators that it was apparent that white girls aged 13/14 years were being targeted by Asian males for sex; they said that older males (in their 40s) would come in cars, sometimes taxis, and hang around a youth club. The youth worker started carrying out awareness raising initiatives at the youth project because of the concerns. The youth worker also recalls Becky

⁸¹ [REDACTED] pg 26

⁸² [REDACTED]

⁸³ [REDACTED] pg 52

⁸⁴ [REDACTED] pgs 50-51

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disclosing being taken out of the area and having sex with Asian males when she did not want to, and, further, that she had told the Safeguarding team about this.⁸⁵ This is not however recorded on the case records the Inquiry has seen.

8.100 The youth worker confirmed that they believed WMP would come back to them for further information during the 2002 investigation following Becky's death, but that WMP did not in fact do so prior to the suspect being charged.⁸⁶

8.101 The November 2012 Review concluded that:

"Becky was fully immersed in a world of sexual exploitation and it appears possible prostitution/trafficking by Asian males from an early age, as young as 11 years old. She witnessed and was subjected to rapes and other serious sexual offences along with other young females". It was the opinion of the reviewing officer that a further investigation was warranted.⁸⁷

8.102 In a document appended to the November 2012 Review, the reviewer also states:

"Investigating officers faced with the same circumstances now and knowing what we do now know because of the chalice/[name of another CSE operation] and other investigations of its type carried out in the UK, would I am sure have today a different perspective and whole additional set of questions they may wish to explore not only with suspects but also with witnesses.

*The fact is however we would wish it otherwise that the attitude towards community sensibilities in 2002 particular[ly] in respect of racial tensions would have been completely different than today. There is now a shift in perception and attitude in the current climate about these matters which would not [have] been available back in 2002."*⁸⁸

8.103 The findings of the November 2012 Review prompted a review by the Major Crime Review Unit ("MCRU") in December 2012. This was following a request from the Deputy Chief Constable to understand whether any further action was required by WMP as a result of the findings of the initial investigation and the November 2012 Review.

8.104 The MCRU review delved into the matters raised by the November 2012 Review and concluded that the 2002 investigation concentrated solely on the road traffic collision, despite evidence which suggested that *"Rebecca WATSON was clearly involved in sexual activity with older Asian males from the age of 12 years until her death aged 13 years"*; this evidence had not been followed up, logged or investigated and the reason for doing so was not recorded. The MCRU review set out suggested investigative opportunities and recommended that the reported offences of rape and sexual offences involving Becky should be recorded and fully investigated.⁸⁹

⁸⁵ [REDACTED] pgs 48-51
⁸⁶ [REDACTED] pg 30
⁸⁷ [REDACTED] pg 32
⁸⁸ [REDACTED] pg 36
⁸⁹ [REDACTED] pgs 5 and 7

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8.105 Following the MCRU review, WMP's own investigation into this case continued and a report was completed in February 2014 (the "February 2014 Report"), intended to provide an update to the Senior Investigating Officer ("SIO") in relation to the evidence gathered against the suspects and any further lines of enquiry identified. The SIO reviewed the February 2014 Report and added comments which confirmed that there was no tangible evidence to support the cases against any of the suspects identified in the November 2012 Review and the subsequent investigation, and that there was no prospect of any successful prosecutions.⁹⁰ None of the cases were submitted to the CPS.

2015

8.106 In 2015, a closing report was produced by the SIO leading the investigation (the "2015 Closing Report").⁹¹ The 2015 Closing Report summarised and appended the findings of the various reviews completed as part of the investigation. The SIO considered that all lines of enquiry had been exhausted and concluded that there was critical intelligence and/or evidence available in 2002, and within the subsequent Operation Chalice review in 2010, relevant to Becky's case, which was not investigated. This included:⁹²

- 8.106.1 An intelligence report that was created in 2002 during the investigation into Becky's death, which recorded a disclosure about Becky being raped in 2001;
- 8.106.2 An A4 piece of paper found in Becky's bedroom with the word 'rapist' next to a name (known to WMP). Contemporaneous police pocket notebook ("PNB") entries of officers indicated that the A4 piece of paper had been handed back to Becky's family a week later rather than being preserved as evidence;
- 8.106.3 The incident log that was created to record a witness' visit to Wellington Police Station in 2002 regarding reports of a rape in 2001. A PNB entry was recovered from an officer who visited the witness in April 2002 and recorded a disclosure that Becky had been raped;
- 8.106.4 Threats which Becky had reported to a friend, telling the friend that: "*they [the Asian males] are going to kill me*";
- 8.106.5 Written WMP report entries that referred to Becky being associated with a witness who had disclosed her own experience of CSE and suggested that Becky was also "*in trouble with Asians*"; and
- 8.106.6 The investigation briefing notes in 2002 recorded that "*enquiries to be made as to whether any connection between RTC [road traffic collision] and this*". The Council had recorded contact notes and/or referrals that would have assisted investigating officers to identify a link with CSE.⁹³ Additionally, there were notes

⁹⁰ [REDACTED] pgs 84-108

⁹¹ [REDACTED]
⁹² [REDACTED] pgs 37-67

⁹³ [REDACTED] pg 6

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from a second briefing in March 2002, which contained entries regarding Asian males, 'prostitution' and pestering of children.⁹⁴

8.107 It is clear that due to the passage of time important evidence was lost, and the 2015 Closing Report confirms that further evidence recovered during subsequent CSE operations was not sufficient on its own to initiate any retrospective criminal proceedings against any of the individuals identified in the November 2012 Review. The Inquiry's police expert considers that if the information and evidence had not been ignored or had been identified at the earliest opportunity, crimes may well have been prevented, there may well have been fewer CSE victims and Telford and the surrounding areas would have been a safer place. I am inclined to agree with this view.

8.108 The 2015 Closing Report did however acknowledge as follows:

"There are a number of men which feature in this investigation where there is information or intelligence to show that they were involved in Becky's life around the time of her death. The information and some evidence seems to suggest that some, if not all, of these men have, at some point, exploited her[.] Although it is clear that no criminal action can be taken against any of these men [due to lack of evidence to pursue prosecutions now] it is essential that West Mercia police does what it can to ensure that these individuals are highlighted as a potential risk to other young girls and young women in the area."⁹⁵

8.109 In his conclusions in the 2015 Closing Report, the SIO states:

"There is no doubt in my mind that opportunities were missed during the investigation into her death, however, that was some 13 years ago, we, as an organisation, and society in general have all learned a lot over recent times regarding the challenges and extent of Child Sexual Exploitation."⁹⁶

Summary

The Council (Safeguarding)

8.110 In light of the referrals it had received, the adequacy of the Council's safeguarding response was unsatisfactory:

8.110.1 Following the first referral from the A&E department, letters were sent to Becky's mother reminding her to ensure that Becky was receiving the appropriate care; but there is no evidence that visits or calls were made to follow up on the letters or to check on Becky's welfare;

8.110.2 The referral in late 2001 from Becky's mother appears to have been quickly, and incorrectly, dismissed by the Council's Safeguarding team. The fact that Becky's mother did not appear to have followed up with a telephone call to agree to an assessment led to a presumption that she did not require assistance. Council

⁹⁴

⁹⁵ [REDACTED] pg 11
⁹⁶ [REDACTED] pg 22

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records indicate that Becky's mother had however in fact been in contact with the Council on more than one occasion following the initial referral from the A&E doctor and had repeatedly asked for assistance with Becky, disclosing that she was aware that Becky was sexually active on at least two occasions. There is no evidence of anyone in the Safeguarding team following up on these disclosures or considering whether Becky's difficulties at school, distressed behaviour, under age sexual activity and frequent missing episodes could all be linked to wider issues of concern; the underage sexual activity should have been subject to child protection enquiries, given Becky's mother reported this when Becky was 12 years of age and therefore could not legally have given consent to sexual activity. Despite obvious red flags, the possibility that Becky was being sexually exploited does not appear to have been on the radar of the Council's Safeguarding team;

- 8.110.3 Safeguarding was also contacted by a youth worker who disclosed that she believed Becky had been raped and that Becky had made a direct disclosure of such to her. Worryingly, the contact records indicate that the youth worker was told to discuss with Becky the need to inform her mother and the police. There is no record of any proposed action by the Council as a consequence of this disclosure until ten days later, when a manager instructed the social worker to take no further action as Becky's mother had not been in contact. I have serious concerns about the adequacy of this response following such a significant disclosure by the youth worker. The Safeguarding team should have immediately reported the matter to WMP as a crime of rape, as well as following up the information themselves from a safeguarding perspective. Given the seriousness of the allegation, and the other general concerns that existed about Becky, a multi-agency meeting should have been convened to consider the threat, risk and harm to the child concerned. If this had happened in Becky's case, it is highly probable that the crimes being committed against Becky would have come to light and should have been recorded and investigated by the police, and steps taken to protect Becky from further harm. The lack of any multi-agency consideration is difficult to understand in the circumstances;
- 8.110.4 There is no evidence of any further action by the Council until early 2002, when the last referral to Safeguarding was made by Becky's mother. This last referral did result in more assertive action by the Council, as an initial assessment was commenced; an EWO was also allocated and home visits took place. Notwithstanding this, I cannot understand why such action did not take place any sooner. Even when the home visits did take place, there is no note made of any risks posed to Becky from CSE or other child sexual offences, the very serious rape disclosure made in late 2001, or generally concern for her welfare against influences outside the home. There is no evidence of any discussion about the reason for missing episodes or seemingly any efforts to address issues as to why Becky might be at risk. The evidence indicates that home visits were conducted by the Council on four separate occasions as part of the initial assessment process. The conclusion of the initial assessment lacked analysis of Becky's situation, did not mention underage sexual activity, or allegations that she was missing from home overnight. She was a child who had just recently turned 13 years old. Given the previous referrals made and the information

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available to the Council, the lack of focus on the risks posed to Becky and ensuring her welfare is astonishing; the focus was entirely on Becky's behaviour; and

- 8.110.5 The Council's records indicate that the first acknowledgment of Becky being at risk was at the end of February 2002, following her disappearance to Birmingham. The Council was notified due to a child protection referral from the school in February 2002.⁹⁷ This information was received by the Council, and shared with Becky's mother two days later during the last home visit by her social worker. Aside from sharing the information with Becky's mother, this should again have prompted a multi-agency meeting to be called. This should have led to a child protection enquiry. This was another missed opportunity.
- 8.111 This case presents a highly concerning, 'hands-off' approach when it comes to child protection. There was a total absence of child protection procedures being instigated; despite the fact that CSE was not as well understood then as it is today, there were clear indicators that this was a child at risk of significant harm and Working Together 1999 made clear the need for swift action in these situations. At this time the Council was also becoming increasingly aware of children potentially being at risk of exploitation or 'child prostitution' in Telford. Social workers attended a meeting at Becky's school in November 2000, over a year before Becky died, along with WMP officers, to discuss concerns about 'child prostitution' and suspicions of grooming of female pupils by older Asian males.⁹⁸
- 8.112 It might be argued that because there was a parent that was actively engaging and seeking to protect their child that such a 'hands-off' and non-interventionist approach was proportionate. I would however strongly disagree with such an argument. Becky's mother was asking for help to protect her child; the evidence shows that she was desperate. I can understand why a more light touch approach might have been appropriate when concerns first arose, but given the seriousness of the allegations and the ever-increasing concerns just a few months before Becky's death, it is difficult to see how these procedures were not instigated, and with some urgency. I consider this a clear failure by the Council in this case.

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- 8.113 Becky interacted with WMP several times before her death. She became known to them as a result of regular missing episodes. During the course of one weekend, officers twice visited Becky's home, but there is no record of any crimes being reported or any reports by the attending officers in relation to any alleged offences. I understand that normal police procedure would require the officers to ask Becky's mother about any concerns or the facts surrounding the missing incidents, but no such conversation is recorded.
- 8.114 At this time, WMP was also becoming aware of a potentially broader issue with concerns around 'child prostitution'; as mentioned above, they attended the meeting at Becky's school in November 2000, together with the Council, to discuss these concerns. It is unclear

⁹⁷ [REDACTED] pgs 3-7
⁹⁸ [REDACTED] pgs 2-5

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whether, as a result of this meeting, any crime reports were submitted. If the discussions at the meeting did suggest crimes had been committed, these should have been reported.

- 8.115 There is strong evidence to suggest that the criminal investigation into Becky's death conducted in 2002 by WMP was, at best, inadequate. The conclusions reached by the various reviews subsequently undertaken indicate that the investigation was conducted in a vacuum; focused solely on the circumstances of Becky's death, failing to take into account critical evidence regarding other offences that was available to investigating officers at the time.
- 8.116 It appears that the investigation team did not investigate (or report to other forces for others to investigate) the offences of rape, indecent assault or USI, as well as drug offences and crimes of false imprisonment, threats to kill and threats to cause criminal damage.
- 8.117 Due to the fact that the other offences were not recorded or investigated, the reality of Becky's situation was not uncovered and justice was not pursued.
- 8.118 The investigation also failed to look at links between perpetrators known to WMP. Had these links been explored or investigated properly in 2002, there is no doubt that ongoing offending and future offences against other children could have been prevented. At the time of the investigation into Becky's death, there was clear information and opportunities available to allow WMP to identify CSE in the area, raise the concerns and to have prevented further offending against more victims. I understand that it was (and still is) standard practice for investigation teams looking into serious crimes or incidents to have regular briefings. There is evidence that such briefings took place with the team investigating Becky's death. The issues of potential offences of at least rape, indecent assault and USI should have been raised and discussed at these briefings. The lack of any reference to these issues begs the question as to whether the lead officers at the briefings directed that the focus should be on the narrow circumstances surrounding Becky's death and not any wider (but still highly relevant) aspects of sexual offences. Taking such a blinkered approach was a missed opportunity for WMP to address and tackle serious crime in Telford and to prevent future offences.
- 8.119 The reasons for the failure to take action during the investigations in 2002 and 2010 have not been clearly established by any subsequent review or investigation. They do not tell the Inquiry whether failures were a product of incompetence, negligence or a deliberate failure to act. Even in 2002, it is difficult to conceive a criminal investigation into the death of a child in such circumstances, and with such other available evidence, that failed to forensically examine the individual's mobile phone or clothing.
- 8.120 My overwhelming conclusion is that had the available evidence been investigated at the time, the extent of Becky's sexual exploitation would have been revealed. I am of the view that had the full extent of the youth worker's evidence been recorded or probed at the time, the police investigation would have arguably been forced into a different (or separate) direction, including the investigation of CSE.
- 8.121 The evidence also suggests that racial tensions could have played a role in decisions that were taken. For example, as referred to above, the reviewing officer from the November 2012 Review of the police investigation said that: "*The fact is however we would wish it*

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*otherwise that the attitude towards community sensibilities in 2002 particular[ly] in respect of racial tensions would have been completely different than today”.*⁹⁹

8.122 In the November 2012 Review, the reviewing officer does review the ‘Policy Book’ used during the 2002 investigation, and refers to:

8.122.1 A “Decision 20/21” which he records as saying: “Community tension (These speak for themselves and put into context and the possible mindset at the time in respect of investigations involving the Asian community did this have a bearing on the failure to investigate the rape or links to sexual involvement between Asian males and Becky at that time?)”; and

8.122.2 A “Decision 35” which he records as saying: “Further community impact assessment to be undertaken To [sic] gauge the level of feeling amongst the community”.¹⁰⁰

8.123 This comment clearly queries whether race played a role in whether or not actions were taken, but does not conclude whether this was the case. I have not seen any direct evidence that suggests that a directive was given not to act to avoid any racial tension, or anything similar. Clearly community tensions were considered as part of the decision-making process, but it is not possible for me to reach any clear conclusions in this regard.

Education and Health Services

8.124 Fairly shortly after starting secondary school, Becky began to have difficulties attending school. It does not appear that the school communicated with Becky’s mother about this, until a meeting was held to discuss why a teacher had approached Becky asking if she was sexually active; it was at this meeting that Becky’s mother first became aware that Becky had not been regularly attending school. There are no records of any follow up meetings regarding Becky’s unauthorised absences or any referrals to WMP and/or the Council’s Safeguarding team regarding the teacher’s clear suspicion that Becky was sexually active at an age when she could not give legal consent to sexual activity. A child protection referral should have been made. This is sadly another example of a lack of professional curiosity; the focus was on Becky’s behaviour, rather than what was causing it.

8.125 Following this meeting, there appears to have been limited effort by the school to engage with Becky or her family, to encourage her to attend or to understand the reasons for non-attendance; there should have been an early referral to the education welfare service. This is despite the fact that, around this time, there were general concerns being raised by the school to WMP and the Council in relation to ‘child prostitution’ and children being groomed.

8.126 Of course, Becky then left the school; another missed opportunity to safeguard a child that was displaying signs of being at risk. By the stage that an EWO did eventually become involved, Becky had been a pupil at three different secondary schools, including one out of the area, and had been home-tutored for a short period; she was 13 years old at this point

⁹⁹ [REDACTED] pg 36
¹⁰⁰ [REDACTED] pg 25

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- 8.127 Medical records indicate that, during 2001 and 2002 when Becky was aged 12 and 13, there were a series of GP consultations where she was prescribed the emergency contraceptive pill. The GP also made a referral and within the letter of referral, the GP noted about Becky that: *"she is obviously in great danger, and I hope she can be seen urgently"*.¹⁰¹
- 8.128 There is no doubt that the GP was aware that Becky was sexually active, and at an extremely young age; an age when she could not give legal consent to sexual activity. A child protection referral should have been made. Becky's circumstances should also have raised safeguarding concerns in the mind of the GP, and in fact the concerns were documented in the referral letter, the description of which is very worrying. I have however seen no evidence that this clear concern translated into a referral being made, or concerns raised, with either the Council's Safeguarding team or WMP. I consider this to be a failure of the GP's safeguarding obligations.
- 8.129 In contrast, only the A&E doctor who treated Becky in August 2001 made a referral to Safeguarding after Becky attended A&E late at night without an adult present. There was nothing concrete here to suggest crimes had been committed or that Becky was at ongoing risk, but clearly the A&E doctor thought something did not feel right about the situation and so made a referral, and rightly so. If the same approach had been taken by other professionals that had contact with Becky - reporting anything that did not feel quite right - steps could have been taken earlier to protect Becky.

Conclusions

- 8.130 There is evidence that the Council knew of relevant concerns at the school as early as 2000, although these concerns were not directly related to Becky. A strategy meeting was held in November 2000. In this meeting, a teacher raised concerns that had arisen *"2½ years ago"*. At the meeting, the representative from the Council asked WMP about 'prostitution' in the area. The meeting notes show they asked *"if the girls are been [sic] taken to Wolverhampton or Birmingham"*.¹⁰²
- 8.131 In this case, there was clear evidence that Becky was sexually active at a very young age but the lack of engagement or professional curiosity on behalf of the agencies involved meant that Becky was not appropriately supported.
- 8.132 The failure by the Council's Safeguarding team to report a rape disclosure to WMP should be considered a serious failing as it denied the opportunity to investigate the allegation fully, which potentially could have prevented Becky from being exposed to further exploitation.

¹⁰¹ [REDACTED] pg 9
¹⁰² [REDACTED] pgs 2 and 4

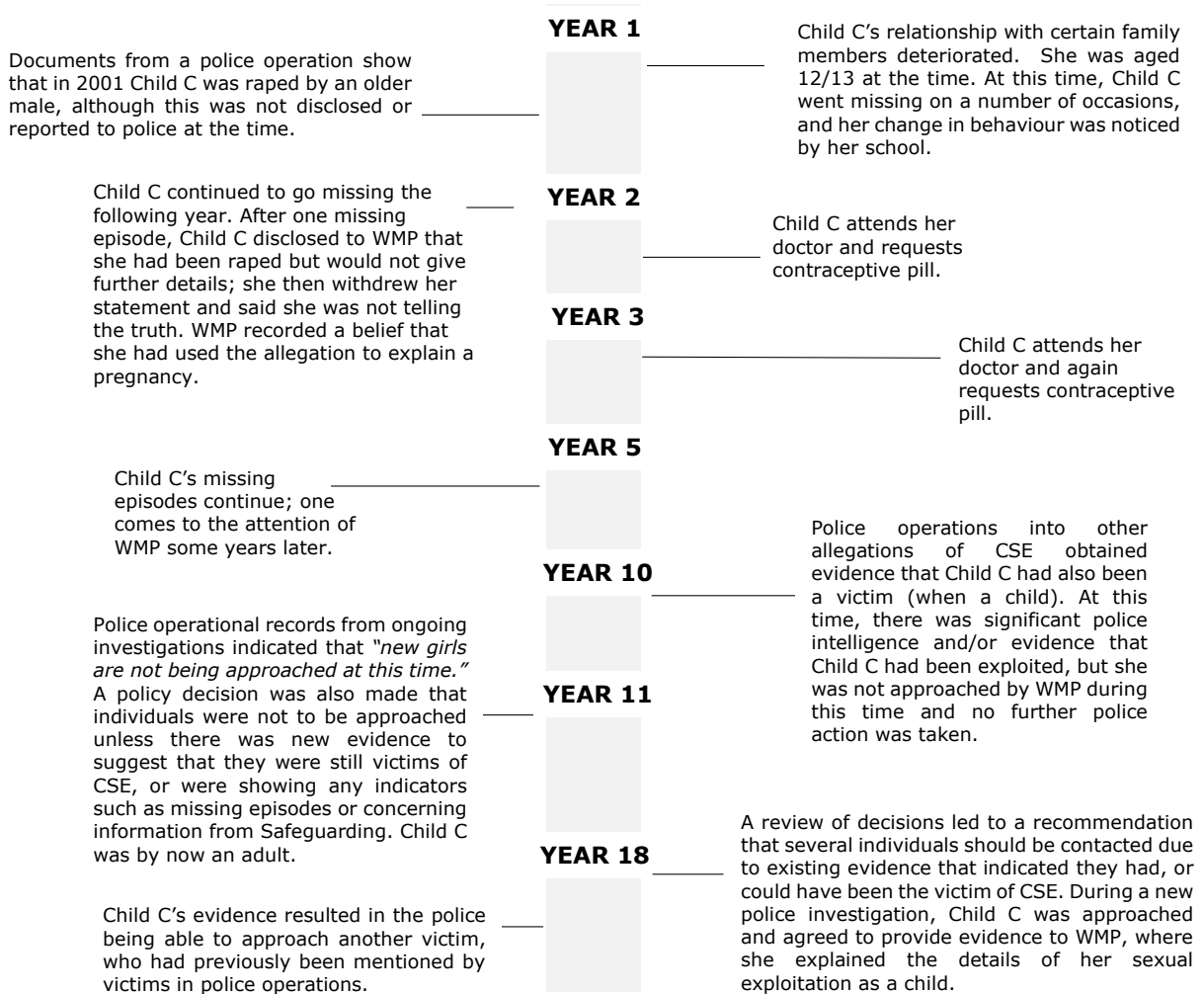
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- 8.133 The common theme across all agencies involved with Becky was a failure to share information and to act appropriately upon receipt of referrals or disclosure of serious offences. Becky was failed by medical professionals, the Council and her school while she was still alive, and let down by the inadequacy of WMP's investigation following her death. These failures all led to opportunities for perpetrators to continue to exploit Becky and others.
- 8.134 If any of the agencies involved had acted appropriately, it is possible that the exploitation of Becky would have come to light sooner and future crimes may have been prevented.

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Case Study - Child C (early 2000s onwards)

Timeline



Overview

- 8.132 In early 2000s, Child C's relationship with certain family members deteriorated. She was aged 12/13 at the time. During this period, Child C went missing on a number of occasions and her change in behaviour was noticed by her school.¹⁰³
- 8.133 Documents from a police operation show that in or around this time Child C was raped by an older male, although this was not disclosed or reported to WMP at the time.¹⁰⁴

¹⁰³ [REDACTED]
¹⁰⁴ [REDACTED] pg 48

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- 8.134 Child C continued to go missing the following year. After one missing episode, Child C disclosed to a police officer from WMP that she had been raped but would not give further details; Child C then withdrew her statement and said she was not telling the truth.¹⁰⁵ The rape allegation was not investigated at the time and WMP records indicate they believed she used the allegation in an attempt to explain an unplanned pregnancy. The WMP records also document that "*It seems she has recently had sex with consent*"; Child C was aged 13 at the time.¹⁰⁶ This comment was not only unacceptable, but this should have prompted a referral to the Council's Safeguarding team – she was a child.
- 8.135 In the same year, Child C attended her GP surgery to request the contraceptive pill. Approximately a year later Child C attended her GP surgery and the same request was made.¹⁰⁷ Again, given her age, a referral to Safeguarding should have been considered; it is unclear from the evidence whether this happened.
- 8.136 Child C's missing episodes continued, and one came to the attention of WMP a few years later.¹⁰⁸
- 8.137 In 2010, WMP operations into other allegations of CSE obtained evidence that Child C had also been a victim (when she was a child).¹⁰⁹ At this time, there was significant police intelligence and/or evidence that Child C had been exploited, but she was not approached by WMP during this time and no further police action was taken.¹¹⁰
- 8.138 In 2011, police operational records from ongoing investigations indicated that "*new girls are not being approached at this time*".¹¹¹ A policy decision was also made that individuals were not to be approached unless there was new evidence to suggest that they were still victims of CSE, or were showing any indicators such as missing episodes or concerning information from Safeguarding.¹¹² Further evidence obtained by the Inquiry indicates that there was a focus on the finite nature of resources in the investigation.
- 8.139 A recent review of the decisions in this investigation led to a recommendation that several individuals should be contacted due to existing evidence that indicated they had, or could have been the victim of CSE.¹¹³ During a new WMP investigation, Child C was approached and agreed to provide evidence to WMP, where she explained the details of her sexual exploitation as a child.¹¹⁴
- 8.140 Child C's evidence resulted in the approach of another individual who was suspected as a victim and/or witness.¹¹⁵ This individual had been mentioned by victims in previous relevant

105 [REDACTED] pg 3
 106 [REDACTED] pg 1
 107 [REDACTED] pg 33
 108 [REDACTED] pg 1
 109 [REDACTED] pgs 25-26
 110 [REDACTED] pg 7, [REDACTED] pg 1
 111 [REDACTED] pg 1
 112 [REDACTED] pg 1
 113 [REDACTED] pgs 24 and 30
 114 [REDACTED] pg 4
 115 [REDACTED]

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police operations, but it is unclear whether this was properly investigated by WMP at the time.

- 8.141 There is evidence that demonstrates that the police investigation was an extremely stressful experience for Child C.¹¹⁶
- 8.142 The suspected perpetrators of CSE against Child C were identified by WMP and interviewed. These individuals had been previously known to WMP in the context of similar offences. A number of suspects were released without charge but some were successfully prosecuted. Child C received support from an Independent Sexual Violence Advisor ("ISVA") throughout the trial, although she dealt with three different ISVAs over a two month period;¹¹⁷ I understand that this was due to staff sickness and staff departures.¹¹⁸
- 8.143 In relation to the decision not to prosecute some of the suspects, this was taken following an early advice conference between WMP and the Crown Prosecution Service ("CPS"),¹¹⁹ where the police would inform the CPS of the charging decisions they intended to refer to the CPS, and those they intended not to proceed with. In Child C's case, the decision not to charge was WMP's, and therefore WMP informed Child C of the outcome.

Summary

West Mercia Police

- 8.144 Child C first came to the attention of WMP in the early 2000s after her allegation of rape. Whilst she retracted the allegation, given the age of Child C at the time, it is the view of the Inquiry's police expert that a referral should have been made to the Council's Safeguarding team. This referral should have detailed Child C's missing episodes and their circumstances, her allegation of rape and withdrawal of her complaint, and suspected sexual activity, all indicating that she may possibly be at risk. A police investigation or a referral may have led to further disclosure of ongoing sexual exploitation and prevented further criminal offences of CSE. However, WMP formed the view that the allegation of rape was fabrication. As a result, no multi-agency meeting, risk assessment or information sharing took place so there was no investigation regarding her vulnerability, missing episodes and CSE indicators; there was a lack of professional curiosity.
- 8.145 There should also have been greater consideration of Child C's age. The above disclosure was recorded by an officer as "*sex with consent*" when Child C was 13 years old. It is the view of the police expert that this matter should have been recorded and investigated as a crime. Referrals should have also been made to other agencies and a multi-agency meeting should have been called, as mentioned above.
- 8.146 In 2010, police operations identified Child C as a victim of CSE. Although Child C's identity was not immediately clear to WMP, it would have taken minimal investigation to work out who she was. But there appears to have been no attempt to do so, despite the access to

¹¹⁶ [REDACTED] pgs 12 and 15

¹¹⁷ [REDACTED] pgs 15 and 24

¹¹⁸ [REDACTED]

¹¹⁹ [REDACTED] pg 2

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witnesses who could have assisted with such identification. A policy decision was also made in 2010 not to 'chase' victims and witnesses of historical CSE. Child C's case was marked as "NFA" – no further action.

- 8.147 The Inquiry has gathered evidence in relation to these policy decisions. I was told that the decisions were made because WMP did not want to be viewed as "*chasing*" victims and they were concerned about the impact of approaching victims directly, as many did not consider themselves victims. The rationale behind the decision was not to cause the victims any further, secondary/tertiary or unnecessary distress, and in some ways this is understandable. This however represents another missed opportunity to bring Child C's perpetrators to justice. The decision about how to approach victims could have been better considered, for example with individuals initially approached as witnesses as opposed to victims, as was the approach being taken by many other police forces at the time in dealing with non-recent CSE. One witness accepted that, in hindsight, there should have been a simple, confidential means of being able to report CSE to WMP, or a confidential third party, and regularly advertising of the investigation, encouraging victims/survivors to come forward.¹²⁰ I must therefore question the rationale for not following up with potential victims/survivors in order to investigate CSE.
- 8.148 In addition, providing support and reassurance to those concerned, who were victims/survivors of CSE, should have been considered as part of the decision-making process about whether or not steps should have been taken to identify them. Sadly, some subsequent distress is always likely in historical sexual abuse, but there are numerous practices, procedures and specialist services to assist individuals. WMP should have worked through a strategy to approach victims/survivors and witnesses to the 'historical' CSE, which could have included estimating how any victims/survivors or witnesses (secondary victims) may need support. Many other UK police forces were undertaking similar investigations into non-recent child sexual abuse at the time and advice on this point could have been sought from them.
- 8.149 Of greater significance however was the fact that intelligence was gathered by WMP back in 1999 in relation to Child C's perpetrators. For example, the intelligence dating from 1999 shows that one of the suspects was known to be a paedophile and acting as a pimp, supplying children to Asian males, and connecting him to an address that was of police concern.¹²¹ This address featured heavily in the sexual abuse of children over the next decade. I have seen no evidence to suggest that this intelligence was acted upon. It is the view of the Inquiry's police expert that this demonstrates a failure on the part of WMP to investigate potential offences relating to child sexual abuse and prostitution. Any police action may have resulted in arrests, a judicial outcome and prevention of CSE for the following years. Had WMP tied together information and intelligence held in 1999, they may have prevented Child C, and others, from becoming victims of CSE.
- 8.150 One can therefore identify three periods of significant failure: the failure to act on intelligence in 1999; the failure to refer Child C to Safeguarding in the early 2000s when there were indicators of concern, and suggestions she may be at risk; and the failure in

¹²⁰ [REDACTED]

¹²¹ [REDACTED] pgs 43, 51, 104-106

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2010/2011 to follow up with Child C as a potential victim of CSE and to investigate further and bring her perpetrators to justice.

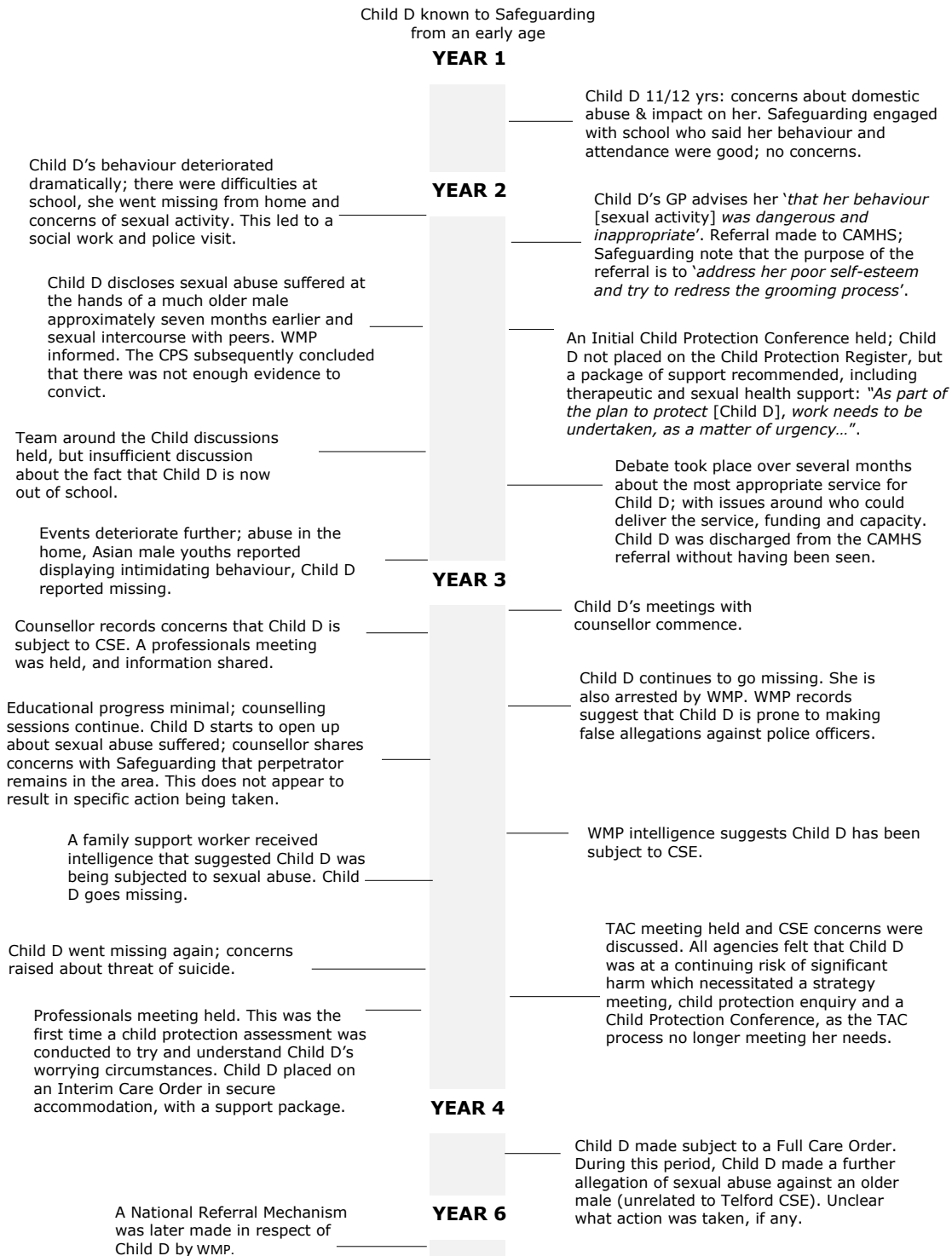
The Council and other agencies

- 8.151 There is no record of the Council having any case files for Child C, therefore it appears that Safeguarding were not aware of any concerns with Child C. Given the concerns held by Child C's school, which were documented, and the missing episodes recorded by WMP and the rape allegation and retraction, it is surprising, and concerning, that no agencies ever raised a referral to the Council. If this information had been shared and a multi-agency conference organised, the authorities could have considered Child C's risk, and assessed whether an action plan was necessary, including considering whether support could be offered.
- 8.152 Child C's GP was also aware that Child C was sexually active as she attended the surgery twice for the contraceptive pill in two years, in her early teenage years. If Child C was considered *Gillick* competent and there were no other indicators of vulnerability or concern, the GP may not have felt there was any basis to make a referral to the Council's Safeguarding team.
- 8.153 It is also of note that Child C was referred for ISVA support following the disclosure to WMP of CSE. This was a positive step, but the allocated ISVA was changed three times during a two-month period. This lack of continuity would be stressful for anybody seeking support through the criminal justice process.

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Case Study - Child D (Mid 2000s)

Timeline



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Overview

- 8.154 Child D had been known to the Council's Safeguarding team from an early age. There was then some involvement when Child D was around 11/12 years old, with concerns about domestic abuse and worries concerning the impact on children.¹²² The Council engaged with Child D's school, who reported that Child D's behaviour and attendance was good and there were no concerns.¹²³
- 8.155 At approximately 12/13 years old, Child D's behaviour dramatically deteriorated; she had difficulties at school;¹²⁴ she went missing from home;¹²⁵ there were concerns of sexual activity; reports from the school said that "*I have not dealt with such highly sexualised behaviour in a child as young as [Child D]*".¹²⁶ There appears to have been a lack of reflection of the meaning of these concerns for Child D who was just 12/13 years old. It is not clear from the evidence exactly what action was taken by the school, but it did lead to a social work and police visit.
- 8.156 During a GP visit at around this time, the "*doctor advised [Child D] that her behaviour [sexual activity] was dangerous and inappropriate*".¹²⁷ An urgent referral was made to CAMHS. Safeguarding records note that this referral was to "*address her poor self esteem and try to redress the grooming process*".¹²⁸
- 8.157 Child D then made a number of disclosures about sexual abuse she had suffered at the hands of a much older male approximately seven months earlier.¹²⁹ She also reported sexual intercourse with peers; again the issue of her inability to give consent given her age does not seem to have been discussed. WMP was informed.¹³⁰ During a police Achieving Best Evidence ("ABE"), interview, it was noted that Child D had been "*extremely explicit*" in her description of events "*using terminology that you would not expect of a child of her age*".¹³¹ The CPS subsequently concluded that there was not enough evidence to convict the perpetrator of Child D's abuse and so no further action was taken and the alleged perpetrator was not prosecuted.¹³² This decision was later noted as having a significant impact on "*the way [Child D] sees herself and her behaviour towards other males*".¹³³ An Initial Child Protection Conference was held at this time and Child D was not placed on the Child Protection Register, but a package of support was recommended, including

122		pg 3
123		pg 1
124		pg 11
125		pg 3
126		pg 27
127		pg 3
128		pg 8
129		pg 3, [REDACTED] pg 15
130		pg 15
131		pg 3
132		pg 36
133		pg 1

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therapeutic work and sexual health support: *"As part of the plan to protect [Child D], work needs to be undertaken, as a matter of urgency..."*.¹³⁴

- 8.158 However, work with a counsellor did not begin until five months later,¹³⁵ and Child D was discharged from the CAMHS referral without being seen,¹³⁶ following a debate about what the most appropriate service was; there were issues with who could deliver the service, funding and capacity.¹³⁷ CAMHS made the point that they were concerned that Child D was subject to "grooming" and this required a different response. This was the first note that Child D should be seen as a child who had been sexually harmed. The evidence shows that the lack of treatment would have a continuing impact on Child D: *"There is a real risk that should the appropriate treatment not be forthcoming she will not be considered as able to attend mainstream schooling and it may be... will have to consider a residential placement"*.¹³⁸ Council-led Team Around the Child ("TAC") meetings were being held around this time and these delays were discussed.¹³⁹ There was however insufficient discussion about Child D now being out of school.
- 8.159 In the meantime, Child D's situation worsened; there was abuse in the home; Asian male youths were seen displaying intimidating behaviour; Child D was repeatedly reported missing.¹⁴⁰
- 8.160 The work with the counsellor finally commenced five months after the Initial Child Protection Conference.¹⁴¹ After a few months of sessions, the counsellor reported to the Council concerns around Child D *"turning up with a lot of new clothes and she says the Asian lads give her money... I am concerned that there may be some sexual exploitation beginning or already happening with [Child D]"*.¹⁴² Similar concerns were then raised by others at around the same time.¹⁴³ A professionals' meeting was held and information was shared.
- 8.161 Throughout this period, and following, Child D repeatedly went missing and was arrested by WMP. The WMP missing person records include comments such as the following:

"Despite her age (13 yrs) [NAME]... feels that [Child D] is fairly streetwise and has started to associate with a number of Asian men in the Wellington area. I have reviewed the R/A [risk assessment] in conjunction with previous reports and agree that it is suitable under the circumstances. I feel the only aggravating factor is her age and the fact that she may be becoming [sic] sexually active. That said, this behaviour is not unusual and there is no information available to suggest she is at immediate risk. The subject is under the supervision of various agencies...";

134 [REDACTED]
135 [REDACTED] pg 31
136 [REDACTED] pg 54
137 [REDACTED]
138 [REDACTED] pg 11
139 [REDACTED] pgs 27-29, [REDACTED] pgs 24-25
140 [REDACTED] pgs 24-25 and 28, [REDACTED] pg 3
141 [REDACTED] pgs 1-2
142 [REDACTED] pg 10
143 [REDACTED] pgs 10-13

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"MISPER [missing person] to be resourced this morning as staffing and commitments allow... this person has been missing so many times now that any risk seems to be more symptomatic of behavioural and attitude problems... medium is a fair assessment at this time"; and

[Child D] is a "sexual predator".¹⁴⁴

- 8.162 It is of concern that at this time WMP's records also stated that Child D may make false allegations:

*"Information states that subject who is becoming a regular misper will make up false allegations against police officers. In particular if a male officer attends to speak to subject by herself, subject will make sexual advances towards them and then make false allegations that the officer has sexually assaulted them. Suggest a double crew at all times to deal with subject in particular when looking for her when missing."*¹⁴⁵

- 8.163 Further reports at the time confirm that educational progress was minimal and Child D had been arrested.¹⁴⁶ The counselling sessions continued and Child D started to open up about the sexual abuse she experienced, detailing disturbing flashbacks and saying that she often saw the man who abused her in the area.¹⁴⁷ The counsellor shared concerns with social workers that the adult perpetrator was in the area and "has accosted [Child D] on at least one occasion...".¹⁴⁸ This does not appear to have led to any specific action.
- 8.164 Just a few weeks later, WMP intelligence suggested that Child D was the victim of CSE.¹⁴⁹ This accorded with reports by the counsellor and Child D's family. There was WMP intelligence suggesting Child D was part of a group of children who were being procured by an adult to be raped by Asian men in Birmingham.
- 8.165 A few weeks following this, a family support worker received intelligence that suggested Child D was being subjected to sexual abuse with Asian men at the age of 13.¹⁵⁰ The information was shared with WMP and a strategy meeting was arranged. Child D went missing for three days.¹⁵¹
- 8.166 At this time, the Council discussed a need for there to be a strategy meeting regarding all the children about whom there were concerns of exploitation, including Child D.¹⁵² A meeting took place a few months later, but operational decisions were not discussed, and

¹⁴⁴ [redacted] pgs 37-40 and pgs 84-88

¹⁴⁵ [redacted] pg 13

¹⁴⁶ [redacted], pg 11; [redacted] pg 3; [redacted] pg 2

¹⁴⁷ [redacted]
¹⁴⁸ [redacted] pg 10

¹⁴⁹ [redacted] pg 12

¹⁵⁰ [redacted] pg 13

¹⁵¹ [redacted] pg 13; [redacted] pgs 18-28; [redacted] pgs 21-23, [redacted]

¹⁵² [redacted] pgs 21-23

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this meeting was part of the development of a CSE response in Telford, as opposed to addressing the concerns specifically related to Child D.¹⁵³

- 8.167 A few days after Child D's return from her missing episode, a TAC meeting was held and concerns were raised: "*Spending this time with Asian adult males who are deemed to be inappropriate, and is reported to be engaging in intercourse and sexual acts with these adult males. Grave fears about her safety, and the high level of risk she places herself at*". All agencies felt that Child D was at a continuing risk of significant harm which necessitated a strategy meeting, child protection enquiry and a Child Protection Conference, as the TAC process was no longer meeting her needs.¹⁵⁴ At the same time, Child D's family made a complaint about the lack of action regarding the allegations of sexual abuse that Child D had made.¹⁵⁵
- 8.168 Child D went missing again and concerns were raised about threats of suicide being made by her.¹⁵⁶
- 8.169 Five days later, as part of the Core Assessment, a professionals' meeting was held.¹⁵⁷ This was the first time that all of the worrying circumstances regarding Child D, who was by then only 13 years old, were brought together. Despite growing concerns over a 14 month period, this was the first time a child protection assessment was undertaken to try and understand her worrying circumstances. The focus, however, was still on what people saw as Child D's problematic sexualised behaviour. There is no acknowledgement of her raising concerns about being sexually abused or being groomed and taken to Birmingham. This is clear in the minutes where it is said that the decision to place Child D "*in a secure unit [was] due to her inappropriate sexualised behaviour*" and Child D was placed in secure accommodation. The Core Assessment also notes that "[Child D] *disputes she is a prostitute. She says she enjoys sex with Asians and it is not prostitution, as she gets clothes, drink and drugs for from [sic] the men not money*". Alongside the Interim Care Order under secure accommodation, a support package also continued for Child D.¹⁵⁸
- 8.170 Child D remained in secure accommodation, changing location a couple times, and was later made subject to a Full Care Order;¹⁵⁹ the interventions were considered to be reducing Child D's risk to CSE, although there were still risks associated with Child D being kept safe. There was also a later allegation of sexual abuse made by Child D against another older male, unrelated to the CSE experienced by Child D in Telford. These allegations were found to be true, but I have not seen any evidence that this was taken forward by the relevant authorities, although documentation on this is incomplete.¹⁶⁰ I have however seen reference

153 [REDACTED]
 154 [REDACTED]
 155 [REDACTED], pgs 1-2
 156 [REDACTED], pg 3, [REDACTED] pg 3, [REDACTED]
 157 [REDACTED]
 158 [REDACTED]
 159 [REDACTED], pg 1, [REDACTED], pgs 1-2
 160 [REDACTED]

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to the fact that the information on Child D's police file that she made false allegations against WMP in the past may have had an influence on action that was taken.¹⁶¹

- 8.171 A National Referral Mechanism ("NRM")¹⁶² referral for Child D was subsequently made by WMP.¹⁶³

Summary

- 8.172 In this case, there were concerning early warning signs; Child D spoke of sexual activity at 12/13 years old and reports from the school said that "*I have not dealt with such highly sexualised behaviour in a child as young as [Child D]*". This does not however appear to have prompted those agencies involved to ask further questions or to explore the cause of this behaviour.
- 8.173 Instead, Child D was treated as a "*sexual predator*": an obviously inappropriate term first used to describe Child D when she was aged 13 years old. This label shows a perception that Child D was not a victim. This mindset may well have skewed the thought processes and subsequent actions that individuals followed whenever they had occasion to work with Child D or any reports relating to her.
- 8.174 It is evident that the Council did not always engage with WMP concerning specific CSE incidents, and in turn WMP do not appear to have communicated their reports to the Council's Safeguarding team. This created a fragmented picture that resulted in ill-informed investigations, decision-making and outcomes.
- 8.175 There is no doubt that Child D was an extremely vulnerable child. It is clear that she was a victim of numerous sexual offences at the hands of older men, her peers, gangs and other men that she encountered.

The Council

- 8.176 When the disclosure of sexual abuse by an older male was made by Child D, this was addressed fairly promptly by the Council, with a TAC process being implemented and a package of support put in place, including therapeutic interventions. That support package was however extremely slow to get off the ground, with disagreements around funding, capacity and whether it was the right support for the child; this lasted for the best part of six months. Meanwhile Child D remained extremely vulnerable to further exploitation.
- 8.177 It is evident that from this point onwards Child D showed consistent patterns of going missing and distressed behaviour, as well as there being reports of getting in trouble with the police. This lasted for more than 12 months. There was increasingly clear intelligence from both WMP, family support workers in the Council, and education providers that Child D was known to be subject to harm by older males and that this was continuing and escalating. Despite the gravity of the concerns being expressed, it took 14 months from the

¹⁶¹ [REDACTED]

¹⁶² The National Referral Mechanism is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

¹⁶³ [REDACTED] pg 2

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date of this intelligence first being recorded for a multi-agency strategy meeting to be convened and a child protection enquiry initiated, following which a Child Protection Conference was held and Child D was placed into a secure unit.

- 8.178 The focus of the Council staff appears to have been to support Child D, rather than protect her; the documents also give an impression of Child D as somehow being damaged and therefore the aim being to address this, rather than address what was happening to her. Had the latter been prioritised, CSE may well have been stopped and further trauma suffered by Child D avoided.
- 8.179 It remains unclear why child protection interventions did not happen earlier in Child D's case, as opposed to the TAC support that was given, particularly when the intelligence received was so concerning and Child D was clearly recognised as being at risk of significant harm, but there was no assessment of her circumstances. If child protection intervention had happened at an earlier stage, this could have disrupted the CSE that Child D then continued to suffer until a secure placement was put in place.
- 8.180 This was recognised by a later review of the case: "[Child D] *should have been subjected to formal child protection planning because of [her family's] inability to protect and rising levels of risk... Further Conference should have been convened once it became known... that [Child D's] risk had increased due to involvement with Asian males and other yp [(young people)] who were known to be at risk from this group... Police almost invisible in case recordings. Professionals responding to [Child D's] presenting behaviour - no examination of impact of family history or current family relationships including... capacity to protect [Child D]*".¹⁶⁴

West Mercia Police

- 8.181 The non-prosecution of Child D's first abuser had a huge impact on Child D. There is a clear link between this experience and low self-esteem and confidence, leading to her being extremely vulnerable to further exploitation. I have not seen any records that show that WMP or the CPS communicated with Child D or her family about the decisions taken not to proceed with charging her first abuser, or gave them any opportunity to understand the decision-making process behind the absence of a prosecution. Had this happened, this could have reduced the impact on Child D.
- 8.182 WMP records show that 12 missing reports were generated on COMPACT (electronic database for missing persons) for Child D over a 14 month period. The records showed that the frequency of her disappearance and regular absconding from home led to a complacent attitude being shown by investigating officers as to the seriousness of the risks that she faced. This is despite the fact that WMP was aware that Child D was sexually active and a potential victim of CSE at the hands of older men. This knowledge is confirmed in WMP records that show that Child D's absconding was linked with a wider pattern of children going missing in the area.¹⁶⁵

¹⁶⁴ [REDACTED]

¹⁶⁵ [REDACTED] pgs 7-12

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- 8.183 It is the view of the Inquiry's police expert that WMP appeared to be dismissive of Child D and any issues surrounding her. This attitude is confirmed in adverse comments made in documents disclosed to the Inquiry. This was also evident during Child D's missing episodes, which were assessed by officers as 'medium.' The Inquiry's police expert maintains that an assessment of 'high risk' to 'acute' would have been more accurate given Child D's age (13 years old) and known concerns to WMP, such as CSE, drugs, alcohol and association with adult males.
- 8.184 There appears to have been limited sharing of information with the Council. The Inquiry's police expert postulates that if information had been shared, Child D and her family may have been taken seriously, an ABE interview may have been conducted in a timely fashion and a fuller picture may have led to a thorough investigation against the many perpetrators of CSE and other sexual offences committed against Child D.

Other Agencies

- 8.185 An example of a positive intervention was the counselling support that was eventually provided to Child D. It is clear from the documentation seen that the counsellor made significant and continuous efforts to find Child D the support that she needed in the time that she worked with her, and remained a constant source of support for several years. The counsellor also remained in constant contact with the Council's Safeguarding team. They highlighted concerns or worrying events, and encouraged the Council to hold a professionals' meeting, copied to all organisations that were involved in service provision to Child D, ensuring that active steps were taken to share appropriate information with all relevant parties. It is noteworthy that it was the counsellor that first made representations to move Child D out of the area, rather than the Council, despite the Council having access to the same information and a wider perspective of other CSE cases involving the same perpetrators.
- 8.186 The therapeutic support itself also appears to have had a hugely positive impact on Child D, with a focus on trying to rebuild Child D's confidence and self-esteem. Without this support, I believe that Child D may have struggled to make positive progress.
- 8.187 In respect of health services, this case is another example of an awareness from the treating GP that Child D was sexually active at an age when she could not give legal consent to sexual activity. A child protection referral should have been made and I have not seen evidence that this happened.
- 8.188 The school was also clearly aware of sexualised behaviour in a child and likely sexual activity at an age where consent could not be given. It is not clear from the documents whether a child protection referral was made by the school in this case.

Attitudes

- 8.189 This case also highlights some concerning attitudes from professionals towards victims of CSE at this time. Comments in the evidence included:

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- 8.189.1 the "doctor advised [Child D] that her behaviour [sexual activity] was dangerous and inappropriate".¹⁶⁶ Child D was 12 years old.
- 8.189.2 "this person has been missing so many times now that any risk seems to be more symptomatic of behavioural and attitude problems...."¹⁶⁷
- 8.189.3 Child D's behaviour was described as "predatory" when she was 12 years old.¹⁶⁸
- 8.189.4 A WMP missing person report refers to Child D as "a sexual predator" when she was 13 years old.¹⁶⁹
- 8.189.5 Another missing person report notes "reported to be very sexually active, mixes with the Asian Community and gets herself into 'awkward situations'".¹⁷⁰
- 8.190 While other evidence I have seen suggests that the understanding of CSE was only just becoming more widespread, this was a 12/13 year child; the comments from a number of professionals suggested that an element of consent or blame rested with the child. I consider that this attitude, particularly from WMP, prevented them from treating the intelligence received sufficiently seriously and taking more proactive action to protect Child D from further harm. The context of general attitudes at this time is however important to consider and I deal with attitudes towards CSE in Chapter 9: Attitudes and Impact.

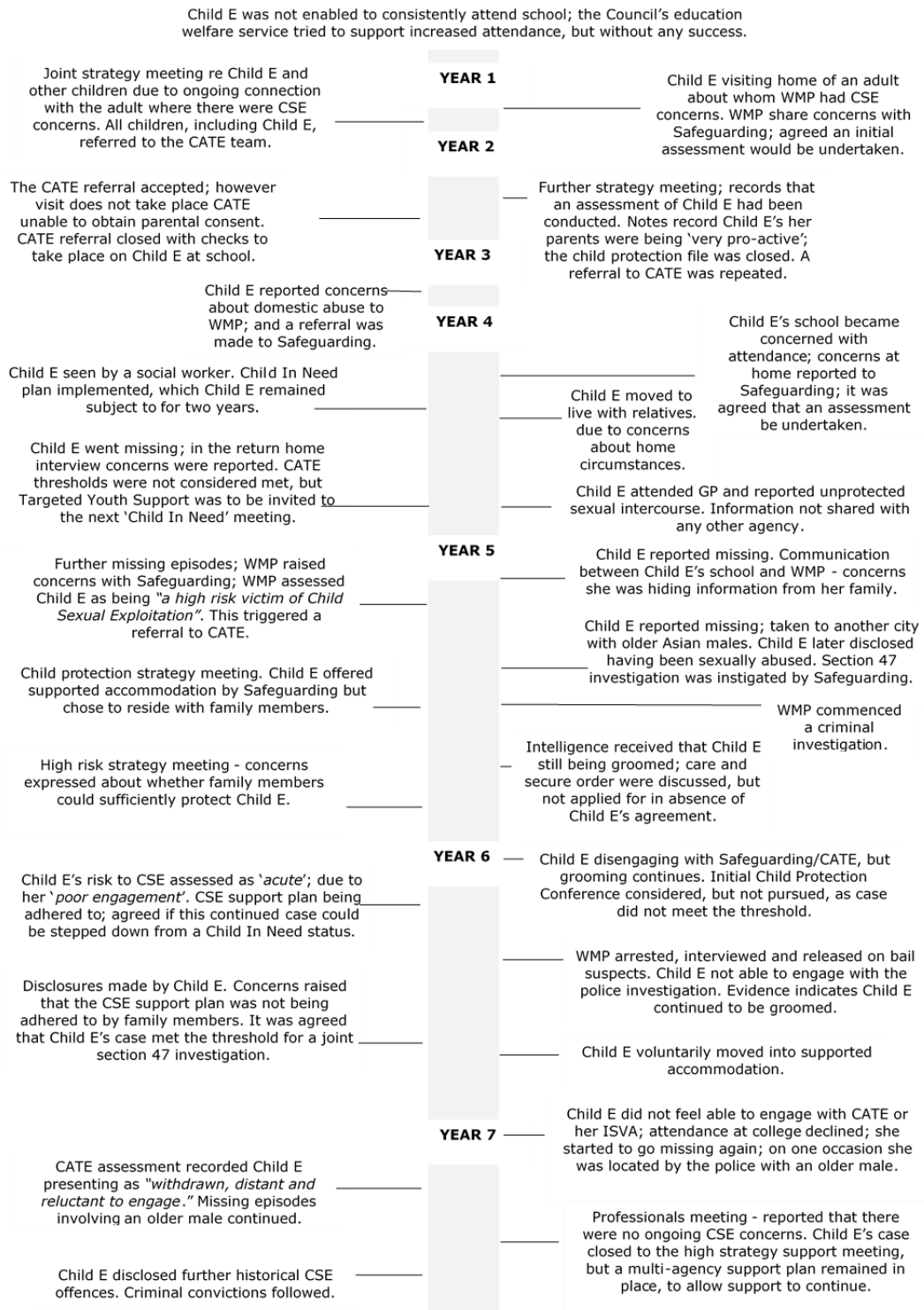
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Case Study - Child E (mid 2010s)

Timeline



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Overview

- 8.191 Child E was not enabled to attend school consistently at primary school and her poor attendance continued through to her secondary school; she came to the attention of the Council's education welfare service who tried to support increased attendance, but without success.¹⁷¹
- 8.192 When Child E was 12 years old concerns were shared by WMP with the Council's Safeguarding team that Child E was visiting the home of an adult about whom WMP was concerned in relation to grooming children for sexual abuse by Asian males, placing a number of children at risk. It was agreed that an initial assessment would be undertaken.¹⁷² Given that Child E was just 12 years old, this should however have been a child protection enquiry. There was evidence that Child E was at risk of significant harm.
- 8.193 A month later there was a joint strategy meeting regarding Child E and a number of other children, due to their ongoing connection with the adult about whom there were concerns regarding grooming children for sexual abuse.¹⁷³ This situation met the threshold for complex child abuse procedures under Working Together 2010; which stated that complex cases involving organised or multiple abuse requires thorough planning, good inter-agency working and thorough investigation. The decision of the strategy meeting was that all children, including Child E, would be referred to the CATE Team and their needs assessed through the CATE process. I have however not seen any evidence indicating what happened with this CATE referral for Child E and whether it was progressed at this time.
- 8.194 In respect of the initial assessment for Child E, the evidence reviewed by the Inquiry indicates that this assessment did not take place until approximately three and a half months later, when it was discussed at a further joint strategy meeting concerning Child E and the same group of children.¹⁷⁴ The minutes from this meeting appear to suggest that an initial assessment of Child E had been undertaken, although this appeared to have only involved meeting with Child E's parents; the evidence suggests there was no input from WMP in relation to this assessment. The minutes from the strategy meeting confirm that the assessment concluded that "*there is nothing new in respect of [Child E]. [Her parents are] being very pro-active and therefore the case was closed*".¹⁷⁵
- 8.195 At this second joint strategy meeting no conclusion was formed, but a number of actions were agreed. One was that all of the children who were discussed at the meeting, including Child E, would be referred to the CATE Team. This replicated the action from the joint strategy meeting from 12 weeks prior, but there is no evidence that the referrals to the CATE Team progressed between the two meetings. There is no evidence that further joint strategy meetings for these children took place, so it is unclear how other actions were taken forward.

171 [REDACTED] pgs 75-78 and pgs 18-60
 172 [REDACTED] pgs 1-3
 173 [REDACTED]
 174 [REDACTED] pg 4
 175 [REDACTED]

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- 8.196 In respect of Child E and the decision to close her child protection file and refer her to CATE, evidence obtained by the Inquiry suggests that professionals thought that Child E was neglected throughout her childhood and early adolescence; one individual never fully understood why no action was taken or consideration given to Child E being taken into care, for her own wellbeing.¹⁷⁶ Documentary evidence also supports a suggestion that Child E's parents had not been proactive over the years, and subsequently this proved to be the case too.¹⁷⁷ This history was not mentioned in the initial assessment, or in the strategy meeting held late that year. If this information had been shared, there could have been more reflection on whether the CATE support was appropriate, given the need for parental consent and a proactive response from parents inherent within the CATE process. The procedures would have suggested a child protection enquiry would be more appropriate.
- 8.197 The CATE referral was made and accepted. A visit to conduct an initial CATE risk assessment was arranged for the following month, which was to be attended by a CATE practitioner and Child E's social worker.¹⁷⁸ The visit did not however go ahead as the CATE practitioner was unable to get in touch with Child E's parents to obtain consent. The CATE case was therefore closed the following month, following no response from her parents. Information was passed to Child E's school to carry out preventative work with Child E's year group, and an action noted of checks to be made on Child E at school.¹⁷⁹ This left Child E without any protective response.
- 8.198 Over the next two years, there was little further intervention or contact with Child E from agencies, although Child E reported concerns about domestic abuse to WMP; a referral was made to Safeguarding.¹⁸⁰ There is no information about what action was taken in response to this referral.
- 8.199 In the mid-2010s, Child E's school became concerned with her attendance and concerns at home were reported to the Council's Safeguarding team. It was agreed that a social worker would be allocated and an assessment undertaken.¹⁸¹ Child E was seen by a social worker the following month.¹⁸² At the time, it was agreed a 'Child In Need' plan would be implemented. Child E remained subject to a Child in Need plan for the next two years. There were regular reviews, but the contents of the plan remained the same and the escalating nature of the concerns around Child E's safety were not fully reflected in them.¹⁸³
- 8.200 Child E moved to live with relatives because of concerns about her home circumstances.¹⁸⁴ At the end of that year, Child E went missing and in the 'Return Home Interview' other concerns were reported, including an incident when Child E had been touched by an older male and felt unsafe.¹⁸⁵ Child E's circumstances were not considered to meet the CATE

176 [REDACTED] pg 28
 177 [REDACTED] pgs 18-60
 178 [REDACTED]
 179 [REDACTED]
 180 [REDACTED] pgs 1-3
 181 [REDACTED] pgs 19-23
 182 [REDACTED] pg 1
 183 [REDACTED]
 184 [REDACTED]
 185 [REDACTED], pg 33

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threshold, and instead Targeted Youth Support (“TYS”) was to be invited to the next Child In Need meeting.¹⁸⁶ Two days later Child E attended her GP and reported unprotected sexual intercourse.¹⁸⁷ This does not appear to have been shared with any other agency and so the connections with the recent missing episode were not made.

- 8.201 Shortly after this, concerns began to further escalate. Child E was reported missing on a number of occasions. There was also communication between Child E’s school and WMP about missing episodes and there were concerns she was hiding information from her family; there was no discussion around why this would be and what the implications might be for her safety.¹⁸⁸ Around this same time, the referral to TYS was made.¹⁸⁹ Following further missing episodes, including being found with older males, WMP raised concerns with the Council; WMP assessed Child E as being “a high risk victim of Child Sexual Exploitation”.¹⁹⁰ It was only at this stage that Child E was again referred to the CATE Team.¹⁹¹ There was however a delay with progressing the CATE referral and during the intervening period Child E was found with an older male during a missing episode.¹⁹² The delay in processing the CATE referral was due to the referral form not being properly sent to the team on the system.¹⁹³ Following the delay, CATE Team intervention recommenced.
- 8.202 A few months later, Child E was reported missing and it was established that she had been taken to another city with older Asian males. Child E disclosed being driven to a location where a number of males sexually abused her.¹⁹⁴ A section 47 investigation¹⁹⁵ was instigated by the Council.¹⁹⁶ At a child protection strategy meeting, WMP expressed concerns that there had been more recent CSE incidents.¹⁹⁷ Child E was offered supported accommodation by Safeguarding but elected to reside with family members.¹⁹⁸ An NRM referral was also made at this time.¹⁹⁹ There was also a MAPPA²⁰⁰ meeting which highlighted concerns about an adult Asian male who was in contact with Child E and was already known to WMP in relation to suspected sexual offences.²⁰¹
- 8.203 As a result of this disclosure of sexual offences having been committed, WMP commenced a criminal investigation in the absence of a formal complaint by Child E. Within three

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The purpose of section 47 investigations is to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

pg 5

pgs 5-6

Multi Agency Public Protection Arrangements

pg 5

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months, the WMP investigation was working with a wider regional investigation and sharing information with West Midlands Police (“WMP”).

- 8.204 Around this time, Safeguarding convened Legal Planning Meetings to discuss the legal orders that could be sought given the current circumstances.²⁰² During these meetings the NRM decision was discussed, which was that there was reasonable grounds to believe that Child E was a victim of modern slavery. It was agreed that WMP would investigate this.
- 8.205 Intelligence identified that in the months that followed, Child E was still being groomed, and a care and secure order were discussed.²⁰³ A specialist residential unit was found for Child E, but at a legal planning meeting a joint decision was made by Safeguarding and WMP that, in the absence of Child E voluntarily agreeing to move into supported accommodation, it was not appropriate to apply for the order as it would undermine the CSE support plan in place with Child E and the trust established between Child E and WMP. Child E continued to reside with family members. At this meeting, WMP explained that they had identified suspects and intended to arrest and interview them.
- 8.206 Minutes from a high risk strategy meeting late that year recorded that Child E’s social worker had been absent from work for three and a half weeks and that, due to this, actions had not been completed.²⁰⁴ The social worker was therefore unable to update the meeting in respect of the CSE support plan for Child E. Concerns were also raised about whether Child E could be sufficiently protected by the family members she was living with at the time.
- 8.207 By early the following year, Child E was disengaging with Safeguarding/CATE but the grooming by males that were identified as presenting a risk continued. Child E’s CATE practitioner believed that Child E had disengaged possibly as a consequence of the heavy police intervention, and Child E viewing the CATE work as an extension of this.²⁰⁵ Further work was put in place to support her family members and provide guidance about what to do, and who to contact, if Child E went missing; regular CATE practitioner meetings and strategy meetings were scheduled.²⁰⁶ After a multi-agency CSE risk assessment had taken place, Child E’s difficulties in engaging with professionals was discussed and, due to her continued grooming by males,²⁰⁷ consideration was given to escalating the case to an Initial Child Protection Conference,²⁰⁸ but it was decided that her case did not meet the threshold.²⁰⁹
- 8.208 At a meeting in Spring of the same year, Child E’s risk to CSE was assessed as “acute” and it was incorrectly said to be due to her “lack of engagement”, as opposed to the actions of

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An Initial Child Protection Conference is to be held where, following a Strategy Meeting and Section 47 child protection enquiries, concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm.

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those seeking to abuse her.²¹⁰ However, the CSE support plan was being adhered to. It was agreed that if Child E continued to follow the plan and there were no further concerns of her being exploited, her case could be stepped down from a Child In Need status. This was very soon (approximately six weeks) after the harm Child E had experienced; the level of CSE perpetrated considered to be so serious at that time that an Initial Child Protection Conference was considered. This meeting put far too much responsibility onto the shoulders of Child E, both for the abuse that she had experienced and for keeping herself safe. This action told Child E that, by engaging with CATE and adhering to the CSE support plan, she would be able to stop the CSE from happening to her; this was inappropriate and untrue and took away the importance of holding the many perpetrators of CSE responsible. This was exemplified by this decision: "*if [Child E] sticks to the identified CSE support plan and [there are] no further concerns in respect of [Child E] being exploited then we can look at stepping her case down*".²¹¹ This meeting showed a mismatch between Child E being described as being at "*acute risk of harm through CSE*", and yet continuing with the ongoing Child in Need status, which was focused on addressing unmet needs, not on the risk of harm.

- 8.209 WMP arrested, interviewed and released on bail suspects they had identified through their investigation concerning Child E.²¹² However, Child E was not able to engage with the police investigation (the reasons for this were not explored) and evidence indicates she continued to be groomed by the perpetrators and other males identified as presenting a risk.²¹³ What needed to be done to address this was also not discussed. Child E reported being scared of the consequences of sharing information with WMP.²¹⁴ This does not appear to have been sufficiently explored, but action was taken by WMP to increase the family's safety.
- 8.210 In the second half of the year, Child E provided her first witness statement to WMP outlining the nature of the exploitation she had been subjected to.²¹⁵ Shortly after this interview, she also disclosed that she had been subjected to a further serious sexual assault.²¹⁶ The CATE Team completed a 'safe and well check' and concerns were raised that the CSE support plan was not being adhered to by the family members she was residing with.²¹⁷ Subsequently, it was agreed that Child E's case met the threshold for a joint section 47 investigation, with the additional police and social work support that this provided.²¹⁸
- 8.211 Shortly after her police interview, Child E voluntarily moved into supported accommodation to enable her to live independently.²¹⁹ By the following year, Child E did not feel able to engage with CATE or her ISVA (who was providing pre-trial counselling). She was also

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struggling to report her whereabouts to staff at the accommodation and her attendance at college declined.²²⁰

- 8.212 Child E started to go missing again during this period; on one occasion she was located by WMP with an older male at a location previously identified as a CSE risk.²²¹ The male was subsequently arrested on suspicion of trafficking a minor.²²²
- 8.213 Approximately six months later, a CATE assessment recorded that there had been a significant change in Child E's engagement with professionals and she was presenting as "*withdrawn, distant and reluctant to engage*".²²³ The changes coincided with Child E's continued contact with an older male and she was going missing from her accommodation and returning during the early hours of the morning. During this timeframe, missing episodes involving this older male continued.²²⁴
- 8.214 Child E was already being supported by an ISVA at this time, but it was agreed that counselling would also be explored.²²⁵ It appears from the action taken that Safeguarding was trying to engage Child E in a number of therapeutic services to assist Child E with her emotional wellbeing.
- 8.215 In a professionals' meeting shortly following this, it was reported that there were no ongoing CSE concerns.²²⁶ However, Child E indicated that she wanted the continued support from her social worker, CATE practitioner and her ISVA.²²⁷ At this stage, Child E's case was closed to the high strategy support meeting, but a multi-agency support plan remained in place and allowed support to continue.²²⁸
- 8.216 Shortly after this, Child E disclosed further historical CSE offences which had been perpetrated by the same males who had transported her to another city.²²⁹ She provided WMP with further witness statements in respect of this.²³⁰
- 8.217 There were criminal convictions that resulted from the disclosures made by Child E.
- 8.218 The CATE Team supported Child E throughout the criminal justice process and this continued post trial for a short period of time. When Child E's case was closed to the CATE Team, Child E was maintaining employment.

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Summary

The Council

- 8.219 Child E was known to the Council as being at potential risk of CSE from the age of 12. She was referred to the Safeguarding team by WMP, due to concerns that she was visiting the home of an adult with a group of other children who were believed to be at risk of CSE; that report contained some concerning details. Child E was referred for an initial social worker assessment as a result and three and a half weeks later a joint strategy meeting relating to all of the children concerned was held. This should have been convened under the complex abuse procedures outlined within Working Together 2010 and individual strategy meetings held for each individual child. As it was not, the meetings held (there were two joint strategy meetings) failed to address fully each individual child's circumstances, because there was only a short amount of time available, and also failed to think more carefully about mapping connections. Child E was referred to the CATE Team for the CATE Pathway to be instigated. The CATE Pathway is explained in more detail in Chapter 3: The Council Response to CSE in Telford.
- 8.220 Although a strategy meeting took place fairly promptly and the referral for an initial social worker assessment and referral to CATE was also made, the actions that followed were however concerningly slow. It took approximately three and a half months for a social worker to conduct the initial assessment. The assessment was conducted with Child E's parents only; it does not appear there was any discussion with Child E or information provided by the WMP. A further group strategy meeting then concluded again that a referral should be made to CATE and that the initial assessment had highlighted that the child protection case should be closed on the basis that Child E's parents were "very proactive". It is unclear from the documents the basis upon which this conclusion was reached as insufficient detail was provided, but the strategy meetings and the initial assessment made no reference regarding long term concerns of neglect which would have brought into question whether her parents/carers could and would work proactively to keep Child E safe; evidence prior to this, and subsequently, suggested that Child E's parents were not always proactive or cooperative.
- 8.221 The CATE referral also took a long time to be followed up. It appears that there was four months between the point of referral and this being actioned. A visit was arranged, but never took place as CATE were unable to get in touch with Child E's parents to obtain consent and the CATE was closed; yet these were parents who a few weeks earlier had been assessed as being "very proactive", leading to the child protection case being closed.
- 8.222 Beyond that, there are no documents that demonstrate what work, if any, was undertaken by Safeguarding and/or the CATE Team during this early period to address the risks of CSE. This was despite the concerns raised by WMP and the lack of response from Child E's parents. This case study demonstrates the vulnerability of the CATE Pathway to issues such as lack of consent. It also does not appear that the Council conducted any further follow up with WMP at this stage to consider to what extent the risk of CSE still persisted. Had intervention work taken place at this earlier stage, it is possible that Child E could have been protected from further CSE. I consider this was a missed opportunity. The Council's CSE procedures make clear that where there are concerns about parents in the context of

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CSE the child should be referred to the Safeguarding team. This did not happen here; the lack of contact from parents should have prompted this referral to Safeguarding by the CATE Team.

- 8.223 It was two years later when concerns began to escalate again, with a series of missing episodes, and a referral was made to TYS. Child E's school was also raising concerns and, following further missing episodes, WMP made a formal disclosure to the Council; WMP assessed Child E as being at high risk of CSE. It was at this point that another CATE referral was made. A referral to CATE had been considered a few months prior, following an incident when Child E disclosed a male had touched her, which made her feel uncomfortable, but Family Connect did not consider this met the CATE threshold; yet the CATE referral form completed just a few months later referred to this incident (amongst others) as one of the reasons why Child E was at high risk of CSE and required CATE intervention.
- 8.224 It is unclear whether the Council was aware of all the concerns held by the school and WMP prior to this; if they were not, there was a failure in information sharing; if they were, there was failure to properly assess Child E as meeting the CATE threshold. To make matters worse, the referral was not immediately transferred to the CATE Team, resulting in a delay of approximately three weeks. In the intervening period, during a 'Return Home Interview' following a missing episode, Child E reported having been with an older male overnight. I consider this represents another missed opportunity.
- 8.225 Child E was then made subject to Child in Need processes and a Child in Need plan was formulated. This process appears to have operated in tandem with the work of the CATE Team and although there were regular Child in Need reviews, the plan did not change significantly over the next two years, despite the changes to Child E's circumstances and risk level. The Child in Need plan and reviewing mechanisms should have been an opportunity to fully consider Child E's needs. Instead, as in many of the meetings, the focus was on Child E's responsibility to keep herself safe and engage with the many professional processes in place. This gave the impression that Child E was somehow responsible for her own safety, not her parents, her carers or professionals; the implication was that her compliance with the plans would prevent the abuse she was experiencing and keep her safe. This was both false and dangerous; it let those who were responsible for perpetrating the harm off the hook, and indicated unhelpful victim blaming.
- 8.226 Matters continued to escalate, with Child E being trafficked to another city. From this point onwards, there was heavy engagement from the various agencies, including WMP initiating a criminal investigation. A section 47 investigation was also initiated and supported accommodation offered to Child E, which was refused. When it became clear that Child E was still being groomed by her perpetrators, a care and secure order were discussed and a specialist residential unit was found for Child E, but in the absence of Child E agreeing to attend the unit, the Council and WMP agreed that obtaining such an order would damage the trust established between Child E and WMP, and could potentially impact the criminal investigation and subsequent prosecutions. While these were factors that should be considered, I am concerned that the safety and welfare of Child E was not the paramount consideration, as it should have been. Child E clearly remained at significant risk and yet continued to reside with family members, when concerns existed about whether they could adequately protect her; and Child E continued to be abused. There may have been too

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much reliance placed on the family and not enough placed on formal child protection procedures to keep Child E safe.

- 8.227 There then followed a period when Child E felt unable to engage with those that were seeking to support her. The evidence suggests that agencies, including the Council, were concerned and were doing what they could to re-engage Child E, for example trying to put in place regular meetings, but this proved difficult.
- 8.228 Child E did however re-engage with agencies and began feeling able to cooperate with the police investigation. The Council supported her through this process and the evidence shows positive work was done, including putting in place important services to provide Child E with the necessary support.
- 8.229 A review of the evidence does give the perception that professionals viewed Child E's difficulties with engagement as being the problem and this being what caused her to be at high risk of CSE. This is incorrect and suggests victim blaming. There was a lack of recognition of the grooming process – it was not once mentioned in the many documents relating to this case - and the costs and consequences to Child E of speaking to the police. Instead of constantly putting Child E under pressure to 'comply', more thought needed to be given to why she felt unable to engage and what, or who, she was afraid of. It concerns me greatly that the responsibility for her abuse and safety was left on her shoulders, rather than holding perpetrators responsible. There is no mention of the perpetrators in the context of strategy meetings. This is exemplified by the comments from one of the meetings: "*if [Child E] sticks to the identified CSE support plan and no further concerns in respect of [Child E] being exploited then we can look at stepping her case down*". Support plans and work with CATE, or any other service for that matter, does not stop adults abusing children, and suggesting this is the case makes the child feel it is their fault.

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- 8.230 WMP first become aware of Child E and other children being at risk of CSE when Child E was aged 12. WMP acted swiftly on a number of occasions to provide organisations with relevant information about the potential risk of CSE. This began in the early 2010s, when WMP made a formal disclosure to the Council about the information they were aware of and the potential risks to Child E. They again raised similar concerns four years later. WMP also appears to have communicated well with Child E's school at this time when there were continuing concerns about exploitation.
- 8.231 WMP's involvement significantly increased after Child E was reported missing. WMP confirmed that the case was being investigated and an NRM referral was instigated.
- 8.232 Although Child E felt unable to engage with agencies, there is also evidence of proactivity on the part of WMP to keep in contact with her; this includes the tenacious work of one officer to keep Child E informed, even when this was proving difficult.²³¹

²³¹ [REDACTED] pg 50, [REDACTED]

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- 8.233 The documentation also shows that WMP was proactive in putting in place a CSE trigger plan/road police support plan in an attempt to safeguard Child E and disrupt the perpetrators, following intelligence she was still in contact with them.²³²
- 8.234 The police investigation into Child E's disclosures also demonstrated partnership working with other regional forces, as a police operation was formed that required cross border policing with WMiP.
- 8.235 The police investigation also led to the charge of suspects in difficult circumstances, with a complex investigation which was commenced in the absence of Child E's support.²³³

Other Agencies

- 8.236 The school's concerns escalated after the EWO addressed poor attendance with Child E and her home life. Due to these concerns, a referral was made to Family Connect. This was a proactive response from the school in recognising and relaying concerns to the relevant authorities at an early stage.
- 8.237 Notwithstanding this, indicators of CSE were only identified by her school four years after the first indicators of CSE were identified. By this time, Child E had already been referred to CATE. Given that, by the mid-2010s, recognition and knowledge of CSE was well established within Telford, it appears that the professionals at the school were still not recognising and/or reporting the signs of CSE quickly enough.
- 8.238 Child E's CATE file was closed during the early period, but with the hope that the school would keep an eye on her. It is not clear if, or how, this happened, and the Inquiry has not seen any evidence of this nature. What is clear however is that Child E remained under the radar of agencies for two years.
- 8.239 The records indicate that Child E attended her GP at the age of 15 after having unprotected sexual intercourse with a casual partner; she attended with a family member.²³⁴ It is unclear whether the GP was in the possession of any other information that indicated there could be CSE concerns or risks. If the GP was not, and did not have any concerns about how Child E was presenting, one would not necessarily expect this attendance to cause the GP to automatically make a referral to the Council's Safeguarding team. Having said that, had the GP been informed that there were concerns about the vulnerability of Child E, this may have prompted such action.
- 8.240 Child E received pre-trial counselling and records indicate that Child E initially embraced this support.²³⁵ A change in staffing however meant Child E was asked to build a relationship with a new worker at a crucial time in the criminal justice process. This resulted in disruption to the service as Child E struggled to engage with her new worker. Child E's CATE

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pg 10
pg 9
pgs 2-3

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practitioner assisted in the process and the records indicate Child E engaged for a period with a new ISVA.

- 8.241 The Inquiry has not been able to assess the full extent of the ISVA's involvement in this case, as the service provider was unable to fulfil a request for disclosure in this case. It confirmed that it was unable to share information without a client's consent, as this would be breaching their trust; trust being a key principle of their service. As has been referred to in earlier in this Report, I made a deliberate decision not to contact victims and survivors unless they indicated they wished to engage with the Inquiry, and this included contacting them to seek their consent for records to be provided. I have therefore not been able to fully assess this element of the support provided.

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Case Study - Child F (mid 2010s)

Timeline



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Overview

- 8.242 Child F had been known to the Council from the age of 13 due to instability at home, particularly related to an allegation from Child F that a family member had been sexually inappropriate towards her and her parents had contacted the Council due to the conflict this caused.²³⁶ It appears that the allegations were not probed further, but support was offered from TYS to address issues related to family relationships and conflict and "support... around CSE".²³⁷ The allocated TYS worker subsequently was not in work for some months and therefore the family relationship and conflict work did not take place. Child F went to live with another family member at this time.²³⁸
- 8.243 Child F had initial contact with the CATE Team due to the allegations raised, as well as concerns that she was in a sexual relationship. The CATE Team arranged for Child F to complete some CSE awareness sessions, which included the topics of sex, relationships and CSE. A CSE educational DVD was shown to her, titled "What is Child Sexual Exploitation?" The CATE file was closed approximately four months later, following completion of the awareness sessions and the view by Family and Cohesion Services that matters had "settled".²³⁹ At the time Child F was living with family members who it was felt provided stability and boundaries.
- 8.244 Approximately nine months later, Child F once again came to the attention of TYS, due to a referral from a family member. The records show that the Council was notified that Child F had taken an overdose and it was reported that she was associating with a "high risk CATE young person". Child F was taken to the sexual health clinic by her TYS worker; TYS then conducted a home visit to try and instigate a CATE referral and "discuss family life", but this proved unsuccessful, with the visiting TYS worker reporting tensions in the home. The TYS worker asked Child F's parents to contact them when they were less "busy".²⁴⁰ The record of contact does not make clear whether any discussion regarding a CATE referral took place, but the follow up action notes state that a CATE referral should be discussed with management and the CATE Team.²⁴¹ The records suggest that at this stage no CATE referral was actually made.
- 8.245 In the weeks after this visit, Child F struggled to attend school and her teachers noticed a change in her appearance and behaviour. These concerns were raised with the Council by Child F's school.²⁴² Within this same period of time, Child F also made attempts to harm herself and was referred to CAMHS.²⁴³ At this time Child F had to leave home again, which led to more instability.

236 [REDACTED]
 237 [REDACTED] pgs 11-12, [REDACTED] pgs 287-288
 238 [REDACTED]
 239 [REDACTED] pgs 280-301
 240 [REDACTED] pgs 316, 333 and 335
 241 [REDACTED] pg 335
 242 [REDACTED] pg 337, [REDACTED] pg 2
 243 [REDACTED] pg 75

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- 8.246 In the weeks following this, Child F was excluded from school and went missing from home.²⁴⁴ Child F then disclosed that she had been raped during the missing episode of a few days earlier.²⁴⁵ WMP became involved. The records reviewed by the Inquiry also indicate that WMP's Harm Assessment Unit ("HAU") referred the rape allegation to Family Connect.²⁴⁶ The evidence disclosed indicates that this allegation of rape was the first time WMP had any involvement in Child F's case.
- 8.247 On the same day that Child F made the disclosure, the Council received information from Child F's parents that Child F had been associating with older Asian men, had been groomed and was potentially the victim of sexual offending.²⁴⁷ The TYS worker visited Child F's parents the following day to discuss further.²⁴⁸ A CATE referral was then made a few days later, due to the disclosure and information received.²⁴⁹
- 8.248 The CATE Team met with Child F just over a week after the referral was received, although telephone contact had been made with Child F's family and school prior to this.²⁵⁰ The day before this first meeting, further concerns had been communicated to the TYS worker by a family member who explained that Child F was being forced into associating with an Asian gang in the area.²⁵¹
- 8.249 During the meeting with the CATE Team, Child F expressed that she did not believe she was being exploited and felt that she was safe: "*They are her close friendship group... [Child F] states that she does not feel she is unsafe and that she can look after herself*".²⁵²
- 8.250 On the same day, a multi-agency child strategy meeting was held by the Council, which was attended by representatives from a number of agencies, including WMP.²⁵³ At this meeting, more information was provided about the risk of CSE to Child F, and WMP also confirmed the rape allegation was being investigated (although there did not appear to be any identifiable link between this particular incident of rape, and Child F being the victim of CSE). It was agreed that a section 47 investigation and a CATE risk assessment should be carried out in respect of Child F and the wider risks of CSE identified.²⁵⁴ The Inquiry understands that, around this time, there were tensions between CATE and Safeguarding due to difficulties in information sharing arrangements.²⁵⁵

244 pgs 51-53, [REDACTED] pg 2
 245 pg 2
 246 pgs 59, 62 and 341
 247 pg 342
 248 pg 3
 249
 250
 251
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 253 pgs 1-5, [REDACTED] pgs 1-7
 254 pgs 16-17, [REDACTED]
 255

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- 8.251 Later that evening, further information was provided to Child F's TYS worker by a family member, explaining that an Asian male had visited Child F at her home address and that Child F had been returning home with new items.²⁵⁶
- 8.252 Almost immediately, Child F went missing again and further serious concerns were raised by family members about the older males she was with.²⁵⁷ As a result of these disclosures, WMP intervened and within a matter of days Child F was moved out of the Telford area to live with family members,²⁵⁸ although her family were not told the reason that she had been moved there. Whilst located out of area, the Council decided to continue to support Child F through the continued provision of a CATE practitioner, and a social worker from the Council also visited,²⁵⁹ although there were delays in these visits taking place. Child F reported feeling left without help. Child F had been assessed as high risk of CSE.²⁶⁰
- 8.253 During this period of time, Child F made disclosures to WMP and her CATE practitioner that she had been sexually active with one of the older males she had been associating with.²⁶¹
- 8.254 Approximately three weeks after this disclosure, WMP and a CATE practitioner planned to conduct a joint visit to meet Child F at her new address.²⁶² The visit was however deferred as Child F attempted to harm herself again and a CAMHS assessment was undertaken.²⁶³ Child F had previously been seen by CAMHS following the earlier referral, but did not attend the follow up appointment. Arrangements were made to forward on the details to Child F's new address, although there was some delay in this happening.²⁶⁴
- 8.255 Around three weeks after Child F was moved out of the area, WMP provided the local police force with a full CSE risk assessment for Child F evidencing all information you would reasonably expect to be shared.²⁶⁵ COMPACT records were also emailed to the local force the same day, allowing them to produce a duplicate on their system.²⁶⁶ The 43 police forces across England and Wales do not share the same policing systems, meaning information sharing of this nature is of paramount importance. Despite this being evidence of good information sharing between forces, there was still a delay of three weeks; as Child F was assessed as being at high risk of CSE, this should have happened immediately.
- 8.256 WMP kept in contact with Child F and made a joint visit to see her with her CATE practitioner.²⁶⁷ At this meeting and in the days that followed, Child F made further disclosures concerning grooming and abuse by an older male.²⁶⁸

256 [REDACTED] pgs 8-9
 257 [REDACTED], pg 3, [REDACTED] pg 11
 258 [REDACTED] pg 1
 259 [REDACTED]
 260 [REDACTED]
 261 [REDACTED] pg 23
 262 [REDACTED] pg 2
 263 [REDACTED], pg 15
 264 [REDACTED] pgs 75-76
 265 [REDACTED] pg 1
 266 [REDACTED] pg 14
 267 [REDACTED] pgs 1-3
 268 [REDACTED] pgs 23-24

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- 8.257 In the three weeks after this visit, family members caring for Child F expressed concerns to WMP and her CATE practitioner that they were unable to keep Child F safe.²⁶⁹ Child F was not feeling able to attend school and also informed her CATE practitioner that there was more she wanted to disclose.²⁷⁰ WMP records indicate that Child F's social worker was considering the option of a therapeutic foster placement, but Child F remained with family members to try and resolve the issues. It is unclear from the evidence the basis of this decision. There was also a change in Child F's allocated social worker at this time.²⁷¹
- 8.258 Within days of this discussion, WMP conducted its first formal police interview with Child F, during which Child F disclosed being the victim of a number of serious sexual assaults facilitated and/or perpetrated by the group of males she had been associating with.²⁷² This exploitation had occurred over several months and commenced a few months before her most recent CATE Team referral. WMP conducted a total of four interviews with Child F over a three month period.²⁷³
- 8.259 In the days that followed her first police interview, Child F was accommodated by a different family member. She went missing from this accommodation with an unknown male.²⁷⁴ In the days after this missing episode, Child F's social worker conducted a risk assessment regarding her placement. The assessment outlined that no placements near her family could be found because of her risks, and no other suitable placements in other regions were available. Child F was deemed at high risk of absconding from any placement, particularly in Telford. The assessment concluded that a specialist CSE placement would be positive for Child F, as it would provide the specialist support required and help to reduce her risk.²⁷⁵ A possible CSE placement was identified. The Council discussed this assessment with WMP who agreed a placement in the Telford area would be inappropriate.²⁷⁶
- 8.260 Within a week Child F moved to her third placement. This placement was outside the Telford area, but was not a specialist therapeutic/CSE placement.²⁷⁷ From the evidence it is unclear why this was the case, but I presume that no specialist placement was available at that particular time. Child F was still being assessed as at high risk of CSE.²⁷⁸ The records indicate that Child F's CATE practitioner visited her 11 times (including several visits to her school) whilst she was at this placement.²⁷⁹
- 8.261 The placement was however problematic; Child F went missing, and concerns were expressed in relation to continuing exploitation; the evidence suggests staff were struggling to cope and a professionals' meeting was requested.²⁸⁰ During a meeting with her CATE

269	pg 13
270	pgs 1-2
271	pg 12
272	
273	
274	pgs 11-12
275	
276	pg 11
277	pg 11
278	
279	pgs 1-3
280	pgs 47-48

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practitioner around this time, Child F also reported that she was struggling emotionally and requested more therapeutic input to deal with what had happened to her.²⁸¹ A multi-agency child exploitation risk assessment meeting took place, with this meeting highlighting concerns that the placement was not suitable for Child F.²⁸² Child F also reported feeling under supported and under pressure due to police action.²⁸³

8.262 The placement served Child F with notice approximately two weeks later as they did not feel able to keep her safe. Notwithstanding this, and as circumstances had settled, a decision was taken that she remain at the placement.²⁸⁴ Child F however continued to go missing; it was reported that Child F had "*potentially been in a risky situation*".²⁸⁵

8.263 Around this time, WMP was also contacted via email by the vulnerability team of the local force who raised concerns:

*"I also need to raise the frustration we have had with not being fully aware of (Child F's) history and the enhanced risks that raises. We seem to have been having to play catch up."*²⁸⁶

8.264 Child F however remained in the placement for a further month. Child F's social worker raised concerns about her remaining in this placement for a number of reasons, including Child F's access to social media, vulnerability to other males and Child F not feeling happy there. In an email to her manager and Child F's CATE practitioner, her social worker suggested another placement be located.²⁸⁷ A new placement was not located immediately, but the placement ended following a further missing episode and involvement with the police.²⁸⁸

8.265 As a result, the Council was forced to seek emergency accommodation for Child F.²⁸⁹ Child F moved to another placement in a different town. This was the fourth different placement for Child F. It was not a specialist therapeutic CSE placement and was intended to be temporary.²⁹⁰

8.266 During a multi-agency assessment meeting around this time, the Council assessed Child F's risk of CSE as 'high'. The Council also indicated they were still seeking a psychological assessment.²⁹¹ This had initially been raised approximately three months previously and the evidence suggests an assessment still had not been completed.

281 [REDACTED] pgs 42-43
 282 [REDACTED]
 283 [REDACTED] pgs 48-49
 284 [REDACTED] pgs 8-9
 285 [REDACTED] pgs 64-66
 286 [REDACTED] pg 9
 287 [REDACTED] pgs 69-71
 288 [REDACTED] pg 8
 289 [REDACTED] pg 72
 290 [REDACTED]
 291 [REDACTED] pgs 29-30, [REDACTED], pg 7

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- 8.267 A month later, the CPS decided not to authorise any charges in respect of the complaints Child F had made and Child F began to disengage with the CATE Team.²⁹²
- 8.268 The following month, the Council reduced Child F's risk assessment to 'vulnerable' to CSE and Child F started to work with an in-house psychotherapist. A local CAMHS referral was also discussed.²⁹³
- 8.269 A couple of months later, the CATE Team informed Child F that it was time to close the CATE case and a few follow up sessions were arranged.²⁹⁴ The primary reason provided for closing the file was that Child F's risk assessment had now been reduced to 'vulnerable' to CSE, her having moved placement and there were no factors to suggest she was at risk of, or being, exploited.²⁹⁵ This was despite the fact that only a couple of months earlier Child F's risk was assessed as 'acute'. It is noted that this was just a few months after the CPS decision not to charge any suspects and the end of the police operation, but it is unclear whether this had any impact on the decision to close the file.
- 8.270 Child F was then given notice to leave her placement the same month due to her behaviour and was placed in emergency foster care in Telford.²⁹⁶ This was Child F's fifth placement. I have not seen any documents that suggest the Council saw an issue in moving Child F to Telford at this time, even though previous assessments only ten months earlier indicated that the risks were too great for her to move to the area. The following month, there were however internal emails between Council staff which suggests that the plans for Child F's accommodation were still being considered.²⁹⁷
- 8.271 A Council risk assessment in the same month assessed Child F's risk of CSE as 'low' and shortly following this Child F was moved to a residential placement in another county.²⁹⁸ Child F's CATE file was officially closed approximately three months later.²⁹⁹

Summary

The Council

- 8.272 The Council knew of Child F and her family when Child F was aged 13, when concerning allegations were made in respect of sexually inappropriate comments and family conflict issues. As a minimum, this should have led to an assessment of the family and some form of action. Instead, Child F moved to live with another family member and no work was completed regarding family relationships or potential trauma to Child F. After that, Child F was moved from home to home and placement to placement, causing massive instability. It is clear from the evidence that Child F's psychological distress was not addressed early

292 [REDACTED] pg 7, [REDACTED] pg 78
 293 [REDACTED] pgs 29-34
 294 [REDACTED] pg 81
 295 [REDACTED] pg 34
 296 [REDACTED]
 297 [REDACTED]
 298 [REDACTED] pg 6
 299 [REDACTED] pg 2

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enough and, by the time it was, Child F had suffered significantly at the hands of her groomers and abusers.

- 8.273 There had been previous CATE intervention in the year before Child F's first CSE disclosure was made. She was shown education/awareness videos on sexual behaviours and CSE. Following the completion of the awareness sessions the file was then closed.
- 8.274 There was then a failed attempt at a further CATE referral, where the social worker who attended her address had difficulty in speaking to Child F's parent. The evidence suggests the social worker therefore left the address and asked Child F's parents to make contact; but I have seen no evidence that there were further attempts made to contact the family or initiate the CATE referral, although TYS were supporting Child F at this time. This was despite the fact that information was starting to be received, for example from the school, which suggested that Child F could be at increased risk. This case study again demonstrates the vulnerability of the CATE Pathway to issues such as consent. The referral pathway suggests that where there are concerns about family, then the work should be undertaken by a social worker rather than via the CATE Pathway. This should have been instigated immediately.
- 8.275 The Council however responded quickly to the disclosure that Child F was a victim/being groomed for CSE, once received. A CATE referral was made within a day of the disclosure and the CATE Pathway initiated.
- 8.276 From that point onwards, Child F was regularly visited by her CATE practitioner, including when she was living in placements out of area, despite the geographical challenges. The Council accepted responsibility for Child F in circumstances where she moved from their local authority area, and there was a clear commitment to this. The family to whom Child F moved were not however initially told why she needed to be accommodated and the vulnerabilities that existed, and there had been no contact from local Safeguarding. Child F's CATE practitioner did support Child F through joint visits with WMP, an approach that would have assisted information sharing between the agencies. Having said that, after Child F's first move out of area following the disclosures of exploitation, the CATE Team took over three weeks to visit Child F in her new surroundings, even though Child F had told the CATE practitioner that there was something she wanted to speak to her about.³⁰⁰ Delay may have had a negative impact on Child F and the family members that were committed to supporting her, as they would have needed support and guidance in that respect. This delay was caused when the CATE practitioner asked if she should visit, but was advised to wait until WMP had given the "go ahead" to meet with Child F, so that this could be coordinated.³⁰¹
- 8.277 As regards the multiple placements and disruption to Child F's accommodation, it was evident that Child F was in need of a therapeutic placement but it was never found, despite the failure of multiple placements due to her complex needs, and family/staff not being able to cope and protect her. Stable and suitable accommodation for Child F may have

³⁰⁰ [REDACTED] pg 17
³⁰¹ [REDACTED] pg 17

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significantly reduced her vulnerability while she remained at risk of CSE and during the police investigation.

- 8.278 There were also issues in how the Council communicated with Child F's family who she stayed with for a period. It does not appear that the Council immediately made the family aware of Child F's history and the continuing risks posed to her.³⁰² This was repeated when Child F moved to live with other family members, and again Child F's background was not communicated to them. This made it impossible for them to take steps to adequately protect her.³⁰³ For example, Child F was provided with a mobile 'phone. This left Child F vulnerable to exploitation and ultimately it was WMP which had to have these difficult conversations with the family.

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- 8.279 The evidence suggests WMP knew little about Child F prior to her disclosures of CSE.
- 8.280 Once the CATE referral had been made and disclosures of CSE received, WMP were an integral part of the multi-agency approach to the concerns about Child F and attended the first child protection strategy meeting.
- 8.281 Following a concerning missing report after the CATE referral had been made, WMP acted swiftly in protecting Child F, and she was moved out of the area. It is also clear that WMP communicated with the Council and attended joint visits to see Child F after she moved and before Child F had made formal CSE disclosures. To this extent, the partnership work appears effective and coherent, the success of which is of note.
- 8.282 When Child F was moved out of county, WMP did communicate a report detailing concerns about Child F to their counterparts in that county. Again, this was positive, although there was a three week delay. However, when Child F was later relocated to another county, WMP failed to communicate any information to their counterparts on this occasion; it is unclear whether they thought others would, but as the investigation team, who were still in contact with Child F, I consider it was WMP's responsibility.
- 8.283 WMP did actively commence a criminal investigation and kept in contact with Child F. The evidence suggests Child F had a tendency to go missing directly after police interviews and there is evidence that shows Child F was understandably concerned about being interviewed and it led to feelings of self-harm. There is however no evidence that structured therapeutic support was offered to Child F by, or on behalf of, WMP during the investigation. As ABE interviews are understood to be joint police and Safeguarding interviews, it was the responsibility of both agencies to plan the ongoing care and support for the victim post interview. In cases involving CSE allegations, the route to immediate pre and post interview support should be easy to access and clear. If support of this nature had been available, it may have prevented Child F feeling the need to run away or to self-harm.

³⁰² [REDACTED] pg 17
³⁰³ [REDACTED] pg 44

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CAMHS

- 8.284 Child F was referred to the Telford CAMHS team by her GP. This was during the period she reported being exploited. Child F was assessed the following month and referred for some individual work from the Telford CAMHS team. The appointment was arranged but Child F did not attend. Telford CAMHS contacted Child F's social worker and were informed that Child F had moved out of the area to live with family. At this stage, Child F's social worker also raised concerns about Child F wanting to harm herself again.
- 8.285 The evidence suggests that Telford CAMHS were however slow to cross refer Child F to her new area. They sent a letter of cross referral approximately one month after they received information she had moved. This was also the day before Child F harmed herself. I have heard evidence during the Inquiry about CAMHS services being stretched and capacity being an issue and therefore I am sure this delay was not due to a lack of urgency. That said, it was clear that Child F was vulnerable and was at continuing risk of self-harm, and ensuring the right support was given to her as soon as possible should have been made more of a priority. The evidence I have heard is that the value of this support for children should not be under-estimated.

Case Study Themes

- 8.286 In respect of each of the case studies reviewed above, a series of individual findings have been made in relation to the response of organisations to CSE, or suspected CSE, including the nature, adequacy and timeliness of any response, and any missed opportunities. These are of course specific to each individual case. It has however also been important to consider whether there were any particular themes, or issues in common, across the case studies.
- 8.287 During the earlier period of these case studies, namely from the late 1990s and early 2000s, up to around 2010, in particular I have found as follows:
- 8.287.1 The welfare of the child at risk, the victim, has not always been the focus of agency response. Many of the agencies who interacted with these children focused on their behaviour, how this could be addressed, and support for their families in dealing with the child, but showed little or no interest in identifying the root cause of their behaviour or working with them. That includes attitudes displayed by the Council's Safeguarding team, WMP and schools; and
- 8.287.2 The attitudes towards children engaging in sexual activity was dismissive in a number of cases. My impression from reviewing these cases is that, during the earlier period, there was a widespread view amongst all agencies that sexual activity by children was essentially a matter of choice; and that where there was no sign of family abuse or violence there was no proper role for official intervention, beyond expression of resigned disapproval. In one case a child of 13 years of age was reported as having "*sex with consent*".³⁰⁴ At a minimum, depending on which agency was in receipt of this type of disclosure, this should have resulted in a referral to the Council or a crime being reported to WMP.

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Some of the attitudes seen in the evidence is concerning and they do not sit comfortably; for example a 13 year old being referred to as a "*sexual predator*".³⁰⁵ The impression given is that these attitudes may have resulted in concerns not being treated sufficiently seriously. It is however important to note that these attitudes were particularly acute during the earlier period; namely the late 1990s and 2000s. From other evidence I have seen, including the case studies from the later period, I consider that the attitudes have softened over time, but were still present in the more recent cases reviewed.

- 8.288 Across the case studies, the key principle, as set out in the Children Act 1989, that "*the welfare of the child is paramount*"³⁰⁶ appears to have been absent in much of the decision making.
- 8.289 In some of the cases there is evidence of drift and delay in safeguarding responses when children were known to CATE.
- 8.290 The evidence of 'Significant Harm' (as defined in section 47 of the Children Act 1989) was evident for all of the case studies; they deserved to be more effectively safeguarded, using the well-established safeguarding processes and principles that have been in place for several years and which were, and should remain, as a 'child centred' system.
- 8.291 The Sexual Offences Act 2003³⁰⁷ represented a major overhaul and review of the Sexual Offences Act 1956. It outlined a legal framework for sexual offences against children and the framework for consent to sexual activity and made clear the range of sexual offences by an adult against a child. A number of these cases required action as outlined under this legislation, but I have seen no evidence that the Act was discussed or that consideration was given to its significance within the context of these cases.
- 8.292 In respect of WMP in particular, the case studies show that there was a reluctance to investigate the wider concerns that were emerging from intelligence concerning CSE. That includes failing to act on intelligence that was developing in the late 1990s, failing to identify clear patterns of CSE offending from reports concerning children and, at the latter stages, not wanting to approach historical victims and bring their perpetrators to justice, which would also prevent future offending. The focus appears to have been on addressing specific incidents, rather than looking strategically at the future protection of children and how that could be tackled more broadly. I have seen references to the fact that CSE was not understood then, in the same way it is today. That is of course true and WMP may not have identified what was happening as 'CSE' and understood the full extent of how vulnerable these children were; but regardless, there was evidence of crimes being committed and children being harmed, and action should have been taken.
- 8.293 The case studies that relate to complaints received by WMP after the conclusion of Operation Chalice – so post 2011 – show that WMP were however more responsive to the issue of CSE. They responded by investigating allegations and communicated concerns to the

³⁰⁵ [REDACTED] pg 84

³⁰⁶ Children Act 1989 (legislation.gov.uk)

³⁰⁷ Sexual Offences Act 2003 (legislation.gov.uk)

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Council where children were seen as at risk. There are also examples of WMP communicating well with schools and support services.

- 8.294 There is no doubt that the response of agencies, particularly the Council and WMP, has changed over the period relevant to the Terms of Reference. The later case studies show concerns being explored, various routes of support being provided and a much more proactive approach. I have seen positive evidence of successful multi-agency working. So it is clear that an understanding of CSE, and how to support and protect those at risk of CSE, has moved on.
- 8.295 In respect of health services, I have had challenges with obtaining clear and complete evidence in all cases due to the availability of information, which means clear conclusions are harder to reach. Based on what I have seen, I have however identified a concerning passive role. In only one case was a referral to Safeguarding made by a health professional (an A&E doctor). Similarly, in some of the case studies the schools have played a passive role, failing to make referrals to child protection when concerns around underage sexual activity are raised. Of course, I do not suggest that doctors or schools should seek to police all underage sexual activity, but when by virtue of the age of the participants or the activity involved there is an obvious concern, child protection plainly outweighs considerations of privacy and referrals should be made.
- 8.296 One of the threads running through these case studies has also been the support provided to victims and survivors of CSE, or those children at risk of CSE. The case studies tell a story of support services that are either not provided, not consistently provided, there being delay in provision, or allocated workers repeatedly being changed. I have no doubt that in many cases this has been due to a lack of funding and pressure on capacity. Inadequate funding of CAMHS is a constant theme and an acute issue. Regardless of the cause, at their moment of need, these victims and survivors have not been adequately supported. For example, the case studies demonstrate that risk of CSE significantly decreases when the Council (alongside other agencies) were able to find stable, appropriate accommodation and therapeutic support. Unfortunately, the case studies also demonstrate that when this support is not provided from the outset, vulnerable children become more vulnerable in circumstances when they are entirely reliant on others to keep them safe.
- 8.297 Linked to this, one concerning feature in these case studies is that the trauma these children experience is barely recognised in the meeting notes, assessments, reports and records. The behaviour of the children concerned is often described negatively, with the assumption that they are all making choices of their own free will and not acknowledging that the behaviour is a manifestation of extreme distress; a common one seen in these case studies is a perceived "*lack of engagement*"³⁰⁸ with agencies, which assumes this is a deliberate choice. It is rare to see any mention of grooming, coercion, control, fear, likely threats; even in recent cases. Assumptions are frequently made that these children are all making free-will choices.
- 8.298 Another common theme has been instances of failures to share information, meaning that information could not be triangulated to join indicators together, which may have resulted in earlier intervention. For example, the case studies highlight a number of instances where

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disclosures were made and crimes do not seem to have been reported to WMP by Council workers. Again, the sharing of information appears to have improved in the later case studies; no doubt due to the increase in multi-agency working, and this becoming standard practice. There is no doubt that the sharing of information, and quickly, is of paramount importance.

- 8.299 Two of the case studies have also shown the vulnerability of parental consent in respect of the CATE Pathway; the issue of consent contributed to the failure of swift CATE intervention. Yet the Pathway is clear that where there are such concerns, cases must be routed through child protection. This system was in place from the earliest days of the CSE strategy. This raises the question as to whether, first, the Council could have done more to obtain this consent and push for effective intervention, and second, whether the onward referral process to child protection was automatically being actioned.
- 8.300 The case studies also suggest that in some cases, again from the earlier period, the Council were sometimes quick to close their files and/or the risk levels from assessments were stepped down quite quickly, before a reasonable period of time had elapsed to be sure that the assessment was accurate or that the file closure was the right action to take, and without the child being seen. In cases of CSE, where children do in some cases hide information for various reasons (e.g. fear or where they do not consider themselves to be at risk), I would have expected Council staff to be more certain that positive improvements have been made before such action was taken; assuming that a non-response meant everything was now fine would not be appropriate. I remind myself that during this early period the CATE Team in particular was however under extreme pressure of work.
- 8.301 The case studies do also demonstrate some extremely positive examples of intervention from professionals and constructive relationships being established which have had positive impacts on the lives of these children. In some cases I have seen some extremely committed professionals going above and beyond to protect a child.
- 8.302 The difficulty is of course, and has been throughout, that 'clear evidence' is hard to come by in cases of CSE as children are often reluctant to complain. Agencies have been slow to recognise the relevance of concerns and the value of behavioural indicators as signs of CSE; and while that may be explicable to some extent in relation to the police, whose culture is necessarily evidence-based, it is less explicable in my judgment in respect of the early Safeguarding response, where the Safeguarding focus on hard evidence led to children falling through a gap in service that was not filled until the creation of the CATE Team.
- 8.303 This comes back to being professionally curious. It might be the automatic response to deal with a problem once it arises; but looking at circumstances with a more critical and enquiring eye may mean that these children are protected at an earlier stage, meaning that such drastic intervention at a later stage is not needed, and the harm they suffer is reduced. That surely has to be the aim.

“

Victim/Survivor Voice

"When these things happened, I was 15 years of age, I should have been enjoying myself with my friends but due to what happened I lost trust in people especially boys. I struggled, and still do to make new relationships with people as I completely lost all of my self-confidence. I felt worthless and I felt that I was just something to be used and then thrown away when I had no further use. I hated myself and I felt like just giving up on life.¹

... only last year I just thought that, for all these years I just felt like I was, it was my own fault and I shouldn't have gone there and but now I'm getting a bit older, I've just realised it's not and why should he have to get away with it because I've had

to live with this forever. I said to the police officer, I said, "I don't hate him for what he'd done, I hate him because of the way I am now", because he just took every bit of, just everything away from me, like I can't even look in the mirror, I feel disgusting and things like that because that's what he's done.

Just how horrible he was and just embedded it into me and then obviously knowing what I did and things like that so it just makes me feel really disgusting so any part of anything I ever had like, got now, he's just took everything away from me. Even now, at my age, he just took it all away really."²

1 [REDACTED]
2 [REDACTED] pgs 13-14

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9. Attitudes and Impact

Introduction

- 9.1 I have considered in some detail the actions and responses of key organisations to Child Sexual Exploitation (“CSE”) in Telford over the period of time relevant to the Inquiry’s Terms of Reference.
- 9.2 The Terms of Reference also require me to consider attitudes towards CSE, including how those attitudes have changed. I consider that ‘attitudes’ could mean the attitude of an organisation, led by its culture, or the attitudes of individual professionals. Of course, the attitudes towards CSE and the perceptions of those who encounter it play an integral role in shaping the response of individuals and organisations to CSE.
- 9.3 The attitudes of individuals and organisations towards CSE are also inextricably linked to the response to, and behaviour towards, victims and survivors; and therefore, to the impact it has on them. The impact of CSE is another aspect that I have considered under the Terms of Reference and I address this particularly in this chapter. Through the evidence, and having heard from victims and survivors, I have been able to gain a greater appreciation of the detrimental impact that CSE has. This has enabled me to make recommendations that focus on improving the actions of relevant authorities for the benefit of those most affected.
- 9.4 It has also been an important part of my work to consider those issues that have most concerned the community in Telford and been the topic of debate; including the role that race and/or racial tensions have, or have not, played in relation to CSE in Telford. For example, some have made allegations that any issues of CSE in Telford are specifically centred around the Pakistani or South Asian community, and others have said that the authorities have shied away from properly acknowledging this. This Inquiry cannot turn its face away from such issues because they are considered controversial or sensitive; I address these issues in this chapter.

Attitudes

- 9.5 In considering the attitudes, and changes in attitudes, towards CSE it has been necessary to consider and reflect on them in the context of the relevant time. It has been more of a challenge to establish clearly the attitudes from the earlier time period of the Inquiry’s Terms of Reference. As has been referred to throughout this Report, documents and witness evidence from this earlier period has been more difficult to obtain due to the passage of time and unavailability of older documents.
- 9.6 I have broken down this section into themes; these are particular themes that I have seen borne out in evidence, both in documents and also what witnesses have said about the attitudes that they saw and experienced.

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'Child prostitution' not being treated as a crime

Late 1980s and the 1990s

- 9.7 For the earlier period of my Terms of Reference, the evidence indicates that professionals, and those interacting with children who were subjected to, and at risk of, CSE did not always view the behaviour of perpetrators as criminal.
- 9.8 Before considering the evidence in this respect, it is however important to place this in context; both of the framework within which professionals were acting at that time, and the awareness and understanding of CSE.
- 9.9 The term 'child prostitution' was one that was used by professionals and this was a term reflected in legislation. That can be a difficult phrase to hear today, and can lead to suggestions of it reflecting a poor attitude towards victims and survivors; the phrase itself suggests an element of complicity from the victim. However, until 2015 there were specific criminal offences relating to causing, encouraging, inciting, controlling, arranging or facilitating child prostitution, and the Sexual Offences Act 2003 ("2003 Act") contained a series of provisions¹ which related to the "*Abuse of children through prostitution and pornography*". It was therefore a term used to describe offences against children. It was not until 2015 that the Serious Crime Act 2015 acted so as to remove all references to "child prostitution" from the 2003 Act, in order to reflect the true nature of this crime as 'sexual exploitation', although the terminology used by professionals and safeguarding agencies had already begun to change before this point.
- 9.10 An awareness and understanding of CSE was also only just emerging at this time. This was not unique to Telford. The evidence I have seen during the course of the Inquiry's work suggests that from around the mid to late 1990s, professionals in Telford had started to identify trends and patterns of behaviour and criminal offending, which raised concerns, which we now understand to be CSE. It was not however until the mid-2000s that a greater appreciation of the nature of CSE, and how complex it can be to identify in some cases - for example where children are not themselves able to recognise that they are a victim - began to emerge.
- 9.11 As a result, I do not consider that the use of the term 'prostitution' in and of itself reflects a particular attitude; I have seen the word used frequently in the documents disclosed to the Inquiry. The Inquiry heard evidence on the point - the following is typical:
- "It would be called child prostitution at that time over 20 years ago ... At that point, because of where we were in terms of thinking, it would have been regarded as prostitution. Which is really quite alarming when you look back, but that's indicative of a time and indicative of a perception".²*
- 9.12 As the witness identified, what is concerning is that the use of the term reveals a perception; I have seen in some cases that the child has not been treated as a victim because they are perceived to be a willing participant and, in fact, been treated as a criminal as a result, with intervention not then taking place to protect them.

¹ Sexual Offences Act 2004, sections 47-50

² [REDACTED], pgs 4, 7

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- 9.13 One witness explained that in the 1980s and 1990s there was little or no recognition of children being sexually abused, and that children subjected to CSE, as it is known today, were “*not recognised as victims of abuse*”.³
- 9.14 Another witness explained that West Mercia Police (“WMP”) did view child prostitution and child rape cases of this type as criminal offences, but described how “*the child would be treated more as an offender than a victim by WMP.*” The witness however believed that “*this was the view of society in general at that time*” and from a child protection perspective, during those years, in such cases “*the child would not be considered ‘a child in need’*”.⁴
- 9.15 I have also seen evidence suggesting that within the criminal justice system, victims/survivors of CSE were viewed as prostitutes and not recognised as victims: “*children could be defined as common prostitutes, they could be cautioned twice and if they were cautioned twice for soliciting or loitering then they were common prostitutes*”. Reference was made to a case where the judge summing up the case and belittling a child victim, labelled her a “*prostitute since the age of 13*”.⁵
- 9.16 I have also seen evidence that victims/survivors who were exploited and suffered at the hands of their perpetrator, were then criminalised by the police as a prostitute; something which stays on their record forever.
- 9.17 Another witness commented that:
- “... in considering the way the law enforcement parts of the criminal justice system function, at that time it was very much predicated on having a criminal complaint made by a victim. There was little chance or use of anything that they would now call a “victimless” prosecution and a great reliance on the credibility of the victim, which at that time would have been felt by CPS or others to have been undermined if any kind of co-operation or consent to sexual activity had been engaged in by the victim. This was very much the case for sex offences generally and... this probably impacted on the view of those where young girls were involved... [the] feeling was that the legal ability to deal with this kind of activity was not as joined up as it is now. For example what would now be recognised as grooming and coercion and elements of control was not seen or known about in quite the same way”.*⁶

2000 onwards

- 9.18 I have seen evidence that demonstrates that this attitude continued into the 2000s. As highlighted elsewhere in this Report, WMP, Telford & Wrekin Council (the “Council”) and teachers from local schools were holding strategy meetings where concerns were raised about children being ‘involved in prostitution’. Again, as mentioned above, given the framework and time within which these professionals were operating, this terminology is not surprising, and I do not consider that alone suggests any particularly concerning attitudes.
- 9.19 What is more concerning is the attitude that ‘child prostitution’ was not something to be concerned about and action did not need to be taken. A witness who worked for the Council

³ [REDACTED], pg 2

⁴ [REDACTED], pgs 4, 6, 8, 12, 19, 20, 21, 23

⁵

⁶

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told the Inquiry that she was informed by other staff members that child prostitution *"had always happened in Wellington"* and was *"nothing new"*.⁷

- 9.20 There is evidence that indicates perceptions did start to change in and around 2007, with evidence describing agencies beginning *"to work together more closely to explore the idea of CSE in more detail"*. I however heard that whilst perceptions started to change, WMP *"as a whole were largely still treating girls involved in CSE situations as offenders rather than victims"*.⁸
- 9.21 The suggestion that perceptions within the Council started to change around this time is evidenced from a Children Abused Through Exploitation ("CATE") meeting in 2009 which shows CATE practitioners highlighting that sexually exploited children should be treated as victims not *"sex workers"*, seemingly challenging the terminology of documentation produced.⁹
- 9.22 Whilst discussing a period of time between 2008 to 2009, a police witness also told the Inquiry that, due to work by WMP officers, they were beginning to see the *"bigger picture" and "the issues we would now call CSE... start to come into focus."* This was around the time that WMP began undertaking joint working with the Council's CATE Team and that WMP *"started to turn around the thinking to find ways to support the children as victims and to find ways of actually tackling the offenders"*. Evidence suggests that it was at around this time, so 2008/2009, that the investigation of this type of behaviour became a priority for WMP.¹⁰
- 9.23 In Chapter 3: The Council Response to CSE in Telford, and Chapter 5: The Policing of CSE in Telford, I have dealt with the parallel development of the CATE Team and WMP's Operation Chalice ("Chalice"); as I have noted in those chapters, the impetus for each came from those individuals in contact with exploited children. That speaks of a deep-rooted concern amongst those individuals; this contradicts the view that continued official use of the term 'child prostitution' implies a dismissive attitude of CSE by those professionals.
- 9.24 I do consider that by the time of the change in the legislative regime in 2015, to remove the terms 'child prostitution', the change in perception was already advanced in Telford.

CSE as a lifestyle choice/consenting behaviour

Late 1980s and the 1990s

- 9.25 Closely linked with the concept of children not being treated as victims, is the idea that professionals and those engaging with these children viewed the exploitation as being a deliberate lifestyle choice and consenting behaviour. Again, this has to be measured against the background of how much was understood about CSE generally, but during this Inquiry I have seen an enormous amount of evidence which does indeed suggest that the children were considered to be making 'poor choices'.
- 9.26 The Inquiry was told that police received intelligence that girls were being *"taken away"* by Asian males but the perception was that they were *"messing about"* and the sexual activity

7 [REDACTED] pg 9
8 [REDACTED] pg 21
9 [REDACTED] pg 2
10 [REDACTED], pg 9

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was consensual therefore not actioned in any meaningful way. The witness told the Inquiry, *"And I think as a problem, I think it wasn't identified as a problem"*.¹¹ The witness went on to say that in the early 1990s:

"[The] perception was that they were children out of control, young women out of control. The parent can't control them, and we as the police, we've got other problems to deal with...¹² It was a life, yes I think the perception was it was a lifestyle choice on behalf of the girls, that in a year or two they'll be over the age you know they can go off and do whatever they want, you know they'll be adults and beyond the control of their parents".¹³

9.27 Evidence from employees who worked in Safeguarding teams around this time also support this view of perceptions at the time. One witness told the Inquiry the following:

*"I think at that time the attitude was that it was a lifestyle choice. These girls had chosen to go with, I don't know, 'bad boys' if you like, because of the excitement of all that, and that may well have been true to some extent. But it wasn't until later on I think, when attitudes did start to change, that we realised they weren't actual prostitutes. It wasn't something that they'd chosen to do at any one time because, well, they couldn't have made that choice really."*¹⁴

9.28 Another witness, reflecting on what was probably the perception at the time, said *"I think back in the day, naughty girls, naughty young women in care, because they were naughty and there was no sense of the power imbalance, there was no sense of grooming there was no sense of understanding that kind of more complex relationship and how could it possibly have been a boyfriend/girlfriend, how could it possibly have been an equitable relationship, how could it possibly be. So yeah I mean clearly that was the thinking and thank goodness it moved forward."*¹⁵

9.29 I have however read other evidence that provides a contrary view. One witness told the Inquiry:

*"I'd actually be pretty defensive of the social work professional mindset in those terms because I genuinely don't think I've ever met a qualified social worker who would present the case that you've just described in summary as a lifestyle choice. I just don't think any trained social worker could reach that conclusion and certainly that wouldn't have been the conclusion I reach now or then or ten years before I went to Telford when I was working with children at risk of exploitation."*¹⁶

9.30 Notwithstanding this, the weight of the evidence obtained by the Inquiry tends to suggest that during this period, the attitude that was prevalent in WMP and Safeguarding, both in Shropshire County Council and Telford & Wrekin Council, did identify what we now know to be CSE as a lifestyle choice.

11 [REDACTED] pg 11
12 [REDACTED] pg 12
13 [REDACTED] pg 26
14 [REDACTED] pgs 6, 7
15 [REDACTED] pgs 4, 7
16 [REDACTED] pg 58

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2000 onwards

- 9.31 The evidence shows that the perception that children were making a lifestyle choice continued into the 21st century.
- 9.32 One witness gave evidence about their experience in 2001 when a known victim of CSE received little compassion from WMP due to a "lifestyle choice" mentality that was in operation at the time.¹⁷
- 9.33 Another of the cases that I have referenced in Chapter 8: Case Studies, contains evidence of some concerning attitudes from professionals towards the child in question, who was a victim of CSE in the mid-2000s. Comments in the evidence included:
- 9.33.1 The "doctor advised [Child D] that her behaviour [sexual activity] was dangerous and inappropriate."¹⁸ Child D was 12 years old.
- 9.33.2 "this person has been missing so many Times Now [sic] that any risk seems to be more symptomatic of behavioural and attitude problems".¹⁹
- 9.33.3 Child D's behaviour was described as "predatory" when she was 12 years old.²⁰
- 9.33.4 A WMP missing person report referred to Child D as "a sexual predator" when she was 13 years old.²¹
- 9.33.5 Another missing person report noted that Child D was "reported to be very sexually active, mixes with the Asian Community and gets herself into 'awkward situations'."²²
- 9.34 While the evidence suggests that the understanding of CSE was only just becoming more widespread and the term 'child prostitution' was still being used, this was a 12 and 13 year old girl; the comments from a number of professionals suggested that an element of consent or blame rested with the child. As set out in my conclusions in Chapter 8: Case Studies, I consider that this attitude, particularly from WMP, prevented officers from treating the intelligence received sufficiently seriously and taking more proactive action to protect Child D from harm.
- 9.35 In the Child D case, I also saw examples of the most unfortunate language being used by health professionals. Telford & Wrekin CCG told the Inquiry:

"It is recognised that historically, an acceptance amongst professionals working with CYP of underage sex (across all disciplines) often driven by a need to be "non-judgmental" combined with a lack of knowledge in respect of CSE as a form of abuse (compounded by there not being an easily identifiable "typical" victim) meant that the response and attitude of health professionals was sometimes one of "victim blaming"."

17 [REDACTED], pgs 7, 12, 17, 20, 22
 18 [REDACTED], pg 3
 19 [REDACTED], pg 37
 20 [REDACTED], pg 3
 21 [REDACTED], pg 84
 22 [REDACTED], pg 18

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- 9.36 As reflected in Chapter 8: Case Studies in relation to the Child D case, I recognise this comment as a refreshing, sensible and open recognition of past failure; and was gratified to note that all CCG staff have been provided with guidance from NHS England and Improvement and the WMP CSE policy which suggested terms to advise and describe victims of CSE.²³
- 9.37 One witness also told the Inquiry that in and around 2004, there was a "real culture" when young girls went missing "The phrase they would use [would be] 'well these are streetwise kids'".²⁴
- 9.38 There is evidence that these attitudes continued to exist in 2007/2008, with one witness saying that at this time:
- "... that there could be a tendency for some to see girls, who we would now clearly see and state were involved as victims or survivors of CSE, as problematic youngsters, displaying 'teenage' behaviour and getting themselves into trouble, rather than as we would hopefully much more readily now see them as victims being exploited and in need of assistance."*²⁵
- 9.39 There is, however, evidence to suggest that in 2007, WMP was starting to recognise the vulnerability of these children, even if the language used was still suggestive of an attitude of complicity. When discussing two individuals that had gone missing officer reports said:
- "Let us not forget that these misspers are 13 years and 16 years of age and although streetwise have to be considered vulnerable by reason of age, gender, and financially, couple with the intelligence from [name] and previously that prostitution is a possibility."*²⁶
- 9.40 There is further supporting evidence that a 'lifestyle choice' attitude still existed in 2009, particularly amongst police officers. In Council case contact notes, a police officer is referred to as indicating:
- "[Name] has no credibility – very often it is her word against [sic] the perpetrators and very often she does not co-operate. Belive [sic] she is making life choices. There are never any witnesses or 3rd parties".*²⁷
- 9.41 There is evidence to suggest these attitudes also still existed within the Council between 2005 and 2009. One witness explained that when issues were raised concerning sexual relationships with older men, the assumption within the Council was that this was "either girls acting out" or making a "lifestyle choice".²⁸
- 9.42 Other evidence suggests that 2009/2010 was a turning point when attitudes began to shift; this was of course around the time when Chalice commenced. Operational policing briefings taking place at this time concerning the sexual exploitation of missing children acknowledged that officers were wrong to view children missing from care as 'street wise', able to look after themselves and a nuisance due to their behaviour.²⁹

²³ Telford & Wrekin CCG's response to Maxwellisation.

²⁴ [redacted], pg 27

²⁵ [redacted], pg 7

²⁶ [redacted]

²⁷ [redacted], pg 1

²⁸ [redacted], pgs 11, 12

²⁹ [redacted], pgs 1, 4

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- 9.43 There is further evidence to suggest this emerging understanding continued in 2009, although the term 'lifestyle choice' was still being used. A document recording one officer's view on the missing episodes of a child says:
- "She is clearly a high risk young person whether she goes missing or not. There is significant information to believe that she is being sexually exploited by groups of Asian men and maybe being plied with drink or drugs. She is 16 and in the eyes of the law is still a child. Whilst there may to some degree be an indication that she has adopted this as a lifestyle choice she is under 17 years and in the care of her parents I note that she has gone missing 32 times and we should not feel that this volume of absences and her return in any way lowers the risk."*³⁰
- 9.44 I note that in the passage above, there is clearly a realisation of vulnerability and/or exploitation. This may indicate that whilst the understanding of the issues concerning CSE was still developing within WMP at the time, there was a clearer understanding of the need to protect these children.
- 9.45 Certainly the CATE case files I have seen from around this point onwards are quite careful about the use of the phrase a 'lifestyle choice', and it is rare now to see a child that has been exploited, or at risk of being exploited, being described as having made poor lifestyles choices.
- 9.46 One witness told the Inquiry those attitudes also changed terminology and, in 2013, the Council took active steps to recalibrate the language that was used to describe behaviour around CSE concerns. The Inquiry was told it was viewed as important to ensure that all partners adopted the same approach, which resulted in a document being produced to identify inappropriate terms and suggested alternative phrases. For example, the document identified that it was inappropriate to describe the child as "*putting themselves at risk*"; the alternative description suggested was that the child may have been groomed or that the child was "*not in a protective environment*".³¹
- 9.47 Additional documentary evidence supports the view that perceptions had further shifted during 2015, and CSE practitioners at the Council acknowledged the need to challenge terminology like "*prostitution*" as it reinforced a perception of blame and suggested victims of CSE were making "*informed choices*".³²
- 9.48 There is no doubt that the early perception towards victims of CSE and them having made 'poor choices' led to an attitude of victim-blaming; this must have been extremely distressing for those children being exploited. I do not however consider that I can blame individuals for the attitudes displayed at the time, particularly for the earlier period; or at least not in all cases. Societal views to a large extent influence those attitudes, and much of the evidence I have seen shows that there was a general view, from professionals, the public and even family members, that here was a child that was 'acting out' or being a 'rebellious teenager'.
- 9.49 The evidence suggests that the changes in terminology during the 2010s, and following the Chalice investigation, did lead to a greater understanding of exploitation and how this manifested itself, and this did have an impact on changing attitudes.

³⁰ [REDACTED], pgs 1, 26

³¹ [REDACTED], pg 10

³² [REDACTED], pg 25

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- 9.50 That is not to say that I am naïve enough to think that a minority of individuals do not still hold these attitudes today. I have seen more recent police evidence of an unacceptable, and quite frankly offensive, attitude towards CSE victims/survivors, with disparaging language being used.³³ I have not, however, found the use of this language to describe victims of CSE to be commonplace; far from it; but as I reflect in Chapter 3: The Council Response to CSE in Telford, in considering the CATE Team from 2016 to date, work still needs to be done on ensuring that victim-blaming language is not inadvertently used, as it can corrupt thinking and response.
- 9.51 I have also heard that this shift in attitude, and accepting the realities of how complex CSE is, has not always been a smooth transition, particularly within the Council.
- 9.52 As part of this Inquiry, I have seen the DVD titled *'My Dangerous Loverboy'*, which was a training resource available in 2010 designed to raise awareness of CSE. The DVD provides a narrative about a girl who was targeted, groomed and abused. At the time, Telford & Wrekin's Local Safeguarding Children's Board ("LSCB") noted that this resource was to be used as part of a CSE preventative programme in schools.³⁴
- 9.53 I have also seen minutes from a CATE Gold meeting in 2011 which states that the video *'My Dangerous Loverboy'* was *"not the best vehicle to deliver a message"* and that the Council's Chief Executive at the time was not willing for it to be used in schools, and *"this was agreed by all present."*³⁵ Evidence gathered by this Inquiry suggests that during the meeting the Chief Executive was so offended by the content of the DVD that he left the room; a reaction that left others incredulous:
- "... if we can't stay in a room while we look at a training material video then for me that was wrong. As a corporate parent, if you are the corporate parent, it means that you are the parent for hundreds of children who have major vulnerabilities and you need to understand what some of those vulnerabilities are for those children."*³⁶
- 9.54 Other evidence details a meeting during which the Council's Chief Executive left the room when attending *"a talk on the subject of CSE"* as he *"couldn't handle what he was hearing"*.³⁷ Whilst it is not clear whether this was the same meeting referred to above, I have heard the view expressed that the Council's Safeguarding team should have been led by someone with a social services background that understood the issues and the needs of children. This is something I address in Chapter 3: The Council Response to CSE in Telford.

Attitude of children not being believed

- 9.55 Another theme that has been mentioned by witnesses is that children were not always believed when CSE disclosures were made.
- 9.56 The Inquiry has considered evidence on the development of police methods in the investigation of CSE, and how the Crown Prosecution Service has changed their approach and guidance to the prosecution of cases involving CSE over the years. This is dealt with in Chapter 6: Other

33 [REDACTED] pgs 12, 25, 26, 27, 31, 32, 34, 42, 71, 76, 82, 85
 34 [REDACTED] pg 2
 35 [REDACTED]
 36 [REDACTED] pg 52
 37 [REDACTED]

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Organisations. I have highlighted in that chapter the legislation in force until the early 1990s that demonstrates the legal framework in respect of child witnesses and their reliability.

- 9.57 In light of the analysis contained in that chapter of this Report, it is therefore no surprise that witness evidence obtained by the Inquiry describes that in the 1990s, there was a culture of children being viewed as difficult, unreliable and untruthful witnesses with particular reference to offences related to child sexual abuse and exploitation. Evidence related to a case concerning child sexual abuse in a school in 1991 shows how this unhelpful attitude exacerbated the problem by discouraging children from coming forward:

*"... that the perpetrator had produced evidence to support the police's perhaps already held prejudice that the looked-after children, who were the subject of the case, were difficult children and unreliable witnesses, in terms of being truthful about the alleged abuse. This contributed to the unhelpful situation where young people reporting abuse were not believed. Some of the local police were friends with the headmaster and would socialise with him. [Name] believes that this led to the young people concerned losing trust in the authorities."*³⁸

- 9.58 Despite there being evidence that more broadly there was a general societal attitude in the 1990s that children were less likely to be believed, certainly over adults, the evidence I have seen during this Inquiry does not suggest that this was particularly the case in Telford concerning CSE disclosures. The challenge in Telford, and for sexual exploitation more generally, was not that allegations were being made and not believed; rather the biggest barrier to addressing CSE was facilitating and encouraging those disclosures to be made, particularly where many victims and survivors were not able to accept or understand the nature and existence of their exploitation, or where they were too scared of repercussions to make any disclosures.
- 9.59 By way of an illustration, in an NSPCC report dated early 2008 into one child's experience, the author stated: *"At the time I was working with her and beyond, [name] was unable, or unwilling, to accept that she was being targeted for sexual exploitation"*.³⁹
- 9.60 The case studies examined by this Inquiry do not tend to show a trend of children not being believed once disclosures were made. The general trends relate to CSE indicators not being recognised and/or acted upon with sufficient speed, or evidence not being properly investigated.

Attitude towards victims and survivors as parents

- 9.61 Another issue that I have seen relates to the experiences of victims and survivors once they have reached adulthood, and the extent to which they were treated differently because of their childhood exploitation. A number of witnesses have expressed to the Inquiry the distress they have suffered at having their own children removed from their care, and I do address this in further detail later in this chapter when looking at the impact of CSE.
- 9.62 The issue that arises in relation to attitude is less about the fact that children were removed, and more about the assumptions that may be made by professionals about the parenting ability of those individuals that have been subjected to exploitation in their past, and therefore the attitude toward them.

³⁸ [REDACTED], pg 5

³⁹

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9.63 Evidence shows this being experienced:

*"... because of her being known as a victim of abuse, there is an increased focus on her family and an over-willingness by social services in particular to get involved, at times when this is not, in fact, necessary. [Name] feels that she is unfairly targeted because of her past history."*⁴⁰

9.64 I have also seen evidence of a parenting report that suggests that a parent needs to "recognise her previous lifestyle choices as risky" as being one of the factors that determined her ability to parent.⁴¹ Another comment included that the parent "did not recognise some of the risks that her past behaviours are, and how they will impact on her ability to parent safely [sic]". I have seen other reports that refer to a history of self-harm or a need for support with mental health challenges due to previous abuse, as impacting on parenting ability.

9.65 Without reviewing the Council case files in relation to the individual children that have been removed from parental care, which is beyond my Terms of Reference, I am unable to say whether decisions taken in that respect were fair or justified. I have however seen evidence which gives the impression that victims/survivors of exploitation are in effect being judged on their past abuse; suggesting that these were lifestyle choices that were made, as opposed to actions they were forced or coerced into.

9.66 An extract from the New Start Report – 'Child Abuse through Sexual Exploitation (CATSE) Learning 2008-2013',⁴² which was commissioned by the local LSCB does suggest such assumptions:

"All of the young people demonstrated some signs of trauma at the point of interview which suggests that the impact of this CSE experience is clearly not over for any of them. Of concern is that none of them reported that they were engaged in therapeutic services or receiving on-going support, other than through the CATE service. This leads us to question how these young people might be expected to successfully manage relationships and the parenting of their own children in the future. It should be noted that neither of the young people who were parents were able to act as primary carers for their own children at the time of this Review."

9.67 Two obvious issues arise from this:

9.67.1 First, it is incumbent upon the Council to understand its own attitudes and those of its staff. While a review of the safeguarding responses to CSE victims'/survivors' own children is beyond this Inquiry, the Council should consider those decisions to establish whether any pattern is apparent, to consider the reasons, and to make any such adjustments to future policy as is necessary to ensure that no unconscious bias has been applied. This is addressed in my Recommendations; and

9.67.2 Second, therapeutic support. I have noted in this Report the Council's long term failure to put in place support for victims/survivors of CSE. It seems to me that if the Council is concerned in any way that CSE victims/survivors are likely to be less effective parents, that support becomes an even more urgent matter; and it should include elements designed to address relationships and parenting, but do so in a way

⁴⁰ [REDACTED] pg 47

⁴¹ [REDACTED]

⁴² [REDACTED], pg 14

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that makes clear that the victims/survivors of CSE are not being blamed for their experiences. Again, this is addressed in my Recommendations.

The issue of race/racial tensions

- 9.68 As mentioned at the outset of this chapter, part of my work has been to consider those issues that have most concerned the community in Telford, where they fall within my Terms of Reference. One particularly sensitive issue that has been the topic of debate within the community concerns the extent to which race and/or racial tensions have, or have not, played a role in relation to CSE in Telford.
- 9.69 The evidence gathered during this Inquiry identified two particular issues and allegations that were raised by witnesses:
- 9.69.1 The first was the allegation that any issues of CSE in Telford are specifically centred around the Pakistani or South Asian community. This is relevant to my Term of Reference that looks at the "*nature, extent and patterns of CSE*"; and
- 9.69.2 The second is the extent to which authorities were reluctant to take action against perpetrators due to their race, either for fear of being accused of being racist, or to avoid escalating racial tensions that existed within the community. This is relevant to my Term of Reference in respect of "*the response of third party organisations to CSE*".
- 9.70 As to the first issue, it would in my judgment be wholly wrong, and undoubtedly racist, to equate membership of a particular racial group with propensity to commit CSE. In the course of the Inquiry I have reviewed evidence relating to many CSE cases. I have seen cases involving perpetrators from different races, nationalities and backgrounds: an early multi-agency meeting discussed CSE concerns relating to a perpetrator who was a middle aged white man; some victims/survivors describe being subjected to exploitation by "*Chinese*" men; a suspect cautioned in respect of a later police operation was a man of African heritage.⁴³ Suspects have come from all races.
- 9.71 That said, on the papers disclosed by key stakeholders, it is an undeniable fact that a high proportion of those cases involved perpetrators that were described by victims/survivors and others as being "*Asian*" or, often, "*Pakistani*". The Inquiry has itself also heard such accounts from victims/survivors. In considering the evidence and in particular the disclosed material, I have been cautious not to infer too much from names, which may indicate wider geographical background and indeed religious heritage, but are wholly unreliable indicators of national background and (in particular) religious belief. Even bearing that in mind, however, the evidence plainly shows that the majority of CSE suspects in Telford during my Terms of Reference were men of southern Asian heritage, including all the men convicted in Chalice, and Operations Delta and Epsilon.
- 9.72 No perpetrator of CSE has volunteered evidence to the Inquiry; there is no evidence to assist me in determining why they committed acts of sexual exploitation. But I regard it as important to consider whether there were any circumstances which might have led perpetrators within the Asian community to feel they could act, as I consider they did, essentially with impunity.

⁴³ [REDACTED]

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- 9.73 In order to analyse fully the role of race and/or racial tensions in respect of CSE in Telford, I consider it is important to highlight some key events that may have impacted racial tensions, and affected official responses, in the area throughout the Inquiry's Terms of Reference. These events were not related to CSE, but provide a necessary background with which to better understand the important pre-existing tensions in the area:
- 9.73.1 It is a matter of public record that in 1991, Ian Gordon, a 24 year old black man, was shot dead by WMP. There were differing accounts of the events that led to his death; the police said that he was in possession of an air rifle and lives were at risk; others believed he had told the police it was a toy gun before being shot by officers. This incident caused angry clashes between the police and the community at the time, including protests requiring the deployment of riot trained officers.⁴⁴
- 9.73.2 On 2 July 1999, Errol McGowan, a black door supervisor was found hanging as a result of an apparent suicide;⁴⁵ the jury at his inquest determined it was death by suicide. There was however speculation surrounding the circumstances of his death, with suggestions that he was subject to a campaign of harassment and death threats by a racist gang.⁴⁶ This led to the suggestion that he was murdered by this group. Errol McGowan had friends in the Asian community and there is an indication that tensions existed after his death due to the threats he allegedly received. Media reports suggested that there may have been a 'turf war' between white and Asian gangs "vying for control of the council estates in the Wellington area of the town".⁴⁷ There was local criticism concerning the WMP response and investigation into his death, which included issues such as institutional incompetence/racism following the Macpherson Report.⁴⁸
- 9.73.3 On 1 January 2000, Jason McGowan, the nephew of Errol McGowan, was found dead in similar circumstances, hanging from railings in Telford.⁴⁹ WMP considered the death a suicide and the McGowan family complained as they viewed the two deaths as connected.⁵⁰ The death of Jason McGowan in these circumstances significantly increased the racial tensions in the area and added to the criticisms of WMP following the death of his uncle.⁵¹ The Inquest into Jason McGowan recorded an open verdict.⁵²
- 9.73.4 In addition to these events, John Elliot, a black male who lived in Telford, was found hanging on 31 May 2001.⁵³ There was a suggestion that his death was linked to drug dealers in the area and there were reports that this led to a further significant rise in racial tensions.⁵⁴

⁴⁴ <https://apnews.com/article/fdd9ba5c10c7c3734ff8829dc9b8a5a0>

⁴⁵ <http://news.bbc.co.uk/1/hi/uk/1425591.stm>

⁴⁶ <https://www.independent.co.uk/news/uk/this-britain/i-am-racist-admits-man-at-telford-inquest-9148248.html>;
<https://www.independent.co.uk/news/uk/this-britain/the-shocking-catalogue-of-threats-and-abuse-suffered-over-two-years-9215849.html>

⁴⁷ <https://www.theguardian.com/uk/2000/apr/28/race.drugsandalcohol>

⁴⁸ A report of an Inquiry by Sir William Macpherson focusing on the police investigation into the death of Stephen Lawrence – February 1999

⁴⁹ <http://news.bbc.co.uk/1/hi/uk/627939.stm>; <http://news.bbc.co.uk/1/hi/uk/618454.stm>

⁵⁰ <https://www.theguardian.com/uk/2002/apr/22/race.ukcrime>

⁵¹ <http://news.bbc.co.uk/1/hi/uk/621548.stm>

⁵² <https://www.independent.co.uk/news/uk/crime/telford-deaths-after-a-long-fight-mcgowan-family-is-vindicated-120713.html>

⁵³ <https://www.theguardian.com/uk/2001/jun/02/race.world>; <https://www.independent.co.uk/news/uk/home-news/family-of-hanged-telford-man-condemns-police-inquiry-as-public-relations-exercise-9209440.html>

⁵⁴ <http://news.bbc.co.uk/1/hi/england/1828933.stm>; <http://news.bbc.co.uk/1/hi/uk/1365478.stm>

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- 9.74 These incidents suggest that racial tensions did exist in Telford in the 1990s/early 2000s.
- 9.75 Witness evidence provided to the Inquiry also indicates that there were racial tensions in the community in the early 2000s. I have heard that the issue of race in local schools was extremely difficult at that time, and if teachers had concerns about inappropriate activity of an older 'boyfriend', and this individual was Asian, there was a concern that if they raised concerns they would be labelled as racist and as a result they felt guarded about speaking out. Indeed, I have heard about a teacher being accused of being racist by one Council officer when they told the Council that there was a "*problem in this authority with Pakistani youths*". I have heard that:
- "... you had got to be careful what you say. It was, it was just the time wasn't it, it was how things were at that time. It was just that you shouldn't ... be saying it, you know, you should know better than that."*⁵⁵
- 9.76 I have also seen evidence that shows that trying to build a cohesive community within a school was hard:
- "It was a time of treading on eggshells because one doesn't like to upset anyone in the community, because these are our people and if there's trouble at school that often spills out into the community".* When considering the concerns that had been raised at that time around known taxi drivers picking up children and subjecting them to CSE, evidence suggests that: "*I wouldn't point any fingers at the local authority or anyone in particular, but there were definitely eggshells about saying that the taxi drivers are Asian.*"⁵⁶
- 9.77 In 2005, the Hadley Learning Community ("HLC") was created, a brand new school accommodating 1,000 secondary and 600 primary pupils. I have been told that upon its inception, there were concerns about a possible gang culture within the school, with Muslim boys displaying violent behaviour and intimidating female members of staff.⁵⁷ Time and resources were spent in addressing this. There is no direct suggestion that this caused racial tensions, effecting the way in which teachers dealt with CSE concerns. It may however be indicative of how some behaviour fed into an existing fear of being labelled racist in response to questionable behaviour or concerns regarding CSE.
- 9.78 At Charlton School, I read evidence that staff were aware of the work being done to help Muslim pupils integrate into HLC, and that the school was approached by an individual who was said to be the self-proclaimed "*leader of the Pakistani community*" who asked if the school would provide a prayer room, which was refused. I understand that the school sought advice from the Department for Education, after being asked several times to provide a Muslim prayer room and to sit boys and girls separately in assemblies. The school did provide halal meat and various dietary requirements for children, but did not offer the same provision for Muslim families as HLC. I understand that the advice from the Department for Education was that the school did not have to change its provision.⁵⁸
- 9.79 In 2006, there were complaints made about the Council's Licensing Team being racist due to their alleged discriminatory treatment of Asian taxi drivers, and an independent investigation

55 [REDACTED] pgs 13-16
 56 [REDACTED] pgs 11, 18
 57 [REDACTED] pgs 5-6
 58 [REDACTED] pg 30

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was undertaken. I deal with this, and the impact it had on the Licensing Team, in greater detail in Chapter 4: Taxi Licensing and the Night-Time Economy.

- 9.80 A witness told the Inquiry that, following this independent investigation, WMP kept the Licensing Team at arm's length and joint 'stop and inspect' operations stopped as they did not want to be viewed as racist.⁵⁹ This evidence provides an example of how the fear of being labelled racist affected the way in which WMP and the Council were interacting and working together as partners.
- 9.81 It is against this backdrop that I have considered the assessment of whether or not issues of escalating racial tensions, or fear of being labelled racist, impacted the action that was taken in tackling CSE. Turning then to the suggestion that authorities shied away from taking action against perpetrators due to their race, either for fear of being accused of being racist, or to avoid escalating racial tensions that existed within the community, I consider that there is evidence that indicates the issue of racial tensions did affect how WMP in particular approached investigations of potential CSE around this time.

The case of Becky Watson

- 9.82 In Chapter 8: Case Studies, I review six case studies, including that of Becky Watson; the detail of that case is contained within that chapter.
- 9.83 That was a case where a child was killed and, upon her death, evidence came to light that indicated that Becky was a victim of CSE, but no investigations of this evidence took place and no suspects were charged for offences related to CSE. In 2012, a review of the investigation was undertaken by WMP to consider whether Becky may have been "*subjected to sexual exploitation.*" That review found inadequacies in the original investigation, with obvious lines of enquiry not being followed by those investigating Becky's death. The review concluded that:
- "Becky Watson was fully immersed in a world of sexual exploitation and it appears possible prostitution/trafficking by Asian males from an early age as young as 11 years old. She witnessed and was subjected to rapes and other serious sexual offences along with other young females."*⁶⁰
- 9.84 It was the opinion of the reviewing officer that a further investigation was warranted.
- 9.85 The review also contained the following comments:

"These speak for themselves and put into context and the possible mindset at the time in respect of investigations involving the Asian community did this have bearing on the failure to investigate rape or links to sexual involvement between Asian males and Becky at that time?"

"Investigating officers faced with the same circumstances now and knowing what we do now know because of the Chalice/[other CSE Operation] and other investigations of its type carried out in the UK, would I am sure have today a different perspective and whole additional set of questions they may wish to explore not only with suspects but also with witnesses."

⁵⁹ [REDACTED], pgs 24-25

⁶⁰ [REDACTED], pg 32

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*The fact is however we would wish it otherwise that the attitude towards community sensibilities in 2002 particular[ly] in respect of racial tensions would have been completely different than today. There is now a shift in perception and attitude in the current climate about these matters which would not [have] been available back in 2002.*⁶¹

- 9.86 During my investigation of Becky Watson’s case, I have not seen any direct evidence that suggests that a directive was given by senior officers, or others, not to act to avoid any racial tension, or anything similar. Nevertheless, the officer who conducted the review of the investigation in 2012 was clearly querying whether race, and concerns around racial tensions in the community, played a role in the lack of action taken to investigate the offences linked to CSE.

Witness evidence of racial tensions

- 9.87 During the course of the Inquiry, I have also read evidence from a number of witnesses who believe that racial tensions did impact upon WMP’s actions:

- 9.87.1 The Inquiry was told about early Asian community feuds (pre-Chalice) and a feeling that certain areas were not approachable to the police leaving parts of the community vulnerable:

*“... a group of men were being allowed to get away with breaking the law, Regent Street at the time was seen as a no-go area, it was creating lots of problems and as a result there were young people who were feeling that, young Pakistani boys were feeling they were above the law and they could do what the hell they wanted, and nothing else mattered. And if you were not known in that area and you came to that area, you would be intimidated. There was a gang mentality that ‘this is our patch and you stay off the patch’.*⁶²

- 9.87.2 I have seen evidence that an officer who served in Wellington in the 1990s said:

*“You would not walk down Regent Street.., it was mainly being taken over by Pakistanis and Indians... you wouldn’t walk down there in daylight, on your own, as a uniformed policeman... they bloody hated us.*⁶³

- 9.87.3 One witness suggested that, up until around 2010, there was a culture of fear and racial tensions between the police and the Asian community in Wellington:

“I can remember some more... senior people than I saying oh you know don’t really go down Regent Street, don’t really go down Victoria Avenue you know you’ll end up with a complaint from the Asian community... There had been a number of instances where officers’ cars had been attacked and torched, there had been a number of instances where officers had been intimidated on the street whilst for example being involved in stop checks and they’d get ‘oh I know where you live, I know where your family live’ and all that kind of stuff. That obviously played a part. And also because of the kind of dynamic and like social dynamic that it is a predominantly Asian area and that it was a lot of fear or anticipation that dealing

61 [REDACTED], pgs 28, 36
62 [REDACTED] pg 9
63 [REDACTED] pg 22

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*with the Asian community robustly would result in complaints and just general kind of issues that were easier to avoid.*⁶⁴

- 9.87.4 I have seen evidence that a police officer who worked in the area said:
- "I think there was a fear I think at that time of dealing with various communities within Telford because the Police didn't want to be seen to be targeting specific ethnic groups ... and I think in relation to Asian community certainly they basically trod on eggshells because they didn't want to be seen to be going heavy handed into groups of people from specific communities."*⁶⁵
- 9.88 I have however also heard conflicting evidence on this issue, with others saying that 'no go areas' did not exist for WMP. Other witnesses explained that some areas of Regent Street were Asian communities, but this did not prevent WMP undertaking active policing.⁶⁶ Indeed, it was a theme of the evidence of most of those who spoke of 'no go areas' – that it would have been other officers, not the witness themselves, who regarded the areas as such, suggesting other officers lacked courage.⁶⁷
- 9.89 I read other evidence that trod a careful path on this point, suggesting that there were not 'no go areas', but rather areas to which officers would choose not to go unless dealing with an incident.⁶⁸
- 9.90 The evidence of certain areas of Wellington being 'no go areas' covered a lengthy timespan; certainly from the mid-1990s into the early to mid-2000s.⁶⁹
- 9.91 The Inquiry also heard evidence from one individual who recalls that in the late 1990s to the early 2000s, there was a practice of WMP allowing individuals from the Pakistani community to use the police car park in Wellington as a 'privilege'. The witness describes this being allowed in order to "pacify" the community.⁷⁰
- 9.92 Another witness recalled that in approximately 2004, they were told that certain members of the Pakistani community could be stopped in cars containing children, but these members would be "straight on the phone to senior police officers".⁷¹ The inference from this statement is that senior police officers would be contacted and criminal investigation deliberately avoided. This is of course an extremely serious allegation – but the difficulty is that I not only heard this information from a single source, but also that the source was not relating matters within their personal experience: they were repeating a rumour or understanding. This could also be viewed as a form of corruption, and this evidence, and the issue of potential corruption within WMP, is addressed in more detail in Chapter 5: The Policing of CSE in Telford.
- 9.93 The Inquiry has also seen evidence indicating that between 2006 and 2008, senior management within the Council were concerned that allegations about Asian male involvement with CSE in Wellington had the potential to start a "race riot".⁷² Evidence suggests that within

64 [redacted] pg 5
65 [redacted] pg 31
66 [redacted] pgs 11, 12
67 [redacted] pg 6
68 [redacted] pg 13
69 [redacted]
70 [redacted] pg 26
71 [redacted]
72 [redacted] pgs 9, 10

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local authority teams at this time the issue of Asian perpetrators was being discussed,⁷³ and I have seen sexual exploitation meeting notes from 2007 which suggest that exploitation by Asian men had been "going on for years."⁷⁴

Witness evidence - fear of being accused of being racist

9.94 The other aspect of this issue I have considered is whether fear of being accused of being a racist had an impact on actions that were, or were not, taken. Witnesses have provided evidence to the Inquiry that suggests that for some there was this fear:

9.94.1 Evidence describes a case where complaints had been made against Asian families. Although the complaints were subsequently withdrawn, a police witness described how WMP "dropped the case like a hot potato" as it fell into the "too difficult" category due to racial tensions. This witness believed that the fear of being labelled "racist" resulted in WMP failing to take the proper action in some investigations and that there was a "tangible feeling" of avoiding racism.⁷⁵

9.94.2 I read similar evidence in relation to the early 2000s and a feeling that certain individuals in the Asian community were not targeted for investigation into CSE because it would have been too "politically incorrect".⁷⁶ Other evidence spoke of senior officers' failure to support rank and file officers when complaints were made, leading to a culture of "second guessing yourself all the time."⁷⁷

9.94.3 The Inquiry has also heard evidence recalling multi-agency meetings taking place in the early 2000s, when inappropriate behaviour by an Asian male towards a child was discussed, but no action was taken forward:

*"It seemed to be ... it was because of the ethnicity of the people involved they felt as if the police were frightened to question or challenge because they didn't want to have the finger pointed at them, saying they were being racist."*⁷⁸

9.95 I deal in Chapter 5: The Policing of CSE in Telford, with the creation of a policing team that would investigate CSE, and which became the backbone of Chalice. I have seen evidence that officers approached to join the team were reluctant to do so: "I said no, and that was because of the Asian element, you know, we're going to be on to a loser."⁷⁹

9.96 I know that racial tensions in the community have continued to exist, particularly in the context of CSE; the CSE prosecutions in Telford have been high profile, and some of the press coverage has indeed focused on the ethnicity of the perpetrators. I know this has led to demonstrations in Telford.

73 [redacted] pgs 15, 16
74 [redacted] pg 4
75 [redacted]
76 [redacted] pg 22
77 [redacted] pg 12
78 [redacted]
79 [redacted] pg 14

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9.97 The Inquiry heard that:

"... once Chalice had kicked off the community were up in arms about the arrests that were made and how the Pakistani and Muslim community had been targeted by the Police – this is the Police getting their own back on them."⁸⁰

9.98 I have also heard evidence about there being racial tensions in community meetings in 2011/2012, with WMP officers being called racist due to the prosecutions.⁸¹ I am aware that these tensions exist today.

Conclusions

9.99 During the course of the Inquiry's work, I have tried to gain balanced evidence, and I have tried to seek views of the Asian community in relation to these issues concerning race and racial tensions in particular. I have met representatives of the Interfaith Council in Telford, who supported the Inquiry in disseminating our calls for evidence to all members of the Interfaith Council, who were in turn were asked to share the Inquiry's advert calling for evidence to their congregations and communities; but there has been a very limited response. While I draw no adverse inferences in relation to this, it is important that I make that clear, as it does mean that I may have heard one side of the story.

9.100 In relation to the Becky Watson case, as I have concluded elsewhere in this Report, community tensions were clearly in WMP officers' minds during the investigation, and the review of the case did identify failures and inadequacies with that investigation. I have however not seen any evidence that demonstrates that a directive was given not to act due to racial tensions, or fear of being seen to be racist; therefore, there is not enough evidence to conclude that the failures in that investigation were due to a desire to manage racial tensions, rather than seek justice.

9.101 In the 1990s and early 2000s, and even beyond, based on the evidence I do believe that WMP allowed a nervousness about race to become prevalent among officers. I am also certain that this led to a reluctance to police parts of Wellington. I have heard so many officers recognise the concept of a 'no-go area' that I am quite sure that was how the locality was perceived among officers; that sort of perception creates its own reality. I have heard evidence from more than one officer who recalled how they strode purposefully up and down Regent Street to break the mould; clearly a mould had been forged. It is an obvious conclusion that any police force which allows such a situation to develop is failing the community.

9.102 In the same way I am satisfied that in some cases the decisions of WMP officers about whether or not to investigate a particular piece of intelligence or complaint were influenced by assumptions about race: whether because of ideas of difficulties investigating what was seen as a closed and hostile community, because of fear of complaint, or because of concern about the impact an investigation might have had on racial tensions, I cannot determine. It would, of course, be nonsense to suggest that considerations of race and ethnicity should play no part in policing a community with a large population of a particular racial or ethnic group; but for those considerations to lead to a situation where certain streets are not patrolled, or where certain crimes are not investigated, is a dereliction of the police's most basic duty.

⁸⁰ [REDACTED], pg 23-25

⁸¹ [REDACTED], pgs 23-25

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- 9.103 As to the consequences of this attitude, it is in my judgment the most obvious explanation – I have seen no plausible other – for the shocking failure to investigate the intelligence and allegations of CSE that I deal with in Chapter 5: The Policing of CSE in Telford concerning the D2276 police material.
- 9.104 This nervousness about race – and its consequence, reluctance to investigate – was not, in my judgment, confined to WMP. I have no doubt that concern about racism, and being seen to be racist, permeated the mind of the Council and the minds of some of its employees. That is not a bad thing: there should be a culture of equality of treatment and fairness in delivery. But as I have noted elsewhere with regard to the Council’s response to complaints of racism in the field of taxi licensing: there was an immediate, almost reflexive, complete retreat which undermined enforcement – a basic public protection programme – for some years.
- 9.105 Further, as I have noted in relation to education at Chapter 3: The Council Response to CSE in Telford, Safeguarding officers in the late 1990s were dismissive of school staff concerns about exploitation simply because the perpetrators were described as Asian. Years later, sexual exploitation meetings attended by representatives of the Council’s Safeguarding team were recording that exploitation by Asian men had been happening for “*years and years*”; a note in one set of minutes suggests that information on CSE be sought from staff members at the very school where concerns had been brushed away almost a decade before.⁸²
- 9.106 I do not suggest there was at any stage a deliberate policy within the Council to ignore allegations of CSE against a perpetrator group with a specific racial profile. But the fact that these allegations were well known within the community as a whole, and certainly within Safeguarding and youth services, leads me to the view that a culture existed whereby certain Council officers discouraged such concerns, perceiving the cost to race relations to outweigh the benefits of investigation; and I have heard and accept evidence that as a result, some complaints went unaddressed.⁸³
- 9.107 In Chapter 3: The Council Response to CSE in Telford and Chapter 5: The Policing of CSE in Telford, I have however found that the ground-level, individual-driven responses to CSE, which ultimately became the CATE Team and Chalice, acted so as to address the allegations that were being made. It is however impossible not to wonder how history might have been different had the culture in the 1990s and early 2000s within the Council and WMP not been overly concerned with questions of race and placed a greater focus on child protection.

Impact

- 9.108 As mentioned above, under my Terms of Reference I am asked to consider the impact of CSE on victims and survivors, as well as on their partners, parents, children, families, and others close to them; that includes looking at the mental, physical, social and economic impact.⁸⁴
- 9.109 A vital element of this Inquiry’s work has been to listen to victims and survivors, and this has been particularly important in allowing me to build up an understanding of the impact that CSE has had on all aspects of their lives, as well as the lives of their families and friends. I do believe that by listening and trying to understand the full impact of CSE, all organisations

⁸² [REDACTED], pgs 2-5

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⁸⁴ See paragraph 2.2 of the Inquiry’s Terms of Reference – <https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/5d2859da1636a90001ba0c84/1562925531616/Terms+of+Ref+erence.pdf>

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working to protect children would be better equipped to address CSE in a way that helps ensure lessons are learned and mistakes made in the past are not repeated.

- 9.110 There is no doubt that the impact of CSE is immeasurable, complex, and in many cases it pervades every aspect of victims' and survivors' lives; one witness described CSE as having "*impacted everything*".⁸⁵ In light of the extent and complexities of the impact that CSE can have, the purpose of this section of my Report is to identify the different ways that CSE can affect people's lives, but at the same time acknowledging that CSE effects will be as diverse and varied as people; this is by no means intended to be an exhaustive 'list' of the many ways in which CSE has a dreadful impact. It is also important to note that these issues are not raised in any particular priority order; the biggest impact of CSE on one victim/survivor will be different to another.

Personal Impact: Confidence and Self-Worth

- 9.111 A common theme in the evidence is the impact that CSE has on the self-esteem and confidence of victims and survivors, both at the time of being subjected to exploitation, and as a long-lasting impact.

- 9.112 As to the point of being subjected to exploitation, I have read evidence from a victim/survivor about their exploitation, who explained that it left her feeling "*lifeless*". She did not view her abuse as "*a problem*" at the time because her self-esteem was so low she believed her exploiters were protecting her.⁸⁶

- 9.113 I have also seen evidence that being subjected to sexual exploitation affected how victims/survivors saw themselves:

*"She recalls she went through a stage where she ate a lot to try and put on as much weight as possible, and make herself as undesirable as possible. She also actively tried to make herself 'ugly'."*⁸⁷

- 9.114 Other evidence said that:

*"When these things happened, I was 15 years of age, I should have been enjoying myself with my friends... I felt that I was just something to be used and then thrown away when I had no further use. I lost all of my self-confidence. I felt worthless."*⁸⁸

- 9.115 The evidence I have seen shows that the negative impact on confidence and self-esteem caused by CSE not only impacts the lives of victims and survivors, but can feed into their vulnerability; this in turn can increase their vulnerability to being subjected to further exploitation, creating a cycle of impact and exploitation. For example, I have seen evidence that shows that in support sessions one victim/survivor "*was also encouraged to focus upon building up her self-esteem and self-confidence so that she does not feel she needs to try to build relationships with males by having sex with them.*"⁸⁹ This illustrates the damaging cycle that can be created.

85 [REDACTED] pgs 7-8

86 [REDACTED]
87 [REDACTED] para 44

88 [REDACTED]
89 [REDACTED]

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9.116 I have seen evidence about the impact on self-worth as an adult:

"I don't hate him for what he'd done, I hate him because of the way I am now, 'cause he just took every bit of, just everything away from me, like I can't even look in the mirror, I feel disgusting and things like that 'cause that's what he's done."⁹⁰

9.117 It is clear from the evidence that the loss of confidence caused by exploitation is not only long lasting, but impacts on the ability to interact in social situations. I have read evidence from one survivor who explained:

"They've messed up my life. Parts of it anyway. They've messed my confidence, the way I act, the way I am around people. They, they've ruined that with all the names they used to say... Now I can't even like to speak to, speak to someone, I can't even like look, look at someone in the eye for longer than five minutes."⁹¹

Families

9.118 The experiences victims and survivors suffer at the hands of those who exploit them frequently result in an immediate impact on their day to day family life and a long term impact, meaning that their inability to build and/or rebuild relationships of trust and affection with family members can be affected. Sadly, I have also seen how their experiences can impact relationships that victims and survivors have with their own children, in some cases losing them to the care system; something which I have seen in a number of cases. I have also touched on this issue above in respect of attitudes of authorities.

Children

9.119 I saw in a number of cases that victims and survivors experienced having their child, or children, removed from their care. In some cases, the Inquiry was told that this was due to their inability to cope, or the circumstances they found themselves in, this being a symptom of the CSE they were subjected to; in other cases this was due to the attitudes of professionals towards them, as a victim/survivor of CSE, not believing that they were able to be a fit parent:

9.119.1 I have seen evidence that one victim/survivor lost her children to the care system because she *"did not know any different"*; she described having children as a result of her exploitation, and feeling too young to cope and still dealing with the effects of being exploited, which led to her reacting in a way that resulted in the Council taking action and removing her children and placing them into care;⁹²

9.119.2 I have seen evidence from parents that their child had *"no chance"* of being able to care for their own child due to the problems faced after being exploited;⁹³ and

9.119.3 Other victim/survivor evidence said: *"I have missed several years of his [her child's] life as I have felt that I have not been able to bond with him in the right way."⁹⁴*

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- 9.120 I have seen evidence from a professional reflecting on the impact that CSE can have on victim/survivors' parenting:

"[Name] has worked with CSE victims who are now adults, and can see the effect that the abuse has had on their lives, blighting their ability to parent appropriately in some cases, and often resulting in mental health issues. It would be difficult for any parent, who has experienced CSE, to allow their teenage daughter, for example, to have the freedom that teenagers crave, when the parent is aware from personal experience of what occurs in the local area... the anxiety which this creates is huge, and should not be underestimated, as it often impacts on the relationship between the parent and child.

In addition... the parent may also harbour a distrust of the services who might otherwise be able to offer support, such as teachers, the police or social services, having received no help from them when it was needed in their own childhood... for this generation of victims of CSE, who are now parents, every element of their lives is impacted".⁹⁵

- 9.121 To realise that CSE victims/survivors have had children removed from their care as a result of the ongoing effects of their own exploitation, illustrates bleakly that in many cases victims/survivors will simply never be free of the consequences of their perpetrators' actions.

Impact on wider family

- 9.122 The evidence I have heard is that at the point that a child is being subjected to CSE, the impact on relationships with their family, and on family life, can be all-consuming. I have seen evidence of the victims/survivors family being placed under extreme stress,⁹⁶ and members of the family blaming themselves for the exploitation, the consequences of which manifests itself in different ways:

9.122.1 *"When I allow myself to look back into the shadows of my childhood, I see not the laughing faces of happy family gatherings and holidays, I can't seem to see past the hollow eyes and shrunken face of my mother whose body and mind had been over taken by depression and anxiety... she worries too much, and I wish I never let my mum find out and just kept it to myself, because of how ill she is, that is my fault as well.";*⁹⁷

9.122.2 *"Me and my wife used to sit up talking until two to three o'clock thinking where the hell was she. Things go through your mind and you think well we have had the sex and the drink, we are on the drugs and she will end up pregnant or dead in the gutter next... I sit there now and think there's nothing that anyone can do to hurt me any more. I have nothing to lose. I have lost probably the most important thing in my life and that was my daughter at the time.";*⁹⁸

9.122.3 *"I broke my family apart, and that's my fault I shouldn't of let it get to the point where it hurt everyone else in the family, but if I could of kept it to myself any*

⁹⁵ [REDACTED] pg 17

⁹⁶ [REDACTED]

⁹⁷ [REDACTED] pg 4

⁹⁸ [REDACTED] pg 4

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longer I would of but I couldn't. It was literally nearly killing me, I felt so hurt that I actually didn't want to be alive anymore.";⁹⁹ and

- 9.122.4 I have heard that the mental and physical health of one parent deteriorated, siblings were bullied and family arguments were caused.¹⁰⁰
- 9.123 I have also heard evidence about the long term impact that CSE can have on family relationships; in some cases those relationships never being the same again:
- 9.123.1 *"...and I feel guilty about all the worry and stress I put them through, and it has taken a long time to rebuild these relationships which is still ongoing."*¹⁰¹
- 9.123.2 I have heard evidence relating to a victim/survivor who found it very difficult to rebuild a previously close relationship with her father after being exploited;¹⁰²
- 9.123.3 Other evidence included: *"My brother doesn't speak to me... the damage to our relationship is irreparable and we don't even have a relationship with each other's kids."*¹⁰³ and
- 9.123.4 Other evidence described how the sibling of a victim/survivor used the fact she had been exploited *"against her"* whenever they fell out.¹⁰⁴
- 9.124 The father of one victim/survivor said that he did not believe he would ever come to terms with the fact that his child had been sexually exploited. He felt responsible for what had happened because he *"wasn't there to protect her"*.¹⁰⁵
- 9.125 Other evidence described that the relationship with a parent was damaged; the victim/survivor's parent felt to blame for not identifying the exploitation and became an alcoholic, suffered from depression and contemplated suicide.¹⁰⁶
- 9.126 One witness said:
- "I think it is probably harder for my family to come to terms with, as they didn't know what was going on... My dad struggles with his mental health as a result of what I went through... I think the depression is so overwhelming that he doesn't make any sense. I think he just can't pick it apart in his head."*¹⁰⁷

99 [REDACTED]
100 [REDACTED]
101 [REDACTED]
102 [REDACTED], pg 2
103 [REDACTED] para 134
104 [REDACTED]
105 [REDACTED]
106 [REDACTED]
107 [REDACTED] para 132

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9.127 Another witness said that:

*"The families of CSE victims continue to be severely impacted by CSE. There are huge ongoing issues for families who have had to deal with this situation, some of whom have developed their own mental health problems."*¹⁰⁸

9.128 The wider family of victims and survivors are impacted in profound ways by the exploitation of their family member. In particular, the evidence shows that parents feel emotions such as guilt and loss which can lead to mental health issues. The disclosure of CSE places stress on the family unit at a time when its support is of paramount importance to the child and his or her wellbeing.

Friendship/Support Groups

9.129 In addition to evidence that relationships within the family are often destroyed, evidence provided to the Inquiry shows that it is common for victims and survivors of CSE to lose their relationship with friends at a time when these are most important. Victims and survivors find it difficult to spend time with peers resulting in isolation from their friendship groups. This isolation can add to a child's vulnerability, which can then in turn make them more susceptible to being exploited.

9.130 In a Safeguarding assessment, one childcare professional supported this view:

*"[Victim/survivor] currently receives very little and limited support from her family and does not socialise well with peers which makes her particularly isolated and a target for exploitation/grooming."*¹⁰⁹

9.131 I have reviewed other documents which show the impact CSE can have on friendships and a social life, including:

9.131.1 *"I lost a lot of people over him. I mean like I left all my friends because I believed that he was telling me the truth that they weren't my true friends and that, but they were they were just trying to help me and protect me from that monster";*¹¹⁰

9.131.2 *"I lost my friends as a result of all this, as I locked myself away, and stopped going out or talking with them";*¹¹¹ and

9.131.3 *"[I] ditched every single one of my friends for him, and it was the biggest mistake of my life."*¹¹²

108 [REDACTED] para 12.6

109 [REDACTED] pg 17

110 [REDACTED]

111 [REDACTED]

112 [REDACTED]

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- 9.132 The evidence also shows that this impact can be ongoing, affecting friendships in the future:
- 9.132.1 "[Name] remains affected by the abuse in that she does not pursue friendships as she does not like when people get too close to her, as she worries that they will find out about her past."¹¹³
- 9.132.2 "[Name] also does not feel that she has any real friends and admits she can become quite clingy with new friends, often becoming jealous of other friendships that they have."¹¹⁴ and
- 9.132.3 "... my social life is non-existent as I don't make friends easily due to not trusting anyone because of what this man has done to me and the way that he has made me look at people and life."¹¹⁵

Personal Relationships

- 9.133 In some cases, victims and survivors also find it difficult to form healthy and loving relationships with future partners due to the impact of CSE.
- 9.134 The evidence shows that in some cases, victims and survivors that have suffered exploitation are conditioned to view personal relationships in a certain way:
- 9.134.1 "I never want to fall in love and get broken ever again. I'm too scared to even look at a boy in that way now, I just think to myself, what if he uses me? What's the point?"¹¹⁶
- 9.134.2 "[Name] has had several violent relationships after her sexual exploitation ended, and she... attributes this to the fact that her exploitation has had a lasting impact on her view on relationships, which has always been 'skewed'. Sex was treated like a business transaction by the perpetrators and so [name] has always thought of sex in that way."¹¹⁷ and
- 9.134.3 I have seen evidence from a parent that the exploitation impacted their child's view of relationships to such an extent that they "will sleep with anybody now, as she does not know any different and she believes that her promiscuous behaviour is normal."¹¹⁸
- 9.135 I have also seen evidence that shows that suffering domestic abuse in a future relationship can be viewed by victims/survivors as acceptable given what has been experienced in the past:
- 9.135.1 I have heard CSE made victims/survivors think in an unhealthy way about relationships: "let's give him his due, he never said he wouldn't hit me."¹¹⁹

113 [REDACTED] pg 30
114 [REDACTED] pg 10
115 [REDACTED]
116 [REDACTED]
117 [REDACTED] para 59
118 [REDACTED] pgs 16-17
119 [REDACTED]

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- 9.135.2 *"... there has always been a pattern of domestic abuse in all my relationships; gradually less so with each relationship... I always make excuses for them; if one beats me, I would say to myself, 'at least he doesn't rape me', and so on."*¹²⁰ and
- 9.135.3 *"... relationships that followed... in her adult life, were all affected by her previous experiences of CSE. [She] suffered a significant amount of domestic violence ... and a relationship that followed after that was also abusive. [She] has now realised she had been 'self-selecting' the same kind of people, and she believes this is because of the experiences she had".*¹²¹
- 9.136 Other evidence describes victims/survivors not feeling able to enter these types of personal relationships as a result of their previous exploitation, which has led to a fear of being used, or a lack of trust:
- 9.136.1 *"... any partner that I would have, would look at me as dirty due to this [past CSE]."*¹²²
- 9.136.2 *"... when my boyfriend told me he loved me, I didn't believe him and it took me some time to trust him as I thought he would just use me like they had."*¹²³
- 9.136.3 I have also seen evidence of one individual where, as a result of her exploitation, she has no sexual or physical contact with anyone and is generally uncomfortable with anyone touching her body;¹²⁴ and
- 9.136.4 Another victim/survivor said that her exploitation has ruined any subsequent intimate relationships, as the idea of sexual closeness makes her feel "dirty".¹²⁵
- 9.137 For most people, the ability to form personal relationships is an essential part of life and by removing this, the impact of CSE can be crushing and isolating for victims and survivors who are often traumatised, vulnerable and require personal relationships for support.

Education and Employment

- 9.138 It is clear from my analysis of the evidence that the prospects of CSE victims/survivors gaining and/or maintaining employment are, in many cases, significantly reduced. This is a direct consequence of the damage caused by the exploitation they were subjected to as a child, which in many cases had a profound effect on their education, as well as the other long-term impacts which permeate every-day life as an adult.
- 9.139 I have seen from the evidence that, in many cases, when a child is being exploited, this has an impact on their behaviour. As regards education, this can include finding it difficult to attend school, difficulties concentrating during lessons, getting into trouble at school, bullying (either being the subject of bullying, or bullying others) and often a negative impact on grades. Focus

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pgs 13-14
para 130
pg 5

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and concentration at school is difficult, and this can sadly lead to poor educational outcomes for the individual.

9.140 For example, I have seen evidence from a parent of a survivor that their daughter:

*"... had difficulty attending school because she had started misusing illicit drugs and alcohol when she was in secondary school. She had reported that she was bullied at school and she often refused to go to school."*¹²⁶

9.141 I have also heard of a victim/survivor failing important examinations when she was raped just days before she sat them.¹²⁷

9.142 Other evidence related to a victim/survivor shows that she was predicted to pass all her exams at age 16, but did not pass any of them due to being subjected to sexual exploitation. She went to college but was so mentally damaged by her exploitation she left within a very short space of time.¹²⁸

9.143 I have seen evidence from a former teacher saying that:

*"... those were girls whose behaviour had deteriorated in school, you know the girls who had started to refusing to engage [sic], their work had suffered, the quality of their work had suffered, their punctuality had suffered, they were getting, in some cases they were getting more angry when challenged on things in school."*¹²⁹

9.144 I have also read evidence that: *"My life was completely wrecked, I wouldn't want to go to school or do anything because I'd always be thinking about that."*¹³⁰

9.145 I did see evidence about one victim/survivor who *"passed 11 of her GCSE's,"*¹³¹ but the evidence shows that this achievement is sadly not replicated by the majority.

9.146 Clearly, poor educational outcomes impact employment prospects in the future, and the evidence suggests that for many victims and survivors this has meant that securing and maintaining employment has been difficult.

9.147 The evidence has also shown that even where victims and survivors have been able to secure employment, maintaining that employment can be a challenge due to the ongoing, and long-term impact caused by CSE, for example, poor mental health, which can make holding down a job more difficult:

9.147.1 I have seen evidence about one victim/survivor who was able to obtain employment, but initially struggled to sustain this for any length of time. When they finally found stable employment, the impact of CSE meant they were unable to manage the stress of the role. The evidence describes *"bottling up her feelings"*, putting it *"all in a box"* which meant her health deteriorated over time;¹³²

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pg 24

para 51

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- 9.147.2 I have also seen evidence about another victim/survivor who gained professional qualifications, but was unable to pursue a career in their chosen field due to the criminal record received as a direct result of their sexual exploitation. The convictions had to be disclosed on job applications and were visible in checks conducted by the Disclosure and Barring Service ("DBS");¹³³
- 9.147.3 I have heard evidence about an individual who was offered an interview, but was not prepared to endure the feeling of "*humiliation*" if interviewed by prospective employers who had knowledge of her past;¹³⁴ and
- 9.147.4 I also heard that "*the majority of CSE victims end up as shop workers or cleaners. They have missed out on those crucial years, in terms of gaining an education and qualifications.*"¹³⁵
- 9.148 It is of no surprise that I have also seen evidence that victims and survivors can lack aspirations for their future with reference to education and employment.¹³⁶ I have heard about victims and survivors that "*barely had an education*"¹³⁷ and having obtained no GCSEs due to the timing of prosecutions concerning their exploitation. I have heard moving evidence about a lack of qualifications ending a victim/survivors dream of entering a particular profession.¹³⁸
- 9.149 There is no question that enormous damage is caused to a child's education by CSE. This damage has a profoundly negative impact on their prospects of future employment, providing a stark example of how the impact of CSE stays with victims and survivors throughout their lifetime.

Mental Health

- 9.150 In almost every case of CSE I have examined as part of this Inquiry, the mental health of the victim/survivor has been affected due to their exploitation.
- 9.151 I have read documents and witness evidence that describe the grief and trauma caused by CSE and the impact that it has on mental health. The evidence provided to the Inquiry demonstrates that CSE is directly responsible for causing its victims/survivors many serious mental health conditions including, but not limited to:
- 9.151.1 Post-Traumatic Stress Disorder ("PTSD") including symptoms such as panic attacks, crying episodes, flashbacks of visualising offenders, intrusive thoughts;
- 9.151.2 Depression (Chronic/Clinical);
- 9.151.3 Anxiety;
- 9.151.4 Disassociation amnesia;

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- 9.151.5 Emotional psychosis; and
- 9.151.6 Sleeping disorders.
- 9.152 Sadly, in many cases, the evidence I have heard, and read, was not of victims and survivors that had clear, clinical diagnoses and therapeutic plans/medication in place to address their mental health; rather it was of individuals that are so badly scarred by their exploitation that they are still struggling to process the full extent of the impact, and that this was likely to be a life-long journey:
- 9.152.1 I have read evidence from one victim/survivor that explained she was unsure as to the exact impact on her mental health and she was "*trying to figure it out*";¹³⁹
- 9.152.2 Another witness said that she does not wish to remember her exploitation, due to the trauma it causes and the humiliation and embarrassment felt during any recollection;¹⁴⁰ and
- 9.152.3 I have also read an extract from a therapeutic referral form that described one victim/survivor as making "*some very positive steps forward away from what has happened, she is still struggling to make sense of it all and is in need of therapeutic work to complete the process.*"¹⁴¹
- 9.153 There is enormous variation in experiences and/or illness caused by mental health issues, and it will be different for every individual. But, some examples of how it can manifest include as follows:
- 9.153.1 "[Name] *struggles to function at an acceptable level with day to day routines. Largely due to what appears to be a sleeping disorder/disturbance which controls her nights and impacts and impedes on her daytime routines and activities. [Name] describes nightmares which I feel are clearly linked to the abuse she has experienced. [Name] moods can be very up and down and sometimes erratic and she often struggles to contain/manage her emotions. [Name] is very bright... but she seems unable to move forward. Again I feel this is linked to the abuse.*";¹⁴²
- 9.153.2 Waking up in fear every day, suffering from nightmares that would replay the circumstances of the exploitation; suffering with panic attacks and anxiety, constantly looking over her shoulder when cars or men came towards her;¹⁴³
- 9.153.3 Experiencing unexpected flashbacks to the incidents that occurred, and now recognising this being part of PTSD;¹⁴⁴ and
- 9.153.4 Sleeping all the time and not wanting to go out of the house or socialise with friends.¹⁴⁵

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Self-harm/attempted suicide

- 9.154 The theme of children harming themselves or attempting to take their own life as a consequence of sexual exploitation is the starkest example of the trauma caused by their abuse. Tragically, I have read numerous documents and witness evidence that provide examples of children, and when they are older as adults, feeling that there is no other way to end their pain and suffering.
- 9.155 The evidence shows that misplaced guilt, shame and a feeling of helplessness experienced by victims and survivors can lead to self-harm and thoughts of suicide as being the only way out, or achieving a sense of relief:
- 9.155.1 *"I have seen or done things too much has happened to say anything... I feel like nothing, I don't know, I don't know what to do anymore. I could easily end it."*¹⁴⁶
- 9.155.2 I have read one example of a child trying to commit suicide whilst in hospital receiving treatment.¹⁴⁷ There are also other examples where children have taken an overdose of medication in an attempt to end their lives;¹⁴⁸ and
- 9.155.3 Other evidence shows one survivor saying *"8 years later and I still wish I was dead. I wish I had took my life while I was there. The last 8 years of my life weren't worth what I went through."*¹⁴⁹
- 9.156 I have read other harrowing evidence providing details of self-harm, where children have choked themselves with toilet tissue,¹⁵⁰ strangled¹⁵¹ and cut themselves.¹⁵² Documents also show a parent describing their child's self-harm:
- "...her arms are all with marks where she's done it with a razor blade, she's tried strangling herself. These are all things I didn't think [she] would do, because I thought she had her head screwed on, but someone's got right in there and they've worked it good."*¹⁵³
- 9.157 The evidence also shows that even when children are contemplating or have attempted to end their lives as a result of CSE, the true reason for their actions is often not disclosed to parents or professionals. For example, I have read documents concerning one child who had attempted to harm herself three times and was taken to hospital. The child was asked why she had harmed herself but simply disclosed she was *"depressed and didn't know why."*¹⁵⁴

Drug/Alcohol Abuse

- 9.158 I have seen during the course of the Inquiry that victims and survivors can experience drug and/or alcohol abuse as a result of being exploited. The evidence suggests that this can be because children may be exposed to drug and/or alcohol misuse by their exploiters, or use it

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- to block out the exploitation they are suffering at the time, and that substance misuse can then also become an issue in later life as a consequence.
- 9.159 The evidence before this Inquiry shows that children who were, and are, exploited, may become involved in using drugs and alcohol at a young age, often as a result of the introduction of substances by their exploiters:
- 9.159.1 I have seen evidence that shows how a child was using and selling drugs for people exploiting her at 13 years of age;¹⁵⁵
- 9.159.2 There is evidence in one case that the child was "*seduced into the murky world of drugs, exploitation and violence*";¹⁵⁶ and
- 9.159.3 There is evidence that shows how one victim/survivor "*spent years coming off the drugs that these men introduced me to*".¹⁵⁷
- 9.160 The general theme of using drugs to 'numb' the memories of abuse and the feelings that it creates has been supported by evidence:
- 9.160.1 One individual said how she turned to drugs and alcohol to "*try and numb the painful memories of my teenage years and the abuse*";¹⁵⁸
- 9.160.2 In a referral form for therapeutic services, one health care professional explained that the relevant child had used "*cannabis in order to try and relax and forget about things*";¹⁵⁹
- 9.160.3 Documents in another case show that one child had said that they "*used alcohol for confidence*" and professionals considered that "*when intoxicated she was extremely vulnerable to abuse from others.*";¹⁶⁰
- 9.160.4 A parent of a victim/survivor said that their daughter "*started misusing illicit drugs and alcohol when she was in secondary school*"¹⁶¹ as a result of the exploitation to which she was subjected; and
- 9.160.5 Another document shows that a victim/survivor "*admits to drinking heavily*" and "*she says this blocks out her life and keeps her happy.*"¹⁶²
- 9.161 The evidence I have seen shows that drugs and alcohol are used by perpetrators to make children more vulnerable and therefore susceptible to abuse.
- 9.162 The longer term consequence is of course that the use of drugs and alcohol can convert into an adult dependency; either because of addiction, or because victims and survivors turn to drugs and alcohol later in life as a way to block out the pain and deal with the trauma they have suffered as a child.

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156 [REDACTED] pg 2
157 [REDACTED]
158 [REDACTED] pgs 3-4
159 [REDACTED] pg 6
160 [REDACTED] pgs 10-12
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162 [REDACTED] pg 2

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- 9.163 Sadly this can have the most devastating effects. I know of at least one case where the evidence suggests that, as a result of exploitation, the victim became heavily dependent on drugs and alcohol to such an extent that this, alongside mental health trauma, led to her death.

Impact on Professionals

- 9.164 It is clear that the weight of the impact from CSE is felt most by those victims and survivors that have been exploited, and their friends and families that have had to live alongside the trauma. I felt however that it was important to acknowledge that during the course of the Inquiry's work I have also seen the impact that CSE has on those who work with children that are being, or have been, exploited. This is something I have heard through the evidence taken by the Inquiry and therefore it is important that I recognise that.
- 9.165 Many of the witnesses I have spoken to, particularly those at the 'coal-face', have expressed how difficult they have found dealing with some of these cases; feeling that they were doing all they can, within the system that existed, but yet feeling helpless. A number have indicated that even after they have left work, these cases – the suffering of these children – dominated, and in some cases dominate still, their thoughts. I have also heard from witnesses about their mental health being impacted as a direct result of dealing with these cases. I have met with witnesses who became overcome with emotion in giving me their testimony.
- 9.166 I do not make these comments about the effect on professionals to dilute the impact on the victims and survivors in any way; the devastation on their lives bears no comparison. What however is apparent is that the impact of CSE has a wide-reaching ripple effect in a number of ways.

Conclusions

- 9.167 Conclusions as to impact are best made by the voices of survivors. One victim/survivor described the impact of CSE as "*Life Changing... Absolutely desecrating childhood.*"¹⁶³ This individual believed that the only way to understand the impact of CSE was to "*listen to it first-hand*". I firmly agree with this assessment.
- 9.168 During the course of this Inquiry I have heard powerful evidence from those victims and survivors who felt able to speak about their lives. I owe them a debt of gratitude for coming forward and providing their evidence with such courage. I hope that by listening to survivors, others will gain a greater understanding of how the effects of CSE are wide-ranging and life-long.
- 9.169 I received many moving and articulate accounts from victims and survivors that described the impact that CSE had on their lives. Whilst it is impossible to adequately summarise the position, there were two particular witness accounts that for me, illustrate the impact in a far better way than I ever could:

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"[Name] compares the abuse to being like a parasite, eating into every aspect of her life and affecting her mental health, her relationships, and her finances... even professionals don't truly understand and that in fact no-one can, unless they have experienced it themselves."¹⁶⁴

"Yes, I suppose I would say I'm less fortunate, other people might argue differently, you know I'm still here. But ultimately it's been a fine line for me not to do so because my life will always feel like a half-life. My life, because of what happened and the level of abuse that occurred over so many years, will never feel quite whole and that's where we leave victims of child sexual exploitation. Never, ever feeling quite whole."¹⁶⁵

Appendix A

Public Consultation Paper on Terms of Reference

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Independent Inquiry into Telford Child Sexual Exploitation Public Consultation on the Terms of Reference

On 10 June 2019, the Commissioning Body announced the appointment of Tom Crowther QC to the position of Chair to the Independent Inquiry into Telford Child Sexual Exploitation (the "Inquiry"). Following this appointment, the first task for the Commissioning Body and the Chair is to agree the Inquiry's Terms of Reference. A key element of that is public consultation.

Early in 2019, the Commissioning Body began working with the Survivors Committee in Telford to start discussions in relation to the Inquiry's Terms of Reference. Early engagement with the Survivors Committee was a priority. This work was designed to ensure that public consultation on the Terms of Reference was focussed, and that once appointed the Chair's work could begin without delay.

Overview

The Terms of Reference of an inquiry are crucially important; they define the breadth and complexity of an inquiry's work. It is important to strike the right balance between:

- (i) Terms of Reference that are too wide or unclear, and therefore an inquiry may end up delivering wide-ranging recommendations that do not address the essential issues, as well as increasing the cost and duration of an inquiry, creating unacceptable delay; and
- (ii) Terms of Reference that are too narrow, thereby restricting an inquiry from dealing with all relevant matters and delivering results.

The objective is to define Terms of Reference that provide answers to the key issues, but which are achievable to deliver within an acceptable timeframe.

Invitation to Consult

The Commissioning Body and the Chair would like to hear the views of those who are directly affected by the matters due to be considered, and those that are likely to be involved in some way with the Inquiry's work. The opportunity to provide input to this consultation process is however open to all, and all responses will be considered.

In broad terms, the purpose of the Inquiry is:

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- (i) to fully investigate and establish the facts of child sexual exploitation (“CSE”) in Telford & Wrekin;
- (ii) to identify if, and where, public, and other, services have failed and where possible, to establish who is accountable for any failure; and
- (iii) to make recommendations for the future.

The Commissioning Body and the Chair would like to invite input and commentary on what the Inquiry’s work should cover.

All comments and views are welcome; the Chair and the Commissioning Body approach this consultation process with an open mind. There are however a few areas where views are specifically sought:

Question 1: What period of time should be under examination?

The Inquiry has not yet received any documentation in relation to CSE in Telford. It is however apparent from discussions that have taken place with CSE survivors that instances of CSE extend back many years, and are also continuing today. There are a number of aspects to consider when defining the period of time that the Inquiry will examine and how far back it should look back:

- The importance of learning lessons and identifying any patterns and trends from historical events;
- The availability of documentation and the availability and recall of witnesses relating to historical events, which may mean that reaching any reliable and meaningful findings in respect of events dating back a number of decades is difficult; and
- The impact that having Terms of Reference that span a number of decades will have on the duration of the Inquiry, and the Chair’s ability to deliver recommendations designed to make things better for the future without unacceptable delay.

The Inquiry is also giving careful consideration to whether the period under examination could be restricted to a specific timeframe, but with a number of case studies being examined from an earlier period, particularly where evidence is available, which would allow meaningful conclusions on that earlier period to be reached.

Views are sought on the timeframe that the Inquiry should consider, and whether historical case studies may serve to cover an earlier period.

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Question 2: Location

The Inquiry has been established by Telford & Wrekin Council. It is therefore important that it is the local community that benefits from the Inquiry's work, although inevitably lessons may be capable of being applied more widely.

The Inquiry's preliminary view is that the instances of CSE relevant to the Inquiry are those where the victim/survivor lived in Telford at the time of the exploitation, or the first instance of exploitation, as there may be instances where the exploitation continued despite that victim/survivor having moved out of the area. This would mean that where CSE has taken place in Telford, but the victim/survivor did not live in Telford, such cases would not be covered by the Inquiry's remit.

Please provide your views and comments on location.

Question 3: How should the Inquiry define 'CSE' and the cases that it looks at?

The Inquiry is tasked with examining CSE. It is therefore important to define what this means in practice, and therefore what cases will/will not fall within the remit of the Inquiry. The Chair and the Commissioning Body invites views and comments on how 'CSE' should be defined. What important aspects should be included? Should the instances of CSE examined by the Inquiry be limited to those where the victim/survivor was a child at the time of the exploitation, and how should this be defined?

Question 4: What do you want the Inquiry to achieve?

It is vital that those who are directly affected by the matters due to be considered, and those that are likely to be involved in some way with the Inquiry's work, have an opportunity to explain what they want the Inquiry to achieve.

Any other additional comments and views on the scope of the Inquiry's work are welcome.

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Consultation Event

On Tuesday 2 July 2019 at 6:00pm, the Inquiry will be holding a public session to provide an opportunity to meet the Chair of the Inquiry and for the Chair to gather input as part of the consultation process. There will be a short opening address from the Chair, but the purpose of the event is for the public to provide their views and comments on the Inquiry's Terms of Reference. Details of the public session are as follows:

Date and Time: Tuesday 2 July 2019 at 6:00pm

Venue: Ramada Hotel, Forge Gate, Telford, TF3 4NA

The public session is open to all. To assist the Inquiry in managing the arrangements, it would be helpful if you could register your interest and likely attendance by emailing mail@iitcse.com by Friday 28 June 2019.

Consultation Timescales

The consultation will **close on Friday 5 July 2019 at 12pm.**

Responses to the consultation can be sent as follows:

- By E-mail to mail@IITCSE.com with the subject "Consultation Response"
- By Post to IITCSE, c/o Eversheds Sutherland (International) LLP, 115 Colmore Row, Birmingham, B3 3AL
- By calling the Inquiry team on 0800 389 4322, and a member of the Inquiry team can make a note of your comments.

Those providing a written response are asked to keep to a word limit of 1,000 words, as far as possible.

The Commissioning Body and the Chair will consider all responses to the consultation, and take these into account when preparing and agreeing the Terms of Reference.

12 June 2019

Appendix B
Terms of Reference

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Terms of Reference

Aims and Objectives

1. The overall aim and purpose of this Inquiry is to raise public awareness of child sexual exploitation (CSE) in Telford during the period covered by the Inquiry. It will provide an opportunity for anyone who has relevant evidence to be heard, particularly victims, survivors and their families. The Inquiry will be informed by their concerns, and information provided by others, to establish what recommendations can be made to ensure CSE is recognised, reported and steps taken to protect children and help prevent CSE in the future.

What will be examined?

2. The Inquiry will be tasked with examining the following:
 - 2.1 The **nature, extent and patterns** of CSE in Telford;
 - 2.2 The **impact** of CSE on victims and survivors, as well as on their partners, parents, children, families, and others close to them, including the mental, physical, social and economic impact;
 - 2.3 The history of changes made to **practice, policy and/or legislation** in place to identify and address CSE in Telford, and the sufficiency of such changes;
 - 2.4 The **attitude, and changes in attitude**, towards CSE and victims and survivors of CSE, including whether, when and how those attitudes changed;
 - 2.5 The local **taxi industry** and taxi licensing, and the night-time economy, and the impact that has had on CSE;
 - 2.6 The **response** of third party organisations to CSE, or suspected CSE, both generally and in specific cases, including but not limited to Telford & Wrekin Council and its relevant departments as well as the local safeguarding board, Police, local NHS organisations, education providers, care homes and others. In particular, the Inquiry will consider:
 - 2.6.1 the nature, adequacy and timeliness of any response, or lack of a response;
 - 2.6.2 sharing of information and the extent of multi-agency working in respect of CSE. How and when was, and is, information shared between agencies;
 - 2.6.3 any missed interventions;
 - 2.6.4 how complaints related to CSE were dealt with, including the handling of whistleblowers;
 - 2.6.5 the decision-making process behind the prosecution of cases;
 - 2.6.6 the response to, and impact on, those who reported CSE crimes; and
 - 2.6.7 the extent to which any failures by those third party organisation has been addressed by changes to practice, policy or legislation.
3. In relation to the matters set out above at paragraph 4, the Inquiry will identify if there were, and are, any organisational and systemic failures.

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Existing local reviews/reports

4. In light of its findings, the Inquiry will consider whether the following **existing reviews/reports** drew accurate conclusions:
 - 4.1 Telford & Wrekin Council's Safeguarding Children Board's report on Child Sexual Exploitation Learning, April 2014;
 - 4.2 Telford & Wrekin Council's Children and Young People Scrutiny Committee's review of Multi-Agency Working Against CSE, May 2016; and
 - 4.3 Ofsted's 2016 report on Telford & Wrekin Council's services for children in need of help and protection, children looked after and care leavers, and a review of the effectiveness of the Local Safeguarding Children Board.

Recommendations

5. If the Chair considers it appropriate, to make recommendations to ensure CSE is recognised, reported and steps taken to protect children and prevent CSE in the future. Any such recommendations will include a two-year review to assess the extent to which the recommendations have been implemented.

Timeframe and Location

6. The Inquiry will hear from all victims and survivors regardless of when they experienced CSE, and will make evidential findings where possible. It is however acknowledged that due to availability of documentation, and the fact that practices will have moved on, it will be more difficult to make meaningful conclusions for earlier periods of time. Therefore, in respect of drawing conclusions and making recommendations for the future, the focus will be on the period from 1989¹ up until such date as the Chair may determine.²
7. The scope of the Inquiry is limited to those cases of CSE where there is some link to Telford. For example, the victims/survivors may have been living in Telford at the time they were exploited, or the first instance of their exploitation, they may have been educated in Telford or they may have been trafficked to Telford to be exploited.

Definitions

8. For the purposes of this Inquiry and instances of CSE, 'Child' means a person up to the age of 18, or in certain circumstances up to 21 or 25.³ If however a 'Child' suffers their first instance of exploitation whilst within this age bracket, and that exploitation continues

¹ This being the date that the Children Act 1989 came into force.

² This date not being earlier than the appointment of the Commissioning Body on 22 January 2019.

³ The Children Act 1989 places duties on local authorities to provide services and support to 'looked after' and previously 'looked after' children as they exit the care system, for such persons up to the age of 21, or up to 25 if in full time education. The Inquiry's remit will include examining the response of organisations, including local authorities, to reported or suspected cases of CSE. Therefore, given these obligations, it is important that the Inquiry's Terms of Reference considers cases where the first instance of exploitation took place when the victim/survivor was a "former relevant child" or a "qualifying person" within the sense of s.23C or s.24 of the Children Act 1989.

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beyond the relevant age, the circumstances of the exploitation throughout the period it subsists will fall within the Terms of Reference of this Inquiry.

9. For the purpose of this Inquiry, "Child Sexual Exploitation" is taken to refer to a situation, relationship or context where another individual/s manipulates, controls, intimidates or threatens a child, or those who are close to the child, to perform sexual activities on them, or others, or allow them, or others, to perform sexual activities on the child. In some cases the child may receive something in return; in others the child may be controlled by fear and/or violence; it may be a combination of both. The perpetrator may be an adult, or may be a peer. The child may become commoditised, with them being sold between perpetrators and trafficked.

Appendix C
List of Issues

Independent Inquiry Telford Child Sexual Exploitation

List of Issues

This List of Issues has been prepared in order to provide guidance as to the interpretation of the Inquiry's Terms of Reference and give an indication of the issues that will be examined during the Inquiry's work.

The List of Issues is not a prescriptive list and is not intended to cover all issues that will be investigated; it is a guide only to assist understanding and interpretation of the Inquiry's Terms of Reference. The List of Issues is a live document and may be added to and amended during the course of the Inquiry. Additions or amendments will be made in tracked changes. Nothing in the drafting of the List of Issues should be taken as an indication of the views of the Chair on the issues to be investigated.

Date: 3 October 2019

The Issues

1. *The **nature, extent and patterns** of CSE in Telford.* The Inquiry will be exploring specific instances of CSE to understand the circumstances under which such crimes are committed, which will include establishing a factual account of:
 - 1.1 The approximate number of victims of CSE in Telford during the relevant period;
 - 1.2 The methods by which CSE takes place and the form the exploitation takes;
 - 1.3 The location/s where CSE happens; and
 - 1.4 Whether there are any patterns and common features of CSE in Telford.
2. *The **impact** of CSE on victims and survivors, as well as on their partners, parents, children, families, and others close to them, including the mental, physical, social and economic impact.* The Inquiry will look to investigate both the short term and long term impact on survivors and victims of CSE, and those close to them. This will include:
 - 2.1 The impact on their health, both physical and mental health;
 - 2.2 The impact on their education and future working life;
 - 2.3 The impact on their families, including children in their care; and
 - 2.4 Exploring whether victims and survivors were, and are, criminalised for circumstances associated with their exploitation, and/or treated differently, and the impact that has had in the future.
3. *The history of changes made to **practice, policy and/or legislation** in place to identify and address CSE in Telford, and the sufficiency of such changes.* The Inquiry will look to investigate organisations and bodies who had a duty to protect

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victims and survivors, and potential victims and survivors, from CSE, examining the policies, procedures and practices that were in place during the relevant time to (i) identify CSE (ii) act when there are concerns, and (iii) prevent CSE, including:

- 3.1 When were any policies, practices and guidance introduced, how did they develop and what is in place now;
- 3.2 Whether those policies, procedures and practices are/were sufficient and “joined up”;
- 3.3 The extent to which such policies, procedures and practices are/were known, understood and implemented across the relevant organisation/s. This will involve an examination of training, and management and supervision of relevant personnel;
- 3.4 The extent to which available resources are/were used to support the implementation of policies, procedures and practices; and
- 3.5 The extent to which there is/was oversight to ensure policies, procedures and practices are working.
4. *The **attitude, and changes in attitude**, towards CSE and victims and survivors of CSE, including whether, when and how those attitudes changed.* In particular, the Inquiry will look at:
 - 4.1 Whether CSE has been/is readily recognised and addressed by professionals? If not, why not?
 - 4.2 Has there been, and is there, a level of insensitivity when dealing with victims and their families?
 - 4.3 Were there victim-blaming attitudes within organisations, and if so, does this still exist?
 - 4.4 Did/do any of these attitudes affect the way that organisations addressed and intervened in CSE cases?
 - 4.5 Has there been any perceived public shift in attitudes to CSE in Telford if/when attitudes changed, and what impact (if any), did this have on the reporting of CSE.
5. *The local **taxi industry** and taxi licensing, and the night-time economy, and the impact that has had on CSE.* The Inquiry will examine the suggestion that taxis have been used to facilitate CSE offences and that the licensing regime has allowed taxi licenses to be used inter-changeably without detection, allowing CSE offences to be committed more easily. The use of the word ‘night-time economy’ is to describe other outlets and premises, that are open during the evening, that may also have been used to facilitate CSE offences, such as restaurants, take away outlets, pubs and clubs. The Inquiry will therefore also examine the extent to which

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the night-time economy has played a role in the committing of such offences. In doing so, the Inquiry will look at:

- 5.1 The operation of the taxi industry and night-time economy and their role in CSE;
 - 5.2 The local authority's management and oversight of these industries; and
 - 5.3 The extent to which changes could be made to help prevent such industries being used to help facilitate CSE.
6. *The **response** of third party organisations to CSE, or suspected CSE, both generally and in specific cases, including but not limited to Telford & Wrekin Council and its relevant departments as well as the local safeguarding board, Police, local NHS organisations, education providers, care homes and others. In particular, the Inquiry will consider:*
- 6.1 *The nature, adequacy and timeliness of any response, or lack of a response. The Inquiry will explore how individual organisations responded, and respond, to CSE concerns and CSE cases, for example:*
 - 6.1.1 where concerns were raised or CSE indicators displayed, how were these addressed?;
 - 6.1.2 what actions were/are taken to both protect children and bring perpetrators to justice?;
 - 6.1.3 were, and are, adequate risk assessments carried out?;
 - 6.1.4 when did organisations become aware that CSE was an issue locally? When should they have become aware?;
 - 6.1.5 if there was/is a lack of action, why was this?
 - 6.2 *sharing of information and the extent of multi-agency working in respect of CSE. How and when was, and is, information shared between agencies. The Inquiry will look to address this by considering the extent to which there was, and is, any sharing and triangulation of data and intelligence across relevant organisations, for example:*
 - 6.2.1 how was/is intelligence collected by organisations and how was/is it shared between organisations?;
 - 6.2.2 when and how would, and do, organisations raise and report concerns to others;
 - 6.2.3 if information was/is shared and reported, what was/is then done with this information, and is it acted on?;

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- 6.2.4 was/is intelligence from Police investigations shared with Social Services, and others, to ensure victims were/are protected on an ongoing basis?;
- 6.2.5 was/is there a cross agency strategic plan for identifying victims and perpetrators?
- 6.2.6 were, and are, professionals adequately trained and made aware of CSE, potential indicators and what to do and who to speak to?
- 6.3 *any missed interventions.* The Inquiry will be looking to identify whether there are specific cases where organisations failed to intervene, missed an opportunity to do so, or did not take adequate steps to protect an individual. This will include identifying whether there are instances where concerns were raised and not followed up, and whether there are specific cases where conducting a Serious Case Review would have been appropriate, but was not carried out?
- 6.4 *how complaints related to CSE were dealt with, including the handling of whistleblowers.* The Inquiry will examine the complaints and whistleblowing policies and procedures of relevant organisations, looking at when they were introduced, the nature of the policies and procedures, and how complaints and whistleblowing reports are managed in practice. This will cover both internal and external complaints and whistleblowing reports. The Inquiry will particularly look at all complaints and whistleblowing reports that relate to CSE and the way that these have been addressed. For example: has there been any attempt to suppress concerns and/or have any whistleblowers been forced out of their employment for speaking out about CSE? Have organisations used non-disclosure agreements to prevent individuals from speaking out further?
- 6.5 *the decision-making process behind the prosecution of cases.* The Inquiry will investigate the decisions made by the Police which determined the files that were submitted by the Police to the Crown Prosecution Service ("CPS") for consideration, and establish:
 - 6.5.1 the standards and relevant guidelines that should have been applied when investigating allegations and referring files for prosecution;
 - 6.5.2 whether or not those standards and guidelines were followed and, if not, identifying the reasons for this.
- 6.6 *the response to, and impact on, those who reported CSE crimes.* The Inquiry will look to establish an overview of the reporting systems that were/are in place within organisations to handle disclosure by children and others of concerns about CSE over the relevant period? A review of these systems will also include an examination of:
 - 6.6.1 with whom was any disclosure shared;
 - 6.6.2 what was the response to the individual making the report and what impact did this have;

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- 6.6.3 at what point would the police become involved (if the report was not made directly to the Police);
 - 6.6.4 what guidance and procedures did/do the police have in place for managing and investigating such allegations; and
 - 6.6.5 the extent to which individuals were/are trained on handling such disclosures, and whether this developed over time.
- 6.7 *the extent to which any failures by those third party organisations have been addressed by changes to practice, policy or legislation.* In order to ensure the Inquiry is able, if appropriate, to make recommendations for the future to effect positive change, the Inquiry will need to examine the extent to which any concerns, weaknesses or failures related to CSE have been addressed by organisations, changes made and the impact of those changes. In so doing, the Inquiry will also need to look at:
- 6.7.1 any assessments, reports, reviews, guidance and other documents that highlighted organisational failures or weaknesses associated with CSE; and
 - 6.7.2 the extent to which the findings were taken on board and addressed.

Existing local reviews/reports

- 7. *in light of its findings, the Inquiry will consider whether the following **existing reviews/reports** drew accurate conclusions:*
 - 7.1 *Telford & Wrekin Council's Safeguarding Children Board's report on Child Sexual Exploitation Learning, April 2014;*
 - 7.2 *Telford & Wrekin Council's Children and Young People Scrutiny Committee's review of Multi-Agency Working Against CSE, May 2016; and*
 - 7.3 *Ofsted's 2016 report on Telford & Wrekin Council's services for children in need of help and protection, children looked after and care leavers, and a review of the effectiveness of the Local Safeguarding Children Board.*
- 8. The Inquiry will examine the reports to establish whether, in light of its own findings, the conclusions reached were a fair and accurate representation at the time, bearing in mind the information available, and if not, why accurate conclusions were not reached.

Timeframe and Location

- 9. *The Inquiry will hear from all victims and survivors regardless of when they experienced CSE, and will make evidential findings where possible.* This means that anyone who has evidence to give concerning CSE in Telford is invited to come forward. The Inquiry will make findings where they can be supported by evidence.

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10. *It is however acknowledged that due to availability of documentation, and the fact that practices will have moved on, it will be more difficult to make meaningful conclusions for earlier periods of time. Therefore, in respect of drawing conclusions and making recommendations for the future, the focus will be on the period from 1989¹ up until such date as the Chair may determine.² What this means in practice is that, when the Inquiry is seeking documents that are relevant to the Inquiry's Terms of Reference from organisations, it will make general requests for any and all relevant documents, but the searches for such documentation are likely to be limited in timescale to 1989 onwards. If however the Inquiry becomes aware that earlier, relevant documents may still be available, it can make specific requests to organisations for that documentation to be disclosed.*
11. *The scope of the Inquiry is limited to those cases of CSE where there is some link to Telford. For example, the victims/survivors may have been living in Telford at the time they were exploited, or the first instance of their exploitation, they may have been educated in Telford or they may have been trafficked to Telford to be exploited.*

Definitions

12. *For the purposes of this Inquiry and instances of CSE, 'Child' means a person up to the age of 18, or in certain circumstances up to 21 or 25.³ If however a 'Child' suffers their first instance of exploitation whilst within this age bracket, and that exploitation continues beyond the relevant age, the circumstances of the exploitation throughout the period it subsists will fall within the Terms of Reference of this Inquiry. The Inquiry recognises that even though the exploitation first occurs whilst a victim/survivor is still a 'Child', it can continue beyond this age, and the incidents of CSE in such circumstances are still relevant to the Inquiry's Terms of Reference.*
13. *For the purpose of this Inquiry, "Child Sexual Exploitation" is taken to refer to a situation, relationship or context where another individual/s manipulates, controls, intimidates or threatens a child, or those who are close to the child, to perform sexual activities on them, or others, or allow them, or others, to perform sexual activities on the child. In some cases the child may receive something in return; in others the child may be controlled by fear and/or violence; it may be a combination of both. The perpetrator may be an adult, or may be a peer. The child may become commoditised, with them being sold between perpetrators and trafficked.*

¹ This being the date that the Children Act 1989 came into force.

² This date not being earlier than the appointment of the Commissioning Body on 22 January 2019.

³ The Children Act 1989 places duties on local authorities to provide services and support to 'looked after' and previously 'looked after' children as they exit the care system, for such persons up to the age of 21, or up to 25 if in full time education. The Inquiry's remit will include examining the response of organisations, including local authorities, to reported or suspected cases of CSE. Therefore, given these obligations, it is important that the Inquiry's Terms of Reference considers cases where the first instance of exploitation took place when the victim/survivor was a "former relevant child" or a "qualifying person" within the sense of s.23C or s.24 of the Children Act 1989.

Appendix D

List of Organisations – Stakeholder Disclosure

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Appendix D

The following organisations disclosed documents to the Inquiry:

NHS Providers

- NHS England
- British Pregnancy Advisory Scheme
- Telford & Wrekin Clinical Commissioning Group
- Charlton Medical Practice
- Court Street Medical Practice
- Dawley Medical Practice
- Donnington Medical Practice
- Hollinshead Surgery
- Ironbridge Medical Practice
- Linden Hall Surgery
- Shawbirch Medical Centre
- Stirchley Medical Centre
- Teldoc
- Wellington Road Medical Practice
- Wellington Road Surgery
- Woodside Medical Practice
- Midlands Partnership NHS Foundation Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospitals NHS Trust
- Shrewsbury & Telford NHS Trust
- Shropshire Community NHS Trust

Schools

- Burton Borough School
- Charlton School
- Telford Priory School
- Telford Langley School

Councils

- Telford & Wrekin Council
- Shropshire Council

Law enforcement

- South Yorkshire Police
- West Mercia Police
- West Midlands Police Regional Organised Crime Unit
- West Midlands Police
- Office of the Police and Crime Commission
- Crown Prosecution Service

Other

- National Referral Mechanism
- National Society for the Prevention of Cruelty to Children

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- Inquiry sourced documents
- Witness documents
- The Holly Project

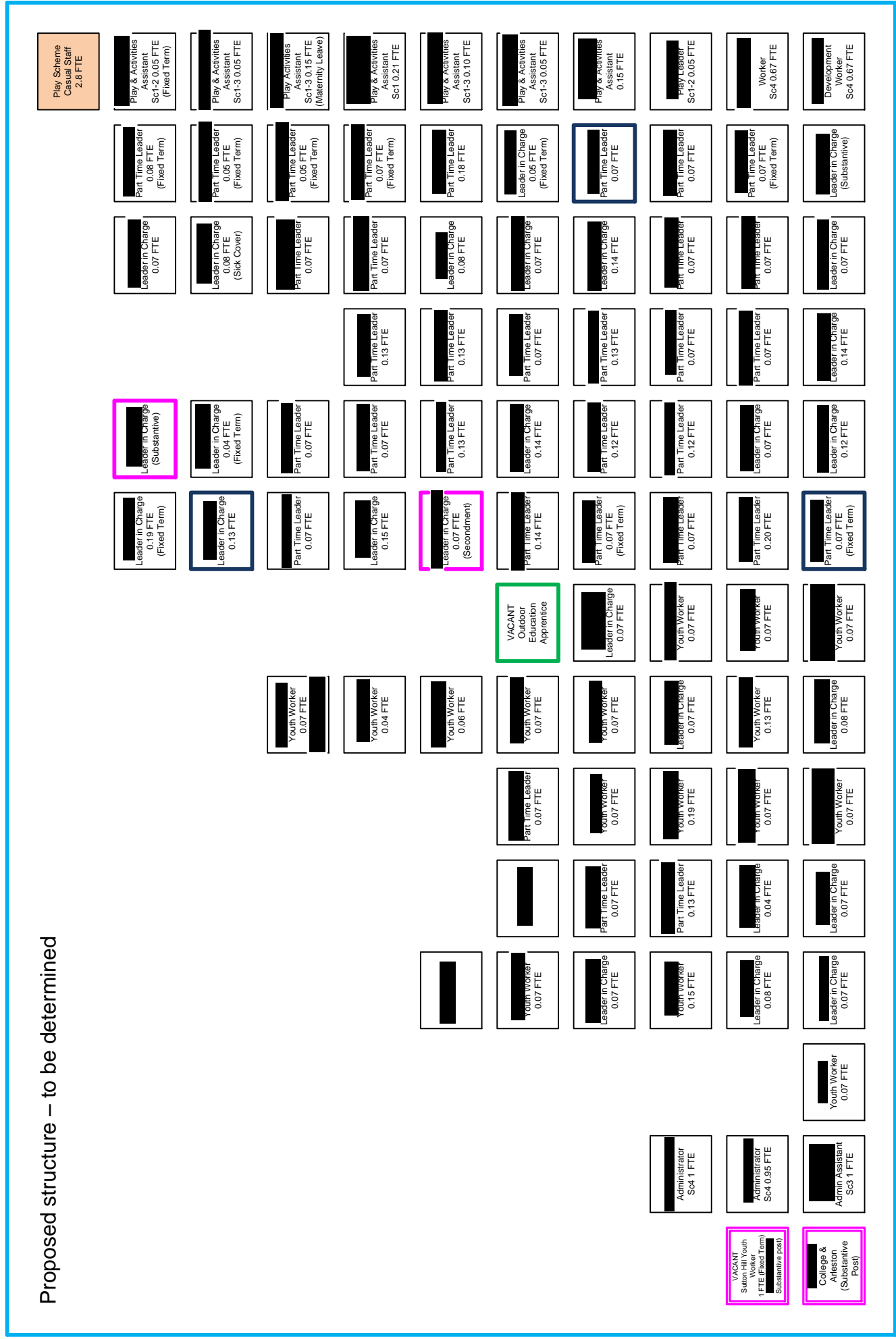
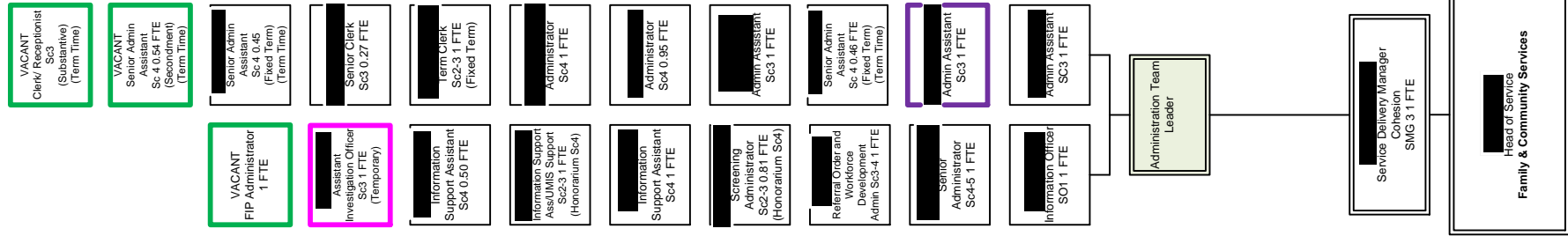
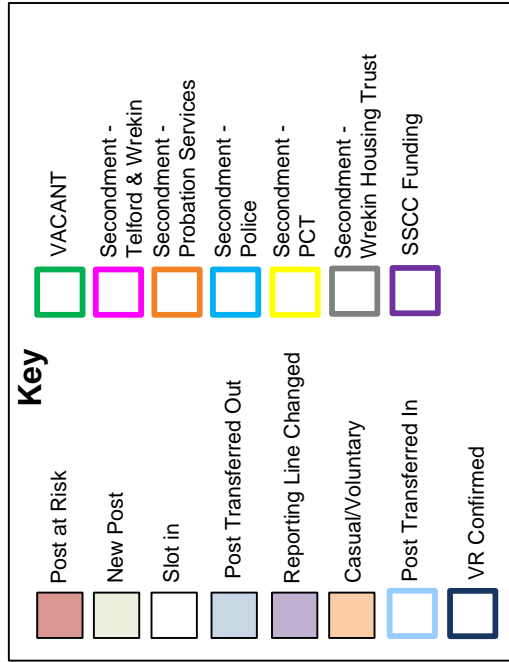
Appendix E

Telford & Wrekin Proposed Restructure Chart

Family & Community Services

Phase 2 Proposed Structure September 2011

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Appendix F

Telford & Wrekin Scrutiny Review of CSE May 2016 - Recommendations

Recommendations

Understanding Scale of CSE

Recommendation 1: Initial work to identify scale of CSE

The Committee recognises that the term CSE is a broad definition that covers a range of criminal offences, and that organisations in Telford and Wrekin are working together to identify the indicators of CSE which will enable them to then identify victims and take appropriate action. The Committee recommends that the current data from the West Mercia Police Problem Profile, Family Connect, the CATE Team and other Council services is used to develop a common understanding the scale and types of CSE in the Borough and how this changes over time. The facts about the scale of CSE in the Borough should be made accessible to the public and used as part of the awareness raising activity with the public, young people of secondary school age and training staff and volunteers. (The committee recognises that recorded data will reflect that CSE is an under-reported crime and that this exercise will not provide a definitive figure but want to ensure that organisations are working together to develop a common understand of CSE in the Borough.)

Recommendation 2: Ongoing Monitoring of Scale of CSE

All LSCB partner organisations and the CPS should flag/record all cases of CSE. This data should be reported initially to the LSCB and then on a 6 monthly basis to the CSE Strategy Group and compared to the data held on Family Connect to ensure that there is a shared understand of the scale of CSE in the Borough and that trends in the data are monitored and inform the planning and delivery of all relevant services. The LSCB should include local data on CSE in the Board's Annual Report.

Recommendation 3: Annual Review of CSE Strategy

That the CSE strategy is reviewed annually by the LSCB and informed by the experience of survivors of CSE, their family and carers and front line staff. The updated strategy should reflect changes in models of CSE and this should inform training for staff and volunteers

Recommendation 4: Impact of Cuts to Services

The Committee was assured in March 2015 that local resources to tackle CSE had not diminished as a result of government cuts. However, as further cuts are made the Committee cannot be sure that this will continue to be the case in the future. The Committee recommends that the LSCB monitors the impact of cuts to local services and also the loss of expertise and knowledge within organisations as staff numbers are reduced.

Recommendation 5: Links to Other Policies and Strategies for Adults

The Committee recognises that, while the definition of CSE sets the age limit for victims as 18 years of age, the impact of CSE for the victim and their family is lifelong. The Committee therefore recommends that the Council and CCG review the following strategies and policies to ensure that the needs of those affected by CSE are recognised and met:

- The Joint Strategic Needs Assessment
- The strategies and action plans for the Commissioning and Transformation Partnerships
- Adult Safeguarding Policies and Procedures

The Committee recommend that these reviews takes place by July 2016 and are then updated following the publication of the NICE Guidance on CSE due to be published in 2017.

Support for Victims and Survivors**Recommendation 6: Mapping Support and Agreeing Thresholds**

The Committee commends the development of the CSE Pathway and the work of the CATE team as an alternative route to child protection procedures to provide support and protection to victims of CSE. The Committee recommends that a mapping exercise is undertaken to identify the support available for victims of CSE from the range of organisations from identification through to prosecution and post sentencing. For example this should include CATE, ISVA, AXIS, CAMHS, PCSOs, Youth workers, Victims

Liaison Officers, Witness Care Unit and other relevant services. This information should be available to victims and their families to explain the roles of the different organisations and how they are accessed.

The mapping exercise should also inform a multi-agency agreement on the threshold of need for different services and set out clearly how organisations support victims/survivors according to the level of risk and how services change as the level of risk increases or reduces. The planning of any transition process should take into account the need for vulnerable young people to have continuity of support from staff with whom they have developed a relationship of trust. In their role as corporate parents, members want to ensure that as part of their assessment and care planning, all children in care are assessed for their risk of CSE and that this is reviewed on an ongoing basis by the Independent Reviewing Officer as part of the child care plan.

Recommendation 7: Therapeutic Support

Local Recommendation 7a

The need for therapeutic support for victims and their families has been highlighted during this review. From the evidence the Committee has received the level of need for this service is far greater than current services are able to provide. The Committee recognises that this is not just a local issue as it has also been identified by Professor Alexis Jay in 2015 and by other local authority scrutiny reviews. Due to the complex and sensitive nature of this service, it must be provided by experienced and qualified practitioners and this will have significant resource implications. The Committee recommends that local organisations work together to ensure that the immediate and ongoing therapeutic need of victims/ survivors and their families are recognised in the commissioning strategies.

National Recommendation 7b

However, given the scale of cuts to local public sector organisations, the Committee also recommends that the Department of Health, the Home Office and the Department for Local Government and Communities urgently review the national funding available to support for victims of CSE and their families. This should include support available from the point at which a young person is identified as a victim of CSE, through the criminal justice process and long term support.

Recommendation 8: Child and Adolescent Mental Health Services

When commissioning the Child and Adolescent Mental Health (CAMH) service, the CCG ensures that:

The role of the CAMH service is clarified with partner organisations, professionals and service users so there is a clear understanding of the role of the CAMH service in both diagnosis of mental health issues and also in providing ongoing intervention and support.

Victims of CSE who are referred to the CAMH service but do not recognise the need for or want specialist help at that time are contacted by the CAMHS at a later stage to invite them to seek support.(currently patients who decline the service are not followed up and a second referral is required)

Appropriate training is provided so staff supporting young people with mental health issues recognise and respond appropriately to CSE. The committee would like to highlight this specifically for services for young people who self-harm or have attempted suicide.

Current gaps in the CAMH service that should be addressed in the commissioning process are support provided by the following professionals: Art Therapist, Family Therapist, Psychologists and Dedicated CSE Consultant.

A more robust CAMH service within the CATE team is developed similar to the CAHM and Youth Offending Team model.

The referral process for GP to access CAMHS and the Family Intervention Service should be streamlined so if a patient is referred by a GP to CAMHS but does not meet the criteria for this service the patient is referred to the Family Intervention Service (not back to the GP to make another referral through Family Connect.)

Recommendation 9: Sexual Health Services

The Committee welcomed the development of the new sexual health service in Telford Town Centre that will have specific facilities for vulnerable young people, including victims of CSE. Given the need identified for this service by a range of different individuals

and organisations during the review, the Committee recommends that, after the service has been in place for 6 months, members of the CSE operational group review how this service is meeting the needs of victims of CSE. Any issues from this review should be reported to the CSE operational group or the LSCB. Some specific issues that have been identified during this review are:

- All victims of CSE should be offered a full sexual health check, for people aged 13 or over through specialist sexual health services commissioner by Telford & Wrekin Council and for those under 13s through the Sexual Assault Referral Centre (SARC) commissioned by NHS England
- When a perpetrator of CSE has a sexually transmitted infection the affected victims are offered support and screening. NB for children under 13 the screening is through the Sexual Assault Referral Centre (SARC) commissioned by NHS England
- All victims of CSE who have been raped can choose to be examined by an appropriately qualified female clinician within the specified timescales required for evidence, through the Sexual Assault Referral Centre (SARC) commissioned by NHS England
- Young people who frequently access emergency contraception services or have repeat abortions receive appropriate support and advice from primary care, pharmacies and specialist sexual health services about CSE. The commissioning responsibilities for these services are as follows:
 - Emergency contraception services in pharmacies and specialist sexual health services – Telford & Wrekin Council
 - Abortion services and emergency contraception in primary care/General Practice - NHS Telford & Wrekin CCG

Recommendation 10: Support for Victims in the Criminal Justice System

National Recommendation: 10a

The Crown Prosecution Service implements a system to flag cases of CSE that they receive to report and analyse this information nationally. (Linked to Recommendation 2 above)

Local Recommendations 10b

Building on the CPS monthly review of failed cases, it is recommended that West Mercia Police and West Midlands CPS report annually to the Telford and Wrekin CSE Strategy Group the number of cases of CSE where an investigation has identified victims and perpetrators of CSE but the cases have not gone to court because of insufficient evidence or where the witness withdrew from the process. This information should be shared with the ISVA service and CATE Team to identify learning from these cases to improve the support provided to victims of CSE during the criminal justice process and increase the chance of prosecution and conviction. Where appropriate victims of CSE should be invited to contribute to this learning process.

Some specific learning points that have been identified in this review are:

- Victims need to retain confidence in the commitment from all organisations to seek justice in their specific case and that the evidence they provide is not used to build a separate case to the detriment of their own.
- Courts and staff supporting victims through the court process review the facilities and processes to ensure that victims of CSE are not in a public area in the court building with defendants.

Support for Families of Victims and Survivors

Recommendation 11: Safety Plans

An audit of all current CSE cases should be carried out to ensure that victims and parents of victims of CSE should be involved in developing a Safety Plan for their child. (where the young person is not subject to a child protection plan). The outcome of this audit should be reported to the CSE Strategy and Operational Groups to identify any actions required.

Recommendation 12: Parent Support Group

The LSCB / local authority should consult with parents of victims of CSE with a view to establishing a local parent support group. It is recommended that PACE (Parent Against Child Exploitation) is involved in this work. This work should include consideration of

specific support that fathers of victims of CSE may find helpful.

Recommendation 13: Mapping Support for Parents

As set out in Recommendation 6 above, parents of victims of CSE should have accessible information about the range of support services available to their children. Organisations supporting parents should work together to co-ordinate their work and map out the support available for parents. Where possible this should identify a 'parent/ family key worker' and provide contact details for out of hours services.

Awareness Raising and Training

Recommendation 14: Raising Awareness

A long term approach to raising awareness of CSE is needed, similar to a public health campaign. The awareness raising needs to be sustained over a long period and target specific groups. Based on the Committee's consultation with a range of groups it is recommended that the LSCB develops a long term CSE awareness raising strategy for the following groups. Where appropriate victims / survivors and their families should be given the opportunity to be involved and consulted about the work.

Recommendation 15: Young People

Young people aged 11-18 in Telford and Wrekin are provided with the information they asked for about CSE as set out in pages 17-22 of this report. The Committee want to ensure that this information is accessible to all young people including those with disabilities and recommends that learning from the NSPCC report 'Underprotected / Overprotected' is used as part of this work.

Recommendation 16: Children

All children at primary school are made aware of risks of abuse and neglect in an age appropriate way including how to stay safe online. (see Recommendations 18a and 18b below)

Recommendation 17: Parents

- All parents should be encouraged and, where appropriate, supported to talk to their children aged 6-11 about safety using the NSPCC PANTS rule.
- All parents are informed about the risks of CSE, what the signs are, and who to contact if they have concerns. This should include information on risks of CSE including through social media, online and gaming and how parents can discuss these risks with their children and help to protect them.
- Information for parents should include case studies and videos that explain the reality of CSE.
- Specific training on CSE should be provided for all foster carers and staff working with children in care of the local authority.

Recommendation 18: Role of Schools and Colleges in Raising Awareness

National Recommendation 18a

The Committee supports the joint letter from Parliamentary Select Committee chairmen that Sex and Relationship Education (SRE) should become a statutory part of the curriculum and the recommendation from the Children's Commissioner that "all school equip all children ...to understand healthy and safe relationships and talk to an appropriate adult if they are worried about abuse". The Scrutiny Committee recommends that informing children and young people in an age appropriate way about CSE should be included in any future statutory SRE curriculum.

Local Recommendation 18b

- Prior to any national decision about making SRE a statutory part of the curriculum, the authority works with the Primary Heads' Forum and Telford & Wrekin Learning Partnership to seek a joint voluntary agreement for all schools, academies and colleges to teach SRE as part of the curriculum and that CSE is incorporated in an age appropriate way to help safeguard all young people at schools in the borough equally. A package incorporating CSE staff training and SRE curriculum content should be developed jointly (as a co-funded or traded service) possibly linked to the Prevent training currently provided. This should build on existing or free to use material and take into account the views of young people set out in pages 15-20 of this report.
- Work in this area should take into account any future guidance from the Department for Education on the requirement for schools to filter inappropriate contact online and also to teach children about online safety.

- The Committee commends the work of Team Safeguarding Voice (TSV) and recommends that this approach is adopted by all primary and secondary schools in the Borough in line with the existing policy of the LSCB. The skills and knowledge of children involved in TSV at Primary schools should be recognised and developed at Secondary School.
- The LSCB works with Further Education Colleges to ensure appropriate systems are in place so that they receive information about vulnerable students and suspected perpetrators from schools and other statutory organisations.
- The Committee recommends that taxi drivers and operators that provide an excellent service for school transport should be recognised eg through a 'taxi driver of the year award' or a register of taxi drivers and companies that are recommended by schools.

Recommendation 19: Local Organisations and the Public

- A range of methods should be used eg through schools, websites, local media, local employers and businesses. As most parents who responded to the questionnaire reported they got information about CSE from the media, the Committee recommend that opportunities to raise awareness of CSE through local newspapers and radio is explored.
- The Committee recommends that the LSCB engages with the Shropshire Islamic Foundation to explore opportunities for joint working to tackle CSE. An issue raised by the Muslim Women's group was the lack of ESOL courses and computers for women to access information. The Committee recommends that consideration is given to finding ways to use the funding recently announced by the Government to develop local provision to meet the needs of the community.
- The Council's Online training module on CSE should be updated in line with Recommendation 32a below and promoted to all organisations in the Borough alongside the continued roll out of the 'Say Something If You See Something' training for local businesses. Organisations should be encouraged to train staff and volunteers including the CVS, housing providers, faith organisations and local businesses. Due to the low number of referrals to Family Connect from Housing Providers, the Committee recommends that this is priority for the LSCB.

Recommendation 20: Elected Members

Training on CSE should continue to be included in the induction programme for all new Councillors. (This should be open to Borough, Town and Parish Councillors.) An annual update on CSE should be provided for Members with specific training for Members with specific responsibility eg Members of Licensing Committee

Recommendation 21: CATE Team Training

The work of the CATE Team has been commended throughout this review and was instrumental in the successful conviction of CSE perpetrators in Operation Chalice. It is recommended that the expertise of the CATE team is used as part of the CSE training offer that can be marketed externally and that the local knowledge is used to enhance training for local organisations.

Recommendation 22: Organisations responding to publicity

The Committee recognises that there may be concerns about organisational reputation when there are media reports of specific cases of CSE. However, the Committee recommends that all organisations consider the impact of their public statements relating to specific cases on victims.

Information Sharing, Identification, Support, Protection and Disruption

The Committee highly commends the development of the Family Connect service and the CSE Pathway which demonstrate the commitment from partner organisations to tackling CSE. (The role of the local authority in leading the development of these services is recognised by the Committee.) However, the Committee also recognises that no system is perfect and makes the following recommendations that will hopefully improve the robustness of these services:

Recommendation 23: Referrals to Family Connect

Family Connect is designed as an open system – referrals made to other teams in the council or external organisations are not followed up. Members were concerned that if a CSE referral was not acted on – this would only be picked up if a second call were made to Family Connect.

The Committee recommend that the robustness of this service is tested by an audit of 10% of the CSE related referrals to identify if the required follow up action was taken by the team or organisation that received the referral. The outcome of this audit should be reported to the LSCB to consider any action required.

Recommendation 24: Monitoring Referrals to Family Connect

The Committee understand that work is under way to review the way referrals to Family Connect are recorded and monitored. The Committee recommend that this review ensures that there is a system in place for recording, analysing and reporting data about CSE related contacts and referrals and that calls from schools to contact a social worker via Family Connect regarding an existing child protection case is not recorded as a referral.

Recommendation 25: Raising Awareness of Family Connect - Public

Through the awareness raising campaign, all organisations and members of the public should be made aware that Family Connect is the service to contact for non-emergency concerns relating to CSE.

Recommendation 26: Raising Awareness of Family Connect with Educational Establishments

There should be an ongoing training programme for schools, academies and colleges on the Family Connect Service so that new staff are aware of how to make referrals to this service and how the information will be used.

As schools, academies and colleges have such an essential role in the safeguarding of children against CSE it is recommended that an audit of all referrals from schools to Family Connect is carried out. If any schools are identified as having a low referral rate the safeguarding leads from these educational establishments should be contacted to find out why and encourage the school to make appropriate referrals and invited to see the service in operation.

Recommendation 27: Online Access to Family Connect

A wider issue about the online accessibility of the Family Connect service was identified during the review (this issue is not specific to CSE). This has been recognised by the Family Connect Service as an area for improvement. The Committee concluded that the online Family Connect Service is totally inadequate and recommends that:

- A Family Connect brand is developed to ensure that telephone and online services provided by Family Connect are recognised as a single service. The website should include information about how the Family Connect Service works and the names / logos of the partner organisations involved.
- A link to the Family Connect webpage is on the Council's home page
- Online service for Family Connect are further developed, particularly to provide information for children and young people

and enable concerns to be raised on line.

Recommendation 28: Capacity of the CATE Team

The Committee had concerns that the work load of the CATE team is above the level recommended by the National Working Group. The Committee recommends that once the support pathways for victims, survivors of CSE and their families is developed that a review of the work load of the CATE team is undertaken to ensure that the specialist skills are used in the most appropriate way while recognising the need for victims and survivors to maintain on-going relationships. The Committee recommend that the maximum number of cases for each CATE worker should be determined by the LSCB. If this limit is consistently breached then it is recommended that through the LSCB partner organisations review the resources available.

Recommendation 29: Out of Area Placements

OFSTED revisits the recommendations from the 2014 report, From a distance, looked after children living away from their home, to ensure that placing authorities provide appropriate information to the receiving local authority, NHS organisations and police with a specific focus on placement of victims of CSE. This work should also ensure information sharing processes are in place between specialist residential homes for victims of CSE and the local statutory organisations and specific risks or issues should be brought to the Telford and Wrekin LSCB and shared with neighbouring LSCBs if required.

Recommendation 30: Information Sharing with Community Health Trust

As a matter of urgency, information sharing systems are put in place to ensure that clinicians working for Shropshire Community Health Trust have access to the same child protection information as the staff at the hospital trust.

Recommendation 31: Whistle Blowing Hotline

A whistle blowing hotline is established to enable people who have information but may want to provide this anonymously to raise concerns about CSE.

Recommendation 32: Disruption Activity

Local Recommendations 32a

- A strategy is developed, supported by an appropriate IT system, to enable licensing and enforcement officers at the Council to record and share intelligence on CSE internally and with the police. This should include bespoke training for all enforcement staff and other Council staff working in public places to ensure they are aware of how to identify indicators of CSE in premises, locations and licensed businesses and how to record this information. It is recommended that the IDB system should be considered as the information sharing platform as this is accessible to other subscribing local authorities but it would be essential that the police and Family Connect also have access to this system.
- Consideration should be given to developing a local authority licensing and enforcement Disruption Toolkit (similar to the toolkit used by West Midlands Police which sets out policing powers) so that staff are clear about the powers that exist and how they can be used by the authority or in conjunction with the police to disrupt CSE activity. This could be developed with peers in other authorities.
- Telford & Wrekin Council's licensing policies are reviewed as a matter of urgency to include the following:
 - A review of taxi licensing policies to bring them up to the same standard as Shropshire's in terms of safeguarding responsibilities. In particular that:
 - CSE training should be a condition of driver licensing
 - Vehicle safety and emissions standards should be consistent with Shropshire
 - A requirement for operators to have a designated CSE contact for drivers to report concerns confidentially
 - A review of the licensing conditions for all licensed businesses where children and young people congregate to strengthen safeguarding conditions. This must include robust conditions for night clubs holding under-18 events by requiring events to be age limited for 12-15 year olds or 16-18 year olds and for all under-18 events to be ticketed in advance.

National Recommendations 32b:

At a national level the Committee supports the recommendation from the Law Commission that there should be consistent national standards for licensing.

That the DBS checking service recognises taxi driving as a high risk occupation that has prolonged, regular and unaccompanied contact with children so that all relevant information is disclosed to licensing authorities.

PCSOs should have access to information to identify drivers of cars that are registered as trade vehicles. The Committee recognises that if this information is not already available that this recommendation should be directed nationally to the Driver and Vehicle Licensing Agency (DVLA)

Support for Staff

Recommendation 33: Supervision for CATE Team

Regular professional supervision arrangement should be in place for members of staff in the CATE team.

Recommendation 34: Personal Safety

All organisations whose staff work with or come into contact with perpetrators of CSE ensure that the personal safety risks for their staff are properly assessed and managed.

Examination of Digital Evidence

Recommendation 35: Forensic Examination of Digital Devices

It was reported that there were delays in forensic examination of electrical devices seized. The Committee recommends that the LSCB monitors the implementation of the West Mercia Force Hub to ensure that there is a 5 day turn around on forensic examination of electrical devices.

Preventing CSE / working with Perpetrators

Recommendation 36: Working with Potential Perpetrators of CSE

Organisations should work together to identify people at risk of becoming perpetrators of CSE and prevent them from becoming involved. This could be linked to the Prevent agenda since perpetrators can groom other young people to procure victims of CSE – this can be seen as a form of radicalisation.

Housing

Recommendation 37: Appropriate Accommodation

Housing providers work with the probation service to ensure appropriate accommodation is available for perpetrators of CSE when they leave prison.

Recommendation 38: Housing Providers

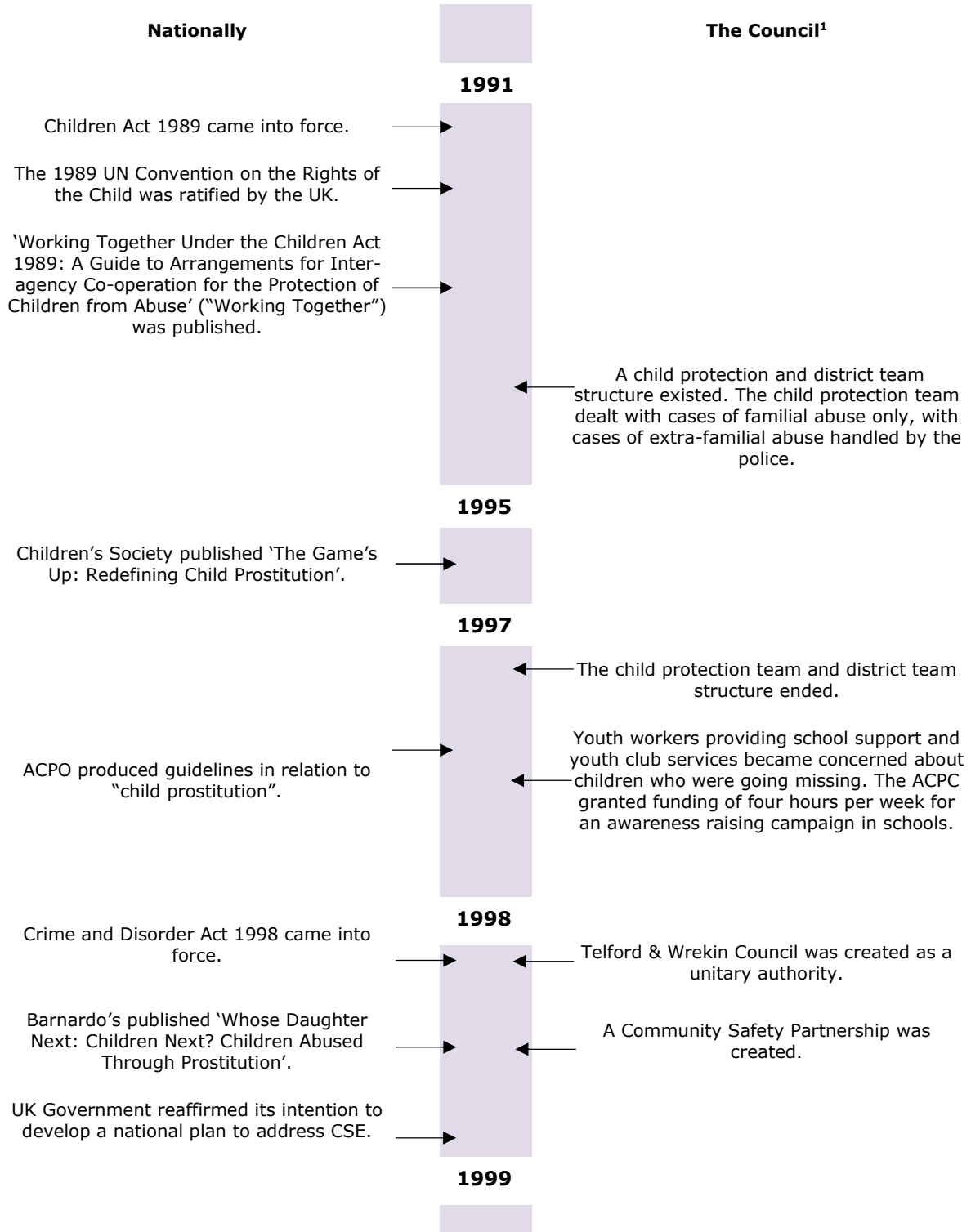
Linked with Recommendation 19 above, the LSCB ensures that relevant information on CSE is shared with all housing providers in the borough and the Board ensures on going engagement of housing providers in tackling CSE.

Appendix G

Chronology of Key Developments within Telford & Wrekin Council – from 1989 to present

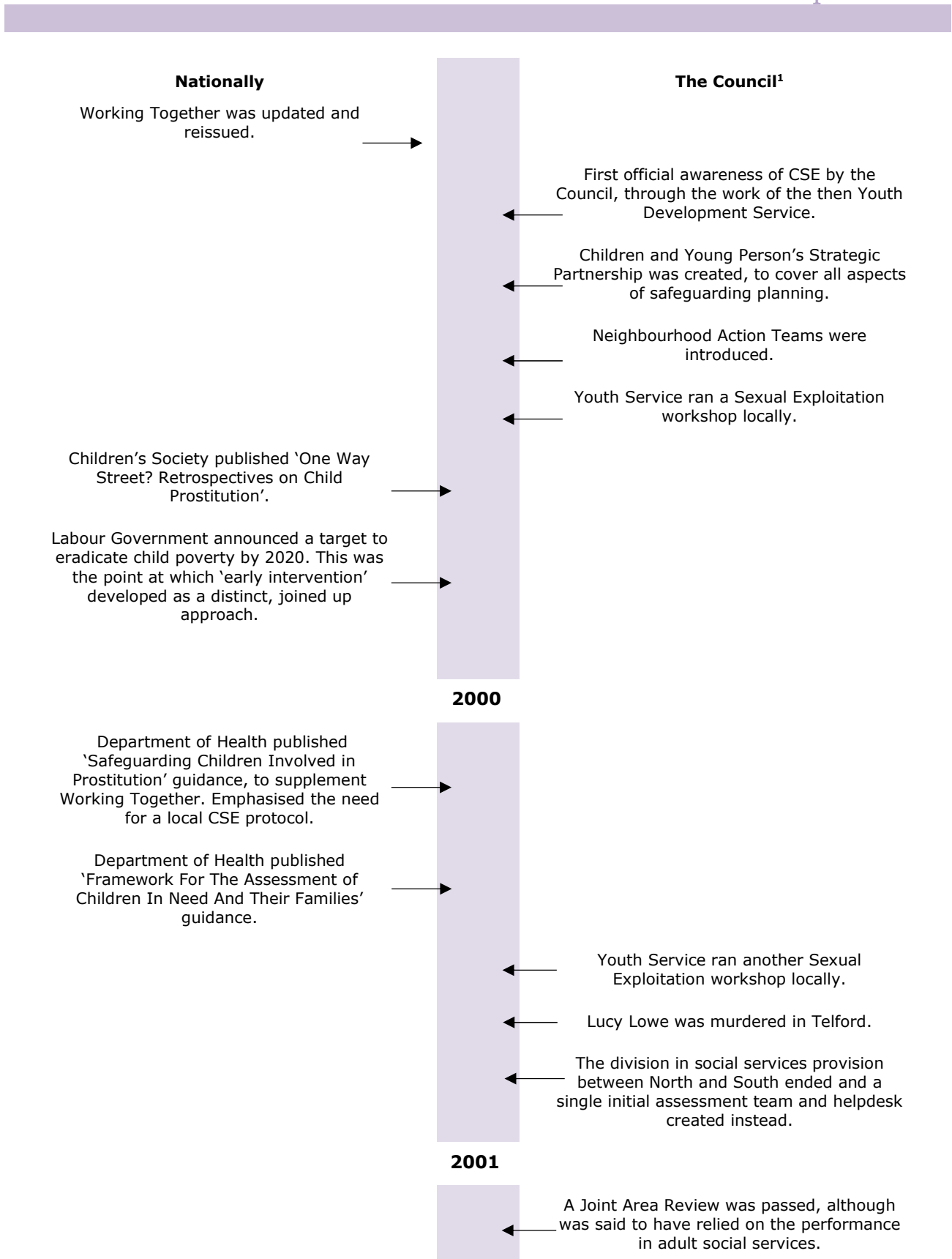
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Key Developments – from 1989 to present



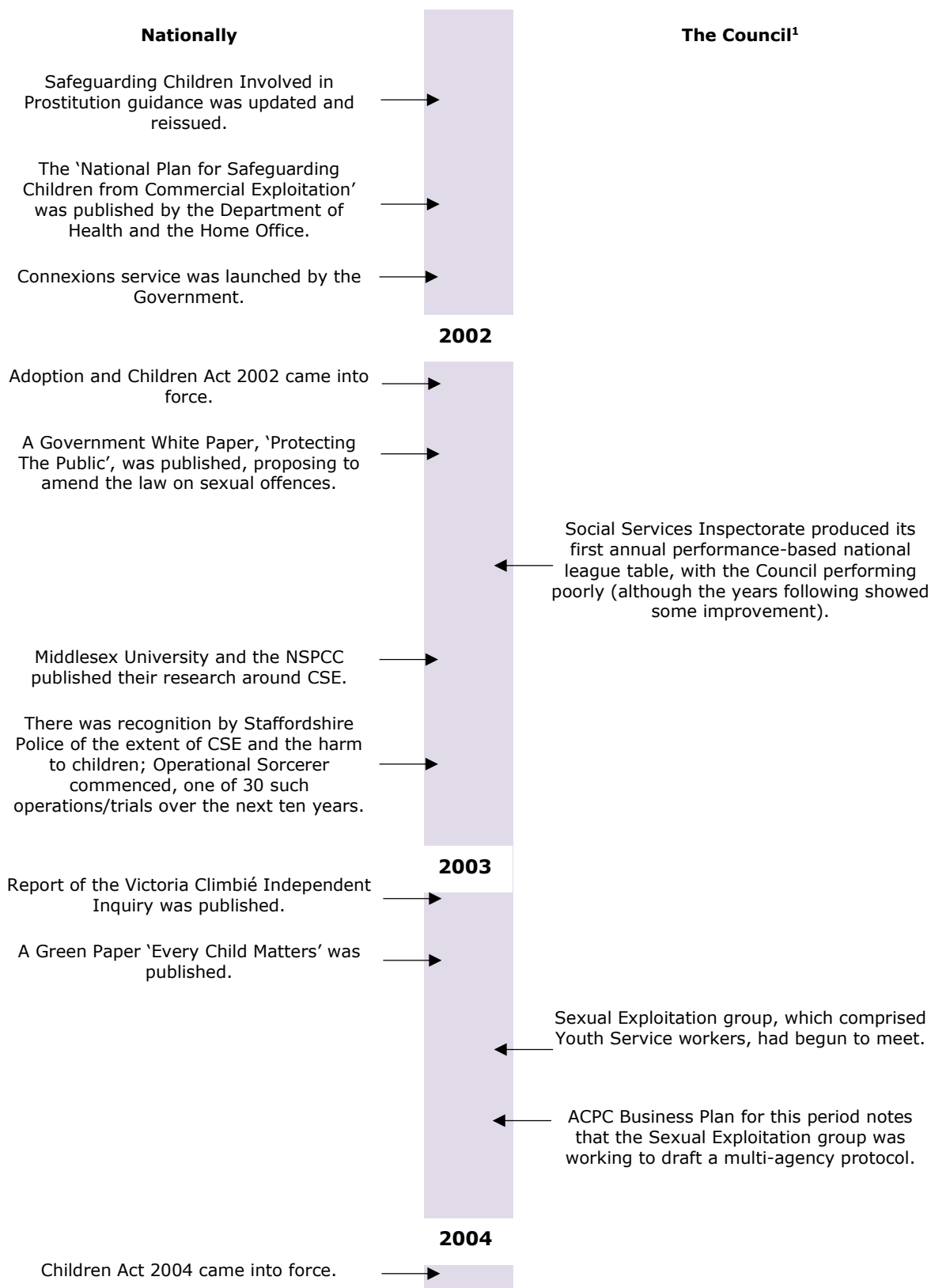
¹ Telford & Wrekin Council did not exist until 1 April 1998. References to the "Council" before that date therefore refer to the actions of Shropshire County Council.

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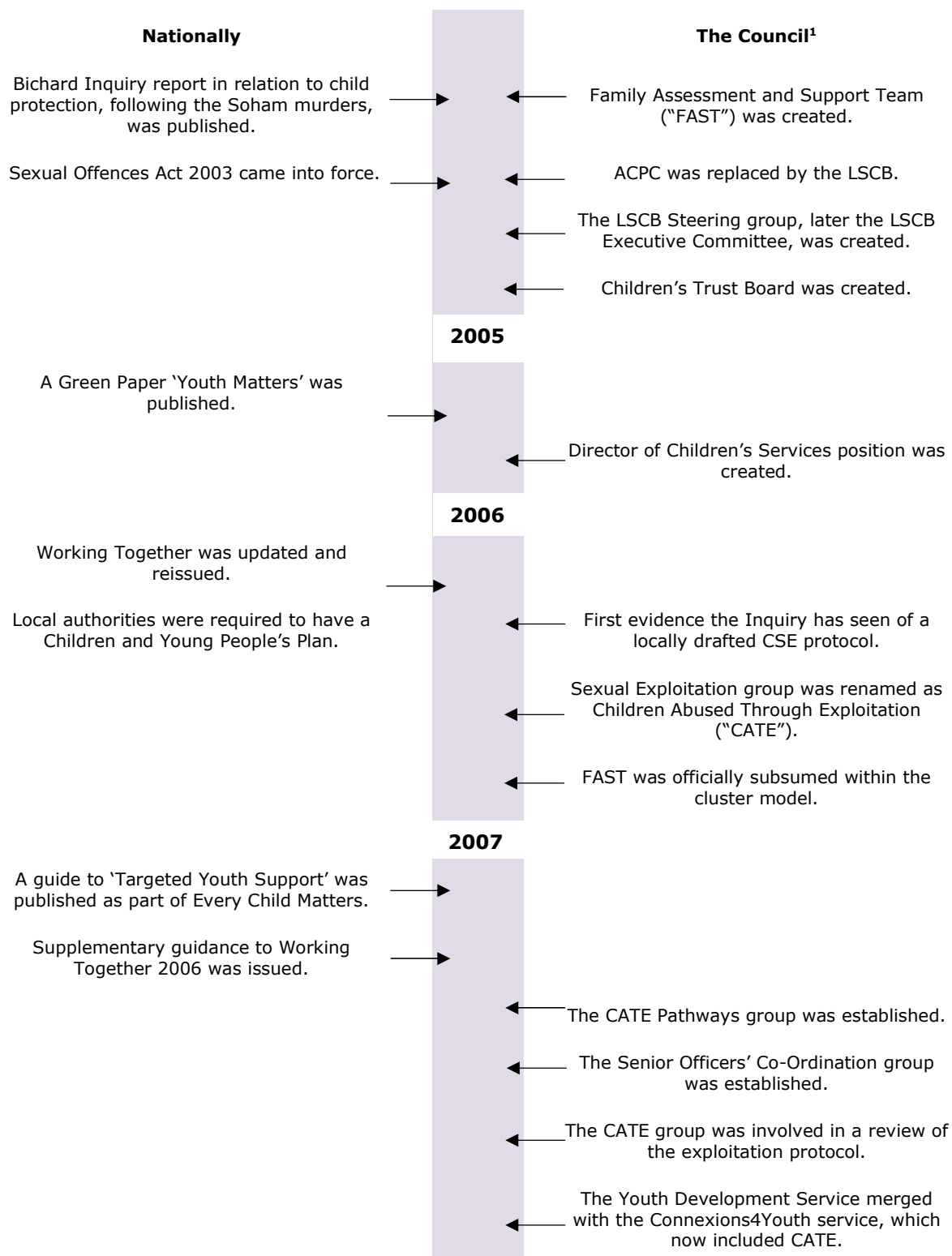
¹ Telford & Wrekin Council did not exist until 1 April 1998. References to the "Council" before that date therefore refer to the actions of Shropshire County Council.

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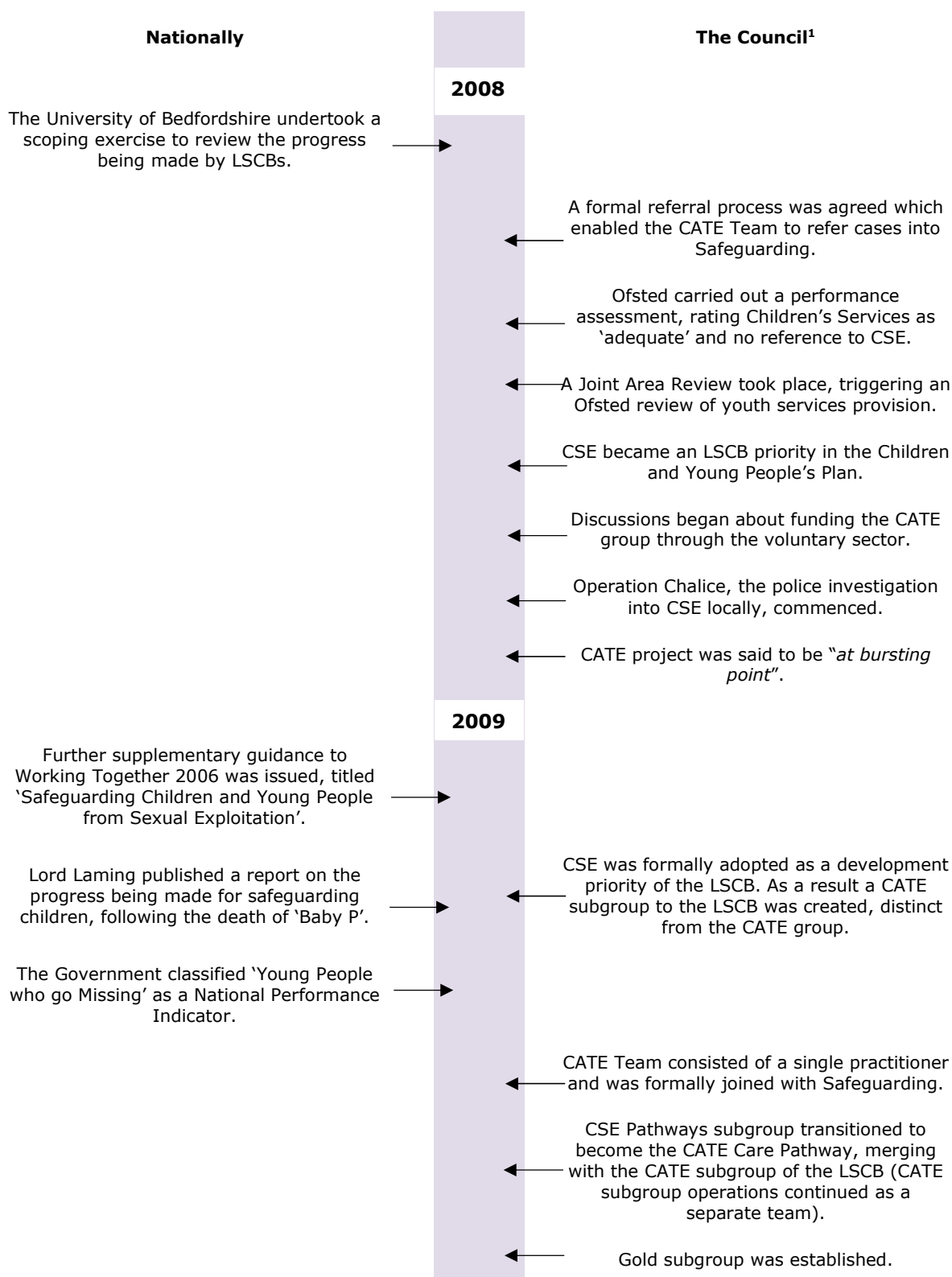
¹ Telford & Wrekin Council did not exist until 1 April 1998. References to the "Council" before that date therefore refer to the actions of Shropshire County Council.

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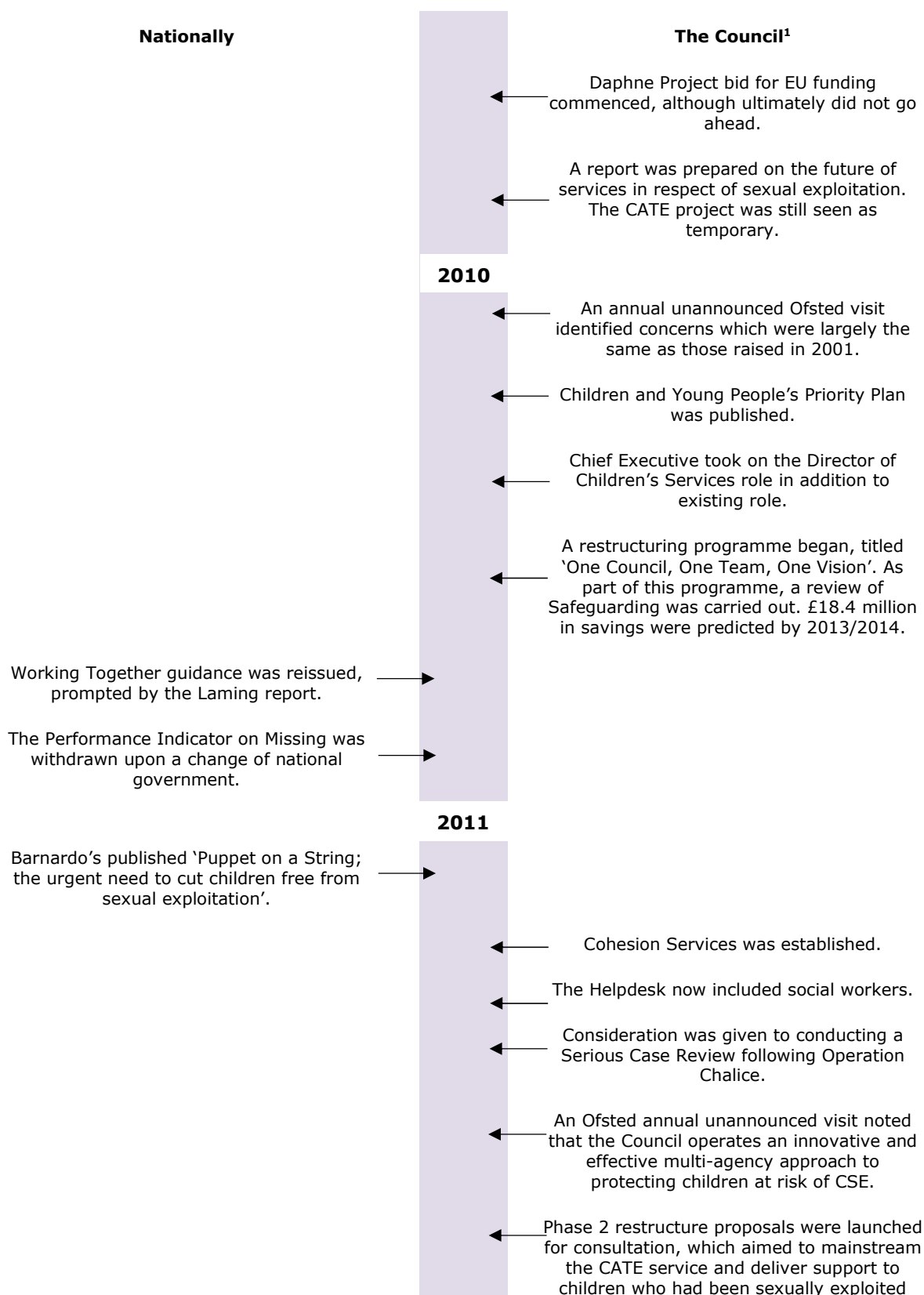
¹ Telford & Wrekin Council did not exist until 1 April 1998. References to the "Council" before that date therefore refer to the actions of Shropshire County Council.

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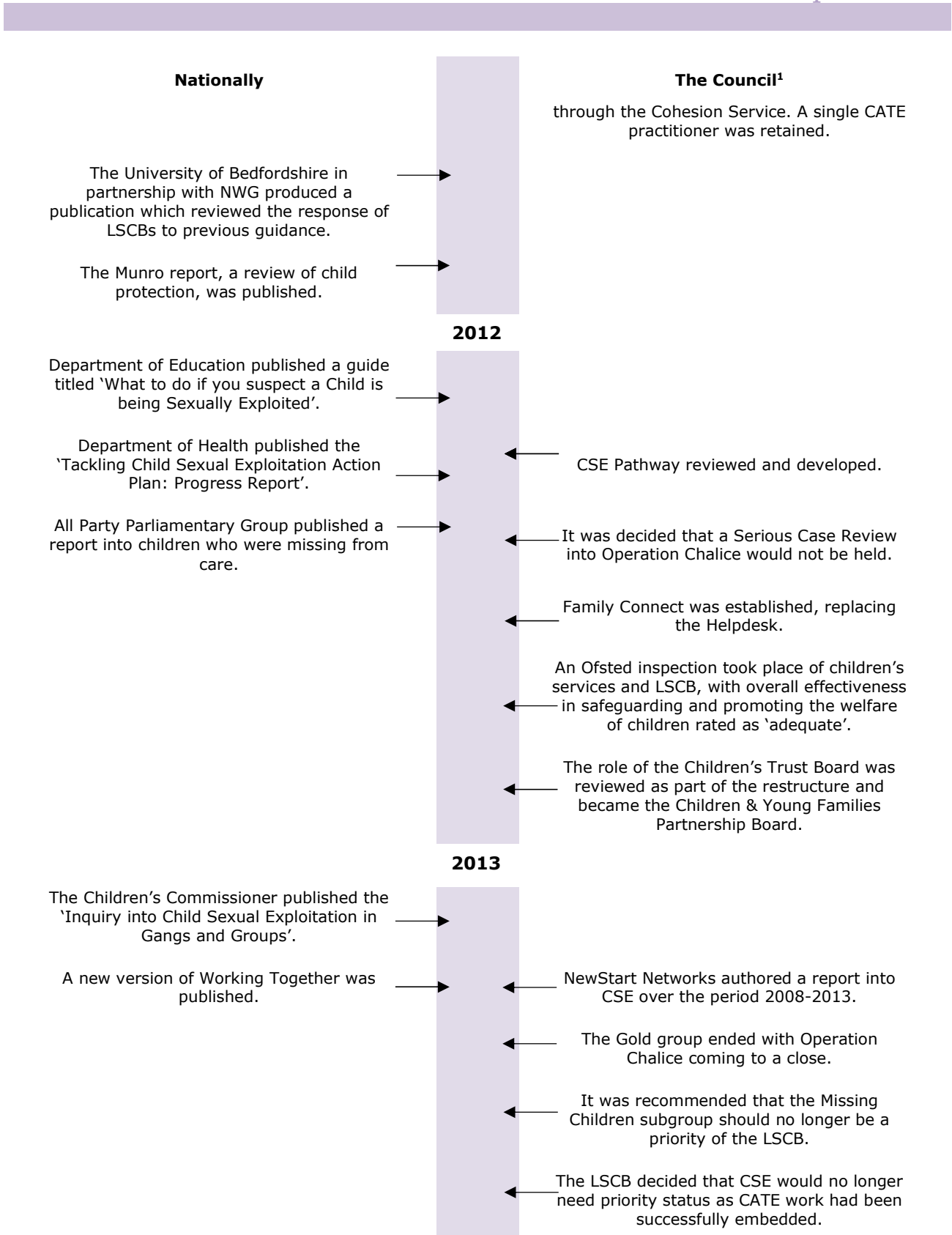
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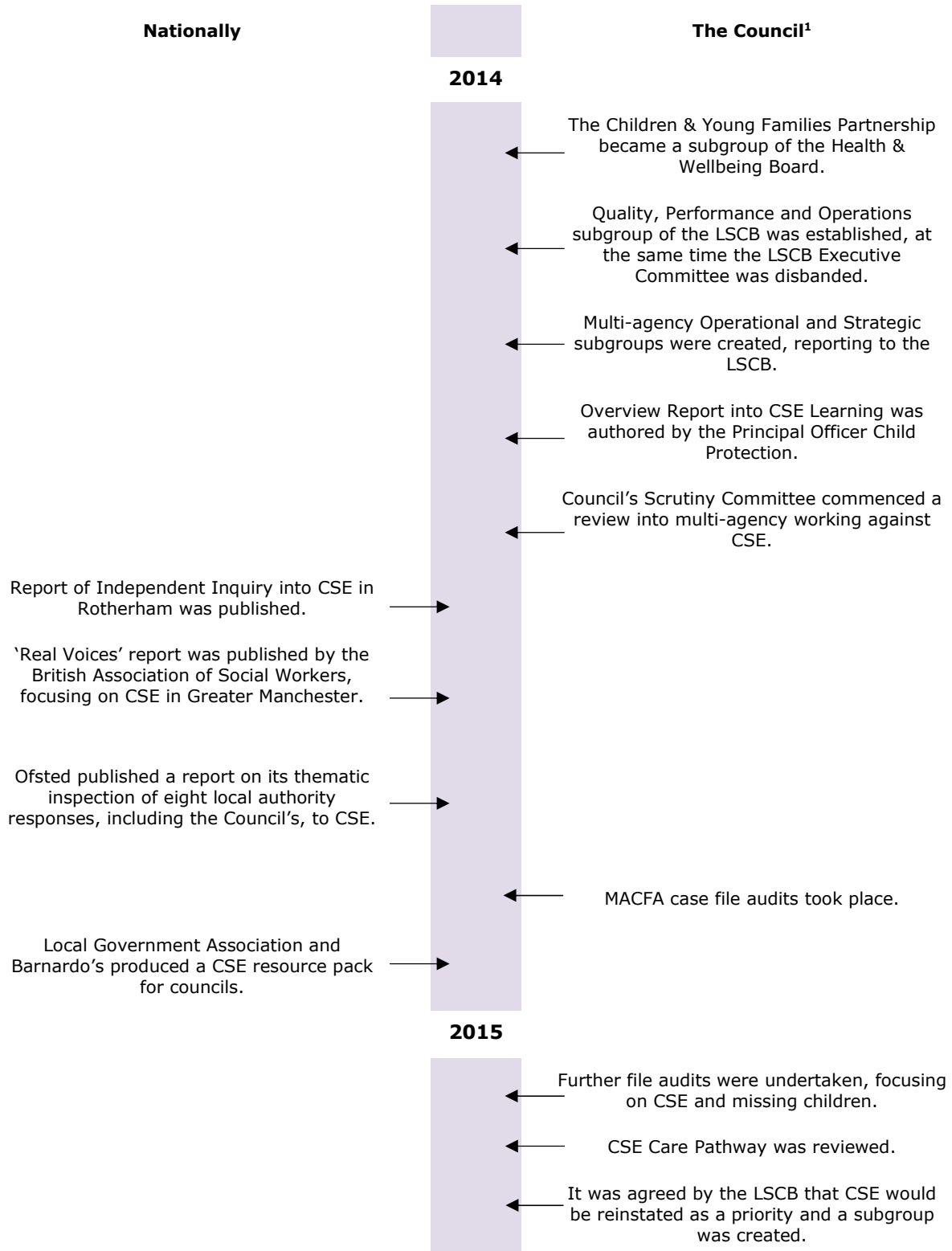
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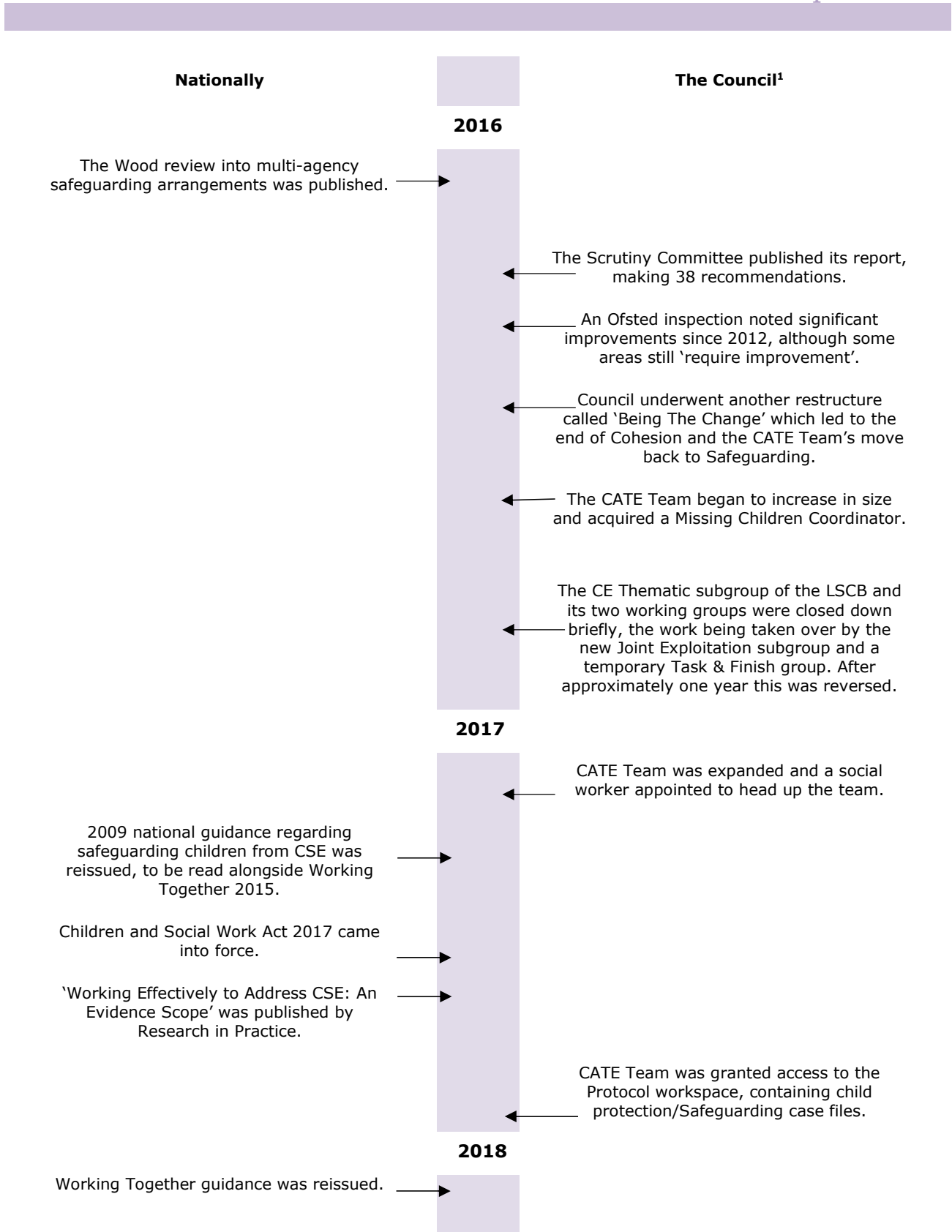
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Nationally

The Council¹



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Appendix H

Chronology of Key Dates – Policing of CSE in Telford

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Appendix H

Key

Green	Legislation *Please refer to Legislative Chronology in Appendix I
Blue	WMP policies, procedures, protocols and reviews
Purple	National guidance/reviews /reports
Orange	Structures and oversight
Red	Police operations
Yellow	Events
Pink	Inspections/Reviews

Date	Key Event
1 January 1957	Sexual Offences Act 1956* came into force.
16 July 1959	Street Offences Act 1959* came into force.
2 July 1960	Indecency with Children Act 1960* came into force.
1988	Cleveland Report regarding the handling of multiple cases of child abuse diagnosed at Middlesbrough General Hospital is published.
1988	The Home Office issues the Home Office Circular 52/1988 . This guidance was produced to assist police with the procedures they adopt in the investigation of child sexual abuse. It also set out the civil proceedings procedures and responsibilities.
16 November 1989	Children Act 1989* came into force.
1989	WMP implements a new Child Protection Policy following a review of the Community Affairs department which led to a WMP working party to consider the setting up of Child Protection teams.
1992	The Home Office introduces a Memorandum of Good Practice for the interviewing of child witnesses in criminal proceedings .
May 1992	WMP sets up dedicated Child Protection Units known as CPUs.
1993	WMP introduces a Force Head of the Child Protection Unit in line with Her Majesty's Inspectorate of Constabulary (HMIC) recommendations in 1993.
August 1993	HMIC Primary Inspection Report - Does not explicitly mention CSE or CSA, but comments on the basic infrastructure of the Force with reference to child protection. Inspections took place on 16 and 17 August 1993. HMIC identified the lack of an established departmental head of the CPU and recommended that the post was created.

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3 November 1994	Criminal Justice and Public Order Act 1994* came into force.
1995	WMP adopts a computerised centralised crime recording system under the acronym CRIMES.
1996	The CPU teams broaden their remit and resourcing to include domestic abuse, therefore they become the Family Protection Unit ("FPU").
1 August 1998	The Crime and Disorder Act 1998* came into force.
November 1998	A series of meetings take place in relation to a number of children, and concerns around their involvement in "child prostitution".
February 1997 to September 1999	The September 1999 Report contains a total of 28 intelligence reports , ranging in date from February 1997 to September 1999. Eight of these reports relate to associated offences of drugs, rather than CSE specifically, but are included due to the links between suspects.
September 1999	A report and package of accompanying documents is written by a police constable and submitted by a police sergeant to a fellow police sergeant, containing information relating to "child prostitution" at identified addresses, including [Premises A] in Wellington.
October 1999	A report by a police constable is addressed to a detective inspector within the Public Protection Unit ("PPU"), highlighting the issue of suspected sexual exploitation of children, and attaching copies of a number of intelligence reports, analysed according to "pimps" and "victims" mentioned within those reports.
November 1999	An intelligence report is written by a detective constable, discussing sexual offences being committed against children in Telford.
August 2000	Death of Lucy Lowe , Linda Lowe and Sarah Lowe in arson attack on their home in Halifax Drive. The investigation into the death of Lucy Lowe commences.
October 2000	WMP reissues the 1989 Child Protection Policy which states that the child protection team deal with familial child abuse with divisional CID teams continuing to deal with non-familial child abuse.
November 2000	Multi-Agency Strategy meeting to discuss concerns about "child prostitution" and children known to be at risk of "child prostitution".
October 2001	The investigation into the death of Lucy Lowe – Perpetrator of the arson attack resulting in the death of Lucy Lowe, Linda Lowe and Sarah Lowe is jailed for life for the death of the Lowe family members; no charges brought relating to sexual activity with Lucy Lowe. During this investigation, three children made disclosures in relation to potential CSE.
2001	WMP introduces a Serious Sexual Offences Policy and an Investigation of Crime Policy.
March 2002	Death of Becky Watson , aged 13, killed in a road accident described as a "prank"; but later found to have been involved in CSE.

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2000-2003	Meetings on sexual exploitation take place between WMP and Social Services , where the issue is discussed in relation to specific children and with concerns being raised by one school in particular.
May 2003	A file is prepared by a detective constable in PPU almost four years after the 1999 Reports and entitled "Prostitution Wellington".
2003	WMP launches a computerised system known as IMPACT (now known as COMPACT) to improve the way that missing cases are managed.
2004	Association of Chief Police Officers' (ACPO) Policy, Strategy and Operational Guidelines for dealing with exploitation and abuse through prostitution is published.
1 May 2004	Sexual Offences Act 2003* came into force.
2004	WMP introduces a Child Protection Force Procedure to identify and promote the development of good practice aimed at reducing the incidence of child abuse and the way in which they respond to incidents brought to their attention. This appears to be as a result of the Joint Chief Inspector's Report on " <i>Arrangements to Safeguard Children</i> " from 2002, the " <i>Lord Laming Review</i> " in 2003 and the Government Green Paper " <i>Every Child Matters</i> " in 2003. An Investigation of Serious Sexual Offences Policy and Procedure and a Missing Persons Policy is also introduced.
2004	The FPU implements a crime recording procedure to ensure that WMP records crimes designed to reflect the National Crime Recording Standard.
2005	ACPO Investigating Child Abuse and Safeguarding Children Guidance is published.
2006	Multi-agency working with the Council is established.
2006	WMP creates a further Missing Persons Policy .
2006	The Chief Constable for WMP becomes the ACPO lead for Management of Violent and Sexual Offenders . Following this, a HQ based Public Protection Strategic Vulnerability Team was set up.
2006	HMIC Baseline Assessment of WMP notes that WMP's response to public protection generated concern. In relation to child abuse investigation, the Assessment notes that the " <i>devolved nature of the organisation has led to an inconsistent approach across BCUs on issues such as staffing levels, supervisory ratios and the management of workloads.</i> " It was identified that WMP had no overall policy for public protection. WMP's overall grade for protecting vulnerable people was found to be "Poor". The Baseline Assessment found that WMP's standards had "declined".
2006	WMP creates an action plan designed to address the failings identified by HMIC in their approach to protecting vulnerable people .

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2007	WMP introduces its Investigating Child Abuse Policy and Procedure .
2007	WMP introduces a new policy for investigating child abuse and the pre-existing FPU teams became known as the Child Abuse Investigation Units .
2007-2008	Operation Rune commences which involved intelligence gathering work regarding two individuals who were involved in CSE. Some of the intelligence gathering/sharing had been going on informally from at least 2006. Operation Rune changed its name to Operation Chalice ("Chalice") in 2007.
2007-2008	Regional serious crime governance groups are established and become known as Threat Reduction Boards ("TRBs") .
2008	WMP introduces the role of 'Specially Trained Officer' whose role was to engage with victims/survivors of serious sexual offences as early as possible to maximise early evidence recovery and facilitate both police and other agency support services to the victim/survivor.
2008	YVPSE Report is commissioned by a detective chief inspector in late 2007 to look at the problem of sexual exploitation of young and vulnerable people in the Telford area.
2008	HMIC Inspection Report - Major Crime assessed the effectiveness and efficiency of WMP's Major Crime response which included rape and serious sexual offences but there is no explicit mention of CSE. WMP was acknowledged to have made significant progress in its ability to protect vulnerable people, resulting in grades of 'Good' for child abuse, domestic violence and missing persons, and 'Fair' for public protection. It was found to have no innovative intelligence-sharing arrangements in place with partners, and did not effectively share major crime intelligence outside statutory arrangements – both were graded 'for improvement'.
2009	WMP formally appoints a Strategic Lead for Missing Persons, Mental Health and Vulnerable Adults to advise on best practice and national guidance along with providing guidance in investigations.
2009	A Joint Protocol for Reporting Missing Young People is agreed between WMP, the Council, Worcestershire County Council, Herefordshire Council and Shropshire Council.
Prior to May 2009	A Sexual Offences Investigation Team ("SOIT") is introduced by WMP to stand as a separate section in CID along with reactive, proactive and the PPU. The SOIT is disbanded following Chalice.
May 2009	Chalice full investigation commences. First senior investigating officer ("SIO") is appointed.
2009	Second Edition of ACPO Investigating Child Abuse and Safeguarding Children Guidance .
2009	Three separate operations take place representing off-shoots of Chalice, and dealt with the following:

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	<ul style="list-style-type: none"> To identify a network of men targeting vulnerable children for the purpose of exploitation; To investigate vulnerable missing children who were reported as missing from care homes; and To investigate alleged sexual activity and grooming at a care home.
September 2009	Chalice - Second SIO is appointed.
14 September 2009	Chalice formally launched , which was a large scale investigation into historical CSE in Telford. Over 200 potential abusers are identified throughout the operation.
8 December 2009	Phase 1 Chalice arrests.
December 2009	WMP and West Midlands Police enter an operational memorandum of understanding agreeing to share information in relation to Chalice suspects and targets.
July 2010	An action was raised by the then SIO on Chalice and assigned to three officers to “conduct a review and ensure all NIRs relating to Operation Chalice have been assessed by the HOLMES team and our [WMP’s] disclosure obligations are met.” This led to WMP uncovering the bundle of reports, referred to as D2276, including the reports/intelligence of September 1999, October 1999, November 1999 and May 2003.
2010	A further offshoot operation from Chalice commenced, which was a single victim CSE operation which involved one witness from Chalice.
9 March 2010	Phase 2 Chalice arrests.
15 April 2010	Chalice - Gold Group status is awarded in around December 2009 and a Gold Group meeting takes place on 15 April 2010.
29 June 2010	Phase 3 Chalice arrests.
3 September 2010	Chalice - A Chalice detective constable reviews the 1999 child ‘prostitution’ evidence and produces a report.
17 September 2010	Third SIO is appointed on Chalice .
7 October 2010	A report is submitted to the Chalice Team in respect of the death of Becky Watson as a result of an action raised.
October 2010	Chalice – a report is produced following further review of historic evidence in respect of Premises A.
2011	WMP’s 2007 Investigating Child Abuse Policy and Procedure is refreshed.
2011	WMP introduces another Missing Persons Policy and a Joint Protocol for Missing Children .

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2011	CEOP thematic assessment entitled “ <i>Out of Sight, Out of Mind</i> ” highlights the need for an assessment of CSE within forces.
2011	Three further offshoot operations from Chalice take place in relation to: <ul style="list-style-type: none"> • Surveillance of one nominal involved in Chalice; • Allegations of false imprisonment and rape of two victims; and • An investigation which arose from evidence obtained during Chalice.
2011-2014	Operation Beta commences as an offshoot of Chalice.
January 2011	Barnardo’s ‘Puppet on a String’ Report published. This report outlined what was known about the scale and nature of sexual exploitation across the UK.
February 2011- August 2011	Operation Alpha commences as an offshoot of Chalice.
16 May 2011	Commencement of Chalice first trial – multiple defendants.
June 2011	The Strategic Alliance (“the Alliance”) is formed - Chief constables of WMP and Warwickshire Police and their respective Police Authorities committed the two forces to deliver policing services as a strategic alliance.
1 November 2011	The Alliance begins formally operating.
5 September 2011	Chalice trial collapses and a series of smaller trials are rescheduled for 2012.
December 2011	The trial of one Chalice arrestee concludes . The Defendant is convicted of rape offences and sentenced.
2012	CSE Safeguarding Panels are introduced with police and partners reviewing potential CSE incidents brought to monthly panel. CSE Subgroups were also established as part of the LSCB framework across WMP.
2012	Two individual operations commence , one of which related to concerns that a victim was controlled by a suspect for the purposes of prostitution, and the other arising from evidence gathered in Operation Beta and Chalice.
February 2012	‘CSE Victims Experience in Court’ Report is produced and sent to the Attorney General.
August 2012	Chalice – conclusion of a trial involving two perpetrators, both of whom were convicted and sentenced. A total of eight men were convicted between 2011 and 2012.
October 2012	The Alliance publishes a CSE position statement setting out the current position at that time and their plans moving forward to develop the

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	strategies, procedures and investigations of CSE. As a result of the position statement, WMP adds a CSE marker to the CRIMES system.
October 2012	Telford PPU/PVP team, known as the CP team, took ownership of Sexual Exploitation , specifically partnership and prevent elements, but not all investigations.
September - December 2012	Chalice - Remaining trials heard with guilty pleas submitted and sentencing.
2013	Harm Assessment Units (“HAUs”) started to be rolled out across the Alliance.
2012-2015	A review commences into the 2002 death of 13 year old Becky Watson and whether this death related to child exploitation. The review concluded in August 2015.
2013-2016	Operation Gamma commences.
January 2013	The Alliance CSE Delivery/Action plan is launched. The document has been updated several times since its launch.
29 April 2013	Debrief and Points of Learning document is produced by the Third SIO regarding Chalice . This document is not intended to be a formal operational debriefing or a comprehensive debrief. No formal operational debriefing took place.
May 2013	Five further guilty pleas entered ¹ – Chalice .
31 July 2013	CSE Problem Profile created for WMP & Warwickshire.
August 2013	A CSE SSG is formed . Membership of this group includes the four regional West Midlands police forces and the Regional Organised Crime Unit (“ROCU”).
June 2014 - present	Operation Hydrant commenced nationally, which was set up to address the need for a national coordination hub between police forces to ensure intelligence from other forces regarding CSE is being coordinated and shared.
January/February 2014	Joint Strategic Needs Analysis is carried out in relation to CSE across the Alliance.
March 2014	The Ministry of Justice publishes a report on review of ways to reduce distress of victims/survivors in trials of sexual violence .
2014	The Warwickshire and WMP Missing Persons Policy and Procedure 2014 is introduced during the Alliance period.
2014	HMIC Inspection – Crime Report remarks upon a lack of access to officers specially trained in child protection at the weekends. It was suggested by the Police and Crime Commissioner (“PCC”) that a change

¹ [REDACTED] pgs 118-135

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	in working practices, rather than recruitment, alteration of shift patterns or an on call response would remedy the situation.
August 2014	The Alliance introduces the Alliance Investigation of Allegations of Child Abuse Procedure .
September 2014	CSE Problem Profile is carried out by WMP and Warwickshire Police.
September 2014	Police Foundation Independent Report into the Strategic Alliance between Warwickshire Police and WMP is published and notes an imbalance in respect of PPU/PVP provision across the two forces, with WMP considered over-provisioned in relation to demand and the Alliance allowing some “rebalancing”.
November 2014	HMIC National Child Protection Inspections – Report identifies significant failures in WMP’s CSE response. Prior to the inspection, WMP carried out a self-assessment of 33 cases against the HMIC criteria. WMP assessed ten of the 33 cases as ‘Good’; 11 as ‘Adequate’ and 12 as ‘Inadequate’. Using the same criteria, HMIC assessed the same cases as part of the inspection and viewed only seven as ‘Good’, nine as ‘Adequate’ and 17 – almost half - as ‘Inadequate’. As a result, HMIC recommended that WMP immediately review all cases where children had been identified as at risk. Corrective action is ordered within six months.
2014-2015	A review of services to protect people from harm takes place across the Alliance, known as ‘Strengthen and Deepen the Alliance’ (“STRADA”). The review was driven by reduced funding.
2015	The national ROCU is formed. Regional Organised Crime Unit West Midlands (“ROCUWM”) appears to have been in existence since 2013/2014.
2015	Creation of the first dedicated CSE teams within WMP , based in North and South Telford.
Late 2015	The Telford HAU is co-located with the Council’s Family Connect Team to create a Multi-Agency Safeguarding Hub (“MASH”) under Council management.
2015	Launch of WMP guidance regarding the use of Child Abduction Warning Notices (“CAWNs”) .
2015	CSE Assessment is prepared as a follow up to the WMP and Warwickshire Police 2014 Problem Profile and notes issues around the use and reliability of CSE markers.
January 2015	A CSE Vulnerability Team is set up to cover Telford and Shrewsbury as part of an Alliance team.
2 – 5 February 2015	College of Policing (“COP”) - Warwickshire and West Mercia Alliance – CSE Peer Review is published. Its aim was to assess the capability of the Alliance to deal with the threat of CSE. Identifies some good working practices, commitment to the National Action Plan with the establishment of specialist CSE teams and provision of CSE training.

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	Findings identified a wish to standardise processes to ensure consistency in how victims/survivors, risk and services were identified. A number of areas for development in the Alliance CSE response were identified, such as the level of awareness and knowledge of CSE within frontline response teams, as the training on CSE had not yet been rolled out to them.
August 2015	CSE Problem Profile carried out by WMP and Warwickshire Police is published.
August 2015	HMIC National Child Protection Inspections – Post Inspection Review – Notes certain improvements, including the creation of the dedicated CSE Team, and the allocation of CSE Coordinators who were tasked with assessing investigations and developing risk management plans for the safeguarding of children. WMP is advised to “ <i>continue to make progress against those areas identified in the original inspection</i> ” from 2014. Inspectors assessed seven cases where children were categorised as being at high risk of CSE: WMP’s approach was considered ‘good’ in three cases, ‘requiring improvement’ in two cases and ‘inadequate’ in a further two. No further recommendations were made by HMIC.
October 2015	PCC response to HMIC’s 2015 Review findings and recommendations.
2016	ROCUWM creates a regional CSE Problem Profile . The profile identifies trends and CSE hotspots in the region which included Telford. The Telford hotspot was identified by data relating to the concentration of crimes within a certain radius.
2016- 2019	Operation Delta commences.
February 2016	HMIC Police Effectiveness, Efficiency and Legitimacy (PEEL): Police Effectiveness Report 2015 into WMP is published. The report found that WMP had made an encouraging start to ensure it is prepared to tackle CSE, but raised serious concerns about the WMP approach to missing and absent children which was a ‘cause for concern’ based on weaknesses identified in the way that WMP assessed the risk to children and young people who go missing and recommendations were made to address this issue. WMP is assessed as ‘requires improvement’ in respect of protecting vulnerable people.
March 2016	HMIC - Missing children; who cares? The police response to missing and absent children – 2016 . Report is published. This report was not WMP specific, but highlighted the link between missing and CSE, including areas for improvement for all forces in their CSE response.
May 2016	The Alliance introduces a new Child Abuse Policy .
August 2016	The Sunday Mirror reports that the problem [CSE] is continuing outside underage discos in the town.
August 2016	The suspect in Operation Gamma is convicted.

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September 2016	Protecting Vulnerable People - Review of Child Sexual Exploitation (CSE) in the Alliance: This internal review was designed to assess the Alliance position following the 2015 COP CSE Peer review 2 – 5 February 2015. A number of areas for development were identified in the Alliance CSE response including a lack of intelligence collection, a lack of clarity in the use of CSE markers and no clear performance framework. At this point, WMP did not have separate CSE analytical support. The issue of 'mainstreaming CSE' was addressed in this report.
January 2017	The North CSE Team separates into two teams , one for Shropshire and one for Telford.
January 2017	The Force introduces the role of 'Vulnerability Detective Chief Superintendents' for each local policing area.
January 2017	The Alliance publishes a Vulnerability Strategy document .
2017	ROCUWM produces a regional CSE quarterly threat update .
March 2017	HMIC PEEL: Police Effectiveness Report 2016 into WMP is published. WMP is assessed as 'good' in respect of protecting vulnerable people and HMIC notes that the force had addressed concerns about the approach to missing children and had developed several problem profiles, including one for CSE which HMIC considered to be 'good'. 'Areas for improvement' include taking steps to ensure that WMP is pursuing justice on behalf of victims/survivors and engagement with partner agencies in response to serious and organised crime.
3 April 2017	The Serious Crime Act 2015* introduces an offence of sexual communication with a child into the 2003 Act.
October 2017	WMP's CRIMES system is replaced by the digital ATHENA system .
March 2018	The Sunday Mirror suggests there could be up to 1,000 victims of the scandal and links five deaths to the abuse .
March 2018	HMIC PEEL: Police Effectiveness Report 2017 into WMP is published. Assessed as 'requires improvement' in respect of protecting vulnerable people and cause of concern' in tackling serious and organised crime where WMP's approach was putting the public at risk of harm.
April 2018	Major Crime Review Team ("MCRT") Review commences to review Chalice.
1 August 2018	Vulnerability & Safeguarding Business Unit – Commissioned "4Ps Review of Police CSE Services at Telford LPA" was published . This report identifies a positive approach to CSE services in Telford, in particular communication with the Safer Neighbourhood Team, close inter-agency working, the provision of feedback to officers concerning professional curiosity, recognising the link between CSE and missing, and WMP's proactive work with hotels and taxi drivers. Confusion in relation to the application of CSE markers was identified as an issue.
October 2018	WMP indicates that it would be withdrawing from the Alliance .

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2018	'Team Telford' , a group comprising senior PVP officers, a local authority assistant director and heads of business provides a strategic lead for partnership working .
2019	Telford's CSE Team is renamed the Criminal Exploitation Team (CE Team) and its remit broadened to all forms of child exploitation.
2019	The Alliance brings together its strategies for vulnerability and safeguarding into one Overarching Policy .
2019	The Philomena Protocol is launched across all police forces . The Protocol introduced a requirement for care homes to share an enhanced personal profile for new admissions in respect of their risk factors and missing persons history so that police and partners could plan and prepare for the child's needs.
July 2019	Operation Epsilon – prosecutions brought.
September 2019	HMIC PEEL: Police Effectiveness Report 2018/19 into WMP is published. HMIC maintained its assessment of WMP as 'Requires Improvement' in an overall assessment of its 'Effectiveness'. In relation to the category 'Protecting Vulnerable People', WMP was again assessed as 'Requires Improvement' and 'cause of concern' in respect of how WMP investigated crime. Tackling serious and organised crime was considered to be 'good'.
January 2020	WMP refreshes its Child Abuse and Safeguarding Policy which appears to be based on the 2016 Alliance Child Abuse Policy.
8 April 2020	The Alliance ends .

Appendix I

Chronology of Key Legislation Relating to Policing and Management of CSE Cases

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Appendix I

Date	Legislation
22 July 1847	The Town Police Clauses Act 1847 came into force. This Act is used to regulate taxi and private-hire trade and works with the Local Government (Miscellaneous Provisions) Act 1982.
13 April 1933	The Children and Young Persons Act 1933 came into force. This Act provided that a child under 14, who, in the opinion of the court, did not understand the nature of the oath might give evidence unsworn; though it was not possible to convict a defendant on such unsworn evidence without corroboration. The Act also made provision for reporting restrictions in relation to proceedings involving children.
1 January 1957	The Sexual Offences Act 1956 came into force. This Act consolidated the English criminal law relating to sexual offences. This Act has largely been repealed by the Sexual Offences Act 2003.
16 July 1959	The Street Offences Act 1959 came into force. This Act was introduced in order to allow for a provision against loitering or soliciting in public places for the purposes of prostitution.
2 July 1960	The Indecency with Children Act 1960 came into force. This Act created the criminal offence of gross indecency towards a child under 14. This legislation was introduced to cover gaps in the provisions of the 1956 Act.
29 May 1970	The Local Authority Social Services Act 1970 , known as the LASSO Act, established a single social services department in each local authority, emphasising the need for a coordinated and comprehensive approach to social care, supporting families, detecting need and encouraging people to seek help.
1974	The Rehabilitation of Offenders Act 1974 and the Rehabilitation of Offenders Act (Exceptions) Order 1975 came into force dealing with when a conviction should be deemed "spent" and with exceptions to the general rules.
1976	The Local Government (Miscellaneous Provisions) Act 1976 came into force. This Act sets out the Council's powers in respect of taxi licensing.
1982	The Local Government (Miscellaneous Provisions) Act 1982 came into force. Together with the Town Police Clauses Act 1847, this Act relates to the licensing and regulation of taxis and private hire vehicles.
12 July 1984	The Child Abduction Act 1984 came into force. This Act introduced the use of Child Abduction Warning Notices ("CAWNS").
1988	The Criminal Justice Act 1988 revoked the requirement for corroboration of unsworn evidence of children. The requirement for corroboration in other circumstances for certain sexual offences, including 'causing prostitution' and 'procuration' under the 1956 Act remained. The Act provides for children under 14 to give evidence, in relation to specified offences, including sexual offences, by way of television link with the leave of the court.

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16 November 1989	The Children Act 1989 came into force to ensure children are safeguarded and their welfare is promoted.
2 September 1990	Convention on the Rights of the Child 1989 came into force. It was brought in by the United Nations and is an international human rights treaty which sets out the rights of children, such as civil, health, economic, social etc. This contained several articles relevant to the protection of children from sexual exploitation.
1992	The Sexual Offences (Amendment) Act 1992 granted automatic lifetime anonymity to victims/survivors of sexual offences.
1 October 1992	Criminal Justice Act 1991 came into force. The Act directed that children under the age of 14 should give evidence unsworn. A child's competence to give evidence – where the issue arose – was to be determined by the ordinary rules applicable to an adult witness.
3 November 1994	The Criminal Justice and Public Order Act 1994 came into force. The Act amended the 1956 Act to spell out that a man would be guilty of rape if he knew the victim did not consent or he was reckless as to consent, and to expand the definition of rape.
3 February 1995	The Criminal Justice and Public Order Act 1994 revoked the corroboration rules in respect of sexual offences.
1996	The Criminal Procedures and Investigation Act 1996 came into force. The Act laid down regulation of prosecution disclosure of unused material and introduced a mandatory defence disclosure regime.
1 November 1996	The Education Act 1996 came into force, placing a duty on local authorities to monitor school attendance in their areas and take the appropriate supportive and enforcement action.
1 August 1998	The Crime and Disorder Act 1998 came into force. This Act introduced Sex Offender Orders, Anti-Social Behaviour Orders, Parenting Orders. It also granted local authorities more responsibilities in relation to strategies for reducing crime and disorder, and the introduction of law specific to 'racially aggravated' offences.
1999	The Youth Justice and Criminal Evidence Act 1999 came into force. The Act provided that all persons, whatever their age, were competent to give evidence in criminal proceedings save in specified circumstances. The Act introduced special measures for giving evidence to assist vulnerable and/or intimidated witnesses to give evidence in criminal court proceedings.
2000	The Local Authorities (Functions and Responsibilities) (England) Regulations 2000 came into force. These Regulations provide that licensing is a function which must not be the responsibility of the Council's Cabinet. The licensing authority is therefore required to set up a licensing committee which is responsible for discharging its licensing functions.
28 July 2000	The Regulation of Investigatory Powers Act 2000 came into force. This Act, developed covert policing and regulates the powers of public bodies to carry out surveillance and investigation and covering the interception of communications.

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28 July 2000	The Learning and Skills Act 2000 came into force. This Act established the Learning and Skills Council and made changes in funding and administration of further education and work based learning.
11 January 2001	The Indecency with Children Act 1960 was amended by the Criminal Justice and Court Services Act 2000 to extend the offence of indecency with a child to those victims aged between 14 and 16.
2002	The Police Reform Act 2002 came into force. This Act provides the statutory provisions for the supervision, administration, functions and conduct of police forces, officers and any person serving with/carrying out functions in relation to the police.
2002	The Adoption and Children Act 2002 came into force. This Act broadened the definition of significant harm in the Children Act 1989, providing that there were no absolute criteria on which to rely when judging what constitutes significant harm.
29 January 2004	The Criminal Justice Act 2003 . Provisions came into force to allow the Crown Prosecution Service ("CPS") to have the final responsibility for charging decisions in criminal cases.
1 May 2004	The Sexual Offences Act 2003 came into force. This Act created many new sexual offences against adults and children, repealing many sexual offences that existed before it. The Act also introduced protective orders - Sexual Offences Prevention Orders ("SOPOs") and Risk of Sexual Harm Orders ("ROSHOs").
15 November 2004	The Domestic Violence and Victims of Crime Act 2004 came into force. This Act concentrates on the legal protection and assistance to victims of crime, particularly domestic violence. This guidance provided structure for forces to tackle domestic abuse and introduced the use of Risk Management Plans.
15 November 2004	The Children Act 2004 came into force. This Act amended the Children Act 1989 and in the interests of children, its primary aim was to give boundaries and help for local authorities and/or other entities to better regulate official intervention. It brings all local government functions of children's welfare and education under the statutory authority of local directors of Children's Services. The Act requires all NHS bodies to make arrangements to safeguard and promote the welfare of children, there is also a responsibility to make arrangements to promote cooperation between NHS bodies and the local authority in order to protect individual children from harm. The Act placed a duty on all local authorities to establish Local Safeguarding Children Boards ("LSCBs") with the transition happening on 1 April 2006.
24 November 2005	The Licensing Act 2003 came into force. The Act dealt with regulation of the sale and supply of alcohol and the provision of entertainment and late night refreshment.
1 April 2006	The Local Safeguarding Children Boards Regulations 2006 came into force. These Regulations introduced the requirement for LSCBs.
8 November 2006	The Safeguarding Vulnerable Groups Act 2006 came into force. This Act was introduced in order to provide a system for employers to check the suitability of volunteers or employees to work with children or vulnerable children.

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2007	Part One of the Serious Crime Act 2007 came into force. Serious Crime Prevention Orders ("SCPOs") were introduced under Part One to allow the crown court to make SCPOs in a defined set of circumstances.
23 October 2007	The Further Education and Training Act 2007 came into force. The aim of this Act was to improve the quality of the provision of further education and in doing so, enable skills gaps to be addressed and increase involvement in further education.
2008	The Local Government and Public Involvement in Health Act 2008 came into force, which imposed a statutory duty on local authorities and primary care trusts to work together to produce a joint strategic needs assessment of health and social care needs to help improve partnership working.
12 November 2009	The Policing and Crime Act 2009 came into force. This Act made provisions relating to police reforms, sex establishments, prostitution and sex offenders.
12 November 2009	The Apprenticeship, Skills, Children and Learning Act 2009 came into force. This act amended section 10 of the Children's Act 2004 by bringing schools, colleges and Jobcentre Plus under the duty to cooperate and requiring all local areas to have a child's trust board which had to prepare and publish a jointly owned Children and Young People Plan.
15 September 2011	The Police Reform and Social Responsibility Act 2011 came into force. The Act transferred the control of police forces from the existing Police Authorities to elected police and crime commissioners ("PCCs").
2011	The Coroners and Justice Act 2009 provided that for eligibility for special measures when giving evidence, anyone under 18 is automatically deemed vulnerable.
18 February 2012	The Localism Act 2011 came into force. This meant that local authorities are specifically empowered to do anything not prohibited by legislation, and subject to public law principles, they have the power to do anything that individuals generally may do.
22 November 2012	The Police (Conduct) Regulations 2012 came into force. These Regulations changed the framework of police misconduct proceedings and included standards of professional behaviour for police officers.
1 September 2013	The School Governance (Roles, Procedures and Allowances) (England) Regulations 2013 came into force. This Act dealt with procedures adopted by governing bodies of all maintained schools in England.
3 March 2015	The Serious Crime Act 2015 came into force. This Act reformed protective orders and removed references to "child prostitution" and "child pornography" in SOA 2003. These references were replaced with sexual exploitation of children, and so recognising children as victims. The Serious Crime Act also amended the Street Offences Act 1959, so only persons aged 18 or over could commit the offences of loitering for the purposes of prostitution.
8 March 2015	The Anti-Social Behaviour, Crime and Policing Act 2014 is amended. This Act made changes to the provisions in the Sexual Offences Act 2003 in respect of protective orders - SOPO and ROSHOs. These orders were changed to Sexual Harm Prevention Orders ("SHPOs") and Sexual Risk Orders ("SROs").
October 2015	The Deregulation Act 2015 came into force. This Act made it lawful for private hire operators licensed within a particular area to subcontract bookings

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	to other operators in other areas. It allows drivers to lawfully operate anywhere in the country regardless of where they are licensed.
26 March 2015	The Modern Slavery Act 2015 came into force. This Act provides the legislative framework to equip law enforcement agencies and local partners to effectively prosecute and convict the perpetrators of modern slavery. The Act consolidated and simplified the previous slavery and human trafficking legislations into a single statute.
2017	The Children and Social Work Act 2017 came into force. This Act created a new framework for the oversight and delivery of services providing multi-agency arrangements for protecting and safeguarding children. Its purpose was to improve joint work at the local level to safeguard children enable better learning at the local and national levels to improve practice in child protection. LSCBs were abolished and were to be replaced with local safeguarding partners.
3 April 2017	The Serious Crime Act 2015 introduced an offence of sexual communication with a child into the 2003 Act.
28 June 2018	Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018 came into force. These Regulations relate to the review of serious safeguarding cases. They set out the criteria that the safeguarding partners must take into account when determining whether serious child safeguarding cases raise issues of importance in relation to the area, along with arrangements for local reviewers and reports.

Appendix J

List of CSE Investigations by WMP

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Appendix J

1. West Mercia Police (“WMP”) CSE Operations

KEY	
[REDACTED]	Operation name has been redacted to avoid risk of identification of victims/survivors. Only published names or those used within the Report are referenced.
	Investigations linked to or arising from Operation Chalice (“Chalice”).
	Operations linked to CSE, but not CSE-focused.

Date	Operation Name	Details of the Operation	Outcome of the Operation
2000-2001	[REDACTED]	This was a targeted arson attack which led to the murder of Lucy Lowe, her mother and her sister, on 5 August 2000.	The perpetrator was convicted of murder/attempted murder in October 2001 and given a life sentence (18 years minimum). There was an appeal to have the sentence cut in 2014, but it was rejected. The offender was eligible to apply for parole in October 2019.

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2008-2009	[REDACTED]	This refers to an investigation of historic child sexual abuse by four perpetrators and five female victims. The victims/survivors disclosed abuse going back many years.	All defendants were charged with serious sexual offences, but the case collapsed at court.
2009-2013	Chalice	Chalice was a four-year operation which formally commenced as an intelligence gathering exercise after the disappearance of two victims, but went on to identify a considerable number of victims/survivors and perpetrators. It attracted widespread press coverage in Telford, and nationally, and was WMP's most extensive operation relating to CSE in Telford.	There were three phases of arrests in December 2009, March 2010 and July 2010. The prosecutions were based upon five main victims/survivors, who were abused between 2007 and 2009. In total during the investigation, 114 crimes were reported, 23 offences detected, 91 offences undetected, and 66 suspects. 12 men were originally charged, with eight ultimately convicted.
2009	[REDACTED]	This was a separate operation undertaken as part of Chalice to identify a network of men targeting vulnerable children for the purpose of exploitation, this was prior to the Chalice Phase 1 arrests in December 2009.	Linked into Chalice.
2009	[REDACTED]	This was an investigation into a vulnerable missing child who was reported as missing in September 2009 and deemed at risk as a victim of CSE. Potential sightings and links to Chalice were explored.	Information from crime stoppers led to an arrest. Links into Chalice.
2009	[REDACTED]	This investigation related to alleged sexual activity and grooming at a care home and involved links with individuals in Chalice.	Linked into Chalice.

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2009	[REDACTED]	This investigation related to intelligence regarding a suspect who engaged children in behaviour for his sexual gratification.	None of the victims/survivors supported complaints that they had been subjected to any abuse or exploitation. No further action.
2011	[REDACTED]	This related to surveillance of a nominal involved in Chalice where CSE was suspected.	Linked into Chalice.
2009-2011	[REDACTED]	This operation was a local policing response to criminal gangs in a certain area of Telford, which primarily focused on drugs and violence, but which also looked for any links with, or evidence of organised group involvement in CSE.	The operation was discontinued due to issues with identification and witness credibility.
2010-2011	Alpha	Operation Alpha involved one victim/survivor who had come to the attention of WMP during Chalice enquiries in October 2010. Investigative work was undertaken until February 2011 when a seven-officer team was attached to the operation.	The investigation concluded in the summer of 2011 without prosecution, after the victim/survivor withdrew support for further investigation. The victim/survivor was informed that if they wished to resurrect their complaint and pursue action, they would be supported. Alpha investigated 19 recorded offences. There were six suspects in total, two of whom were arrested during Alpha; two were arrested as part of Beta; whilst the remaining two were not arrested.
2010-2014	Beta	Operation Beta ("Beta") involved a single victim/survivor who disclosed close to 100 possible offences committed by over 100 potential suspects.	Over its duration, Beta had investigated 35 offences; and close to 30 men were identified as suspects. More than 10 men were arrested. This investigation concluded in January 2014 following a decision from the Crown Prosecution Service ("CPS") that due to evidential challenges, there was insufficient prospect of a

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			successful prosecution. The victim/survivor and their family were notified of the decision.
2010	[REDACTED]	This was a single victim/survivor CSE operation which ran at the same time as Chalice. This operation involved at least one witness from Chalice, but it was a standalone investigation with no link between suspects in Chalice.	Several arrests were made, but no charges were brought as the matter was discontinued for evidential reasons.
2011	[REDACTED]	This was a spin-off investigation from Chalice involving one suspect, and related to allegations of false imprisonment and rape of two victims.	The suspect was charged for various offences against the two victims.
2011	[REDACTED]	This operation arose from evidence obtained during Chalice and following a number of missing episodes involving the victim, who had been in local authority care.	Work was done with the victim/survivor and the care home to reduce these missing episodes and safeguard the victim/survivor.
2012	[REDACTED]	This CSE operation involved one suspect, who was known to WMP, and arose after concerns were raised that the victim was being controlled by the suspect for the purpose of prostitution and drug dealing. Both the victim/survivor and suspect featured in another operation arising from Chalice.	Linked to another operation arising from Chalice.

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2012	[REDACTED]	This investigation arose from evidence gathered in another operation arising from Chalice. It related to a very young victim being exposed to sexual exploitation.	Linked to another operation arising from Chalice.
2013-2014	[REDACTED]	This investigation related to two female victims and various male suspects alleged to be part of an offending group comprised of men who were suspected of targeting children for sex.	Due to lack of evidence and victim support, no further action was taken. However, one suspect was charged with offences relating to the possession/distribution of indecent images of children.
2013-2015	[REDACTED]	This operation was the review into the 2002 death of Becky Watson who was killed when she fell from the bonnet of a moving car. The driver was subsequently convicted of causing death by dangerous driving and imprisoned. Evidence came to light which suggested that at the time of her death, Becky had also been the subject of sexual exploitation.	This review confirmed there was evidence of CSE offences having been committed against Becky. The suspect was interviewed under caution, but due to lack of evidence, no charges were brought. The review of the case concluded in 2015 with no further action.
2014	[REDACTED]	This operation related to stopping suspicious vehicles containing children around the Wellington area after CSE concerns were raised.	This operation was superseded by a later operation.
2013-2016	Gamma	This operation related to an investigation which took place from 2013 to 2016 into the exploitation of a 12 year old child. The operation identified 70 potential suspects and the CPS considered 19 offences.	The operation resulted in a single conviction for sexual offences against the victim/survivor, a conviction by guilty plea. Two other individuals were convicted with non-sexual offences in relation to the victim/survivor; 16 other men had no further action taken against them based on evidential insufficiencies.

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2016	[REDACTED]	This operation involved concerns relating to a 15 year old victim from Telford found in vulnerable circumstances in Manchester. Further potential victims/survivors were interviewed in Telford.	The suspect committed suicide after being released from custody.
2016	[REDACTED]	This operation related to attempts to support other ongoing CSE investigations with number plate recognition and vehicle links.	Intelligence gathering operation.
2017	[REDACTED]	This was a wider operation in relation to organised crime networks in Telford, but which also considered any links to CSE where there had been a suggestion of the same, and tactics were separately employed where necessary to investigate any suspected CSE activity.	No further action taken due to the victim/survivor admitting they told the suspect they were 18 years old.
2017	[REDACTED]	Operation originally related to money laundering but which involved children being groomed into the laundering and into making money via sexual favours.	The suspect was interviewed, but there was insufficient evidence and charge was refused.
2017	[REDACTED]	This operation related to allegations of drugs offences and the rape of a 15 year old who was trafficked to Telford by two males.	The result was 'No Further Action' due to the victim/survivor withdrawing their support and issues surrounding the reliability of evidence.
2017	[REDACTED]	This was a standalone crime of child sexual abuse with one victim/survivor and one suspect. Around the same time, the suspect was under investigation for a number of attempted child rape offences.	The victim/survivor was not willing to assist the police with their investigations and it was decided that it should be a social services-led investigation.

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2017	[REDACTED]	<p>This operation focused on criminal activity relating to grooming and sexual exploitation of young females, with allegations that a group of male suspects were exploiting a number of young females who worked for them at specific locations. The investigation did not identify any offences at the location.</p>	<p>The investigation concluded when one of the suspects was arrested and charged for another offence in 2017.</p>
2018	[REDACTED]	<p>This operation involved surveillance to support the investigation of abuse/exploitation of a CSE victim via social media, and arose from disclosures originally made as part of Chalice.</p>	Surveillance/intelligence operation.
2018	[REDACTED]	<p>This operation was a joint initiative across the Shrewsbury (Shropshire) and Telford areas focusing on the night-time economy and any problems arising. Officers worked with security and night-time staff to identify vulnerable or underage children and to be vigilant for signs of CSE.</p>	Intelligence gathering operation.
2018	[REDACTED]	<p>This related to an incident in 2018 where a number of children in care from various authorities were missing (all noted to be high risk of CSE), and were found in a house with a number of adult males. There was an allegation of rape, which led to an investigation into sexual offences against three females.</p>	<p>There was no further action due to insufficient evidence.</p>
2018	[REDACTED]	<p>Operation involved a suspect engaged in online grooming of a 12 year old child.</p>	<p>The suspect was convicted in September 2019 of various offences including possession and making of indecent images of a child and attempting to incite a child under 13 to engage in sexual activity.</p>

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2018	[REDACTED]	Operation related to CSE of a number of young females.	The male suspect was charged and convicted of causing/inciting sexual exploitation of a child aged between 13-17 years.
2018	[REDACTED]	This investigation related to intelligence received regarding suspected CSE activities, and related to allegations and surveillance in respect of certain premises.	Intelligence gathering operation.
2018	[REDACTED]	This operation followed intelligence received in relation to suspected CSE of children visiting a restaurant.	No evidence was obtained to confirm CSE was taking place, so the operation was discontinued.
2018	[REDACTED]	This related to an investigation of human trafficking between the UK and overseas.	No charges were forthcoming.
2018-2019	[REDACTED]	This was an online CSE investigation.	The suspect was convicted of making indecent images of children.
2016-2019	Delta	This operation focused on a victim/survivor who made disclosures of being trafficked on a number of occasions to a nearby city and of being raped by multiple men. This operation initially identified eight suspects.	The victim/survivor was referred to the National Referral Mechanism Single Competent Authority on the basis of their trafficking/modern slavery. Operation Delta linked a total of 11 suspects with 15 potential victims/survivors. In March 2017 arrests took place in respect of Delta, by a different force. WMP re-took ownership of the case, and the investigation eventually led to a conviction for human trafficking and rape offences in 2019.

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2019 - present	[REDACTED]	<p>This is an ongoing multi-force operation involving four police forces in the West Midlands and aims to target suspected paedophiles operating online. The dedicated team set up for the operation was the Online Child Sexual Exploitation Team ("OCSET"), which links in with work/investigations carried out nationally by the Child Exploitation and Online Protection Command ("CEOP").</p>	<p>This has included one arrest in Telford, but investigations remain ongoing.</p>
2019	[REDACTED]	<p>This operation was an investigation into drugs and CSE. Intelligence suggested two premises were being used.</p>	<p>No victims/survivors or offences were identified.</p>
2018 to 2019	Epsilon	<p>Epsilon related to the investigation of non-recent CSE in the Telford area. This operation identified 113 potential victims/survivors and 48 potential suspects were named.</p>	<p>The Epsilon investigation resulted in the convictions of four men for offences under the 1956 Act including rape.</p>
2020	[REDACTED]	<p>This operation was set up to reinvestigate allegations of historic CSE by a single victim/survivor, but went on to incorporate allegations made by other victims/survivors, due to suspected links.</p>	<p>The initial victim/survivor later withdrew their complaint.</p>
2020	[REDACTED]	<p>This is a CSE investigation with allegations of numerous sexual offences including rape between 1992 and 1993 involving a number of suspects.</p>	<p>No further information available at the time of writing.</p>
CSE Operations in other forces (where linked to Telford)			

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2002	[REDACTED]	<p>This was an operation into CSE in Staffordshire which identified 47 victims/survivors of CSE. WMP contacted Staffordshire to investigate any overlap of nominals during Chalice.</p>	<p>Linked to Chalice.</p>
2009-2010	[REDACTED]	<p>This was an operation into CSE in Staffordshire. WMP contacted Staffordshire to investigate any overlap of nominals during Chalice.</p>	<p>Linked to Chalice.</p>
2009-2010	[REDACTED]	<p>This operation arose from individual investigations revealing a series of sexual assaults on children in care and it preceded Operation Protection (below) in relation to exploitation of vulnerable missing children and involved looking at trafficking to neighbouring forces/towns, including Telford, as well as links between victims/survivors and perpetrators.</p>	<p>The operation did not go beyond intelligence gathering, but it did raise the profile of trafficking of young females for the purposes of sexual exploitation at a local level.</p>
2009-2012	Protection/P rotection 2	<p>Operation Protection encompassed and superseded the earlier operation (above) and CEOPS' national investigations into online grooming and other internet based forms of CSE. WMP gathered material relevant to Telford to feed into those national investigations. This operation was an intelligence collection plan to ascertain the exact scale of CSE across the West Midlands as a whole.</p>	<p>Intelligence gathering operation.</p>

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2016	[REDACTED]	<p>Operation commenced by West Midlands Police to support Operation Delta. The victim/survivor had made disclosures of being trafficked to and exploited in Birmingham. As part of its investigations, WMP uncovered a number of possible suspects and victims/survivors who lived in the West Midlands area.</p>	<p>Linked to Operation Delta.</p>
2016	[REDACTED]	<p>West Midlands police operation around CSE complainants who would not report offences. Police worked with the families of at risk children in an attempt to identify the perpetrators.</p>	<p>This resulted in several Sexual Risk Orders being obtained against suspected offenders, one of whom had been implicated in WMP's Operation Delta.</p>
2014-present	Hydrant	<p>Operation Hydrant ("Hydrant") was set up to address the need for a national coordination hub, an interface between police forces and the Independent Inquiry into Child Sexual Abuse ("IICSA"). It was set up when it became apparent that forces around the country were investigating a significant number of non-recent allegations of child sexual abuse involving persons of public prominence or within institutions. Hydrant is informed by individual forces or investigations and then coordinates the information among forces to prevent duplication. Some of these investigations include rape and serious sexual offences, some of which feature in cases of CSE in Telford.</p>	<p>Ongoing national CSE and CSA operation.</p>

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Glossary

ACPC	Area Child Protection Committee. Local forums created after the Maria Colwell Report in 1974, which brought together representatives of each of the main agencies and professionals responsible for helping to protect children from abuse and neglect. The ACPC was an inter-agency forum for agreeing how the different services and professional groups should co-operate to safeguard children in that area, and for making sure that arrangements work effectively to bring about good outcomes for children. Replaced by Local Safeguarding Children Boards under the Children Act 2004.
Access to Records	Formal authority for clients to see case records. This is determined by the Data Protection Act and Access to Records Legislation.
ACO	Assistant Chief Officer
ACPO	Association of Chief Police Officers
Assessment Framework	The "Framework For the Assessment of Children in Need and their Families" (2000) was developed to provide a systematic way of assessing children in need under the Children Act 1989. It was issued jointly by the Department of Health, Department for Education and Skills and the Home Office.
AWARE	A system which brought together data from a number of agencies to be accessed by practitioners involved in caring for the child.
BPAS	British Pregnancy Advisory Service
C&F	Child and Family
CAF	Common Assessment Framework: The CAF aims to streamline the process of helping at-risk children by allowing multiple agencies to communicate and work together as a team. The CAF is intended to streamline the process of helping at-risk children by allowing multiple agencies to communicate and work together as a team.
CAFCASS	Children and Family Court Advisory Support Service
CAFLs	Children and family locality service – provides help to coordinate universal and targeted services effectively.
CAIU	Child Abuse Investigation Unit
CALLA	Local parent support service set up in Telford to support victims and their families affected by CSE.
CAMHS	Child and Adolescent Mental Health Service
Care Order	A court order directing that a child is in the compulsory care of a named local authority, and vesting shared parental responsibility in that authority. This definition includes both interim and full care orders, and includes care orders transferred from other jurisdictions within the UK. A care order lapses when a young person reaches age 18.
CATE	Children Abused Through Exploitation

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CATSE	Child Abuse through Sexual Exploitation
CAWN	Child Abduction Warning Notice
C&YP	Children and Young Persons
CCC	Chief Constables' Council
CE	Criminal Exploitation
CCG	Clinical Commissioning Group
CCU	Complex Case Unit
CEOP	Child Exploitation and Online Protection
CEOP TUK	Child Exploitation and Online Protection Centre Think You Know
CYPFB	Children, Young People and Families Board
Chalice	West Mercia Police intelligence gathering and investigative operation and prosecutions relating to CSE between 2008 and 2012
Child	Any individual under the age of 18.
Child Assessment Orders	An Order made by a Court that lasts for 7 days, which requires the production of a child for assessment.
Child Protection Conference	A formal meeting, following an enquiry under section 47 of the Children Act, which decides whether the level of risk to a child is sufficient for the child's name to be placed on the Child Protection Register.
Child Protection Register	Until 1 April 2008 (in England), a central record of all the children in the area who, following a section 47 enquiry, are considered to be suffering from, or likely to suffer from, significant harm. Since 2008, replaced by Child Protection Plans.
Child In Need	Children who are defined as in need under section 17 of the Children Act 1989 are those who are unlikely to achieve or maintain a reasonable standard of health and development, or their health and development is likely to be significantly impaired, without the provision of services.
CID	Criminal Investigation Department
CIMM	Critical Incident Management Meeting
CIN	Child In Need
Clusters	Local teams of multi-agency practitioners set up to support children and young people.
COMPACT	Database maintained by West Mercia Police to manage and track missing person enquiries
County Lines	The name given to the practice of transporting illegal drugs from one area to another, usually by children or vulnerable people who are coerced into it by gangs.
COP	College of Policing

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Core Assessment	A structured assessment framework for social workers to record information gathered from a variety of sources to provide evidence for their professional judgments, facilitate analysis, decision making and planning; designed to be used in more complex situations, it should be completed within 35 working days of referral. Timescales were changed following the Munro report 2011.
CP	Child Protection
CPOMS	Child Protection Online Monitoring System. A data recording system implemented in some local schools from 2017, as a replacement for the previous hard copy paper system.
CDRP	Crime and Disorder Reduction Partnership
CPS	Crown Prosecution Service
CPU	Child Protection Unit
CPTDA	Central Police Training and Development Authority
CQC	Care Quality Commission
CRB	Criminal Records Bureau (now part of the DBS)
CRIMES	Crime Recording Information Management Enquiry System – a database maintained by West Mercia Police
CROP	Coalition for the Removal of Pimping (predecessor of PACE)
CSE	Child Sexual Exploitation
CSARP	Child Sexual Abuse Review Panel
CSEI MAG	CSE Inquiry Members Advisory Group
CSP	Community Safety Partnership (known locally as the Safer Telford & Wrekin Partnership)
CTB	Children’s Trust Board
CYPP	Children and Young People’s Plan
CYPSP	Children and Young People’s Safeguarding Partnership
C4Y	Connexions4Youth, formerly known as Connexions
DBS	Disclosure and Barring Service (encompassing former CRB)
DCS	Director of Children’s Services
DPP	Director of Public Prosecutions
DSL	Designated Safeguarding Lead
Duty to make Enquiries	Under the Children Act 1989 where the Local Authority are informed that a child who lives, or is found within their area, is the subject of an emergency protection order, is in police protection, or they have “reasonable cause to suspect that a child who lives, or is found within their area, is suffering, or is likely to suffer, significant harm” there is a duty to make such enquiries as the local authority consider necessary to decide whether it should take any action to safeguard or to promote the child’s welfare.
EHP	Early Help Partnership

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EIA	Early Investigation Advice
Emergency Protection Order	A court order granted under section 44 of the Children Act 1989 on the grounds that a child will suffer significant harm if they are not removed to Local Authority accommodation: or if the child is moved from the place where they are currently accommodated.
EWO	Education Welfare Officer
Exclusion Order	A range of powers available under the Family Law Act 1996 which allows orders to be made against individuals in respect of occupation of the family home.
Family Connect	Multi-agency safeguarding hub in Telford & Wrekin Council
FAST	Family Assessment and Support Team
FIB	Force Intelligence Bureau
FIP	Family Intervention Practitioners
FJB	Family Justice Board
FPU	Family Protection Unit
GDPR	General Data Protection Regulations
Genie	Management system that holds intelligence about offenders and individuals, maintained by West Mercia Police
GUM Clinic	A sexual health or genitourinary medicine (GUM) clinic specialises in sexual health
HAU	Harm Assessment Unit – a West Mercia Police unit which operates to filter referrals and liaise with safeguarding services.
HRU	Harm Reduction Unit – a West Mercia Police unit which operates together with the HAU, but as a problem solving hub rather than dealing with referrals.
Helpdesk	Point of first contact for the Council’s safeguarding service (from early 2000s until 2012 when Family Connect was established)
HGSCC	Healthcare Governance Safeguarding Children Committee
HMI	HM Inspectorate
HMIC	HM Inspectorate of Constabulary
HOCR	Home Office Counting Rules (for the recording of crime)
ICIDP	Initial Crime Investigations Development Programme
ICS	Integrated Children’s System
IICSA	Independent Inquiry into Child Sexual Abuse
IITCSE or Inquiry	Independent Inquiry into Telford Child Sexual Exploitation
IMPACT	Database maintained by West Mercia Police to manage and track missing person enquiries; precursor to COMPACT.

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Initial Assessment	A brief assessment of each child referred to Children's Services with a request for services to be provided.
IRO	Independent Reviewing Officer
IRT	Information Referral and Tracking
ISM	Integrated Service Manager
ISSP	Intensive Surveillance and Supervision Programme
ISVA	Independent Sexual Violence Advisor
JAR	Joint Area Review
Key Social Worker	A social worker allocated specific responsibility for a particular child whose name is on the Child Protection Register.
LAC	Looked After Child
LACORS	Local Authority Coordinators of Regulatory Services
LADO	Local Authority Designated Officer. The LADO is responsible for managing all child protection allegations made against staff and volunteers who work with children and young people.
LGA	Local Government Association
Looked After	A child is "looked after" when in the care of a local authority by Court Order or where there is a voluntary agreement between the parent(s) and the local authority. More recently termed "care experienced".
LSCB	Local Safeguarding Children Board
MACFA	Multi-agency Case File Audit
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
MASH	Multi-agency Safeguarding Hub
MATES	Multi-agency Team Enforcement Strategy
MCRT	Major Crime Review Team
MCRU	Major Crime Review Unit (another name for MCRT)
MISPER	Missing Person
MORILE	Management Of Risk In Law Enforcement – scoring system used in police analysis
MSHT(U)	Modern Slavery and Human Trafficking (Unit)
NACRO	National Association for the Care and Rehabilitation of Offenders
NCA	National Crime Agency
NCRS	National Crime Recording Standards
NDG	Neighbourhood Delivery Group
NFA	No Further Action

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NOMS	National Offender Management Service
NPCC	National Police Chiefs' Council
NPIA	National Policing Improvement Agency
NRM	National Referral Mechanism
NSPCC	National Society for the Prevention of Cruelty to Children
NWG	National Working Group for Sexually Exploited Children and Young People
OCG	Organised Crime Group
OCSET	Online Child Sexual Exploitation Team
Ofsted	Office for Standards in Education, Children's Services and Skills
OIC	Officer in the Case
OIS	Operational Information System – a database maintained by West Mercia Police
OLA	Other Local Authority
OLLIE	Online training and development tool maintained by Telford & Wrekin Council
OPCC	Office of the Police and Crime Commissioner
PACE	Parents Against Child Exploitation
PCC	Police and Crime Commissioner
PCP	Police and Crime Plan
P&C Panel	Police and Crime Panel
PCSO	Police Community Support Officer
PCT	Primary Care Trust
PEP	Personal Education Plan
PHV	Private Hire Vehicle
Perpetrator	An individual who has been named in any account seen by the Inquiry as committing an act of CSE. That does not mean they have been convicted, or charged with such offences, or even interviewed by the police.
PNC	Police National Computer
PPU	Public Protection Unit
Protocol	File management and recording system maintained by Telford & Wrekin Council (also known as "Liquid Logic")
PTF	Police Transformation Funding
PVP	Protecting Vulnerable People Unit (also known as PPU)
RASSO	Rape and Serious Sexual Offences

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Recovery Order	An Order to produce a child who is in care, the subject of an Emergency Protection Order or in Police Protection who has been unlawfully taken or kept away.
Referral	A request for support to be provided by Children's Services.
RHI	Return Home Interview of a child following a missing episode
RIU	Regional Intelligence Unit
ROCU	Regional Organised Crime Unit
ROCUWM	Regional Organised Crime Unit West Midlands
ROSHOS	Risk of Sexual Harm Orders
RSO	Registered Sexual Offender
RTTCG	Regional Tactical Tasking and Co-ordination Group
SARC	Sexual Assault Referral Centre
SAS	Safeguarding Advisory Service
SATH	Shrewsbury and Telford NHS Hospital Trust
SCIE	Social Care Institute for Excellence
SCAS	Serious Case Analysis Section
SCPO	Serious Crime Prevention Order
SCR	Serious Case Review
SCRG	Serious Case Review Group
Section 17	This section of the Children Act 1989 places on every local authority a general duty to safeguard and promote the welfare of children in their area who are in need by providing a range and level of services appropriate to that need.
Section 47	This section of the Children Act 1989 requires every local authority to make such enquiries as they consider necessary to enable them to decide whether action should be taken to safeguard or promote the welfare of a child whom they have reasonable cause to suspect is suffering or is likely to suffer significant harm.
Section 8 Orders	The four Orders under the Children Act 1989 – Residence, Specific Issues, Prohibited Steps and Contact Orders – which regulate the exercise of parental responsibility
Secure Order	An Order under Section 25 of the Children Act 1989 to place a child in secure accommodation
SHPO	Sexual Harm Prevention Order
SIO	Senior Investigating Officer
SOCA	Serious Organised Crime Agency
SOCU	Serious Organised Crime Unit
SOIT	Sexual Offence Investigation Team

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SOPO	Sexual Offences Prevention Order
SPOC	Single Point of Contact
SRB6	Single Regeneration Funding received by Telford & Wrekin Council in around 2004
SSCP	Safer and Stronger Communities Partnership
TAC	Team Around the Child. A TAC is for children and families who might need support from professionals in order to achieve expected standards of health, education, development or welfare. The TAC is a group of people, including the child, family members and professionals, who will work together to support the child and family. This requires consent from the parent(s) to take place.
TRB	Threat Reduction Board
TSV	Team Safeguarding Voice
TWSCB	Telford & Wrekin Safeguarding Children Board
TYS	Targeted Youth Support
VLO	Victim Liaison Officer
ViSOR	Violent and Sex Offender Register: an electronic management system for violent and sexual offenders.
USI	Unlawful Sexual Intercourse
Welfare Checklist	A checklist to which Courts must refer in Section 8, Care and Supervision proceedings, to ensure that the child's needs are met. Based on the Children Act 1989.
Working Together	"Working Together Under the Children Act 1989: A Guide to Arrangements for Inter-agency Co-operation for the Protection of Children from Abuse" (1991) was a guidance document produced by the government, and updated over time, setting out how all agencies and professionals should work together to promote children's welfare and protect them from abuse and neglect. It has been updated over time and the latest iteration is 2018, revised 2020.
YISP	Youth Inclusion and Support Panel
YOS	Youth Offending Service
YSS	Youth Support Service