Report of the Independent Inquiry Telford Child Sexual Exploitation

Chaired by Tom Crowther QC

VOLUME ONE
OF FOUR

12 July 2022

Commissioning Body: Eversheds Sutherland (Intl) LLP

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This statement aims to set out the various steps the Chair and Commissioning Body have taken with regards to accessibility of the Report.

Format of the Report

The Inquiry is conscious that the majority of those accessing and reading the Chair's Report will do so via the Inquiry's website, meaning that the Report will be read on screen as well as in printed form.

Given its length, the Inquiry has taken the following steps in an effort to ensure the Report remains as accessible as possible:

1. Volumes

The Report has been split into four volumes. Each volume is in a separate PDF document to reduce the download speed.

2. Executive Summary

The Report includes a comprehensive Executive Summary at the beginning, which includes the key sections from each chapter, so that readers can benefit from a higher-level overview of the Report either in advance, or instead of reading the Report in full.

3. Recommendations

The Chair's Recommendations have been collated into one section, which directly follows the Executive Summary in order for readers to see clearly the recommendations made by the Chair. This section also includes an overview setting out the Chair's findings which underpin the individual recommendations.

4. Contents Pages

The Report has a master Table of Contents at the beginning of the Report, together with individual contents pages at the start of each Volume and chapter, to help the reader to navigate the Report and locate sections or topics of particular interest.

5. Sections

Each chapter is split into sections, with clear headings, in line with the contents pages.

6. Appendices

The Report is accompanied by a number of appendices which are intended to help summarise certain processes, or provide overarching timelines of events, to assist readers in following the narrative of certain chapters or sections, and the Chair's discussion of these within the Report.

7. Glossary

A Glossary of key terms and acronyms is provided at the end of the Report, so that the reader has a separate reference point for words regularly recurring within the Report.

8. Searchable text

The CTRL+F search function can be used to search for particular words, names or phrases.

9. Plain Language

The Inquiry has sought to avoid the use of overly complicated language so far as possible, to avoid barriers to understanding. It is acknowledged that there are inevitably a significant number of acronyms[1], with which the Glossary will hopefully assist.

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* Public Sector Bodies (Websites and Mobile Applications) (No.2) Regulations 2018

CONTACT:

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Foreword

I began my career as a lawyer in the 1990s in South Wales. In the very early days, a retired police inspector told me that during his first week as a cadet, in the 1950s, he had been taken aside by a grizzled sergeant who said that incest was the "secret shame" of the South Wales valleys: that the younger man should remember it, but not expect anyone to complain – because no-one ever did.

I suspect that there have always been complaints; that the "secret shame" line was a convenient explanation for a lack of action – for a failure to listen to and act upon those complaints. Historically, the voices of children have not been heard. Seventy years ago, the concept of social care was in its infancy following the National Assistance Act 1948. The new Sexual Offences Act 1956 barely contemplated the sort of abuse and exploitation that I have heard about in this Inquiry. The police followed the lead of the courts in regarding children as essentially unreliable witnesses.

Society has changed and continues to change. We are learning to listen to children, and to listen to what happened to people when they were children. Over my career as a barrister, then as a judge, I saw victims and survivors come forward to tell their stories. I saw women in their 70s describing rapes which had taken place so long ago that the offences were charged under the Offences Against the Person Act 1861. I saw people give evidence about sexual abuse and exploitation that had happened in schools and church settings in the 1970s and 1980s. Increasingly, over time, I saw younger and younger children giving evidence about what people had done to them. The youngest victim I saw give evidence was four years old.

I know that when that child is in their 70s, they will not have forgotten the abuse; I know that sexual abuse of children marks lives. And so, when I was appointed as Chair to this Inquiry, I was acutely aware of how important the work would be: important to the victims and survivors whose childhoods were shattered and whose lives have been forever altered by sexual exploitation; to the parents, some tragically bereaved, who had felt alone and powerless in the face of a clear danger to their children; and to the professionals who had fought for recognition of and response to Child Sexual Exploitation ("CSE") as a threat to children's safety.

It is important that at the outset I pay tribute to all those victims and survivors whose experiences have informed the work of this Inquiry, and I offer particular thanks to those who have felt able to come forward to give evidence. This Inquiry's processes were deliberately not modelled on a court, to encourage those who may have felt that atmosphere confrontational, but I do not underestimate the difficulty of simply telling someone about an experience of childhood sexual exploitation, or the bravery of those who have done so. I also recognise and respect the absolute right of those victims and survivors about whom I have read, but from whom I have not heard, not to engage: lives will have been subsequently built, and it is not for the Inquiry to force a victim or survivor to reckon with their past.

The Terms of Reference for the Inquiry are very wide; going back many years and reviewing wide-ranging aspects of CSE and the response of a number of organisations. This has necessitated obtaining huge quantities of documentary material, which in some cases has not been a straightforward process, and speaking to many witnesses. It has been challenging and complex to collect, review and analyse that material and that testimony; not least because the majority of this work has been conducted during the Covid-19 pandemic, which presented additional challenges. Nevertheless, I am confident that the evidence obtained has enabled me to fulfil the Terms of Reference.

Large sections of this Report deal with bureaucratic structures and their operation: a necessary consequence of properly meeting my Terms of Reference, as to judge the adequacy of a response involves understanding how it was put together and meant to work. Throughout, though, I have borne in mind that the story of CSE in Telford is fundamentally not a story of committees, acronyms, task and finish groups and audits; but of children's lives interrupted. I have sought to tell some of those stories through case studies and, interleaved between chapters, extracts of survivor accounts. I have been cautious to protect individuals' privacy – occasionally by restructuring the evidence and changing some facts - but consider that what remains is an illustration of the evidence obtained that demonstrates the unrelenting nature of selfish and pitiless crime.

Inquiries like this, at their best, drive change. They can only do so if the organisations and agencies that are subject to criticism accept the spirit in which those comments are made, and review the findings I have made in a way that is reflective and self-critical. Neither reflexive denial, deflection of blame, nor excessively optimistic statements would be a useful response. It would be particularly disappointing if my conclusions, which are essentially apolitical, were to be used for political gain.

So far as individuals are concerned, I should make a basic point: the individuals responsible for CSE in Telford are the people who perpetrated it. Men have been convicted of CSE crimes; their names are a matter of public record. It is no part of this Inquiry's – or any inquiry's – function to attribute criminal liability: I have no power to do so. I have not sought to attribute guilt in cases which did not result in convictions or in which proceedings were not brought; what I have done is to review approach, actions and attitudes of the key agencies in accordance with my Terms of Reference. In undertaking that task, my general approach has been that attributing blame to individuals unnecessarily can lead to others absolving themselves of any responsibility and may detract from what is important; learning lessons and making changes to improve the lives of children and young people in Telford. Nevertheless, where I consider it necessary and fair to criticise the actions of individuals, which has occurred primarily where an individual is in a senior position of responsibility, I have not shied away from doing so.

So far as Telford as a community is concerned, I hope that this Report will serve as a substantial record of the incidence of CSE and of official response during the period of my Terms of Reference. This Report will bring no comfort to those who deny a problem ever existed or those who take the view that the reaction could not have been improved. If there is an overarching theme to be identified, I consider it is that concern and action about CSE came from individuals within organisations, rather than from the organisations themselves; and indeed, the organisations often seemed, at least initially, to regard these informal or ad hoc responses from proactive individuals with some suspicion.

There were a great many of these proactive individuals who contributed to the response to CSE. In my review of the evidence, however, I have come to the view that some were pivotal - that without their refusal to ignore the unacceptable, without their dogged insistence that things must change, Telford's CSE response would have looked quite different. There might, without them, have been in time an equivalent to the Operation Chalice investigation and the Children Abused Through Exploitation team at the Council; I cannot speculate. However I am sure that these individuals - acting, often, with scant resources and little support, and sometimes at personal risk or at subsequent personal cost – drove responses that helped children. In my view there can be no higher accolade and I consider that it is right that I name them so that their contributions may be recognised. These are my 'Telford Ten':

Donna Chapman	Fran Holehouse	Helen Morris	Phil Shakesheff
Alan Edwards	Alastair James	Diane Partridge	Steve Tonks
	Dawn Lewis	Ian Rutherford	

Before this Inquiry was constituted – before the Commissioning Body was appointed – Councillor Lee Carter, cabinet member responsible for establishing an independent inquiry, said:

"*The Survivors Committee is crucially important in ensuring that the independent inquiry reflects the needs and concerns of victims and survivors of child sexual exploitation and that we all acknowledge the pain that they have and continue to feel*."[1]

I adopt those words and pay tribute to the role of the Survivors' Committee in working tirelessly to ensure that Telford's history of CSE is uncovered, and that the town is best placed to face future risk. During the course of this Inquiry I have met the Survivors' Committee on several occasions to listen to their views on my work and its progress. The Survivors' Committee has not directed this Inquiry or in any sense sought to, but I have been grateful for its members' unique perspectives, their dedication and insight – and, during a time beset with unforeseen obstacles, the occasional opportunity to explain.

There is little guidance to an Inquiry chair as to how their function should be fulfilled. A recent textbook on the topic notes:

"[e]*very public inquiry differs from those that have come before… Those who have previous involvement in public inquiries will know that lessons about how best to set up and manage an inquiry are frequently overlooked.*"

In chairing this Inquiry I have had the privilege to work with two of the authors of that text, Sarah Jones and her colleague Isabelle Mitchell; and their strategic and practical insights have been an inestimable advantage. None of the lessons from their vast experience has been overlooked. I am grateful, too, to Catherine Henney and to Anna Lois Senter, both indefatigable, who led teams on the police and council sides respectively. Those teams also included these others, to whom I offer my thanks:

Charlotte Belcher	Piers Doggart	Gina Margaroni	Adele Shakespeare
Lucy Bishop	Matt Greene	Lucy Parton	Grace Walker
Chaitali Desai	Lisa Farrer	Gemma Ruff	Tina Wing

I should also note my gratitude to the Eversheds Sutherland Litigation Technology team, who answered my frequent calls with good humour and patience, and to the Eversheds Sutherland Privacy team, the complexity of whose role in the days of GDPR should not be underestimated.

[1] https://newsroom.telford.gov.uk/News/Details/14253

Independent Inquiry
Telford Child Sexual Exploitation

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Executive Summary

Introduction

1. The Terms of Reference for this Inquiry, which are set out in full at Appendix B to this Report, provide that its overall aim and purpose is to raise public awareness of child sexual exploitation ("CSE") in Telford during the period from 1989 to date.

2. In fulfilling that aim, I was tasked with examining the nature, extent and patterns of CSE in Telford; the impact of CSE; the history of changes made to practice, policy and legislation as they affect response to CSE in Telford; prevailing attitudes and changes in attitude; the taxi industry and night-time economy; and, most significantly, the response of third party organisations to CSE, or suspected CSE, and the adequacy of those responses.

3. The work involved has been very significant. In Chapter 1: Background to the Inquiry, I set out in some detail the extent of material received by the Inquiry in the course of its work. The volume of disclosure was vast. Not all of that material was relevant; but a very significant amount was.

4. The result is this, very lengthy, Report. This Executive Summary is itself long; it contains my primary findings and conclusions and essentially follows the chapter structure of the Report. Some chapters have not been summarised - Chapter 1: Background to the Inquiry, for example, is a technical background account of the Inquiry's set up; and I have deliberately chosen not to summarise the case studies within Chapter 5: The Policing of CSE in Telford, and Chapter 8: Case Studies; these are accounts of real lives and deserve to be read in full to understand the misery that CSE caused children in Telford and how those children and hundreds, if not thousands, of others were failed by the institutions that should have protected them.

5. The sections of this Executive Summary are set out in the table on the next page, with chapter references identifying where these issues appear in detail in the Report.

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Nature, Patterns and Prevalence of CSE (Chapter 2)

6. I am required to consider as part of this Inquiry the "*nature, extent and patterns of CSE in Telford*" (Terms of Reference, paragraph 2.1, Appendix B). In doing so, I have considered the accounts of those victims and survivors who have given evidence to the Inquiry, and those who have spoken previously to key stakeholders – particularly the Council and West Mercia Police ("WMP"). Those stories have allowed me to form an understanding of how perpetrators were able to sexually exploit children. In estimating the prevalence or extent of CSE in Telford over the years, I have listened to witness accounts over the decades, as well as reviewing published reports and articles and considering the data produced by the Council and WMP.

Nature and Patterns of CSE in Telford

7. By far the most common method by which children were introduced to CSE in Telford was by what studies have called the 'boyfriend' or 'lover boy' model. A child would meet a man, perhaps by an apparent chance meeting in the street, or by virtue of the man's job as a taxi driver or food delivery driver.[2] A police witness told the Inquiry that the typical perpetrator's plan was to meet as many girls as they could, and persuade one to become their 'girlfriend'. Perpetrators sought out those who were much younger than them and/or vulnerable; perhaps those that were on the edge of friendship groups, or craving attention. The

[1] It is important to note that Telford & Wrekin Council (the "Council") did not exist until 1 April 1998. References to the "Council" before that date therefore refer to the actions of Shropshire County Council.
[2] [redacted]

perpetrators would often begin by giving children lifts, buying them fast food, alcohol and cigarettes, and/or topping up their mobile phones with credit. The children involved often saw this as a 'relationship',[3] notwithstanding differences in age. However, the children were then encouraged to become involved in sexual activity, which they were led to believe was part of the relationship; in this way, the perpetrator would establish control.

8. I heard an explanation of this 'boyfriend' model from Sara Swann MBE, a social worker who developed the first multi-agency response to CSE in the UK:

"Stage one I called 'ensnaring'. There tended to be some vulnerability and one of the issues that we found, definitely, was missing from home… Very quickly this guy [be]comes the most important, he begins a sexual relationship and she falls head over heels in love with this guy.

Stage two was about effective dependency on him so [she] would cut the ties with family and friends…

[Stage three] led into the taking control and that's when the violence started but it's not unremitting violence, it's interspersed with good times, buying her presents… that's an effective way to exert control…

Then those three stages make total domination [stage four]. He's the most important person in her life and the only person in her life and then she will do favours for him and that includes having sex with his mates and whatever he asks her to do then she'll do it".[4]

9. The degree of control exercised by perpetrators led to children becoming involved in sexual activity with other men as a 'favour' to their 'boyfriend' or as payment for the gifts they had been bought. Children were led to believe that this was normal or what they deserved, and crucially, as a result, they did not consider themselves to be victims or as being exploited.

10. One child disclosed to professionals that she had been subjected to sexual intercourse with multiple men, and that she thought that "*if she had sex with someone then to her, they became a boyfriend*". The child had disclosed that her "*main boyfriend… was a* [middle-aged] *taxi driver*", but that in a short space of time she admitted "*she had at least 3 boyfriends that… were Asian taxi drivers*". The child disclosed that she would 'go out' with one male, have sex with him, and then "*move on to his friend*". A professional witness concluded in respect of this child: "*She believed it was her choice, but from my standpoint, I believe she was being passed around for sex*".[5]

11. Multiple witnesses told the Inquiry that perpetrators did not use contraception, placing victims at obvious risk; pregnancies were expected to be (and in many cases were) terminated, though some victims and survivors went on to bear the children of their perpetrator(s). Many victims had of course been lured into believing that the perpetrators

3 [redacted]
4 [redacted]
5 [redacted]

were their 'boyfriends', or that they loved them, and they believed that they had therefore 'consented' to the sexual activity – and, as a result, the pregnancy.[6]

12. In another method of perpetration, children were put into vulnerable situations by perpetrators who would then exploit their vulnerability. For example, the Inquiry has heard multiple accounts of children being driven by a perpetrator to a remote location at night, where the perpetrator would threaten to abandon them if they did not engage in sexual behaviour; or would simply rape them.[7]

13. Once a child had been 'introduced' to exploitation, violence and its threat were commonplace. The Inquiry was told that girls being gang-raped was not unusual. I have read two horrifying survivor accounts in particular, disclosing that:

"…there were times I'd say no but I didn't know it was being videoed and there was him, [multiple other men] *and there were a lot of witnesses involved"*;[8] and

"*The men were rotating, taking turns to rape me. It seemed to go on forever. Once I started to get the feeling back in my body, I struggled and kicked out, and they forcibly held me*".[9]

14. Further, I heard that in several cases victims received death threats against them or their family members, or threats that their houses would be petrol-bombed or otherwise vandalised in retaliation for their attempts to end the abuse; in some cases threats were reinforced by reference to the murder of Lucy Lowe, who died alongside her mother, sister and unborn child in August 2000 at age 15: *"Abusers would remind girls of what had happened to Lucy Lowe and would tell them that they would be next if they ever said anything. Every boy would mention it".*[10]

15. The Inquiry also heard that offences took place in various known licensed premises in Telford and beyond; in nightclubs, restaurants and take-away establishments – with children being 'pimped' out there, being taken into rooms within the premises in order to be exploited. Perhaps most shockingly, I also read evidence relating to what was described as a 'rape house' in Wellington which, it became clear, had been operating for years.

16. A variation on this theme is the commercialisation of exploitation: perpetrators selling children to other men for sex. I have seen evidence that, certainly in the earliest period with which I am concerned, many children who were seen to be involved in 'prostitution' were indeed treated as 'common prostitutes' under the Street Offences Act 1959. Indeed, I have seen a cutting from a local newspaper, dated 20 June 1998, which makes plain that 'child prostitution' was a public concern at that time, with telephone boxes being used as "*a pick up point for teenage prostitutes".*[11] Distressingly, I have seen evidence that some children even regarded themselves as 'prostitutes'.[12]

6 [redacted] pg 4, [redacted] pg 11, [redacted] pg 3, [redacted] pg 9
7 [redacted] pg 9, [redacted] pg 11, [redacted] pg 3
8 [redacted] pg 4
9 [redacted] pg 10
10 [redacted]
11 [redacted], pg 272
12 [redacted], pg 410

17. A consistent theme running through the experiences of all victims and survivors was that, once caught up in this cycle of abuse, it was extremely difficult for them to escape it. In many cases the pattern of offending had become such that many victims did not recognise themselves as victims – it had, I believe, become a way of life to which they had become accustomed, and in many cases the child believed that they were loved, and believed it to be a consensual relationship.

18. This explains exactly the manipulative and powerful hold that perpetrators of CSE exerted over their victims in Telford. The nature of the crimes often involved brainwashing young people into believing they were in meaningful, loving and reciprocal relationships – even if such apparent reciprocity involved them engaging in things that deep down, they knew they did not want to do. Although some children spoke to professionals about their situations, for some time those professionals failed to understand that these 'relationships' were exploitative.

19. Some children left the Telford area, and while this may have physically removed them from the immediate threat, in many cases it also meant distancing them from any local family support system they may have had; often this meant that, despite the risk to themselves and knowing what they would come back to, children would often return to Telford, and fall back into the hands of their perpetrators.[13]

20. Another common pattern amongst victims was the tendency to go missing. The Inquiry was told that the issue of missing children "*seemed to be growing in severity*",[14] and that it involved children from all areas and backgrounds but that the police would struggle to get the children to cooperate; to encourage them to remove themselves from harm, and tell the authorities what had happened to them.

21. **There is no doubt that the significance of children going missing, and other indicators of CSE, were not recognised as such in the 1980s and 1990s.**

22. The Inquiry heard that although there was a growing awareness amongst school teachers, police officers, social workers, youth workers and, in some cases, healthcare practitioners that "*something was not right*",[15] the nature of the problem was not clear. One witness recalled:

> "*… 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, if that makes sense… there weren't the systems for* [the children] *to come forward and share that information… and from the professionals that I worked with there wasn't a sense of how to manage that,* [because] *it didn't fit into the traditional child protection processes and it didn't feature on the police's radar, so actually it was really difficult then to gather and draw in any response that was going to be effective."*[16]

23. **So far as WMP was concerned, it seems that for many years prior to Operation Chalice ("Chalice") the focus had been on securing actual complaints upon which**

13 [redacted] pg 17; [redacted] pg 20; [redacted] and other case study evidence
14
15 [redacted] and [redacted]
16

the police could react, and arrest perpetrators. But victims were not coming forward to make complaints as they simply did not recognise themselves as victims/survivors of a criminal offence. In the same way, social workers struggled to get children to open up about what was happening to them.

24. **It is clear to me that, as a result of individual professionals forcing the issue over many years, and refusing to ignore what were, perhaps now, obvious warning signs, the issue was finally sympathetically addressed by the youth workers who became the Council's Children Abused Through Exploitation ("CATE") Team, and investigated as part of Chalice.**

Prevalence of CSE in Telford

25. The first widely-publicised estimate given in relation to the prevalence of CSE in Telford was that published by the Sunday Mirror in March 2018, which said that "*up to 1,000 girls*" may have been subjected to sexual exploitation in the town, over four decades.[17] This figure has been criticised by some, with one individual stating that the figures contained in the Sunday Mirror articles were "*patently untrue*" and "*based on a misrepresentation of published data and crude, unsubstantiated estimates of prevalence*".[18]

26. I have considered the sources attributed by the Sunday Mirror and other material made available to the Inquiry in order to try to provide clarity around what I consider to be a realistic estimate of the extent of CSE in Telford over the years.

27. Insofar as witness evidence is concerned, more than one witness expressed the view that CSE "*had been present for a long time*" and some considered that it had "*generational*" roots - as in it had become a behaviour passed down through generations; not only from the point of view of perpetrators, to whom such exploitative behaviour had become normalised, but also from the point of view of victims and survivors, some of whom may have grown up around such abuse and whose parents may have also been exploited previously.[19]

28. From those victims and survivors who were able to speak about their experiences, it is clear to me that this type of exploitation dates back at least to the 1970s. I have seen evidence from one individual who recalled being touched inappropriately in the late 1970s by multiple men in a corner shop while she was scarcely of secondary school age, and being offered sweets by another man after he had sexually assaulted her; she reflected *"*[my] *innocence was stolen for the price of those sweets"*.[20] One witness also told the Inquiry that she recalls walking home from school as a teenager in the mid-1980s, when she was approached by a man who subsequently raped and physically assaulted her. This abuse became a regular occurrence, with the perpetrator allowing relatives to do likewise and forcing the child to comply.[21] The Inquiry heard from another witness that, also within this time period and when barely a teenager, a boy from her school "…*had sex with her. This began a pattern, with the*

[17] https://www.mirror.co.uk/news/uk-news/britains-worst-ever-child-grooming-12165527
[18] [redacted]
[19] [redacted]
[20] [redacted]
[21] [redacted] pg 2 and pg 6

boy bringing his cousin along on the next occasion, who [she] *was also forced to have sex with and then, on a subsequent occasion, another friend*".[22]

29. I have also seen evidence that, during Chalice, disclosures were made suggesting that there were "*minibuses*" full of children being trafficked out of Telford for the purposes of CSE.[23] When asked about the estimated '1,000' figure published in the press, a number of witnesses considered that, whilst there was no hard evidence proving there to be as many as 1,000 confirmed victims of CSE in Telford, looking at the number of victims identified during Chalice – and since – and when considering that some allegations dated back to the 1990s, the estimate of victim/survivor numbers reaching 1,000 was considered conservative, or in the words of one witness "*tame*".[24]

30. Reliable police data in relation to CSE only exists for relatively recent years. I do not regard this as a failure on WMP's part, as I recognise that forces nationally did not begin to collate and report specifically on CSE data until 2011.

31. I have however considered a series of 'CSE Problem Profile' documents prepared in relation to the WMP force area for the years 2012 to 2015, which revealed an "*upward trend"* in reported CSE cases.[25] This was following Chalice, and the prediction in 2013 that "*…offences are likely to be sporadic, emerging and potentially increasing over many months – even years, before falling again to a residual level with the conclusion of an operation and sentencing of offenders*".[26]

32. That prediction – of a levelling off – was to prove over-optimistic. Statistics set out in the Home Office report entitled "*Telford & Wrekin Child Sexual Exploitation 1 April 2012 to 21 March 2018*"[27] provided estimates based on the number of police 'CSE markers' which had been applied to crimes entered onto WMP's systems. This revealed that over that six year period (2012 to 2018), a total of 431 offences with a CSE marker were recorded in Telford & Wrekin, with a significant increase in reporting after April 2015 – which gave an average in excess of 71 offences per year. However, the Home Office report is presented with the caveat that "*it is almost certain that the figures do not reflect the true scale of CSE due to poor allocation of markers*" – for example because markers may have been used inappropriately in cases involving victims/survivors over the age of 18 at the time of going missing; or because no CSE marker may have been used at all by the officer entering the crime on the system at the time.

33. I have also seen statistics which show a narrowing in the age gap between victims and perpetrators, with 50% of all CSE perpetrated against females aged 14 to 17 by males aged 16 to 34, and 10% of all CSE perpetrated by "*younger male offenders, particularly aged 16-17 years*". This is perhaps unsurprising when one considers the increase in 'online' CSE

22 [redacted] pg 3
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24 [redacted]
25
26
27 [redacted] pg 24 onwards

alongside the increasing use of social media as a means of communication between younger age groups – and, also, the sharing of obscene material and grooming over social media.[28]

34. Insofar as actual rates of offending are concerned, figures provided by WMP show that from 2015/16 to 2020/21, a total of 831 crimes associated with CSE were recorded across Telford & Wrekin. WMP considered that there was no discernible trend in the annual rate, and provided statistics to support that contention.[29]

35. The most recent figures made available to the Inquiry show that in the first six months of 2020, WMP received 172 referrals from all sources, relating to CSE – which represented a 54% increase compared to the same period in 2019.[30]

36. As to Council data, Home Office statistics as reported by the Council's 2016 Scrutiny Review showed that for the period September 2014 to September 2015, Telford & Wrekin recorded 256 child sex crimes – which, while not the highest number of recorded child sex crimes within a local authority area in England and Wales, it equates to the highest rate of recorded child sex crimes at 15.1 per 10,000 residents.[31]

37. In the seven months from 1 January 2015 to 31 July 2015, data collated by the Council itself showed that there were over 4,000 contacts into the Council's Family Connect service of which there were 137 contacts (3%) with an indicator of CSE. Over the same period there were 44 referrals to the Council's specialist CATE team with between five and ten referrals each month.

38. It is relevant to note that in 2016, Ofsted inspected the Council's services for children and recommended that more needed to be done to understand the scale of CSE in Telford. It was acknowledged that steps had been taken to create a "*multi-agency dataset*" and to understand the trends of child sexual offences taking place in the borough, which included looking at victim and perpetrator profiles:

"*Over the last 12 months the TWSCB has worked with partners to establish a multi-agency dataset which is used to monitor the impact of the CSE Pathway… A joint piece of work between TWC and WMP has also been undertaken to understand the trends in child sex offences over recent years, looking specifically at victim and perpetrator profiles. This information will help to further develop the intelligence around perpetrators within the Borough and enable further targeted disruption activity".*[32]

39. Generally, it has been difficult for this Inquiry to confirm by way of any tangible data the scale of CSE within Telford historically. This is due to the lack of understanding around this type of criminality in the 1980s/early 1990s; the attitudes towards 'child prostitution' at that time; and the fact that many children were considered to be 'borderline' in terms of their proximity to the age of consent. I believe this led to a subjective view being taken by professionals, across the board, as to whether or not the child was consensually 'engaging'

28 [redacted]
29
30 [redacted] pg 213-214
31
32 [redacted] and see specifically [redacted] pg 2

in such activity, rather than being subjected to it under some form of grooming, coercion or duress.

40. Sadly, it is clear to anyone that reads the national press that CSE still exists today, and is prevalent across the country as a whole. In Telford, 2019 saw the most recent CSE convictions as part of Operation Epsilon – and other convictions have followed suit elsewhere: 2020 saw three men sent to jail in Oxford for a total of 35 CSE-related offences; and, until it was wound down in 2021, Operation Marksman involved Humberside Police looking at a further 34 suspects involved in CSE, following an initial prosecution of a number of men in 2018. In 2021, Greater Manchester Police announced it had set up a dedicated CSE Unit, tasked with looking into fresh allegations of CSE across Greater Manchester, including new victims and perpetrators in Rochdale since Operation Span – and over 300 victims and 500 offenders have already been identified.

41. This goes to show that this dreadful, life-altering crime has not gone away – in Telford, or elsewhere – and it must remain high on the radar of police forces, local authorities, health authorities, education providers, and all agencies that have a role to play in ensuring the safety and protection of children.

42. **For CSE to be properly addressed, a number of things need to happen. First, children need to be supported in being able to recognise exploitation; second, victims and survivors of any age need to be confident that their voices will be heard if they complain; and third, there needs to be accurate, consistent and regular monitoring and reporting of the incidence of CSE within Telford so that patterns can be identified quickly and resources directed appropriately. I have made a number of detailed recommendations to these ends, which appear in the recommendations section of this Report.**

43. **Finally, as to the true extent and prevalence of CSE in Telford, the detailed statistical information which I have seen, and to which I have referred here and throughout this Report, of course only deals with the relatively recent past, when published data has been made available. That information is also agency-specific data and not based on shared data. It does not provide a retrospective analysis or confirmation of estimates of victim/survivor and perpetrator numbers dating back to the 1980s, 1990s, or early 2000s; and, of course, those who have chosen not to complain can never be counted. It follows that I simply cannot determine the number of children abused by sexual exploitation within Telford during the time covered by my Terms of Reference. However, taking the witness evidence and all the available data into account, the extent of CSE in Telford has plainly been very significant: I certainly cannot say that the Sunday Mirror's figure is "*patently untrue*" as quoted above; sadly, I regard it as a measured, reasonable and non-sensational assessment.**

The Council Response to CSE in Telford (Chapter 3)

44. Telford & Wrekin Council provided the Inquiry with the bulk of the evidence it has considered. The resulting chapter is very lengthy – an entire volume - and, as required by my Terms of Reference, covers over 30 years. As a result, and for ease of navigation, I have split Chapter 3: The Council Response to CSE in Telford, into three time periods: 1989 to 2004, 2004 to

2012, and 2012 to date. Within each time period I have analysed the national landscape – the relevant legislation, guidance and practice – and the Council response. This section retains the same structure.

1989 to 2004

National Landscape

45. In the period before the mid-1990s, children were perceived by society generally, and in law, to engage willingly in sexual activities for financial gain. They were labelled as 'child prostitutes', and, in terms of the act of 'selling sex', they were considered, in legal terms, as no different from adults. For example, between 1989 and 1993 the police issued 1,758 cautions and 1,435 convictions to female children in England and Wales for 'prostitution' related offences. In the same period there were 46 cautions and 48 convictions of male children for offences relating to 'prostitution'.[33] If local authorities responded at all, their response was to bring these children into local authority care for being exposed to 'moral danger'.

46. In 1989, the Children Act was passed; it placed a range of new duties on local authorities and the courts to place the welfare of a child at the centre of decision making, to promote the welfare of children in need and to take reasonable steps to prevent ill treatment and neglect. Of particular relevance to CSE, the Children Act 1989 set out thresholds which, if met, prompted an investigation by a local authority into the need for the provision of services to children. This included:

46.1 Section 17 – if a child in a local authority area is deemed to be in need, then there must be an assessment by that authority to identify the needs of the child, and to ensure the family are given appropriate support to enable them to safeguard and promote the child's welfare. A child in need is defined as one who is:

46.1.1 Unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority; or

46.1.2 Their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the local authority; or

46.1.3 They are disabled.

46.2 Section 47 where a local authority has reasonable cause to suspect that a child is suffering or is likely to suffer significant harm, that local authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to

[33] Scott et al (2019) What works in responding to child sexual exploitation. DMS, Barnardo's & the University of Bedfordshire https://www.dmss.co.uk/pdfs/what-works-in-cse.pdf

decide whether they should take any action to promote or safeguard the child's welfare.

47. '*Working Together Under the Children Act 1989: A Guide to Arrangements for Inter-agency Co-operation for the Protection of Children from Abuse*'[34] was first published in 1991. This was statutory guidance. It made clear how the local authority should exercise its responsibility to identify children whose health and development would be impaired without support, and recognise those in need of protection who were being sexually, physically, or emotionally harmed and neglected, resulting in actual or likely significant harm. It did not address the needs or circumstances of those individuals regarded by society as 'child prostitutes'. *Working Together*, as it has become known, has been through many iterations since.

48. In the mid-1990s the voluntary sector, led by the Children's Society, Barnardo's and the NSPCC, challenged the criminalisation of children and campaigned for the concept of 'child prostitute' to be changed and for these children to be seen as being subject to abuse, and the 'pimps', 'punters' or other perpetrators to be seen as abusive adults.

49. The 1999 iteration of *Working Together* required local authorities' Area Child Protection Committees ("ACPCs") to act as an inter-agency forum for agreeing how the different services and professional groups should co-operate to safeguard children in their area, and to agree procedures.[35]

50. In 2000, the '*Framework For The Assessment of Children In Need And Their Families*'[36] guidance ("the Assessment Framework") was published by the Department of Health. The guidance identified that those children involved in prostitution were a particularly vulnerable group who can be invisible to statutory agencies, with their wellbeing overlooked, and the planning and interventions for them were not adequate.

51. In May 2000, the Government introduced supplementary guidance to '*Working Together 1999'*, entitled '*Safeguarding Children Involved in Prostitution*'.[37] Although this guidance still described the concern as one of children involved in prostitution (the emphasis is mine), it did outline that the children were primarily victims of abuse and that it was necessary to safeguard and promote their welfare, alongside investigating and prosecuting those who abused them and coerced them into prostitution. The guidance highlighted that where a professional believed that a child involved in prostitution was at risk of significant harm then they should always refer those concerns to the local authority's social services.

52. In 2003, the Green Paper '*Every Child Matters*'[38] was published. Criticism had been raised in the past that professionals had failed to understand each other's roles or to work together effectively in a multi-disciplinary manner, leading to poor services for children and families. One of the primary objectives of *Every Child Matters* was to change this, stressing the

[34] Home Office, Department of Health, Department of Education and Science, and the Welsh Office (1991) Working together under the Children Act 1989: a guide to arrangements for inter-agency co-operation for the protection of children from abuse.
[35] [redacted]
[36] https://webarchive.nationalarchives.gov.uk/ukgwa/20130107105354/http:/www.dh.gov,.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014430.pdf
[37] https://lx.iriss.org.uk/sites/default/files/resources/055.%20Safeguarding%20Children%20Involved%20in%20Prostitution.pdf
[38] https://www.gov.uk/government/publications/every-child-matters

importance of multi-agency working - all professionals working with children being aware of the contribution that could be made by their own, and each other's, service and to plan and deliver their work with children accordingly.

Local Structure

53. Telford & Wrekin sits within the historic county of Shropshire. Until 1998, responsibility for social services provision within Telford, including children's Safeguarding, lay with Shropshire County Council.

54. From 1991 to 1997 there was a child protection team and district team structure in children's Safeguarding. District social work teams dealt with issues involving neglect and emotional abuse. The child protection team dealt with familial abuse only and was seen as the elite service and seat of expertise. This was perceived as a distinctly two-tier structure and the remit of the elite child protection team did not include CSE cases.

55. A reorganisation merged the child protection team and district provision and allowed referrals from the public, rather than solely from other professionals. This structure was intended to foster the attitude that provision for children should be seen in the context of a "*continuum of need*"[39] rather than a series of specialist and separate teams; the new structure endured through the creation of Telford & Wrekin Council in 1998. Thereafter there remained a view that CSE cases, as they would now be described, were not the business of Safeguarding save in those cases where parental support was inadequate. It was believed that Safeguarding's sole role was to refer other CSE cases to WMP. This may have been influenced by the fact that child protection duty officers, who dealt with initial referrals, were rarely social workers with the ability to assess more complex cases.

56. I heard that the new Council was small and struggled with resources. Additionally, its primary focus was on education, rather than children's Safeguarding. This may have been a result of lack of political and administrative experience in relation to social services; failure to attract well-qualified staff; or simply the priorities of the time - a witness told the Inquiry: "*Care – adult and children – really wasn't as sexy, it really wasn't seen as such a high priority as Education and Training. Education and training was very much the flagship*".[40]

57. Further, evidence suggests that there was initial resistance to cooperative working in Safeguarding services between Shropshire County Council and the newly created unitary authority. The Inquiry also heard evidence that working relationships broke down within different geographical areas of the new unitary authority's Safeguarding provision, leading to the north and south Wrekin teams not sharing information with each other or attending strategy meetings in respect of vulnerable children; ultimately these teams were combined and a public facing 'Helpdesk' was put in place to deal with referrals.

58. In 2001, a Social Services Inspectorate report on Telford Social Services was damning in respect of the children's provision. There were concerns about routine practice, staffing levels, competence of staff, and the effectiveness of the referral, recording and information systems. As I will set out, these issues were to endure for well over a decade. Witnesses

[39] [redacted] pg 19
[40] [redacted] pg 8

confirmed the official findings: I heard repeatedly about staffing problems; at one stage there was a vacancy rate of 22%. The Helpdesk laboured under "*masses of unprocessed referrals*".[41] Attempts to reduce the vacancy rate by recruiting social workers from abroad proved counter-productive.

59. While the Council reformed the leadership of children's Safeguarding, with some success, I heard that an increased national focus on early intervention work with children led to a focus on reducing the costs of children in care so as to divert funds to this new priority, despite increased referrals to the Safeguarding team. Furthermore, the goal of having free flow of information between social workers and other agencies was never fully achieved, with the result that social work and other agency provision was seen as separate and mutually exclusive, and cases assessed as involving children requiring behavioural or family support would not be considered by Safeguarding. This culture of separation was to prove significant when, later, specialist provision for CSE was considered.

Local Response

60. Although the Inquiry heard evidence that there were simply no reports to Safeguarding of gang grooming or boyfriend model-type CSE in the 1990s, I have seen material which shows that exploitation was taking place, and that there was Safeguarding involvement in some cases: child protection conference reports from the mid to late 1990s report exploitation, though often described as a result of children putting themselves at risk, rather than focusing on perpetrators' actions.

61. Nevertheless, individuals were expressing concern about the patterns they saw. In 1997/1998 an "*interest group*" was formed around Stirchley, principally by youth workers, following concerns about young people who were going missing at weekends, being taken to Birmingham by older men.[42] Witnesses told the Inquiry that, when concerns were raised about there being no provision for these children, the view was that: "*… the police see them as a nuisance, the care providers from the care home weren't interested, it was almost like it's their choice, if they want to go missing it's their choice*".[43]

62. The Inquiry heard that the Youth Development Service identified the need for a Sexual Exploitation project in Telford and sought ACPC funding. As a result:

> "*… a project was established by the service to "monitor and evaluate the numbers of children involved in or at risk of sexual exploitation" through the allocation of a worker in the Council's Youth Development Service for 4 hours a week. The project worked to raise awareness of child exploitation through, in particular, education services*".[44]

63. The remit of this project was described in a later report to the Children and Families Collaborative Reference Group, as one to run workshops and submit statistical returns. It was not an intervention scheme. The Inquiry heard that there was no data available from

[41] [redacted] pg 7
[42] [redacted] pg 3
[43] [redacted] pg 3
[44] [redacted], pg 9

the project, and a witness involved told the Inquiry that the paltry time allowance meant that no statistical work had in fact been possible.[45]

64. From evidence provided to the Inquiry it is clear that the perception of those youth workers involved was that there was not a good working relationship between the Youth Service, an arm of the Education Directorate, and Safeguarding, and that their concerns about exploitation went unrecognised. Furthermore I heard that, at the time, Youth Service support was seen as a more appropriate response than Safeguarding, given that they were able to form longer term and more informal relationships with children, unrestricted by statutory processes.

65. Documents from 1999 detail the introduction of the Neighbourhood Action Teams, apparently intended to formalise multi-agency working at a local level.[46] These seem to me to have been – if properly implemented – ideally placed to identify and report concerns about young people; indeed minutes of one Neighbourhood Action Team meeting refers to sexual exploitation as an "*issue/concern*",[47] though there is no indication of follow up. The Inquiry understands from the Council that the Neighbourhood Action Teams were not intended to be a CSE response.

66. Minutes of another body, the Telford & Wrekin Collaborative Team for Children and Young People, record that the Youth Service organised a Sexual Exploitation workshop in December 1999 in Trench (later repeated in July 2000 at Stirchley), designed – according to a witness - to equip youth workers and others with the latest learning on CSE.[48] The Council was not able to furnish any further detail about this event.

67. By 2003, multi-agency Sexual Exploitation meetings were taking place. It is not entirely clear whether these were intended to have a strategic or operational function, and although specific cases were discussed, witnesses have criticised the absence of practitioner input in these meetings. Although a plain pattern of CSE was identified, there was no discussion about referral to Safeguarding.

68. Despite these meetings, witnesses have conceded that, in the early 2000s, an obvious indicator of CSE – a teenage pregnancy spike - was seen as relevant only to the health or economic wellbeing of the children involved. Although at one meeting CSE was said to have been a "*big issue for schools*",[49] there was no enhanced provision beyond the four hours per week awareness raising.

69. ACPC records show that, in May 2003, an attempt to set up a working group for a CSE action plan had failed; the plan was still not drafted by November of the same year and minutes lament that Sexual Exploitation meetings were poorly attended. Though I have seen reference to a "Sexual Exploitation Group" "*working to draft a multi-agency protocol*",[50] the

45 [redacted]
46 [redacted]
47 [redacted]
48 [redacted] pg 2 and [redacted] pgs 4, 16
49 [redacted] pg 4
50 [redacted]

plan appears not to have been realised until 2006; there is no evidence that it was used in practice thereafter.

70. The documentation provided to the Inquiry relating to the ACPC has been scant which, although understandable given the passage of time, is nonetheless disappointing given the key role the Inquiry understands the ACPC had in the Council's early response to CSE. From the documents available, it is apparent that, from an early stage, the ACPC heard concerns about whether information relating to CSE cases could be shared with other agencies. Perhaps in reply to those concerns, the ACPC commissioned joint training exercises in respect of CSE in or about 2004. That training underlined the importance of joint strategy meetings being held to determine the proper response to cases of CSE, though it is not possible to determine whether that training was delivered to all relevant partners – for example WMP.

Conclusions

71. **There can be no doubt on the evidence I have seen that the signs of CSE were apparent to anyone prepared to recognise them during this period.[51] However, while some individuals plainly recognised the problem, the structures in place did not serve victims of CSE well.**

72. **The Shropshire child protection structures enforced a rigid hierarchy between child protection and district teams, which led to an inflexible approach, which was ill-equipped to deal with CSE. Although there was a restructure designed to make the approach to child protection recognise a "*continuum of need*",[52] this appears not to have been successful. I derive this conclusion from the fact that I see no evidence that anything was done.**

73. **At the same time, the continued hierarchical separation of child protection from the remainder of other safeguarding services/teams, including Youth Services, led to little engagement by Safeguarding with CSE. The Youth Service's early attempts to engage with the CSE problem were met with disinterest from Safeguarding.**

74. **While it is clear that Safeguarding were involved with children where the section 47 threshold was thought to be met, it is less clear that there was any effective Council response to CSE cases thought to fall below the threshold, for whatever reason.**

75. **In the move to a unitary authority, the focus was on building a strong education department and the structures associated with education provision. There is no sign of parallel enthusiasm for, or interest in, Children's Social Services. The early days of child protection were marred by a lack of focus and resources, and there was a lack of strong professional expertise – at management and at practitioner level - in the Council's Children's Services in the very early days.**

[51] [redacted] pg 3, [redacted] pg 38, [redacted]
[52] [redacted] pg 19

76. **The response of the ACPC appears – on admittedly scant documentation – to have been minimal. While it was reported to the ACPC that this was a "*big issue for schools*"[53] there is little evidence of co-ordinated response and no response involving dealing with victims of CSE. Attempts in the early 2000s to set up sexual exploitation policy meetings failed for lack of engagement.[54] The ACPC appears not to have recognised missing or teenage pregnancy as indicators, or their relevance to CSE.**

77. **The only response was that the Youth Service – the agency whose staff had been closest to CSE and had been most concerned by it - allocated a worker for four hours per week, with a plainly unachievable brief, not only to produce training materials and deliver training to schools, but also to evaluate and monitor the prevalence of CSE.**

2004 to 2012

National Landscape

78. The Children Act 2004 (the "2004 Act") mandated the replacement of ACPCs by Local Safeguarding Children Boards ("LSCBs"). LSCBs were charged with drawing all the relevant partner agencies together to work cooperatively, to improve safeguarding outcomes for children and young people and to hold those agencies to account in respect of this work. The scope of the LSCBs' role included safeguarding and promoting the welfare of children, aiming to identify and prevent maltreatment, or impairment of health or development, and ensure children would grow up in circumstances consistent with safe and effective care.

79. LSCBs were to have a primary role in developing procedures and protocols, including specifically with regard to "*children abused through prostitution*".

80. LSCBs were to be chaired by a person of sufficient standing and expertise to command the respect and support of all partners.

81. The 2004 Act also required that local authorities appoint an overall Director of Children's Services, ending the split between the oversight of education and children's social services provision.

82. *Working Together* was updated in 2006; the guidance made clear that where children were identified as being either involved in prostitution or were at risk of being drawn into prostitution, this should *always* trigger the agreed local safeguarding procedures.

83. In 2007, supplementary guidance to *Working Together 2006* was issued,[55] regarding safeguarding children who may have been trafficked. This guidance was intended to support those working with children to identify and respond to trafficked children, including those trafficked for sexual exploitation both into, and within, the UK. The guidance reiterated the

53 [redacted]
54 [redacted] pg 27, [redacted] pg 38, [redacted] pgs 22-23, [redacted]
55

use of existing safeguarding procedures. In 2009, further supplementary guidance was issued titled '*Safeguarding Children and Young People from Sexual Exploitation'.*[56] This moved the discussion away from 'child prostitution', and all that that implied, and focused on CSE as child abuse.

84. *Working Together* was reissued in 2010.[57] The new version outlined the safeguarding responsibilities of all agencies. There was a brief section on CSE and a reminder of the responsibilities contained in *Safeguarding Children and Young People from Sexual Exploitation,* and of the fact that children and young people who are sexually exploited are the victims of child sexual abuse, and their needs require careful assessment. They are likely to be in need of welfare services and – in many cases – protection under the Children Act 1989. It also highlighted the role of the LSCB to ensure that there was appropriate training and supervision of those responsible for safeguarding children and young people.

85. In 2011 the Government published the '*Tackling Child Sexual Abuse Action Plan'.*[58] The plan reinforced the expected role of LSCBs in respect of data collection, mapping need, developing an effective local strategy and providing training as a priority.

Local Responses

General

86. The Council's Safeguarding service was in difficulty from the beginning of this period. There was a continuing struggle to find social workers: I heard that Telford was "*not an area in which social workers were choosing to work*";[59] it was known to have complex social care issues thought not to be unusual for a new town. Further, there was a lack of supervision of social worker teams and morale was low.

87. The Safeguarding service had been depleted of its leadership because of absences through illness. There was only one senior manager in Safeguarding at the time in 2008/2009. I heard that the extreme shortage of senior staff meant that the department was in *"very poor shape*".[60]

88. In 2008 the Council appointed a new Director of Children's Services, whose background was in education. There had been what one witness called a lengthy "*interregnum*"[61] (pause) when the post was vacant; a sense of strategic direction had been thought to be missing. In late 2009, the Director of Children's Services left and the Council appointed a new Interim Director. Subsequently, in a decision that witnesses to the Inquiry have universally panned, the Chief Executive took on the Director of Children's Services role.

[56] Department for Children, Schools and Families (2009) *Safeguarding Children and Young People from Sexual Exploitation.* HMSO: London.
[57] [redacted]
[58] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/180867/DFE-00246-2011.pdf
[59] [redacted] pg 4
[60] [redacted] pg 4
[61] [redacted] pg 5

89. These difficulties are reflected in reports: an Ofsted inspection relating to the period April 2007 - March 2008 rated the overall effectiveness of children's services as "*adequate*".[62] A Joint Area Review ("JAR") published on 9 September 2008[63] found that the quality of practice in social care services was variable: not all children received timely and purposeful support; some children were not being safeguarded sufficiently; quality assurance and performance management were not strong; there was particular weakness as a result of capacity pressure on children's social care, and deficiencies in the arrangements for case allocation for the case management teams.

90. During this period there was a plethora of groups which all appeared to have some responsibility for CSE. Piecing together the roles and governance structure of these various groups and committees has been an immensely difficult job.

The LSCB

91. The primary group, the LSCB, was beset by difficulties from the start. It was thought that it could not afford an independent chair until a secondment from the charitable sector was arranged; that appointee perhaps did not have the degree of experience and seniority which the role demanded. Further the LSCB grew too large to be effective, while failing to attract sufficiently senior people to its meetings; it had insufficient funds for the training it was required to provide; its information flow was controlled by the LSCB Steering group (later known as the LSCB Executive); there was, at least initially, no representative of sexual health services on the LSCB; over time, subgroup memberships became so large that those groups, too, became unwieldy and ineffective.

92. There was a perception amongst witnesses that the LSCB was run by the LSCB Executive, which in turn was run by the Council: for a number of years the Chair of the LSCB had no seat on the LSCB Executive. There is some support for that notion in the fact that two very significant developments in this time period - the genesis of the Children Abused Through Exploitation, or CATE, Team and its near-abolition in a 2012 restructure (which I deal with below) – went largely unremarked in LSCB minutes.

The Sexual Exploitation Group

93. The Sexual Exploitation group was renamed the CATE ("Children Abused Through Exploitation") group and became a subgroup of the LSCB in 2006. Its membership was widened; this was a deliberate attempt, the Inquiry heard, to broaden response beyond the Youth Service. The purpose of the CATE subgroup of the LSCB was "*to be a planning and support group for agencies providing services to young people who are, or may be, at risk of CSE*".[64]

94. I have previously referred to Sexual Exploitation meetings; I have seen minutes for a Sexual Exploitation meeting on 18 October 2005[65] which appears to have been much more strategic

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in character than the previous meetings, though there was doubt about its precise function: "*This group is part of the LSCB staying safe group but its function is still unclear*."

Development of a CSE Response

95. In 2004, to follow national guidance, the Council created 'locality teams', which were groupings of agencies and services working together to support children and young people. These were termed "*Clusters*"; there were five. The Clusters housed multi-agency teams including Family Support workers, Youth Intervention Service workers, Education Welfare Officers, Children and Adolescent Mental Health Services ("CAMHS") presence and teachers specialising in behavioural support, but not (until 2010) social workers.

96. The Clusters had not been designed to be a CSE response; nevertheless the Wellington Cluster had become so concerned about exploitation that an informal record was made of all children suspected to be victims; this was the only active CSE monitoring going on in the Council at the time. The concern about CSE was not apparently shared by Safeguarding, which told the Cluster that child prostitution had "*always happened in Wellington*".[66] Cluster staff were told that exploitation was not the business of Safeguarding and that detailed reports should not be shared by email, as the allegations could "*start a race riot*".[67]

97. In 2006, a review of resources for CSE conducted by the Council concluded that Telford should develop a clearer understanding of the local issues and map them to direct work successfully: to develop strategies to combat exploitation and exit strategies, to continue to raise awareness through training and outreach and, most significantly, to provide a specialised service professionals could access for support, advice and to carry out one to one work with young people at risk of, or being subjected to, sexual exploitation. It recommended that a professional, experienced person be appointed to lead the project full time and to develop the project by recruitment of both a further officer, to work directly with young people, and an administrator.[68]

98. The Inquiry heard that this review "*didn't land well*".[69] A refined proposal was put to the LSCB Executive. This made clear the post should sit within Safeguarding rather than rely on Youth Service funding; this did not land well either, and there was discussion about funding the project through the LSCB itself, through the Clusters, through lottery-based funding and through charities.

99. It was not until 2007 when the CATE group recognised that youth workers were now performing an effective *'sexual exploitation prevention officer'* role with victims of CSE in Telford, though informally, that a funding solution was found. At a strategy meeting on 30 August 2007, in respect of a child who would ultimately be named as a victim in the Chalice indictments, it was reported that CATE had made a formal request of the LSCB for a funded role to work with victims of CSE.[70] The LSCB tasked Connexions4Youth, an evolution of the Careers Service, with formalising its response; two Connexions4Youth workers were

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assigned to what became the CATE project. A witness told the Inquiry their view of the rationale:

"*Connexions4Youth staff don't cost as much as social workers. So, it almost felt a little bit like we were back to being resource-led and if we're being resource-led the option to do this as cheaply as possible seemed to be the better option at the time*."[71]

100. When Connexions4Youth was given responsibility for the CSE response through the CATE project, the Wellington Cluster was told to "*step away*" from the issue.[72]

101. In October 2007, a Senior Officers' Coordination group – comprising representatives from the Council, from WMP, and from health agencies - was formed, apparently in response to growing evidence of organised CSE within Telford.[73] The LSCB's CATE subgroup would request additional funding from this group as a first and main point of contact. The Senior Officer's Coordination group considered the model of intervention, and in particular whether the question of children being sexually exploited should be dealt with through existing safeguarding procedures.

102. In the meantime, the emerging CATE project was working with more children who would be named as victims in the Chalice indictments. The CATE project practitioners' role was primarily to befriend the victims and to secure the cooperation that was elusive with a more formal approach. I have heard that in furtherance of this there was informal information sharing between WMP and the CATE project. A WMP officer told the Inquiry:

"[*we*] *started to interact with the CATE team, which… obviously they were doing it from the Council point of view. So we started to work together on that side of things. There was no formal agreements, there was no bosses' agreements, there was nothing*."[74]

103. At the same time, the CATE Pathway group – sometimes known as the CSE Pathway group - was established. This was apparently accountable to the LSCB and the Senior Officers' Coordination group. The result of this was that there were at least three different LSCB subgroups dealing with CSE, with an inevitable lack of clarity over purpose and function.

104. The Inquiry heard that those involved with dealing with CSE were frustrated by the attitude taken by Safeguarding, and particularly the Council's Helpdesk, to reports of exploitation – that such reports "*didn't… go anywhere*".[75] A year later, the LSCB CATE subgroup was told that there was a lack of awareness within the Safeguarding team of the CSE problem and its extent.[76] Teenage pregnancy and children having babies was still not seen as a safeguarding issue, but rather one of sexual health.

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105. The nature of the CATE project response was such that it "*wasn't child protection, again it was being seen as something that could be changed under a behavioural modification type working relationship*".[77]

106. Despite the fact that the CATE project was not a Safeguarding response, its developing procedures used the terminology (but not procedures) of *Working Together* and Safeguarding, although this was not the response that *Working Together* mandated.

107. Furthermore, those working with the CATE project felt an abandonment which had been familiar to those dealing with the problem in the Wellington Cluster, with contemporary documents showing that information passed to other agencies was not acted upon. Witness evidence suggests that Safeguarding regarded the CSE problem as exaggerated by the Youth Service.[78] Additionally, there was no central repository for information in respect of victims of exploitation. The CATE project had no access to Safeguarding IT systems and resorted to making records in password-protected Word documents. This obviously militated against effective sharing of information even if such sharing would have been welcomed, a situation described by a witness as "*a little bit bonkers*"[79]: a characterisation with which I agree.

108. Indeed, there is material which indicates that, even in late 2007, Safeguarding were simply unaware of the Connexions4Youth/CATE CSE response, and – in an apparent reversal of its previous attitude - pushed for the Clusters to perform the role.[80] The result seems to be that at this stage there were three different possible ways in which services could be provided to sexually exploited children: firstly, where significant harm was found or contemplated, this would trigger the usual child protection procedures; secondly, through the Clusters; and thirdly, through the CATE Team.

109. CATE work quickly "*snowballed*".[81] Victims were largely identified by word of mouth rather than through a formal referral process.

110. There was a problem finding money for the new CATE Team; the funding allocated was for a 0.6 full time equivalent, which was being fulfilled by two practitioners. There was no funding for weekend work. The CATE work was demanding and those undertaking it went far beyond their allocated hours. For example, the CATE Team manager took on practitioner work during other practitioner absences. There was talk of finding alternative funding sources but none was pursued. The CATE project was said to be "*at bursting point*"[82] as the Operation Chalice investigation gathered pace.

111. Despite recognition, first, that similar CSE responses in other local authorities were funded by a combination of partner agencies, and second, that the natural home for CATE was within Safeguarding, in January 2009 Connexions4Youth renewed its funding commitment for a

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year. This was welcomed by those involved, but I heard that the funding settlement was plainly inadequate for the volume of work.[83]

112. During the course of 2009, CSE was said to be increasing at "*an alarming rate*",[84] but the CATE project was reduced to a single practitioner; a CATE Team member described the workload as "*unsustainable*".[85] At the same time, the LSCB adopted CSE as a priority with another distinct subgroup to the LSCB being created, with the stated aim to "*commission a sustainable service based on the successful pilot and the experience of good practice elsewhere*".[86] The suggestions were virtually indistinguishable from those which had been made in the 2006 review.

113. There were then significant changes made to the CATE Team: first, by the end of 2009 the team (of one) was described as now full-time and managed by a senior social worker.[87] This was the first time that the CATE Team had formally sat within Safeguarding. One senior social worker told me that CATE should always have been placed within Safeguarding, "*because it's safeguarding and high risk business*".[88] Second, CATE was co-located with WMP's Operation Chalice investigative team and its role was essentially providing support for those victims identified by the investigation.

114. Notwithstanding CATE's (new) place within Safeguarding, a response model, known as the CATE Pathway, was devised that was quite separate from the Safeguarding response under the Children Act. This was a formalisation of the divergence between a Safeguarding and a CATE response which implicitly characterises CSE cases as not presenting a risk of serious harm. The CATE Pathway formalised criteria for when victims of CSE should move through the CATE process and when they should be subject to Safeguarding procedures. The criteria for where Safeguarding would apply was if a child was aged 13 or under, or their parents were either implicated in the CSE or had knowingly failed to prevent it. It is notable that, at this time, the 2010 Ofsted inspection remarked that social worker capacity was limited, that assessment quality was variable and that screening systems for contacts and referrals were insufficiently robust: in short, Safeguarding was itself under extreme pressure.[89]

115. The change in management for the CATE Team did not, apparently, solve the funding difficulties,[90] though the relationship with Safeguarding was more productive.[91] As to funding, a bid for a European grant (named 'Daphne') which had the potential to address the shortfall in CATE capacity was pursued, but abruptly terminated "*due to funding issues*".[92] I heard various accounts which suggested that the successful bid would not have caused costs to be incurred, and that Daphne was in fact not pursued because of the potential for it to illuminate Telford's CSE problem, as well as a dislike of European schemes. **I regard the failure to pursue the European grant as a missed opportunity, but in keeping**

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with the Council's reluctance to pursue third party funds throughout the period of my Terms of Reference.

116. In 2011, there was reference in LSCB material to "*mainstreaming*" CATE.[93] This innocuous – indeed, benevolent – sounding word, indicative of universal adoption of CATE's approach to CSE, had been used previously with no result. It appears to have resurfaced as a result of the Council's proposed restructure; termed 'One Council, One Team, One Vision', designed to save £126m.[94] The proposal spoke of the Council having to be:

"*… honest and realistic in what we can and can't do. We can't do everything that we would like to do nor are we the only organisation available locally to offer support. And in the current financial climate with reducing levels of public service funding from the Government, we will need to prioritise and focus on the things that matter most*."[95]

117. What became apparent as the detail became clear is that CATE was not one of the things that "*mattered most*", notwithstanding that these decisions were being made at a time of extreme sensitivity during the Operation Chalice trials. A contemporary organogram of the proposal does not include CATE at all;[96] there were no salary-appropriate roles for the CATE practitioners. The solution was that CATE was to be "*mainstreamed*" in the sense that all members of Cohesion, a new service based on the targeted support model, would be trained to provide CSE support – though there was no provision to retain a trainer. After protest from the CATE Team itself, a single CATE practitioner post was retained, though sited within Cohesion – despite the obvious success of CATE's move to Safeguarding after years of trying.

118. There was perhaps one positive from the change, as a senior figure in Safeguarding told the Inquiry: "*It wasn't until it went to Cohesion that CATE was in base budgets at all, it was merely a project*".[97]

Conclusions

119. From the outset the LSCB was beset by difficulties. Some were carried over from the ACPC – there was no strategy for funding and the funding that existed was inadequate. **In my view, the LSCB was never appropriately resourced to fulfil the functions it set out to do.**

120. Another difficulty arose which would be perennial in all its iterations: **the LSCB quickly became too big to do any real work and there was inconsistency in its attendees.**

121. **From the start the LSCB lacked true independence, being isolated and run through the LSCB Executive group, which put itself in control of day to day decisions and monitoring. This led to an isolation which, in my view, rendered the LSCB unable to provide the oversight role as envisaged by the 2004 Act.**

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122. This was not a short term situation, or the result of teething troubles. Successive independent chairs were kept out of the decision-making body, one having to make representations to be allowed a seat on the LSCB Executive, and kept ignorant of major changes – for example the 'One Council, One Team, One Vision' restructure.

123. **There were, even at the earliest stages, too many groups dealing with CSE. There was insufficient clarity as to their roles and purpose, and confusion as to whether the groups had a strategic or operational role.** In 2005 the volume of sexual exploitation work was noted to be "*incredible*"[98] and there was a need to "*collapse as many meetings as possible*"[99] to cope with workload; this was never done although decisions were urgently needed.

124. This bureaucratic paralysis showed itself in particular with regard to the early funding of the CATE project: the CATE group recommended practitioner funding to LSCB; the LSCB delegated the decision to Connexions, which scrabbled around looking for solutions while in the meantime, CATE work (as it would become known) was being done by youth workers in addition to their 'day jobs'. The obvious answer – that CSE demanded a safeguarding response and that children's Safeguarding should provide it – was not seriously considered. **All suggestions for funding of the CATE project were left to wither except that those already doing the work (out of reluctance to ignore the problem) would be allowed to continue.**

125. **CSE was not taken seriously enough by Safeguarding, which discouraged others' (for example, the Clusters') attempts to engage with the problem.** Whether this was because of an over-rigid approach by Safeguarding, focusing on finding 'evidence' rather than acting on indicators, or if the service simply did not have the resources to address itself to CSE, or a combination of these factors, is not clear.

126. It is regrettable that, as the CATE Team developed, it was not better known. **So far as the Clusters were concerned, there was little knowledge of the existence of, let alone the work of, the CATE Team, despite the Clusters' historical role in identifying and raising concerns about CSE. For a time, there were three potential services for victims/survivors of CSE – Safeguarding, the Clusters, and CATE, without common referral or working practices. This speaks of a lack of strategic thinking on the part of the Council. Moreover there was not, as *Working Together* contemplated, a single entry-point.**

127. Nevertheless, it would plainly have been desirable that there was close working between the CATE Team and Safeguarding; CATE should not have been seen as a substitute for a Safeguarding response. **The evidence I have seen shows that the relationship between the CATE project and Safeguarding was poor.**

128. **The CATE project was left to deal alone – and at times during this period that meant a single practitioner was working alone – with actively helping CSE victims, including those who would be witnesses in Chalice. CATE practitioners were not social workers and, until 2009, were not supported by social workers.** They

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developed their own working methods and practice, but in so doing adopted some of the terminology of *Working Together*, which may have given the impression that the CATE response was of itself a Children Act, *Working Together*, safeguarding response. It was not.

129. **Throughout this time the CATE project struggled for funding and throughout the Chalice investigation its survival was precarious. Its funding was carved out of existing resources; there appears to have been no serious attempt to find funding from external sources. This insistence on an in-house solution and reluctance to pursue alternatives is a theme of the Council's approach throughout my Terms of Reference.**

130. While CATE being brought under Safeguarding management in 2009 is to be welcomed, no work appears to have been done to create a truly unified service. CATE remained as a separate response and it was plainly not embedded within the Council's practice as the 2012 restructure would, but for the protests of practitioners, have erased CATE entirely.

131. **The Council's plans to "*mainstream*" CATE work meant the dismantlement of the CATE project. There was no role for the existing practitioners and no training budget for new ones. I have seen clear indications that Telford CSE was broadly regarded as coterminous with Operation Chalice; and I am fortified in that view by this decision to scatter the project to the winds.**

132. Furthermore, and astonishingly, the planning for CATE's stand-down must have taken place before the first Operation Chalice trial collapsed. Had there been any true understanding of the nature of the skilled work done by the CATE project members, or its importance, then the idea that such work could be continued by others, who were untrained, would have been dismissed in an instant. The suggestion that the retained CATE practitioner would train an entire cohort of youth workers to undertake CATE work fails to understand the support workload, and the fact that the CATE practitioners had hitherto been essentially volunteers. The history of the team itself shows that such work is not for everyone. The idea that it could simply be added to everyone's skill set, as one might mandate a half day course on timekeeping software or safety in the workplace, is utterly inadequate. **I am driven to the view that the Council thought CSE had ended with the listing of the first Operation Chalice trial and that no further response was necessary.**

133. **CATE's reprieve was due entirely to the protests of its practitioners and those of its supporters in Safeguarding. It was not much of a reprieve – the team (as it now was described) was a team of one person. That it was reprieved within Cohesion, not Safeguarding, does not appear to me to have been a considered decision but one likely based upon a desire not to increase Safeguarding's budget, and the decision was plainly a mistake. CATE's new manager was, though committed, utterly unfamiliar with the complex issues involved. There are the clearest echoes here of the decision to site the CATE response within the Youth Service/Connexions4Youth in 2007; no thought appears to have been given on either occasion to what would make the service work better, only to how it could be most cheaply accommodated.**

2012 to date

National Landscape

134. In 2012, a step-by-step guide was published by the Department of Education titled '*What to do if you suspect a child is being sexually exploited'.*[100] It made clear the central role that LSCBs should play in ensuring that appropriate local procedures were in place.

135. The All-party Parliamentary Group produced a report in 2012 into children who go missing from care.[101] This focused on issues of CSE, and similar recommendations were made to those of the recent Children's Commissioner report. The importance of data collection and local knowledge was highlighted.

136. The Home Affairs Select Committee also started taking evidence regarding CSE and localised grooming. This led to a report being published in June 2013[102] which reinforced the need for children who were subject to CSE to be seen as victims of abuse and the notion of consent to be challenged.

137. The final report from the Office of the Children's Commissioner's '*Inquiry into Child Sexual Exploitation in Gangs and Groups*' was published in November 2013.[103] The report criticised services for persistently failing to safeguard children and being in denial about the scale of the issue. The Children's Commissioner's Inquiry had found that fewer than 6% of LSCBs were complying with the 2009 guidance on CSE in full, with one third not meeting half of the requirements. It said that substantial gaps remained in the availability of specialist provision for the victims of CSE. The report outlined the need for significant improvements in the response to CSE.

138. In 2013, a new version of '*Working Together to Safeguard Children'* was published,[104] which replaced the guidance from 2006. It contained a whole section on early help and suggested that local agencies should have in place effective ways to identify emerging problems and potential unmet needs for children and families. This would require all professionals to understand their role in recognising emerging problems and to share information with other professionals to support early identification and assessment.

139. In August 2014, the report from the '*Independent Inquiry into CSE in Rotherham'* was published.[105] This was a comprehensive and critical report regarding addressing the safety and wellbeing of children subject to CSE. A weakness was identified in that the local LSCB was rarely checking whether inter-agency policies and procedures for tackling CSE were being implemented or actually working in practice. The report also highlighted ongoing

[100] https://www.teescpp.org.uk/media/1248/what-to-do-if-you-suspect-a-child-is-being-sexually-exploited.pdf
[101] https://www.gov.uk/government/publications/report-from-the-joint-inquiry-into-children-who-go-missing-from-care
[102] https://publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/6802.htm
[103] Berelowitz et al (2013) "If only someone had listened" Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report; https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/07/If_only_someone_had_listened.pdf
[104] https://www.workingtogetheronline.co.uk/documents/Working_TogetherFINAL.pdf
[105] Jay A (2014) *Independent Inquiry into Child Sexual Exploitation in Rotherham: 1997-2013.* Rotherham: Rotherham Metropolitan Borough Council.

concerns about risk assessment processes and the provision of effective long-term support for child victims of CSE.

140. Ofsted published a report on its thematic inspection of eight local authority responses to CSE in November 2014.[106] The findings showed that professionals continued to fail to properly apply child protection processes to address CSE. LSCBs were considered to have shown poor leadership and had failed to adequately challenge the slow progress being made in developing strategies and meaningful action plans. There were continued concerns about poor data collection and a lack of local knowledge about the extent and patterns of CSE. Many areas had been slow to implement the 2009 guidance. The inspection found huge variability in front line practice, with some excellent practice while others were failing to safeguard children, leaving them at risk of ongoing harm. There was poor attention being paid to the disruption and prosecution of the perpetrators of CSE. The review called for more action by LSCBs and the ongoing need for training and awareness raising.

141. In October 2014, the Coffey Report '*Real Voices*' was published.[107] It gave prominence to the voice of children and looked at what changes had been made in safeguarding children from sexual exploitation since the Rochdale grooming case, and what more needed to be done. Although the focus of the report was on Greater Manchester, the report contained several national recommendations. Many were for local authorities to consider their response to CSE with other local agencies and improving the safeguarding of children. This report highlighted the important role of communities and schools in tackling CSE. It noted that there was a continued gap in services to address the needs and circumstances of the victims of CSE.

142. In September 2017, '*Working effectively to address CSE: an evidence scope*'[108] was published by Research in Practice. This highlighted that across the child welfare sector there was increased knowledge and awareness of CSE but that addressing it in practice remained a significant professional challenge. This evidence scope suggested that work regarding CSE needed to be unified with approaches to intra-familial sexual abuse, harmful sexual behaviours and peer sexual abuse.

143. In 2017, the Children and Social Work Act 2017 provided for the abolition of LSCBs and set out new requirements for the safeguarding partners to make any arrangements they, and any relevant agencies, considered appropriate to work together in exercising their functions. This included arrangements for the safeguarding partners to work together to identify and respond to the needs of children in their area.

144. *Working Together* guidance was again reissued in 2018. Chapter 3: The Council Response to CSE in Telford, details clearly the leadership role to be played by the statutory safeguarding partners. It states that, "*strong leadership is critical for the new arrangements to be effective in bringing together the various organisations and agencies*".[109] It had nothing

[106] Ofsted (2014) The sexual exploitation of children: it couldn't happen here, could it? https://www.gov.uk/government/publications/sexual-exploitation-of-children-ofsted-thematic-report
[107] https://www.basw.co.uk/resources/real-voices-child-sexual-exploitation-greater-manchester
[108] Eaton J & Holmes D. (2017). Working Effectively to Address Child Sexual Exploitation: Evidence Scope (2017). Dartington: Research in Practice: https://www.researchinpractice.org.uk/children/publications/2017/october/working-effectively-to-address-child-sexual-exploitation-evidence-scope-2017/#32f
[109] [redacted] pg 73

new to say about early help or early intervention. These concepts have developed individually within each local authority and LSCB. Although successive versions of *Working Together* have highlighted the importance of these concepts, there has been no clear mandate or statutory authority for them.

Local Responses

The LSCB

145. Notwithstanding the plentiful contemporary guidance about the proper function of an LSCB in relation to CSE, during this period the Telford LSCB occupied itself to a great extent with its own procedures, including the selection of priorities, and structures, including innumerable subgroups.

146. **There were too many LSCB subgroups dealing with CSE leading, in my judgment, to a lack of clarity and focus.** I do not propose in this Executive Summary to set out the various roles and responsibilities but simply to illustrate my reasoning by setting out some of the groups dealing with CSE: the Multi-Agency Operational and Strategic groups; the LSCB Child Exploitation ("CE") Operational subgroup; the CE Thematic subgroup; the CSE Thematic subgroup (which may have been the same as the CE Thematic subgroup); the Quality, Performance and Operations ("QPO") subgroup, which replaced the LSCB Executive and took on the work of the CSE Thematic subgroup; the CE Prevention group; the CSE Task and Finish group; the Joint Exploitation Board, which temporarily replaced the LSCB before the change was reversed; the Missing Children priority subgroup which closed down in September 2015; the Missing Children group which was instigated in July 2016; the Missing Operational group; the Missing multi-agency core group. All these groups suffered from the joint blights of having too many scheduled invitees and poor attendance. That is in my view not surprising: people do not go to meetings that are repetitive and do not produce results. Apart from the sheer number and size of these meetings, two other features are notable: how few of these meetings discussed any of the key national developments, and how infrequently matters which had been discussed ever reached a conclusion or led to action.

147. **In so far as the LSCB did take action with regard to CSE, it was, in my judgment, regrettable - in 2014, the LSCB stood down CSE as a "*key area for development*" (a working group having decided not to use the single word "*priority*" any more); this was a remarkable decision in my view, given the state of the CATE Team since its absorption into Cohesion.**

148. LSCBs were replaced nationally by Safeguarding Partnerships in 2019, having been deemed by an independent report to be overly focused on process rather than outcomes; a judgment that I regard as amply supported by the evidence of how the Council's LSCB operated in the period from 2012 onwards.

CATE under Cohesion

149. CATE within Cohesion was, from the start, a bad fit. Those with management responsibility for CATE were utterly inexperienced in child protection and inadequately briefed even as to

their expected role: a Cohesion manager asked in respect of CATE in 2012: *"I am now unclear as to my role. What responsibility do I have – Practice? Supervision?".*[110]

150. This was at a time of extreme pressure on the CATE Team, which was, in reality, a single person, with responsibility for 35 open cases.[111] There were many CSE *"hot spots"* recorded in the borough at the time.[112]

151. The result was that the single transferred CATE practitioner could not manage the workload. The burden was shared with Targeted Youth Service ("TYS") practitioners within Cohesion, with plaintive pleas being recorded as early as April 2012: *"…if you have spare room on your case load, please see* [*the CATE worker*] *for CATE allocations..."* while noting, *"... training for this will be arranged in June."*[113]

152. In late 2012, the LSCB heard that Cohesion were looking for CATE "*cases which can be stepped down to other services*".[114]

153. The need for Safeguarding input into CATE had not gone away with the restructure. Correspondence showed that Safeguarding understood the risks and its own obligations: "*someone from Safeguarding needs to chair the risk panel and strategy meetings as* [they are] *clearly safeguarding responsibilities*".[115]

154. The parallels between 2012 and 2007 are unavoidable: once again, the CSE response was overwhelmed; once again, it was being run essentially by untrained volunteers and without obviously relevant input from Safeguarding.

155. The parallels and the risks are not simply my analysis; they were expressed at the time within Safeguarding:

"My concern is, if this is the case, how dangerous this practice is (and how this mirrors the same situation we found ourselves in back in 2007 and what a scary place the Council found itself in with inappropriately supervised staff working CSE - which called for urgent action by [a senior official] *due to the risk to both yp* [young people] *and staff)."*[116]

156. The difference between 2007 and 2012 was, of course, that it could no longer be said that CSE was a hidden problem or that the Council was learning its response; it had simply chosen in the restructure to disband the existing team, and, having relented to the extent of retaining a single practitioner, had placed them out of sight and out of mind. It is difficult not to see the truth in this reflection from a witness:

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"I think [CATE] *was seen as a bit of a pet project and probably not something that would go a long way beyond Chalice."*[117]

157. Attempts at training a newly-minted cohort of CATE practitioners continued but the ability to deliver it was an issue: there was a query in early 2013 as to whether WMP officers who had been involved in Chalice could offer the training[118] – which shows the extent to which the CATE process had become synonymous in some quarters with supporting witnesses in a prosecution. It was apparent that managers and social workers in children's Safeguarding had not all received CATE training and few social workers were aware of the service.[119]

158. CATE still did not have access to children's Safeguarding IT systems.

159. Notwithstanding this state of affairs, the LSCB Annual Report of 1 March 2013 declared that CATE had been "*successfully mainstreamed*".[120]

160. That was simply not correct. It was reported elsewhere that "*staff found it difficult to work outside their boundaries. Some professionals were still traumatised – some were upset in the staff forum. Concern was raised over loss of networks. The forum stated they were unsure of the referral process now*".[121] This seems to suggest that newly-trained CATE staff had not appreciated the potentially upsetting nature of the work and that existing staff had been discombobulated by the transfer from Safeguarding.

161. In 2014, concern was expressed that, in terms of CATE performance, young people were not being visited, risk assessments were not being updated, and tasks not completed from one CATE strategy meeting to another. The same meeting heard that there were increasing numbers of cases open to CATE.[122] CATE was divesting itself of cases without making formal assessments.[123] Nevertheless, there was (yet) another proposal "*to save money*" by removing the senior CATE practitioner role, leaving the incumbent to move into management of a different team or to take a salary cut.[124] It seems that representations were again successfully made for the retention of the role, but I regard it as quite astonishing that the Council should have again thought to risk losing such expertise at a time of obvious continued need.

162. In 2015, senior managers within Cohesion were told that the CATE caseload was not manageable. It was noted that CATE "*borrowed*" staff from Cohesion, rather than having recruited, and that CATE was close to being "*swamped*".[125] Simultaneously, the adoption of a new social work model had caused intense pressure on Safeguarding, with resultant loss of social workers and reliance on agency practitioners.[126]

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163. An audit in 2015 found concerns in the capacity of the CATE Team and a rise in demand, with evidence of delay, drift and lack of recognition of CSE.[127]

164. In March 2015, the LSCB reinstated CSE as a priority and an attendee lamented the "*drift in focus*".[128]

165. The Council's Children & Young People's Scrutiny Committee review ("the Scrutiny Review"),[129] which reported in May 2016 but which, I heard, had been open about its likely recommendations since its inception in November 2014, noted that the CATE Team's workloads were almost double the National Working Group recommendation. It commented further that CATE practitioners did not have within Cohesion the supervision and access to expertise that would be available to social workers. These were obvious points; but their expression in a politician-led review was, in my view, important and likely influenced what came next.

166. Cohesion's role with CATE came to an end in 2016 with another restructure known as '*Being the Change',* which led to the end of Cohesion and the CATE Team's move back to Safeguarding.[130] It is notable that the LSCB appears not to have discussed this and to have had no notice of, or influence on, the process.

167. A Council witness told the Inquiry: "*I never felt in all of the time I was there that the CATE resources were adequate.*"[131]

168. Another witness reflected on the Cohesion years: "*You needed to have a really experienced service delivery manager that was a social worker. I don't think we gave it the priority that it needed.*"[132]

169. And another: "[*CATE*] *came back in 2015/16 because that's where it should sit. It probably should always have sat there. I would not have put CATE into Cohesion if I was in a position to influence anything.*"[133]

170. CATE went into Cohesion in 2012 in a last-minute swerve because its effective oblivion had been planned. It spent the next four years under-resourced and inadequately managed, and it suffered another botched attempt to remove its most senior practitioner. When it finally returned to Safeguarding, it was not because there was any official recognition that it had been wrongly placed within Cohesion, but because Cohesion ceased to exist. In the light of that, it is remarkable that the CATE Team exists today.

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CATE Team – 2016 to date

171. Since 2016, the CATE Team's strength has been transformed. By 2018, the team was reported to be now "*comfortable*" with capacity.[134] A Missing Children Coordinator had been appointed in the team.[135] Meanwhile, LSCB subgroups continued to tussle with existential questions - a paper dated October 2018[136] posed the question in respect of CSE:

"*Which operational groups underpin this work? CSE Operational Group, CATE Risk Panel? Other multi-agency groups?*"

172. The CATE Team's structure and work was thought to be "*particularly impressive*" in a November 2018 National Working Group review,[137] which also found the CATE Team to be knowledgeable and with a broad skill set.

173. I have been told that there are 11.6 workers currently in the CATE Team, comprised of two managers, one senior practitioner, 7.6 FTE (full time equivalent) CATE practitioners and one senior social worker. According to data provided to me by the Council in its Corporate Submission,[138] the CATE Team received the same number of referrals in 2010/2011 as it did in 2019/2020. Despite this, the size of the CATE Team was dramatically smaller in 2010/2011. This demonstrates to me the extent of historic underfunding of the CATE service.

174. Happily, Ofsted's 2020 inspection of children's safeguarding services in the Council showed a very marked improvement since 2016; the inspection report opens "[c]*hildren's services in Telford and Wrekin are outstanding"* and so far as the CATE response was concerned the inspection noted that the response to children facing risks outside the family was "*very strong*".[139] I have, with the assistance of the Inquiry's social work expert, considered the CATE Team's current processes. This has involved a review of a small sample of risk assessments completed between 2018 and 2020, and reflection on the evidence in the light of what I understand to be best practice.

175. I regret that I have seen in my review of some of these documents unfortunate language being used. Terms such as "*being too trusting*" and "*sneaking off to have sex*", do not recognise coercion and suggest blame on the part of the child.[140] A particularly unfortunate example was "[She has been given] *advice on what the risk factors are, however can't implement these in her own life… and* [she cannot] *keep herself safe".*[141]

176. The expert evidence I have seen suggested that these meetings focused on victim behaviour in a way that was not useful, and which tended to suggest the child was responsible for their own safety and, by implication, their exploitation. Professionals were concerned that *"the risk to* [the child] *would not reduce unless* [the child] *worked on her trust element with people she did not know*";[142] this ignores the fact that a child changing their behaviour does

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not stop others seeking to sexually exploit them using coercive control, threats, violence and grooming.

177. I accept that there has been a refocusing of priorities since 2019, exemplified by some changes in the document format; and a parallel welcome change in terminology. It does seem to me to be important that the Council ensures that those who operated under the 'old' CATE system appreciate the fundamental purpose of these meetings - to understand and reduce all risk including *external risk* - and to appreciate the importance of rigorous recording of information to that end. Without detailing exploitation and naming exploiters, and considering contextual factors, then mapping becomes more difficult – and with it, disruption and protection.

178. A moment's reflection is all that is required to see why the CATE Team's approach has been directed towards victim behaviour modification. It was never a Safeguarding service. It was an ad-hoc project run by youth workers who had never been trained in safeguarding. They saw a problem that was not being dealt with by Safeguarding and addressed it as they could. They made their own processes according to the techniques they knew – those of the youth service, the remit of which was about instilling behaviours rather than addressing risk. The team's processes received the approval of the Council through the CATE Pathway group and remained essentially unchanged from 2008 until 2016. The move from Cohesion to Safeguarding has brought welcome changes in approach including a broader focus on contextual risks as well as victim behaviour.

Conclusions

179. The story of the LSCB from 2012 until its demise in 2019 was one of enthusiastic embrace of the worst excesses of bureaucracy. The tone was set by the adoption of the "*strategic business cycle*"[143] in 2013, plainly designed to give the appearance of scrutiny and activity by demanding a revision of "*strategic priorities*" every year.

180. Mandating change runs the risk that things are changed which should not be; **in my view, CSE should not have been stood down as an LSCB priority, and to have done so reinforces the narrative that CSE was, by 2013, yesterday's problem. I further consider that standing down the priority group for CSE, with its direct reporting to the LSCB as a whole, not only made it less likely that the LSCB would be able to perform its statutory function, but that it did not effectively perform its statutory function: I have in mind the specific assertion in the LSCB Annual Report of 1 March 2013, that "*the CATE service has been successfully mainstreamed*",[144] when, in fact, the CATE Team was at that stage deprived of personnel, struggling with workload and on the brink of another attempt to cancel out its senior practitioner. If that is what "*successfully mainstreamed*" was intended to mean, it is doublespeak of the highest order.**

181. **The very shape of the LSCB and its subgroups served as a barrier to scrutiny and action.** A bureaucracy appeared to exist for its own sake, and:

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181.1 There were too many groups;

181.2 There was too much overlap in their areas of interest;

181.3 There was excessive churn: group after group was rebranded or refreshed leading to lack of clarity about purpose, exemplified by the occasion that a group could not decide whether it should be strategic or operational;

181.4 All the groups (including the LSCB itself) were too big to be effective; and

181.5 Too many people were part of more than one group with the result, inevitably, that attendance was poor – because people have better things to do than sit in interminable repetitive meetings – and the meetings were ineffective.

182. **During this period the CATE Team needed scrutiny, oversight, and support. The overwhelming preponderance of the evidence I have heard is that CATE should never have been placed under Cohesion, but should have remained under Safeguarding; and I agree. In my view the reality is that the Council did not expect there to be a CATE Team after the 2012 restructure and, as a result, no proper thought had been given to where it sat; exemplified by the fact that the manager with responsibility for CATE and Missing had no experience of either.**

183. At a time when demand for CATE services was increasing, and CSE was very firmly not in abeyance, the single remaining CATE practitioner was overburdened with active cases and, initially, the burden of performing risk assessments; CATE was reduced to begging for help from the (itself overstretched) TYS team and looking to step down CATE cases to other, presumably less resource intensive, services. From 2012 to 2015, there were no more than four CATE practitioners and open cases numbering 40-50. Concern was expressed that young people were not being visited, risk assessments were not being updated, and tasks were not being completed from one CATE strategy meeting to the next. Practitioners were unsupervised, often upset by the work and, it was suggested, in many ways in a situation similar to that which had pertained in 2007 when the response was simply ad hoc. CATE appropriate cases were not being referred and CATE cases were being "*cut*".[145]

184. That in 2014, against this background, the Council proposed that the senior CATE practitioner post be removed is staggering; to risk losing the lynch-pin of the specialist CSE response at a time of increasing demand for what must have been a very modest cost saving, and at a time when (again) there was a training need. **Once again, I am driven to conclude that the Council either formed the view that CSE was over, or that it was not worth a properly funded response.**

185. **The CATE Team under Safeguarding from 2016 to date has been transformed. It has increased staff and has process integration with Safeguarding. The Council has finally recognised the importance of the work done by the CATE Team and put that work on a sound financial footing. The team is properly staffed and supervised.** It is an integrated part of the Council's provision for children and no longer a "*poor relation*".[146]

[145] [redacted] pg 17
[146] [redacted] pg 19

I understand that there is, by today, better integration and more fluidity between the CATE and Safeguarding processes.

186. Any reflection on the current state of the CATE Team must necessarily include a recognition that for most of its life, its very survival was precarious. **CATE was not a top-down response to a social problem but a ground level reaction from youth workers and others who would not stand to see the blatant exploitation of children go unremarked any longer. That ground level response should have been celebrated, adopted, and formalised - as it has been since 2016. Instead, from the team's earliest days (as the CATE project) until 2016 it was repeatedly ignored, starved of funds, and left to wither; on two distinct occasions real attempts were made to decapitate it.**

187. **While I have no doubt that the CATE Team serves a valuable purpose, the Council should reflect on the proper limits of its usefulness, and ensure that it never again becomes – as it began – a substitute for a safeguarding response in CSE cases.**

Overall Conclusions

188. **From the 1990s, it was clear that there was a problem with CSE in Telford.**

189. That information was coming from the community, from schools, from youth workers; it was even reported in the local press.

190. Such attempts as there were to address CSE were ad hoc groups or projects put together by concerned individuals, though none then worked directly with victims of CSE.

191. **Both the ACPC and LSCB were slow in addressing any sort of response.**

192. The CATE project itself was another ground level scheme, conceived and staffed by individuals who had knowledge of the problem and who were unprepared simply to stand by.

193. **The understaffed and resource-poor Safeguarding system quite simply failed to recognise that CSE was a child protection issue. If, as seems to be the case, this was because of a view that safeguarding was only appropriate when parents were failing to ensure their children's safety, that was in my view an unnecessarily narrow approach and a false reading of the test.**

194. **As a result, the initial form of CATE was ad hoc. There was no safeguarding model of CATE intervention; in those early days the project, and later team, were offering essentially a youth worker service – seeking to educate and change victims – rather than actively to safeguard.** It could be described as a 'fix the child' rather than a 'fix the problem' approach. I deal in the body of this Report of clear examples where section 47 procedures were not, but should have been, instigated.

195. **The Council was not, for whatever reason, committed to maintaining CATE. In my judgment it was seen as an easy target for saving money in 2012 and 2014, when on each occasion it was almost decapitated. Under Cohesion, the CATE Team was**

short of people, resources, supervision and (notwithstanding the LSCB and its innumerable subcommittees) had no effective oversight.

196. **Nor is there evidence of any interest in CATE by elected members until the Scrutiny Review of 2016; and I am quite satisfied that it was this political intervention that made CATE whole and sustainable. Given that the problem had been apparent on the ground for over twenty years by the time of the review, this lack of political support is certainly regrettable; and, as politicians, particularly local politicians, are also members of the public, it speaks at least initially of a societal reluctance to acknowledge CSE victims as anything other than badly behaved children on the margins of society.**

197. What is less obviously explicable by old-fashioned and outdated attitudes is the fact that, post Operation Chalice, there was not more engagement with CSE. I do not underestimate the degree to which local government budgets were diminished in the second decade of this century, or the difficulties that caused in terms of apportioning precious resources. The economist Galbraith said that politics is the art of choosing, and choices were made in respect of CATE - how it was funded, where it sat – under local administrations of both political colours. Those choices very nearly led to its withering away in 2009, in 2012 and in 2014. **The choice was also made, again and again, from as early as 2000 until at least as late as 2015, not to seek the assistance of experienced voluntary or third sector bodies in the CSE response. I have seen no evidence that those choices were made by politicians, and I do not suggest that it is practical for elected members to make every decision necessary in running a council. It is, however, the responsibility of the elected members, particularly the cabinet members, to give direction and to assert priorities; to determine what is essential and what may be foregone. I have seen in my review of the evidence no indication that before 2016, a CSE response was ever regarded as an essential service. I consider that a glaring failure on the part of a generation of Telford's politicians.**

Education sector (Chapter 3)

Background

198. In accordance with section 11 of the Children Act 2004, school bodies have a statutory responsibility to make arrangements to safeguard and promote the welfare of children. There is also a statutory duty to promote co-operation between the local authority and schools in order to protect individual children and young people from harm.

199. There are two types of schools within the borough; those maintained by central government grant, or 'academy schools', and those who derive their income from the local authority. The Council only has direct influence over the latter class of school, but does have a statutory responsibility to safeguard and promote the welfare of children in the borough regardless of the funding mechanism of the school they attend.

1989 to 2004

200. So far as early awareness of CSE was concerned, a witness told the Inquiry that, in the 1990s, pastoral teams within local schools were largely concerned with behaviour management and dealing with children who broke the rules or who struggled with school life. There were no formal policies and practices in place for dealing with issues of CSE.

201. I heard that social workers were very rarely involved with children in schools, and usually only when neglect was thought to be an issue. The school would deal with other issues itself. A witness told the Inquiry that there was simply not the same access to services or the same level of cooperation between agencies as exists today.

202. The Inquiry heard that schools began to be concerned about children being sexually exploited in the 1990s. At that time, four secondary schools were located in close proximity to Wellington, and to each other.[147] Concerns about children at these schools being sexually exploited began to arise in the 1990s, with a staff member of one of the local schools recalling that three of the schools' head teachers used to meet and were: "*… sharing information at that stage about the concerns* [they] *had about these girls… and what might or might not be happening."*[148]

203. Another witness said there was "*chatter*" amongst the students, and concern within the staff of the school that something was not right, "*but people didn't know how to manage that and how to put their finger on it".*[149]

204. This was a repeated theme: the Inquiry heard that while suspicions grew about behaviour which would now be classed as CSE, it was considered that there was not any "*direct evidence or direct proof*".[150] It seems that this lack of "*concrete"*[151] evidence, coupled with the lack of awareness about CSE, meant that the staff largely did not act upon their concerns or suspicions, or, shockingly, were not listened to when they did: the Inquiry heard that teachers with management responsibility had sought to raise the issue of child exploitation with Council officers, telling the Council that there is a "*problem in this authority with Pakistani youths"*[152] – only to be accused of being racist by a Council officer.

205. The fact that certain schools were funded differently from others appears to have affected the relationship between grant-maintained schools and the Council. The Inquiry heard in respect of one grant-maintained school:

"*… our relationship with the authority was not a good relationship really. They resented us being a grant-maintained school … We grew further and further and further apart from the*

147 [redacted] pg 3
148 pg 9
149 pg 4
150 pg 9
151 pg 9
152 pg 15

authority really as a grant-maintained school and then as a, just a school managing themselves basically."[153]

206. The Inquiry has heard evidence that, in the absence of support from the Council, CSE issues were managed by the school itself, as best it could. A particularly striking example is the fact that, when two teachers heard a rumour about a pupil being "*in a house of ill repute*"[154] in Wellington, they went to the house and knocked on the door, bringing the pupil back to school and then reported the matter to Safeguarding. It is not clear what response, if any, this engendered.

207. Concerns grew in the early 2000s. Although there were still no disclosures forthcoming from pupils, the Inquiry heard that there were obvious indicators of sexual activity amounting to CSE:

"*It was thought that it was consensual although there were staff beginning to think maybe it isn't because of the way the girls general… you know, they stopped talking. So girls usually are bubbly aren't they, and they'll chat about things and form tutors were very aware of that girls were clamming up. So if a form tutor was sitting down with somebody they wouldn't give any information. So they were becoming more secretive."*[155]

208. The Inquiry heard further that some teachers felt they were bound by confidentiality when children did confide in them, and that there was no way to discuss these concerns as "*there was no safeguarding system".*[156]

209. I heard evidence from witnesses that Lucy Lowe's murder was well known within a particular school and served to intimidate children against making complaints:

"Every single one [*of*] *our girls that was involved with the Pakistani community in any kind of part of their lives that we might be concerned about, and might be talking to them about, they were all clamming up big time because,… Lucy had lost her life. And they knew…."*[157]

210. I heard further reports of an offhand response to teachers' concerns when they were expressed; a witness told the Inquiry that Safeguarding's response to an exploitation concern was "*what we deal with is far worse than that, that's nothing*";[158] nothing was done. Contemporaneous documents show that Safeguarding was well aware of an exploitation problem around schools in the late 1990s but it is unclear that any action was taken.

211. I heard evidence that another source of information about exploited children were Education Welfare Officers ("EWOs"). Local authority schools automatically received the support of an EWO; academies could opt to buy in EWO services. However the Inquiry heard that, regrettably, information-sharing between the EWO and Safeguarding team was not good:

153 [redacted] pg 20
154 pg 8
155 pg 13
156 pg 14
157 pg 12
158 pg 17

"*I think we all worked in silo and I think where we had concerns about particular children I don't feel like those concerns were shared… I don't really feel like I ever met a threshold to get action from a social worker or proactive action from a social worker."*[159]

212. Attempts at awareness raising amongst parents were not always welcomed:

"*… they're walking a sensitive path between that accusation that parents either would say "you're teaching my children things that I don't want them to know about"… some parents, fathers particularly, not being happy with what we were delivering and feeling like we were scaremongering them."*[160]

"*..now some parents were very grateful to us, other parents tore us off a strip as it's got nothing to do with you what my child does on a Saturday night. So that's the kind of conflict you were in."*[161]

213. In the early 2000s, the ACPC considered the position with schools and heard that there was no single worker on any team who had a significant role to respond to sexual exploitation, though the hope was expressed that someone could be trained to take a lead, "*or to point people in the right direction*". It appears that the role being contemplated was a training role, not an intervention role, although it was stated that there was "*a lot of anecdotal evidence of child prostitution".*[162]

214. Training was organised; the ACPC had acquired a training coordinator. The Inquiry heard:

"*… we provided specific training for the Wellington schools in 2003/4, and developed specific PSHE … modules for teachers and young people on grooming and awareness of sexual exploitation… we used the Barnardo's videos on grooming, awareness of the use of the internet, awareness of girls receiving gifts, we developed training materials and modules of work for both teachers and for pupils. And particularly for Year 7 upwards. We also provided specific support for* [two schools] *in relation to training for their pastoral staff. We had a named linked police officer. We involved school nurses, the* [Connexions] *Service and the Multi-Cultural Development Service too, in terms of developing awareness about perpetrators and victims...."*[163]

2004 to 2012

215. From 2005 onwards the majority of local schools had opted into awareness raising training sessions, delivered to school staff. This three hour course included information about CSE and, in addition, designated safeguarding leads were given further training and expected to disseminate this to all staff. One school made its own arrangements; I heard the school became:

159 [redacted] pg 14
160 pg 9
161 pg 28
162 , pg 5
163 pg 41

"*… a bit of an island in a way as we got more and more running ourselves as our own business, a grant maintained, an ex-grant maintenance that became a self-running school, and* so [the school] *didn't go to the child protection meetings at all."*[164]

216. It must be remembered, though, that the Sexual Exploitation project was, at the earliest part of this time period, funded for only four hours per week. I heard that there was to be a new PSHE advisory service within the borough from April 2006 which, it was hoped, would bring consistency to PSHE; I have seen no indication that those hopes were fulfilled.

217. Whilst awareness of CSE within schools appears to have improved during this period, the Inquiry has seen evidence that a number of pupils were still being exploited and that the exploitation was left unremarked by members of staff, despite what we would now recognise as common behavioural indicators being present. Victims of CSE were often excluded because of what school saw simply as behavioural issues. Additionally, there was little support for victims who remained in school: name-calling and bullying by peers were common.

218. A striking example of the lack of support was given by a witness who told the Inquiry that she became pregnant and was excluded, the teacher telling her by way of parting shot to "*stop sleeping with these boys or she would never make anything of herself".*[165]

219. The Inquiry has heard that at this early stage children would often be picked up from the schools by men in cars – some taxis - at the end of the day and even during lunch breaks. I understand that it was even known for the perpetrators to enter the school's grounds. Concerns about this issue were to be repeated at various schools and colleges over the years to come.

220. In July 2006 a review of available CSE resources was completed by the Council and dealt with the specific work undertaken to raise awareness in schools:

"… a workshop has been developed jointly by the Youth Development Service and Education Welfare Service which aims to raise awareness of this issue with young people in schools. This has been piloted in a selection of secondary schools within the area with success. Workshop evaluations [from schools] *have always been positive. However there is no resource to enable this workshop to be delivered Borough wide. The pilot is coming to an end and consideration needs to be given to how Telford will continue to develop preventative strategies and raise awareness for young people."*[166]

221. A package of support was offered to schools, which some took up and others did not. It was suggested that a named member of staff in a particular school be spoken to as they had a "*wealth of knowledge".*[167] I have not heard that suggestion was followed up.

164 [redacted] pg 9
165 pg 4
166 pg 2
167 pg 3

222. A 2007 meeting of the Sexual Exploitation Senior Officers' Coordination group, a multi-agency group, heard that there were difficulties meeting with school heads.[168] I have seen evidence suggesting that engagement with head teachers locally was "*variable*".[169] There was to be a meeting of heads; the result is not clear.

223. On 8 January 2009, minutes of a CATE Team meeting[170] show that there was WMP involvement in a case, arising from a cluster of reports in a particular school, where Safeguarding had declined to act although a child had disclosed sexual exploitation by a man and was ready to speak with the police. This underlines the point, repeatedly made, that CSE was seen as outside the sphere of Safeguarding responsibility.

224. On 14 January 2009 a CATE meeting reported delivery of training workshops at one school,[171] intended to serve as a model for work in other schools, but which also noted that there were only the resources to work in one school at a time. The minutes note "*all are mindful capacity may become an issue, if referrals are raised following these* [*school*] *workshops*". To be concerned about capacity so early tends to show a failure of preparation.

225. The LSCB, on 27 January 2009, recorded that the work to mainstream exploitation awareness into PSHE in schools was outstanding – in the sense of 'not done'. The Inquiry heard that: "*the Catholic schools were quite reluctant*".[172]

226. In the same vein, the Inquiry also heard that:

> "*... for* [a particular] *school… it was quite a leap for them to say that they needed help and they needed support because they were a strongly religious school who had… I think they'd had difficulties with even having sex education on the agenda … so then to add on sexual exploitation and what that might mean for a school*."[173]

227. Minutes of an LSCB Executive meeting on 11 June 2009 shows that there was still insufficient capacity for preventative work in schools.[174] The evidence shows however, that from 2010 there was increased emphasis on implementing the CATE strategy in schools. A CATE Care Pathways meeting on 5 March 2010 decided to adopt a training programme with specific modules on CSE into PSHE lessons in 11 schools, with targeted work for key children in a particular school.[175]

228. At a CATE Gold meeting in November 2010, a DVD entitled "*My Dangerous Loverboy*" was discussed.[176] This was a training film about a child who was targeted, groomed and abused. Two months later, the LSCB noted that the DVD was to be used as part of a preventative programme in schools; but the next day it was recorded that the DVD would "*not be the best vehicle to deliver a message*".[177] The Inquiry heard that the Council's Chief Executive

168 [redacted] pg 17
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172 [redacted] pg 26
173 [redacted] pg 57
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vetoed its use and indeed that he had walked out of a meeting when the DVD was shown, offended by its content.

229. I have seen documentary evidence indicating that, in November 2011, there was no CATE training being delivered in schools. It was recognised by Safeguarding that the loss of the Daphne project was likely to impact negatively upon awareness raising in schools.

2012 to date

230. The NewStart Networks report of 2013 identified CSE information in education as needing attention. Perhaps as a result, from 2013 there was a stated intention to deliver CSE awareness training to local schools. A CATE Training Plan 2013/2015 confirms that intention. The training was to be delivered by a CATE practitioner, with support from the Education Safeguarding Trainer. An email dated 2013 referenced the fact that "*a small amount of money has been made available by the TWSCB to deliver CSE training to schools staff"*[178]*;* the underlining is mine.

231. More positively, a CATE Pathways meeting on 4 October 2013 noted that Police Community Support Officers ("PCSO"s) were working in schools,[179] the PCSO being a position funded by both the Council and the Police and Crime Commissioner ("PCC").[180]

232. Despite the repeated references after 2010 to increasing awareness within schools, I have seen a number of documents where concerns were subsequently raised about the awareness of CSE within schools and the training being delivered:

232.1 An email from early 2015 notes the need to "*consider how we are going to move forwards in supporting schools to raise their awareness of CSE. Schools are keen to have the support….[the Education Safeguarding Trainer] doesn't have the capacity – or the job roll [sic] to be rolling out CSE training to schools but is keen to be able to support it if we can find some way forward*";[181]

232.2 In January 2015, a college's request to the Council for CSE training was rebuffed on the basis that CATE practitioners had no capacity to run the sessions due to their increased workload;[182] and

232.3 In May 2015, concerns were raised within the CATE Team after a discussion with a member of staff at a school who was "*unclear about the CATE service and the whole process in relation to CSE in Telford";*[183] the fact that a senior member of staff at a local school was unclear about the CATE process after almost a decade of its existence is scarcely credible and speaks to failures in training.

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233. The response to the CATE practitioner who raised the concerns in May 2015 was, in my view, surprising; they were told that the Council was looking at external funding to support training and awareness raising in schools, but "*the danger is always about opening floodgates …*".[184] The reference to the risk of opening the floodgates by raising awareness of CSE shows a regrettable focus on costs rather than outcomes for children; furthermore, there was extreme pressure on the CATE Team at this time so one would imagine every reason why external training should be sought.

234. The issue of capacity had not been resolved in July 2015 when there was an apparently serious suggestion that members of "*affected communities*" be called upon to deliver CSE training;[185] just a year later, the LSCB dispensed with the services of its longstanding training coordinator.

235. It seems that schools ultimately took a decision for themselves; in 2017, a Learning Community Trust (the "Trust") was created, incorporating seven schools. The Trust has since purchased a Service Level Agreement, designed to provide support for safeguarding practices. This gives schools access to a 'hotline', from which they can gain immediate advice.[186]

236. Disappointingly, in April 2018 the Exploitation subgroup of the LSCB discussed CSE and identified schools as being a gap in service provision.[187] More positively, something appears to have been done relatively rapidly, in that in June 2018 it was reported that a CSE education and awareness post had been created with funding from the PCC.[188]

Conclusions

237. **It is clear that head teachers in the schools around Wellington were aware of children being exploited and that they shared information about this amongst themselves. It is also clear that there was no understanding of what should be done with this information and no understanding in schools as to the proper referral pathway for victims of CSE. This is hardly surprising; as I have shown elsewhere, there was a reluctance on the part of Safeguarding to engage with CSE cases, and this is borne out in relation to schools by the evidence that "*the service wasn't there*".[189]**

238. **The evidence has further shown that in schools, as in Safeguarding, there was a reluctance to engage or report concerning activity unless there was "*proof*" (or even "*concrete proof*").[190] This was, in my judgment, an overly cautious approach; the nature of exploitation is such that victims often do not perceive themselves to be victims. Further, school staff were afraid to make disclosures because they thought that to do so would be breaking the rules.**

184 [redacted] pg 1
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186 [redacted] pg 23
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189 [redacted] pg 16
190 [redacted] pg 11

239. The evidence tends to suggest that within schools, **obvious CSE indicators such as markedly changed behaviours, absence and teenage pregnancy often went unremarked by school staff.** Victims of CSE were bullied by other children without enquiry from staff as to the underlying causes.

240. The Inquiry heard that although there was some WMP presence at school gates, it appears this was ineffective to stop adult men coming onto school premises to collect children. This was still a problem ten years later; it is clear that no solution had been found. **It is a statement of the obvious that this is wholly unsatisfactory, and that it is incumbent on all agencies to ensure that children are safe on school premises and around them.**

241. Undoubtedly the situation improved when the CATE Team was formed, as it was prepared to act where Safeguarding had declined; but it took some time for the work of the CATE Team to become known and understood by schools. I am disappointed though that at this time, when the issue was more fully recognised, some schools were reluctant to accept exploitation PSHE input; to recognise a problem is not a reputational ill but a sign of effective child protection. **Similarly, that the Chief Executive should decline to endorse use of a professionally produced training film because of his squeamishness about the content suggests in my view a warped sense of priorities. I am quite satisfied that the refusal to use this film and the demise of the Daphne project set back awareness-raising within schools materially.**

242. I accept the evidence that, even in 2015, there was little capacity on the part of the Council to run training for schools; this is unsurprising, as at that time the CATE Team was in one of its regular troughs. **It seems to me to be plain that if the CATE Team is unable to provide that training then it is incumbent on the Council to provide a properly funded training post or commission training – not to scrabble around for alternative solutions as it did in suggesting "*members of affected communities*" could deliver training.**

243. **I note that so far as Wellington schools are concerned, training is now regularly provided by the Council and school staff are focused on CSE. There is access to safeguarding advice through a Service Level Agreement and a "*hotline*". This is plainly a transformation; but I am compelled to note that like so much I have examined in the course of this Inquiry, the transformation is relatively recent. For too long schools in Telford were struggling with a problem they did not know how to deal with, with a Safeguarding department that gave the appearance of being dismissive, and with inadequate resources to train teachers or raise awareness in children.**

Taxi Licensing and the Night-Time Economy (Chapter 4)

244. The Inquiry has been tasked with examining the local taxi industry and taxi licensing, and the night-time economy, and the impact that this has had on CSE.

245. Whilst gathering evidence from CSE victims and survivors, the Inquiry heard numerous accounts of children being subjected to unwanted sexual attention in taxis,[191] which led in some cases to rape or other serious sexual assault by the driver.[192] Many of these victim/survivors' first experience of CSE arose following interaction with, or the befriending of, men who drove taxis locally for a living.[193]

246. Other CSE victim/survivors who have come forward to the Inquiry, told me that they were subjected to CSE after gaining weekend employment in fast food establishments locally, where they met the perpetrators of their eventual abuse, even being employed by them in some cases.[194] I have heard of several cases of children being raped by food delivery drivers.[195] Further, at least one local nightclub has been named as a venue where children were exploited.[196]

Taxis

Licensing of Taxis

247. 'Taxis' as popularly understood fall under two licensing regimes – those for 'Hackney carriages' and those for Private Hire Vehicles ("PHVs"). In each case, the Council's Principal Licensing Officer is usually the person responsible for licensing decisions.

248. Drivers of both Hackney carriages and PHVs will only be issued licences if they satisfy the "*fit and proper person*" test.[197] The application of the test is a matter for the licensing local authority, though guidance exists; particularly the Department for Transport and Home Office Circulars 2/92 and 13/92 (the "Circulars"), plus related supplemental guidance, issued following the grant of additional powers to local authorities in the Road Traffic Act 1991. The Council told the Inquiry that in relation to applying the "*fit and proper person*" test it will follow the provisions laid out in its Suitability Policy, said to have been originally introduced in 2004.[198] The Inquiry heard that there "*is no knowledge of systems or processes in place for the period 1989–1999*" however, "*there is **some*** [emphasis original] *corporate knowledge of the situation post-1999 but this is limited*".[199]

249. The 2004 Suitability Policy declares that no application for a licence would be considered from an individual convicted of serious sexual offending within three years of the conviction – this is the minimum period contemplated in the Circulars' draft policy. I am surprised that the minimum term was chosen; the contemporary sentencing guidelines[200] for rape and the release regimes operating in the 1990s[201] and 2000s[202] combine to mean that a person

[191] [redacted] pg 37, [redacted], pg 12, [redacted] pg 2
[192] pg 10 [redacted], pgs 3-4, [redacted] pg 5, [redacted] pgs 5-6
[193] pg 9
[194] pg 4
[195] pg 9
[196] pg 4, [redacted] pg 45, [redacted], pg 6, [redacted] pgs 6-7
[197] Local Government (Miscellaneous Provisions) Act 1976, Town Police Clauses Act 1847, Road Traffic Act 1991
[198] [redacted] pg 67
[199] [redacted] pg 67
[200] R v Billam [1986] 1 WLR 349
[201] Criminal Justice Act 1991, section 33
[202] Criminal Justice Act 2003, section 244

convicted of a rape offence could have been eligible to apply for a licence to drive a taxi immediately, or very soon after, release from prison. While I have not seen evidence that there were any such cases, a longer prohibition period would have removed this worrying possibility.

250. In 2009, the Council's Suitability Policy was redrafted and expanded. So far as applicants with previous sexual offending were concerned, their application would now automatically be put before the Council's licensing committee for determination.[203] A further update in 2010 provided that such applications would not normally be granted.[204] It was not until 2017 that the Council chose to adopt the 2010 Local Authority Coordinators of Regulatory Services' ("LACORS") proposal,[205] that an applicant with recorded sexual offending should have been free of conviction for ten years.[206] The 2020 version of the Suitability Policy provides that where an applicant has a relevant sexual or other criminal exploitation conviction they will not be licensed.

251. In 2015, the Council introduced compulsory CSE awareness training for all new and renewing drivers.[207]

252. In terms of information gathered by the Council before making any decision as to whether to grant a licence, the Council told the Inquiry it receives information from the following sources: from Shropshire Council, since 2015; from the Council's own Personal Safety Precautions ("PSP") Register, since 2017 (although the database has existed since 2003); from the Council's Safeguarding team, in respect of new applications and renewals, since 2018; and from NR3, a voluntary information sharing system amongst local authorities, since 2019. **It seems to me to be regrettable that greater use was not made of obvious information sources at an earlier stage.**

Taxi Regulation and Enforcement

253. The Council has no power to exclude Hackney carriages and PHVs licensed by another local authority from operating in Telford, and has no enforcement power over those drivers. Further, there is no national or regional licensing standard for the application of the "*fit and proper person*" test; and wildly different standards can apply, even between neighbouring authorities. This led to a situation, following a High Court decision in 2008, that drivers who were refused licences, or whose licences had been revoked, by the Council were able to operate in Telford while licensed by another authority.

254. Moreover, licensing teams operate on a cost-recovery basis, so a licensing team's income depends on the number of licences granted. In 2011, there was a 400% increase in the number of drivers licensed by Shropshire Council, whereas the Council, with its more rigorous licensing regime, suffered a precipitous decline in applicants and with them, staff numbers - the Licensing Team being significantly reduced from ten to four.

203 [redacted] pg 9
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255. Telford's politicians have, over a decade, actively and with obvious urgency lobbied central government for national standards to be implemented, to no avail.

Relationship with the Trade

256. The Inquiry heard evidence that the relationship between the Council and the taxi trade was not always smooth, and was on occasion very difficult.

257. In May 2006, concerns were raised by drivers about what they saw as heavy-handed enforcement by the Council. A complaint, including allegations of racism, led to a Cabinet Member expressing their view that licensing enforcement should cease, pending an independent investigation.[208] An independent investigation was undertaken, but during this time the Licensing Team became effectively paralysed, unwilling to act without express permission. In July 2006 a member of the team sought permission to deal with 11 outstanding enforcement cases, including suggestions of licensed drivers' inappropriate behaviour with children. It is not apparent whether permission was given.

258. The publication of the investigation report, in September 2006, did not restore enforcement, but rather recognised that "… *on a number of occasions the impact of enforcement activity has disproportionately affected Asian drivers*…".[209] It bemoaned the lack of a working relationship between the Council and the trade, noting that there was "*an unhelpful prevailing culture within the Licensing Team which is more concerned with enforcement than developing a positive and mutually beneficial relationship".*[210] Subsequently, regular monthly vehicle enforcement exercises were stopped;[211] all enforcement operations had to be approved by senior management. A witness told the Inquiry that the Licensing Team became a "*shadow of its former self*".[212]

259. These events took place at the time of the Chalice intelligence-gathering phase, when it is clear from the evidence that CSE perpetrators were active in Telford and when the Safeguarding team had become aware of taxi drivers offering children free rides in return for sexual activity;[213] and when, according to various witness accounts given to the Inquiry, taxis were being driven by people other than the licensed driver,[214] in the illegal practice of licence sharing, known as 'badge swapping'.

260. Enforcement was slow to recover from the pause, and then was further sapped by the loss of revenue following the cross-border licensing decisions. During the Inquiry the Council was asked specifically about 'badge swapping', and indicated that it had detected no such incidents; but I note that many of the reports of 'badge swapping' can be dated to the period of the mid-2000s, when there was a hiatus in licensing enforcement activity; it is obviously difficult to detect 'badge' swapping when there is no enforcement activity.

208 [redacted] pg 1
209 pg 4
210 pg 4
211 pgs 11-12
212 pg 25
213 pg 11
214 pg 11

The Night-Time Economy

261. The "*night-time economy*" is an ill-defined concept. I have considered it principally to relate to licensed premises, and I have sought to understand the steps that key stakeholders took in relation to such premises.

262. The Council has, since the Licensing Act 2003, been the licensing authority in respect of licensable activities including liquor sales, provision of late night refreshment and food businesses. Prior to the introduction of the Licensing Act 2003, the Council had no involvement in liquor licensing, which was the responsibility of the magistrates' court.

263. The Licensing Act 2003 requires licensing authorities to have regard to four licensing objectives, one of which is protection of children from harm.

264. From March 2015, the statutory guidance issued under section 182 of the Licensing Act 2003 has included that licensing authorities "*must also consider the need to protect children from sexual exploitation when undertaking licensing functions*".

Nightclubs

265. I have heard witness evidence that children were frequenting nightclubs,[215] taking drugs or being drugged,[216] and leaving nightclubs in a potentially vulnerable state.[217] The Inquiry sought disclosure from key stakeholders in respect of material relating to premises of interest; I have seen evidence relating to various initiatives and actions:

265.1 At Christmas 2008 there was violence and disorder in a particular area of Telford around a nightclub; as a result WMP "*flooded*" the area with officers during a targeted operation;[218]

265.2 In 2008, a WMP Strategic Assessment noted "*problematic streets*" in named areas of Telford. Wellington centre was also noted as a priority, with the remark "*the night-time economy acts as a crime generator*";[219]

265.3 Also in 2008, a volunteer group began operating to provide a safe place for clubbers at the end of the night and to direct young people to taxis;[220]

265.4 A formal Taxi Marshal scheme was introduced in 2009/2010, initially funded by Wellington Town Council and the Council jointly.[221] A similar marshal scheme was created for the town centre as a joint venture between the Council and the town centre's owners. The Taxi Marshals share information with the Council. The scheme has received PCC funding;

215 [redacted] pg 7
216 pg 10
217 pg 3
218 pgs 3-4
219 , pg 49
220 pg 4
221 pg 29

265.5 A Street Pastor Scheme was funded by the PCC in 2011. While the original remit was to calm volatile situations and offer assistance to the public after closing time, the Street Pastors went further than this, collating information about perceived threats. A weekly Street Pastors' email report would be sent to WMP and the Licensing Team, amongst others, listing suspect vehicles and behaviour. Minutes of meetings suggest that these reports were reviewed by the Council's Assistant Directors for Safeguarding, and that information was passed to the Safeguarding team for action;[222]

265.6 Reports from 2015 show targeted WMP patrols were being made in Wellington centre on Saturday nights, largely driven by concerns about licensed premises and antisocial behaviour. Significantly, these reports contain car registration details and cross reference intelligence to be handed over in briefings for subsequent patrols;[223] and

265.7 From 2015 there were multi-agency Night-Time Economy meetings, hosted by the Council but including representatives of WMP, local businesses, the Street Pastors and others. I have seen minutes of these meetings which show significant sharing of information. Currently, the Council operates a Night-Time Economy meeting attended by WMP's Harm Reduction Unit ("HRU") Sergeant and the Safer Neighbourhood Teams Inspector; WMP also provides a weekly snapshot of all licensing visits across the borough.[224]

266. The Inquiry heard mixed views about 'under 18s events' in clubs. Some witnesses took the view they were well-run and safe; others objected to the idea of children in nightclubs in any circumstances. The diversion of views seems to split between those responsible for monitoring and running the events themselves – the Licensing Team – and those concerned with what happens outside – the Street Pastors and WMP.

267. As to the difficulty presented by children attending adult events in clubs, I heard that in recent years, the CATE Team has shared details of the children involved with the Licensing Team, who would speak to clubs; this proved to be effective in preventing children going to clubs in Telford, though I heard that on occasion it drove them to other towns and cities where they were not recognised.

Other premises

268. There are many references to perpetrators being linked with takeaways and restaurants, and to associated residential premises being used for exploitation. It is important to note that the licensing role of the Council is limited to those premises serving late night refreshment, including alcohol or hot food; the Council has indicated that only 20 of the approximately 107 takeaways in the borough currently have such a licence, so its role is necessarily limited.[225]

222 [redacted] pg 4
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224 pgs 6-8
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269. Given the prevalence in witness accounts of the names of certain premises, I asked the Council for specific disclosure related to specified restaurants and takeaways that were mentioned by witnesses. The outcome of that request was essentially that there was no relevant information. I am particularly concerned, given the victim accounts, that certain restaurants have no concerns relating to them on the part of the licensing authorities, despite being identified as known CSE locations within the local population. Given this, it is clear to me that there has been a failure of information sharing by CATE and the WMP team, in particular, with licensing.

270. As to specifics, I have seen material which shows that, in 2010, uniformed officers from local policing teams were tasked with visiting licensed premises, to address – by visible deterrence - the problem of under 18s buying alcohol.[226] I have also seen material from 2015 which shows targeted patrols being made in Wellington centre on Saturday nights.

271. As to the role of WMP, ensuring that the streets are safe in town centres at night is obviously a core part of any police force's everyday responsibilities. The police have the power to apply to the licensing authority for summary review of a premises licence,[227] where there are concerns of serious crime or serious disorder associated with the premises; such a review allows for imposition of interim measures (including licence revocation) and an expedited review process or hearing.

272. The Council told me that, in October 2015, in response to concerns regarding the role played by licensed premises in the exploitation of children, the Licensing Team provided information relevant to licensed premises and hotels to WMP's HRU who delivered training to the hospitality trade, including hotels and bed and breakfast accommodation. I have been told by the Council that this training included how to spot the signs of exploitative activity, how to make a referral in the event of any suspicions regarding exploitation and what steps could be taken within premises to limit the risk of children and young people being exploited.[228]

273. I heard further from the Council that the Licensing Team has worked closely with WMP since 2007 in investigating any concerns that have been raised in respect of activity occurring on licensed premises under the Licensing Act 2003; and that, in 2017, Public Protection became a partner in the Multi-Agency Team Enforcement Strategy ("MATES") which brought together a number of enforcement partners, led by WMP's HRU, to tackle problem premises and individuals.[229]

Conclusions

274. As to taxis, it seems to me to be **regrettable that the Council did not make earlier use of obvious information sources when making taxi licensing decisions and enforcement. I have in mind particularly the PSP Register and use of information known to the Safeguarding and CATE teams.**

[226] [redacted]
[227] Sections 53A-53D of the Licensing Act 2003
[228] [redacted] pg 89
[229] [redacted] pgs 89-90

275. **In my view, the 2006 decision to suspend licensing enforcement was a disastrous one. On the material I have seen it was borne entirely out of fear of accusations of racism; it was craven.** It is quite apparent from the evidence I have seen that the Licensing Team's strength and effectiveness was much diminished by that decision over the coming years, which were, of course, the years that CSE offending, particularly related to Chalice, with its reports of exploitative behaviour by taxi drivers and misuse of badges by those purporting to be taxi drivers, was at its height.

276. **As to the night-time economy, the evidence I have seen tends to suggest that WMP was aware of those areas that I have heard were CSE hotspots and that the need for a visible presence was appreciated from at least 2008.** The evidence shows that there were efforts to address young people buying alcohol. By 2015, WMP's approach was not only designed to disrupt by presence but to gather intelligence.[230]

277. **The Taxi Marshall and Street Pastor schemes were both, in my view, exceedingly valuable; the latter and its members deserve particular credit as a voluntary organisation.** I accept that WMP worked to filter the mass of information it received from the Street Pastors for useful intelligence. Although Street Pastor material was also passed to the Council, I have seen no evidence as to what use, if any, it was put.

278. **To their credit, I can see that the Licensing and CATE teams co-operated to protect named children in clubs.**

279. I have heard a significant number of accounts of exploitation taking place in restaurants and particularly takeaways. Perhaps it is not a coincidence that it is these establishments over which the Council has the least degree of licensing control. **Nonetheless I am surprised that, given the number of these reports, I have not seen evidence of information sharing with regard to these premises and I regard that as a failure.**

280. **The arrangements in recent years for awareness raising and training of people who may come into contact with CSE are to be commended; the evidence suggests that the training of hotel staff has been particularly important. In this regard, though, it is important to remember that the hospitality trade generally has a high staff turnover and training – however delivered - must be an ongoing process and not a 'one off' event.**

Missing Persons (Chapters 3 and 5)

281. Children who are missing from their homes are vulnerable to exploitation. Accordingly it has been important for me to consider the attitude and response of the key stakeholders to missing children. In the body of this Report, I have dealt with this issue in the chapters relating to the individual stakeholders. In this Executive Summary, however, I have brought together a summary of the analyses here.

230 [redacted]

282. I heard that in 1997/1998 youth workers became concerned about children going missing.[231] Witnesses told the Inquiry that: "*the police see them as a nuisance, the care providers from the care home weren't interested, it was almost like it's their choice, if they want to go missing it's their choice*".[232]

283. '*Safeguarding Children Involved in Prostitution'*, published by the Department of Health on 1 May 2000, provided, "*It is known from research that children looked after who run away are particularly at risk of sexual exploitation. Local authorities should monitor carefully the incidence of children looked after who go missing, particularly from residential care. Local authorities should have protocols in place with the police and other agencies on the action to be taken whenever a child goes missing and when she or he returns*".[233]

284. In Telford, the ACPC appears not to have recognised missing as an indicator of CSE despite this guidance or, indeed, the prevalence of missing episodes in the histories of children exploited locally. I have seen no evidence of the monitoring contemplated being undertaken.

285. WMP confirmed that prior to 2003, officers dealt with missing person cases in hard copy and shared details with Local Intelligence Officers ("LIOs"), who would update the Police National Computer ("PNC"), leading to a marker being placed against the missing person's name. Police anywhere in the country would be able to establish whether a person was recorded as missing.[234] I have however heard from an officer involved with missing persons cases at the time, who told me that the paper-based system was "*cumbersome, ineffective and unreliable".*[235]

286. From 2002, WMP had a Strategic Lead for Missing Persons and in 2003 a computerised system, COMPACT, was adopted for dealing with missing cases. This allowed sharing of missing information with Safeguarding – previously faxes had been relied on[236] - and the system sent email requests for the Council to conduct Return Home Interviews ("RHIs") when children were found. COMPACT was "*the first real regular engagement between Police and partner agencies in dealing with the issue of managing missing person investigations*".[237]

287. I have however seen evidence which suggests that missing cases were dealt with on paper even after the adoption of computerised crime recording, notwithstanding the fact that paper-based system could not be monitored to identify any patterns or repeat cases.

288. WMP also introduced a 'safe and well' check for all returned missing children and the debrief from that check would contribute to a 'closing report' within COMPACT. It has been noted that "*experience has shown that these Police debriefings are of little to no value as the officer does not have the confidence and ear of the formerly missing person …* [who] *may well want*

231 [redacted] pg 3
232 pg 3
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234 pg 131
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236 pg 15
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to protect their support network of friends and associates …they may see it in their best interests to remain mute…".[238]

289. Another witness questioned the quality of the checks completed, noting that there was no real consideration of the missing person, it was more a case of checking "*the child is still standing and they are back in their care home".*[239] As a result, a checklist was developed in the mid-2000s for officers conducting 'safe and well' checks.

290. From 2003, WMP local policing team members also started attending multi-agency meetings in respect of children going missing.[240] In 2004, the WMP Force Missing Persons Policy and Procedure was implemented; this effectively excluded the police from responsibility for dealing with children missing from care in almost every case, stating it was the responsibility of Safeguarding or education to locate and return the child.

291. The Inquiry heard from a witness who gave their recollection of attitudes in the mid-2000s "[A]*round about that time, that 2004, that some of my staff were coming to me with concerns that they were working with young people who were going missing… certainly systems are much, much better now in terms of how we respond to people going missing."*[241]

292. In July 2006 a review of the Council's sexual exploitation service noted that missing episodes could be used as a tool to identify children who could be "*targeted for specific work".*[242] In parallel, WMP's approach to missing persons developed; from 2007 onwards in particular, when cases were deemed to be high risk, information was shared with the Child Abuse and Investigation Unit ("CAIU") Detective Inspector and a decision would then be made in relation to the necessity of a strategy discussion with partner agencies. Further, from 2007 missing cases were highlighted at Daily Management Meetings in Telford, chaired by a WMP Command team member.

293. I have heard that the number of repeat missing episodes continued to be a concern in 2009, particularly because a significant proportion of cases involved vulnerable children in care who were known to be at risk of harm. One witness told me about a particular child: "*I heard that men were picking them up from there or they'd walk on, the staff had no power to control them. No power to put their hands on them. So they get in a cab with someone and away they go".*[243] Care home staff were not active in preventing these missing episodes and were "*doing little to go out and find* [*the child*]. *It was just pick up the phone, phone the Police and get them to do the job …there was little being done to look at what the options could be to actually disincentivise* [*the child*] *from going missing".* [244]

238 [redacted] pg 22
239 pg 11
240 pg 135
241 pg 5
242 pg 2, [redacted], pg 2
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244 [redacted] pg 52

294. As an indicator of scale, in 2008/2009 WMP formally investigated 3,306 missing reports. 2,304 of those reports involved 984 children; 213 children went missing three or more times, and one child went missing on 51 occasions.[245]

295. By 2009, each policing area had a Public Protection Unit or Protecting Vulnerable People Unit (PPU/PVP) (the terms were interchangeable), led by a Detective Inspector who would "*take an interest in reducing missing person reports and liaise with colleagues from Local Authorities or Safer Neighbourhood Teams who would be required to problem solve and reduce the incidence and risks associated with the person going missing*".[246] This was done in accordance with the '*Joint Protocol for Reporting Missing Young People 2009',*[247] which was agreed between the Council, neighbouring authorities, and WMP. The Joint Protocol set out the approach to be taken for children who go missing on more than one occasion, including an 'intervention meeting' in certain repeat cases. At those meetings Safeguarding and WMP would monitor absences of individual children, and the findings were presented in a quarterly report.

296. Despite the Joint Protocol, a pan-West Mercia scheme to set up a RHI agreement across four local authorities appears to have gained no traction.[248] Other local authorities were investigating using third sector providers including the NSPCC and the Children's Society to carry out the RHIs. I have seen evidence that the view was taken within the Council that there was no legal requirement for Telford to have RHIs, which may have undermined the impetus to put a formal system in place.

297. Witnesses have told me that WMP's Strategic Lead played a key role during this period; one of the most significant contributions being to tackle outdated views on missing people, particularly the idea of a child being considered 'streetwise' as a result of multiple missing episodes without coming to any apparent harm. The witness said the Strategic Lead:

"… felt that if a child, for instance, went missing a number of times that [sic] *the more times they went missing it would logically follow that there would probably be a better chance for them coming to harm or more chance of them coming to harm or more chance of them being at risk".*[249]

298. In July 2010, the LSCB Missing Persons group raised concerns that the level of data coming in would take a dedicated administrator to deal with properly.[250] This was to be raised at the LSCB but following the next LSCB meeting there was no advance; the minutes record that "*MISPERS are being recorded but they are not recorded as found when they return. This is an admin issue. Resource is needed for data collection and analysis*".[251] I have seen evidence

245 [redacted] pg 3
246 pg 136
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248 pg 3
249 pg 27
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that a lack of budget was responsible for a failure on the part of the Council to conduct RHIs or collate data in respect of missing children.[252]

299. In November 2010, at the LSCB Missing Persons Group[253] a system was agreed whereby WMP would furnish the Council with information on missing children on a monthly basis – but the group did not determine whether a child being supported by CATE who went missing should be reported to WMP – this was despite the fact that WMP had stressed the importance of this years before.

300. From 2011, WMP's Strategic Lead introduced the concept of 'skeletal missing person plans'. These were plans created on COMPACT for locating looked after children before missing incidents had taken place, the rationale being:

"… *once a child had been identified as vulnerable and likely to go missing…* [h]*otspots were identified and work carried out to ensure… that the local authorities and police forces in the areas the children were likely to run to, were on notice and involved in searching for that child, rather than leaving it to WMP*".[254]

301. In 2012, the LSCB Executive noted that "*support for missing children is a significant gap*". Although voluntary group involvement in RHIs was recommended as "*very effective*", Telford was to pilot using its own Targeted Youth Service.[255] Cultural resistance to voluntary group involvement appears still to have been strong.

302. The Council's restructure in 2012 gave responsibility for missing children to the new service Cohesion.[256] One practical feature of this was that RHIs could not be recorded on Safeguarding's computer system as Cohesion staff did not have access to it.

303. As from 2014, the local authority was required by statutory guidance to offer an RHI when a looked after child returned from a missing episode.[257] Evidence provided to the Inquiry suggests that if the interview was actually completed, it was more of a tick box exercise than anything of value: a witness told the Inquiry that the requirement to hold a RHI had been interpreted by some local authorities, including the Council, as a requirement to 'offer' rather than to undertake an interview.[258]

304. WMP's work to increase the profile of missing persons continued and in 2014 it recruited a Missing Persons Coordinator ("Misper Coordinator") to focus on preventing missing incidents in Shropshire and Telford policing areas.[259] The Misper Coordinator arranged monthly operational meetings with partners, including the local authorities, to discuss missing persons. More of a focus was given to repeat missing children, with plans being developed

252 [redacted] pg 35
253 [redacted]
254 [redacted] pg 6
255 [redacted]
256 [redacted]
257 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf
258 [redacted]
259 [redacted] pg 138

to reduce repeat missing episodes. I have been told that these meetings have been a success and still take place today.

305. After the formation of the CSE team in Telford in 2015, the team worked closely with the Misper Coordinator and latterly, the Missing Person Prevention Officer ("MPPO"), to identify any elements of CSE involved in any child who was regularly going missing and therefore likely to do so again.[260]

306. From 2015, all missing notifications were to come to the Council through Family Connect. So far as RHIs were concerned, any missing child open to Cohesion would have their RHI conducted by their allocated case worker; any not open to Cohesion would have an allocation within 72 hours. The system was not working perfectly – CATE was not being informed that missing children had returned, and RHI statistics were getting worse.[261]

307. From 2016, within the Council, Safeguarding took over responsibility for missing from Cohesion; [262] though not, it appears, where missing children had not been open to a service, and it was suggested external funding be explored. [263]

308. In April 2016, the LSCB CE Thematic subgroup heard that Her Majesty's Inspectorate of Constabulary ("HMIC") had completed a vulnerability inspection of West Mercia and Warwickshire (who were at that time working in an alliance) and were given a grade of "*requires improvement*" with regard to missing people. One of the main failures was using information from previous episodes to prevent repeat episodes, with completion and sharing of RHIs a significant feature. The subgroup noted that of 383 missing episodes between April 2015 and March 2016, only 57 RHIs were shared with the police.[264]

309. In July 2016, analysis showed only 50% of RHIs were being completed within timescale and there was an issue with RHIs not being sent to Family Connect or the police HAU,[265] and "*a lack of communication between social workers and agencies regarding the information that is provided on missing children.*" [266]

310. In mid-2017 the LSCB Missing Operational group was re-instigated (though prior references are scant),[267] to meet monthly to review young people who have gone missing and to provide reports into the LSCB's CE subgroup. I have however seen documents which suggest that in September 2017 the "missing" element of the LSCB CE Subgroup was stepped down as it was felt that the actions were being picked up appropriately through the Council's improvement plan and through operational joint working with WMP.[268]

260 [redacted] pg 139
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311. In late 2017, the Corporate Parenting Strategic Group[269] heard a proposal from the Missing Multi-Agency Core Group "*to meet monthly to consider specific children and young people who go missing and to also identify patterns and missing trends*". I have seen material which suggests that the Missing Multi Agency Core group endures, meeting every six to eight weeks to discuss "high level" missing cases, chaired by a member of the CATE Team.[270] Additionally, multi-agency Missing Operations meetings are held on a monthly basis.

312. By early 2018, a missing children coordinator had been appointed in the CATE Team.[271] The CATE Team was now dealing with missing and, when the missing child was open to CATE or had an allocated social worker, with the RHI, with information obtained being recorded on Protocol (the Safeguarding IT system) and shared with WMP. Missing children without CATE or social work involvement would be interviewed by members of the Strengthening Families team. Regardless of whether the RHI interviewer was from CATE or from Strengthening Families, the practitioner would be expected to complete the same form and take any referral to Family Connect.[272] Protocol will now flag when a child has reached three missing incidences in 90 days, which will trigger a Missing Intervention meeting, chaired by CATE with the police representative for 'Missing' also in attendance. [273]

313. I understand that the current WMP position with regard to missing persons is that when a person is reported missing, a report is registered on the national police COMPACT system for missing people. The 'missing' and 'found' reports created by WMP are shared directly with Safeguarding when the missing person is a child. In addition to this, there is a flag on COMPACT for CSE to alert anyone viewing the record to the person's CSE vulnerability. There is also a CSE flag that can be added to any crime or incident which then alerts the HAU and the relevant CSE team to the person's CSE vulnerability.[274]

Conclusions

314. As to WMP, I consider that it was fortunate in having an officer as Strategic Lead who was interested in and engaged with the issue of missing children; but notwithstanding that, and the early adoption of COMPACT, **learning and practice relating to missing was not embedded early in WMP's working. Although the link between missing and CSE was well known in the early 2000s, it was not expressed in policy relating to missing children until 2009.**

315. Nevertheless, WMP was in advance of some partners in this regard, particularly the Council. **I am driven to conclude that in the early days the Council gave no real credence to missing as a risk indicator for CSE, notwithstanding official guidance having been issued as early as 2002. Even as Chalice was ongoing the Council failed to pay sufficient attention to the importance of properly conducted RHIs until statutory guidance required it to; and even after that, its conduct of RHIs under Cohesion**

269 [redacted] pg 107
270 pg 31
271 pg 60
272 pg 29
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was marked by inefficiency, both in conducting interviews and in disseminating information from them.

316. Within WMP, the current close working between the CSE team and Missing Persons Coordinator and Missing Persons Prevention Officer is plainly helpful, as is the use of flagging for missing cases and sharing of information with the CATE Team. **My view is that, as in so many areas relating to CSE, WMP has created an appropriate response to the problem of missing children; but it has taken time to do so, and would not have happened without the impetus of a particularly dedicated individual.**

317. **As to the Council, I take the view that the current provision for missing is properly resourced and managed.** Appropriate weight is given to the link with CSE and the need to monitor carefully children who go missing and learn from the episodes. **That is, though, a relatively recent state of affairs; it was only in 2016, with missing moving to Safeguarding, that the issue of children going missing had the management and resource that it obviously required.**

The Policing of CSE in Telford (Chapter 5)

318. Telford is policed by West Mercia Police ("WMP"). WMP came into being in October 1967 upon the merger of Worcestershire, Worcester City, Herefordshire and Shropshire constabularies. Until the early 1990s, the force comprised six divisions; Telford was one. From April 1991, Telford was covered by Malinsgate and Wellington subdivision.

319. In June 2011 WMP and Warwickshire Police announced they would operate in an alliance (the "Alliance"). The driver was cost-saving: WMP alone needed to reduce its operating costs by over £20 million by 2015/2016. The Alliance formally began operating on 1 November 2011; it ended on 8 April 2020.[275]

320. In addressing the approach taken by WMP to the policing of CSE in Telford, I have considered the framework of offences within which police forces nationally have worked over the years, and how the law has changed with reference to relevant sexual offences against children. In the body of this Report, I have set out what I consider to be key guidance in existence over the years, insofar as this was available to police forces to inform policy and practice regarding the policing of CSE and related offences. I have also set out an overarching legislative chronology at Appendix I in order to show the overall genesis of the legislative framework surrounding CSE and safeguarding.

Criminal offences and guidance

321. The legislative framework applicable to sexual offences against children in England and Wales is the Sexual Offences Act 2003 (the "2003 Act"), which came into force on 1 May 2004.[276] Prior to the 2003 Act, the key statutory provisions covering sexual offences against children were the Sexual Offences Act 1956 (the "1956 Act") and the Indecency with Children Act 1960 (the "1960 Act").

[275] [redacted] pg 15
[276] Sexual Offences Act 2003 (Commencement) Order 2004 (SI 2004/874)

322. The 2003 Act created a wide range of distinct criminal offences against children including, exploitation offences relating to 'prostitution', pornography and trafficking: although the language of sexual exploitation of children was not completely adopted until the 2003 Act was amended in 2015 and the references to 'prostitution' and pornography were removed.

323. Insofar as 'child prostitution' is concerned, a much older piece of legislation, the Street Offences Act 1959 (the "1959 Act"), created the criminal offence of "*loitering or soliciting for the purposes of prostitution*" and meant that a child who had attained the age of criminal responsibility - just eight years old from 1933[277] and ten years old from 1963[278] - could, until 2015, be convicted under this provision.

324. The earliest guidance seen by the Inquiry is the Home Office Circular 108/1959,[279] which explained the motivation for the approach under 1959 Act was to *"divert from prostitution women, and particularly girls, who are taken to that way of life".*[280]

325. Home Office Circular 52/1988 directed that there should be joint investigation of child sexual abuse allegations with social services. It noted that "*children will rarely make a formal claim of abuse"*;[281] in such circumstances the guidance required a multi-disciplinary assessment followed by an investigation into any criminal offences.

326. It was not until '*Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working together to Safeguard Children – 2000'* that there came official recognition that children involved in 'prostitution' should be treated as *"victims of abuse".*[282]

327. The same guidance also indicated that the primary law enforcement effort must be against perpetrators,[283] and that children 'involved in prostitution' should be treated as children in need *"who may be suffering, or may be likely to suffer, significant harm"*, with a referral to Safeguarding.[284]

Child Protection Arrangements

328. From 1989, each WMP division had a Community Affairs Department ("CAD"), centrally managed at Headquarters, responsible for responding to child sexual abuse and engaging with Safeguarding.

329. In 1992, WMP established specialist Child Protection Units ("CPUs") to deal with incidents of child abuse. CPUs were to be supported by the Criminal Investigation Department ("CID").

330. In 1996 the remit of the CPUs was broadened to include domestic abuse, and divisional Family Protection Units ("FPUs") were created.[285] FPU teams dealt with referrals of familial sexual and physical abuse, whereas all non-familial abuse was investigated by divisional

[277] Section 50 of the Children and Young Persons Act 1933
[278] Children and Young Person's Act 1963
[279] [redacted]
[280] HO 108/59, pg 1
[281] [redacted] HO 52/1988, pg 3
[282] [redacted] Department of Health, 'Safeguarding Children Involved in Prostitution' (May 2000), pg 6
[283] [redacted] Department of Health, 'Safeguarding Children Involved in Prostitution' (May 2000), pg 12
[284] [redacted] Department of Health, 'Safeguarding Children Involved in Prostitution' (May 2000), pg 12
[285] [redacted] pg 5

CID. Nevertheless, the term CPU continued to be used and in 2007 the term Child Abuse investigation Unit ("CAIU") briefly surfaced to describe CPU/FPUs.

331. Crimes amounting to CSE would be dealt with by CID. CID itself was subdivided into reactive and proactive squads – offences related to CSE would have been within CID's reactive (as opposed to proactive) remit.

332. It follows that different teams were responsible for dealing with child sexual offences according to the relationship between suspect and victim. Sometime before May 2009, a Sexual Offences Investigation Team ("SOIT")[286] was 'trialled', with a remit to investigate sexual offences generally. Such teams are known in other forces as a 'RASSO' – Rape and Serious Sexual Offences – team. The SOIT was, however, quickly subsumed into the Operation Chalice investigation and it did not re-remerge following Chalice's conclusion. The proposal for a RASSO team post-Chalice was vetoed in the early negotiations for the Alliance on costs grounds. Accordingly, mainstream CID retained responsibility for non-familial cases including CSE until the inception of a specialist CSE team in 2015.

333. The effect of the CSE team was that, for the first time, non–familial investigations where CSE was suspected were no longer directed to CID for investigation.

334. In 2019, Telford's CSE team was renamed the Criminal Exploitation ("CE") team and its remit broadened to all forms of child exploitation. WMP told the Inquiry that an increase in reporting of criminal exploitation offences led to the team being overwhelmed, and as a result it was allocated more staff.

335. **The decision not to maintain the SOIT after Chalice was an obvious failure: the need for a specialist team investigating all child sexual offences was recognised by senior officers in WMP in 2012, but no such team was created until 2015. Given WMP had seen the nature, impact and complexities of CSE cases throughout the Chalice period, I view this delay in adopting a specialist CSE team as a failure by WMP. I have no doubt upon the evidence I have received that this delay was primarily driven by costs considerations.** The lack of specialist provision plainly impacted upon investigations – see Operation Delta, to which I refer further below in this Executive Summary. Most disappointingly, this Report will show that the impetus to create a specialist CSE team appears not to have come from within WMP or as a direct consequence of Chalice, but as a response to external inspections and reviews.

Policies and Procedures

336. WMP initially issued a Child Protection policy in 1989 following a review of the CAD; although the Inquiry heard that no actual copy of the policy could be found.[287]

337. In 2000, WMP reissued the 1989 Child Protection policy. It made no mention of exploitation or of 'child prostitution'.

286 [redacted]
287 [redacted] pg 112 and pg 223

338. In 2004, WMP published its '*Child Protection Force Procedure'* ("CPFP 2004"). This acknowledged that children were being abused through 'prostitution', and that the exploitation was as a result of coercion and threats rather than behaviour that was voluntarily entered into. The procedure expected such children to be considered as 'children in need' for the purposes of multi-agency referrals, and that the FPU would be involved in managing any such cases on behalf of the police.

339. The CPFP 2004 also mandated that every complaint or referral should result in a crime being recorded, with a supervisory FPU officer involved in any referral or strategy meeting with other agencies involved in child protection.

340. Also in 2004, the FPU implemented a procedure to ensure WMP recorded crimes in a way which reflected the National Crime Recording Standard. This also included a 'non-crime' child protection incident record – i.e. where no actual offence had been committed, but concerns needed to be recorded.

341. In 2007, WMP introduced its '*Investigating Child Abuse Policy and Procedure'*[288] (the "2007 Child Abuse Policy"). The policy states in its preamble that it is important that "*safeguarding children is not seen as the solely as the role of the CAIU. All officers must understand that it is a fundamental part of their duties… it is a 'whole force' responsibility*".

342. The 2007 Child Abuse Policy was written in anticipation of a two-year review, due to have taken place in May 2009, but I have seen no evidence of such review; it appears the policy was next refreshed (with very few amendments) in 2011.[289]

343. In October 2012, now under Alliance arrangements, WMP set out *"the current position and planned activity within the West Mercia and Warwickshire areas in relation to the identification and investigation of CSE"* in what it referred to as its 'CSE Position Statement'.[290] This remarked that CSE had not been examined during the planning phase of the Alliance, notwithstanding the currency of Operation Chalice, and simply asserted that a "*coherent strategy*" was required in order to tackle CSE.

344. In 2013, the Alliance published its Child Sexual Exploitation Delivery Action Plan. WMP told the Inquiry that this plan was *"introduced in order to drive strategic and tactical activity specific to CSE"*[291] and followed the release of the national ACPO CSE Action Plan in 2013 which was considered a *"benchmark"* towards which all police forces should work.[292] The action plan contains limited information on precise action being taken, but in relation to professional investigation of CSE,[293] the use of suitably accredited investigators is marked as *"in progress"* suggesting that at this stage, the issue was one that still required development within the Alliance.

288 [redacted]
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291 [redacted] pg 115
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293 [redacted], pg 2

345. The 2014 '*Alliance Investigation Allegations of Child Abuse Procedure*'[294] contained no detailed focus on CSE;[295] nor did the '*Alliance Child Abuse Policy;* of 2016[296] or the 2017 '*Alliance Vulnerability Strategy*'[297] - though WMP told the Inquiry it supplemented the strategy with CSE-specific training. Despite this, the Alliance's '*Overarching Policy on Vulnerability and Safeguarding'* of 2019[298] still contained no specific reference to CSE, and nor does WMP's post-Alliance *Child Abuse and Safeguarding Policy 2020*. I do note, however, that general reference is made within these policy documents to general child protection procedures to be followed, where a child is considered to be suffering, or at risk of suffering significant harm, and that "*prostituting or trafficking a child*" is acknowledged as falling within such categories of potential harm.

346. **WMP explained to the Inquiry that it has sought to update its learning and practice since national guidance was first published in 2009,[299] and that the force has contributed to regional engagement and CSE plans. It stated that criminal exploitation (CE) – and not just CSE – was "*at the forefront*" of its Vulnerability Strategy, and that the Vulnerability and Safeguarding Command team "*supports the CSE/CE delivery by looking at effective practice nationally and providing a platform for improving practice and strengthening culture across the organisation*".[300] I am afraid to say that my assessment of the policies and procedures provided to me does not appear to support that assertion.**

Recording of Offences

347. WMP has at all times had to abide by the Home Office Counting Rules ("HOCR") for the recording of all crimes, including child sexual offences. Prior to 1995 all crimes were recorded by WMP on a paper-based system. In 1995, WMP adopted a computerised centralised crime recording system ("CRIMES"). Written reports were faxed to a centralised bureau for logging onto the CRIMES system. All recorded crimes resulting in charge, caution or other admission (for example being taken into consideration at sentencing) were to be regarded as 'detected'.[301]

348. Following a national inspection of crime recording standards in 2000, the National Crime Recording Scheme was launched in 2002.[302] This system was intended to ensure a consistent approach to the recording of child sexual (and all other) offences.

349. In 2004, the FPU implemented a crime recording procedure to ensure WMP recorded crimes designed to reflect the National Crime Recording Standard ("NCRS"). This also included a

294 [redacted] pg 9
295 [redacted]
296 [redacted]
297 [redacted]
298 [redacted]
299 Safeguarding Children and Young People from Exploitation 2009 - https://www.basw.co.uk/resources/safeguarding-children-and-young-people-sexual-exploitation-supplementary-guidance-working
300 [redacted] pg 61
301 [redacted] pg 41
302 [redacted]

'non-crime' child protection incident record – i.e. where no actual offence had been committed, but concerns needed to be recorded:

"[All] *reports of crimes, or reports where there was a concern for the safety or welfare of a child would result in a record being made on the Force's crime recording system CRIMES to ensure the intelligence was captured and an investigation undertaken which would include appropriate supervision*".[303]

350. It is not apparent how child protection information logged onto the CRIMES system during this period would have been followed up, or whether this was simply a way of 'marking' the incident against a child or family's name for future reference.

351. I infer from the material provided to me that the system for recording CSE-related crimes remained as per the above until a review took place in 2014 looking at 'Crime Data Integrity',[304] when WMP was found to be 74% compliant in converting logged incidents into reported crimes. The force was tasked with the following:

"*…[it] should establish and begin operation of an adequate system for the auditing by the FCR* [Force Crime Manager] *of all referrals to the Force from other organisations of incidents and reports of crime, with special attention being directed to those involving vulnerable adults and children*."[305]

352. **I am satisfied, from the information provided to me by WMP, that as a result the force did take a number of steps to improve its crime recording standards in all areas,** including appointing auditors and establishing a HOCR training programme for staff.[306]

353. The CRIMES system was replaced by 'ATHENA' in October 2017.[307] This coincided with further changes to the HOCR in 2016/2017 to include 'crime flags', two of which were 'CSE' and 'CSA'. WMP explained that the quality of crime recording and particularly application of specific 'flags' to crime reports, suffered during this period and that remedial steps were taken.[308]

354. An inspection by HMIC in 2019 recognised WMP was one of only 11 forces to be graded "Good", noting that it had "*developed a positive culture towards crime recording*" and commended its quality assurance processes for correct incident and crime reporting.[309]

303 [redacted] pg 47
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305 pg 51
306 pg 43
307 pg 171
308 pg 54
309 pg 53

'Tasking & Coordination'

355. The process of understanding threat, then tasking and coordinating appropriate resources in response, must be a fundamental facet of any policing response. Without appropriate management and oversight, there can be no proper allocation of policing assets in a way that proportionately addresses the threat and/or risk presented.

356. To assess the frequency of CSE being identified as an issue within tasking and coordination and other strategic meetings over time, the Inquiry reviewed a large number of disclosed tasking documents and records.

357. These documents and records were searched for key terms to identify and review those relevant to the issue of CSE. The results were that:

357.1 2003 to 2005: 1.83% of documents disclosed were relevant;

357.2 2006 to 2010: 9.24% of documents disclosed were relevant;

357.3 2011 to 2015: 21.15% of documents disclosed were relevant; and

357.4 2016 to 2020: 67.03% of documents disclosed were relevant.

358. The analysis tends to show that issues surrounding CSE were rarely discussed in 'tasking documents' as a whole prior to 2005. While the percentage of relevant documents rose over the years, the starting point was essentially negligible at 1.83%: CSE was effectively not on the tasking radar. **Despite other statistics showing an upward trend, the prevalence of CSE as a tasking issue remained low until the advent of WMP's dedicated CSE team in 2015, when prevalence reached 67.03%.**

359. **I consider this shows that CSE was given significantly greater prominence in tasking and briefing by WMP over time, and that this must have led to greater awareness on the part of officers**.

Training

360. WMP explained that all officers received training on sexual offences, including Unlawful Sexual Intercourse ("USI"), during their initial training, however in the early days "*it was the norm for female officers to be given responsibility for victims of sexual assault, domestic abuse and child abuse*", and "*as a result of this, female officers primarily undertook the associated training*".[310]

361. In 2003 WMP commissioned the Sexual Offences Investigation Trained Development Programme, which was intended to run from 2004. However, "*delivery of the course never*

[310] [redacted] pg 106

materialised". WMP's submission does not make clear why this was the case, but it may be that the lack of a dedicated sexual offences team was an important feature.[311]

362. The CPFP 2004 came into being the following year, and child protection officers working within FPU were required to hold the rank of Detective, and they "*will receive training and development opportunities commensurate to that role".*[312]

363. In 2005, there was national guidance on '*Investigating Child Abuse and Safeguarding Children'*, which indicated that staff dedicated to child abuse investigation should have completed multi-agency training to *"understand the role of other agencies".* WMP confirmed that this training then became mandatory for any staff involved in child abuse investigations.[313]

364. In 2007, a Specialist Child Abuse Investigators Development Programme ("SCAIDP") was introduced and training was delivered to CPU officers.[314]

365. This was followed in 2008 by First Responder Specially Trained Officer training, which was based upon the Sexual Offences Investigation Trained Programme, but the requirement for officers to be specially trained before interviewing victims was removed. The rationale was said to be that WMP did not maintain a dedicated sexual offences team.

366. On 24 February 2010, WMP ran what appears to have been the first officer training course with 'exploitation' in its title (Children Abused Through Exploitation), and whilst exploitation was to become a recurrent theme in further training over the next decade, the Inquiry notes that CSE-specific modules were not introduced through WMP's 'Managed Learning Environment' until 2014/2015.

367. In 2018, WMP introduced the Serious Sexual Assault Investigators' Development Programme ("SSAIDP"), and the decision was taken to merge this with the SCAIDP "*due to the resourcing pressures placed on local CID as a result of abstractions*"; the course was reduced to one week, but WMP reassured the Inquiry that:

"*officers that were required to manage child abuse investigations and sexual offence investigations received all of the necessary training, ensuring that they were suitably equipped and informed to be both confident and competent in their actions and decision making*".[315]

368. **So far as training is concerned, I accept much has improved although the introduction of the CSE specific courses on the 'Managed Learning Environment' was relatively late; and as I show in Chapter 5: The Policing of CSE in Telford, occurred at a time of renewed priority being accorded to CSE across WMP.**

311 [redacted] pg 108
312 pg 82
313 pg 82
314 pg 83
315 pgs 97, 98

Multi-Agency Working

369. I have seen clear evidence that WMP was involved in multi-agency working with Safeguarding from an early stage; for example, material shows that in 1990, officers from the CAD attended 946 case conferences.

370. WMP told the Inquiry that when the CPUs were formed, they were relocated from the main police station in Telford to premises in Donnington that were next door to Safeguarding. CPU officers would regularly speak with Safeguarding and share case papers. Joint visits to victims by police officers and social workers were routine, although the focus was upon what one might call 'typical' cases of child abuse or neglect, and primarily within the family setting, rather than upon CSE.

371. I have seen documents which show that from at least November 1998 multi-agency meetings were being held, at which WMP officers were present, with concerns raised about children known to be at current risk of 'child prostitution'/exploitation.[316]

372. The system did not work perfectly; material from the late 1990s shows information was not being shared between Safeguarding and the police. At one stage, safeguarding material notes that "*liaison with West Mercia Police broke down, resulting in there being no representation*"[317] at a key strategy meeting.

373. The records of multi-agency meetings are instructive as to knowledge of CSE. At a meeting in 2000, a social worker asked the police officers "*if there had been any queries regarding Regent Street and prostitution and if the girls are been* [*sic*] *taken to Wolverhampton or Birmingham*". In response, the police say that "*it is not clear… whether there is prostitution or drugs involved but there is definitely some kind of cohersion* [*sic*]". WMP resolve to "*liaise with Vice Squads in other areas and car numbers could possibly be checked*", and the recommendation is that "*police and social care to speak to parents and girls individually".*[318]

374. Unfortunately it appears that, in a further meeting some months later, the decision was taken that there should be no further action in relation to the children, as there was "*no evidence of prostitution*" following joint interview.[319] It is to be noted that WMP is not present at this follow-up meeting, and it is not clear why; although the minutes of the meeting appear to indicate that the Detective Constable involved agreed with the decision. I regard it as more than regrettable that 'prostitution' was seen as the threshold for action.

375. The CPFP 2004 stated the following in relation to the expectations for multi-agency working in child exploitation cases – essentially directing officers to the position set out in the national guidance of the time:

"*Children exposed to exploitation will be treated as 'Children in Need' who may be suffering, or likely to suffer, significant harm. For further guidance which provides advice on the*

316 [redacted] pg 67, [redacted] pgs 192 to 196
317 [redacted] pg 192
318 [redacted], pg 63
319 [redacted] pg 16

appropriate inter-agency approach to such investigations, practitioners should access the Department of Health document 'Safeguarding Children Involved in Prostitution' which supplements 'Working Together' and can be obtained from Divisional Family Protection Units".[320]

376. The Inquiry was told by an officer working in child protection at around this time that, in practice, there would be daily liaison with Safeguarding, who would make referrals into the police if a child made a disclosure, but that the mainstay of the work remained intra-familial neglect and sexual assault.

377. Evidence showed that later multi-agency meetings with Safeguarding would usually be attended by officers ranked sergeant or above. Notably, the earlier meeting minutes that I have seen from the late 1990s and 2000 show the officers attending were all constables; whether there had been an intentional change post-2004, that a more senior officer should attend, is not apparent.

378. WMP's Corporate Submission goes on to say that in 2006, "*multi-agency working arrangements between the… FPU teams and the… local authority… were established*"[321] – suggesting to me that perhaps, prior to this, liaison between the two was considered to be ad hoc, rather than in accordance with any established practice or policy.

379. As to practice, WMP explained that following a referral there would be a routine check of incident logs by control room staff to identify those which had been tagged for FPU/CAIU. These incidents would be considered at the morning Superintendent's briefing and be investigated by the FPU/CAIU, which would also create a referral to the Council's 'Referral and Assessment Team'. These briefings were "*unscheduled but formal… known as strategy discussions*", and there would then be a jointly agreed decision and action plan – as envisaged by the '*Working Together'* guidance.[322]

380. The Inquiry heard witness evidence that from 2007 onwards there were a number of multi-agency meetings which were designed not only to address the needs of the victim/survivor in question, but also to ensure the wider family had support, and to ensure other professionals were aware of what was happening.[323] These appear, at least initially, to have been strategic meetings which seemed to identify themes rather than to deal in specifics.[324]

381. In the early stages, it appears there was some nervousness on the part of the police at the idea of receiving information from the Council: at a Senior Officers' Coordination Group meeting in October 2007, the FPU representative reacted to the suggestion that the Council share information by suggesting: "*This may give the police clearer information, but there is also the issue of confidentiality and trust.*"[325]

320 [redacted] pg 13
321 pg 6
322 pg 13
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382. It was left to a representative of Safeguarding to make the obvious point that if the information was not shared with the police, they could not decide whether it would be worth pursuing as evidence.

383. However, by September 2008 CATE minutes note "*Police Update… Information sharing is very positive.*"[326]

384. The witness evidence I have reviewed in this regard suggests that the information sharing between the CATE team and the Chalice officers was informal, though effective; one witness told the Inquiry:

"*We had a very close working relationship. I would send emails directly to* [Chalice] *with intelligence on those emails. I would have daily telephone contact and it all went through* [a Chalice officer] *and that was just the structure until, I would say, we started having structures in place… if I've got my dates right up until 2012.*"[327]

385. The Inquiry was told that the quality of information sharing was much improved by the creation of the CATE team, which at one stage shared premises with WMP's Chalice team. I saw evidence that the Chalice team worked in partnership with a number of different organisations, including schools and health services, to share information and identify potential victims. A witness suggested to me that, historically, conversations probably had not happened as intended, and that it was perhaps "*too easy to hide behind confidentiality*".[328]

386. CSE Safeguarding Panels with partner agencies were established in 2012, where reported CSE incidents were reviewed on a monthly basis. WMP says the panels "*developed partnership working and information sharing*";[329] they appear to have been a formalisation of the previously ad hoc information sharing developed between the CATE Team and Chalice.

387. **I have seen examples of relevant post-Chalice intelligence in respect of children at risk being shared at Safeguarding panels;[330] it seems to me the system works, and the formalisation of the good practice that developed during Chalice is to be welcomed.**

Harm Assessment Units and the MASH

388. In 2013, three 'Harm Assessment Units' ("HAU") were created across the Alliance. WMP explained:

"Harm Assessment Units managed and coordinated all referrals and information sharing between the police and multi-agency partners… The aim of the HAU was to be a single hub

326 [redacted] pg 58
327 [redacted] pg 114
328 [redacted] pg 32
329 [redacted]
330 [redacted]

that assessed risk relating to all forms of vulnerability including CSE. The Unit provided an appropriate referral process to partners and an entry point for information sharing".[331]

389. Associated with the HAUs, the Harm Reduction Unit ("HRU") – I understand more recently referred to as the "*problem solving hub*" - was responsible for assessing the specific risks highlighted, and considering action that should be taken as a result.[332]

390. The concept of the HAU was designed to address the situation in which officers in the CPU had to 'trawl' force systems to identify CSE issues and refer cases they deemed appropriate; the lack of any central hub meant that where officers referred incidents directly to Safeguarding (or other partners) there would be no record of what information had been shared.

391. The HAU system was intended to create a formalised information sharing process, with CSE referrals able to be made via the HAU, direct to Safeguarding and CATE – rather than via individual officers in child protection.

392. The HAU was further refined in late 2015 when it was co-located with the Council's Family Connect team to create a Multi-Agency Safeguarding Hub ("MASH") – essentially bringing back the premises-sharing model that had worked in the early 1990s for the CPU and later for Chalice. It was described as follows:

"*The MASH is a function delivered by a multi-agency group of people who work together as a single team but continue to be employed by their own agencies. The purpose of the MASH is to build an intelligence picture to inform better decision making, identify and manage risk and make decisions on appropriate responses to risk."*[333]

393. The ethos behind the MASH was to "*share information with confidence in partnership*", and for it to act as a *"sealed envelope"* where all relevant police information would be shared. WMP has explained that a *"triage team"* would review police referrals to decide whether referrals would enter the MASH process. If they did not enter the process, they could be referred to other teams such as Early Help or closed down without further review.[334]

Current practice

394. I heard evidence from a serving officer that members of WMP's CE team attend the fortnightly multi-agency CSE risk panels, and that information is shared more widely with Council departments including licensing.[335] The relationship with the local intelligence department was said to be useful, with daily assessment and sharing of relevant material. Prior to any child protection conference taking place with Safeguarding, child protection practitioners will prepare reports detailing all of the police involvement with the child/family and those WMP officers attending multi-agency meetings would also bring any new information from those conferences back to the CE team.

331 [redacted] pg 10-11
332 [redacted] pg 46
333 [redacted]
334 [redacted]
335 [redacted] pg 23

395. So far as information sharing by the CE team is concerned, following a review of Chalice in 2018 and considering the multi-agency pathways for CSE that are in place now, it was noted by WMP that:

"*The current CSE team provide a dedicated response to CSE and there is evidence that there is good engagement with the intelligence department, CATE workers and other partner agencies".*[336]

396. **I am left in no doubt that the more recent CSE multi-agency pathways have ensured that investigations and information sharing remains with those who are most experienced and knowledgeable in the area of CSE.**

397. **While it would be tempting to conclude that the modern practice has simply formalised what went before, I do not consider that the evidence shows this to be the case; I cannot say with any confidence that there was a meeting in every case that demanded it or that disclosure was properly made in every case. I come to that conclusion because it is plain that for some time information sharing was dependent upon individual officers deciding to share that information, and as such must have been susceptible to differences in officer experience, skill and interest. In this regard I bear in mind the evidence I have seen that even in 2007, FPU officers who should have been familiar with the rules about disclosure and when safeguarding overrides privacy, were not confident about applying those rules in practice;[337] a situation which I consider would be inconceivable today.**

Early intelligence regarding CSE

398. During the course of the Inquiry, WMP disclosed a file of intelligence material dating back to the late 1990s, which indicated that officers were, at that time, collating information and intelligence relating to reports of 'child prostitution' taking place in Telford. The reports came from a variety of sources, and had been shared with senior officers, as well as with Safeguarding. This intelligence file was assembled and reviewed as part of Chalice, and became known as "D2276" - the document number assigned to the file.

399. I have set out three case studies relating to this era within Chapter 5. I regard them as key cases demonstrating the nature of CSE as it was conducted at that time; the attitudes and responses of the agencies involved; and ultimately the action that was, or was not, taken as a result. As I noted at the introduction to this Executive Summary, I do not propose to distil these case studies; they deserve to be read in full.

400. D2276 contained the following:

400.1 A report and package of accompanying documents written by a Police Constable and submitted by a Police Sergeant in September 1999, to a fellow Police Sergeant[338],

336 [redacted] pg 41
337 [redacted]

containing information relating to 'child prostitution' at identified addresses in Wellington (the "September 1999 Report");[339]

400.2 A report by a Police Constable, written in October 1999, addressed to a Detective Inspector within the 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 (the "October 1999 Report");[340]

400.3 An intelligence report from November 1999, written by a Detective Constable, discussing sexual offences being committed against children in Telford (the "November 1999 Intelligence");[341] and

400.4 A file prepared by another Detective Constable in PPU almost four years later, in May 2003, and entitled 'Prostitution Wellington' (the "2003 Report").[342]

401. Having reviewed the intelligence material in detail, I consider this to be crucial information documenting early, clear reports and concerns of CSE activity at several locations within Telford. It signifies a key point in Telford's CSE history. In the body of this Report, I therefore consider in detail what was done with this intelligence at the time in the late 1990s/early 2000s, but also the response in 2010, when the material was reviewed as part of Chalice.

402. In summary, however, the position was as follows:

402.1 The September 1999 Report followed instructions from a Police Sergeant to "*pay attention*" to a "*suspected brothel in Arleston"*, as:

"*It is suspected that girls are being used at this flat* [a named premises, "Premises A"] *as prostitutes … Another brothel that is being looked into by USG is* [a named premises, "Premises B"]. [A named premises, "Premises C"] *is the home address of* [adult Male A] *and* [adult Male B]… [adult Male B] *has young girls at the house. From 10.30pm onwards to early hours both white and young Asian men arrive at the house. A small red car appears to do a shuttle services to the house mainly dropping off Asian youths".*[343]

402.2 The September 1999 Report included a series of intelligence reports which raised concerns such as:

"*a lot of activity at* [Premises A]*, Wellington involving Asian males and young girls* [and] *it is suspected that the girls are being used at* [the] *flat as prostitutes*"[344]; and

339 [redacted]
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341 and [redacted]
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344 pg 15

"*two Pakistani men (I/D unknown) are 'running' two girls (prostitutes) from a flat…* [in proximity to Premises A]*, Wellington*" and that "*this has been going on for about 6 months*", and noting that "*there are frequent male visitors to the flats… 6-7 men a day visit*" and noting of the "*brothel*" that "*there is a connection to [*certain*] telephone boxes*" within half a mile radius of Premises A.[345]

402.3 Having received the results of the observations, the Police Sergeant forwarded the September 1999 Report to his fellow Sergeant on the opposite shift – it is understood by way of local information sharing. On the face of that report, there is a handwritten entry, marked for the attention of another Police Constable, who was responsible for the subsequent report written in October 1999 (see below), stating "*This is now filed no action. For your information re child prostitution*", and signed by a different Sergeant. It is not clear to me that any action was taken at this point.

402.4 The October 1999 Report was written upon the instructions of a Detective Sergeant in the FPU "*to ascertain if there was a child prostitution problem in Telford*". The author considered 28 intelligence reports, ranging in date from February 1997 to September 1999,[346] which had been submitted by 18 different officers ranging in rank from Police Constable, Detective Constable, Police Sergeant, Detective Sergeant and, on two occasions, Detective Chief Inspector. The reports include information such as:

"*…* [two named children] *are visited daily by a group of Asian youths aged 20-25yrs from Birmingham.* [The] *house is a magnet for local dropouts & mispers. The house has no furniture except a mattress in every room… The Asian youths are giving the girls drugs & having sex with them, the majority of whom are under-age…* [a child] *aged 15 years was the I.P. about a year ago in a case of U.S.I., involving one of the Asian lads, but the case was dropped.* [mother] *is very concerned as her 15 year old daughter and friends are visiting* [premises] *daily, & often spending the night there";* and

"[Named child] *was reported missing from home and was subsequently found to have gone to* [town] *with* [older white male] *who had taken her there to be assessed for prostitution.* [Named child] *was also… used as a drugs courier".*[347]

402.5 The author of the October 1999 Report concluded:

"*It is blatantly clear that there is a problem that has not been recognised by the Telford Division due to lack of information and sightings. The officers who continue with this enquiry will have to ascertain the involvement of the major pimps who are travelling between Telford, Wolverhampton and Birmingham. The child prostitutes have to be treated in such a manner that we will gain maximum information for the best prosecutions. The children will have to be treated as victims as per the Wolverhampton and Northampton pilot project. This will undoubtedly be a long*

345 [redacted], pg 22
346 [redacted]
347 [redacted] pgs 21 and 23

winded and drawn out affair that will take officers some time to collate and act upon the information".[348]

402.6 The Detective Inspector[349] who ultimately received the October 1999 Report was unable to recollect receiving it, believing that they had been posted to a major incident room on Division[350] at the time it was sent.

402.7 The Inquiry has ascertained that of the suspects and victims named in the October 1999 Report, only one of the defendants in Chalice convicted of facilitating child prostitution following a guilty plea was referred to by name, within three intelligence reports from June 1999.[351] These were all in relation to concerns regarding children attending Premises A, which later featured as a premises used for CSE as part of Chalice.

402.8 As regards the November 1999 Intelligence, this was written by a Detective Constable, discussing sexual offences being committed against children in Telford. This report was based on three separate intelligence reports from late October and November 1999, which included a number of concerns raised by relatives indicating that children "*may be getting involved in drugs and/or prostitution*"; that a man had "*in his possession a list of young girls, including* [a named child]" which was apparently offered out "*with the promise of a good time… for a price*"; and that a 12 year old child was "*working as a prostitute hanging around the phone box…*".[352]

402.9 The report was copied to two Inspectors in the Wellington neighbourhood team, to a Detective Constable in the intelligence unit, to a Detective Constable in the drugs unit, and to the Detective Inspector in reactive CID with a request "*for further instructions pls*". Unfortunately, as with the earlier reports noted above, after submission of these November 1999 Intelligence Reports, there remained no concerted response by WMP to these reports of 'child prostitution'.

402.10 Almost four years later, a file was prepared by a Detective Constable entitled '*Prostitution Wellington'*.[353] This report related to a complaint of CSE activity in 2000; that complaint, made by the family of a 12 year old child, was closed within a month, apparently at the express wish of the child and her family. The 2003 Report refers to the incident in 2000 coming back to light in a report from 2003, which states that:

"…. *a few months ago a 14 year old girl was found to be pregnant… and the baby is due in* [date]… *The girl was introduced to* [Asian males] *who hang* [a named street], *Wellington when she was 12 years old. At this age she was raped by one of the*

348 [redacted]
349 [redacted]
350 [redacted]
351 [redacted]
352 [redacted]
353 [redacted]

males. The rape was reported to police at the time but the victim does not feel she got the outcome that she wanted therefore will not speak to the police again".[354]

402.11 The report was sent to a Detective Sergeant and was also discussed at a multi-agency meeting in May 2003, at which attendees commented that "*this sort of situation has occurred before*".[355] The professionals at the meeting appeared to agree that little could be done in the case of this particular child, unless she supported a formal complaint – but that "*if in a few years* [she] *felt able to talk to the police*" this might be possible. The police also appear to give up on trying to pursue the incident further, and it is filed as NFA – no further action - with the face of the report marked as follows:

"*23-9-03: Having discussed this with you I agree. There is no direct evidence at present. The situation will continue to be monitored. My concern is that this is historical information and she* [the victim] *is nor currently at risk. If we now do a 'cold call' the risk is that an assault or other incident may occur on* [the victim]. *Please file*".[356]

403. All of the above intelligence from between 1999 and 2003 was reviewed as part of Chalice. WMP explained that the file which became D2276 came to light when it was handed to a senior Chalice officer in 2010 by the same Detective who had previous knowledge of intelligence reports in 1999, whilst a Detective Sergeant in the FPU.[357]

404. When the material was reviewed, it was noted to be "*over 10 years old, but related to a house on the searched premises list for the* [Chalice] *arrest phase*". This was Premises A, as mentioned above. When Premises A was searched as part of Chalice, it was found to have "*a number of extremely stained mattresses on the floor… from semen, and multiple men*". It is, sadly, assumed that these are the same mattresses as mentioned in the intelligence reports referenced above, in 1997 and 1999. The reviewing officer was not asked to consider whether there was any evidence that this information had been acted upon; merely whether it provided further evidence which would help advance Chalice. They concluded that:

"*I believe the information contained within this review could lead to further evidence being obtained in relation to this investigation. There are persons mentioned within the report who gave information going back to 1999. Some of these persons, possibly unwilling to give information initially may now, ten years down the line, be willing to speak to the police in relation to Operation Chalice*".[358]

405. The Inquiry has ascertained that, in relation to those individuals mentioned within D2276, 24 victims were known to the police for their involvement in CSE or for having associations with those suspected of CSE between 1999 and 2003, and as a result 22 were visited as part of Chalice or later police operations.

354 [redacted] pg 2 onwards
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357 pgs 164-165
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406. I have dealt with the period up until 2003; what came next is notable, because there appears to be an identifiable gap in information between 2003 and 2006: the Inquiry has been provided with very limited evidence from this period demonstrating what action, if any, was being taken following the raft of earlier intelligence and known cases of 'child prostitution', as well as the murder of Lucy Lowe, her mother, sister and unborn child in August 2000 and the death of Becky Watson in a road traffic collision in March 2002.

407. **Given that the national understanding of CSE was growing at this stage, and that WMP published its CPFP 2004 with reference to 'child prostitution' during this period, the dearth of evidence relating to proactive policing of the issue, and CSE investigations during this period, is remarkable and inevitably tends to suggest that CSE was not afforded sufficient priority by WMP.**

408. **Overall, as to this early period, the evidence shows two things: first, that there was an obvious problem of CSE in Wellington at the time, commonly known among police officers, police civilian employees, and the public; and secondly, that the intelligence system was working as intended, at least to the extent of harvesting these reports.**

409. It also shows, in the absence of any indication that these intelligence reports had been acted upon, that **at least between February 1997 and July 1999, no steps were taken to assess, investigate or disrupt what I consider to have been obvious patterns of organised and serious sexual offending against children.**

410. **The inevitable conclusion from those two findings is that decisions were made that these matters should not be investigated.** I have not seen any material that points to a positive decision to that effect; indeed the evidence I have seen as to structure and lines of reporting tends to suggest that it was unlikely to have been a single officer choosing to bury the problem; more likely that this culture simply developed as a path of least resistance.

411. **I have heard a great deal of evidence (as set out later in this Report) that children involved in 'prostitution' were widely regarded as making unwise life choices, rather than being seen as victims of exploitation. I have also heard a great deal of evidence that there was a nervousness about race in Telford and Wellington in particular, bordering on a reluctance to investigate crimes committed by what was described as the 'Asian' community. I accept the evidence I have heard on those points and consider it likely that each of those considerations featured in this most abject failure.**

412. In respect of the early 2000s it is important to bear in mind two things:

412.1 First, that CSE could not have been forgotten about at the turn of the century. The October 1999 Report was not incinerated or held in a secure vault, but appears to have been held by the Detective Sergeant in the FPU for over a decade when, as a Detective Inspector, he passed it on to the Chalice team; other evidence I have seen shows that reports of exploitation of children were being made to the police in the intervening time; and I have spoken to officers who remained in post in Wellington for years from the late 1990s; and

412.2 Second, I regard it as highly unlikely that a single Detective Inspector could or would have made the decision to veto an investigation of this sort, particularly when, as the November 1999 Intelligence shows, the problem was ongoing.

413. **I am accordingly driven to the firm conclusion that the culture of not investigating what was regarded as 'child prostitution' was still very much in force in the years up to the inception of what became Chalice in around 2007.**

414. It is, of course, impossible to know whether, if the intelligence reports had been followed up, if the children had been approached sensitively and spoken to without judgment at the time, and there would have been successful prosecutions in the late 1990s. It is also impossible to know whether, absent complaints and prosecution, active disruption tactics might have dissuaded the perpetrators; and might have made clear that WMP would not turn a blind eye to such exploitation.

415. **The reality is though that WMP did turn a blind eye, and chose not to see what was obvious. I am certain that the absence of police action emboldens offenders; and I am certain that perpetrators of CSE were bold and open in their offending during the late 1990s and early 2000s. It is impossible not to wonder how different the lives of those early 2000s victims of CSE – and indeed many others unknown to this Inquiry - may have been, had WMP done its most basic job and acted upon these reports of crime. It is also impossible, in my view, not to conclude that there was a real chance that unnecessary suffering and even deaths of children may have been avoided.**

Operation Chalice

416. Chalice was WMP's first major investigation into CSE in Telford. It commenced in early 2008, and concluded with trials of multiple offenders in 2012.

417. Although the Inquiry heard from a police officer that "*CSE came onto FPU radar in 2005, though there were police officers at Telford who were aware that there had been a problem for what seemed to me like a million years",*[359] the trigger which prompted the beginning of Chalice was an episode involving two children going missing in late 2007. Following such reports, a senior officer familiar with the cases approached a Sergeant in reactive CID, telling him: "*I think we've got a problem with child sexual exploitation*".[360] A small team under the Sergeant was formed to investigate these concerns.

418. An intelligence gathering operation was then set up using the newly-formed team. It was named Chalice.

419. At about the same time, a report (the "YVPSE report") was commissioned by a Detective Chief Inspector to "*look at the problem of sexual exploitation of young and vulnerable people*

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in the Telford area, particularly instances that relate to young females who frequently are reported as missing…".[361]

420. The YVPSE report's author was given access to Safeguarding paperwork:

"Immediately, there was a clear pattern. The same names were coming up every time. You looked at the age of the girls, you looked at what was happening to them, the various notes that had been made by social services and there was a clear pattern".[362]

421. The YVPSE Report considered that an "*alternative and co-ordinated approach*" needed to be adopted in order to tackle the issue. It was acknowledged that the problem of CSE "*had been identified… but little* [had] *been done to press the matter forward*".[363]

422. The approach recommended in the YVPSE Report essentially mirrored that being developed by the Chalice team – i.e. that Specially Trained Officers ("STOs") should team up with CATE practitioners to build relationships with the vulnerable children in an effort to instil trust and encourage disclosures. The YVPSE Report acknowledged that the progress of any investigation into CSE would be reliant upon ensuring that victims/survivors had a safe space in which to speak, and upon officers being able to develop a rapport with the child so that they felt comfortable and confident to open up.

423. The YVPSE Report concluded on a cautionary note:

"Public confidence in both the police and social services could be eroded due to the perception that apparently no action into these incidents is being taken. The general perception is that the authorities are not interested in the problem and are not taking it seriously enough and are failing to protect the vulnerable. This could result in these negative perceptions being publicised to a greater audience should an incident occur that merits wider media attention…".[364]

424. It is a matter of regret that, as I will show, WMP did not immediately and decisively respond to the YVPSE Report with appropriate resources.

425. For the duration of 2008 and into 2009, the small Chalice team worked to co-ordinate the gathering of intelligence, much of which initially focused on the two children who had gone missing in late 2007. Three members of the SOIT were engaged in the gathering of CSE intelligence and interacted with the recently-created CATE team; this was the first time the multi-agency engagement had stepped outside the usual FPU/Social Services gateway.

426. Each child was allocated a SOIT officer as their STO, and a CATE practitioner, who would visit the children and try to get them to open up about what was happening to them. There was no formal way of working between CATE and the STOs at this point; officers were trying to come up with any strategies that would encourage disclosures from the children.

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427. As these two children began to trust their STOs, they made formal disclosures of offences that had not only been committed against them, but also against a number of other children. As a result, the police investigation grew, with one officer telling the Inquiry:

"…2008 to 2009 things started to mushroom and it became really obvious to me that this was going to grow into something quite substantial and was clearly something quite serious".[365]

428. In early 2008 a Detective Chief Inspector wrote to the Chief Superintendent in charge of Operations at the time requesting *"a team of officers to be dedicated to the investigation with access to a full range of investigative options".*[366] This was the first suggestion that Chalice might move to a full investigation rather than simply remain an intelligence gathering operation.

429. It was clear that, during 2008, the increasing volume of material was changing the nature of the Chalice enquiry; the "*snowballing effect"* of disclosures enabled the police to establish *"an evidential base for the problem: specific information about who the offenders were".*[367]

430. As at 1 July 2008, however, officers had still not been assigned exclusively to the Chalice enquiry,[368] causing frustration among the team.[369]

431. An experienced Detective Chief Inspector was appointed to Telford CID in May 2009. The Inquiry heard that the Detective Chief Inspector was very quickly approached by two officers with a box labelled 'Operation Chalice'. Within the box was information relating to the rape of a 15 year old child, not formally investigated for 15 months: *"the police had not approached the girl or her family, nor had it been 'crimed'".* The new Detective Chief Inspector became engaged with Chalice and ultimately took on the role of its first Senior Investigating Officer ("First SIO").

432. Within a matter of weeks, and by June 2009, a decision was made at senior level to direct the operation towards the goal of prosecution, rather than simply intelligence gathering. However, there was still no full-time team because "*ward resources* [were] *stretched*" – the investigation was to use other officers abstracted from SOIT.[370]

433. At this stage, a total of 21 individuals were suspected of sexual offending against 34 "*young females*". There was an early decision that the investigation should be tightly focused on two main suspects who had initially been identified as central to the CSE activity, it being thought that this presented the best chance of providing WMP with evidence on which to mount a prosecution.[371]

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434. At the same time, however, it was noted that a focused investigation on a smaller number of victims was not only desirable for the sake of the investigation itself, but also for the victims:

"*The victims' wellbeing is also paramount. If mission creep comes into the investigation then the risk to victims already identified will intensify… We have to balance the victims' wellbeing and the need for evidential integrity. This means we concentrate on our nominals and arrest at the earliest opportunity where there is a strong prosecution case following advice from the CPS".*[372]

435. In September 2009, the First SIO was replaced by a more senior officer (the "Second SIO"), the justification being:

"*…the operation now requires significant resourcing from Force resources… The operation is also viewed as a major risk and will therefore be resourced accordingly and actioned expeditiously*".[373]

436. Evidence suggested it was felt that "*CID at Headquarters… were pressing for arrests*".[374] Notwithstanding this, neither the Second SIO – who was based in WMP Headquarters at Hindlip - nor the SOIT team had yet been assigned to Chalice full-time.

437. By this stage, the number of individuals under investigation in Chalice had grown, with 40 open investigations within the CATE team, and with 13 of these requiring intensive support. It was also acknowledged that a number of isolated investigations had taken place in respect of single victims/survivors but that none had yet made it to court, as there had been "*a difficulty in getting a proactive response as reactive and isolated enquires are not succeeding through want of corroboration*".[375]

438. On 16 October 2009 there was a meeting comprising WMP representatives (the Deputy SIO and the OIC), Safeguarding (an Assistant Director and senior safeguarding officers), and others. The meeting notes record that:

"*There was full agreement that this should now be owned at the highest level and that only a partnership approach will address the issue. There is need for an overarching strategy which has the work integral to all the work we do with young people*".[376]

439. In preparation for a "*strike*" (arrest) week in December, the Second SIO ordered liaison with the UK Human Trafficking Centre ("UKHTC") to obtain "*Palermo*" (trafficked) status for the victims, and with the Crown Prosecution Service ("CPS") to ensure the early allocation of a reviewing lawyer. The CPS was told that, by this point, the CATE team now had 46 children on file for CSE activity, 24 of whom had been linked to the suspects under investigation in

372 [redacted]
373 [redacted] pg 39
374 [redacted] pg 11
375 as above [redacted]
376 [redacted]

Chalice. Those 24 children had been split into four groups, according to high to low risk/ priority.

440. The focus of the operation remained the two suspects previously identified, because "*whilst other Asian males are identified as being involved in child exploitation in Telford, the* [2] *are consistently identified as co-ordinating the sexual exploitation by a number of victims*." [377]

441. By early December 2009, however, investigations had revealed intelligence that led to the identification of three further suspects who had been associating with the two main suspects – leading to the decision to prepare profiles on those suspects, and include new suspects in the arrests.

442. Five arrests took place on 8 December 2009 although there were at that stage no supporting victim/survivor complaints:

"The Operation Chalice team was aware that there would be a custody review within six hours of the arrests. The plan was to arrest six or seven of the main suspects and to identify a group of the victims. The victims selected were those which research showed would be able to corroborate each other's reports; nine victims were identified as part of this group. The strategy was to arrest the suspects for drug offences and as soon as possible afterwards, for STOs to visit the nine victims. This was 'a roll of the dice'". [378]

443. The strategy worked. All nine victims agreed to attend the police station, when informed that the perpetrators had been taken into custody. Following initial reticence, one of the victims/survivors "*began talking about the suspects committing sexual offences against a friend, who was in another interview room, and once one victim started talking, the interviewers were able to use this in other interviews".* As a result, and before the custody review (which may otherwise have resulted in the suspects' release) *"all of the victims were talking to WMP and making allegations of various sexual offences against themselves or others".* [379]

444. On 10 December 2009 charges of conspiracy to traffic and to engage in sexual behaviour with a child (section 58 and section 10, 2003 Act) were brought variously against the five men arrested. The Second SIO also took the decision to serve section 2 Child Abduction Act harbouring notices on all five suspects "*where association with any of the 9 victims can be evidenced*". [380]

445. Discussions then began around expanding the scope of the investigation, proposing 'Phase 2' investigations[381] in relation to ten potential CSE victims. This led to a further strike day, planned for 9 March 2010.

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446. A CATE risk evaluation dated 20 January 2010 listed 35 children in four tiers representing differing levels of risk; 19 of the children were working with CATE. However the following day, a Phase 2 list identified six target children and 37 nominals, or potential suspects. [382]

447. On 9 March 2010 a total of nine suspects[383] and 11 potential victims of CSE were identified for the Phase 2 arrests, and by 25 March 2010 the investigation was already working to identify Phase 3 suspects.[384]

448. On 1 April 2010 the CPS approved charges for six Phase 2 arrestees,[385] but was soon to offer cautionary advice about the manageability of trials in the light of the size of the investigation:

"… we are firmly of the view that Chalice 3 — unless there are grounds to suspect that people against whom there is very strong evidence are about to do a runner — should be put on ice for the time being. Chalices 1 and 2 need bolstering and that will require a great deal of resources". [386]

449. On 15 April 2010 it was noted that the use of divisional SOIT officers alone was no longer sufficient for Chalice but that the abstraction of officers from other divisions should be carefully monitored so as not to affect those divisions' "*operational/investigative resilience*".[387]

450. Phase 3 arrests took place on 29 June 2010 despite the CPS warnings. The CPS advice in respect of the seven suspects then arrested was for "*long bail dates and standalone cases*", noting "*Making the trial any bigger in terms of the number of defendants before the court at one time is likely to be counter-productive".*[388]

451. Chalice's scope had transformed: no longer a limited investigation focused on two suspects, but now a wide ranging investigation into non-recent CSE.

452. As at summer 2010, the Chalice team was 60 strong including staff from Telford Division, Major Investigation Unit STOs and the Serious and Organised Crime Unit ("SOCU"). Potential victims numbered 72. The Second SIO indicated that Phase 3 required a separate investigative team. The growth of the investigation was plainly causing some disquiet.

453. In September 2010 the Second SIO was replaced. The Inquiry has heard that there was a perception that "*there was some fall out at Headquarters*" with regard to the growth of the investigation; that the Third SIO had been asked to take control of Chalice because it had become a "*massive entity*" and was regarded as "*unmanageable*".[389]

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389 pg 61

454. The Third SIO expressed the view that his priority was to ensure that WMP was ready for the first trials, and that it was his intention to focus the investigation on existing complaints. It was noted within the policy books I have seen that:

"At this time around 70 young females have been identified as victims, some have not, however all are being managed via a multi-agency approach. There have also been around the same number of potential offenders identified to some degree, [including] *those now charged".*[390]

455. The Third SIO felt the focus should be "*to concentrate the investigation team on actions which relate to those currently charged and those enquiries which will support the prosecution case against these men"*; and expressed concern that there "*did not appear to be any formal direction for Division in recognition of the Chalice issue, or disruption of those involved*".[391]

The Chalice Trials

456. The figures in respect of the Chalice investigations are difficult to reconcile. The first Chalice indictment I have seen dated 28 May 2010 charged eight men with 30 counts including rape; sexual activity with a child; inciting, facilitating and controlling child prostitution; trafficking for sexual exploitation and related conspiracies. The earliest date of alleged offending was 1 January 2008.[392]

457. Two of the men initially indicted were severed from the original case due to ill health.[393] The first trial – now comprising seven defendants - began on 16 May 2011 (the "First Trial").[394] There were seven complainants. On 5 September 2011, the judge decided to discharge the jury. This was for evidential reasons; the trial had already run for 16 weeks. One of the complainants was cross-examined for over three weeks.[395]

458. The collapse of the First Trial also led to the Third SIO making the decision that all outstanding complaints now needed to be reviewed:

"Each complainant will be contacted to establish if they still wish to pursue their complaint. Should a complainant wish to pursue the case then each will be reviewed for evidence. A decision will then be made by me, as to whether we will continue or not with the enquiry. This will be based on the strength and quality of evidence and the potential of a successful prosecution".[396]

390 [redacted]
391 [redacted]
392 [redacted]
393 [redacted]
394 pg 2, [redacted] pg 1, [redacted]
395 [redacted] pg 7, [redacted]
396 [redacted]

459. The Inquiry was told that following this review of the complaints and consultation with victims, there was a total of 19 men who had been suspects but had not been arrested and who would now be listed as "NFA" – meaning no further action.

460. So far as measures to mitigate the risk presented by those suspects not proceeded against, later material suggests[397] that in respect of those men "*a process was set-up whereby local intelligence officers maintain a 'watch' on the activities of these individuals and to take action when required"* and that *"all nominals identified but not arrested in relation to Operation Chalice are actively managed by the Intelligence Department and the CSE team, by way of a 'marker'".*[398]

461. The shape of the trial was re-cast; defendants were tried separately or in smaller groups. The first single defendant trial to run to its conclusion was that of a Phase 3 arrestee; he was convicted of rape offences and sentenced in December 2011 to ten years' imprisonment.[399]

462. The first group – of two Phase 1 defendants – took place in the summer of 2012 and resulted in the conviction of both men for various offences including controlling child prostitution, rape, sexual activity with a child, and trafficking for sexual purposes. They were sentenced to 18 and 14 years' imprisonment respectively.

463. Thereafter, five Phase 1 and 2 defendants pleaded guilty; one Phase 2 defendant's case was dismissed and another acquitted. A total of eight men were therefore convicted between 2011 and 2012 as a result of Chalice.

464. Across the whole Chalice investigation, 128 potential victims/survivors were identified and "*all but 13*" were visited by officers; 45 victims/survivors gave a statement or video interview and 21 of those led to crimes being raised. Insofar as perpetrators were concerned, across all Chalice investigations, plus the 'spun-off' Alpha and Beta operations, a total of 94 suspects were identified, 27 of whom were never arrested.[400] There are conflicting figures regarding the total number of crimes recorded across the whole Chalice investigation; some documents suggest it was 114[401] and another suggests a total of 119 crimes[402] were recorded on behalf of those 21 victims. Regardless of the total, it is not clear how many of these were 'detected' crimes involving an identified suspect.

465. Thereafter, Chalice was closed down; one view expressed to the Inquiry was that, by the end of the second Chalice trials in 2012, Chalice had "*run its course*".[403] The investigative team focused on other investigations which had been spun-off from Chalice; the STOs were reduced "*massively*" and the wider team began to be disbanded. Crucially, in my view, the SOIT was not reinstated, following a report that suggested there was "*no role for it*".[404]

397 [redacted]
398 [redacted] pg 13
399 [redacted] pg 7
400 [redacted]
401 See [redacted] and [redacted]
402 [redacted] calculated from pages 6 to 10
403 [redacted]
404 [redacted] pgs 34, 35

Conclusions - Chalice

466. The roots of the Chalice investigation had come from a concerned officer who, upon promotion, found himself in a position to assemble a team. **Plainly the structures of CID in Telford at the time were unhelpful, particularly the limits on FPU involvement with non-familial cases. This meant that the expertise of FPU officers, and their interest in cases involving sexual abuse of children, was not being used to the benefit of victims of CSE,** and at the same time reactive CID, to which CSE would be assigned, had no specialism in cases involving children.

467. To some extent the formation of the SOIT addressed this gap in provision, and it was members of that team who took part in the intelligence gathering operation that was to become Chalice. The operation began with closely defined parameters, working with two specific children, to engage and build trust. The tactics used here – particularly the use of STOs and the recording of information received so that response officers dealing with the children in future had access to a complete picture – were thoughtful and sensible. Progress was, however, slow, and without any great enthusiasm demonstrated at senior levels within WMP.

468. When it became an investigation, as opposed to an intelligence gathering exercise, Chalice had been narrowly focused on two specific offenders. But the operation grew inexorably in scope, initially by the identification of other men who had associated with the main suspects, which led to consideration of further victims. Under the Second SIO it became a general investigation into historic CSE; this investigation was doing the work of a sexual offences team, and indeed had subsumed the relatively new SOIT. While the Third SIO was brought in, I believe, to narrow the focus of the investigation and to concentrate on the trials, he remained concerned that there was no direction in respect of the "*Chalice issue*".[405]

469. **It seems to me clear that WMP was seeing CSE entirely through the prism of Chalice and gave no thought to how this "*Chalice issue*" – that is, the investigation into non-recent CSE, including the 13 victims not visited as well as ongoing and new reports of CSE – was to be addressed after the prosecutions had run their course.** I am fortified in that by the fact that there was no formal debriefing after the convictions; such an exercise would surely have revealed the obvious gap in provision for investigation of non-familial child sex offences that had existed at least since the late 1990s, and which was not to be filled for some years to come.

470. **Mystifyingly in this regard, the SOIT which as I have shown was subsumed within Chalice, and which I consider would have been the obvious candidate for meeting this gap, was not revived after the operation ended and its officers were returned to reactive CID. It seems to me that this decision was a missed opportunity to capitalise on the knowledge, experience and methods those SOIT officers derived from Chalice, and use this to continue to address CSE offences in Telford.** While the trials had completed the initial goals of Operation Chalice, they did not complete the broader investigations that had begun as the scope had widened to historic CSE.

[405] [redacted] pg 5

CSE Investigations Post-Chalice

471. In the course of the Inquiry I have reviewed a great number of CSE investigations post-Chalice. Two non-recent cases, Operations Alpha and Beta, had been spun off from Chalice and for a time ran in parallel, with officers shared between the operations.

472. Alpha arose when a victim/survivor of CSE was identified during the Chalice investigation in October 2010.[406] The individual concerned was in her 20s when she was interviewed, but in accordance with Chalice policy at the time, no further investigative work was undertaken until February 2011 when a seven-officer team was attached to the operation.

473. In Alpha, while investigators were not restricted about following leads quite so narrowly as they had been in Chalice, policy decisions were nevertheless designed to reduce the scope of the investigation. For example, potential witnesses were not to be asked if they had any sexual 'relationship' with a suspect, and the victim was not to be asked about offences committed against them by men other than those they had already named. That last decision was reversed when the complainant decided not to pursue a prosecution, and the police indicated that they intended to *"try and identify all those men who have offended against* [the victim] *before this case is closed".*[407]

474. It considered the actions in the event of identification as follows:

> *"If these men are identified, if they feature in Operation Beta and are to be arrested as part of that enquiry then no further action is required. If they do not feature elsewhere and we are satisfied with their identity then enquiries will be made via West Mercia Intelligence and information sharing protocols with other agencies, to establish if these men pose risk to others. If it is established that they are either continuing with these activities or they pose a real risk to others then positive action will be taken to deal with the risk they pose."*[408]

475. The complainant in Beta gave an account which disclosed close to 100 possible non-recent offences committed by over 100 potential suspects.[409] A review of the suspects and offences resulted in reducing the number to 41 suspects covering 52 offences.[410] A further winnowing strategy led to WMP proposing the 'best 10' for pre-charge advice from the CPS. Those offences had been selected by "*discounting those where there was no real corroboration or where* [the victim] *does not provide enough detail*" and identifying "*the most serious offences, ones committed by individuals who may pose a continuing risk, or where there was some corroboration available*".[411]

476. The CPS pre-charge advice noted a difficulty with this winnowing approach:

> *"There are a large number of offences not proceeded with and if no investigation has taken place with respect to those at all, reasons as to why not will need to be provided… If we do*

406 [redacted] pg 3
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not believe her account sufficiently to prosecute in respect of those, why do we believe her more in respect of the matters which we do pursue? This looks as though we do not accept her word on some matters and could be used to attack the credibility of the prosecution at any trial…".[412]

477. The case progressed further than Alpha. Over its duration, Beta had investigated 35 offences; close to 30 men were identified as suspects;[413] and more than ten men were arrested.[414] Ultimately, however, the CPS decision on Beta was that there was no realistic prospect of conviction upon evidential grounds; I have reviewed that decision and consider it to be unobjectionable.

478. This case illustrates again the difficulties that had been faced in Chalice – when a team is focused on a prosecution, it must consider manageability, timeliness, and narrow resources, and when the case is, for whatever reason, over, the team has no continuing role in addressing any issues which may have arisen. On the other hand, a team focused on addressing CSE as a whole can look at a wider picture, look more generally at trends, at long-term investigative and disruptive tactics, and at public protection. Chalice had started as the first model, become the second, and reverted to the first; those running Alpha and Beta plainly worked very hard to remain within the first model, but in doing so, inevitably leads were not followed that a second-model team would have pursued.

479. A further difficulty presented by the lack of a dedicated team to investigate CSE is illustrated by Operation Delta, which spanned the introduction of the CSE team in Telford. This operation commenced in 2016 and was focused around a child who was contacted by her exploiters via social media.[415] The child persistently went missing from home and was assessed following a RHI by a police officer as being at high risk of CSE.[416] She had made disclosures of being trafficked on a number of occasions to a nearby city and of being raped by multiple men.

480. Delta was initially staffed by reactive CID, and it was certainly restricted in resources; for example, there was no SIO appointed despite an obvious need for high level policy decisions to be taken.[417] During the course of the investigation there was pressure at Detective Inspector level for the case to be handed to a neighbouring Force; at one stage a senior officer "*told all the staff to pack up their stuff and get back to their day jobs… making people cry.. because* [he] *wanted the staff back into the Reactive office*".[418]

481. Despite this, impassioned junior officers continued to work on Delta without the knowledge of that senior officer "*until he found out about it and confronted some of the DCs… That… ran for a little while until the CSE team* [was] *formulated and there was a change of management*".[419] **Once again, as has been shown by the history of the CATE team**

412 [redacted]
413 [redacted] pg 27
414 [redacted] pg 13
415 [redacted]
416 [redacted]
417 [redacted]
418 [redacted] pg 13
419 [redacted]

and by the Chalice investigation, the CSE response in Telford was driven by a number of 'ground-level' staff rather than being mandated by senior officers; although, to be fair to WMP's management, Delta was relied upon as an example in the successful business case for a standalone CSE team in WMP. The Delta investigation eventually led to a conviction for human trafficking and rape offences in 2019.[420]

482. There cannot, in my view, have been any genuinely held belief that the system prior to the inception of the CSE team was working as it should; it seems plain that the officers investigating Delta did not think so, choosing to go against orders and to continue an investigation they believed in; and as I set out in detail in the body of Chapter 5, by this point WMP had been subject to a series of critical reviews and reports.

483. **It seems to me remarkable that WMP, having been through Chalice, needed to be told that a dedicated CSE team was the correct way to deal with the issue. It underlines what I regard as the absolute folly of the SOIT team not surviving Chalice.**

484. When Chalice was closed down, a decision was taken at senior officer level that it was not to be subject to the major crime review process.[421] I regard that as an indication that the closure was intended to be final. In 2018, however, following Freedom of Information requests by individuals named as targets of CSE in the Chalice investigations, WMP did commission a review to be carried out by the Major Crime Review Team (the "MCRT Review").

MCRT Review

485. The MCRT Review notes that Chalice led to the identification of 128 potential victims; 114 crimes were recorded, 13 men charged and ten convicted.[422] As I have referred to above, the figures are difficult to reconcile; these figures in the MCRT Review are different to other reports about Chalice I have seen.[423] I assume that the MCRT has reached these figures by including all men charged and convicted across Chalice and its linked investigations, but it is not clear.

486. The principal focus of the MCRT Review was not to review the Chalice investigation as a whole but to consider those suspects and victims/survivors with whom WMP had not engaged during the original investigations. It notes that of the 128 potential victims in wider Chalice, including Alpha and Beta, accounts were taken from 23 victims; 24 individuals gave witness statements which did not contain disclosures about their own experiences "*or require crime reports to be recorded*"; 68 people were seen but either declined to provide disclosure or indicated they had nothing to give; and 13 people had not been seen by the police at all. Of the 24 where crime reports did not need to be recorded, I take this to mean that insufficient information was given by the individual to amount to a description of a criminal offence.[424]

420 [redacted]
421 [redacted]
422 [redacted] pg 6
423 For example, [redacted] pgs 8, 9
424 [redacted] pg 18

487. The MCRT Review looked at the outstanding 13 people and noted that seven people had been excluded by the Third SIO's policy decisions. The remaining six could not be traced. Of those six, the MCRT Review identified that there was information that may assist the tracing of all but two; of those two, one was an individual who had given an account of consensual sex in 1999. In respect of the seven individuals about whom there was a policy decision not to engage, WMP held information on all but one of them.

488. The MCRT Review recommended that there should be renewed effort to speak to the six victims not yet traced, and so far as the seven not contacted were concerned, there should be a reassessment to decide whether each should be seen, noting: "*A decision should be made as to whether it is necessary, reasonable and proportionate to engage with any of them recognising a potential breach of article 8 right to family and private life*".[425]

Operation Epsilon

489. Operation Epsilon followed the MCRT Review and arose from the declaration by WMP of a critical incident following the March 2018 Sunday Mirror reporting of non-recent exploitation in Telford. Its aim was to identify potential victims from Chalice, and to:

> "*…engage with them in a sensitive and informed manner; provide and sign post them to support services; inform them of the options available to them; and capture information and evidence that they may have.*"[426]

490. By July 2018, Epsilon had identified 113 potential victims/survivors; eight were identified by first names only; six were dead. 76 of the potential victims had been seen by officers, and of those, two individuals disclosed offences and were willing to provide complaints; 22 others disclosed offences but were unwilling to complain; ten had disclosed offences and accepted referral to ISVAs (Independent Sexual Violence Advisers).[427]

491. Epsilon had traced those whom Chalice had been unable to locate (which included some victims referred to in D2276, see discussion above). Epsilon also spoke to the seven individuals who had not been visited as a result of the policy not to pursue cases where there was no indication of contemporary offending taking place. As a result of those enquiries, three disclosed offences were recorded; three denied any involvement in or knowledge of CSE; and one made a complaint involving a number of suspects of whom five were tried.[428]

492. As part of Epsilon, 48 potential suspects had been named. Intelligence profiles were created on the suspects "*to identify any current safeguarding risks*"[429] and a divisional Field Intelligence Officer ("FIO") was assigned to each suspect. The FIOs would run checks through police national databases and the local systems GENIE and Athena and prepare short reports on each. The same task would be undertaken in respect of Chalice, Alpha and Beta

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428 and [redacted]
429 pg 13

nominals.[430] This was noted to be "*in addition to the current work and monitoring that is conducted as part of the CSE team's daily business*".[431]

493. The Epsilon investigation resulted in the convictions of four men for offences under the Sexual Offences Act 1956, including rape. This was plainly a positive result; it would have been a more positive result had Chalice been allowed to run its course a decade prior.

Inspections and Reviews

494. As part of the Inquiry's work a number of inspections and reviews of WMP have been considered. They are clearly important, providing a contemporaneous and impartial measure of performance over the years. In this Executive Summary I shall set out only key findings arising from those inspections and reviews.

495. One of the earliest inspections of WMP reviewed by the Inquiry was carried out by HMIC in 1993.[432] Whilst it did not explicitly mention CSE or CSA, it noted *"an impressive advanced course in child abuse investigation to cater for the training needs of Child Protection Units"*.[433]

496. A key assessment took place some years later, in 2006. The HMIC Baseline Assessment[434] stated:

"*West Mercia's response to public protection (sex offender management) generated concern, along with the absence of reliable information on the caseload of child protection and domestic violence officers… commanders would be assisted in their determination of resource levels by clearer guidance and more robust monitoring by the force on acceptable workload levels in this high-risk area*".

497. There was general concern about staffing levels in public protection:

"There is no rationale for staffing levels that takes proper account of workload and resilience. Figures provided by the force show that officers are managing high levels of registered sex offenders (RSOs) and potentially dangerous offenders (PDOs) per officer per year…The force needs to review urgently the role and responsibilities of such post holders to determine a manageable caseload, and construct methods of monitoring these workloads".[435]

498. The Baseline Assessment further noted that FPU officers were being abstracted for other duties such as burglary initiatives, or leaving vacancies unfilled, and that "*given the high risk nature of* [the FPU] *roles, the force should revise these approaches as a matter of urgency…*".[436]

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430 [redacted], pg 13
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433 pg 21
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435 pg 51
436 pg 50

499. WMP was rated as 'poor' overall in the Baseline Assessment, which means "*an unacceptable level of service. To attract this very critical grade, a force must have fallen well short of a significant number of criteria set out*".[437]

500. The Inquiry has heard that as a result, a strategic project around public protection was developed and the Detective Superintendent in the PPU was *"given increased resource to assist in this endeavour, which funded an additional 50 officers within the PPU, at a time of competing demand".*[438]

501. By 2008, a further HMIC Inspection into Major Crime acknowledged that *"significant progress"* had been made by WMP in its ability to protect vulnerable people, resulting in individual grades of 'Good' for *"child abuse, domestic violence and missing persons, together with a Fair grading for public protection in 2007".*[439]

502. Nevertheless, the 2008 Inspection noted that "*No innovative intelligence-sharing arrangements are in place with partners, such as anonymous third party reporting by health professionals of rapes or serious assaults*"; and that "*While established relationships with other agencies exist at divisional level, major crime intelligence is not effectively shared outside statutory arrangements"*.[440]

503. In 2014, WMP carried out a self-assessment of 33 cases against the HMIC criteria for National Child Protection Inspections. WMP assessed 10 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'.[441] HMIC also carried out an audit of five cases where children were categorised as at risk of CSE, rating four as 'Inadequate', commenting that "*poor investigations were particularly noticeable in cases of child sexual exploitation*".

504. In particular, it found that:

"*A force-wide problem profile (September 2014) identified 280 children at risk of child sexual exploitation, but only 32 of these had been identified, 'flagged' on police information systems, and even fewer had risk management plans".*[442]

505. The Inspection recommended that WMP *"immediately reviews cases where children have been identified as being at risk and, with partner agencies, takes appropriate action to safeguard the children".* It also recommended *"improvements in referral allocation, investigation planning and supervision*".[443]

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437 [redacted] pg 6
438 pg 9
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440 pg 17
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442 https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/west-mercia-national-child-protection-inspection.pdf pg 13 and [redacted] pg 6
443 [redacted] pg 6

506. The fact that HMIC identified that WMP CSE investigations were particularly poor suggests, in my judgment, that either lessons had not been learnt from investigations like Chalice or WMP simply lacked the organisational motivation to make provision for the effective investigation of CSE.

507. HMIC made a number of recommendations which appear to have been a major impetus to the formation of the WMP CSE team.

508. The following year, the 2015 PEEL Effectiveness Report[444]was carried out against the criterion "*How effective is the force at protecting from harm those who are vulnerable, and supporting victims?*", and graded WMP as "*requiring improvement*", and "*not always fully addressing the needs of some of the most vulnerable victims*". So far as CSE was specifically concerned, the Report found that "*...the force has made an encouraging start in ensuring it is adequately prepared to tackle child sexual exploitation".*

509. In 2016 there was an internal review: '*Protecting Vulnerable People: Review of Child Sexual Exploitation (CSE) in the Alliance*'. It identified *"lack of clarity or process around performance/demand"* in the Alliance CSE response. In particular, there was concern over data recording, preventative work, intelligence collection and the absence of a clear performance framework. A particular absence was the lack of analytical support for the Telford CSE team.[445]

510. A further PEEL Effectiveness Report in 2016[446] showed improvement. It noted "*There is excellent proactive work by the CSE team*".

511. Notwithstanding the existence of the new CSE Team, the 2018 "4Ps Review",[447] found that some CATE-referred cases would be "*retained and investigated by reactive CID*" – staffing did not allow for the unit to retain ownership of all investigations. 10% of crimes with a CSE marker were not investigated by officers who had completed specialist sexual offences investigation training. This was because of "*abstractions due to limited resources there was no ability to release staff for additional training…*".

512. **These inspections, reviews and reports do not, in my view, show a police force which had responded appropriately quickly to CSE. I regard it as simply astounding that ten years after officers in FPU began to respond to CSE in a way that would generate Chalice, that the author of the 2016 report should have to bemoan the lack of intelligence collection and comment that the organisation was at risk of not fully understanding demand in this area. While a specialist CSE team now existed, it is clear from that 2016 report that the team did not have the tools at its disposal; in particular, analytical support and proper use of CSE markers, to address the problem of CSE effectively in Telford.**

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Complaints and corruption

Complaints

513. I have carefully considered the disclosed material for evidence of misconduct, performance issues or indications of corruption within the police, which may have negatively affected the policing of CSE in Telford.

514. At my request, WMP conducted a search of its complaints system, which had been in place since 2004, against relevant terms. The search returned 24 results in total, and showed a range of failings in professional standards, including failing to progress investigations efficiently, use of inappropriate language, and in disciplinary outcomes. Most complaints were dealt with by sanctions short of dismissal. Dismissal was reserved for individuals thought to have been involved in criminal offences.

515. I would simply note this: it is obvious that not all valid complaints relating to a CSE case should result in dismissal. Failures of language and attitude will happen when humans interact, and I consider it will often be appropriate to take a non-punitive course that allows officers and staff to learn and complainants to be reassured that their experience will not be repeated. I have noted that WMP delayed in replying to some CSE related complaints and that record-keeping could have been improved.

Corruption

516. There is no authoritative single legal definition of the word 'corruption', though there is a specific criminal offence;[448] however, I have to recognise that corruption is an everyday word, and that certain behaviours may be regarded by members of the public as corrupt while not satisfying the actual offence. Focus group research on public perceptions of corruption suggests that it amounts at its most basic to "*doing something wrong*".[449]

517. I have read evidence from individuals who told the Inquiry that they believed WMP failed to take the proper action in some investigations, in order to avoid being labelled racist,[450] or because the involvement of Asian males in CSE meant that to investigate would potentially attract negative headlines;[451] in essence, such concerns related to police inaction driven by a fear of dealing with difficult issues. I have also read evidence of allegations of preferential treatment of certain individuals.

518. **As to failure to take proper action, I am quite satisfied on the evidence that in the 1990s and early 2000s - and even beyond - WMP allowed a nervousness about race to become prevalent among officers, and that this led to a reluctance to police parts of Wellington, in particular.** I discuss this in more detail in Chapter 9: Attitudes and Impact; however I regard this as the development of bad culture and practice, rather than being corruption.

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[448] Criminal Justice and Courts Service Act 2015 section 26(1)
[449] https://webarchive.nationalarchives.gov.uk/ukgwa/20170914191254mp_/http://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/public_views_of_police_corruption_May_2012.pdf
[450] [redacted]
[451] [redacted] pg 23

519. As to preferential treatment, I have received and accept repeated accounts that certain members of the Pakistani community were allowed to park in Wellington car park as a 'privilege'. **I have, however, seen no indication and heard no evidence to suggest that there was a consequential compromise of integrity, or that individuals were allowed any favours beyond parking.** It seems to me that, if anything, this episode shows that any indulgence, even something as innocuous as allowing use of a parking space and however well-intentioned its motive, needs to be very carefully explained to avoid misunderstanding among the wider community. Any perception that the police are offering favours is corrosive to public trust.

520. I have also seen evidence from a witness who suggested that in approximately 2004, they were told that certain members of the Pakistani community had been stopped in cars containing children, but these members would be *"straight on the phone to* [unnamed] *senior police officers".*[452] The inference from this statement is that senior police officers would be contacted and criminal investigation of those in the car deliberately avoided. This is of course an extremely serious allegation of what, if true, would clearly amount to police corruption and gross misconduct. However, I have to note the description of these events was provided to me by a single source, and as hearsay (that is, not from an eye witness to the event or someone with direct or even detailed knowledge of these events). Further, I have not seen any other evidence or material in support of this allegation, and without such evidence, while I accept the witness was told these things, I do not feel able to accept this account is sufficient evidence to show whether these events happened.

521. In the same way, I have been provided with witness evidence to the effect that they believed the police were prepared to look the other way in relation to CSE, as they may have been "*doing deals*" with the perpetrators.[453] I consider such evidence to be an expression of belief by the witness, without any associated factual basis or supporting evidence which would strengthen the assertions made, and as a result it is not evidence I can rely upon to conclude that such an incident actually occurred.

522. Bribery is undoubtedly corruption. I have considered evidence concerning an allegation provided to the Inquiry by a member of the public who believes they witnessed a specific act of bribery of an officer engaged in a CSE investigation. This allegation was previously investigated by WMP following a mandatory referral to the Independent Office for Police Conduct ("IOPC") in 2019; I have reviewed that investigation very carefully, as plainly these allegations are of the highest seriousness. The investigation was, it seems to me, very thorough. The investigation concluded that there was no case of corruption for the accused officer to answer. There were good grounds – which I review in Chapter 5: The Policing of CSE in Telford - to find the complainant unreliable and the allegations to be contradicted by independent factual evidence. There was, though, room for criticism of the original handling of the complaint, which had not been acted upon in a timely way.

523. Delay has the potential to feed suspicion, resentment and public disquiet. It plainly did so in this case and in others I have seen. Any complaint or allegation of corruption should be dealt

452 [redacted]
453 [redacted] pgs 12, 39, 43, 51, 52

with fully and swiftly, with the complainant kept informed; this is particularly so where the background is a CSE case, where emotions are understandably heightened.

Conclusions – Complaints and Corruption

524. **In summary, I consider in general terms that WMP has produced evidence which suggests to me that it deals effectively with recording complaints relating to CSE matters. I have however seen specific instances in which there were delays in dealing with complaints.** It seems to me to be incumbent on WMP to deal with all complaints as swiftly as possible and to keep complainants apprised of progress; this is not only good practice, it is in WMP's interests. A person who complains is, by definition, aggrieved. Aggrieved people are generally not mollified by being ignored.

525. As regards corruption, the evidence shows that certain decisions made in Wellington – particularly the indulgence over parking – led people to suspect corruption (regardless of whether or not this met the legal definition of an offence). I have noted that however much a police force wants to accommodate the community it serves, the perception that favours are being done is corrosive to wider public trust. It is clear that, over the years, trust in WMP has been lacking because of public perceptions around potential corruption within the force, and I have reported above the sorts of accounts related to the Inquiry by witnesses. **Nevertheless, I have not seen any evidence that allows me to conclude that WMP was, in fact, corrupt (either as an institution, or on the part of individual officers) at any stage during my Terms of Reference – and indeed, the detailed corruption investigation that I have seen concluded rightly, in my view, that the allegations were unfounded.**

526. That is different, however, from the clear sense that has prevailed among some victims and survivors that CSE could not have happened without WMP being corrupt. The reality is that crime exists and can thrive without corruption; but it is also true that a failure to act, whilst falling short of 'corruption' as defined, is still a very significant failure, and only further erodes public trust in the police.

527. **To be clear: I have seen no evidence from which I can conclude that WMP was institutionally corrupt or that individual officers were corrupt; but I do accept that certain incidents – for example, failing to police certain areas and allowing parking in police stations – have led to a suspicion amongst the public of corrupt behaviour. On the evidence I have seen, however, I have seen no evidence to suggest that such incidences of preferential treatment or inaction continue today.**

Other organisations (Chapter 6)

528. I have considered the role of certain other agencies within the policing and prosecution of CSE, including national policing bodies; the PCC; and the CPS.

National Policing Bodies

529. Nationally, all police forces must have regard to the Strategic Policing Requirement ("SPR"), which sets out the Home Secretary's view on national threats and the appropriate policing

capabilities required to address them.[454] The SPR was updated in 2015 to include child sexual abuse as a stand-alone national threat.

530. There are a number of key national policing bodies that assist police forces in providing a nationally consistent approach to CSE. These include organisations such as the National Police Chiefs' Council ("NPCC"); the National Crime Agency ("NCA"); and the Child Exploitation and Online Protection centre ("CEOP").

531. In the late 1990s and early 2000s, the now-defunct Association of Chief Police Officers ("ACPO") published guidance relating to 'child prostitution'. This guidance was updated in 2011.[455] In 2012 the NPCC, replacing ACPO, developed an initial national CSE action plan addressing all aspects of policing CSE including training, prevention and intelligence gathering.[456] The plan was refined in 2014, in 2016,[457] and in 2017 was replaced by the National Vulnerability Action Plan ("NVAP"). The implementation of the NVAP is an example of the NPCC seeking to achieve a common approach between forces in respect of CSE.

532. The national child sexual abuse operation, Operation Hydrant ("Hydrant"), was established in 2014 following the Jimmy Savile revelations. Hydrant still exists and seeks to assist police forces with the growing number of complex investigations in this area. It does not conduct any active investigations itself; it disseminates information amongst all forces, and regional and national units, to prevent duplication. The Alliance[458] began to submit referrals to Hydrant in January 2016.

533. The NCA was established in 2013 to act as a national law enforcement agency creating a uniform approach to UK policing with specialisms in areas, including in 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. The NCA develops and coordinates a national intelligence picture. CEOP is a command of the NCA, focused on addressing the serious, organised and growing threat to children from offenders online, both nationally and internationally. It is staffed with police officers, social workers and other individuals who specialise in locating and gathering evidence against online offenders. In the first six months of 2020, WMP received 172 referrals from CEOP and other agencies.

Anti Human Trafficking Organisations

534. 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. The Inquiry has seen how this convention was used by WMP in Chalice, as 'Palermo' status letters were prepared and trafficked status

[454] The PCC and the Chief Constable must have regard to the SPR when developing the regional Police and Crime Plan
[455] 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
[456] By ACPO
[457] [redacted]
[458] 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.

sought to afford the victims more protection from other agencies within the criminal justice system.

535. The UK Human Trafficking Centre ("UKHTC" – now known as the Modern Slavery Human Trafficking Unit ("MSHTU")) was established in 2006 as the central point for the development of expertise and operational co-ordination concerning the trafficking of human beings. I have seen evidence that confirms an expert from UKHTC was consulted at the earliest stage of Chalice, due to the mounting evidence of young people being trafficked out of Telford for CSE, with a view to exploring trafficking offences.

536. The National Referral Mechanism ("NRM") was introduced by the UK Government in April 2009 to identify and support victims of trafficking in the UK. It is designed to make it easier for all agencies to co-operate, share information about potential victims and facilitate victim/survivor access to advice, accommodation and support. Since 1 November 2015, specified public authorities (including the police and local authorities), have had a duty to notify the Home Office about all potential victims of trafficking and slavery via NRM referral.

537. I have seen evidence of a NRM referral for a Chalice victim (by reference to Palermo letters) in November 2009, as well as two further referrals relating to other CSE victims in 2010 and 2016. In total, only six witnesses made a comment about the NRM. The victim/survivor evidence tended to suggest that they were told either that a NRM referral was pointless, or something they personally needed to take responsibility for. Evidence from professionals suggested to the Inquiry that the referral may be considered where required, but this had no impact upon the way cases of CSE were dealt with in practice. **Overall, I have some reservations as to whether the NRM process has been used to best effect, and I am concerned that there may not have been referrals in every qualifying case.**

The Office of the PCC ("OPCC")

538. 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. There have been two PCCs in West Mercia. 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.

539. The PCC has overall responsibility for the delivery of community safety and crime reduction. However, the PCC is not permitted to *"fetter the operational independence of the police force and the Chief Constable who leads it."*[459]

Budgeting, Funding & Decisions

540. In terms of budgeting and funding dedicated to CSE, the Inquiry heard that whilst the PCC sets the budget, it is for the Chief Constable to determine how best to use it. The PCC provided the Inquiry with a list of references to CSE in the final papers used to set the annual

[459] The Policing Protocol Order 2011, para 18

budgets.[460] These references included deployment of additional officers and staff, awareness raising in schools and reassurance of communities.

541. The PCC has also made grants I consider relevant to the Inquiry. These include grants for the Street Pastors and for taxi marshalling schemes, and funding for a Sexual Assault Referral Centre ("SARC") and ISVA services. There was also some CATE Team funding from 2018.

Scrutiny of WMP

542. There is evidence that 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. I have reviewed a summary of the meetings where CSE was raised; there were 11 such meetings. CSE was not a standing agenda item. The discussions include the PCC asking whether more resources should be invested into tackling CSE and the rise of reporting of non-recent allegations of CSE in 2014. I have not seen any evidence of HTA meetings considering CSE before 2014, which I regard as surprising.

543. 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".*[461]

Conclusions - PCC

544. **I 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. 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; it follows that I regard the decision to make the record of HTA meetings public in 2016 as positive.**

545. **I have seen evidence of the PCC funding useful CSE-related projects,** as I have set out above (and do so in greater detail in Chapter 6: Other organisations). I was surprised to note the absence of CATE Team funding prior to 2018, but have been 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.

546. **I do, though, consider that earlier consideration should have been given by the OPCC to what funding could and should have been directed at tackling the issue of CSE in Telford.**

460 [redacted] pg 20
461 [redacted]

The Crown Prosecution Service

547. The CPS was established in 1986 and is responsible for the prosecution of criminal cases in England and Wales. It also has responsibility for advising the police in certain types of criminal investigations and reviewing cases, to make the final decision on whether charges should be brought. Criminal cases relating to offences in Telford are dealt with by CPS West Midlands.

548. 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 2004[462] for all but minor cases, and prior to that decision making rested with the police who would simply take advice from the CPS when they deemed it necessary.

549. The CPS operates in accordance with the Code for Crown Prosecutors ("the Code"). There have been various versions of the Code. The section of the Code which sets out the threshold for charging is now 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 two stages of the FCT, namely:

    549.1 The prosecutor is satisfied that there is sufficient evidence to provide a realistic prospect of conviction; and

    549.2 The prosecutor is satisfied that a prosecution is required in the public interest.

550. The 2004 Code made formal provision for the first time for the CPS to have a role as advisors to the police in the investigative process by providing Early Investigative Advice ("EIA") during an investigation. The current guidance indicates that cases involving death, rape or other serious sexual offences should *always* be referred for EIA.[463]

551. The manner in which the CPS has dealt with rape cases has evolved significantly since 2002, when HMIC and Her Majesty's Crown Prosecution Service Inspectorate ("HMCPSI") recommended that rape cases should be prosecuted by specialists with a lead lawyer in each of the prosecution areas.

552. In 2007, the CPS implemented a standard for rape specialists including a requirement to undertake specialist national and local training, and in 2008, CPS West Midlands created a Public Protection Unit in which experienced lawyers dealt with a range of cases including rape and other serious sexual offences, including child sexual abuse/exploitation. This move was formalised across the CPS in 2012 and the specialist teams named Rape and Serious Sexual Offences ("RASSO") teams. The RASSO unit within the CPS West Midlands currently deals with all CSE cases.[464]

[462] The implementation of this responsibility stemmed from Lord Justice Auld's 2001 review and the subsequent Criminal Justice Act 2003.
[463] Charging (The Directors Guidance) – Sixth edition - December 2020
[464] [redacted] pg 13

553. The first guidance for the CPS which was exclusively focused on prosecuting cases of child abuse was published in 2009.[465] 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 until the Guidelines were reissued in 2013.[466]

554. The *'Victims Right to Review Scheme'* ("VRR"), which allows challenge to decisions not to charge, was launched in 2013. CSE cases fall within the remit of this scheme, but I have seen no suggestion that a VRR has been requested in any case the Inquiry has considered.[467] Additionally, the Child Sexual Abuse Review Panel is designed to review cases pre-dating the creation of (and entitlement to) VRR. Again, I have seen no suggestion of Panel involvement in any case the Inquiry has considered.

Examples of CPS Decisions in cases of CSE in Telford

555. During the Inquiry I have seen a **number of CPS advice notes and charging decisions**. I have extracted examples in Chapter 6: Other organisations. While I do not propose to summarise them here, **I should say that I do not consider the examples to show examples of poor practice or bad decision making. The charging decisions were not overly cautious; they did not judge likelihood of conviction by reference to what had happened in other cases, but by strict focus on the evidence; they show an understanding of the nature of exploitation and did not use victim-blaming language; they explored alternative offences where the conclusion had been reached that sexual offences could not be prosecuted; and they showed proper reflection of the effect of legal proceedings upon victims and survivors and appropriate weight given to victims' and survivors' views. I regard the advice given in Chalice, for example, with which I deal in the Chapter 5: The Policing of CSE in Telford, as entirely sensible, particularly with regard to keeping focus on the manageability of the first trial.**

Conclusions - CPS

556. 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. **Furthermore, the charging decisions that I have seen have been rational and objective.**

465 [redacted]
466
467

557. I have received witness evidence encouraging me to recommend that the police "*should prosecute all known perpetrators, regardless of a lack of evidence.*"[468] 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.**

Health Agencies (Chapter 7)

558. Sexually exploited children may access a broad range of healthcare in different settings.

Basic obligations

559. 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. NHS bodies are also statutory members of the Local Safeguarding Children's Boards under section 13 of the 2004 Act.

560. 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 delivering 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.

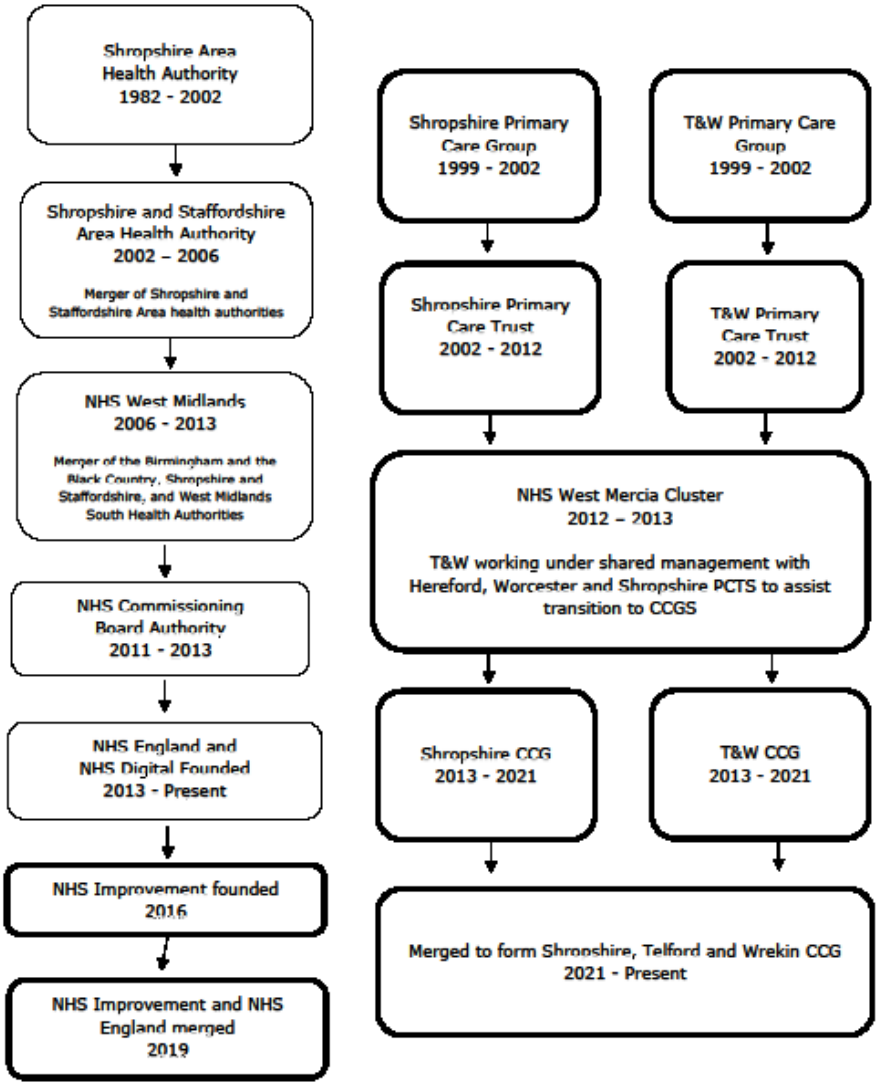
561. It also remains the responsibility of provider organisations to develop and maintain quality standards and quality assurance, to ensure appropriate systems and processes are in place within the organisation in order to ensure a safeguarding culture is embedded throughout.

562. 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. I deal with structural changes in more depth in Chapter 7: Health Agencies; the following serves as an illustration of the number of changes and their complexity:[469]

[468] [redacted]
[469] As approved by Telford & Wrekin CCG in June 2020

NHS Commissioning History

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



563. The evidence available for the earlier part of my Terms of Reference was limited by lack of availability of documentation, but also the availability of witnesses. The constant re-organisation of the NHS has meant that documents have not been retained, and that many people that were involved prior to 1 April 2013 are no longer around, and the corporate memory does not exist.

Chronological overview

564. In order to consider the role that health agencies have played in responding to CSE and safeguarding children in Telford, and key reviews that have taken place during that time, I set out below a brief chronological review taken from evidence collated during the Inquiry.

565. I heard that there was a lack of awareness of CSE during the early period; professionals 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: *"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."*[470]

566. This lack of recognition led to a lack of proper response: one survivor witness who suffered exploitation in the 1990s said that she repeatedly visited the same GP practice for the morning after pill. No one ever asked any questions about her age or why she needed the morning after pill; the witness said it felt like no one really cared. She was 14 years old.[471]

567. I have frequently heard evidence from witnesses that during the early part of my Terms of Reference, 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.[472]

568. 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.

569. During the first years of the 21st century professionals began to pick up on signs of CSE and began to consider that there could be a wider problem. One witness told the Inquiry that it was around 2000/2001 when these concerns first started to be explored and discussed at the Telford & Wrekin ACPC.[473]

570. Following the increased awareness at the ACPC level, in around 2003/2004, one training package for raising awareness of child protection began to be updated to include an element that related to raising awareness of CSE.

571. While this was clearly a positive step, 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*

470 [redacted] pg 4
471 [redacted]
472 [redacted]
473 [redacted] pgs 3-5

issue than that… there was no structures to actually address that..".[474] At this time, only four hours per week was dedicated to raising awareness about CSE.

572. 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 and some regrettable attitudes and approaches; I have seen evidence of a child visiting her GP and being asked whether she was *"a lady of the night":* she was then 15 years old.[475]

573. It was at this time that LSCBs were established, by virtue of the 2004 Act. I know from LSCB documentation that the Primary Care Trust ("PCT") (and latterly the CCG) in Telford played an active role in the LSCB. While multi-agency communication 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:

573.1 The sexual health clinics often had temporary staff, or bank nurses, so staff would not always see the same children attending. I was told 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."* [476]

573.2 The sexual health clinics were always very busy, with over 30 patients coming through a day; it was described as *"overwhelming".*[477]

574. 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, acknowledged at the time in minutes of a CATE Group meeting on 29 July 2009 recording one attendee commenting on "*… frustration at the lack of awareness from health professionals who fail to identify sexual exploitation as an issue."*[478]

575. Safeguarding training of health professionals was also 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.[479] I have heard that the first CSE specific training one health professional recalls attending was training delivered by the Council in 2011.[480]

474 [redacted]
475 [redacted] pg 40
476 [redacted] pg 18
477 [redacted] pg 27
478 [redacted]
479 https://www.cqc.org.uk/sites/default/files/documents/safeguarding_children_review.pdf
480 [redacted]

576. 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 was 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.

577. 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.

578. 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.[481] 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. The findings of this report suggest that, at a strategic level, there was active and positive multi-agency working, but on the ground the experience was not the same.

579. In November 2015, the LSCB conducted a multi-agency case file audit on files related to CSE; the CCG took part as a safeguarding partner.[482] Some of the findings included concerns that GP records suggested they were not aware of CSE concerns and information was not always being shared with GPs or school nurses, and in some of the files there was limited evidence of multi-agency working within health records. Actions taken in respect of health included a task 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.[483] 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 alert the new surgery to make them aware of the risk, and the information does not always carry over.[484]

580. 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; that there was more training on CSE and other safeguarding topics, with dedicated contacts at the police and more joined up working with other agencies, for example the multi-agency meetings that were then happening monthly. 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 limitations, as those records would only contain records from the sexual health service; the system was not integrated to see, for example, GP records.[485] The evidence from this

[481] https://files.api.beta.ofsted.gov.uk/v1/file/50004181
[482] [redacted]
[483] [redacted] pg 14; [redacted] pg 65
[484] [redacted] pg 14
[485] [redacted]

time is also not universally positive. Evidence shows that interactions with GPs was still a challenge. [486]

581. During 2015 and 2016, the Council conducted its Scrutiny Review of multi-agency working against CSE in Telford. The review took 18 months and was published in May 2016.[487] Findings included:

"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."

582. Further reviews followed this, with Ofsted carrying out an inspection of children services and a review of the effectiveness of the LSCB in June-July 2016, reporting in August 2016.[488] In relation to agency response to CSE, the regulator commented that:

"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."

583. While it appears that the multi-agency partners, including health agencies, were alive to the issue of CSE and were committed to making improvements, this was not always translating to the services being received by those accessing them:[489] I have seen evidence that shows that at this time professionals were raising concerns about the difficulties vulnerable children were experiencing in accessing sexual health services, with clinics being too busy and some GP surgeries no longer providing contraception in practices.[490]

584. In June 2018, LSCBs were abolished by the Children and Social Work Act 2017, which significantly amended the 2004 Act. The LSCBs were 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 considered appropriate, to co-ordinate their safeguarding services. The Inquiry heard that during this time, CSE training for health professionals was continuing, and other positive changes were taking place.[491] At an operational level, evidence also suggests that interactions with the sexual health services supporting children had been more positive; with clear lines of communication to set up screenings at clinics and supporting individuals through the process.[492]

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486 [redacted]
487 [redacted]https://www.telford.gov.uk/downloads/file/4499/final_report_scrutiny_review_of_multi-agency_working_against_cse
488 https://files.ofsted.gov.uk/v1/file/50004335
489 [redacted]
490 [redacted]
491 [redacted] pg 92
492 [redacted]

Information sharing

585. One issue that has consistently come up during my work in respect of health agencies and health professionals has been the sharing of information. 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, and that may include the sharing of otherwise confidential information, including health information.

586. The journey to understanding clearly how and when information should be shared has not been straight forward. It 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. The evidence I have seen is that throughout this period there has been an increased level of nervousness and confusion on the part of some health professionals about sharing of information and when it can be done.** I do not underestimate the difficulty of these decisions for clinicians, but the guidance has been clear since '*Working Together 2013*': *"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."*

587. The other challenge that was highlighted to me was one of terminology. 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'.[493] 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.

Conclusions

588. **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… 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."***[494]

[493] 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.
[494] [redacted]

589. **The fragmentation of sexual health services is a real concern.** For example:

589.1 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;

589.2 CCGs[495] are responsible for commissioning GPs for general medical services e.g. contraception and also termination of pregnancy and sterilisation services;

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

589.4 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.

590. **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 safeguarding obligations, and holding them to account becomes a challenge.**

591. **Further, I have heard that while some health professionals were extremely supportive of victims and survivors, the response of all providers has not been consistent.** It should not be 'pot luck' as to whether these children are responded to appropriately. **Training alone is not enough; or at least, 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.**

592. **What I have seen from the health service at a commissioning level demonstrates that there was, and is, real commitment to meet 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.**

593. **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 survivors and victims 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.**

[495] Now Integrated Care Boards, from 1 July 2022

Attitudes and Impact (Chapter 9)

594. The attitudes of individuals and organisations towards CSE affect the response to, and behaviour towards, victims and survivors; and therefore, to the impact it has on them. As a result, I have sought to understand attitudes and how they have changed during the period of my Terms of Reference. 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 has, or has not, played in relation to CSE in Telford.

Attitudes

595. 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. The term 'child prostitution' was one that was used by professionals and this was a term reflected in legislation. Indeed, 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 activity as 'sexual exploitation', although the terminology used by professionals and safeguarding agencies had already begun to change before this point. This context, and how it has evolved, is explored in more detail in Chapter 9: Attitudes and Impact.

596. Regardless of terminology, witness evidence suggests 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*".[496]

597. The evidence 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.

598. These patterns of behaviour were not always recognised as exploitation. For example, I have also seen evidence suggesting that exploited children within the criminal justice system at this time, victims/survivors of CSE, were viewed as 'prostitutes' and not recognised as victims.

599. 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 – including that not seen as 'prostitution' - as being a deliberate lifestyle choice and consenting behaviour. **I have seen an enormous amount of evidence which does indeed suggest that in the 1990s the children were considered to be making 'poor choices'.**

600. A police witness told the Inquiry

"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 …".[497]

496 [redacted] pg 2
497 [redacted] pg 26

601. Another witness gave this account

"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."[498]

602. Ideas of 'prostitution' and 'lifestyle choices' endured in the early days of the 21st century. There is some evidence that these attitudes continued to exist in 2007/2008, with one police 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 children, 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"* [499]

603. There is, however, some evidence of changing attitudes within WMP in 2007, particularly in a discussion of missing children when an officer reports: *"Let us not forget that these mispers are 13 years and 16 years of age and although streetwise have to be considered vulnerable…."*[500]

604. By 2009, the terminology of prostitution was firmly under challenge. Evidence from a CATE meeting in 2009 describes CATE workers highlighting that sexually exploited children should be treated as victims not "*sex workers*".[501] A police witness also told the Inquiry that, due to work by WMP officers, at this time 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*".[502]

605. Despite these positive signs, other material shows that the 'lifestyle choice' attitude still existed in 2009; I have seen notes of a police officer's view:

"[Child] has no credibility – very often it is her word aginst [sic] the perpetrators and very often she does not co-operate. Believe [sic] she is making life choices. There are never any witnesses or 3rd parties."[503]

606. Still further material does tend to show, **in my view, that 2009/2010 was a turning point when attitudes began to shift; this was of course around the time when Operation Chalice was underway.** Operational policing briefings taking place at this time

498 [redacted] pgs 6, 7
499 pg 7
500
501 pg 2
502 pg 9
503 pg 1

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.[504] **Happily, from my review of the evidence I consider that it is rare now to see any child that has been exploited, or at risk of being exploited, being described as having made poor lifestyle choices.**

607. I heard that 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. By 2015, 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*". [505]

608. **There is no doubt in my mind 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'.**

609. **There remains work to be done. I have seen more recent police evidence of an unacceptable, and quite frankly offensive, attitude towards CSE victims, with disparaging language being used. 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, work still needs to be done on ensuring that victim-blaming language is not inadvertently used, as it can corrupt thinking and response.**

Attitudes to victims and survivors as parents

610. 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. 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 in relation to the parenting ability of those individuals that have been subjected to exploitation in the past.

611. I have seen a parenting report which suggests that a parent needs to "*recognise her previous lifestyle choices as risky*"[506] as being one of the factors that determined her ability to parent. This obviously not only perpetuates victim blaming into adulthood, but also brings

504 [redacted] pgs 1 and 4
505 [redacted] pg 25
506 [redacted]

consequences for a victim's/survivor's failure to recognise personal responsibility where there was, in reality, no personal responsibility for being exploited.

612. 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. But two issues arise from this:

612.1 First, it is incumbent upon the Council to understand its own attitudes and those of its staff. 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 or will be applied; and

612.2 Second, therapeutic support. It seems to me that if the Council is concerned in any way that CSE victims/survivors are likely to be less effective parents, then support becomes an even more urgent matter; and it should include elements designed to address relationships and parenting, but do so in a way that makes clear that the victims/survivors of CSE are not being blamed for their experiences.

Race and Racial tensions

613. One particularly sensitive issue that has been raised within the community concerns the extent to which race and/or racial tensions has, or has not, played a role in relation to CSE in Telford.

614. As to the suggestion, raised by witnesses, that Telford's CSE issues are specifically centred around the Pakistani or South Asian community:

614.1 It would in my judgment be wholly wrong, and undoubtedly racist, to equate membership of a particular racial group with propensity to commit CSE;

614.2 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.

615. 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.

616. In that regard, I have no doubt that there was a background of nervousness around race in Telford from the earliest days of my Terms of Reference. The following features of the evidence are relevant in my view:

616.1 First, there were significant events which caused tensions between WMP and the wider community and concerns over race, which I detail in Chapter 9: Attitudes and Impact;

616.2 Second, I heard evidence that during the 1990s teachers and parents were reluctant to address potential CSE issues for concerns that they would be labelled racist;

616.3 Third, I heard evidence from a number of witnesses who suggested that certain areas of Wellington were not approachable by the police:

"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'."[507]

617. **I have no doubt that concern about racism, and being seen to be racist, permeated the mind of WMP, and indeed of the Council and the minds of some of its employees, given the apparent tensions at the time. That is not a bad thing: there should be a culture of equality of treatment and fairness in delivery in government. But I am satisfied that this nervousness led to a reluctance to act.**

618. So far as the Council is concerned, I have seen evidence that:

618.1 In relation to the early 2000s, there was a feeling that certain individuals in the Asian community were not targeted for investigation into child exploitation because it would have been too "*politically incorrect*";[508]

618.2 At a multi-agency meeting at which inappropriate behaviour by an Asian male towards a child was discussed, 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*"; [509]

618.3 Between 2006 to 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*";[510]

507 [redacted], pg 9
508 [redacted] pg 22
509 [redacted]
510 [redacted] pgs 9 and 10

618.4 In around 2007, sexual exploitation meeting notes suggest that exploitation by Asian men had been "*going on for years*", suggesting knowledge and inaction;[511] and

618.5 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.

619. 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.** One witness told the Inquiry that on being approached to join the Chalice team, they were reluctant*: "I said no, and that was because of the Asian element, you know, we're going to be on to a loser."*[512]

620. **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.**

621. **It is impossible, sadly, 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

622. Our attitudes influence our behaviour; and our behaviour affects others. CSE has a long-standing impact on the self-esteem and confidence of victims and survivors, and it is destructive to family life. Friendships suffer, and forming relationships often becomes difficult. Education and employment are marred; lives are changed irreversibly.

623. I have read documents and witness evidence that describe the grief and trauma caused by CSE and the impact that it has. The evidence provided to the Inquiry demonstrates that CSE can be directly responsible for causing its victims and survivors many serious mental health conditions. Often there is resort to harmful coping mechanisms: 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 to block out the exploitation they are subjected to at the time, and the use of drugs and alcohol can convert into an adult dependency as a consequence.

511 [redacted] pg 4
512 [redacted] pg 14

624. I have read other harrowing evidence providing details of self-harm, where children have choked themselves, strangled and cut themselves.

625. 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.

626. I do not ignore the impact on professionals. A clear theme of my findings is that the CSE responses of key stakeholders was driven by professionals who, though often not tasked with a CSE related role, nevertheless took on responsibility because they were not prepared to stand aside while children suffered. Some of those professionals put themselves physically in harm's way; many others have been deeply affected by what they saw happening to the children, and by their perceived inability to help them effectively.

627. 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 professional witnesses who became overcome with emotion in giving me their testimony and who have plainly been changed by their experiences.

628. 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 across society.

629. **Conclusions as to impact are best made in the voices of victims and survivors and their families.** In Chapter 9: Attitudes and Impact, I set out numerous affecting examples of impact related to me by victims, survivors and their families. I have extracted some on the next page;[513] though, as with Chapter 8: Case Studies, the chapter bears reading in full.

[513] [redacted] pgs 4-5, [redacted] pg 4, [redacted] pg 4, [redacted] pg 105

"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."

"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."

"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."

"... 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...".

"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 anymore. I have nothing to lose. I have lost probably the most important thing in my life and that was my daughter at the time."

"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."

"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..."*

Recommendations

Overview

1. The first paragraph of the Inquiry's Terms of Reference require that I "*establish what recommendations can be made to ensure CSE is recognised and reported*" and to determine what steps can be taken "*to protect children and help prevent CSE in the future*". I have made 47 recommendations with those essential aims in mind, and I set them out in the table below.

2. While it is my intention that the Executive Summary and these recommendations provide together an overview of the Inquiry's work and conclusions, the detailed rationale for the recommendations appears in the body of the Report itself. This Report is long, detailed and thorough, with each chapter identifying failures, weaknesses and/or gaps that should be addressed. I have therefore deliberately placed the recommendations towards the beginning of my Report, and not at the end, to help the reader understand from the outset the action I am recommending be taken, so that this can be borne in mind when reading the detailed findings and conclusions that then follow.

3. There is criticism of key stakeholders in this Report, and some recommendations propose changes to established practice. I hope that all key stakeholders – and in particular Telford & Wrekin Council (the "Council"), which has over the years shown a reluctance to accept criticism - will commit to a reflective response to my conclusions and to full implementation of the recommendations.

4. The Inquiry's Terms of Reference include a two-year post-publication review – which will be published - to assess the extent to which recommendations have been implemented, and I will require all key stakeholders to demonstrate that steps have been taken, and are being taken, in respect of each relevant recommendation, or to give good reason why they have not.

5. References in these recommendations to the Telford & Wrekin Clinical Commissioning Group and/or the NHS Shropshire, Telford & Wrekin Clinical Commissioning Group (together the "CCG") should be read to apply to its successor body[1], the Integrated Care Board.

Areas requiring action

6. In order to provide sufficient context, I have set out below, by reference to each chapter of this Report, the main issues that have arisen during this Inquiry, and which require action on behalf of stakeholders. This is, of course, not a substitute for reading individual chapters in full, to understand the wider basis upon which I have reached these findings, and why such recommendations are necessary.

7. My recommendations are not intended to create additional excess bureaucracy. Complicated and ever changing bureaucratic structures have – particularly so far as the Council is concerned – occupied inordinate time and focus over the years. There has been too much concern about process and procedure and not enough emphasis on outcomes for

[1] As of 1 July 2022

children. That being said, I do propose a new structure to oversee the collection of data relating to the incidence of CSE and the response of key stakeholders. My purpose in that primary recommendation, as in all others, is to ensure that CSE is recognised and reported, and that children are protected in the future.

Data collection and statistical analysis relating to CSE (Chapters 2, 3, 4, 5, 7)

8. In Chapter 2, I deal with data collection and statistical analysis relating to CSE, insofar as this has been used to determine the nature, patterns and prevalence of CSE in Telford. From that chapter and others it has become clear that accurate data collection and mapping of CSE is of crucial importance to ensure there is ongoing and reliable monitoring of its prevalence across the Telford area. Key stakeholders can only engage in prevention and disruption if they understand the trends around CSE, and the public deserves to know what is happening in their community.

9. While this need for measuring and mapping has been repeatedly recognised in the past, effective and concerted multi-agency action has been lacking in Telford. To this end, I have made specific recommendations below relating to the formation by key stakeholders of a 'Joint CSE Review Group' (I am not prescriptive as to the name), which will collate data from individual agencies and publish an annual report setting out incidence, trends and key statistics relating to CSE. I expect the first of these reports to have been published within 18 months of the date of this Report, so as to allow me to assess whether CSE is in decline in Telford by the time of my two-year review.

10. I hope that by adopting these recommendations, those key stakeholders will together be able to provide the public with an ongoing, reliable and contemporaneous picture of CSE in Telford.

Information Sharing (Chapters 3, 4, 5, 7)

11. In a similar vein, it has been clear to me that across all stakeholders there has been, to a greater or lesser extent, insufficient and ineffective information sharing.

12. Indeed, the Council has accepted that there has been "*concern around data sharing*"[2]; this reflects a general theme throughout the Inquiry's work of a nervousness about sharing of information, which has made practitioners in many agencies uncertain about when they should not share information and when they must. In particular, ideas of confidentiality have led to plainly relevant and important information not being shared in some cases, and to the seeming default position that information should not be shared. I consider that this situation is unlikely to have improved following the relatively recent introduction of new data protection legislation.

13. It is crucially important that practitioners who have safeguarding responsibilities understand the principles underpinning information sharing, and how this interacts with current data protection legislation. As a result, I have made a general recommendation that key stakeholders commit to immediate implementation of repeating information sharing training programmes.

[2] [redacted] pg 31

14. I deal in my report with a specific incident, involving the discovery of a risk of HIV to exploited children, in which concerns about information sharing occupied far too much time and effort at the expense of timely action. Ultimately not only were all proper steps taken but the delay did not have any adverse impact upon the children concerned. Nevertheless, as a result I recommend that all relevant agencies – the Council, WMP and the CCG – ensure that there is a protocol in place for such situations that makes clear what information must be shared and when.

15. My investigations on this point further led me to the understanding that there is currently no mechanism by which the Council or the Police are able to determine whether a complaint of (in particular, non-recent) exploitation relates to a known HIV positive perpetrator; I further recommend that the relevant agencies consider how this obvious and concerning gap can be addressed.

Complaints Handling (Chapters 3, 4, 5, 6)

16. A recurrent feature of the cases I have examined, spanning many years, is that parents of exploited children often feel helpless and without support. That has led to complaints, which have not always been dealt with well. I have made separate recommendations with regard to the provision of support, but it would be unrealistic to think that will eliminate complaints.

17. Furthermore, complaints are a valuable resource for key stakeholders in terms of assessing the effectiveness of the service they provide, and for the public in assessing the quality of the service they receive. As a result, in addition to specific recommendations with regard to individual stakeholders' approach to complaints, I have recommended the collation of complaints data relating to CSE and its publication in the 'Joint CSE Review Group's' Annual Report.

Training

18. While I have made specific recommendations as to the way in which the CCG should disseminate guidance and training, based upon the evidence I have heard about the current methods of delivery, I make these observations generally in respect of all the recommendations below which go to the issue of training: training is not effective when it is the mere dissemination of information. Distribution of a leaflet or uploading a talk is not enough. Effective training needs engagement, testing and above all monitoring of its application to embedded practice, and I have recommended that details of relevant training undertaken by each stakeholder be included in the 'Joint CSE Review Group's' Annual Report.

The Council (Chapter 3)

19. I have already referred to my finding that the Council's approach over the years has been essentially defensive. That is not useful; recognition of mistakes is as essential to learning and to growth in institutions as it is in individuals.

20. In terms of that defensiveness being exhibited, I have seen an enduring reluctance on the part of the Council – through various administrations – to engage with voluntary, charitable and non-statutory agencies. It is no admission of defeat to recognise the skills of others; the third sector has long had expertise in working to address sexual abuse and exploitation, and other local authorities have taken advantage of that. It is third sector work that has

often advanced the agenda. As a result, my recommendations include key stakeholder engagement with third sector groups, particularly with regard to victim/survivor and family support, and to transparency about the extent to which third sector groups are part of the Council's CSE response.

21. The Council's Children Abused Through Exploitation ("CATE") Team's survival has been precarious for most of its existence. It is strong now, but it is not a statutorily protected service and its remit has expanded to cover criminal exploitation of children. In order to ensure the CATE Team's ongoing strength, I recommend that the Council should commit to its continued existence, to ring-fencing its resources, and to preservation of current budget, practitioner numbers and workloads.

22. The CATE Team's published working method, or Pathway, has not been substantially updated since 2008 when it essentially formalised what had been ad-hoc practice by youth workers, not social workers. The Council has told the Inquiry that since 2016 the CATE response has been more flexible, allowing fluid interaction between CATE and Safeguarding processes, but it is not currently clear how the two work together; I have recommended that the Council reviews and updates the published CATE Pathway so that the public may understand what service they might expect.

23. My review of CATE files has shown that the CATE risk assessment process has focused heavily on a child's behaviour as a risk factor. Although welcome changes have been relatively recently made to take contextual factors into account, I consider that training is necessary to ensure that CATE practitioners and social workers have an up to date understanding of concepts of risk and harm; and that such training is underpinned by regular external file audit.

24. In order to foster a culture of openness and learning it is necessary for the Council to recognise and admit mistakes. In this regard I have made recommendations as to dealing with complaints. The systems should be reviewed and a comprehensive complaints procedure for CSE to be published and made readily available. The Council should be watchful to ensure that people are able to complain: there should be signposting to support in making complaints; and practitioners should be able to identify complaints or feedback from service users which suggest cause for concern. All CSE complaints should be centrally recorded and the results of complaints published in a suitable form.

Education (Chapter 3)

25. I have made recommendations relating to schools and colleges. These recommendations should be understood to apply to schools and colleges as specified within Telford & Wrekin, however their income is sourced. The recommendations should be considered within the overall framework and context of Keeping Children Safe in Education, the statutory guidance for schools and colleges published by the Department for Education, most recently in September 2021.

26. Telford's history of CSE is undeniable and the Inquiry has seen evidence to suggest that CSE is ongoing. In the past, the approaches of different schools were highly variable. In an effort to ensure a unified provision, I recommend that all schools and colleges commit to training teachers and staff in CSE awareness and that there are programmes of CSE awareness for pupils (including some primary pupils) and for parents. I also recommend that in addition to the existing requirement for a Designated Safeguarding Lead, secondary schools and colleges in Telford should appoint a named CSE Lead.

27. In the past, teachers and school staff have been reluctant to share information regarding children thought to be sexually exploited. In addition to recommendations regarding information sharing training, I recommend that secondary schools and colleges prepare and share with the CATE Team a list of children thought to be at risk of CSE and a mapping report to identify potential 'hotspots' of exploitation. Additionally, schools using the CPOMS recording system should review procedures for recording and sharing data.

28. On the evidence I have seen, school and college site security has been a problem over many years with unauthorised access onto school and college sites being widespread, and children going missing from school. I recommend that schools and colleges immediately review site security, which the evidence has shown to be a long-standing concern.

Taxi Licensing and Night-Time Economy (Chapter 4)

29. Many witnesses suggested to the Inquiry that I should recommend that taxi drivers are only able to operate in the areas in which they were licensed: in other words, only Telford-licensed drivers should be allowed to operate in the town. The law does not currently permit such a restriction, and a change would be a matter for central government. However, while I can see that it is initially an attractive proposal, I am not sure that it survives scrutiny. I consider the driver's licensed area less important than the standards to which they must adhere; a driver's geographical familiarity with an area is, given technology, far less important than once it was and it does not in my view impact on CSE. Nevertheless, the fact that differences in standards exist across different, even neighbouring, local authorities is wholly undesirable. In my view, simply to wait for a central government response would be a mistake. As a result, I recommend that the Council commits to seeking to agree with its neighbouring authorities a stricter information sharing agreement, a joint enforcement protocol and a common licensing pricing structure; this will undoubtedly need political buy-in, but would serve as a national example of good practice.

30. The Council's taxi licensing has, for some years, included CSE awareness training for drivers. I recommend that the Council should publicise the high standards to which Telford licensed taxis are held, and raise awareness of how to recognise a locally-licensed taxi. Furthermore, the CSE awareness training for drivers could usefully be offered, at a cost, to neighbouring authorities and to individual drivers who sought the accreditation.

31. While the Council should commit to an enhanced enforcement regime, it should recognise the value of the public as an information source for enforcement, and commit to publicising what is expected of taxi drivers and how members of the public can raise concerns. Consideration should be given to instant reporting by way of text or online services.

32. The public has a right to know whether its Licensing Team is effective; accordingly, I recommend that the Council regularly publishes details of the number of complaints it has received about taxi drivers, the nature of those complaints, and their results.

33. I heard evidence that the Council has inherited a number of premises with 'historic' licences – those issued prior the Council assuming responsibility for liquor licensing - that allow the presence of children at adult events. I regard the continuation of such licences as undesirable, and have recommended that all possible steps are taken to ensure that those premises are subject to licences with appropriate conditions. In the meantime the Council should indicate that it expects nightclubs to operate an '18 or over' entry policy.

34. The collection of information with regard to restaurants and takeaways has been surprisingly scant, particularly given the many complaints the Inquiry has seen of perpetrator behaviour around such establishments. While the Council makes the fair point that its licensing role is particularly limited in respect of late-night takeaways, I have recommended that it reviews information collection and sharing with regard to CSE concerns involving restaurants, takeaways, mobile food outlets and associated residential premises to ensure that full use is made of all information received, whatever its source.

West Mercia Police ("WMP") (Chapter 5)

35. WMP's CSE Team is a relatively recent innovation. I conclude in Chapter 5 that there should have been a specialist CSE team sooner, particularly as there had previously been a Sexual Offences Investigation Team in 2007, which did not continue after Chalice.

36. Already, the CSE Team's remit has broadened to cover Criminal Exploitation more generally (changing its name to the 'CE Team') and I am concerned that the Team might, if charged with other responsibilities, lose its essential focus. The CE Team is an extremely valuable resource in addressing CSE. As I result, I recommend that WMP commit to its continued existence and to ring-fencing its resources, and to preservation of current budget, officer/staff numbers and workloads.

37. The effective collection and use of data is essential to providing an accurate picture of CSE and its trends. I have concluded that WMP did not use the intelligence marker system to its full extent and that, following the conclusions of a 2018 review of WMP's practice, it is not clear whether markers have been properly applied to all Chalice nominals. Accordingly I recommend a review of practice and of records to ensure appropriate and consistent use of markers in CSE cases.

38. The Inquiry has seen evidence which suggests that public-facing officers and staff have, on occasion, used insensitive and inappropriate language in dealing with CSE cases and with victim/survivors and their families. This has the potential – particularly where there is a sense of victim-blaming – to discourage complaint. As a result I recommend a widely drawn training programme for officers, Police Community Support Officers ("PCSOs") and public facing staff, to address this issue.

39. In reviewing material relating to police complaints, the Inquiry has seen material which tends to suggest that complaints are not always dealt with in a timely way. As a result, I recommend a review of CSE complaints handling and, so that issues around CSE complaints handling may be better understood, provision for collation and publication of CSE related complaints.

The Police and Crime Commissioner ("PCC") (Chapter 6)

40. It is right that I note in particular the positive contribution of the PCC to the improvements in the night-time economy response in Telford in respect of funding aimed at supporting the taxi marshalling and street pastor projects (which are discussed separately in Chapter 4 of this Report). It is important, in my view, that this contribution is not regarded as dispensable in the face of other priorities. Funding for these initiatives should be continued and their value should not be underestimated; however they should not be regarded as, or regard themselves as, a primary evidence gathering source.

41. So far as the PCC's oversight role is concerned, I have commented in Chapter 6 that I consider the PCC could improve its 'Holding to Account' ("HTA") process. I therefore recommend that the regular HTA meetings with WMP's Chief Constable include provision of specific data; and, in addition, the more informal weekly meetings are minuted.

National Referral Mechanism ("NRM") (Chapter 6)

42. The evidence that I have seen in respect of WMP and the Council suggests that improvements are also needed in relation to NRM referrals. The NRM is not optional or dependent on child consent. To this end, I consider that there needs to be clarity about responsibility for NRM referral in multi-agency cases and maintenance of shared records as to referrals, and I have made a recommendation to this effect.

Health Authorities (Chapter 7)

43. It has been suggested that I recommend that any child under 16 accessing sexual health services should be referred on to a safeguarding authority. I am not prepared to follow this course - I am concerned that this would dissuade children from accessing much-needed healthcare support. However, it is a concern that many witnesses I spoke to said that no questions were asked of them although they were so young. There is a balance to be struck between making sure children feel comfortable accessing services without fear of repercussions, and being professionally curious and ensuring the duty to safeguard is being met. So many witnesses I heard from were looking for a 'way out' and wanted someone to uncover what they were going through, without having to make an official complaint. The recommendations I have made in relation to providing information sharing training plainly apply to health agencies. I have also made a further, specific recommendation as to the need to review guidance given to sexual health professionals; not least because a health professional may well be the first professional who has contact with a child, and their attitude and approach can affect that child's future engagement with support services generally.

44. I have seen and heard repeatedly through the course of this Inquiry that a lack of resources has often meant that there has been a failure to offer children further support once they have been identified as a victim or survivor of CSE. Mental health services often have a high threshold for access; those who do not have a diagnosed mental illness, but have experienced trauma, are often told that there is no suitable support available. While, of course, I am aware that capacity issues are increasing in a post-pandemic world, I have made recommendations that these provisions be reviewed.

45. A theme that has consistently come up is the information sharing to and from GPs and how this has not happened consistently. It is important that GPs play their role in safeguarding children at risk of CSE; GPs need to know if there are any CSE concerns about a child patient, particularly when a child moves GP practices. I have been told that there is currently no CSE code applied to GP systems to identify individuals that have been involved with, or at risk of CSE; although I understand one exists where there are concerns of FGM; there should be one for CSE. I recommend that this should be rectified.

Recommendations

1.	**Establishment of a 'Joint CSE Review Group'** The **Council** and **WMP** should take the lead in establishing a joint group, and shall identify and include other key stakeholder authorities, to include education and health sectors and such third sector agencies as the Council and WMP as lead agencies deem appropriate. The Joint Group's function will be to meet every six months, in order to: • Consider data and information gathered – such data to include: the incidence, trends and locations of CSE within the borough; missing persons/truancy data; referral numbers and investigations/complaints; licensing and night-time economy information; and any other data considered relevant; • Analyse such data and information in order to provide a reliable set of statistics against which the threat/risk and prevalence of CSE can be measured, and any apparent increase or decrease in the number of CSE cases considered; • Maintain minutes of each meeting, with appropriate action plans attached; and • Publish a report setting out the results of the analysis and accounting to the public for the action being taken in response – as set out in **Recommendation 2**. ***Relevant chapters: All chapters***
2.	**'Joint CSE Review Group' to publish an annual CSE Report** The **Council** and **WMP** should lead the 'Joint CSE Review Group' in publishing an annual report, titled "Joint CSE Review Group Annual Report" (or similar). This report should include, at a minimum: • The output of the statistical analysis carried out in accordance with **Recommendation 1;** • Current staffing numbers/caseload ratios within the WMP CE Team and the Council's CATE Team; • The extent of collaboration and support sought from third sector organisations, including transparency about the level of funding ring-fenced for such support; • Details of steps taken in relation to CSE training and awareness campaigns; • Details of PCC funded resources and initiatives relevant to CSE; • Statistics regarding the number of NRM referrals; • Updates as to work undertaken to improve relevant services to children within the health and education sectors; and • A summary of any complaints received by any of the member authorities regarding the handling of a CSE matter. Each member organisation should publish a copy of the report on its website. ***Relevant chapters: All chapters***

Recommendations

3.	**WMP to prepare mapping and prevalence data to be shared with the Joint CSE Review Group** In line with **Recommendations 1 and 2:** in advance of each Joint CSE Review Group meeting, and for the purposes of its Annual Report, **WMP** should prepare the following: • An analysis of the incidence of, and its response to, CSE within Telford (a "prevalence report"). Subject to the need to protect the integrity of ongoing investigations and policing tactics, this should include reference to the numbers of complaints, reports, investigations, arrests, charges and conviction rates, as well as geographical distribution of CSE 'hotspots' within Telford. • A CSE activity analysis (a "mapping report") based on intelligence received from its own sources (including that collated via the 'Joint CSE Review Group'), in order to ensure that an ongoing and targeted approach to CSE is maintained. Copies of the prevalence report and mapping report should also be shared with the PCC in line with **Recommendation 41.** ***Relevant chapters: Chapters 2 and 5***
4.	**Council to prepare CATE data to be shared with the 'Joint CSE Review Group'** In line with **Recommendations 1 and 2:** in advance of each 'Joint CSE Review Group' meeting, and for the purposes of its Annual Report, the **Council** should prepare the following: • An analysis of its response to CSE within Telford & Wrekin to include numbers of CSE cases dealt with by Safeguarding processes, those dealt with by CATE processes, and to detail how many are new cases, how many are active, and how many have been closed. ***Relevant chapters: Chapters 2 and 3***
5.	**Schools and colleges to prepare data to be shared with the 'Joint CSE Review Group'** **Secondary schools and colleges** should prepare the following, in association with the **Council:** • A six-monthly CSE statement (to be submitted prior to the six-monthly 'Joint CSE Review Group' meeting) giving details of specific children showing indicators which may be indicative of CSE (the "children at risk report"), whether or not that behaviour merits immediate referral to CATE or Safeguarding; and • A further six-monthly report (to be submitted prior to the six-monthly 'Joint CSE Review Group' meeting) containing such information as may allow effective mapping of CSE ("school mapping report"), including but not limited to, ages of children involved, the place of exploitation where known, their general places of residence, and any information which may establish the identities of perpetrators. • The above information should also include statistics and information relating to any missing from school episodes/ truancy records, in order to agree any steps that should be taken in relation to children that are shown to have regular difficulty attending school. The children at risk report and the mapping report should be shared with the CATE Team, which in line with **Recommendations 1 and 2** will share the reports with the 'Joint CSE Review Group' meeting for the purposes of its Annual Report. ***Relevant chapters: Chapter 3***

Recommendations

6.	**Information sharing training to be implemented in order to clarify responsibilities around confidentiality, information sharing and safeguarding** **All organisations with safeguarding responsibilities,** to the extent it is not already in place, should: • Implement an immediate programme of information sharing training for all those dealing with children, or in positions where referrals to Safeguarding is a possibility, to include at a minimum, police officers, PCSOs, social workers, CATE practitioners, youth workers, licensing officers, teachers, school counsellors and nurses, sexual health advisors, GPs, GP practice nurses, A&E doctors and nurses; • Ensure such training sets out the principles of when information should not be shared and when it must be, including practical exercises; and • Ensure that the above training is mandatory for any future recruits, and is repeated for existing team members no less than every two years, with training records to be made and retained. ***Relevant chapters: Chapter 3, 5 and 7***
7.	**Ring-fencing of CATE Team resource** • The **Council** should commit to the continued existence of the CATE Team within Telford at no less than its current strength in both numbers and budget (adjusted for inflation), for a period of no fewer than five years from the date of publication of this Report. • Following the expiry of that period, in the event of no such further ongoing commitment, the Council should state publicly the reasons why, and the proposals for future management of children at risk of CSE. • The Council should ensure that (i) CATE practitioners are protected from abstraction to cover other work; and (ii) practitioner caseload remains no higher than the current level. • The Council should publish information regarding the resourcing and workloads of the CATE Team as part of the 'Joint CSE Review Group's' Annual Report. ***Relevant chapters: Chapter 3***
8.	**Ring-fencing of WMP's CE Team resource** • **WMP** should commit to the continued existence of the CE Team within Telford – at no less than its current strength in both numbers and budget (adjusted for inflation), for a period of no fewer than five years from the date of publication of this Report. • Following the expiry of that period, in the event of no such further ongoing commitment, WMP should state publicly the reasons why, and the proposals for future management of CSE investigations within WMP. • WMP should publish information regarding the resourcing and workloads of the CE Team as part of the 'Joint CSE Review Group's' Annual Report. ***Relevant chapters: Chapter 5***

Recommendations

9.	**Council should review its subgroups** • The **Council** should review the number, membership and remit of all groups and subgroups – internal and with partners - dealing with CSE. • Group membership should be limited, to ensure effective meetings, and be open to those most qualified to bring value - not be based simply on seniority. • Strategic meetings should always include a practitioner – someone working directly with children and their families. ***Relevant chapters: Chapter 3***
10.	**CATE Pathway to be reviewed** • The **Council** should carry out an immediate and thorough review of the published CATE Pathway to ensure that it sets out, with clarity, the model of response, intervention and support to be expected where a child has been sexually exploited, or is considered at risk of future sexual exploitation, including the circumstances in which a child on the child protection pathway can obtain CATE support, and vice versa. • This review should include consideration of current research and national best practice. • The CATE Pathway should be reviewed annually to ensure that it remains fit for purpose. ***Relevant chapters: Chapter 3***
11.	**Implementation of an adulthood transition meeting** The **Council** should commit to immediate implementation of an adulthood transition meeting as part of the CATE Pathway for cases where a CATE child transitions to adulthood. ***Relevant chapters: Chapter 3***
12.	**Training of CATE Team and social workers** The **Council** should ensure that all CATE Team members and social workers in Safeguarding receive regular external training covering: • The concepts of risk and harm; and • The importance of rigorous recording of information (including detailing the exploitation suffered and naming children and perpetrators). ***Relevant chapters: Chapter 3***

Recommendations

13.	**Case File Review/Audit** The **Council** should commit to an annual external audit of no fewer than ten randomly selected CATE case files and of no fewer than ten randomly selected Safeguarding case files relating to children who have been exploited or are at risk of exploitation, to ensure proper emphasis is established and maintained. The **Council** should also ensure that: • Safeguarding and CATE Team members focus appropriately on contextual safeguarding and not simply upon child behaviour modification; and • The extent and quality of information sharing is properly assessed. ***Relevant chapters: Chapter 3***
14.	**CATE's information sharing protocols with schools to be reviewed** The **Council** should review the information sharing protocols in place with schools, and update them as necessary to ensure that the CATE Team shares information with schools that identifies CSE threat levels, trends and groups as well as individuals; with a view to allowing schools to react, monitor and protect children better. ***Relevant chapters: Chapter 3***
15.	**Treating parents as partners** The **Council** should commit to treating parents as partners in CSE cases and should set out publicly what a parent is entitled to expect when their child is being supported by the CATE Team. ***Relevant chapters: Chapter 3***
16.	**Approach to victims/survivors as adults** The **Council** should undertake a review of social care cases to establish whether there is any identifiable bias in respect of parents who are victims/survivors of CSE and actions that have been taken in respect of safeguarding their children, and the reasons for such actions. If the review reveals any patterns, future policies should be reviewed and training provided to ensure no unconscious bias is applied. ***Relevant chapters: Chapters 3 and 9***
17.	**Counselling for victims/survivors** The **Council** should commit to the provision of contingency funding for continued access to counselling for affected victim/survivors and family members following the publication of this Report. ***Relevant chapters: Chapter 3***

Recommendations

18.	**Council to review annually all CSE therapeutic support services** The **Council** should annually review its CSE therapeutic support offering, to include services it provides directly and services it commissions, to ensure that: • The offering is sufficiently broad in scope, encompassing mental health support and specialist trauma based support; • The support is available for victims/survivors as children, when transitioning to adulthood, and ongoing support for victim/survivors in adulthood, including a focus on relationships and parenting; • Such support is sourced from a range of providers, including national and local third sector groups; • The support offering as a whole is clearly signposted to CSE victims/survivors and their families; and that • The allocated budget is sufficient for need. The review should be published annually as part of the 'Joint CSE Review Group's' Annual Report. ***Relevant chapters: Chapters 3 and 9***
19.	**Youth support** The **Council** should commit to collaborating with those bodies best able to offer replacement for community support services for children - for example, youth club provision - no longer provided by the Council. ***Relevant chapters: Chapter 3***
20.	**Council, WMP and CCG to review processes relating to information sharing in respect of risk of HIV** The **Council**, in association with the **CCG and WMP,** should review its processes relating to information sharing in the event of discovery of risk of exposure to HIV by a perpetrator of CSE and, if no such document exists, draft an infection protocol which makes clear: • When information relating to risk of HIV exposure must be shared and with which bodies; • The legal basis for that sharing, to avoid doubt; and • Which body should take the lead on matters relating to information sharing, including identification of at risk contacts. Furthermore the Council, WMP and the CCG should consider whether their existing individual and joint processes allow for the effective identification of risk of HIV exposure when a complaint is made of (particularly non-recent) exploitation; and if it is considered they do not, to amend those procedures, or to indicate why such procedures cannot be amended to allow such effective identification of risk ***Relevant chapters: Chapter 3***

Recommendations

21.	**Council should refresh its system for reporting of concerns** • The current website based system for reporting of concerns via Family Connect requires registration. This could serve as a barrier to reporting. • The **Council** should institute and publicise a system whereby such concerns can be reported truly anonymously via a number of channels, whether by whistle-blowers or members of the public. ***Relevant chapters: Chapter 3***
22.	**Council to review its CSE complaints procedure** The **Council** should carry out a full review of its complaints process, insofar as this relates to the handling of CSE cases. This should include: • Preparing and publishing a comprehensive complaints procedure for complaints relating to CSE which should be readily accessible and published on its website; • Setting out a uniform process for dealing with all complaints relating to CSE, led by a named team within the Council; • Establishing a suitable repository for all complaints relating to CSE, so that all documents relevant to a complaint including, ultimately, its outcome, are readily accessible; • Ensuring that all staff, in particular CATE practitioners, are suitably trained so as to identify complaints, or feedback from service users which is not in the form of a complaint but which suggests cause for concern; • Signposting to assistance which can support individuals with the process and substance of a complaint; and • Publishing annually, as part of the Joint CSE Review Group's Annual Report, a summary of suitably anonymised CSE complaints and a review of complaints or concerns relating to CSE to include themes and lessons learned. ***Relevant chapters: Chapter 3***
23.	**Licensing information sharing with neighbouring authorities** The **Council** should seek to agree with its neighbouring authorities a stricter information sharing agreement, a joint enforcement protocol and a common licensing pricing structure. ***Relevant chapters: Chapter 4***
24.	**Taxi driver training** The **Council** has an established CSE training programme for taxi drivers; this course should be offered, at a cost, to drivers licensed elsewhere. In the interim, the Council should publicise the high standards that Telford licensed taxis are already required to meet and raise awareness of how to recognise a locally licensed taxi. ***Relevant chapters: Chapter 4***

Recommendations

25.	**Council to review and improve its complaints process for public complaints or concerns in relation to licensing and/or taxi drivers** The **Council** should: • Review the ways in which the public can report licensing complaints, to include consideration of instant reporting by way of text or online services; • Publicise its role in taxi regulation, the need for the public to report concerns, and the ways in which concerns can be reported, to include prominent advertising in night-time economy 'hotspots' and a requirement for in-taxi notices; and • Ensure a continuing programme of public awareness raising the requirement for licensed drivers to display their licence, so as to address 'badge-swapping'. ***Relevant chapters: Chapter 4***
26.	**Council to collate data relating to complaints against taxi drivers** The **Council** should publish annually, as part of the 'Joint CSE Review Group's' Annual Report, a taxi licensing review to include: • How many complaints it has received about taxi drivers; • How many of those complaints related to drivers licensed by the Council; • How many complaints related to sexual behaviour, including use of sexualised language or harassment, and of those, how many related to complaints involving such behaviour towards children; and • How many complaints resulted in action by the Licensing Team, and what action resulted. ***Relevant chapters: Chapter 4***
27.	**Council to implement a protocol for the sharing of safeguarding information for the purposes of taxi licensing** The **Council** should draft and publish within six months of this Report a protocol for the sharing of safeguarding information for the purposes of taxi licensing, setting out: • The procedures by which, on receipt of a new application, renewal, or a complaint about a driver, information will be requested by the Licensing Team from Safeguarding, WMP, neighbouring local authorities and such others as are deemed appropriate; and • The circumstances in which the Licensing Team will share information with Safeguarding, WMP, neighbouring local authorities and such others as are deemed appropriate, upon the receipt of a complaint and, if applicable, later imposition of a sanction against a taxi driver. ***Relevant chapters: Chapter 4***
28.	**Council to explore implementation of CCTV in taxis** • The **Council** should explore the possibility of installing CCTV in taxis. It should begin by carrying out a full consultation amongst interested parties, in the borough and in the region. • The Council should consider any funding applications that may be available to assist in this regard. ***Relevant chapters: Chapter 4***

Recommendations

29.	**WMP role in taxi licensing enforcement to be reviewed** • **WMP** should carry out a review of its current involvement in joint taxi licensing enforcement exercises in order to ensure that the exercises are sufficiently regular and rigorous, and that any information or intelligence of concern relating to CSE activity is captured and acted upon. • This should include considering which officers are involved in such enforcement exercises, and that those officers are of an appropriate rank and level of training. • If not already in place, a named officer should be designated to liaise with colleagues in the Council's Licensing Team to ensure appropriate sharing of information relating to taxi drivers who may pose a risk/concern. ***Relevant chapters: Chapter 4***
30.	**Council to review historic premises licences** • The **Council** should take steps to ensure that appropriate conditions are applied in respect of any premises operating under a historic licence; and • Whatever the terms of a historic licence, the Council should make clear its expectation that any nightclub should operate an '18 or over' entry policy. ***Relevant chapters: Chapter 4***
31.	**Council to review its oversight of restaurant and take-away establishments** • In association with its Night-Time Economy officer, Licensing Team and **WMP**, the **Council** should review information collection and sharing with regard to CSE concerns involving restaurants, takeaways, mobile food outlets and associated residential premises. ***Relevant chapters: Chapter 4***
32.	**All schools and colleges to review and refresh training around CSE** Where this is not already happening, **all schools and colleges,** in association with the **Council**, should: • Commit to annual training of all teachers and staff in CSE awareness; • Repeat such training at least every two years; • Set out a programme of age-appropriate CSE awareness raising sessions for their pupils, whether that programme is delivered in the context of PSHE or otherwise; and • Arrange a CSE awareness raising session for parents, no less frequently than annually, in the opening months of the academic year. Where the school in question is a primary school, such CSE awareness should be aimed at pupils in Year 5 and above, or, if not felt appropriate, a letter should be sent to all parents explaining why such a programme is regarded as undesirable within the school, and enclosing written information on CSE awareness. ***Relevant chapters: Chapter 3***

Recommendations

33.	**Schools and colleges to appoint a CSE Lead** All **secondary schools and colleges** in Telford, in association with the **Council**, should designate a CSE Lead (who should not be the Designated Safeguarding Lead ("DSL")), but whose identity should be known to parents and children, and who must be easily accessible to children. The CSE Lead should compile the children at risk report and the mapping report (in accordance with **Recommendation 5**) in consultation with colleagues, including the DSL. ***Relevant chapters: Chapter 3***
34.	**Schools to review CPOMS policy and systems for information sharing** In association with the **Council, all schools and colleges** in Telford using the CPOMS system should ensure that: • The school or college has a written policy in place to govern the recording of CSE-related information onto CPOMS; • The policy sets out how information from CPOMS should be shared with partner agencies (namely WMP and Safeguarding) and considers the practicalities for doing so; • All relevant information is routinely recorded on CPOMS; • The information should include a statement of what the concerns are, what action was taken, and what follow up was thought to be needed; and that • A six monthly review is carried out of the information logged on CPOMS, to ensure all relevant information (i.e. information which may have been identified as a possible indicator of CSE) is routinely recorded. This process should be led by the DSL. ***Relevant chapters: Chapter 3***
35.	**Schools and Colleges to carry out an annual review of site security** In association with the **Council, all schools and colleges** in Telford should carry out an annual review to consider the adequacy of the school's site security provision, including arrangements for monitoring and recording any unauthorised access, to ensure that pupils are protected from potential perpetrators of CSE while at school, and to ensure appropriate liaison with WMP or Safeguarding where required. ***Relevant chapters: Chapter 3***
36.	**WMP to review use of CSE marker system** **WMP** should review the use of the intelligence marker system in CSE cases. The review should include: • An assessment of the suitability of training, and of effectiveness of guidance and procedures for the application of CSE markers; and • A historic search (to the extent possible) of CSE cases to ensure markers have been appropriately applied. ***Relevant chapters: Chapters 2 and 5***

Recommendations

37.	**Police officer and staff CSE training to be reviewed** **WMP** should ensure that: • All its officers, PCSOs and public facing staff receive, as part of their initial induction and learning, training on CSE; • All such staff should also receive regular refresher training and updates on CSE to include: the latest known trends around how CSE may be perpetrated; warning signs to look out for; and reminders as to the action to be taken in response to any concerns about CSE; and • Any such training addresses the appropriate use of language and techniques to encourage victim disclosure and to avoid victim-blaming. ***Relevant chapters: Chapter 5***
38.	**Review of WMP complaints handling procedures required** • **WMP** should review its internal complaints handling procedures to ensure that any complaint raised in a CSE matter is acknowledged immediately and dealt with in a timely fashion. If there are any existing timescales for a response, the review should consider whether those timescales are being met, and if not, it must consider why not and how this should be rectified. • WMP should also ensure that whenever a complaint is raised about an officer or staff member's conduct which relates to a CSE matter, consideration is given to whether any further training is required on the part of that individual, regardless of any other action that may be taken in relation to misconduct or performance issues. • WMP should publish annually, as part of the 'Joint CSE Review Group's' Annual Report, a review of complaints or concerns relating to CSE to include themes and lessons learned. ***Relevant chapters: Chapter 5***
39.	**Multi-agency approach to NRM referrals to be reviewed** The **Council** and **WMP** should: • Review and enhance the current NRM training provision to ensure that all staff who may deal with trafficked children are appropriately trained; • Ensure that such training includes when a referral should be made, and the appropriate pathways and protocols to be followed in all NRM-qualifying cases. • Liaise with one another to ensure that each organisation's protocols for NRM reporting is clear; that relevant information is shared; and agreement reached as to which authority should be responsible for making the referral, in circumstances where both authorities are involved. ***Relevant chapters: Chapter 3, 5 and 6***
40.	**PCC to commit to continued funding of CSE initiatives** The **PCC** should commit to continued funding of the following initiatives: • Taxi Marshal scheme; and • Street Pastors. ***Relevant chapters: Chapter 4 and 6***

Recommendations

41.	**PCC Holding to Account ("HTA") Meetings to be improved** The **PCC** and **WMP** should ensure that: • The Chief Constable provides relevant data and statistics relating to CSE (including risk/threat analysis; case numbers; trends, and the information prepared for the 'Joint CSE Review Group' as per **Recommendation 3** above) and raises any related budgetary concerns at the HTA meetings; • Any complaints or concerns reported to WMP relating to the handling of any CSE cases are shared with the PCC as part of the HTA meetings; and • Minutes of the PCC and Chief Constable weekly meetings are to be maintained. ***Relevant chapters: Chapter 6***
42.	**Quality of CSE training delivered to NHS providers and practitioners** In respect of CSE training, in order to increase the likelihood of training translating into practice, the **CCG** needs to: • Ensure that the training delivered to providers and practitioners includes training on effective ways of engaging with children and encouraging professional curiosity at every contact; • Review the content and format of the training to ensure that it does not simply consist of the dissemination of written information; • Ensure there is creativity in how the training is delivered; for example, practical exercises and/or tests to show understanding, including a minimum pass mark, to ensure the training is embedded in practice; and • Review the method by which assurance is provided as to the percentage of providers/ practitioners that have completed the necessary training; for example, simply because a practitioner was on a distribution list is not sufficient assurance. ***Relevant chapters: Chapter 7***
43.	**Improvements to trauma-related mental health services for victims and survivors of CSE in Telford & Wrekin** **CCG** and **NHS England** should consider all avenues to secure an increase in funding for trauma-related mental health services, in particular for victims/survivors of CSE. ***Relevant chapters: Chapter 7***
44.	**The Council to consider increasing capacity for health services to sexually exploited children** The **Council** should review the current capacity (and ability to meet demand locally, compared to the average nationally) of the following services, and where possible commit to a further increase in capacity by 2024: • Health visitors; and • School nurses. ***Relevant chapters: Chapter 7***

Recommendations

45.	**Guidance for sexual health clinics/to all health providers responsible for giving sexual health advice to be reviewed** Current sexual health guidance issued to practitioners should be reviewed, and kept under review, by the **CCG** to ensure that it: • Reminds professionals of the need to consider the potential for CSE to be a reason that the child is seeking sexual health support; and • Clarifies the policies and referral pathways to follow, in the event they have a concern that a child may be being sexually exploited, or at risk of sexual exploitation. ***Relevant chapters: Chapter 7***
46.	**GPs in Telford & Wrekin to be consulted about CSE data collection** • The **CCG** should consult with GP practices in Telford & Wrekin to consider what can be done to implement a system for flagging CSE concerns on a child's medical records. • The **CCG** should seek to raise this issue at regional and national meetings, wherever possible. ***Relevant chapters: Chapter 7***
47.	**GPs to implement review system for children moving to a different practice** • The **CCG** should ensure that the GP practices within the borough introduce a system so that, when a child moves to a different GP practice, the patient records are reviewed and any concerns regarding CSE are flagged to the new GP practice. • **GP practices** within the borough will be accountable to the CCG to confirm it has a policy in place for such file reviews. ***Relevant chapters: Chapter 7***

Chapter 1: Background to the Inquiry

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1. Background to the Inquiry

Terminology

1.1 At the outset of this Report it is important to flag up a few points on terminology.

1.2 I have thought very carefully about how best to describe those individuals that are at the heart of this Inquiry; those that have been subjected to Child Sexual Exploitation ("CSE"). I know from discussions with these individuals and from evidence I have seen that how they view their experiences is very personal to them. Some consider themselves as victims and wish to be described as such; others are adamant that they are not victims and wish only to be known as a survivor. I wish to respect that and not pre-judge how they want to be identified; therefore, throughout this Report I have referred to these individuals as "victims and survivors".

1.3 Telford & Wrekin Council (the "Council") commissioned this Inquiry. It is important to note, however, that the span of the Inquiry's Terms of Reference predate the Council's creation in 1998; before that, responsibilities for Telford fell upon Wrekin District Council and, in terms of social services and education provision, upon Shropshire County Council. Therefore, unless otherwise specified, references in the Report to 'the Council' refer to Shropshire County Council before 1st April 1998 and to Telford and Wrekin Council thereafter.

1.4 It is also relevant to note that terminology used to describe the Council's Children's Services provision has changed over the period under review; for example, at times it has been described as 'social services', 'child protection', 'Children & Family Services', 'Children's Services'. For the purposes of this Report, I have however sought to use a consistent term for ease of understanding and to ensure there is no confusion, and, unless there is reference being made to a specific team, the social work child protection response by the relevant local authority has throughout been described as 'Safeguarding'.

1.5 In addition, in relation to the term "perpetrator", I have used this word in this Report to describe 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.

Telford & Wrekin - Area and Geography

1.6 The borough of Telford & Wrekin (the "Borough") sits within the county of Shropshire, once Salop. Telford is a large town within the Borough and originates from the creation of Dawley New Town in 1963, which covered the areas of Oakengates, Dawley, Wellington, Wenlock and Shifnal.

1.7 The development of Dawley New Town was led by the Dawley New Town Development Corporation (the "Corporation") with new housing estates being built and occupied in the late 1960s. The proposed extension of this town in 1968 led to the Dawley New Town

(Designation) Amendment (Telford) Order,[1] extending its geographical area and renaming the town as Telford.

1.8 Telford is located 13 miles east-south-east of Shrewsbury and 15 miles north-west of Wolverhampton; it covers an area of approximately 30 square miles.[2]

1.9 As a new town, Telford accommodated the excess population from the West Midlands conurbation and grew rapidly throughout the 1960s and 1970s,[3] coinciding with major housing development led by the Corporation. Evidence provided by the Council states that the 1980s recession slowed the population growth, and there was a shift in emphasis from public development, to growth led by the private sector.[4]

1.10 There is also a significant rural area in the Borough, which is located to the north and west of Telford town, which covers approximately 72% of the Borough's total area.[5]

1.11 The 2001 Census of the Borough[6] (the "2001 Census") reported its total population as 158,325 people; this marked a growth from 1991 of 16,825 people (11.9%). The census explained:

"Since the designation of New Town status in the 1960s, Telford has been a regional and national population growth point. This growth continued throughout the 1990s when Telford & Wrekin was the fastest growing local authority area in the West Midlands and among the 20 fastest growing in England."

1.12 The 2001 Census reported that a significant proportion of growth in the Borough was the result of inwards migration; 7,030 people moving in with only 5,129 moving out in the 12 months prior. The age profile was also younger than the national profile, with 22.3% of the Borough's population aged 15 years or under, compared with 20.2% nationally. The census also showed an increase in the proportion of black or minority ethnic ("BME") people in the Borough, rising from 3.5% in 1991 to 5.2% in 2001, which represented an increase of 3,469 people. This was below the English rate of 9.1% over the same period.

1.13 The 2001 Census conducted of Telford[7] (as opposed to the Borough) indicated it had a total population of 133,523 people, marking a growth in population of 13.6% from 1991. In terms of geographical size, Telford accounted for only 27.4% of the Borough's area but in 2001 accounted for 84.3% of the population. This census also reported 5.9% of the population coming from a BME group; rising from 4% in 1991.

[1] Order made 29 November 1968;
http://search.shropshirehistory.org.uk/collections/getrecord/CCA_X6235/;
https://www.thegazette.co.uk/London/issue/44735/page/13433/data.pdf.
[2] British History Online - *Census*, 1971; https://www.british-history.ac.uk/vch/salop/vol11/pp1-19
[3] [redacted] - Council Corporate submission, pg 6
[4] [redacted] - Council Corporate submission, pg 6
[5] [redacted] pg 2
[6] https://www.telford.gov.uk/downloads/file/1506/telford_and_wrekin_borough_2001_census_profile
Telford & Wrekin Borough 2001 Census Profile
[7] https://www.telford.gov.uk/downloads/file/1508/telford_2001_census_profile
Telford 2001 Census Profile

1.14 The Census is conducted every ten years across the country, and the 2011 Census of the Borough[8] showed a further population increase; the total population rising by 8,300 (5.2%) from 2001. The total population in 2011 was estimated at 166,641 people. In 2011, 10.6% of the population reported being from a BME group which marked an increase from 2001.

1.15 The Borough has a current population of 179,000 people living in 78,130 households with a predicted population of 198,000 people by 2030.[9] Evidence obtained from the Council explains that:

"Rapid growth has been predicated on inward migration from, primarily, the West Midlands of households with children. This has resulted in the borough having a population age structure that is younger than the national position. As the borough has grown, it has also become more diverse - including phases of South Asian, African and European migration."[10]

1.16 Evidence provided to the Inquiry also indicates growth in the Telford economy, with 87,000 jobs and 5,560 businesses currently operating in the area across a broad range of sectors including manufacturing, business and professional services and tourism. In respect of tourism, the Borough is home to Ironbridge Gorge, a UNESCO World Heritage Site, which generates approximately £800 million per annum in revenue.[11]

1.17 Despite the growth in population and economy, the Index of Multiple Deprivation ("IMD") in 2019, which measures relative deprivation from one area to another, indicated that in 2019 the Borough had 17 areas that ranked in the 10% most deprived nationally. All of these areas were located in Telford itself.[12] Additionally, more than one in five children in the Borough aged between 0-15 were affected by income deprivation.[13]

1.18 Evidence obtained by the Inquiry suggests income deprivation in the area is not exclusive to 2019, as the IMD in 2004 indicated some of the most deprived areas in the country were clustered around Telford and the surrounding areas.[14]

1.19 In 2018, the Council also produced a 'Facts and Figures' document concerning vulnerable children and young children living within the Borough.[15] The evidence indicates that, as at March 2018:

[8] https://www.telford.gov.uk/info/20121/statistics_and_data/61/census_.The 2011 Census Profile Telford & Wrekin
[9] https://www.telford.gov.uk/info/20121/facts_and_figures/410/population_characteristics_[redacted] - Council Corporate submission, pg 6
[10] [redacted] - Council Corporate submission, pg 6
[11] [redacted] - Council Corporate submission, pg 6
[12] https://www.telford.gov.uk/downloads/file/10945/vulnerable_children_and_young_people_-_october_2019 T&W Council website – Source: The Index of Multiple Deprivation 2019; and [redacted] - Council Corporate submission, pg 6-7
[13] https://www.telford.gov.uk/downloads/file/10945/vulnerable_children_and_young_people_-_october_2019 T&W Council website – Source: The Index of Multiple Deprivation 2019; and [redacted] - Council Corporate submission, pg 6-7
[14] [redacted] – HMIC Baseline Assessment 2006, pg 11
[15] https://www.telford.gov.uk/downloads/file/10945/vulnerable_children_and_young_people_-_october_2019_T&W Council website - Source: ONS & Telford & Wrekin

1.19.1 There were 55,600 people aged between 0-24 living in the Borough, amounting to one third of its population, and by 2031 there is predicted to be a rise of 6,600. This marks a predicted increase of 12% from 2018.

1.19.2 There were 370 'looked after' children in the Borough; a rate of 92 per 100,000 and *"significantly worse"* than England's average of 64 per 100,000.

1.19.3 There were 1,379 'children in need' in the Borough; a rate of 343.5 per 100,000 and *"similar"* to England's average of 341 per 100,000.

1.19.4 There were 229 children subject to a Child Protection Plan in the Borough; a rate of 57 per 100,000 and *"significantly worse"* than England's average of 43.5 per 100,000.

1.20 Additionally, the Council's data indicates that hospital admissions as a result of self-harm by children and young adults aged between 10-24 is *"significantly worse"* than England's average. In 2017/2018 there were 168 admissions for self-harm within this age range, a rate of 518.4 per 100,000 (421.2 being England's average).[16]

What is CSE?

1.21 The statutory definition of sexual exploitation within the Sexual Offences Act 2003 is limited to conduct which, in earlier versions of the Act, was termed 'prostitution'.[17]

1.22 In February 2017 the Government released non-statutory guidance[18] (the "Guidance") which defined CSE as follows:

"Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology."

1.23 This definition encompasses a wide range of offences and behaviours. The Guidance acknowledges – rightly, in my view – that CSE is complex, and by its nature the exploitation may take on numerous different forms; victims may be seen to 'consent' to the activities they are subjected to, and in many cases there may be no overt indication that the child is at risk, such is the nature of the grooming. Witnesses have told me that this definition does not however recognise that CSE is not always as a result of deception, manipulation or coercion; sometimes it is simply the threat of violence that forces a child into CSE.

[16] https://www.telford.gov.uk/downloads/file/10945/vulnerable_children_and_young_people_-_october_2019
T&W Council website – Source: Public Health England
[17] Section 51 Sexual Offences Act 2003 as amended by Serious Crime Act 2015 s.68
[18]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf

1.24 This Inquiry has had the opportunity to hear from victims and survivors, whose experiences of CSE in many cases have been very different, but in all cases extremely harrowing. I am indebted to them for the time they have given; I know it will have been incredibly hard for them to re-live their experiences, but it has been invaluable for me to hear their accounts.

1.25 The definition of CSE adopted by the Inquiry, as set out in its Terms of Reference, is as follows:

"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."[19]

1.26 This definition was created following a public consultation as part of the creation of the Inquiry's Terms of Reference, which is explained in more detail below.

The National Picture - Other CSE Investigations

1.27 Telford is not the first town where CSE has occurred; sadly it will not be the last. It is a crime that has been going on for a long time, but is one that has only become more widely recognised, and defined, as CSE over the last few decades. At a national and public level, recognition has largely come from a series of high profile investigations and prosecutions.

Derbyshire – Operation Retriever

1.28 In January 2009, an undercover policing operation was commenced by Derbyshire Police, looking into the issue of CSE taking place in and around Derby. The investigation was known as Operation Retriever and it led to the prosecution of 13 men, with nine being convicted in November 2010 for a range of offences including rape, sexual activity with a child, and witness intimidation.[20]

1.29 Many of the 27 victims who came forward to make complaints against the perpetrators were already known to social services in Derby, and some were in the care of the authorities at the time they suffered abuse. Their stories began to come to light via the local charity 'Safe and Sound', which had been established in the region in 2002, and sought to offer free advice and support to children at risk of exploitation and trafficking.

[19]https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/5d2859da1636a90001ba0c84/1562925531616/Terms+of+Reference.pdf
[20] Derby sex gang convicted of grooming and abusing girls - BBC News

Rotherham – Operation Central

1.30 Another CSE scandal to come to light was that which took place in Rotherham in 2010. Operation Central, led by South Yorkshire Police, was set up in 2008 and went on to uncover the organised exploitation of young girls in the South Yorkshire town from the late 1980s until the 2010s. It was reported that in the early to mid-1990s, community workers were beginning to notice that children within the care of Rotherham Council were being targeted by taxi drivers for the purposes of sexual exploitation – or, as it was referred to at that time, 'child prostitution'.

1.31 Following the conviction of five men in 2012, Rotherham Council commissioned an independent inquiry led by Professor Alexis Jay OBE (the "Jay Inquiry"), which reported in August 2014.[21] The Jay Inquiry found that approximately 1,400 girls had been exploited in Rotherham over a six-year period, and that the authorities in South Yorkshire had been aware of the abuse dating back many years but had failed to address it. The Jay Inquiry report covered the period 1997 to 2013.

1.32 As a result of the failures identified by the Jay Inquiry, the Government commissioned an independent inspection of Rotherham Council to be carried out by Louise Casey in 2014, and in 2015 Ms Casey produced a report entitled '*Reflections on Child Sexual Exploitation'* (often referred to as '*The Casey Report'*).[22]

1.33 In 2015, the Government published its official response to the Jay Report – entitled '*Tackling Sexual Exploitation',*[23] where a number of commitments were made to ensure that scandals such as Rochdale and Rotherham should "*not be allowed to happen again."*[24]

Rochdale – Operation Span

1.34 Operation Span was launched by Greater Manchester Police in 2010, two years after Operation Central was begun by South Yorkshire Police in Rotherham. As in Rotherham, the authorities in Rochdale had begun to identify children at risk of sexual exploitation with links being made to takeaways and taxi companies.

1.35 Charges were brought against a number of perpetrators in June 2011, leading to the conviction of nine men in 2012 – two of whom, it was found, had been arrested four years earlier in 2008 for the rape of a 13-year-old girl, but were not prosecuted at the time because the Crown Prosecution Service ("CPS") ruled that the victim was "*not credible*". The story of that young girl, and the abuse and exploitation of her friends, was later televised in the BBC drama series '*Three Girls'*, which aired in 2017.

Oxford – Operation Bullfinch

1.36 Again, at a similar time, Operation Bullfinch was launched in May 2011 by Thames Valley Police and Oxfordshire County Council, representing a joint investigation into allegations of

[21] independent-inquiry-into-child-sexual-exploitation-in-rotherham
[22] Title (publishing.service.gov.uk)
[23] Tackling Child Sexual Exploitation (publishing.service.gov.uk)
[24] Ibid, pg 3

CSE and serious sexual offences against children across Oxfordshire during the 1990s and early 2000s.

1.37 The investigation led, initially, to the prosecution of seven men, who were convicted in 2013 of a total of 59 offences between them, including for rape, trafficking and of 'facilitating prostitution'. However, five further trials have followed since 2013, the last taking place in February 2020, resulting in Operation Bullfinch securing the conviction of a total of 21 offenders in its decade-long investigation into CSE in the county.

1.38 A Serious Case Review ("SCR") was conducted in 2015, and a report produced by the Independent Chair of the Oxfordshire Safeguarding Children's Board, Maggie Blyth, estimated that up to 373 children in the county may have been targeted by an organised network of abusers.[25] The review looked at the handling of concerns by the authorities between 2005 and 2012 and found that there was a culture within those in power that failed to recognise signs of grooming, and instead victims were disbelieved and assumed to be "*precocious and difficult";* it also noted a "*pessimism*" about the prospects of the successful prosecution of offenders, as victims were alleged to have withdrawn their support or changed their stories.

Bristol – Operation Brooke

1.39 The CSE operations continued over the following years elsewhere in the country. Avon and Somerset Police launched Operation Brooke in May 2013 following the recovery of a vulnerable 14-year-old girl from an address in Bristol, who went on to disclose that offences had taken place at those premises and others, involving multiple victims and offenders. A series of trials followed, resulting in the conviction of 13 men for a total of 42 offences including rape, sexual activity with a child, trafficking and facilitating child prostitution.

1.40 Like Operation Bullfinch, a SCR followed, and the '*Brooke Report'* published in 2016[26] focused on the multi-agency approach taken to CSE and considered whether or not this was effective in identifying and protecting children at risk of exploitation.

The National Response

1.41 In light of the number of CSE operations and prosecutions, the House of Commons Home Affairs Committee released a report into '*Child Sexual Exploitation and the Response to Localised Grooming'*[27] in June 2013, which found that:

> "*… both Rochdale and Rotherham Councils were inexcusably slow to realise that the widespread, organised sexual abuse of children, many of them in the care of the local authority, was taking place on their doorstep.*"

1.42 There have been a number of actions taken on a national basis since then to tackle CSE. For example, in April 2015 the Home Office provided Police Transformational Funding ("PTF") to Chief Constable Simon Bailey (then the National Police Chiefs' Council lead for

[25] scr-into-cse-in-oxfordshire-final-for-website.pdf (wordpress.com)
[26] Serious-Case-Review-Operation-Brooke-Overview-Report.pdf (safeguardingsomerset.org.uk)
[27] Microsoft Word - HC 68-I LCG CRC FINAL report vol 1.docx (parliament.uk) – pg 29

Child Protection Abuse Investigation), and the funding was used to appoint a network of ten regional CSE analysts and ten coordinators within Regional Organised Crime Units ("ROCUs") in England and Wales; in 2017, the Government also issued non-statutory guidance aimed at practitioners, local leaders and decision makers who work with children and families to support them in identifying CSE and taking appropriate action in response; and in 2019 the Home Office published a child exploitation disruption toolkit to help frontline staff and safeguarding partners understand their legislative powers and use best practice to disrupt the sexual and criminal exploitation of children.

1.43 What the above history and background shows, is that while there has been an increased understanding of CSE and steps are being taken to tackle it, the issue of CSE is not a recent one – whether in Telford, or across the country as a whole.

Public Awareness of CSE in Telford and Calls for an Inquiry

The Chalice Prosecutions – 2012

1.44 CSE first hit the news in Telford in 2012, the same year as the convictions in Rotherham and Rochdale, when during the course of 2011 and 2012, eight men in Telford were convicted of CSE-related offences after the completion of a four-year long investigation into exploitation and trafficking of children, led by West Mercia Police ("WMP"). This investigation was known as Operation Chalice ("Chalice"), and it became well-known to many across the Telford community.

1.45 In 2013, Telford again made national headlines when the Channel 4 documentary entitled '*The Hunt for Britain's Sex Gangs*' was aired. The programme tracked the work of the Chalice Team between 2010 and the conclusion of the trials in 2012, and followed an earlier Dispatches documentary called '*Britain's Sex Gangs'*, which aired in 2011 covering the UK-wide issue of young girls being groomed for sexual exploitation.

1.46 Following Chalice, a number of reports were commissioned both by the Council and WMP, which considered learnings from the police investigation and the multi-agency response to CSE. This included the Council's own Scrutiny Review of '*Multi-Agency working against CSE'*, published in May 2016,[28] which acknowledged that "*despite the success of Operation Chalice, it is clear that CSE is still taking place in Telford & Wrekin*" and that there were "*particularly compelling eyewitness accounts of predatory behaviour going on in the night time economy*" which suggested that "*a new generation of post-Chalice perpetrators is growing up*" in Telford.

1.47 I address the various reports and reviews undertaken during this period later in this Report. Suffice to say that Chalice signified a pivotal moment in acknowledging the scale of CSE in Telford.

[28] [redacted]

2016 Press Reports

1.48 It was however some four years after the Chalice trials, in the late summer of 2016, when two press reports appeared in the Sunday Mirror likening Telford to Rotherham, and alleging that the authorities had failed to act on concerns raised by the Telford Street Pastors (after Chalice) that young girls were being groomed at under 18s discos in the town.[29] The reports made reference to Home Office statistics obtained that showed Telford had the "*highest child sex crime rate in the country*" with 15.1 crimes reported per 100,000 in the year to September 2015.

1.49 The Sunday Mirror journalists went on to spend considerable time engaging with victims and survivors in Telford. Along with the MP for Telford, Lucy Allan, they began the campaign for a public inquiry.

1.50 In September 2016, during Prime Minister's questions, Lucy Allan called for a Government-led public inquiry after an abuse victim told her that many of the worst offenders had not been prosecuted and still lived in the area. The then Prime Minister, Theresa May, said in response:

"My honourable friend has just shown the cross party concern that there is on the issue of child abuse and child sexual exploitation. It is absolutely right, as she says, that we are able to look into the abuses and crimes in the past.

We will need to learn important lessons from that as to why institutions that were supposed to protect children failed to do so.

It is for the authorities in Telford to look specifically at how they wish to address those issues in Telford, but I am sure that my Right Honourable Friend the Home Secretary has heard my Honourable Friend's comments and that she will want to take that up with her."

1.51 The following week, on 22 September 2016, a letter was sent by the leader of the Council, Councillor Shaun Davies, to Amber Rudd, the then Home Secretary, which said as follows:

"We all welcome examination of the effectiveness of our services and remain absolutely committed to tackling this issue working alongside our national and local partners.

We have had three inquiries into this issue in 2016 and understand that the independent inquiry into child sexual abuse chaired by Professor Alexis Jay OBE will assess the extent to which we have learned lessons, implemented recommendations and put in place effective strategies to prevent child sexual exploitation in the future. The three reviews this year include:

- Telford & Wrekin Council's Children's Services were reviewed by seven independent Ofsted inspectors, who were based at the Council's Addenbrooke House headquarters for four weeks during June and July.

[29] Sunday Mirror, 28 August 2016 and 4 September 2016.

- The Telford & Wrekin Safeguarding Children Board has also been inspected by OFSTED and its work was rated as good.
- The Council carried out an independent all party scrutiny review over a period of 18 months, into how agencies work together to tackle child sexual exploitation.
…

Given the recent findings of Ofsted and the fact that the Government's own independent inquiry, chaired by Alexis Jay, is already committed to looking at what happened here in Telford, we do not feel at this time that a further inquiry is necessary.

We would like to be clear that we are under no illusions that there are significant concerns around the sexual exploitation of children in Telford. In towns and cities across the country it is clear that some of the most abhorrent offences are being committed against some of our most vulnerable members of our society.

We are not blind to this issue though. We are not sticking our heads in the sand or sweeping it under the carpet. Instead, we have acknowledged the problem and committed ourselves to taking action to address it. We are keen to emphasise that investigating these crimes and protecting children from harm remains a top priority locally for all the partners concerned.
We feel that good progress has been made in tackling this issue in Telford in recent years. That progress has been recognised by numerous official bodies and must be acknowledged. However it is clear there is no complacency.
…

To summarise, we remain committed to tackling this difficult issue in Telford and will support Professor Jay in any way that we can with the independent inquiry into child sexual abuse. It is vital that we all ensure that lessons have been learned and implemented, and that effective strategies are in place across the Country for preventing child sexual exploitation."[30]

1.52 This letter was counter-signed by a number of members of the Council, the then Chief Officer of Telford & Wrekin's Clinical Commissioning Group ("Telford & Wrekin's CCG"), David Evans, the Chair of Telford & Wrekin's Local Safeguarding Children's Board ("LSCB"), Andrew Mason, and West Mercia's Police and Crime Commissioner ("PCC"), John Campion.

1.53 At that time, the Independent Inquiry into Child Sexual Abuse ("IICSA") had been established and Professor Alexis Jay had very recently taken over the role of Chair to IICSA; IICSA being a wide-ranging, national inquiry into child sexual abuse, commissioned by the Government and established under the Inquiries Act 2005, which is still running today. One of IICSA's investigations is focused on institutional responses to CSE by organised networks and the lines of enquiry for this particular investigation at the time confirmed that:

"Building upon the body of work on child sexual exploitation following specific instances in places such as Devon and Cornwall, Oxford, Rochdale, Rotherham, and Telford, this investigation will assess the extent to which a wide range of relevant authorities have

[30] http://newsroom.telford.gov.uk/News/Details/13389

learned lessons, implemented recommendations, and put in place effective strategies to prevent child sexual exploitation in future."[31]

1.54 There was therefore a suggestion that IICSA may look at CSE in Telford, as well as other areas, but the extent of those investigations was unclear.

1.55 The letter from the Council and others to Amber Rudd was then subsequently followed up by a letter sent on behalf of the Conservative Councillors at the Council, which explained that they did not share the confidence expressed within the Council's letter of 22 September, and believed that there was a "*compelling and urgent case for an immediate and independent review into CSE within the Borough of Telford and Wrekin."*[32]

1.56 Public and political pressure continued, and on 25 October 2016 Lucy Allan reiterated her call for an independent review during a Westminster Hall debate. This was however resisted on the basis that IICSA already existed as a public inquiry with broad Terms of Reference to consider CSE.

Continued Calls for an Inquiry

1.57 Some 18 months later, in March 2018, Telford made national headlines again when a series of press articles were published by The Mirror newspaper group, reporting that "*up to 1,000 girls, some as young as 11 [were] groomed and sold for sex*" in the town. The exposé was based on 18 months of investigative journalism, and the articles said that the information gathered indicated that "*hundreds of young girls [were] raped, beaten, sold for sex and some even killed over 40 years, as authorities failed to act.*" The story was front page news, carrying the headline "*Worst Ever Child Abuse Scandal Exposed*".[33] The story again drew comparisons with previous high-profile investigations into CSE in both Rochdale and Rotherham, but claimed that Telford was "*the most brutal and long-running of all.*"

1.58 The evidence suggests that the estimates of prevalence and duration of CSE in Telford produced by the Sunday Mirror - that "*up to 1,000 girls*" may have been subjected to sexual exploitation in Telford over a 40 year period – were based on a significant amount of research and Freedom of Information Requests which included interrogating WMP and Council data.[34] The data collated sought to identify the number of CSE investigations and resultant prosecutions over that period, as well as the number of referrals to the Council's Children Abused Through Exploitation ("CATE") Team by the Family Connect service between 2013 and 2016. Other data relied on included (but was not limited to) data set out in the Home Office Report entitled '*Telford and Wrekin Child Sexual Exploitation 1 April 2012 to 21 March 2018*' and data published by the Home Office in 2016, which indicated that for the period between September 2014 and September 2015, Telford & Wrekin recorded 256 child sex crimes, which equated to the highest rate of recorded child sexual abuse crimes reported to police per head of the population, at a rate of 15.1 per 10,000 residents.

[31] https://www.iicsa.org.uk/child-sexual-exploitation-organised-networks-media-pack
[32] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.wrekinconservatives.org%2Fsites%2Fwww.wrekinconservatives.org%2Ffiles%2F2016-10%2FAmber%2520Rudd%2520letter%2520CSE%252024th%2520October%2520%252716.doc&wdOrigin=BROWSELINK
[33] The Sunday Mirror, 11 March 2018, https://www.mirror.co.uk/news/uk-news/britains-worst-ever-child-grooming-12165527
[34] [redacted] pg 24 onwards

1.59 I deal with the question of prevalence and extent of CSE in Telford as an individual limb of this Inquiry's Terms of Reference in greater detail in Chapter 2: Nature, Patterns and Prevalence of CSE in Telford; but it is important to note that it was against the backdrop of these reports that calls for an independent inquiry into CSE in Telford gained momentum.

1.60 Following the March 2018 expose by the Sunday Mirror, public pressure continued to mount with ongoing campaigns by a number of survivors for an independent inquiry focused on CSE in Telford.

1.61 On 12 March 2018, the Council wrote to Professor Jay, Chair of IICSA, indicating its belief that an investigation into Telford CSE was best carried out by IICSA within its broader remit.[35] Then on 13 March 2018, the Council asked the Home Office to begin an independent inquiry into CSE in Telford, and repeated this request again on 19 March 2018.

1.62 On 26 March 2018, the Council received confirmation from IICSA that its Truth Project would be coming to Telford later in May and June 2018, as part of the Inquiry's work. IICSA's Truth Project was launched as a listening exercise, designed to give people a chance tell their stories and have their voice heard; but it was not a formal evidence gathering process. On 28 March 2018, IICSA clarified its position in relation to Telford in a statement on its website:

"We have reviewed the reports and other papers sent to us by Telford and Wrekin Council. They show the council is taking steps to address child sexual exploitation. In our investigation into child sexual exploitation by organised networks, we are currently looking at documents gathered from institutions within a number of different local authority areas. We will consider whether we need further information from Telford and Wrekin Council as we plan for the next phase of this investigation."[36]

1.63 On 3 April 2018, the Home Office's Deputy Director, Safeguarding Unit responded to the Council's request for an independent, government-commissioned inquiry into CSE in Telford. The response said that IICSA already had 13 ongoing separate investigations, including one which was looking at the institutional response to the sexual exploitation of children by organised networks, and therefore it was not appropriate to establish a second statutory inquiry to look at issues which were already within the scope of the existing national inquiry. The Deputy Director went on to say that it was for IICSA to decide how to take this forward, without interference from government.

1.64 During the Inquiry's work, there has been contact with IICSA, and specifically the team running the investigation into CSE by Organised Networks. Given the potential for victims and survivors to decide to engage with both IICSA and this Inquiry, it was important that lines of communication were established with IICSA to ensure that any cross-over between the two inquiries could be addressed at an early stage, and importantly to reduce the impact on victims and survivors. The response from IICSA informed me that Telford would not be specified as one of its case studies, and therefore IICSA did not anticipate there being any cross-over between the two inquiries. There was also an additional complexity in relation to legal protections afforded by the General Data Protection Regulations and the privacy

[35] https://newsroom.telford.gov.uk/News/Details/14017
[36] https://www.iicsa.org.uk/news/inquiry-updates-position-telford

policies inquiries are required to have in place; evidence provided by witnesses to IICSA as part of its Truth Project could not be obtained by this Inquiry for the purposes of my work. This inevitably meant that for witnesses who decided to engage with the IICSA Truth Project and this Inquiry, there would need to be a degree of duplication of the evidence they gave. Witnesses unfortunately had to provide evidence afresh to this Inquiry, unless they chose to obtain a copy of the information they had provided to the Truth Project themselves, and share this with me.

The Establishment of the Inquiry

1.65 In light of the Government's decision not to establish a separate statutory inquiry into CSE in Telford, combined with continuing public pressure and following a Motion from local opposition members seeking the commissioning of a local inquiry, it was unanimously agreed at a Council Extraordinary General Meeting on 10 April 2018 that an independent, non-statutory inquiry into CSE should be established within the borough. During a Cabinet meeting on 19 April 2018, the implications of this decision was further considered, including how the inquiry would be set up. At this meeting the following was discussed:

1.65.1 That an independent cross-party advisory body would be set up to consider how best to implement a process that ensured the Inquiry was as independent as possible from the Council. This group became known as the CSE Inquiry Members Advisory Group, or "CSEI MAG"; and

1.65.2 A proposed four stage process for commissioning the inquiry, to ensure it remained independent from the Council, was also presented and discussed. This process proposed that the CSEI MAG appoint an independent organisation to set up the Inquiry and recruit a Chair – subsequently described as the Commissioning Body - and the Inquiry would then be led by the Chair.

1.66 Around this time, a group of survivors, victims and supporters, including those who had campaigned for the Inquiry, created a group that became known as the Survivors Committee. The Survivors Committee was invited to contribute to the design of the tender documentation to engage a Commissioning Body for the Inquiry and was consulted during the tender process. Representatives from the Survivors Committee also sit as lay members of the Council's CSEI MAG.

1.67 The CSEI MAG then commenced the commissioning process; the first stage being to appoint an independent Commissioning Body. Following a competitive tender process, Eversheds Sutherland (International) LLP was formally appointed as the Commissioning Body on 22 January 2019.

1.68 The first task for the Commissioning Body was to recruit and appoint an independent Chair to lead the Inquiry. I am told that a draft recruitment pack for the role of the independent Chair was prepared by the Commissioning Body and delivered to the CSEI MAG on 12 February 2019 and the Council's Cabinet on 14 February 2019, for noting, comment and observations. At its meeting on 14 February 2019, the Cabinet approved the recommendations from the Commissioning Body to start the recruitment process for the Chair.

1.69 Shortly following these meetings, on 19 February 2019, the role of Chair was advertised and open for one month. The recruitment process consisted of the following stages:

1.69.1 An applicant sift, with the most suitable candidates being invited for interview;

1.69.2 First formal interview - the Commissioning Body carried out formal interviews;

1.69.3 Meeting with the local Survivors Committee, following which the Survivors Committee provided their feedback to the Commissioning Body; and

1.69.4 Undertaking due diligence on the final candidates, including taking up references.

1.70 On Friday 7 June 2019, the Commissioning Body offered the role of Chair to me; of course, I accepted, with my appointment being formally announced on Monday 10 June 2019.

The Terms of Reference

1.71 Following my appointment, the first task for me and the Commissioning Body was to draft and agree the Terms of Reference. The Terms of Reference of an inquiry are crucially important; they define the breadth and complexity of an inquiry's work. The challenge is to ensure the right balance is struck between Terms of Reference that are too wide or unclear, which may lead to an inquiry delivering wide-ranging recommendations that do not address the essential issues, as well as increasing the cost and duration of an inquiry and creating unacceptable delay; and Terms of Reference that are too narrow, thereby restricting an inquiry from dealing with all relevant matters and delivering results. The objective was to define Terms of Reference that provide answers to the key issues, but which are achievable to deliver within an acceptable timeframe.

1.72 Earlier in 2019, the Commissioning Body began working with the Survivors Committee to start discussions in relation to the Inquiry's Terms of Reference. Early engagement with the Survivors Committee was a priority, to help understand the main issues to be considered when designing the Terms of Reference. There was however a recognition that wider consultation on the Terms of Reference was important to ensure that all victims and survivors, stakeholders and members of the public, had an opportunity to comment on the scope of the Inquiry's work, and to ensure that the final Terms of Reference were informed by as many views as possible.

1.73 On 13 June 2019, shortly after my appointment, a public consultation on the Terms of Reference was launched on the Inquiry's website. The public consultation particularly invited the views of those who were directly affected by the matters due to be considered, and those that were likely to be involved in some way with the Inquiry's work; but the opportunity to provide input to the consultation process was open to all.

1.74 The consultation invited all comments, but also posed four questions on key issues. A copy of the paper put out for consultation appears at Appendix A to this Report.

1.75 At the point of launching the consultation, the Commissioning Body contacted a number of key stakeholders,[37] other contacts (including witnesses who had already contacted the Inquiry), and local organisations, to notify them of the consultation, invite them to contribute by providing their views and asking them to pass on the information to others who may be interested in the Inquiry's work.

1.76 The Commissioning Body also advertised the public consultation in a number of ways, including:

1.76.1 Placing an advertisement in the West Midlands Metro, which ran from Friday 14 June 2019 to Thursday 20 June 2019; and

1.76.2 Leaflets promoting the consultation were distributed in the local area, including to GP surgeries, leisure and fitness centres, libraries, Telford Ice Rink, Meeting Point House in Telford, the Holly Project at the YMCA in Wellington, Telford After Care Team in Wellington, Maninplace in Wellington, Recharge, the Job Centre Plus and Malinsgate Police Station.

1.77 The consultation also involved a public event, which took place on Tuesday 2 July 2019, at the Ramada Hotel in Telford. The event was attended by over 50 people. The consultation remained open until 5 July 2019.

1.78 The consultation was open for just over three weeks. In light of the calendar of Cabinet meetings, I had to decide whether to conduct the consultation in time for the Cabinet meeting in July, with a meeting of the CSEI MAG taking place just prior to this, or conduct a slightly longer consultation process and then have to wait until the Cabinet meeting in the middle of September 2019 to have the final Terms of Reference approved. I took a decision with the Commissioning Body that although a thorough and effective consultation process should be undertaken, it was important that this happened quickly, so that the work of the Inquiry in beginning to gather evidence could start as soon as possible. Based on the number of detailed and well-considered responses submitted in response to the consultation, which contained repeated themes, I had no reason to think that a longer consultation period would have resulted in a significant increase in responses, with new issues being raised.

1.79 All responses to the consultation were considered in full and all of the comments made at the public consultation event on 2 July 2019 were taken into account when preparing the final Terms of Reference.

1.80 The final draft Terms of Reference were prepared and provided for members of the CSEI MAG to discuss and consider at a meeting on 9 July 2019. Comments on the Terms of Reference and suggested amendments were provided by the CSEI MAG, and by a member of the local Survivors Committee, who was a lay member of the CSEI MAG. This included comments on the proposed time period that the Inquiry would be considering, which was originally proposed as being from 1995 to the present day; 1995 being shortly before the establishment of Telford & Wrekin as a unitary council, allowing any findings as to handover and organisational memory from Shropshire County Council to be considered and taken into

[37] This included Telford & Wrekin Council, Shropshire Council, Telford & Wrekin's LSCB, WMP, West Mercia Police's PCC, Telford & Wrekin CCG, the local Survivors Committee, and local MPs, amongst others.

account. Representations were however made that the Inquiry's Terms of Reference should go back further, to the passing of the Children Act in 1989, which was supported by members of the CSEI MAG. The Commissioning Body and I considered those comments and agreed to reflect those changes in the final Terms of Reference.

1.81 The final Terms of Reference governing this Inquiry were ratified by the Council's Cabinet on 11 July 2019 and were published on the Inquiry's website on 12 July 2019. A copy of the Terms of Reference appear at Appendix B.

1.82 In order to provide guidance as to the interpretation of the Inquiry's Terms of Reference and give an indication of the issues that I would be examining during my work, a List of Issues was also prepared and was published on 3 October 2019. The List of Issues was not designed to cover all issues that would be investigated, and it was not a prescriptive list, but it was intended to be a guide to assist understanding and an indication of how the Terms of Reference were being interpreted. A copy of the List of Issues appears at Appendix C.

Timescales

1.83 At the outset of the Inquiry's work, I had a limited understanding as to how many witnesses might have relevant evidence to provide, and how many would be willing to engage, as well as the number of relevant documents stakeholders would hold. As a result, the scale of the work that faced me was unclear and therefore designing an inquiry process with a fixed timetable was something of a challenge; it was therefore essential for this Inquiry to have a degree of flexibility. I was however aware that victims and survivors had been waiting a long time for this Inquiry and that any recommendations I make should be put in place as soon as possible if they were to achieve a positive outcome. It has therefore been a constant balance between delivering this Inquiry quickly, but ensuring it is thorough and delivers sound recommendations.

1.84 In order to ensure that the Inquiry's work stayed on track, there were a number of factors I felt were important:

1.84.1 Ensuring that documents were provided by stakeholders in a timely and thorough manner, whilst allowing those organisations a reasonable amount of time to seek out, in some cases very historic, material;

1.84.2 Considering the parameters of disclosure requests made to stakeholder organisations, to ensure that such requests were necessary, proportionate and relevant to the Terms of Reference, and therefore to avoid time being spent on irrelevant or duplicated material;

1.84.3 Providing a process whereby documents could be disclosed in a secure and organised way;

1.84.4 Allowing, and indeed encouraging, witnesses coming forward to speak to the Inquiry and provide evidence, in circumstances where the Inquiry has no power to compel witnesses to provide evidence;

1.84.5 Giving victims and survivors sufficient time to think about this Inquiry, and whether they wish to come forward and tell their story – recognising that many find such a decision incredibly hard; and

1.84.6 Working proactively with key stakeholders to ensure continuing engagement and cooperation, again, where I have no powers to compel them to do so.

1.85 While I initially hoped to conclude this Inquiry within a timescale of approximately 21 months, there have been delays. Perhaps unsurprisingly, the Covid-19 health pandemic has had a particular impact.

1.86 With the Inquiry's work starting in earnest following the ratification of its Terms of Reference in July 2019, just nine months later the Covid-19 public health crisis had significantly developed and was having a huge impact on the nation. As a result, the Inquiry had to adapt the way it was working to ensure that the Inquiry's work continued, as far as possible, during the pandemic. This included:

1.86.1 Adapting its working arrangements, with the team and I all working remotely, although we remained contactable on the Inquiry's usual email/telephone details;

1.86.2 All witness evidence being taken via secure video or telephone conferencing, if the witness agreed to proceed on this basis; and

1.86.3 Delaying the taking of face to face meetings where witnesses only wanted to provide their evidence in this way.

1.87 Inevitably there was also some interruption to the progress being made in gathering relevant evidence, with the pandemic impacting many of those stakeholders who were providing documents, information and evidence to the Inquiry. A number of the stakeholders have been on the front line of the emergency response to the pandemic. In particular, this impact has been felt in the following ways:

1.87.1 The practicality of access to hard copy material was a challenge for all stakeholders due to restrictions around access to premises, including the requirement for premises to be 'Covid Secure' which, amongst other things, resulted in a limit on attendees. Unsurprisingly, access to paper documents has taken longer for stakeholders to arrange than might be the case in ordinary times;

1.87.2 As a number of stakeholders have been extremely busy in their primary roles, time which might have been spent organizing the disclosure of documents to the Inquiry was, understandably, diverted to supporting the community and prioritising those most in need. As a result, the disclosure process has taken longer than otherwise might have been the case. I have taken account of the fact that this will have been a difficult period for some stakeholders and their staff, and therefore, where it was felt appropriate, I have allowed a number of extensions to deadlines for documents and information to be provided. In some cases I have allowed significantly longer than would normally be the case; and

1.87.3 For the same reason there was more of a delay in seeing stakeholder witnesses than originally planned.

1.88 In addition to the impact of Covid-19 on the Inquiry's timescales, the sheer volume of material received is far greater than I had originally anticipated. In total, the Inquiry has received over 198,000 documents/1,285,000 pages of disclosure from organisations. This takes time to sift and distil and it was crucial that the documents be considered and any further follow up be made as necessary.

1.89 This therefore means that my work has taken three years to complete, almost to the day, from start to finish. It has been important to get this right and not to simply 'make do' in a shorter period of time.

Constitution of the Inquiry

1.90 When commissioning this Inquiry, the Council was clear that it should be led by someone entirely independent of them; as explained above, the Commissioning Body was appointed following a competitive tender process, and they in turn appointed me, following a rigorous recruitment process, which included input from the Survivors Committee. Throughout the Inquiry's work, independence has been of paramount importance. This has been an Inquiry led by me and it has been my responsibility to fulfil the Terms of Reference. The findings and recommendations in this Report are mine alone.

1.91 That said, whilst the Inquiry has been led by me, this has not been a small undertaking and I have been necessarily supported by a team from the Commissioning Body. That team has assisted with setting up the necessary Inquiry processes, contacting and communicating with stakeholders and witnesses, taking evidence, requesting, gathering and reviewing disclosure, and the general administration of the Inquiry. That has all been at my direction. The support provided has also included legal advice about the Inquiry's powers and privacy and data protection issues, as and when needed.

1.92 As well as support from the Commissioning Body, I also made a decision that my work should be supported by independent expert evidence. I conducted a number of interviews with possible candidates for the role of the experts, and ensured that those I appointed were free from conflict. During the course of the Inquiry I appointed two individuals to provide expert evidence:

1.92.1 The first was social work expert, Jane Wiffin, who is a freelance social care consultant with a professional background as a social worker. Jane has over 25 years' experience of practice across Children's Services in safeguarding roles, with extensive experience of reviewing safeguarding practice, undertaking SCRs/safeguarding adult reviews and developing policy. Jane was formally appointed in November 2020 following a recruitment process. Jane was appointed particularly to assist me in examining whether social work practices, approach and structures reflected published guidance and contemporary practice relevant at the time. This also included reviewing some of the case studies featured in this Report and the actions taken in response to these cases. It has been critical to assess social work practice and the actions taken in the context that was relevant

at the time, rather than the context as we now know it. Jane's assistance with this has been invaluable.

1.92.2 The second was an expert in policing, André ("Andy") Baker QPM, LLB (Hons) AKC. Andy was a career detective in the Metropolitan Police Service where he attained the rank of Commander (Assistant Chief Constable in county forces) and was a member of the Command Team in the Serious Crime Directorate at New Scotland Yard, which oversaw all child protection units across London. Earlier in his career, he was a Detective Inspector on the Bexley Project, which was a joint police/safeguarding project working together to tackle child sexual abuse that led to similar combined teams being formed across all London boroughs. In 2005, Andy was appointed as a Deputy Director in the Serious Organised Crime Agency (that is now known as the UK's National Crime Agency), leading a number of commands, and was the Deputy Director/Chief Operating Officer for the Child Exploitation and On-Line Protection ("CEOP") Unit. Andy also led the team that reviewed South Yorkshire Police's handling of the grooming cases in Rotherham, a review which recommended a number of investigative opportunities into the grooming gangs, which led to arrests, charges and imprisonment of those responsible for exploitation offences. Andy was formally appointed by the Inquiry in January 2021. Andy has assisted me in relation to the relevant national policing policies, guidance and practices that have applied over time and how these influenced operational responses to CSE (or, formerly, 'child prostitution'). He has also reviewed information and documentation provided by WMP (and others), both from a corporate perspective and in relation to specific case studies, in order to provide me with his view as to whether the police response was appropriate and proportionate. Again, Andy's evidence during this Inquiry has been of great assistance.

Data Protection

1.93 Given the nature of the Terms of Reference, the Inquiry was always going to receive personal data and sensitive personal data. The necessary framework for receiving and processing this data therefore had to be put in place, which included a clear privacy policy that was given to anybody that provided such data to the Inquiry.[38]

1.94 That privacy policy made clear that, as a general rule, information provided to the Inquiry would be confidential and would not be shared with any organisations or individuals without consent. That was however subject to a few exceptions, which were set out in some detail in the privacy policy. A simplified explanation of how that works in practice was also set out in a frequently asked questions ("FAQ") document that was shared on the Inquiry's website.[39]

1.95 At the outset of the Inquiry's work, I also made clear that when it came to preparing this Report, I would not make the following information public:

[38]https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/5f69d06ba444b2584a1ffd42/1600770155808/Privacy+Policy+21.09.2020.PDF
[39]https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/5f731a33b3ae0a703eda8319/1601378868211/Revised+FAQs+-+published+on+29.09.2020.pdf

1.95.1 The identities and any identifying information of victims and survivors, without their consent; and

1.95.2 The identities of those accused of sexually exploiting children, unless they have been convicted of that offence.

1.96 To avoid disclosure of any of this information, and to ensure that evidence provided to the Inquiry by witnesses remains confidential, alterations have been made to this Report. For example, some information has been redacted, which means information which could reveal a person's identity has been blacked out. That includes redacting all Inquiry document references included in the footnotes of this Report, as there is a risk that linking documents together could identify individuals. In other cases some information has been withheld to avoid identification; evidence given to the Inquiry has been quoted but has not been attributed to the relevant witness; in other places in the Report I have also altered the facts, for example changing dates, places, or other potentially identifying information in order to protect the identities of individuals, but so that I am still able to convey the information upon which my findings are based. I have taken a cautious approach to the publication of any such information.

1.97 There are some exceptions to this. For deceased individuals, there is no obligation to protect their personal information, and in some cases their identities as victims of CSE are widely known within Telford and have been referenced in information in the public domain. This is particularly so with two case studies I chose to consider given they have featured so much in people's minds when they consider CSE in Telford. Having said, although those individuals are tragically no longer with us, of course their family members are, and it has been extremely important that I keep them in mind. Therefore, in such cases, where possible I have kept particularly sensitive or distressing information out of the Report, and only included that which I believe is necessary to illustrate the circumstances of their cases and allows me to draw the conclusions that I need to, in order to do right by those individuals themselves.

1.98 The framework around protecting data provided to the Inquiry has not, however, inhibited my investigation nor prevented me from being able to identify failings, individual or organisational, where they have occurred.

1.99 I have also had to consider the handling of sensitive information contained within documentation received by the Inquiry, in particular within the WMP disclosure. I have had to ensure that any references made within this Report do not compromise:

1.99.1 The ongoing investigation of any CSE complaints, and in turn the identities of any potential victims, witnesses or suspects involved; and

1.99.2 The highly confidential nature of police tactics, such as intelligence gathering and surveillance techniques, which are used to investigate and disrupt CSE.

1.100 To do so would clearly risk the ongoing efforts of the authorities to bring perpetrators to justice. To that extent, where necessary, names of WMP operations, reports or officers may be removed, or limited details included within the Report; but again, I have sought to do so

in a way that allows me to highlight any significant findings which I deem to be central to the Terms of Reference. This has been the case particularly where I deal in the Report with the historic intelligence reports held by WMP and actions taken over subsequent years in relation to individual cases – where those cases have never come to light, and/or victims/survivors and perpetrators have not been identified or had a criminal justice outcome. There is a risk of identification of those individuals 'by aggregation', if certain identifying features are included from those cases, so care has been taken to protect this information.

1.101 In all such cases I have sought the advice of specialist data protection lawyers to ensure that the privacy of individuals is considered at all times.

Public Communications

1.102 Another key principle of conducting this Inquiry has been ensuring that key stakeholders, individuals, and members of the public, have been kept updated about the work and progress of the Inquiry. As this is a non-statutory inquiry, there is no obligation to do so, but from the outset I felt this was key in trying to ensure there was public confidence in the work being undertaken.

1.103 Principally, information has been shared with the public via the Inquiry's website – www.iitcse.com. The website contains: information about me and the Commissioning Body team; contact details; details of the dedicated witness support service in place and details of other services that could assist; key Inquiry documents;[40]a FAQ document that was intended to help people interested in the Inquiry by providing answers to some of the common questions they may have; and a copy of all progress reports that contain information about the progress of the Inquiry's work.

1.104 At an early stage, a number of individuals also expressed to me that they would like to monitor the Inquiry's progress via social media; this being an easier way to track any newly published information, rather than having to periodically log on to the Inquiry's website to check for any new information. I took that feedback on board, and consequently a Twitter page was set up for the Inquiry - @Official_IITCSE. Whenever new information is added to the Inquiry's website, details are tweeted via this Twitter account. I however deliberately took the decision that this Twitter account was only to be used to push information out to those following the account; it was not used to communicate directly with members of the public, and so did not respond to tweets or comments. The issues being considered by this Inquiry are extremely sensitive and some witnesses are very nervous about coming forward and speaking to the Inquiry. I wanted to ensure that any discussions between the Inquiry and those who have information to provide, be conducted in private and not risk personal details being shared via a social media forum.

1.105 The other tool used by the Inquiry to provide updates on its work has been the use of quarterly progress reports. These have been published on the Inquiry's website every quarter and have contained information concerning the work of the Inquiry, for example the

[40] Such as the Inquiry's Terms of Reference, List of Issues, privacy policy, details of the public consultation for the Terms of Reference.

number of witnesses that have been seen, the number of documents disclosed, and details of the experts that have been appointed.

1.106 I had originally intended to hold a number of these progress updates in public, at suitable junctures. Unfortunately, due to the Covid-19 pandemic, the opportunity to do this has been limited. I had however hoped that as government restrictions lifted, such opportunities would arise.

1.107 I had originally intended to hold a progress update meeting in public in July 2021, and expressed this intention in the Progress Report dated 7 April 2021. However, following the announcement that the lifting of government Covid-19 restrictions was to be delayed, that update meeting needed to be converted to a virtual one. The live virtual update took place on the originally intended date, 5 July 2021, but via Zoom, with a recording of the meeting then being posted on the Inquiry's website thereafter for those unable to attend.

1.108 The next progress update was then held in person on 11 October 2021 at the Holiday Inn Hotel in Telford, with a summary of the information provided during the meeting also being published to the Inquiry's website the following day. At this update I shared the likely timetable for completion of the Inquiry's work and therefore I was keen that this information was shared as widely as possible. To that end, awareness of the update meeting was promoted as follows:

1.108.1 A Facebook advertisement, via an Inquiry Facebook account, was published from 6 to 11 October 2021, which promoted details of when and where the meeting would be held, which targeted those located in Telford & Wrekin, and within a 10km radius. The advertising campaign confirmed that the advert appeared on screen 77,503 times, and that 47,990 people saw the advertisement at least once;

1.108.2 All witnesses that had provided evidence to the Inquiry were contacted to notify them of the meeting; and

1.108.3 Key stakeholders were also informed.

1.109 In addition to information provided on the Inquiry's website, there has also been regular correspondence and meetings with key stakeholders on procedural matters and progress of the Inquiry's work. This has included meetings with the Survivors Committee, at various stages of the Inquiry's work.

Disclosure and Stakeholder Engagement

1.110 As this Inquiry is non-statutory, I have had no powers to compel evidence from organisations and individual witnesses. This means that I have not been able to make anyone provide documents or information to the Inquiry and have had to rely on the co-operation of organisations and individuals in this respect. Therefore, engagement with stakeholders has been vital to the success of the Inquiry.

1.111 One of the first steps taken in advance of my appointment and the Terms of Reference being finalised, was that key stakeholder organisations were contacted in writing by the Commissioning Body with a request to preserve any potentially relevant documents and to suspend any document destruction policies in place, in advance of the Terms of Reference being finalised and more specific requests for documents being made by the Inquiry. I understand that in all cases, the relevant organisations acknowledged the correspondence and confirmed that action would be taken in this respect.

1.112 Following ratification of the Inquiry's Terms of Reference, the Commissioning Body and I then held early meetings with key stakeholders, whom I believed were likely to hold relevant information. This included (amongst others): the Council; WMP; West Mercia PCC; Shropshire Council; Telford & Wrekin CCG; the Survivors Committee; Lucy Allan MP and Mark Pritchard MP. These meetings were intended to introduce the work of the Inquiry, set expectations for the documents that I was likely to request from the individual stakeholders and start to commence discussions for how, and when, that disclosure would take place.

1.113 I was aware that a number of stakeholders may have concerns about their ability to share information with the Inquiry bearing in mind their data protection and related legal obligations, and I was keen that this did not become a barrier for disclosure, or cause any delay. At an early stage, and with assistance from the Commissioning Body, a Data Sharing Guidance document was therefore prepared, the purpose being to set out the legal grounds which may be used to facilitate the lawful sharing of information, including personal data under data protection laws.[41] The Data Sharing Guidance was also designed to provide reassurance around how any information provided to the Inquiry would be handled and stored.

1.114 In the absence of statutory powers to force organisations to provide documents, I also sought to rely on the provisions of section 10 of the Children Act 2004 (the "2004 Act"), which was used to require certain organisations to provide information to the Inquiry. Section 10 of the 2004 Act imposes a general legal obligation on certain public bodies, known as 'Relevant Partners',[42] to co-operate with each other for the purposes of improving the well-being of children relating to, amongst other things: their physical and mental health and emotional well-being; and their protection from harm and neglect. In particular, section 10(8) of the 2004 Act provides that the 'Relevant Partners' are required to have regard to any guidance issued by the Secretary of State and this includes the '*Working together to Safeguard Children*'[43] statutory guidance. Pages 76-77 of '*Working together to Safeguard Children*' provides that:

"Safeguarding partners may require any person or organisation or agency to provide them, any relevant agency for the area, a reviewer or another person or organisation or agency, with specified information. This must be information which enables and assists the safeguarding partners to perform their functions to safeguard and promote the welfare of

[41] Which include Regulation (EU) 2016/679 (General Data Protection Regulations ("GDPR") and the Data Protection Act 2018 ("DPA")
[42] Referred to in the Children Act 2004 as 'Relevant Partners', and defined under section 10(4)
[43] '*Working together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*' dated July 2018

children in their area, including as related to local and national child safeguarding practice reviews."

1.115 If such a request is not followed, the safeguarding partner making the section 10 2004 Act request may take legal action against them.

1.116 Against this statutory backdrop, I therefore asked that the Council issue section 10 instructions to 'Relevant Partners' in relation to the Inquiry's work. This included relevant education providers and NHS providers, Telford & Wrekin CCG, individuals within the Council, Telford & Wrekin's LSCB, and WMP; these being the 'Relevant Partners' in the Council's local authority area, as provided for under the 2004 Act legislation. The instruction asked the relevant organisations to provide to the Inquiry, when requested, any information that it holds that relate to the Inquiry's Terms of Reference and to cooperate with the Inquiry's requests for assistance with its work.

1.117 This step was taken in order to strengthen the Inquiry's ability to ask for information, rather than there being any perception that organisations would be un-cooperative. In fact, to the contrary, in the majority of cases stakeholders have co-operated and assisted the Inquiry throughout its work and I comment on this further below.

1.118 There have been a number of organisations that have provided documents to the Inquiry. A full list of these organisations is contained at Appendix D to this Report.

1.119 I have provided further details of the process adopted in relation to the disclosure requested and received from the key stakeholders; namely the Council, WMP, Telford & Wrekin CCG and other NHS organisations, and Shropshire Council. The approach to obtaining relevant information has rightly been adapted in each case; depending on the organisation, the information they may have to provide and the set-up of their files and IT storage systems. Further detail is provided below.

Disclosure approach – Telford & Wrekin Council

1.120 The Council was the organisation that established the Inquiry. Given this, and the scope of the Terms of Reference, it was clear from the outset that the Council was going to have a large quantity of relevant documents that the Inquiry would need to review. This has been no small task and although there have been challenges, from the outset of my engagement with the Council, they have been open and willing to provide information and documentation to the Inquiry.

1.121 Discussions concerning disclosure of documents relevant to the Inquiry began as early as 17 July 2019, when I met with the Council, along with the Commissioning Body, to discuss disclosure generally and to understand the different categories of documents held by the Council. At that initial meeting, the Council confirmed that it had commenced the collation of documents, that hard and soft copy documents were held across various systems, but that it was in a position to commence disclosure of relevant documents by August 2019.

1.122 The approach I took to requesting disclosure from the Council was, in broad terms, a two stage process:

1.122.1 First, I made a general request for all documents relevant to the Inquiry's Terms of Reference, but also asked specifically for: a list of key staff, relevant policies and procedures throughout the relevant period, Safeguarding records for individuals who had been in contact with the Council's CATE team, internal and external reports relating to CSE and all emails of relevance to CSE. The general request, which was made formally in writing on 25 July 2019, provided guidance and clarification to assist the Council in collating relevant material. The letter acknowledged that the request was likely to result in the Council having to generate further searches for relevant material; and

1.122.2 In addition to the wide-ranging general request for any relevant documents, I have also made a series of specific document requests throughout the course of my work. These requests either arose from material provided by the Council, with further information and documents being sought, or from other lines of enquiry the Inquiry was pursuing, and these specific document requests have been made as and when they arose.

1.123 In response to the Inquiry's general request, the Council began to disclose documents from September 2019 and continued until October 2021.

1.124 The categories of documents disclosed to the Inquiry by the Council has included:

1.124.1 Safeguarding and CATE team files;

1.124.2 Policies and procedures;

1.124.3 Document destruction policies;

1.124.4 Key reviews including Ofsted inspections, Scrutiny Review, NewStart Review and National Working Group review;

1.124.5 LSCB papers;

1.124.6 Business and action plans;

1.124.7 Children and Young People's plans;

1.124.8 Minutes from relevant groups, committees and boards;

1.124.9 Complaints material;

1.124.10 Taxi licensing information;

1.124.11 Information about schools and academies;

1.124.12 Information from the public protection team;

1.124.13 Reports to Cabinet;

1.124.14 Documents relevant to police operations;

1.124.15 Relevant legal files; and

1.124.16 Emails.

1.125 In terms of the email disclosure provided to the Inquiry, searches were conducted in stages to avoid delay. Searches were conducted against all relevant 'key personnel' emails. 'Key personnel' included all relevant members of staff and was not limited to personnel at senior manager level. The Commissioning Body liaised with the Council to ensure that appropriate search terms were used. The search terms were agreed and were intended to reduce the volume of irrelevant material generated by the searchers of mailboxes, but without missing anything key to the Terms of Reference.

1.126 In addition to the documents disclosed to the Inquiry, the Commissioning Body was also granted access to the Council's Protocol system. Protocol is the Council's Safeguarding case management system used to capture social care cases, and more recently cases referred to the CATE service. Access to Protocol was provided to a small number of the Commissioning Body in October 2019. Due to data protection, the Commissioning Body naturally did not have permission to search against all cases open on Protocol and it was agreed with the Council that the Commissioning Body would only search against specific case reference numbers provided to the Inquiry by the Council. It should be noted that whenever the Inquiry requested access to a particular file, access was always granted. In light of the fact that Protocol is a live system, the Commissioning Body's access was restricted so that it could not extract information directly from the system. However, when information of relevance to the Inquiry's work was identified on the Protocol system, the Council arranged for the relevant documents to be extracted from the system and disclosed to the Inquiry in the usual way.

1.127 During the course of the disclosure exercise, and once email disclosure had commenced in January 2020, it became apparent that documents disclosed by the Council had not been filtered to remove duplicates or sifted to ensure that the material was of relevance to the Terms of Reference. As a result, the Inquiry received a significant volume of emails and documents which were either not relevant or duplicates. This was in part because a number of different IT systems and mailboxes were being searched by the Council, and they were capturing the same documents, but these were not being filtered out at disclosure stage. I therefore agreed that disclosure should be paused temporarily and two steps were taken:

1.127.1 The Inquiry provided additional guidance to the Council in relation to the sifting of material, to ensure that it was being considered for relevance to the Inquiry's Terms of Reference; and

1.127.2 The key word search terms that had been agreed, as referred to above, were reviewed and revised, to reduce the number of false positive search results being generated.

1.128 Once that process had been amended and agreed, the Council subsequently completed searches of the email system using the revised search terms and disclosed further tranches of emails in June and July 2020.

1.129 As the work of reviewing the disclosure provided by the Council progressed, it became apparent that the volume of duplicate documents and irrelevant material was having an impact on how long it was taking for the Inquiry team to review the documents provided, and was of course also increasing the cost. In April 2020, steps were therefore taken to look at efficiencies/alternative options for managing the disclosure. It had not been possible to make these assessments until a certain volume of material had been reviewed in order to provide an overview of the nature of the disclosure and therefore enable decisions to be taken around potential additional efficiencies that could be built into the process. The steps taken included as follows:

1.129.1 Bulk tagging - Given that a proportion of the Council's disclosure was not relevant to the Inquiry's Terms of Reference, steps were taken to identify groups of documents that could confidently be excluded from the pool of documents, although remained on the Inquiry's system. This included standard daily news mail shots, and accepted/declined automatic responses to appointments. This reduced the pool of potentially relevant documents by over 50,000 documents; and

1.129.2 Use of technology – using a technology platform to de-duplicate exact, or near, duplicates. For example, if the same group of ten people received the same email, it would filter out nine of these, leaving only one email requiring review; or if there were emails as part of a chain, only the chain with all emails in would be retained. The technology reduced the pool of documents for review down by 332,764 pages.

1.130 Bearing in mind issues of time, cost and proportionality, I also considered whether there were other options available to me to reduce the volume of disclosure that the Inquiry was receiving from the Council. For example, I could have decided that not all categories of information, or particular custodians/case files should be reviewed. Or I could have revised the requests for documents being made, to reduce the volume of documents being received, for example by only asking for samples of documents. While those options would have reduced the volume of material the Inquiry received, I did not however consider that these were acceptable options; I did not want to end up in a situation where I was not asking for material I would ideally like to see, which may impinge on my ability to fulfil the Terms of Reference and conduct an Inquiry that will stand up to scrutiny.

1.131 That has meant that the disclosure from the Council has been vast – in total the Council has provided 187,042 documents/1,164,195 pages of material to the Inquiry.[44] This made up the large majority of all disclosure received by the Inquiry. The material received all had to be reviewed, considered and, where necessary, further follow up investigations undertaken and queries raised.

[44] Plus an additional 332,764 documents which were received from the Council, but were identified as being duplicates, junk, or logos and therefore excluded by the technology in use.

1.132 When requesting documents, in some cases I have been told by the Council that documents requested by the Inquiry are no longer available, or could not be located despite extensive searches. The passage of time will inevitably have had an impact on the availability of documents, and documents will no longer be available due to document destruction policies that have been in place in the past. I have however been surprised that some documents have not been available.

1.133 I asked the Council for copies of all minutes for the Area Child Protection Committee ("ACPC") meetings (the predecessor to the LSCB) which was in existence until 2005. A number of witnesses who have provided evidence to the Inquiry have spoken about the role the ACPC had in the Council's response to CSE and the minutes were therefore of particular interest to me. Others who have provided evidence, including other safeguarding partners, have directed me to the Council to obtain copies. However, only a small number of these minutes have been disclosed to the Inquiry. The minutes that have been disclosed illustrate the relevance of the ACPC and I therefore pressed the Council to extend their searches in an effort to identify further copies of the minutes. I have been reassured by the Council that they have undertaken a thorough search for any documents relating to the ACPC. The search included email searches against personnel who would have been involved in the ACPC, discussions with relevant officers, as well as a physical search of diaries of individuals who may have attended the ACPC. The Council has not confirmed the retention policy for these minutes, but the fact that some of the minutes have been located suggests that the minutes were not destroyed in an orderly fashion in accordance with document retention policies, otherwise none would have been available.

1.134 As part of the specific disclosure requests made to the Council, I also requested full suites of minutes for a number of groups, committees and boards that have held responsibility for the Council's response to CSE. In each instance, I have not been provided with a full suite of minutes for the groups, committees, or boards. This has made the task of analysing the roles and governance structures of these groups incredibly difficult, and I comment on this in further detail in Chapter 3: The Council Response to CSE in Telford. It also calls into question the appropriateness and robustness of the Council's document management and retention processes. I have been surprised that the Council does not have a repository for the various minutes and was unable to provide full suites of minutes, even for some of the more recent groups which are still in existence.

1.135 I was also particularly interested in a protocol that was referred to in the Council's '*Children Abused Through Prostitution Policy'*. I deal with this in Chapter 3: The Council Response to CSE in Telford. This protocol was said to have been updated in 1999/2000. The Council's search for this document did not yield any relevant information. The Council was unable to confirm the retention policy for this document given the likely date of the document, and explained that since 1999 the Council transitioned to digital working, taking steps to reduce its paper storage. Whilst it would be unrealistic for the Council to retain all documents no longer in use, the Council has assured me that no documents potentially relevant to the Inquiry's work have been destroyed since the Council became aware of the Inquiry. I have had no reason to doubt this assurance.

1.136 Although the Council conducted a number of IT searches across its systems in order to identify potentially relevant documents, I was however aware that any documents not held on these systems would not be caught. The Council confirmed that no documents should be

held outside their systems, as this would be against the Council's document handling procedures. I however wanted an assurance that this was the case. I therefore also asked the Council to provide signed declarations from relevant Council staff which confirmed that no documentation or information relevant to the Terms of Reference was held outside the Council's computer network or otherwise away from the Council premises. These completed declarations were provided in August 2020.

1.137 The process of disclosing documents to the Inquiry has undoubtedly been time consuming for the Council. The Council has disclosed a vast number of documents – over 1,164,000 pages of material. The Inquiry has been greatly assisted by the representatives working for the Council's 'Disclosure Board' who were tasked with managing and processing the disclosure. They have responded promptly to queries raised about the disclosure and facilitated the process of transferring the large volume of documents from the Council's systems to the Inquiry. At no point have I felt that the Council was being uncooperative or deliberately unhelpful in relation to disclosure; to the contrary.

1.138 Having said that, and while I do not underestimate the Council's task of collating all relevant disclosure, the process has been, at times, long-drawn-out, often with longer delays than I would have expected. I have of course had to bear in mind that some of this was inevitable, with the impact that the Covid-19 pandemic will have had on the Council and its staff, with attention rightly being diverted to where it was needed most. I cannot, and do not, criticise the Council for that. There were however delays in the disclosure of documents even before the impact of the Covid-19 pandemic was felt by the Council, with the deadline to comply with a number of the original requests being extended several times.

1.139 The approach of not sifting the documents for relevance prior to disclosure to the Inquiry was another challenge which had an impact on the Inquiry's work and progress. Again, I do not believe that this was a deliberate attempt to inundate the Inquiry with irrelevant information, but was an unfortunate consequence of the lack of the Council resources available to review the documents. The Council has always been amenable to suggestions by the Inquiry as to how to streamline and improve the process of disclosure.

1.140 As I have said, I do not believe that the delays in disclosure and the unavailability of some of the documents requested reflects a lack of cooperation; rather I believe it is illustrative of the resource pressure felt by the Council. The Covid-19 pandemic only served to exacerbate that pressure as it directed the already limited resources away from assisting the Inquiry.

Disclosure approach – West Mercia Police

Initial Engagement with WMP

1.141 Given the Terms of Reference require me to examine the response of third party organisations, such as WMP, and the response to, and impact upon those who reported CSE crimes, it was clear that I would need to send a number of requests for documents to WMP. In terms of disclosure of material to the Inquiry, WMP is the second biggest document provider.

1.142 Prior to my appointment, the Commissioning Body wrote to WMP to request that any documents which may be relevant to the Inquiry be preserved. WMP confirmed to the Commissioning Body that such steps would be taken.

1.143 Once I was appointed as Chair, I wrote to WMP to request a meeting. On 1 August 2019, the Commissioning Body and I met with WMP to discuss disclosure of relevant documents to the Inquiry. At this initial meeting, it was agreed that a protocol for the provision of documents should be drafted; this became known as the Memorandum of Understanding ("MOU"). This formalised the process between the Inquiry and WMP in respect of the sharing of documents. The MOU was first agreed on 30 October 2019, although annexes have since been added to the MOU during the course of the Inquiry, resulting in further versions being agreed.

1.144 At the meeting on 1 August 2019, I was told that the volume of documents held by WMP was expected to be very large, and it was made clear to me that, due to the way in which police systems in general operate, it was not possible to simply type 'CSE' or other key words into a database and provide all of the ensuing results. I therefore requested a data map for each known WMP CSE operation, to include the location and format of hard copy and electronic material, and an estimated volume of that material, together with a list of key personnel for each operation. WMP also raised the possibility of them being able to create a dedicated team to respond to the Inquiry's requests for documents.

1.145 On 30 September 2019, WMP provided the relevant data map and list of key personnel for each known WMP CSE operation, at that time. For Chalice alone, there was in excess of 15,000 documents, and that information was spread across a number of systems. It was clear from this data map that there was a significant volume of material held by WMP which may be relevant to the Inquiry's Terms of Reference.

1.146 WMP also confirmed the details of its data retention policies (including its adherence to the Management of Police Information ("MOPI") guidelines), so that I could assess the potential impact on disclosure for the Inquiry. Additionally, WMP informed me that two police officers would be assigned as a dedicated resource to assist the Inquiry by collating the disclosure requested (the "Disclosure Team"). I felt it was important that any police officers assigned to respond to my requests for documents were independent and therefore had not been involved in CSE police operations in Telford, and I sought confirmation of this independence from WMP in a letter dated 11 October 2019.

1.147 The Commissioning Body and I then met with WMP again on 21 November 2019 to discuss in further detail the process for disclosure of evidence to the Inquiry. At this meeting I met the Disclosure Team for the first time and I was reassured by their credentials that they had both the necessary experience to assist with the collation of relevant material, and that they would be appropriately independent. Following initial discussions it was agreed that the most useful starting point for disclosure would be for the Disclosure Team to prepare an initial pack of key documents and reports relating to Chalice for review by the Inquiry, which was to include reference to other prior and subsequent CSE cases. This seemed to me to be an eminently sensible starting point, given the early stage of the Inquiry and that the most well-known CSE investigation at that stage was Chalice. It was intended that this would also provide me with an overview and chronology of investigations, which I could then work both

forwards and backwards from, when making further disclosure requests. This first disclosure was received on 26 November 2019.

1.148 During the meeting on 21 November 2019, we also discussed the importance of ensuring that the Inquiry did not prejudice any ongoing police investigations. This had been anticipated in the MOU but the details of how the Inquiry and WMP would go about this, without disclosing highly sensitive police material or, indeed, disclosing witness or victim identities, required careful consideration. Following this meeting, WMP and the Inquiry developed a system to ensure that the Inquiry was regularly kept appraised of the high level detail of live CSE investigations/complaints, to ensure that the Inquiry's work did not prejudice those investigations. This became known as the 'red flag list'. I have not however found that the existence of any ongoing CSE investigations/complaints has impeded the Inquiry's work, or prevented me from obtaining documents or evidence that has been requested.

Meetings with WMP Data and Records Team and Disclosure Team

1.149 From a review of the initial disclosure provided in November 2019, it was clear to me that the Inquiry would need to direct WMP to undertake specific searches of certain systems, to ensure a comprehensive data trawl was carried out – and in order to do so, it was necessary for the Inquiry to understand all of the different systems and document repositories involved.

1.150 On 14 January 2020, the Commissioning Body and I met with the Disclosure Team and WMP's Data and Records Team. In addition to establishing the potential volume and location of material and how the WMP systems could be searched, the purpose of the meeting was also to understand whether any relevant information may have been destroyed in accordance with MOPI guidelines (which WMP is required to follow).

1.151 Following the meeting, I requested a technical explanation of all WMP systems and a timeline of when each system was in operation, so that the Inquiry knew which systems could be interrogated for information relevant to the Terms of Reference. I received that summary on 6 February 2020. The Disclosure Team was also able to explain the likely searches which could be undertaken on the systems; for example, searching via crime codes or tags for "CSE" or similar phrases; or using past offences/terminology; although it was also explained to me that due to the number of system changes and updates over the years, this would require the assistance of a WMP analyst. It was also clear that, for example, in some cases it may not be possible to narrow search terms to return results solely for Telford; in the vast majority of cases, searches would have to be performed using 'nominals' (individual names).

1.152 Together with the Commissioning Body, I then met with WMP again on 23 January 2020. The Disclosure Team suggested a data analyst would be helpful to understand the scale and complexity of the disclosure requests. It was hoped that the analyst could present the different types of data available in an association chart, so that I could decide what information to request.

1.153 During this meeting, we also discussed how I would make further requests for documents, given the logistics involved regarding the number of systems and search parameters. I considered whether to send a list of key search terms to WMP, as I had done with the Council; however, for all the reasons explained above it was clear that this was not possible. Instead

I proposed that, in addition to the MOU, there be a written process agreeing parameters for each disclosure request: a list of documents would be requested as a minimum, but this list would not be exhaustive and WMP was directed to voluntarily disclose any other material found to be relevant in addition to the documents requested. I was reassured by the support offered by WMP, and the Disclosure Team were encouraged to adopt an inquisitorial approach towards disclosure requests and take a proactive approach to identifying and providing any material which they believed would assist the Inquiry, even if it was not expressly requested.

1.154 As a result of this process, the approach to requesting disclosure from WMP has been iterative; following receipt of the data map of CSE operations mentioned above, and the meetings on 14 and 23 January 2020, I sent the first disclosure request to WMP on 3 February 2020. The first disclosure request was broad, and asked for all information relating to the following:

1.154.1 Various individuals (known victims and suspects);

1.154.2 Known CSE operations;

1.154.3 Complaints material;

1.154.4 Missing persons information;

1.154.5 Policies and procedures;

1.154.6 Crime statistics;

1.154.7 CSE training materials;

1.154.8 Protocols for multi-agency working and agendas/minutes from multi-agency meetings;

1.154.9 Reports for senior officers or external agencies on the issue of CSE in Telford;

1.154.10 CSE problem profiles;

1.154.11 Independent Police Complaints Commission/Independent Office for Police Conduct referrals relating to CSE;

1.154.12 National Crime Agency ("NCA") intelligence packages in relation to CSE; and

1.154.13 Copies of Serious Case Reviews involving CSE activity.

1.155 As the Inquiry began to review documents from WMP, I was able to begin narrowing the original request for disclosure to make further specific requests based on my review of documents, and the witness evidence I heard. This led to the development of a 'master disclosure request list', which tracked all of the requests the Inquiry sent to WMP, their status, and any amendments following a narrowing of the request. To assist the Disclosure Team, I then sent requests periodically, in priority order.

1.156 Part of the process also included a quality assurance check, involving dip sample requests of material identified by WMP as 'non-relevant', so that I could assure myself that WMP was carrying out its obligations properly, and that the agreed search parameters and approach to disclosure did not risk the Inquiry missing any relevant material.

1.157 In total, the Inquiry sent 20 separate requests for disclosure to WMP; all of these were broad requests, narrowed down as appropriate over time.

1.158 Through my early discussions with WMP, I was also able to identify other departments that would hold information on separate systems; systems to which the Disclosure Team would not have access, given the sensitivity around the material held on them. This included information about covert operations (the Covert Authorities Bureau), WMP intelligence (the Force Intelligence Bureau) and on complaints (the Professional Standards Department). I considered all of these departments could hold information relevant to the Terms of Reference. Given the nature of the material, these requests were made directly to those departments rather than via the Disclosure Team and arrangements were made for those departments to be able to contact the Inquiry directly. During the course of the Inquiry's work I made two disclosure requests directly to the Professional Standards Department and two to the Covert Authorities Bureau.

CSE Operations

1.159 A number of the disclosure requests I made related to CSE police operations. I was told by the Disclosure Team that the majority of CSE operations had been recorded on the police HOLMES system. This meant it was possible for WMP to provide an index of all documents held on HOLMES for these investigations; the index included the title of each document. When I reviewed the indices, it became apparent that, often, the title of the document gave enough information regarding the contents to assess whether it would be relevant to the Inquiry. Therefore, I was able to use these indices to request specific documents relating to those investigations which appeared to be relevant to the Inquiry. It was also possible to narrow requests according to the type of document – for example, all statements, all reports, all intelligence etc.

1.160 Where an index was not available, because the investigation was not held on the HOLMES system, or because the investigation was historic and only held in hard copy, I set out a list of documents which I would expect to be disclosed, as a minimum (such as officer reports or statements, for example). This list, as agreed, was not intended to be exhaustive. As the Inquiry progressed, I also identified a number of categories of documents which were not relevant to the Inquiry, and I included these in a list called the 'Excluded Documents list'. The Disclosure Team was informed they did not need to disclose these categories to the Inquiry going forwards.

1.161 As the Inquiry continued, and I reviewed more material, I identified WMP operation names of which I had not previously been aware; equally, the Disclosure Team came across information and operations not previously known to them at the time the initial list was provided in September 2019. It was not always clear whether these operations related to CSE, or other criminal behaviour. Where this was the case, the Disclosure Team was asked to provide summaries of these WMP operations, so that I could assess whether they were

relevant to the Inquiry, and if so, whether to make a disclosure request in relation to them. Where the Disclosure Team became aware of any additional CSE operations, or standalone investigations, they notified the Inquiry and provided a summary, so that I could undertake the same assessment.

Individuals

1.162 As referred to above, I also made requests for disclosure in relation to a number of individuals, including victims and perpetrators of CSE (as explained above, searching by names was also referred to as 'nominals'). These requests involved the Disclosure Team collating all information relating to the named individuals across all WMP systems, including contacting the Covert Authorities Bureau, and disclosing any information relevant to the Inquiry's Terms of Reference.

1.163 I asked the Disclosure Team to err on the side of caution with disclosure; if in doubt as to its relevance, I asked for the document to be disclosed. The Disclosure Team would provide a list of any documents considered 'not relevant' to the Inquiry's Terms of Reference, including the title of those documents so that the Inquiry could conduct a 'dip sample' of those 'not relevant' documents to ensure that the Disclosure Team was undertaking appropriate checks for relevance. I found that the checks undertaken by the Disclosure Team were at all stages accurate; those documents dip sampled proved not to be relevant to the Inquiry and I was reassured that the Disclosure Team was acting with integrity and in accordance with the agreed process.

Resources and Progress with Disclosure

1.164 As mentioned above, the Disclosure Team comprised two police officers, one of whom worked part-time. The Disclosure Team was initially contracted to run until September 2020, but as the Inquiry progressed these contracts were extended, to allow the Disclosure Team to continue to assist the Inquiry. At times, the Disclosure Team also sought approval for analysts to assist with their work, for example to locate material, in particular historic data, or perform specific system searches. The use of analysts, when requested, was always approved by senior officers at WMP.

1.165 In terms of timeliness of the disclosure from WMP, I have found the Disclosure Team to be dedicated to the task at hand and I was reassured that they progressed disclosure as quickly as they were able, given the nature of the systems they needed to interrogate, the historic nature of some of the disclosure requests, and the resources available to them. This does not mean the turnaround time was always quick; given the volume, it did take some time (and in some cases, months) for material to be disclosed. But I was satisfied that resources were devoted to the task and the Disclosure Team was doing all they could. Generally, I have found that the Disclosure Team has been extremely responsive and helpful in all dealings with the Inquiry's team.

1.166 On 26 October 2020 I did write to WMP to address disclosure progress and timescales. The Disclosure Team was making progress with the requests, but urgently needed administrative support in order to speed up the response time. I was concerned that the Disclosure Team may become overburdened, given the amount of information to be disclosed to the Inquiry. This request for additional resource was met without issue.

Disclosure Received

1.167 In response to the Inquiry's first disclosure request dated 3 February 2020, WMP began to disclose documents from 13 March 2020 and disclosure continued until the last formal request was sent on 12 July 2021. Since then, there have also been further discrete requests made to WMP, which it has continued to respond to in a timely way.

1.168 The majority of material disclosed by WMP has been disclosed electronically and the Disclosure Team uploaded it to a secure platform for transfer to the Inquiry. Some material was available in hard copy only, and was hand delivered to the Inquiry. During the course of the Inquiry, I and representatives of the Commissioning Body also attended the office of the Disclosure Team in order to review material in hard copy and on WMP's electronic systems. As a result of those reviews, I was again able to narrow the disclosure requests to more targeted requests for material relevant to the Inquiry.

1.169 In total, the documents received from WMP amounted to 9,742 documents/94,867 pages. This does not of course include those documents that were reviewed in hard copy, or the not relevant material that was 'dip sampled'.

1.170 While the process of making and amending requests made to WMP has been more involved than for other stakeholders, I am absolutely certain that this was the correct approach to take to the WMP disclosure. While the volume of material received from WMP is substantially less than that received from the Council, for example, the proportion of those documents found to be relevant was significantly higher – meaning that the initial approach to narrowing and focusing the disclosure requests to WMP was worth the investment of time.

Disclosure approach – Telford & Wrekin Clinical Commissioning Group and NHS providers

1.171 Again, I met with Telford & Wrekin CCG at an early stage, on 29 July 2019, as part of early stakeholder engagement, to discuss the Inquiry's work and particularly the requests for documents that were likely to be made of Telford & Wrekin CCG in due course.

1.172 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, re-formed from the Telford & Wrekin Primary Care Trust ("Telford & Wrekin PCT").[45] I was told that any records prior to that date would have been held by Telford & Wrekin PCT and on the dissolution of the PCT these will have been transferred to NHS England. They also confirmed to me that Telford & Wrekin 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 and audits and assurance documentation concerning statutory obligations related to safeguarding, and related material.

[45] See Chapter 7: Health Agencies in relation to health agencies, including the re-organisation of the NHS.

1.173 It is this type of material that I therefore requested from Telford & Wrekin CCG, and they have helpfully provided the information that they can. It was however notable that there was not a huge quantity of material provided that was directly relevant to my Terms of Reference, and to CSE, and this is in part due to the role that Telford & Wrekin CCG play. Chapter 7: Health Agencies discusses further the role of health agencies.

1.174 Given the absence of documentation prior to 1 April 2013 available via Telford & Wrekin CCG, I also 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 should be retrieved from storage, as well as any documents that were listed as handover documents or organisational transition documents, from PCT to CCG, as well as anything related to the Telford area and children's safeguarding.

1.175 The contacts at NHS England were extremely helpful and material was disclosed in an ordered, and clear way. But again, the material that was CSE-specific was fairly limited, particularly for the earlier period.

1.176 In relation to NHS providers approached, for example relevant hospitals and GP practices, without exception they 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, and I am grateful to Telford & Wrekin CCG who assisted me in coordinating some of the disclosure provided by the GP practices.

1.177 The documentation disclosed by NHS providers tended to be general safeguarding information, including policies and procedures, annual reports, minutes of safeguarding meetings and training material; with a limited amount of CSE-specific training material also provided. I was told that very few providers have electronic records and therefore again there were issues with historical information being available. The providers have also suffered from frequent 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.

1.178 In terms of patient specific information, providers do not file or record patient details by reference to any abuse or sexual exploitation suffered. I therefore only requested patient-specific information in a small number of cases, for example in relation to the case studies that have been adopted in my Report, 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 there are specific requirements for retaining child

health records for a certain period of time,[46] then it was up to the individual organisation when/whether they were destroyed.

1.179 It is my view that the gaps in evidence have not been due to a reluctance or unwillingness to assist, but rather due to the unavailability of some documentation as a result of constant re-organisation, in some cases inconsistent record keeping, and the document retention policies in place which means that some documents no longer exist.

Disclosure approach - Shropshire Council

1.180 Given the breadth of the timescale that is covered by the Inquiry's Terms of Reference, namely from 1989 to the present day, and the fact that Telford & Wrekin Council only came into existence in 1998, I was conscious of the fact that documentation for this earlier period would need to be obtained from other sources, and in particular from Shropshire Council; given the fact that pre-1998, Shropshire County Council's social services department was responsible for the protection of children in Telford.

1.181 I therefore met with Shropshire Council in September 2019 as part of the early stakeholder meetings, but also particularly to discuss the Inquiry's approach to disclosure generally to try to understand the volume of documents that might be held by Shropshire Council and in what format the documents may be held. I was mindful of the fact that due to the passage of time, Shropshire Council was likely to face challenges in accessing historic or hard copy documents and I was keen to understand the way that documents had been archived and filed, so that requests could be made accordingly.

1.182 During this initial meeting, Shropshire Council confirmed that the majority of the material that it would consider to be of relevance to the Inquiry, particularly relevant case files, were 'handed over' when Telford & Wrekin Council came into existence in 1998. Whilst it recognised that pre-1998 Shropshire County Council was the relevant body which had responsibility for social care in Telford, it was explained to me that all 'live' cases were transferred over to Telford & Wrekin Council during the reorganisation in 1998. Shropshire Council therefore considered that it was unlikely to hold many relevant records.

1.183 For those records that were not transferred over to Telford, for example closed case files, Shropshire Council also confirmed that its historic files are not archived on the basis of issue, but are stored by family name, so it would be very difficult to identify archived files which related to CSE for example, without further details to allow a targeted search to be undertaken, for example a name or date of birth. Shropshire Council also made clear that they were not prepared to trawl their files in order to identify potentially relevant cases, and were not willing to provide the Inquiry with access to files to do the same, for reasons of data protection and protecting the identities of individuals. Shropshire Council was however confident that more recent relevant files may be easier to identify, particularly if staff were able to recall specific cases. In relation to other documents, aside from case files, for example policies, procedures and guidance documents from 1989 to 1998, Shropshire Council could

[46] Records relating to children, including community child health records, are currently retained until the patient's 25th birthday, or 26th birthday if an entry was made when the child was 17; or if deceased, eight years after death - https://www.nhsx.nhs.uk/information-governance/guidance/records-management-code/records-management-code-of-practice-2021/#appendix-ii-retention-schedule

not foresee any problems with providing these types of documents, as long as the documents were still available.

1.184 Shropshire Council also expressed a concern at that first meeting about the time and resources that may be needed to address any requests for documents. It was made clear to me that Shropshire Council intended to fully cooperate with the Inquiry, but they registered a concern that this was an inquiry that Telford & Wrekin Council had made a decision to hold, and to fund, and that it was not a Shropshire Council inquiry; they said they were happy to assist the Inquiry with simple requests, but if the requests were more challenging on resource, they would have to consider this.

1.185 In order to fulfil the Inquiry's Terms of Reference, it was clear that I would need to ask Shropshire Council for documents in order to be able to address the earlier period of time. As a result of the discussions with Shropshire Council and given the challenges around the availability of documents, it was clear however that I could not take the same approach as I had with Telford & Wrekin Council and ask for all documents that were potentially relevant to the Inquiry's Terms of Reference. The approach taken was therefore as follows:

1.185.1 To make general requests for policies/procedures, relevant minutes, reviews and audits; and

1.185.2 To make specific and targeted requests for case files and other specific documentation, or categories of documentation, that arose from particular lines of investigation being pursued.

1.186 Given the scale of the disclosure that was, and would be received from Telford & Wrekin Council and WMP, I therefore prioritised obtaining and reviewing the material from these two organisations, as well as obtaining witness evidence from victims and survivors, which also then allowed me to identify specific lines of enquiry that could be followed up with Shropshire Council in due course, where relevant.

1.187 The requests for disclosure to Shropshire Council were therefore made as follows:

1.187.1 The first request was made in June 2020. This included requests for documents from 1989 to 1998, and particularly safeguarding policies and procedures, local ACPC minutes, any Part 8 reviews and audits, and internal or external reports or reviews related to CSE, complaints related to CSE and any handover documents to Telford & Wrekin Council in relation to CSE and related matters;

1.187.2 This request was then followed up in October 2020, with an additional request for copies of 25 children's case files, which were identified as being of interest to the Inquiry due to their early involvement with CSE. The individuals were known to the police, but it was unclear whether they had social care involvement. The Inquiry also requested a copy of taxi licensing information. I revert to the request for taxi licensing information further below; and

1.187.3 A further request was then made in November 2020 for Social Services Committee reports/minutes, and reports and minutes from committees, panel

and Cabinet meetings, dated between 1989 to 1998 where reference was made to 'Child Prostitution', 'Child prostitutes', or 'Child Sexual Exploitation'.

1.188 There were various discussions between Shropshire Council and the Commissioning Body over the following months, for example to clarify the requests and establish what was available, and if documents were not available the reasons for this. Overall, although some documentation was provided, this was limited, and this was said to be for the following reasons:

1.188.1 In relation to the 25 case files requested, Shropshire Council did not hold any of these files. Shropshire Council confirmed that they searched their electronic database and a search was undertaken of the historic records located at Shropshire Archives and the records system managed by the service, including a physical check of possibly relevant files, but no files were located. Shropshire Council offered that this may be because none of these 25 individuals had any involvement with social care, or the file was no longer available;

1.188.2 In respect of any safeguarding policies, procedures and guidance from 1989 to 1998, any Part 8 reviews, audits and internal or external reports or reviews relevant to CSE, or CSE cases, from 1989 to 1998, I was told that Shropshire Council did not have these documents and believed that they no longer exist;

1.188.3 In respect of any ACPC minutes from 1989 to 1998, again Shropshire Council could not locate any documents and considered that they no longer exist;

1.188.4 In relation to complaints related to CSE, in the absence of specific names to whom the complaint might relate, Shropshire Council confirmed that they could not identify any potentially relevant documents; for example they could not provide an index of complaints attributed to CSE without specific details of individual cases, as complaints are filed under family name rather than the reason for the complaint, so no documents could be provided;

1.188.5 In relation to details and copies of any handover material or briefing notes that were prepared upon the creation of, and transfer to, Telford & Wrekin Council and its ACPC, as it was then, in relation to CSE and related matters, Shropshire Council confirmed that it did not hold any records, but that Telford & Wrekin Council may hold such documents; and

1.188.6 In relation to the request for relevant Social Services Committee reports/minutes, and reports and minutes from committees, panel and Cabinet meetings, Shropshire Council helpfully provided a spreadsheet listing all documents held in its archives which may fall within the request made. The Inquiry was then able to use this spreadsheet to identify documents that may be potentially relevant and request copies. In January 2021, Shropshire Council confirmed it could make these documents available in hard copy for the Inquiry to then review in person at the records storage in Shirehall. This review was undertaken in February 2021, following arrangements for a Covid secure environment being available and the Inquiry team was granted access to the hard copy reports and minutes that had been identified as potentially relevant. The

documents that were identified as relevant during that review were copied and provided to the Inquiry at our cost.

1.189 Additional specific requests were also made by the Inquiry during 2021, including for a copy of another specific case file and any documents associated with a sexual exploitation project that was running at Stirchley in Telford in the 1990s. Shropshire Council was unable to locate any relevant documents in response.

1.190 At the time of writing, there is one request for documents that remains partially outstanding, and that relates to taxi licensing information. As referred to above, in October 2020, I asked for a copy of all Shropshire taxi licensees, from 1989 to the present day, asking that the list include details of all licence suspensions, revocations, written warnings, other interventions and the reasons for those interventions.

1.191 Shropshire Council queried the rationale for the request and the scope of the information that was being requested, as it was concerned that the request was not proportionate. In response it was explained that I wished to examine the 'cross-border' taxi licensing issue and consider whether there is any evidence that licenses granted by Shropshire Council are being used to traffic and exploit children in Telford, but that I welcomed a discussion with Shropshire Council to understand more about the information that is available, and in what format, in an effort to identify ways of narrowing the request, to ensure it was proportionate. A discussion then took place in January 2021, to clarify the request being made. It was agreed that a member of the licensing team would speak with her team in order to better understand how the information requested by the Inquiry could be pulled together in a proportionate way.

1.192 In April 2021, Shropshire Council contacted the Inquiry to record its continuing concerns about the request being disproportionate. I understand that Shropshire Council also had concerns about the legitimacy of this request as it was concerned about releasing personal data of all licensees where the Council's records did not suggest, even at the lowest level of credibility, any indication of a connection to CSE. Shropshire Council therefore suggested that rather than provide a full list of names, they would instead provide a list of taxi and private hire drivers, vehicle proprietors and operators where there is an indication of a connection to CSE and/or other exploitation generally could be provided instead.

1.193 On 28 May 2021, Shropshire Council then provided the first tranche of disclosure in respect of taxi licensing. The work involved a manual check of 600 taxi and private hire driver licenses going back to 2013 (which is the date its current licensing IT system was implemented) and the records related to matters that had been addressed by officers under delegated decision making powers. In respect of the wider request, Shropshire Council told the Inquiry that it had in the region of 20,000 individual records that were potentially taxi/private hire related. It indicated that it was unlikely to have many, if any, records that stretched as far back as 1989.

1.194 I expressed concern to Shropshire Council that its disclosure focused on drivers, vehicle proprietors and operators where there was an indication of a connection to CSE and/or other exploitation only. Important and relevant information could be missed with this approach and I therefore requested that Shropshire Council provide the Inquiry with a complete list of taxi licenses held by Shropshire Council, dating as far back as 1989, where available. I took

account of the difficulties Shropshire Council had faced in collating all information about interventions on licences, which is why I only sought the names of all taxi drivers, proprietors and operators, rather than any additional details. It was explained that I wished to cross-refer this list of names with information already held by the Inquiry and, if necessary, I would then make further and more targeted requests for information if there were any individuals of particular interest to the Inquiry.

1.195 In July 2021, a second tranche of data was then provided by Shropshire Council. This related to drivers where matters were referred to Shropshire Council's 'Licensing Panel' for consideration prior to a delegated decision being made by an officer. The records all related to matters considered since 2013 to the current date and where there was an indication of a connection to CSE and/or other exploitation. A full list of names was still not provided.

1.196 In response, the Inquiry team suggested that, if resourcing this task was a challenge, a member of the Commissioning Body could attend Shropshire Council's premises and have access to the relevant systems to carry out the necessary searches and cross-referencing of names, in order to obtain the information that I required to satisfy the Inquiry's Terms of Reference.

1.197 In September 2021, Shropshire Council provided a list of records relating to vehicle proprietors or private hire operators where the matters were referred to Shropshire Council's 'Licensing Panel' for consideration prior to a delegated decision being made by an officer, where there was a potential link to CSE or other exploitation. This again was for the period 2013 to present.

1.198 In March 2022, and in response to the Maxwellisation process, Shropshire Council disclosed the fourth tranche of disclosure which was a list of records relating to drivers, vehicle proprietors and private hire operators from the electronic databases used by Shropshire Council from 2009 to 2013. Again, the records related to matters where there was an indication of a connection to CSE or other exploitation. The Inquiry was informed by Shropshire Council that where there was an element of doubt as to relevance, the records had been included in the spreadsheet.

1.199 Shropshire Council also confirmed that Shropshire Archives do not hold any historical licensing records prior to 2009.

1.200 In relation to disclosure generally, where the purposes or scope of a request for documents has been unclear, Shropshire Council has raised questions about this; either to clarify why a request is being made or to assess whether the request is proportionate. It is absolutely right that they should do this. They hold personal data and, in some cases, very sensitive information, and it is their right, and indeed their obligation, to ensure that there are necessary and clear grounds for sharing any information.

1.201 That said, the Commissioning Body has spent a great deal of time pursuing requests for documents and working with Shropshire Council to understand how requests can be re-framed, so that the information required is obtained, but in a proportionate way. In total, the relevant material received by the Inquiry from Shropshire Council consisted of 22 documents/214 pages of material.

1.202 There will be conspiracy theorists that may read into this that Shropshire Council has something to hide and therefore has deliberately not provided documents. I want to address this head on; I do not believe that to be the case. When they have said that documents cannot be located, I believe that is the case and that searches have been undertaken; when they have said that documents no longer exist, I believe that is the case; many of the documents requested are historic and were created at a time where records and documents were not digitised and stored in the way they are today.

1.203 I have also been mindful of the context during which these requests have been made; during 2020 and 2021, when Shropshire Council was, and still is, on the front line response to the Covid-19 pandemic. I am therefore sympathetic to the fact that this has been a difficult time for Shropshire Council and its staff, and appreciate that some of the disclosure requests may have taken longer to deal with as a result of staffing resources being under increased pressure, rather than there being any perceived lack of co-operation.

1.204 Shropshire Council has always confirmed its intention to cooperate with this Inquiry and I have trusted that is the case, and I am grateful for the assistance they have provided. Having said that, it is clear that there has been something of a reluctance along the way to spend time and resources on locating documents, and consequently the responses received have not always been viewed as helpful to the Inquiry's cause and could, at times, have been viewed as combative.

Corporate Submissions

1.205 In addition to requesting disclosure from key stakeholders, I also asked for corporate submissions to be provided by the Council, WMP, Telford & Wrekin CCG, the Holly Project,[47] the CPS and West Mercia's PCC. These corporate submissions were designed to set out the organisation's response to, and experience of, CSE during the relevant period and in some cases I asked a series of questions, for example about their role, responsibilities, funding, staffing, training, and other aspects that I felt were relevant to my Terms of Reference.

1.206 In a number of instances, upon receipt of the corporate submissions, further information was requested and further requests for witness or documentary evidence were also made. This was an iterative process, which helped ensure that the evidential picture about each organisation was as complete as possible.

1.207 In some cases, these corporate submissions took some time for organisations to prepare and disclose to the Inquiry. As mentioned in my progress update dated 7 January 2021, in the case of the Council, the original request for a corporate statement was sent in May 2020. While I am sympathetic to there having been some delay at this time due to the Council being on the front line of responding to the Covid-19 pandemic, and many of its staff, who would have contributed to the corporate statement, being drawn away from their usual duties, it took until early March 2021 for the corporate statement to be provided.

[47] The Holly Project is a free support service for survivors of CSE, based in Wellington, Telford. It is an independent drop in service that is run by survivors of CSE.

Witness Evidence

1.208 In addition to documents, the other crucial type of evidence I have considered has been witness evidence. I am indebted to the witnesses that have come forward and have willingly provided evidence. I am aware that in many cases this will have been a very difficult experience and for some it will have brought back many painful memories. I am enormously grateful to all witnesses that have given their time; I would have been unable to complete my work without their help.

Witness Support Service

1.209 It has been a key objective of this Inquiry to ensure that all witnesses providing evidence, on extremely difficult matters, should be properly supported through that process. It is for that reason that shortly following the final Terms of Reference being approved, and prior to any witness evidence being taken, the Inquiry asked the Council to commission and pay for a separate, dedicated support service, independent from both the Inquiry and the Council, which could provide confidential support to any witness who wanted it. I recognised that providing evidence may be a very difficult process for some people; particularly for victims and survivors and their families, but for others too. I also wanted to ensure that these services were accessible before individuals met with the Inquiry and provided their evidence.

1.210 The Council readily agreed to commission and pay for such a support service, and the process of procuring that service was conducted by the Council, independent of the Inquiry. The service was due to be in place during the course of September 2019, but there was a short delay, with the service being established and in place to support witnesses from November 2019. That service was delivered by Base 25, who are an independent charity established in 1998 that provides services, programs and projects primarily aimed at improving the lives of young people, particularly those who are marginalised, vulnerable, or at risk. I understand that it has been a really valuable service to those witnesses that have used it.

Process of Taking Witness Evidence

1.211 Witnesses were identified in two ways:

1.211.1 Those who contacted the Inquiry, expressed an interest in giving evidence and had evidence to give that was relevant to the Terms of Reference; and

1.211.2 Those individuals that the Inquiry contacted and asked to give evidence, believing that they had relevant evidence to offer.

1.212 When the Inquiry's work first began in July 2019, following finalisation of the Terms of Reference, there were a handful of witnesses who had already been in contact with the Inquiry expressing a desire to provide evidence. I was reluctant to take any evidence from witnesses until the support service was in place. I was however keen that the Inquiry's work be allowed to continue while the support service was being established, and I therefore contacted a small group of witnesses - those who had already proactively contacted the Inquiry to offer to provide evidence - seeking their evidence and arranging meetings, where

these individuals might be prepared to give evidence without the availability of witness support, if it was considered appropriate to do so.

1.213 From November 2019, with the support service in place, the work of taking witness evidence was then able to start in earnest. The majority of evidence has been gathered by the Commissioning Body team, and they have guided witnesses through this process, although there are a number of witness meetings that I have also attended. The general order of taking witness evidence has been to see victims and survivors and their families first, and then to take evidence from professionals. The order of evidence has been deliberate; I wanted to hear first from those that had experienced CSE and who could give first-hand experience of the response from authorities; the Inquiry was then able to use the benefit of that information to take evidence from those who had worked, or still work, within those organisations.

1.214 Of course, this order of taking evidence has not always worked perfectly; some witnesses have approached the Inquiry later during the process; others have been seen at other times due to availability; and others only wanted to provide their evidence face to face, and therefore due to the impact of the Covid-19 pandemic, this has meant delaying the evidence-taking process in some cases.

1.215 The approach taken has been to be as flexible as possible in how, when and where evidence has been taken. Some has been taken at the Commissioning Body's offices; some at witnesses' homes; others at locations of the witness' choosing; some evidence has been provided in writing only; evidence has been taken during face to face meetings and some has been virtual; meetings with witnesses have happened during the evenings, or during the day, depending on the witness' preference. Witnesses have been able to be accompanied by a friend or relative, or someone else to support them during the process. They have also been able to request an all-female or all-male interviewing team. It has been important that evidence has been gathered in a way that makes the witness feel most comfortable.

1.216 When witnesses approached the Inquiry, in some cases they were clear that they wanted to provide evidence. In other cases, witnesses were less certain, and wanted to discuss how the process would work and what it would involve. The Inquiry team has always been happy to speak to witnesses, without obligation, to talk them through the process and answer any questions they have, whether that be over the phone or in person, before someone commits to providing evidence.

1.217 As to the process of collecting witness evidence, initially all evidence was recorded in note form during the meeting with the witness and then prepared into a draft meeting note. The draft meeting note was then sent to the witness to review, add to or amend, and check that it accurately reflected the evidence they had given. On the whole this worked well when the meetings were held face to face, as they initially were at the beginning of the Inquiry's work. The experience has been that when witness evidence is recorded, witnesses tend not to open up as much, and are concerned about anything they say being 'on the record'; it can create an environment that can be uncomfortable and quite formal. Preparing a meeting note in this way, with the evidence ordered into sections and chronologically, rather than using the transcript of a meeting, also means the evidence is easier for me to analyse and review during my work.

1.218 Following feedback from some witnesses, who raised concerns about the fact that interviews were not being recorded, the process was adjusted so that witnesses had the option to either have their evidence recorded on a device, and a transcript produced verbatim, or by way of notes prepared by the Inquiry team which was then prepared into a note of their evidence, as described above. This again gave witnesses the flexibility to choose the best way for them to give their evidence.

1.219 In early 2020, when the Government imposed restrictions in response to the Covid-19 pandemic, the Inquiry then put in place arrangements to use telephone, video, and other technology, to ensure that witness evidence could continue to be taken as far as possible, if witnesses agreed to provide their evidence on that basis. There were however some witnesses who wished to only give their evidence face to face, and in these cases, once restrictions had lifted, we were able to meet with these witnesses to take their evidence.

1.220 Once final meeting notes, or transcripts of a meeting, had been checked and approved by a witness, a copy was provided to me for my review. In some cases, I decided to then meet with some witnesses again, where I felt they may have additional evidence to give. I felt it was important that I did speak to some of the witnesses direct.

Contacting Witnesses

1.221 Victims and survivors of CSE have been central to this Inquiry. I made a decision from the outset that I would not look to proactively contact victims and survivors and ask them to provide evidence to the Inquiry, unless they had already been in contact with the Inquiry and/or indicated to the Inquiry, or to others that were engaged with the Inquiry, that they might be willing to do so. This was primarily to protect those individuals. I was very aware that some individuals may not want to revisit painful memories; some may have made a deliberate decision not to engage in order to protect their mental health; others may be with partners, or have families, that do not know what they have been through before and they may not want to risk them becoming aware; others may still be in contact with perpetrators, and the Inquiry getting in touch could put them at risk; others may not even be aware that they were victims of CSE, such is the nature of this horrific crime.

1.222 That does not mean that the experiences some of those individuals went through will not be included within the Inquiry's work. Documents provided by both the Council and WMP record cases from victims and survivors that have not directly spoken to the Inquiry, yet I have been able to use this evidence to build up a picture of what these children went through.

1.223 In relation to approaching perpetrators as witnesses, I took the same approach. I did not directly approach any individuals whom I knew or suspected, from documents I have seen, to be perpetrators. But if any such individuals chose to approach the Inquiry to give evidence, they would have been heard. Ultimately, none came forward.

1.224 There were other individuals that contacted the Inquiry about other matters which were outside of the Inquiry's Terms of Reference; for example CSE in other parts of the country. Unfortunately I have not been able to take evidence from such individuals, as to do so

would be beyond the scope of what I have been asked to do. Where possible, the Inquiry team has however sought to direct those individuals to other organisations that might be able to assist them.

1.225 In respect of professional witnesses, I was able to determine who I wanted to speak to using information disclosed by stakeholders and evidence given from other witnesses, and they were proactively contacted; this has been an iterative process, and as more evidence has come to light, more individuals have been approached to provide evidence to the Inquiry. For those professionals still employed, the initial request to provide evidence was sent via their employer, but all contact in relation to the arrangements for their evidence and communications regarding approving the evidence given, took place direct, unless the witness requested that this communication still happen via their employer. No employing organisations have been provided with a copy of the evidence that their employees have given. For those no longer employed, they were contacted directly.

1.226 I also wanted to ensure that those within the community were aware about the Inquiry's work and that anyone who had evidence to give knew how to contact the Inquiry. It was also important to encourage people to give evidence. During the course of the Inquiry's work I have therefore made a number of calls for evidence to encourage those with relevant evidence to come forward. This did not reflect any perception of public reluctance; it was simply to advertise–that the Inquiry was now fully open for business and to make people aware of how they could get in touch. It is quite common for inquiries to make public calls asking for witnesses to come forward. This Inquiry's calls for evidence has included the following:

1.226.1 November 2019 – I produced a video encouraging witnesses to come forward to give evidence to the Inquiry. This was posted to the Inquiry's website (with Tweets notifying followers of the video) and was also sent to a number of media outlets, including the Local Democracy Reporter, BBC West Midlands, BBC National News, the Shropshire Star, Free Radio, and a Mirror reporter, with some of those outlets then choosing to use the video to report on the Inquiry's work and how witnesses could get in touch;

1.226.2 December 2019 to January 2020 – an advertisement was then included in the Metro, West Midlands, calling for witnesses to come forward and give evidence. The advertisement ran daily between 9 to 13 December 2019 and 8 to 13 January 2020;

1.226.3 September 2020 – Further advertisements in the form of posters, again calling for witnesses to come forward, were then placed in the local area. The timing of these advertisements was a challenge due to the ongoing pandemic affecting the community at the time. I would have liked to place the advertisements earlier, but given the restrictions on non-essential travel this had to be carefully timed to ensure that they would have maximum impact. This resulted in the advertisements going live in September 2020 in the following locations:

1.226.3.1 Telford Train Station – appearing one week per month for two to three months;

1.226.3.2 Southwater Car Park – interior posters – appearing for two to three months;

1.226.3.3 Darby House Wall – walkway from train station to Telford town centre – appearing one week per month for two to three months;

1.226.3.4 Southwater One rolling plasma screen – appearing for two to three months; and

1.226.3.5 Darby House rolling plasma screens (this being the building that is home to the Council's adult and child Safeguarding teams) – appearing for two to three months.

1.226.4 October 2020 – I also undertook interviews with BBC News and Free Radio to continue the call for evidence and to encourage witnesses to come forward;

1.226.5 September to November 2020 – during this period a Facebook advertisement calling for witnesses to come forward was also published, via the Inquiry's Facebook account. This advertisement appeared on 16 different Facebook platforms[48] and targeted those located in Telford & Wrekin, and within a 10km radius. The advertising campaign confirmed that during this period the advert appeared on screen 273,244 times, was seen by 76,056 people at least once and 1,673 people clicked on the link to the Inquiry's website which appeared on the advertisement; and

1.226.6 January 2021 – In an effort to target those within the education sector particularly, as well as parents of school-aged children who may have evidence to give, a communication about the Inquiry's work and a call for evidence was sent via the Council to the local Education Noticeboard which is used to communicate with schools, with schools then using this information to communicate with their school communities.

1.227 During the course of the Inquiry's work, from November 2019 to the point of writing this Report, there has been a steady stream of witnesses approaching the Inquiry; that has slowed down as the Inquiry's work has progressed, but the occasional witness was still coming forward until a few months before this Report was published. As far as possible, we have seen all witnesses who wished to give evidence; that is particularly the case for any victim or survivor that has come forward; I have ensured that they have had the chance to tell their story. I had to however stop the witness evidence gathering process at some point to enable my Report to be finalised, and the findings and recommendations delivered. I do not however consider that any new witness evidence will fundamentally change my conclusions.

[48] Facebook feeds, Instagram feeds, Facebook marketplace, Facebook video feeds, Facebook right column, Instagram explore, Facebook messenger, Facebook groups, Facebook stories, Instagram stories, Messenger stories, Facebook stream Facebook search, Facebook in article, Facebook apps and sites.

Witness Statistics

1.228 The Inquiry has met with and taken evidence from 170 witnesses. A number of those witnesses have been seen on more than one occasion. Of those 170 witnesses:

1.228.1 60 are Council/former Council witnesses;

1.228.2 40 are police/former police witnesses;

1.228.3 33 are from other organisations/stakeholder bodies; and

1.228.4 37 are survivors and victims, or their families or supporters.

1.229 There were a number of witnesses who the Inquiry had contact with, or attempted to contact, and for various reasons these witnesses did not provide evidence to the Inquiry. The details of this are set out below:

1.229.1 There were four witnesses approached who were unable to provide evidence on grounds of their health;

1.229.2 There were 19 witnesses that got in touch with the Inquiry, or via a third party, indicating that they would like to give evidence, but then during the course of the process they either changed their mind, or ceased communication, and therefore we were unable to take any evidence from them. Of these 19 individuals, 15 were victims or survivors, or their family members. In some cases, an initial approach was made and then no further contact; in others, part way through the process the individual changed their mind. If individuals said that they found it too difficult to share information, this was completely respected;

1.229.3 There were seven individuals that we were unable to locate, despite several attempts to do so;

1.229.4 There were another 13 individuals where contact details were obtained, but repeated attempts to contact them were unsuccessful. It is not always clear why this was the case; whether they have moved on and their contact details are no longer correct, or whether they have chosen not to respond. It is difficult to make assumptions in this respect;

1.229.5 There were 11 individuals who either refused to provide evidence, provided very limited evidence, or refused to consent to their contact details being passed on to the Inquiry to allow me to make contact. The reason often given was that, due to the passage of time and no longer having documentation available to refer to, they did not think they could provide useful information; and

1.229.6 Finally, there were two additional witnesses that were approached, but following communications with the Inquiry it became clear that they did not have relevant evidence to give.

1.230 While it is not appropriate for me to comment on everyone who refused to engage or who provided very limited evidence, and the reasons for that, there are a handful of instances where I was surprised, and disappointed, at the extent of engagement, and given their positions it is appropriate for me to comment as such.

1.230.1 Victor Brownlees – Mr Brownlees was the Chief Executive at the Council from 2009 to 2011. For a period of time in 2010 and 2011 he also held a dual role of Chief Executive and Director of Children's Services, while that role lay vacant. I believe he would have been able to give relevant evidence. For example, he asked for a review of Children's Services and Adult's Services in 2011, and was involved with decision-making concerning a restructure of the Council, including placement of the CATE team and funding between 2009 and 2011. After a series of communications with the Inquiry team, including redacted documents being shared with Mr Brownlees to help jog his memory, Mr Brownlees declined to meet with a member of the Inquiry team. He provided a very brief statement by way of email where he indicated that he had not retained any documents upon his departure from the Council and was therefore doubtful that he could provide any further information to the Inquiry. He confirmed that he acted in a leadership capacity, chairing the multi-agency project team and acting as spokesperson. He conveyed his admiration for the diligence and commitment shown by his own staff in Safeguarding who worked as part of that team, as well as for the work of WMP and the other agencies who worked with the Council. He declined to provide any information in relation to the areas that I was specifically interested in exploring further, as outlined in correspondence to him.

1.230.2 Mark Pritchard MP – Mr Pritchard did not refuse to provide evidence. After early engagement with Mr Pritchard as referred to above, I wrote to him again in March 2021 and June 2021 to ask if he wished to give evidence to the Inquiry. The response that came was from his office to say that "*Mr Pritchard has decided to leave the giving of evidence to those experts and professionals who have been dealing personally with these cases. He hopes the Inquiry will bring justice for the victims and produce the substantive reforms needed at those institutions which have fallen short of the required standards."* During the Maxwellisation process in March 2022, Mr Pritchard confirmed that his office held no information on *"a single or individual CSE case",* and noted in respect of my previous requests that *"we could not offer any such 'information' or 'evidence' to your Inquiry...".* Mr Pritchard wrote further that he had been deliberately precise in his response so as to avoid saying he had no evidence, lest that serve, inadvertently, to undermine the Inquiry (although, for my part, I do not see how it could have done so). Mr Pritchard further explained that he did not offer his views, recommendations or opinions because he did not regard this to be *"evidence"* or *"information"* (which is what this Inquiry had asked him for) and because they are well documented. Mr Pritchard invited me to consider public records of his views, which I am happy to relate include support in 2012 for what became IICSA and his work in Parliament in 2018 onwards as a member of the Cross Party Working Group on Child Sexual Exploitation, including expressing support for this Inquiry.

1.230.3 Clive Harding – Clive Harding held a number of senior ranking positions within WMP during the period with which this Inquiry is concerned. In August 2000, he was also Detective Chief Inspector serving on the major incident team and was on call on the night of the Halifax Drive fire in which Lucy Lowe, her mother and sister all tragically died (a case that is mentioned later in my Report). DCI Harding assumed responsibility for that triple murder investigation, as Senior Investigating Officer, and as such he directed the lines of enquiry within that incident room. Given the significant media coverage surrounding the deaths of the Lowe family, and evidence suggesting Lucy Lowe had been subjected to CSE prior to her murder, that police operation is included within this Report as an important case study. The Inquiry approached Clive Harding as the Senior Investigating Officer of the police operation, in order to discuss the evidence arising from that investigation; specifically in relation to disclosures made at the time regarding CSE. Mr Harding however declined to speak the Inquiry, maintaining that he could not add anything further to the documentation held and disclosed by WMP in relation to the investigation. He stated:

"*It is now some 20 years since that tragic event and whilst a triple murder of such magnitude will forever be remembered by me, the details will have faded. However, all the information regarding every aspect of that investigation is available to this inquiry through the comprehensive documentation available. That documentation includes the SIO Policy Book; Family Liaison Contact Logs; the HOLMES system actions and other material; witness statement and subsequent testimony at trial; and correspondence between the SIO and CPS throughout. I am confident that there is nothing outside of the information therein that I could possibly provide without depending on memory - that I am not prepared to do because I am confident that my recording of facts, policy, strategy and decisions is both comprehensive and accurate. I do not believe I have any other information that I can give that would be of value to the inquiry*".

1.230.4 Whilst I accept that memories fade and that recollections of matters over two decades ago may be hazy, I am of the view that someone of such a senior rank, with responsibility for such a major investigation in Telford's history, would nevertheless have been able to provide important evidence and essential context surrounding the investigation into the murder of Lucy Lowe. The Inquiry team wrote to Mr Harding setting out details of the evidence reviewed, in order to try to assist his memory of events and steps that may or may not have been taken, however he chose not to reply to that letter.

1.230.5 Geoff Harding – Geoff Harding retired from WMP in 2005 in the rank of Detective Chief Inspector. During his time with the force he worked as a Detective Constable and then Detective Sergeant in Wellington CID,[49] before transferring to the Child Protection Unit ("CPU"), when it was first established in 1992, covering Shropshire and Telford & Wrekin. Mr Harding was promoted first to Inspector, and then in 1999 to Chief Inspector, when he moved into the Community Safety Department, where he was responsible for community relations across the Telford Division. Between 2001 and 2005, Mr Harding held

[49] Criminal Investigation Department

the rank of Detective Chief Inspector in Telford, with responsibility for all departments of CID. He then retired from WMP in 2005 before joining the Council as an Integrated Services Manager ("ISM"), working in the Dawley cluster area – a role created after the Laming Inquiry, in line with '*Every Child Matters'*, with the specific aim of working with children and families who were experiencing difficulties and required support.

1.230.6 The Inquiry made contact with Mr Harding through WMP in an effort to seek evidence in relation to his time both within WMP and the Council, as it was clear to me that he held a number of important posts at a sufficiently senior level in both organisations, during critical time periods. Mr Harding did not engage directly with the Inquiry, and instead chose to submit a very short written summary of his roles (which adds little to the summary I have given above) via WMP. This was of course Mr Harding's choice, and he indicated that, despite a list of areas and issues being provided, he was not prepared to speak to the Inquiry without having sight of all of the relevant information the Inquiry held. This was of course not possible, and the reasons were explained to Mr Harding. Disappointingly, Mr Harding still chose not to provide evidence. Mr Harding's short written summary stated that he did not believe he had any information to offer, as he had "*no recollection from [his] time involved in child protection with the police or the Council of any case now referred to as either child prostitution or child sexual exploitation, particularly in the Telford area*". He stated that: "*in the five years I led the CPU, we had no reported cases of the nature alluded to*". The fact that Mr Harding cannot remember is remarkable, given that there were, during his stewardship of the CPU, a great many reports of CSE within Wellington; and during his time as an ISM, WMP and the Council's joint working led to the CATE Team and Chalice (I deal in detail with this at Chapter 3: The Council Response to CSE in Telford and Chapter 5: The Policing of CSE in Telford.

1.231 Despite the fact there are witnesses that I was unable to contact and some witnesses declined to engage, or the level of engagement was limited, I am satisfied that on the basis of the witnesses I have spoken to and the evidence they have provided, bearing in mind their roles and when they were in post, I have still been able to fulfil my Terms of Reference.

Maxwellisation

1.232 This Inquiry is not a legal process. The Inquiry does not have the power to make any determination of any civil or criminal liability. I do not have any powers to award compensation. Instead, my role is to set out the facts of the evidence I have seen and heard and make observations, including criticisms where deemed appropriate, drawing conclusions from that evidence, and then making recommendations based on this evidence. I am not subject to any particular standard of proof when making these observations and conclusions. I am however obliged to do this fairly; ensuring that those affected by any criticisms I am proposing to make have had a fair opportunity to address the potential criticisms and respond accordingly, before I finalise my Report. This process is known as Maxwellisation.

1.233 What this means in practice is that when preparing this Report, where the inclusion of a significant, potential criticism of an individual or organisation was being considered by me, they were notified in advance of this Report being finalised and offered an opportunity to respond. They were notified by providing them with a summary detailing the nature of the criticism/s and the evidence upon which this was based. In some cases, it proved impossible to adequately summarise the criticism/s and the evidence upon which they were based without providing extracts of the draft report; to do so would have effectively meant re-writing the report which I did not feel was justified due to the significant impact this would have had on the time it would take to deliver this Report and the use of public funds. I am also duty bound to fairly convey the evidence upon which criticisms are based to enable organisations, or individuals, to respond. I did however do this by exception, and only if absolutely necessary, as I did not feel that sharing copies of sections of the draft report would be fair to others who would not have advanced sight of the same information.

1.234 In total, 29 organisations and 40 individuals were notified of potential criticisms that were to be made. If a criticism could be construed as being directed at both an individual and an organisation, both were notified.

1.235 In response, I received 46 responses. I considered each of those responses very carefully. Many of these were very helpful and in some cases provided new evidence. I have taken all of this into account when finalising my conclusions and this Report.

1.236 To be clear, criticisms have only been altered where I have been satisfied that additional evidence has been provided that has persuaded me that this would not be a fair criticism to make. Where evidence conflicts, I have weighed up the different sources available and made findings based on the evidence I have found more persuasive. If evidence has not been available, or not clear enough, I have identified this in the Report. As this is not a legal process, and my findings and recommendations are not binding, criticisms are a matter for my judgement, rather than being subject to any evidential threshold.

1.237 I wish however to be clear that the purpose of this Inquiry has not been to assign blame; rather it has been about finding out the truth and identifying any improvements that can be made to help keep the children in Telford safe in the future.

Recommendations

1.238 As mentioned above, the Terms of Reference provide that, if I consider it appropriate, I should make recommendations to ensure CSE is recognised, reported and steps taken to protect children and prevent CSE in the future.

1.239 In making recommendations, it has been important for me to do so having regard to the system as it is now constituted. This has meant taking into account the changes that have taken place over the years. Given the extent of reform and procedural change during the period of time relevant to the Inquiry (1989 to the present day), this has been no easy task; not least because there has been enormous changes in the field of child protection over the past four decades. That includes the fact that CSE was not always understood in the same way as it is today.

1.240 I have also had to consider that I have been able to reach these conclusions with the benefit of hindsight; and with the benefit of evidence from organisations and witnesses about what was happening at that time. I have had to bear that in mind when making future recommendations.

1.241 It has also been important for me to take into account what is known about CSE happening in Telford today; what is happening now for children. What I know from evidence provided by witnesses, and seen in relation to current investigations, is that CSE very much exists today in Telford, as it surely does throughout the United Kingdom.

1.242 CSE is criminal behaviour. It is likely perpetrated everywhere. Telford is no different; tragically it will continue to occur. That for me however is no reason not to take action and make recommendations in an attempt to improve the lives of those children in Telford that suffer this appalling offending. The fact that some towns and cities are not as far advanced as Telford in tackling CSE is not a reason for Telford to stop and rest on its laurels; there is always more that can be done.

1.243 One recommendation that has been suggested to me is whether, based on the evidence I have seen and the conclusions I have reached, a statutory public inquiry should be held into CSE in Telford. A statutory public inquiry would have the power to compel witnesses and organisations to give evidence; whether that is witness evidence or documents.

1.244 I have mentioned in this chapter the evidence that has been provided to me by the various organisations and the number of witnesses that have provided evidence. I have also referred to those witnesses that have not engaged with the Inquiry, for a number of reasons. A statutory inquiry would of course have the ability to compel some of those individuals to give evidence, although in some cases that would not always be appropriate, for example for victim and survivor witnesses or in cases where, for health reasons, witnesses were unable to provide evidence.

1.245 In respect of documentary evidence, I am satisfied that, with very few exceptions, where available, information I have asked for has been provided to me. In some cases documents were no longer available; either due to the passage of time, or they could not be located. I am however satisfied that organisations took thorough steps to try and locate such documents. I therefore do not believe that if I had the power to compel documents from such organisations, this would have made any difference to the evidence that was produced.

1.246 I have also considered the extent to which I have been able to fulfil my Terms of Reference in the absence of certain witnesses providing evidence. While there are of course other individuals I would like to have spoken to, and some of them I have referred to above, I do not consider that this has hampered my ability to fulfil the Terms of Reference. Having considered what was asked of me, and the extent of evidence gathered during the course of the Inquiry, both documents and witness evidence, I am confident that I am able to reach evidence-based conclusions covering each aspect of the Terms of Reference.

1.247 A statutory inquiry would of course be able to compel witnesses to give evidence. I am however mindful of the fact that this does not necessarily mean the evidence elicited would be of good quality; an inquiry can gain little value from a compelled witness who is vague,

or who cannot remember. The power to compel someone to give evidence does not guarantee that useful evidence is received.

1.248 For those reasons, I do not feel able to recommend that a statutory public inquiry should be held to further investigate CSE in Telford.

1.249 The recommendations I have made are not binding; there is no obligation on any individual or organisation to implement them, as would be the case even if this was a statutory inquiry. That said, this Inquiry has been commissioned by the local authority, and key safeguarding partners have engaged with and contributed to the Inquiry's work. Therefore, my hope is that this Report will be read and taken seriously and the recommendations adopted as far as possible. I would like to think that those organisations would be able to publicly account for the steps they have, and will, take in response to this Report. Some of the recommendations are necessarily high level and will require considerable further detailed work to enable them to be implemented and effective.

1.250 The Terms of Reference also made clear that any recommendations made would include a two-year review, at which point there should be an assessment to consider the extent to which the recommendations have been implemented. This future review is vital. Often the momentum created by an inquiry can be quickly forgotten. This cannot be the case here. Again, my expectation is that in two years' time, organisations would be able to publicly account for the recommendations that have been implemented and the effect this has had.

1.251 My recommendations appear in a standalone section of the Report, after the Executive Summary.

Victim/Survivor Voice

"Okay. It was … I don't know what year it was, but I … it was the autumn after my twelfth birthday. I had a friend and she'd been hanging round with people, and the one night she asked me to go… she said it would be fun. So I went along… and that's where it all started.

… I don't know how he got my number, whether my friend gave it to him … but from that day it was call after call after call, and it did first start with this one individual,… and then once I was with him alone and he … he took me to … it was a flat in Arleston. It was above … I dunno if it was a shop or something. And when I went in there, there was three older men, and I don't know their names … (crying) … and he said … that I had to have sex with them, and I didn't want to and I told him no. I got dragged into this little room. There was a really dirty old mattress on the floor, and he pushed me down and I kept telling him no … he still carried on. He took my underwear off and then he raped me. He stood up and walked out of the room after he'd finished. And I do remember money was passed. I do know that. I don't know how much. When I tried to get up he told me to stay there … and this time another man came in … He was a bit younger, quite tall. I don't know his name. Didn't really speak much English. Again I told him no, I didn't want do it. I tried to push him away, told him I wanted to go. And again … I was raped again. And I screamed for it to stop. I just blacked out really. I just felt numb … empty … and just gave up all fight and just lay there. He got off, he walked out the room… he came back in, told me to go. I got in the car, he dropped me off home. That was the first time.

… That's when other people got involved… there was a group of them… At first they were quite nice to us. We used to just hang around and have a laugh in the churchyard in Wellington. Then as time got on … things just started to go wrong. It started first with oral sex that they made us do. If we didn't do it we'd get called a slag. They were passing our numbers round. Every day you'd get a call, but you don't know who it was. Your number was getting passed around.

… and we went to the Wrekin. I told him I wanted to go. He said that I would do what he says and when he says it … and if I didn't do it he'd threaten my family. He said that he'd burn the house down to the ground … and he said he'd kill me … so I had to go along with it. And that night … I was on my own … and they took it in turns … in the back of the car … each one of them … took it in turns and they had sex with me. I just lay there and let them do it. I had no fight left. It was no use saying no. I just lay there and let them do it. Taking it in turns… (crying)… and when they were satisfied and they got what they wanted … the usual verbal abuse, you little slag … and then they took me home and it was the same for months … (crying).

… This went on a long, long time. I can't remember exactly how long. The same thing day in, day out.

… And they made my life hell for years, and they put me through so much, and I just wanted it to end. So many times I sat there and I just thought killing myself would be easier than dealing with this every day, hiding it from everyone. Going through the torture, the threats … the control."[1]

1 [redacted] pgs 3-7

Chapter 2: Nature, Patterns and Prevalence of CSE in Telford

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2. Nature, Patterns and Prevalence of CSE in Telford

Introduction

2.1 I am required by paragraph 2.1 of my Terms of Reference to consider as part of this Inquiry the "*nature, extent and patterns of CSE in Telford*". In doing so, I have considered at length the stories told to me by victims and survivors, as it is the narrative of their experiences that best describes the true nature of how Child Sexual Exploitation ("CSE") has been perpetrated in Telford over the years.

2.2 I have also reviewed a number of published reports, articles and reviews, which have sought to estimate the prevalence of CSE – both nationally and within Telford. I have equally considered various sets of data produced by Telford & Wrekin Council (the "Council") and West Mercia Police ("WMP"), to try to clarify the extent of the problem within the borough of Telford & Wrekin (the "Borough"), over the period considered by this Inquiry – i.e. between 1989 and the present day.

2.3 I have also relied on the evidence the Inquiry has heard from professionals across multiple disciplines – health, safeguarding, the police, and social care – to consider whether any particular patterns emerge in relation to acts of CSE committed in Telford, and whether these differ from or mirror patterns observed elsewhere in the country.

2.4 Later in this Report I deal with the culture, attitudes and practices towards CSE which I believe developed in Telford, taking into account the nature and patterns of CSE offending that have emerged over time (Chapter 9: Attitudes and Impact). I have of course borne in mind the national picture of CSE as it has been reported over the years – the warning signs, the trends, and the patterns that have been witnessed elsewhere, and I have found that many of the same patterns could be seen in Telford.

2.5 In this chapter I have considered the nature and patterns of CSE in Telford alongside one another, as I consider that they go hand-in-hand when it comes to how the authorities were – or should have been – responding to children at risk of CSE. I then go on to consider the prevalence, or extent, of the crime within Telford over the years.

Nature and patterns of CSE in Telford – victim/survivor experiences

Victim inducement into CSE

2.6 The Inquiry heard how many victims'/survivors' first experience of CSE was as a result of being introduced to the perpetrator(s) by a friend,[1] or when they had been approached in the street by a man, with whom they began what they initially saw as a 'relationship'.[2] In

1 [redacted]
2

other cases the first contact was made as a result of the perpetrator's job, for example as a taxi driver or food delivery driver.

2.7 Often perpetrators ingratiated themselves with their victims by buying them mobile phones, SIM cards, phone credit or other gifts[3], or by otherwise paying them compliments and giving attention and affection[4], in a pattern which proved initially attractive and flattering to the child. In other cases, children were 'set up' by the perpetrators – for example, the perpetrator would drive the child to a remote location and threaten to maroon them unless they gave 'payment' in the form of sexual acts. Other children had sexual activity forced upon them, when they had no chance of escape.[5]

2.8 In many instances I have seen alcohol and drugs were used to induce victims into sexual acts: "*it was quite common to exchange drugs for a blow job*" or to be told, "*give me a blow job and I'll get you a bottle of* [alcohol]."[6] A typical grooming pattern, on the evidence I have seen, involved a man who "*was often the organiser, ensuring that there were girls for the men to have sex with, but also the one who acted as the girls' protector."* In one such example the Inquiry was told:

"[Perpetrator] *would be the one who would buy* [victim] *a new phone or make sure she had a drink on a night out, for example. He made her feel special and, in return, she treated him as a confidante and trusted him to look after her in any situation."*[7]

2.9 I have also read evidence recounting an incident where one victim/survivor had been given excessive amounts of alcohol and was taken home by her 'protector', where she passed out on the sofa, later waking to him performing a sexual act on her whilst she had been unconscious.[8]

2.10 It is clear from the evidence I have seen that perpetrators would exploit any vulnerability on the part of the child. In many cases this included, at the most basic level, exploiting the child's inexperience about what a healthy relationship looked like. The Inquiry heard that:

"[Victim] *believed that* [perpetrator] *would have no hesitation in carrying out the violence that he often threatened. Nevertheless, in his next breath,* [perpetrator] *would be telling her that he loved her and forced kisses on her."*[9]

2.11 In the case of one victim/survivor I read that:

"*The boys… knew where she lived and began to realise she was home alone much of the time, knocking at her door when they saw* [no parents were home]. *When this happened there were* [multiple] *boys at her door and* [victim/survivor] *could not stop them from coming in. She began to be gang raped in her own bed."*[10]

[3] [redacted] pg 4
[4] pg 2 [redacted] pg 18
[5] pg 9 [redacted] pg 11 [redacted] pg 3
[6] pg 3
[7]
[8] [redacted] pg 8
[9] pg 3
[1] [redacted] pg 4

2.12 I also read evidence that, in some circles, once it became known that a female child was being subjected to sexual exploitation, it was often perceived by her peers as a choice she had made, and "*the boys lost all respect for* [these] *girls*".[11] Children were deliberately humiliated[12] and made to endure degrading sexual practices[13] or perform sexual acts in front of other men.[14] One witness told the Inquiry about another child's experience:

"*… when the ordeal was over, she was bleeding profusely and could not stand up… she was unable to push any of the men away… realising the men must have been 'spiking' her drinks.*"[15]

2.13 In some cases, instances of sexual exploitation were filmed by the perpetrators.[16]

2.14 I have seen evidence that perpetrators rarely used contraception, thereby exposing their victims to risks of both pregnancy and sexually transmitted infections; indeed, the evidence from multiple witnesses was that any pregnancies were expected to be (and in many cases were) terminated, although I have seen that other victims and survivors went on to bear the children of their perpetrator(s).[17] As I have indicated above, many children had of course been lured into believing that the perpetrators were their 'boyfriends', or that they loved them, and they believed that they had therefore 'consented' to the sexual activity – and, as a result, the pregnancy.

2.15 I have seen evidence that in some cases victims would be ostracised from their peers, leading to bullying and name-calling,[18] which exacerbated issues those individuals were experiencing at school, such as deteriorating academic achievement and truancy.

2.16 Fights between children were not uncommon, with the perpetrators playing them off against each other and using their vulnerabilities against them.[19]

2.17 Sexual assault by the initial perpetrator was, in many cases, just the beginning. Abuse from other perpetrators often followed – with other perpetrators being friends[20] or family members[21] of the initial perpetrator, but sometimes being other men to whom the children had been 'sold' for sex.[22] The Inquiry was told that children being gang-raped was not unusual. I have read two horrifying victim/survivor accounts in particular:

"*There were times I'd say no but I didn't know it was being videoed and there was him,* [multiple other men] *and there were a lot of witnesses involved*";[23] and

11 [redacted] pg 2 [redacted] pg 10 [redacted] pg 2
12 [redacted] pg 5 and pg 8 [redacted] pg 15 [redacted] pg 8
13 [redacted] pg 48 [redacted] pg 18 [redacted] pg 24
14 [redacted] pg 10 [redacted] pg 6, [redacted] pg 7
15 [redacted] pg 27
16 [redacted]
17 [redacted] pg 4 [redacted] pg 11 [redacted] pg 3 [redacted] pg 9
18 [redacted] pg 3
19 [redacted] pg 9
20 [redacted] pg 3
21 [redacted] pg 6 [redacted] pg 4
22 [redacted] pg 4 [redacted] pg 19
23 [redacted] pg 4

"*The men were rotating, taking turns to rape me. It seemed to go on forever. Once I started to get the feeling back in my body, I struggled and kicked out, and they forcibly held me.*"[24]

2.18 There were, in addition, threats of, or actual, violence to the children themselves or to their loved ones, if they failed to comply.[25] One witness explained that "*the motivation for complying with the sexual assaults was that she knew she would be beaten if she did not.*"[26] Another victim/survivor recalled an occasion when her rapist approached her in broad daylight, and assaulted both her and her child, in an effort to prevent her from speaking out.[27]

2.19 Abuse escalated in many cases, with victims' details such as phone numbers and addresses being shared amongst perpetrators.[28] In several cases victims received death threats[29] or threats that their houses would be "*petrol-bombed*"[30] or otherwise vandalised[31] in retaliation for their attempts to end the abuse.

2.20 The Inquiry heard accounts from a number of witnesses that the murder of Lucy Lowe, her mother, and her sister in an arson attack committed in August 2000 by her 'boyfriend', would often be used by perpetrators to frighten victims.[32] One witness recounted:

"The CSE situation became much worse in Telford. Abusers would remind girls of what had happened to Lucy Lowe and would tell them that they would be next if they ever said anything. Every boy would mention it."[33]

2.21 One professional witness also noted that:

"*The power was enormous and it all goes back to Lucy Lowe and the fire because the threats, although girls never told us that, I never heard a girl say to me, "they've told me if I say anything they'll burn my house", we all knew that that was what the fear was. I don't know how we knew, but we knew. We knew that that was the fear. It had happened once, it could happen again.*"[34]

2.22 I have seen evidence that one victim/survivor also disclosed the following to the authorities:

"[Victim's friend] *fell out with me because I didn't tell her and… then* [name of perpetrator] *threatened to kill her and he's drove around like a mad man looking for her, he used to come to school and everything. And she told my dad… that he said he was going to burn*

24 [redacted] pg 10
25 pg 7
26 pg 7
27 pg 8
28 pg 2[redacted] pg 4
29 pg 11
30 pg 3
31 pg 24[redacted] pg 28
32 pg 15
33 pg 20
34 pg 48

my house up… after that I did get scared… and then he started giving me death threats as well."[35]

2.23 It is clear to me from the wide range of witness evidence I have reviewed that the one consistent pattern running through the experiences of all victims and survivors was that, once caught up in this cycle of abuse, it was extremely difficult for them to escape it. In many cases the pattern had become such that many children did not recognise themselves as victims – instead, it had, I believe, become a way of life to which they had become accustomed, and in many cases the abuse was allowed to continue because the child believed that they were loved; they believed it was part of their 'relationship':

"*Now I see, but before when I was a kid and (inaudible) I used to just sleep* [with] *him whenever… he'd want it. Now, now I see that I was just a… a vulnerable kid. Just because I thought… he loved me... the way he used to make me feel and the things he used to say, it made, it made me think that he… wanted me for who I am and the person that I looked like and all that, but not really, he just wanted to, just, really he just wanted to… someone to shag, that was it. And now I know that I was vulnerable and that… I was like pushed into it all."*[36]

2.24 This summarises exactly the manipulative and powerful hold that perpetrators of CSE exerted over their victims in Telford. The nature of the crime often involved brainwashing children into believing they were in meaningful, loving and reciprocal relationships – even if such apparent reciprocity involved children engaging in things that deep down, they knew they did not want to do. Often, however, and particularly in the late 1990s and early 2000s – this was something that I have seen children were relaying to professionals, but which professionals failed properly to understand. The knowledge and attitudes of professionals in response to such reports is something I deal with specifically in Chapter 9: Attitudes and Impact, however in my view the following extract sums up why many professionals were confused about the nature of what was happening at that time, and the perception that children were apparently 'consenting' to such behaviour. This extract is taken from an interview with a child victim:

"[Interviewer]: *And why would you have sex with him?*

[Victim]: *Cause he told me he loved me.*

[Interviewer]: *Right, so you wanted to have sex with him or you didn't want to have sex with him? No?*

[Victim]: *No.*

[Interviewer]: *So why did you have sex with him?*

[Victim]: *He was just giving me the attention.*

[35] [redacted] pg 17
[36] pg 58

[Interviewer]: *Right, that was my next question I was going to say, did he, did he ever give you anything?*

[Victim]: *Apart from attention and love, no.*

[Interviewer]: *So, he, you're saying he did give you attention and love…*

[Victim]: *Yeah.*

[Interviewer]: *but you didn't want to have sex with him?*

[Victim]: *I told him I didn't want to have sex with him.*

[Interviewer]: *So you did tell him….*

[Victim]: *Yeah.*

[Interviewer]: *and what did he say?*

[Victim]: *He just laughed."*[37]

2.25 In other cases, victims knew that the way in which they were being treated was not right, but they could not escape it. As one child explained:

"*At school,* [name] *was constantly being humiliated and laughed at by the Asian men. She remembers that she could not stand the thought of people laughing at her and would cry when on her own, but that at school she would put on a front, even joking about it herself and letting everyone believe that she wanted to have sex with these men... Even* [name's] *friends … believed that* [name] *was consenting to sex with these men."*[38]

2.26 I have seen evidence of some cases where, eventually, the abuse became so bad that it often necessitated the child leaving the area completely – and whilst this may have physically removed them from the immediate threat, in many cases it also meant distancing them from any local support system they may have had.[39] Often this meant that, despite the risk to themselves and knowing the potential exploitation that they would come back to, children would often return to Telford, and fall back into the hands of their perpetrators.[40]

2.27 To illustrate what I have found to be a common victim/survivor experience, I have included below "*Lilly's story*". Lilly is not the person's real name, and in order to protect her identity and those of others, names and certain facts have been changed. I have, sadly, during the course of this Inquiry, come across many victims/survivors such as Lilly. Her story typifies that of many vulnerable children who suffered CSE in Telford, and whose voices deserve to be heard.[41]

37 [redacted], pg 11
38 [redacted], pg 5
39 [redacted] pg 17, [redacted] pg 20
40 [redacted] and other case study evidence
41 [redacted]

Lilly's Story

*When I was 13, me and my friend **Helen** were always together, especially in the school holidays. I used to walk down and meet her in town, and we would hang out at each other's houses. One day I remember we started getting followed. We started to see the same cars coming up and down, the driver would slow down and there would be men inside who would stare out of the windows at us. We didn't know them. We laughed about them being "weirdos".*

Then one day one of them actually stopped the car. The guy in the passenger seat started chatting and saying we looked "fit" and asked how old we were. When we told him our age he said, "you look older". I remember one of them saying they liked my school bag. We started to think they were actually alright, and not "weirdos" after all.

*One evening when I was walking back from **Helen**'s house, one of the same cars stopped again, with three guys in it. They offered me a lift. At first I said no because I only recognised one of the ones in the back seat, but then the driver said he knew **Helen**, so I thought it would be okay.*

But they didn't take me home. Once I got in the car they were all joking around and turned the music up really loud. I didn't know where I was going and I started to feel scared. The guy I recognised asked me for a blowjob but I didn't know anything about sexual activities or sex. I asked what that was and all of them started laughing at me. He said "I'll show you…". And then he made me do it, while the other two in the front watched. They said I couldn't go home until I'd finished. I don't remember what happened and whether he came or not. I just remember eventually getting dropped back home and feeling really embarrassed, but I didn't really know why.

I didn't know anyone else who'd had sex or what it was like, I just remember I didn't like it.

*After the weekend, when I went back to school, I remember people at school naming the guys in the car and telling me they knew what had happened. Everyone was calling me a slag and saying they would give my number out to these other guys. I told **Helen** what really happened, and she said something similar happened to her – so I started to think maybe that was how it worked, the whole sex thing.*

*I remember that after that things just escalated really quickly, and before I knew it **Helen** and I would be picked up from school in a taxi, and taken to places where we would end up having sex with different guys, some I remember thinking were really old, but I knew from what happened before that if I didn't do it, I wouldn't get a lift home again. We kept changing our phone numbers but somehow it still got passed around and we'd get calls from men we didn't know.*

I remember things got really bad when my parents got a visit from social services, as I hadn't been going to school. It was easier to let my mum think I was just acting out, rather than telling her the truth. My dad would have gone ballistic.

I've tried to have counselling since, but it hasn't helped. It's affected every relationship I've had, and still now when I walk around Telford, I worry about who I will see, or whether people still think I'm that slag from all those years ago. People knew what was happening, but they chose to look the other way. Those people are still around, and they are still choosing to pretend it never happened.

Methods of grooming used by perpetrators in Telford

2.28 I have set out above many examples of the nature of victim/survivor experiences of CSE in Telford, and the clear patterns that can be seen from their exploitation. Based upon the evidence made available to me during the course of this Inquiry, I have also considered what those experiences have revealed in terms of common themes, or methods that have been adopted by perpetrators of CSE in Telford over the years.

2.29 In my view, there have been two distinct approaches to the grooming of children in Telford, which have been adopted either separately or together, by many perpetrators over the years:

2.29.1 The 'Boyfriend' or 'Lover boy' Model – i.e. where the perpetrator grooms their victim into believing they are in a relationship together, and the child is then subjected to sexual exploitation by their 'boyfriend' and, potentially, others; and/or

2.29.2 Exploiting the victim via 'child prostitution' – i.e. following various forms of inducement, the child becomes trapped into a situation where either their 'boyfriend' or the initial perpetrator facilitates their sexual exploitation by others, sometimes in return for some form of payment, but where there is a clear element of trafficking, selling, or passing the child around for the purposes of sexual exploitation.

2.30 I deal with both of these methods below.

2.31 I then go on to consider two other aspects which I have identified from the evidence as common methods of grooming used by perpetrators of CSE in Telford, and one which I believe was mistakenly assumed to be a theme of grooming, but which was not in my view common to all cases:

2.31.1 The use of repeat locations as 'sites' where exploitation and sexual abuse would take place;

2.31.2 Links between CSE and repeated episodes of victims going missing from home; and

2.31.3 The misconception that either all or the majority of victims were children in the care of the local authority.

'Boyfriend' or 'Lover boy' Model

2.32 By far the most common method, or type of offending, appears to have been what has been called the 'boyfriend' or 'lover boy' model. It is a model described by one of the Operation Chalice ("Chalice") police officers as "*very crude*" and something that did not involve "*sophisticated grooming techniques*"[42]: the plan of the suspects was to meet as

[42] [redacted]

many children as they could, and persuade one to become their 'girlfriend' – which simply meant that she became under his control:

"Since they were fairly good looking men with cars, money and made the victims feel loved and in a relationship, this enabled them to easily exploit victims."[43]

2.33 This technique featured heavily in the evidence the Inquiry has heard, which, as set out in the first section of this chapter, painted a picture of perpetrators intentionally seeking out children who were much younger than them and/or may have been vulnerable; perhaps those that were on the edge of friendship groups, or were craving attention. The perpetrators would often begin by giving the child lifts, treating them to fast food, alcohol and cigarettes, and topping up their mobile phones with credit. In many cases this soon led to the perpetrators introducing the child to drugs; to buying them the mobile phones as well as paying for the credit; and in some cases involving them in other criminal enterprises such as dealing drugs or laundering money – which the child would do for their 'boyfriend'.

2.34 Inevitably, however, it also led to those children becoming involved in a whole range of sexual activity that they were led to believe was consensual or part of a relationship. In some cases it led to them being subjected to exploitation by others as a 'favour' to their 'boyfriend' or because they 'owed them' in some way. Either way, these children led to believe that this was normal or what they deserved, and crucially, as result, they did not consider themselves victims or as being subjected to any form of exploitation – sexual or otherwise.

2.35 One particularly striking description came from a case in which a child disclosed to professionals that she had been subjected to sexual intercourse with multiple men, and that she thought that "*if she had sex with someone then to her, they became a boyfriend*". The child had disclosed to this professional that her "*main boyfriend… was a* [middle-aged] *taxi driver*", but that in a short space of time she admitted "*she had at least 3 boyfriends that… were Asian taxi drivers*". The child disclosed that she would 'go out' with one male, have sex with him, and then "*move on to his friend*". A professional witness concluded in respect of this child:

"*She believed it was her choice, but from my standpoint, I believe she was being passed around for sex.*"[44]

2.36 I have considered evidence provided by Sara Swann MBE[45], a social worker who pioneered the first multi-agency response in the UK to CSE – or 'child prostitution', as it was more commonly referred to – which was the Streets and Lanes Project in Bradford. I come on to talking about 'child prostitution' in more detail below, however as part of her evidence to the Inquiry Ms Swann explained the four-stage process of the 'boyfriend' model as follows:

"*Stage one I called 'ensnaring'. There tended to be some vulnerability and one of the issues that we found, definitely, was missing from home… Very quickly this guy* [be]*comes the*

43 [redacted]
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most important, he begins a sexual relationship and she falls head over heels in love with this guy.

Stage two was about effective dependency on him so [she] *would cut the ties with family and friends…*

[Stage three] *led into the taking control and that's when the violence started but it's not unremitting violence, it's interspersed with good times, buying her presents… that's an effective way to exert control…*

Then those three stages make total domination [stage four]. *He's the most important person in her life and the only person in her life and then she will do favours for him and that includes having sex with his mates and whatever he asks her to do then she'll do it."*[46]

2.37 As time moved on, in the early 2000s, it was clear that more was being understood as to what CSE was, and what some of the indicators were. Those in youth and social work were beginning to hear about, and see evidence of the 'boyfriend model' being used on vulnerable children – but, even at this point, it was hard for them to reconcile what was abuse and exploitation, and what was considered 'voluntary behaviour' on the part of the child. As one witness put it, in relation to the early 2000s:

"*I think I saw evidence of the boyfriend model and, I guess, and it's awful to use the language that we would have used then, but I think there definitely was a belief then that it was a lifestyle choice. That young people were consenting… I find* [that] *a lot more challenging now to reflect back on and think gosh, they* [sic] *were definitely… I would say missed opportunities.*"[47]

2.38 That particular witness felt that this was a "*hard culture to shift*"; moving people away from the idea that this was an expression of "*streetwise*" behaviour, to a position of understanding that this was, in fact, what was described by another witness as "*coercive consent*"[48] – that is, a false consent made on the basis of a misrepresented relationship.

2.39 The Council Scrutiny Review carried out in relation to CSE in Telford in 2016 acknowledged that this 'boyfriend model' of grooming had been used by perpetrators in Chalice – and indeed, as I will come on to discuss later in this Report (see Chapter 3: The Council Response to CSE in Telford), members of the Area Child Protection Committees ("ACPCs"), as they then were, received the benefit of training from Ms Swann on this model prior to Chalice.

2.40 This grooming model has become widely recognised within CSE literature over the years. Ms Swann and Barnardo's produced the first educational video in the UK on the topic in 1998, entitled '*Whose Daughter Next?*', and a decade later, another short film was produced called '*My Dangerous Loverboy*', based on cases seen in Holland. I have seen the film '*My Dangerous Loverboy'* as part of this Inquiry and I have asked witnesses about it. It is, I

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believe, as relevant today as it was 20 years ago. I cover the use of this film, and the Council's approach and attitude towards its use further in Chapter 9: Attitudes and Impact.

'Child Prostitution'

2.41 Another method of grooming that I have seen emerge from the evidence alluded to above is that the 'relationships' between perpetrator and child, if not mistakenly considered girlfriend/boyfriend, instead amounted to (and were interpreted as) 'child prostitution'. I am inclined to see this as more of an attitude, or culture, that pervaded over time, rather than it being an actual manifestation of CSE – and to that extent I deal with the attitude towards 'child prostitution' by professionals more fully in Chapter 9: Attitudes and Impact. However, it is relevant here in the context of children who were trafficked in and out of Telford for sex, and who were 'sold' to men by their apparent 'boyfriends' or perpetrators. This is relevant in the context of 'child prostitution' because I have seen evidence during the course of this Inquiry that, certainly in the earliest period with which we are concerned, many children who were seen to be involved in 'prostitution' were indeed treated by the authorities as 'common prostitutes' under the Street Offences Act 1959.[49] I have seen evidence of cases where children assumed to be 'child prostitutes' were arrested and charged, regardless of the fact that they were still considered underage for the purposes of safeguarding legislation, and with the question of their ability to consent to such activity when underage failing to be considered.

2.42 I have noted above that Ms Swann set up the Bradford Streets and Lanes Project whilst working for Barnardo's.[50] This was as a result of managing a number of social workers who were expressing concerns about very young children "*working*" on the streets. The project was the first of its kind, set up in 1993, to deal specifically with the issue of children and young women up to the age of 18 who were involved, or at risk of becoming involved in 'prostitution'. Ms Swann and her colleagues had come to realise that, under the law at the time, "*children could be defined as common prostitutes… if they were cautioned twice for soliciting or loitering then they were common prostitutes*" and would be treated the same as adult prostitutes. Ms Swann reflected that the law was based on the attitudes of society at the time, and there was a "*huge attitude about that type of girl, the notion of you know, a bit of a tart, asking for it*" but that such assumptions did not acknowledge how the young person became involved, and what perpetuated them to stay involved with their perpetrators.

2.43 As a result, Ms Swann went on to create the 'Triangle Model' of 'child prostitution', and she authored a number of reports on the issue during the late 1990s which sought to dispel the myths around 'child prostitution' being a voluntary lifestyle choice, or only involving children in care, and instead sought to educate professionals (in social work in particular) to regard it as an indication of sexual exploitation.

2.44 Ms Swann took on the National Lead role for Child Prostitution with Barnardo's, and went on to carry out a review in 2001, which involved carrying out an assessment of all 146 ACPCs in England and what they were doing in relation to the problem. As a result of this review, Ms Swann went on to provide specific training to a number of local authorities on

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the issue of 'child prostitution' – including to the Council in 2004. I consider this training specifically in Chapter 3: The Council response to CSE in Telford.

2.45 I have also been able to consider the evidence of two senior police officers from a different force area about another project known as the Wolverhampton Sexual Exploitation Project, which was launched in the 1990s.

2.46 Both the Bradford Streets and Lanes Project and the Wolverhampton Sexual Exploitation Project arose as a result of work being carried out by Barnardo's, which had identified an issue with children becoming involved in on-street 'prostitution'.

2.47 The Inquiry understands that at that time, and following publication of a Home Office Circular entitled '*Safeguarding Children involved in Prostitution*' in May 2000, the Association of Chief Police Officers ("ACPO") was seeking to develop a best practice policy for authorities across the country to use – including all police forces – in order to tackle the issue of 'child prostitution', as it was then seen. The Inquiry was told that a number of forces "*looked inwards*" at what was happening in their localities and in particular the known 'VICE' or red light districts, in order to establish whether or not there appeared to be a problem with child on-street 'prostitution'. Wolverhampton acknowledged there were signs of 'child prostitution', which led to the Wolverhampton Sexual Exploitation Project being established by West Midlands Police.[51]

2.48 The evidence I have read indicates that that by the time the ACPO Child Prostitution Strategy came out in 2004 and the policy was picked up and fully understood, forces across the country had to accept that the issue needed to be addressed, and that the policy should be implemented within their own area.[52] I address this ACPO strategy in more detail in Chapter 5: The Policing of CSE in Telford, where I set out the relevant legislative framework and guidance that has been in place over the years.

Repeat Locations

2.49 The Inquiry has heard evidence from victims/survivors who told of how they were frequently taken to the same locations, where acts of CSE would be perpetrated. Often they would be driven to discreet locations, taken into the remote countryside or "*up the Wrekin*"[53], where they were then told to perform sexual acts and threatened with being left where they were with no way of getting home: "*some victims would perform the sex act just to be able to go home.*"[54]

2.50 I have seen a statement provided in 2013, describing how "*cars full*" of Asian males would turn up at the same locations, in the early 2000s, behaving in a "*slimy*" way towards children:

"*I was aware immediately… of the sleazy attitude of the Asian males towards white girls, this seemed to be well established behaviour. It was apparent to me that the white girls*

51 [redacted]
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of school age 13-14yrs were being targeted by Asian males in there [sic] *late teens for sex, the girls were quite open about it…the males would say things such as 'Come on, I will take you up the Wrekin, you know you want to, I'll drop you back in an hour…'… the girls were only young and seemed flattered by the attention but they were just being used for sex."*[55]

2.51 The Inquiry also heard that offences took place in various known licensed premises in Telford and beyond; in nightclubs, restaurants and take-away establishments – with children either being 'pimped' out there, or in some cases being taken into rooms within the premises in order to be abused.[56]

2.52 I have seen cutting from a local newspaper, dated 20 June 1998, which makes plain that 'child prostitution' was a public concern in Telford at that time. Headlined '*Sex and Drugs 'Picked up at Phone Boxes''* the article reads:

"*Two telephone boxes at a busy Telford road junction are being used as contact numbers for drug dealers and a pick up point for teenage prostitutes, residents claimed today.*

The corner of [named roads] *in Wellington had also become a regular haunt at night for groups of rowdy teenagers…*

Young females, some still of school age, are believed to be involved in prostitution with girls using the kiosks as a contact and pick-up point…

[A resident] *said residents had complained to police, Telford and Wrekin Council and to British telecom about the daily activities around the kiosks, but the problem remains.*

Telford police confirmed that they had received complaints from residents."[57]

2.53 Perhaps most shockingly, I also read evidence that some children regarded themselves as 'prostitutes'[58], and also that there existed what was described as a 'rape house'[59] in Wellington which, it became clear to me, had been operating for many years.

2.54 I have read press reports and heard witness evidence that the Telford Street Pastors began to notice the same vehicles and same drivers behaving suspiciously around the town, outside the nightclubs hosting under 18s events, and trying to tempt children into their vehicles – many of which were noted to be private hire vehicles that had not been pre-booked.[60]

2.55 One witness explained that at one point, taxis would also circle the four main schools in Wellington around finishing time, "*often with three or four men in a car*"; the taxis would go from one school to the next, with the men trying to engage children in conversation. It

[55] [redacted] pg 8
[56] [redacted]
[57] [redacted] pg 272
[58] [redacted] pg 410
[59] [redacted]
[60] https://www.bbc.co.uk/news/uk-england-shropshire[redacted] and [redacted]

was explained by the witness that being picked up in this way made some children "*feel important and more grown up than their peers*".[61]

2.56 Lastly, I have seen accounts from more than one witness that describe CSE being perpetrated in All Saints Churchyard, in Wellington, from as early as the 1990s.[62] One witness explained that when it became public knowledge that such abuse had taken place within the church grounds, it was a shock to the parishioners.[63]

Children in care

2.57 In considering themes and patterns of offending it is important that I dispel a myth: victims of CSE were by no means all in care, or open to local authority intervention.

2.58 One professional summarised it in this way:

"I mean some of the myths that surrounded the girls was that they were all in care, they weren't all in care."[64]

2.59 Indeed, one of the common features of a number of cases I have seen is that children from what might be described as 'stable' homes were manipulated by, and became ensnared in a spiral of exploitation at the hands of their perpetrators - and whose concerned parents felt powerless to stop what was happening.

2.60 One officer described the situation as follows:

"Whilst one could oversimplify it as young girls wilfully arranging to meet men, the key feature was always their young age. There was also a wide variety of girls from varied backgrounds, so there seems to be no obvious pattern or place or offender to focus on. For example these were not looked-after children from care homes running away, but included young girls from stable "nuclear" family homes too."[65]

2.61 That the child in care is the 'classic' victim model is false is also illustrated by evidence from one witness who pointed out that there were at one stage in excess of 200 care homes in Shropshire as opposed to only 30 or 40 in Telford, but that CSE has, over the years, appeared to be more prevalent in Telford – proving that CSE is not confined to children who are already considered 'vulnerable' by the state, or within the care of the local authority. In that witness's view, the issue with Telford was perhaps less about the demographic of victims/survivors and more about the offenders: "*Telford perhaps has more perpetrators than Shropshire does.*"[66]

61 [redacted]
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66 pg 7

Links with missing episodes

2.62 One of the commonalities amongst victims/survivors of whatever home situation, however, was their developing a propensity to go missing. I deal with this topic and how this impacted the way in which authorities interacted with, and responded to children at risk of CSE who repeatedly went missing from home in greater detail at a number of points throughout this Report. However, it is important to acknowledge here that missing episodes formed a pattern which has been identified in the overwhelming majority of CSE cases I have seen in this Inquiry, and indeed missing episodes themselves became an important early indicator to the authorities that there was a link between children going missing and their being at risk of CSE.

2.63 Police officers recounted to the Inquiry that they:

"*… began to see increasingly that many of the Missing Persons reports related to young females and that often they would be found in the company of older males known to* [WMP]*, and sometimes a long distance from home.*"[67]

2.64 I was told that the issue of missing children "*seemed to be growing in severity*"[68], and that it involved children from all areas and backgrounds but that the police would struggle to get the children to cooperate; to encourage them to remove themselves from harm, and tell the authorities what had happened to them.

Growing awareness of CSE in Telford

2.65 I have heard evidence that, in the earliest period we are concerned with – around the 1980s and 1990s – many of those in direct contact with vulnerable children did not have an awareness of what sexual exploitation involved:

"*We were aware alcohol and drugs were used by the young people that we worked with, but with regards any sexual exploitation, or what we may have termed… harmful sexual behaviour or worrying behaviour, I don't really recall a lot… Maybe there was small focus on teenage pregnancy, but… I don't really recall anything more than that.*"[69]

2.66 I observe in Chapter 9: Attitudes and Impact that certain attitudes prevailed at that time, in relation to, for example what one witness called "*truculent teenagers*" who were "*difficult to manage*", and that therefore the "*actual reality* [of CSE] *wasn't prevalent*".[70]

2.67 It is clear to me that in the late 1990s there was a growing awareness amongst school teachers, police officers, social workers, youth workers and, in some cases, healthcare workers that "*something was not right*"[71], but the nature of the problem was not clear to them.

67 [redacted] pg 6
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70 [redacted] pg 19
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2.68 As one witness recalled:

"… 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, if that makes sense… there weren't the systems for [the children] *to come forward and share that information… and from the professionals that I worked with there wasn't a sense of how to manage that,* [because] *it didn't fit into the traditional child protection processes and it didn't feature on the police's radar, so actually it was really difficult then to gather and draw in any response that was going to be effective."*[72]

2.69 And as another professional explained:

"I remember…a manager who would often go and talk to people on the frontline, and one officer started to talk about… a young woman who… would get transported from Telford into the West Midlands, didn't understand why. Didn't understand what was going on there but it didn't seem right and we agreed it wasn't right. But did we understand it? Did we know about it? Did we categorise it as CSE or exploitation? No, we didn't and certainly that didn't translate at the time into a policy."[73]

2.70 In this Report, I include a section on Case Studies at Chapter 8: Case Studies, and I also deal with some specific cases that have come to my attention from the late 1990s/early 2000s within a specific section in Chapter 5: The Policing of CSE in Telford, where I discuss early intelligence around CSE and identify that a number of concerned individuals were beginning to raise concerns, ask questions, and seek referrals in relation (mostly) to children who they feared had become involved in 'child prostitution', and many of whom were regularly going missing.

2.71 It is clear to me that it was as a result of those individuals forcing the issue over many years, and refusing to ignore what were, perhaps now, obvious warning signs, that the issue was finally sympathetically addressed by the youth workers who became the Children Abused Through Exploitation ("CATE") Team, and then investigated as part of Chalice.

2.72 One may of course ask why it took so long for the issue to come to the fore; the first signs had begun to be reported over a decade before Chalice began. In my view this was not simply because of the time it took for awareness to grow, or the difficulty in encouraging children to speak up, but also a determination on the part of police and Safeguarding alike that only 'hard evidence' could found action.

2.73 Certainly prior to Chalice, WMP had been focussed on securing actual complaints upon which they could react, and arrest perpetrators – but as noted above, victims/survivors were not coming forward to make complaints as they simply did not recognise themselves as victims of a criminal offence. Equally, as noted earlier in this chapter, social workers struggled to get the children to open up about what was happening to them – but eventually the recognition came that the authorities needed to work together and invest a lot of time with

[72] [redacted]
[73]

the vulnerable children at risk, to gain their trust and encourage them to realise what they were involved in – and as one professional witness told the Inquiry:

"Relationship building takes time [and] *it's about the prevalence of it happening and then people, more people, more professionals dealing with that and then coming together and saying 'something's going on here… it's more than one individual'."*[74]

2.74 A sense of the change in approach can be seen in 2008, during the intelligence gathering phase of Chalice, when a Detective Inspector provided a briefing to the Telford Division which explained the situation as follows:

"The typical situation within Telford at this time, is where girls aged in the region of 13-17 years, become involved with older men and are introduced into a lifestyle where they are forced/threatened into sexual acts with different men. Traditionally this area has been difficult to investigate as the girls are reluctant to provide any information let alone give evidence. This activity is also frequently linked to the use of controlled drugs and 'commercial' prostitution.

Officers should particularly consider this operation when dealing with missing persons who may be involved in this type of criminal activity. Can I ask that if you become aware of any information that causes you to think that you are dealing with a person (victim or offender) who is involved in this, you submit an NIR [intelligence report] *and flag it up for Op Chalice."*[75]

2.75 I deal with the response of individual agencies and the effectiveness of their actions in separate chapters of this Report; the point to be made here is that there was a clear pattern over time which went from a failure to follow up evidence and signs of exploitation occurring; to misinterpretation of it as something which was the fault of the child; to a growing awareness that the behaviours exhibited by children involved in this activity were not 'normal'; to an understanding that those vulnerable children were being manipulated and exploited for sexual gain.

2.76 I have set out at the end of this chapter my views on the nature of CSE today, where I also seek to answer the question of whether CSE still exists in Telford. First, though, I deal with the question of the prevalence and extent of CSE over the years in Telford.

Extent of the problem: prevalence of CSE in Telford

Overview

2.77 As noted in Chapter 1: Background to the Inquiry, the first widely-publicised estimate given in relation to the prevalence of CSE in Telford (and which, understandably, garnered significant attention) was that published by the Sunday Mirror in March 2018, that "*up to 1,000 girls*" may have been subjected to sexual exploitation in the town, over four decades. This figure has been criticised by some, with one individual stating that the figures contained in the Sunday Mirror articles were "*patently untrue*" and "*based on a*

74 [redacted]
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misrepresentation of published data and crude, unsubstantiated estimates of prevalence".[76] Another individual went on to say that a "*leading figure in the field*" felt that the estimates given were "*done on the back of a fag packet*", and that Telford was "*no different from many other comparable towns*".[77]

2.78 In my introduction in Chapter 1: Background to the Inquiry, I explain that the Sunday Mirror's estimate was based on a number of considered sources, as well as FOIA requests, including:

2.78.1 The number of referrals made to the CATE Team by the Family Connect service between 2013 and 2016[78];

2.78.2 Data published by the Home Office in 2016, which indicated that for the period between September 2014 and September 2015, Telford & Wrekin recorded 256 child sex crimes - which equated to the highest rate of recorded child sexual abuse crimes reported to police per head of the population[79], at a rate of 15.1 per 10,000 residents;[80] and

2.78.3 Statistics set out in the Home Office Report entitled '*Telford and Wrekin Child Sexual Exploitation 1 April 2012 to 21 March 2018*'[81] (the "Home Office Report"), which looked at the number of investigations and prosecutions for CSE-related offences across that period.

2.79 However, in this section I consider the above data and other statistical analyses made available to me in more detail, in order to consider that data within the context of what I have already set out above about the nature and patterns of CSE in Telford. I have also considered the historic position, based on extensive witness evidence provided to the Inquiry, in order to try to provide clarity around what I consider to be a realistic estimate of the extent of CSE in Telford over the years.

Historic Data

2.80 The Inquiry has heard evidence from several witnesses, who expressed the view that CSE had been prevalent in Telford decades before Chalice, and before the Sunday Mirror exposure piece. I have seen evidence of more than one witness that the crime "*had been present for a long time*"[82] and some considered that it had "*generational*" roots - as in it had become a 'behaviour' passed down through generations, not only from the point of view of offenders, to whom such exploitative behaviour had become 'normalised', from witnessing friends and relatives engaging in the same activity; but also from the point of view of victims and survivors, some of whom may have grown up around such abuse and whose parents may have also been exploited previously: "*you speak to the parent and then*

76 [redacted]
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79 i.e. while not the highest number of recorded child sex crimes within a local authority area in England and Wales, it equates to the highest rate of recorded child sex crimes at 15.1 per 10,000 residents.

80 [redacted] pg 24
81 [redacted] pg 24
82 [redacted]

they will disclose to you that they've had their own experiences of exploitation or sexual abuse."[83]

2.81 It has been very difficult for this Inquiry to clarify those views other than anecdotally; because the Inquiry made the decision that it would not proactively engage with convicted offenders or suspects, and also because, whilst it was the evidence of some, this has not necessarily been the case for all victims and survivors coming forward to give evidence to the Inquiry.

2.82 From those victims and survivors who were able to speak about their experiences, it is clear to me that this type of exploitation dates back at least to the 1970s. I have seen evidence from one individual who recalled being touched inappropriately in the late 1970s by multiple men in a corner shop while she was scarcely of secondary school age, and being offered sweets by another man after he had sexually assaulted her; she reflected "[my] *innocence was stolen for the price of those sweets*".[84]

2.83 One witness also told the Inquiry that she recalls walking home from school as a teenager in the mid-1980s, when she was approached by a man who subsequently raped and physically assaulted her. This abuse became a regular occurrence, with the perpetrator allowing relatives to do likewise and forcing the child to comply.[85] The Inquiry heard from another witness that, also within this time period and when barely a teenager, a boy from her school:

"*… had sex with her. This began a pattern, with the boy bringing his cousin along on the next occasion, who* [she] *was also forced to have sex with and then, on a subsequent occasion, another friend."*[86]

2.84 I have also been provided with evidence that, during Chalice, disclosures were made suggesting that there were "*minibuses*" full of children being trafficked out of Telford for the purposes of CSE.[87] When asked about the estimated '1,000' figure published in the press, a number of witnesses considered that, whilst there was no hard evidence proving there to be as many as 1,000 confirmed victims/survivors of CSE in Telford, looking at the number of victims/survivors identified during Chalice – and since – and when considering that some allegations dated back to the 1990s, the estimate of victim/survivor numbers reaching 1,000 was considered conservative, or in the words of one witness "*tame*".[88]

2.85 I have therefore felt compelled to consider what hard data there is available regarding the extent of CSE in Telford, and whether or not such a figure could be substantiated – and I attempt to do so below with reference to data collated by WMP and the Council, as well as published data within reports and inspections.

83 [redacted] pg 2 and pg 6
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86 pg 3
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Police Data

2.86 Insofar as established and reliable police data is concerned, it is unfortunately the case that this only exists for more recent years in relation to CSE. This is not, I should clarify, down to any failure on the part of WMP to collate or provide such data, but simply because forces nationally did not begin to collate and report specifically on CSE data until after the publication of the Government's overarching CSE Action Plan in 2011 and the thematic assessment of CSE carried out by Child Exploitation and OnLine Protection ("CEOP") in its '*Out of Mind, Out of Sight'* report.

2.87 The Home Office Report referred to above provides estimates based on the number of police 'CSE markers' which had been applied to crimes entered onto WMP's systems. This revealed that over that six year period (2012 to 2018), a total of 431 offences with a CSE marker were recorded in Telford & Wrekin, with a significant increase in reporting after April 2015 – which gave an average in excess of 71 offences per year. However, the Home Office Report is presented with the caveat that "*it is almost certain that the figures do not reflect the true scale of CSE due to poor allocation of markers*" – for example because markers may have been used inappropriately in cases involving victims/survivors over the age of 18 at the time of going missing; or because no CSE marker may have been used at all by the officer entering the crime on the system at the time.

2.88 With this in mind, I have considered a series of 'CSE Problem Profile' documents prepared for the years 2012 to 2015, in order to understand the scale of the problem, as it was identified to the police via such problem profiles.

CSE Problem Profiles

2013

2.89 In a report created on 31 July 2013[89] ACPO officers carried out a problem profile of CSE in West Mercia and Warwickshire (the "2013 Problem Profile") – as the two forces were, at this time, operating in an alliance (the "Alliance" – discussed further in Chapter 5: The Policing of CSE in Telford). This was said to be the "*first year of the CSE evaluation*" and relied upon data from the CRIMES system in WMP as well as from data retrieved from the following:

"1. CSE Interest Marker;

2. Sexual Offences Database where notes had been recorded to indicate CSE;

3. All non-familial sexual offences committed by an adult against a child;

4. Via a query to extract trafficking and exploitation offences;

5. Child Incidents from daily briefing. All of the data was read through and grouped according to CSE Type and non-relevant offences/intel removed."

89 [redacted]

2.90 I have commented upon the use of CSE markers in Chapter 5: The Policing of CSE in Telford, however it is important to note that these markers had only been introduced in West Mercia in November 2012 – post-Chalice. As acknowledged in this problem profile, the markers were intended to be used "*to record potential or actual CSE*" and "*a large part of the responsibility for identifying CSE cases and further intelligence gathering falls to local policing.*" WMP confirmed to the Inquiry that the intention behind the marker system was to address the "*need for intelligence to be considered through existing tasking and co-ordination systems to consider threat and harm*" which could then be considered on a regional basis for CSE threat reduction.[90]

2.91 The 2013 Problem Profile released figures as follows for the year 1 April 2012 to 31 May 2013:

2.91.1 172 CSE incidents had been reported across the region, with 36 in Telford & Wrekin;

2.91.2 25% of all CSE incidents reported in the region were complaints of rape and 47% of all CSE reported involved penetration of some form;

2.91.3 147 offenders in total across the region had been identified, 80% of whom were males aged between 16 and 35 years;

2.91.4 90% of victims were female, almost half of which were aged between 13 and 14, and six victims were under the age of 11;

2.91.5 40% of all victims had been identified as missing previously – half of which three times or more; and

2.91.6 Where known, 25% of CSE offences were 'consensual' (though in some cases the victim may be below the age of consent), 21% were by force, 19% by surprise and 13% by coercion.

2.92 Insofar as the patterns identified within the problem profile, the 2013 Problem Profile found that there was:

"… [a] *clear bias in offences being committed during holiday periods and evenings and weekends* [suggesting] *that recreational time and certain related activities may increase the likelihood of offences. However, direct links to ASB* [anti-social behaviour] *or other criminality has not been established at this stage."*

2.93 In terms of the methods of perpetration, the report found that "*some form of threat, inducement or reward was offered in 17 CSE offences. This equates to about 11% of cases where enough detail is available for facts to be established.*" Whilst this number may seem low, given what has been established above in this chapter about the nature of CSE and how it is commonly perpetrated, the data published by the police relies upon children considering themselves victims/survivors, and disclosing the inducements and/or threats in a way that would then be reported as such. As is clear from the foregoing – and as is noted

[90] [redacted] pg 9

in the 2013 Problem Profile, the nature of CSE is such that "*victims and offenders are more likely to be acquaintances (66%) than strangers (22%)*", and the sexual offending might be perceived to have been 'consensual'.

2.94 In my view, therefore, it is likely that the published statistics for threats and inducements are much lower than was (or is) the reality. Equally, I view the 25% of cases considered to be 'consensual' with a considerable degree of scepticism, knowing that in the overwhelming majority of cases I have considered as part of this Inquiry, such 'consent' was not true, informed consent but was rather apparent consent obtained via deceptive and coercive means.

2.95 The 2013 Problem Profile considered, on the basis of these statistics for the Alliance, that:

"[There was] *no current intelligence to suggest an increase in CSE* [and] *the prediction is that CSE… offences are likely to be sporadic, emerging and potentially increasing over many months – even years, before falling again to a residual level with the conclusion of an operation and sentencing of offenders.*"

2.96 This was of course with reference to Chalice, which had concluded during the period covered by this problem profile. In my view, there was perhaps a sense within West Mercia at this time that the problem had been 'dealt with', and that the initial 'wave' of CSE victims in Telford had already come forward, at the time of this problem profile; as a result, I would say, that this makes this particular problem profile perhaps a less reliable indicator of the prevalence of CSE in Telford. I say this not in terms of the figures being unreliable, but in the sense that its conclusions as to trends and residual offending levels are perhaps less reliable than one might hope, as a result of false assumptions being made.

2014

2.97 Further to the 2013 Problem Profile, the Alliance produced updated figures for CSE prevalence in West Mercia and Warwickshire in September 2014[91], covering data gathered by WMP between 1 April 2013 and 31 August 2014 (the "2014 Problem Profile"). In addition to the searches performed in the 2013 Problem Profile, this review relied on further data made available via WMP's COMPACT system for missing persons as well as information from the command and control logs, and NIRs (intelligence records). Data was also said to be made available through the Local Safeguarding Children Board's ("LSCB") CSE Panels.

2.98 At the time the 2014 Problem Profile was produced, it was noted that there were five "*current live operations running*" across the region, and two organised crime groups in Telford, linked to Chalice and a second high-profile CSE investigation.

2.99 The findings of the 2014 Problem Profile were as follows:

2.99.1 For the 12 months between 1 April 2013 and 31 March 2014, 557 offences/incidents relating to CSE were recorded in West Mercia – stated to be "*an upward trend which has continued through to mid-2014*"; so much so, in

91 [redacted]

fact, that "*when comparing April* [2014] *to August 2014 to the same period in 2013, there is an overall increase of 69.6%.*"

2.99.2 Indeed, in the five months between April and August 2014, 456 CSE offences in total were recorded across the region as a whole - 48 of which related to Telford & Wrekin, ranging between five and 15 incidents recorded per month.

2.99.3 From the information from LSCB CSE Panels, 292 "*CSE panel victims*" had been identified as vulnerable to CSE since April 2013 across the region as a whole; 63 of the 292 resided in Telford. Whilst all 63 had an allocated CATE worker, only 6 had a CSE warning marker against them on the police systems. I am surprised that consideration as a CSE Panel victim does not result in inclusion upon police systems with a CSE marker, and it seems to me that serious consideration should be given to such an approach.

2.99.4 Based on recorded incidents since April 2013 across the Alliance as a whole, "*721 persons were identified (victim or child in protection) where CSE was likely to be an element*", plus 49 nominals had a CSE warning marker placed on them as a potential victim – meaning that "*there are around 750 individuals currently on the crimes system who are potentially a victim (or have previously been a victim) in a CSE type offence or related incident recorded since April 2013.*"

2.99.5 Across all data, a total of 399 CSE perpetrators (including suspects) were identified, and since April 2014, 191 intelligence logs had been created "*with links to nominals, locations and ongoing operations*".

2.100 It is clear to me from these figures that, contrary to the position envisaged in the 2013 Problem Profile, the prevalence of CSE in West Mercia had increased over the course of the previous year – and this cannot simply be explained by an influx of victims/survivors reporting historic CSE offences either. Such data was included within the problem profile and I think warrants replicating here so that the figures over the years may be considered against previously published estimates:

Non-recent offences/crimed incidents recorded April to August 2014

First committed year	Number of offences
1950-1959	2
1960-1969	12
1970-1979	21
1980-1989	13
1990-1999	8
2000-2009	21
2010-2012	34
2013	96
Jan-Mar 2014	55
Total	262

2.101 The above statistics show a narrowing in the age gap between victims/survivors and perpetrator, with 50% of all CSE perpetrated against females aged 14 to 17 by males aged 16 to 34, and 10% of all CSE perpetrated by "*younger male offenders, particularly aged 16-17 years*". This is perhaps unsurprising when one considers the increase in 'online' CSE alongside the increasing use of social media as a means of communication between younger age groups – and, also, the sharing of obscene material and grooming over social media – all of which was also acknowledged as an increasing threat in this problem profile.

2.102 The analysis conducted in the 2014 Problem Profile is far more thorough than that in 2013 – most notably so in the work done to identify CSE Panel victims and the links and associations between victims/survivors and perpetrators. In this particular report a chart is produced with identified victims/survivors, and the summary states that:

"*Utilising analytical software and based on intelligence within police systems it is possible to easily identify links between the victims that are currently being managed through partnership arrangements.*"

2.103 As a result, the review identified that "*81% of CSE panel victims currently have intelligence linked to them*" and it was possible to show where "*victims had links to other victims from within the partnership data set*".

2.104 The authors make the following observation in this problem profile – or, as I consider it, a stark warning to the Alliance:

Observation:

There is vulnerability for Warwickshire Police, West Mercia Police and the Safeguarding Childrens' Boards with regard to resources available to ensure that the ongoing increasing risk is managed appropriately.

The 750 persons identified through Warwickshire and West Mercia crimes systems are **potential** victims of CSE only. Through further investigation and case development it would no doubt transpire that many are not being (or many never have been) subjected to CSE.

However, the gulf between the 750, and the 97 children within this total, who have been discussed at CSE panel meetings is wide and there are no doubt worthy cases that have been missed from this process.

2.105 Overall, the 2014 Problem Profile shows two concerning aspects: the failure above to refer 653 of 750 identified potential cases of CSE to the Panel, and the failure to add a CSE warning marker to over 90% of children open to CATE. Unless actions are taken to ensure that children are likely to be identified as at risk, the creation of the problem profile simply becomes an exercise in compiling statistics.

2015

2.106 Further to the 2014 Problem Profile, the Alliance commissioned an updated report the following year, which was published in August 2015[92] (the "2015 Problem Profile"), and this time adopted the analysis under the '4 Ps framework' – i.e. to *Pursue, Prevent, Protect and Prepare*.

2.107 The statistics in the 2015 Problem Profile showed that:

2.107.1 In 2015, 269 individuals had been flagged as CSE victims and 45 offenders had been identified across West Mercia and Warwickshire;

2.107.2 38% of children "*have been reported as missing at some point during their time within the safeguarding system*";

2.107.3 5% of female victims had "*fallen pregnant, experienced a termination",* whilst "*records in relation to seven victims have included the presence of a sexually transmitted disease at some point during their engagement with safeguarding professionals*"; and

2.107.4 From April 2014 when the Alliance "*jointly began recording and researching intelligence via GENIE*", there was "*a fourfold increase in CSE intelligence… from 20 logs recorded per month to over 80 in March and April 2015*" – which it felt was as a result of increased awareness and the creation of the dedicated CSE teams in 2015.

2.108 The review set out a total of 23 recommendations for the Alliance to consider as part of its overall CSE control strategy. It is outside the scope of this particular section to consider those recommendations specifically; this is more properly dealt with as part of Chapter 5: The Policing of CSE in Telford.

2.109 It is difficult not to conclude that, based on these wider accumulated figures from police data for the years 2013 to 2015, the use of police CSE markers (at least historically) is an unreliable metric to determine the scale of CSE within Telford.

2.110 Indeed this was noted in the 2013 Problem Profile, which considered that it was:

"… *difficult to assess whether the prevalence of the threat from CSE* [was] *increasing… because it is likely that offences remain hidden for some time before coming to the notice of authorities*".

2.111 It recommended that "*vigilance for the problem needs to be promoted constantly and awareness refreshed frequently*" in order to ensure that risks of CSE are identified, and potential offenders "*marked*". Similarly, the 2015 Problem Profile echoed the issue that:

"*There is no single offence of Child Sexual Exploitation, as perpetrators face being investigated for many different offences including rape, trafficking, sexual assault or incite*

[92] [redacted]

a child into sexual activity. Therefore capturing accurate CSE offence data is reliant on the appropriate use of the CSE interest marker [and] *this assessment has highlighted that in a number of offences, the CSE marker has been inappropriately used."*

2.112 The profile went on to confirm that, whilst the CSE marker was first introduced by WMP in 2012:

"*… it was not widely adopted to flag incidents and offences related to CSE until June 2014. Since this date the CSE marker has been applied to 678 offences and crimed incidents in West Mercia.*"

Other police data

2.113 Insofar as actual rates of offending are concerned, figures provided by WMP show that from 2015/16 to 2020/21, a total of 831 CSE crimes were recorded across Telford & Wrekin. WMP considered that there was no discernible trend in the annual rate, as can be seen from the relatively consistent figures in the chart below, setting out the number of CSE recorded crimes for Telford & Wrekin from 2015 to date.[93]

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTAL
2015/16	10	8	35	8	6	9	7	6	10	9	12	14	134
2016/17	13	14	12	10	4	6	8	4	10	7	14	11	113
2017/18	10	7	15	24	21	20	11	11	10	6	8	10	153
s2018/19	15	11	22	10	8	26	13	6	14	10	9	7	151
2019/20	23	16	6	24	13	6	13	7	9	7	8	7	139
2020/21	11	13	16	13	12	29	2	4	9	11	7	14	141
2021/22	11	8											19

2.114 WMP has provided the Inquiry with further statistics from its Online Child Sexual Exploitation Team ("OCSET"), to give some context to the current rates of offending in Telford & Wrekin, alongside changes to the grooming methods being used by perpetrators – which includes far more contact being made online. Those statistics show that:

2.114.1 Since its inception in 2016, OCSET has developed and disseminated 1,109 intelligence packages relating to sexual exploitation of children. This has led to the arrest/voluntary interview of 594 suspects, and the identification of 6,489 children perceived to be at risk.

2.114.2 In June 2020, 896 CSE intelligence packages had been generated by WMP's Force Intelligence Bureau since 2016; and

[93] [redacted] pg 18

2.114.3 In the 16 months between 1 January 2018 and 30 June 2019, a total of 616 cases of CSE were referred to WMP either by the National Crime Agency or other Local Authorities.[94]

2.115 It is interesting to note the comparison between these rates of referrals, and those a decade or so earlier: between 2006 and 2008 WMP received only 51 OCSET referrals from CEOP.[95] This may reflect the degree to which the internet became an embedded part of everyday life during those ten years.

2.116 The most recent figures made available to the Inquiry show that in the first six months of 2020, WMP received 172 referrals relating to CSE from all sources – which represented a 54% increase compared to the same period in 2019. As a result, WMP indicated to the Inquiry that it had enhanced the resourcing of OCSET, with 14 Detective Constables now operating under two Detective Sergeants.[96]

2.117 WMP expressed the following to the Inquiry in relation to its current view of CSE within Telford, and its handling of CSE cases today:

"*Whilst we cannot and never will be complacent, we believe that there has been significant progress over the course of the last decade, in particular, in how the police, partners and communities are better equipped to identify the indicators of child exploitation and then take collective agreed action to protect children.*"[97]

2.118 It went on to say that it believed it had demonstrated "*ever evolving investment and commitment… to better equip* [WMP] *in understanding the nature and scale of the problem.*"[98]

Council Data

2.119 As mentioned above, in the early 2000s Sara Swann and Valerie Baldwin were commissioned to carry out a review which involved looking at all 146 ACPCs in the country.[99] Their review, published in 2002, revealed that 76% of all ACPCs were aware of children being involved in 'prostitution' in their area. From statistics gathered across all ACPCs and the identification of specific cases from a targeted review of 50 out of the 111 ACPCs, Ms Swann and Ms Baldwin considered that at that time an average of 21 children – the vast majority female - were being abused through 'prostitution' in each authority, at any given point in time. Further studies have taken place since then,[100] which have proven to suggest that Ms Swann and Ms Baldwin's estimate was "*extremely conservative*"[101] or, in the words of the Government in its '*Safeguarding Children and Young People from Sexual Exploitation*

[94] [redacted] pgs 200-213 [redacted] pgs 77-78
[95] [redacted] pg 210
[96] [redacted] pg 213-214
[97] [redacted] pg 221
[98] As above
[99] Swann and Balding: *'Safeguarding Children Involved in Prostitution, Guidance Review'* (Department of Health, 2002).
[100] Such as the one carried out by Harper and Scott in London in 2005 – '*Meeting the needs of sexually exploited young people in London*' (Barnardo's).
[101] 'R*educing the Risk: Barnardo's support for sexually exploited young people*' (2006).

Supplementary Guidance to Working Together' published in 2009, a "*considerable under-estimate*".[102]

2.120 Almost a decade later, research carried out by the University of Bedfordshire[103] indicated that over half of all LSCBs reported that they did not record any data on the nature and prevalence of CSE in their area, and many did not identify it as a priority issue in their area.

2.121 Insofar as Telford is concerned, the statistics quoted in the press reports in 2018 and referenced above, that the Council had recorded 256 offences of CSE in the year to September 2015 and that this equated to "*the highest rate of recorded child sexual abuse crimes reported in the UK*"[104], were based upon data published in the Council's 2016 Scrutiny Review of CSE, obtained from the Home Office as follows:[105]

Table 1

Child sex offences for the year up to and including September 2015 – areas with highest rates[20]

Community safety partnership area	Child sex crimes	% Change since last year	Rate per 10,000 people
Telford and Wrekin	256	146.20%	15.1
Rochdale	300	98.70%	14.1
Stoke-on-Trent	338	32.00%	13.5
Rotherham	350	90.20%	13.5
Barrow-in-Furness	88	49.20%	13
Northampton	278	93.10%	12.7
Doncaster	385	25.00%	12.7
Great Yarmouth	122	60.50%	12.4
Southampton	302	102.70%	12.3
Calderdale	249	156.70%	12
Bradford	623	89.90%	11.8
Nottingham	365	135.50%	11.6
Blackpool	163	16.40%	11.6
Barnsley	274	90.30%	11.5
North East Lincolnshire	178	28.10%	11.1
Hastings	97	94.00%	10.6
Braintree	159	231.30%	10.6
Isle of Wight	146	124.60%	10.5
Nuneaton and Bedworth	132	109.50%	10.5
Waveney	121	51.30%	10.4

[102] HM Government *'Safeguarding Children and Young People from Sexual Exploitation – Supplementary Guidance to Working Together to Safeguard Children (2009)'* pg21.
[103] '*What's going on to safeguard children and young people from sexual exploitation?*' – Research by Sue Jago and Jenny Pearce from the International Centre for the Study of Sexually Exploited and Trafficked Young People (2011).
[104] [redacted] pg 3
[105] [redacted] pg 25

2.122 In response to the Home Office findings, the Scrutiny Review indicated that it had requested data on the number of CSE related contacts coming into the Family Connect service at the Council, and the result was that:

"*In the seven months from 1 January to 31 July 2015 data from Protocol (the system used by children's services) showed there were over 4,000 contacts into Family Connect of which there were 137 (3%) contacts with an indicator of CSE. This could be either where CSE was recorded as the reason for the contact or where any words associated with CSE had been highlighted through a data text matching process built into the Family Connect system as a safeguard to flag potential risk factors.*"

2.123 The Scrutiny Review went on to confirm that, of those 137, 45 of the CSE contacts were referred to Safeguarding, and that, from further data obtained from CATE:

"*… over the same seven month period there were 44 referrals to the CATE team with between 5 and 10 referrals each month.*"

2.124 However, the authors recognised that the figures "*must be treated with caution*" as it was felt that CSE would not necessarily always be a factor in those cases that were referred (or had been picked up by the text matching), and bearing in mind the data was not "*disaggregated*" into existing or new contacts, so there could be repeat numbers for the same individuals. In summary, therefore, the Scrutiny Review Committee held that:

"*Clearly we cannot make any assumptions about the scale of CSE from the data… but it does provide a snapshot in time of the number of reports where there were indicators of CSE... the data provided to us showed weaknesses in the system for collecting and managing CSE data but we understand that this has been recognised and that there are plans to review the systems to improve performance management and data analysis.*"[106]

2.125 In order to understand those figures in more detail, the Inquiry requested further statistics from the Council, specifically confirmation of the number of children thought to be at risk of CSE. In its Corporate Submission to the Inquiry, the Council provided the following figures:[107]

Table 9: Reports to Family Connect of concerns about CSE*

Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Number of reports (emails, telephone calls etc.)	92	121	331	346	292	391	318
Number of young people who are the subject reports	66	92	203	218	194	248	228

2.126 The Inquiry was told that Table 9 represents the number of children who were the subject of reports to Family Connect about concerns of the risk of CSE. It also includes the number

106 [redacted] pg 26
107 [redacted] pg 54

of individual reports received in each of these years. It was explained that the number of reports and number of young people do not match as it is not unusual for Family Connect to receive information about an individual from more than one person or organisation.

2.127 I was also provided with further figures from the Council relating to data collated by Family Connect between 2013 and 2020 as follows:[108]

Table 10: Outcome of each report (emails, telephone calls etc.) to Family Connect of concerns about CSE

Outcome	2013/14		2014/15		2015/16		2016/17		2017/18		2018/19		2019/20	
	Reports	Number of young people	Reports	Number of young people	Reports	Number of young people	Reports	Number of young people	Reports	Number of young people	Reports	Number of young people	Reports	Number of young people
Referred to CATE service	37	36	54	53	76	62	90	68	58	39	108	86	87	43
Referred to Safeguarding service	34	30	39	35	105	91	112	112	67	64	79	74	52	51
Referred to other agency - schools, health professionals, police or Council services	8	8	10	10	36	35	70	56	115	97	170	125	186	149
Information and advice provided	13	11	22	20	114	94	78	62	55	47	38	32	46	40
Total outcomes	**92**	**85**	125	**118**	**331**	**282**	350	**281**	295	**247**	395	**317**	371	**283**

2.128 I have highlighted in Table 10 where the figures do not appear to tally with the earlier table regarding overall number of reports received for the years 2014 and 2016 to 2020. In the years 2014, 2016, and 2018 the numbers are consistently out by four; in 2017 there is a difference of three, but in 2019/2020 the difference is quite considerable, with an error margin of 53.

2.129 The Council has explained that there are differences between the numbers in Table 9 and Table 10, because sometimes there can be more than one outcome for a report to Family Connect. For example, in 2016/17, there were 346 reports to Family Connect but 350 outcomes. The Inquiry was told this happens because further information and clarification about a child becomes available and as a result a different service needs to be involved. It was also explained that these statistics are generated based upon a text-matching via word search, and therefore consistency is dependent upon the same terms being used and applied.

2.130 The Council also went onto to explain that, in relation to this data:

"A report into Family Connect will be initially classified as CSE where relevant risk factors are present. Such a classification does not mean that the young person is a victim of CSE or even at significant risk of CSE. Each report is assessed and triaged as to what appropriate action/support should be provided. This process explains why not all reports of CSE are referred to CATE or the Safeguarding Service as shown in table 10.

Across the period covered in tables 9 and 10, the total of the annual number of young people subject to reports about CSE to Family connect is 1249. We have looked at these 1249 young people to identify any "duplicates" i.e. where a young person was subject of a

108 [redacted]

report to Family Connect in more than one year. This analysis has shown that across the period these reports related to 969 individuals. Of these, 597 were referred to either CATE and/or Safeguarding Services:

- *203 were referred to CATE only*
- *245 were referred to Safeguarding Services only*
- *149 were referred to both CATE and Safeguarding Services".*

2.131 From a national perspective, I have noted that in October 2016 the Department of Health announced that it had commissioned NHS Digital: "*to develop, collect and publish a CSA data standard in a way that will provide commissioners with a better understanding of the prevalence of CSA in England…* [in order] *to improve health outcomes, through more timely support"*[109] – this would include mental health as well as medical intervention in order to minimise the risk of long term impacts of abuse on children.

2.132 It is relevant, from Telford's point of view, to also note that the Ofsted inspection of the Council's safeguarding provision in 2016 recommended that more needed to be done to understand the scale of the problem in Telford. It was acknowledged that steps had been taken to create a "*multi-agency dataset*" and to understand the trends of child sexual offences taking place in the Borough, which included looking at victim/survivor and perpetrator profiles:

"*Over the last 12 months the TWSCB has worked with partners to establish a multi-agency dataset which is used to monitor the impact of the CSE Pathway… A joint piece of work between TWC and WMP has also been undertaken to understand the trends in child sex offences over recent years, looking specifically at victim and perpetrator profiles. This information will help to further develop the intelligence around perpetrators within the Borough and enable further targeted disruption activity.*" [110]

2.133 However, I am not in a position, based on the information made available to me to date, to be able to assess how robust those systems now are.

2.134 The Inquiry has, however, seen copies of Action Plans produced by the Child Exploitation Thematic Sub Group which show that, for the period 2015/2016, concerted efforts were being made to look at, for example, training and performance frameworks; risk assessment tools; missing strategies; and health and support services, as various routes into, and opportunities to assess children at risk of CSE in order to understand better and seek to reduce the prevalence of CSE.[111]

2.135 The Children and Young Persons Scrutiny Committee ("CYPSC") minutes from 2017 also note that all LSCBs for Telford and Wrekin are required to flag/record all cases of CSE, as part of ongoing monitoring of the scale of CSE in the area, and that such statistics should

[109] [redacted]
[110] [redacted] and [redacted], pg 2
[111] [redacted], [redacted] – consistently referenced in plans across 2015/16.

be reported initially to the LSCB and then on a six-monthly basis, to the CSE Strategy Group so that trends can be analysed and responses considered.[112]

2.136 I have also noted however, that a similar priority was included within LSCB material some years earlier than this, in 2012 – where the primary objective of CATE was to implement "*a co-ordinated data collection system… to monitor the nature and prevalence of CSE locally, and to assess outcomes for children and young people*".[113] I discuss the issue of delays in the collation of data within Chapter 3: The Council Response to CSE in Telford.

2.137 Whilst not specific to Telford, I noted with interest a report issued by the Academy of Medical Royal Colleges in September 2014 entitled '*Child Sexual Exploitation: improving recognition and response in health settings*',[114] which identified a number of reasons for considering that available data for CSE represented an under-reporting of the true extent of the crime, including:

2.137.1 Children failing to perceive themselves to be at risk of, or having been exploited and therefore failing to report it;

2.137.2 Children experiencing obstacles when they do try to tell someone;

2.137.3 Assumptions being made by professionals, or perceptions that the exploitative behaviour is a '*choice*' of a '*streetwise*' child;

2.137.4 Nervousness amongst professionals about confidentiality and sharing information with other agencies, meaning onward disclosures or referrals are not made where they should be; and

2.137.5 CSE not being seen as a "*health diagnosis*" and therefore not being consistently recorded by professionals.

2.138 Many of these accord with my findings above about the nature and patterns of CSE historically; why growing awareness has been slow; and why it has taken a long time to get to a position where data might be considered a reliable indicator of the prevalence of CSE in Telford.

The current picture of CSE in Telford

2.139 The view expressed to me universally is that CSE in Telford – as with anywhere in the country – may have reduced, or changed, but it has not gone away fully. It is accepted by the authorities – Safeguarding and police in particular – that CSE is still likely to exist, to some degree, within the town; albeit both authorities indicated in their Corporate Submissions to the Inquiry that they felt the action they had taken over the years, and in particular during and following Chalice, has meant that the issue is far less prevalent and, when identified, far better managed than in years gone by.

112 [redacted] pg 7
113
114 [redacted], pg 10

2.140 WMP explained to the Inquiry that:

"In 2020 WMP still maintains its dedicated CSE team for Telford and Wrekin working closely with partner agencies to address CSE. The Child Sexual Exploitation team is now the Child Exploitation team which has resulted in a realignment of Police resources in this critical area of business. The uplift in the Police team mirrors the approach of the Telford and Wrekin Local Authority. This empowers both organisations to better understand the scope and nature of the problem in the Borough. An important part of this work is the early identification of children at risk of CSE…

We are very clear the responsibility of tackling CSE lies with every police officer and staff member. As a community and as a Police service, we still face huge challenges; many victims may not realise they are a victim and it is important that not only do we investigate CSE but that we, in partnership with the local authority and schools, educate parents and children to enable them to identify the signs of abuse."[115]

"WMP are committed to continue working with partners, third sector organisations and the community in doing everything possible to protect children from being exploited and where necessary pursue perpetrators. Whilst we cannot and never will be complacent, we believe that there has been significant progress over the course of the last decade, in particular, in how the police, partners and communities are better equipped to identify the indicators of child exploitation and then take collective agreed action to protect children. Within this submission there is considerable evidence that demonstrates the ever evolving investment and commitment that has been made to better equip us in understanding the nature and scale of the problem; and structures, systems, processes and governance arrangements that ensure that we are constantly striving to be better."[116]

2.141 The Council describes the position as:

"Over the past 20 years, Telford & Wrekin Council has been at the front line of how local and national government has responded to CSE. The challenges of identifying CSE, realising the nature and scale, responding, and supporting and engaging with victims and survivors have been the ongoing focus of the Council."[117]

2.142 As I will discuss in Chapter 3: The Council Response to CSE in Telford, I simply do not accept that the Council has maintained appropriate focus on CSE over the last 20 years, and am surprised at such a resolutely up-beat assessment.

2.143 As one witness reflected on CSE post-Chalice:

"*It* [has] *changed its picture, perpetrators are very good at changing. Our services become aware that they are going under the radar and then they come up again. It was a changing picture and I think the awareness was of a much wider scope of exploiters to bring in young people… and we recognised that it wasn't all through the boyfriend model."*[118]

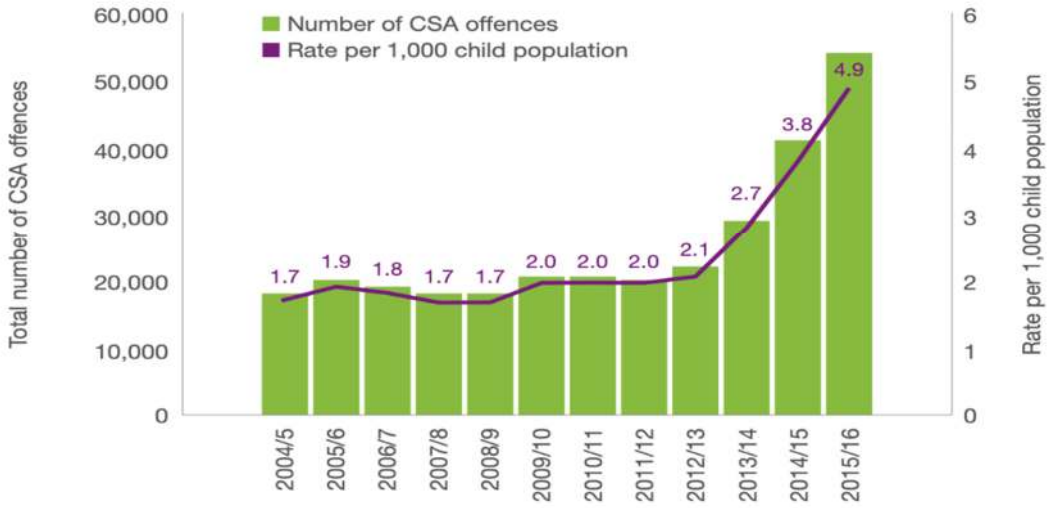
115 [redacted] pgs 197 and 201
116 pg 221
117 pg 3
118

2.144 I have also seen views expressed that CSE has been prevalent in Telford since the 1960s, and became "*mafia-like*" in the sense that it involved a network of "*well-connected alleged perpetrators"* who managed to evade the authorities as family members would *"close ranks*".[119]

2.145 I have referred to evidence of witnesses feeling extremely threatened, and I have seen that in some cases such fear still exists and in some cases prevents those individuals from returning to Telford or it remains a fear that lives with them today, as they walk around the town and fear bumping into their perpetrator.[120]

2.146 One witness expressed the view that the situation had, in fact, got worse with incidents of CSE escalating after Chalice as it was "*as if the gangs know that 'they have got away with everything' and so this has made them more brazen*".[121] Another interpretation of this, of course, is that awareness was much greater following Chalice; authorities were looking for CSE and hence the statistics for reporting of incidents increased dramatically as a result.

2.147 Furthermore, there has been a general increase in recording of child sexual abuse crimes since 2012/13 as this graph shows, taken from the CSA Centre:



2.148 Some caution is required here, as CSE and CSA offences are not separately recorded, and while the graph shows a marked increase since 2012/13, it is familiar to all who have experience in this area that the Jimmy Savile scandal increased reporting of non-recent offending. Indeed, the Crime Survey for England and Wales noted that in the year ending March 2016 reporting of childhood sexual abuse was most prevalent in those aged between 45 and 59.[122]

119 [redacted]
120
121
122 https://www.csacentre.org.uk/documents/scoping-report/, pg 11

2.149 It has been clear to me, from my review of evidence spanning very many years, that two decades ago child protection processes both within the police and Safeguarding appeared to focus solely on issues within the home such as neglect and abuse – it was, as one witness described, "*very much seen as inter-familial*"[123] and the context around wider safeguarding concerns from extra-familial influences were not on the radar. This is something I deal with separately in Chapter 3: The Council Response to CSE in Telford and Chapter 5: The Policing of CSE in Telford dealing with the Council and WMP respectively. Nowadays, I am confident on the evidence made available to me from those organisations – and others – that CSE is much better understood within Telford, and that there are now processes in place to deal with it. However, it would be a mistake to assume that this, in itself, is enough to stamp out CSE – because it is also apparent that the nature of CSE has changed over recent years, most notably due to the increased capabilities of, and access to children via technology and social media.

2.150 As one police officer reflected:

"*In hindsight… WMP and all police forces had only seen the 'tip of the iceberg' of CSE and that there are so many possible indicators and even multi-generational factors involved that, like all police forces,* [WMP] *may have been missing clues which had not yet been identified as indicators. Even now, in the present day… we cannot be sure that CSE as a crime is fully understood or known. However… as awareness is much greater, it would now be identified at a much earlier stage, in whatever form it has evolved, or evolves, into.*"[124]

2.151 In December 2019, The Independent reported that official figures collated by Local Authorities showed that "*almost 19,000 children* [had] *been sexually groomed in England in the past year*".[125]

2.152 In August 2021, the NSPCC[126] released statistics based on Freedom of Information Requests made to 42 police forces in England Wales, which demonstrated that reports of online grooming to the police had jumped by around 70% in the last three years, reaching a record high in 2021: with a total of 5,441 offences of "*sexual communications with a child*" recorded within the year April 2020 to March 2021. This demonstrates the huge increase in perpetrators gaining access to victims via technology; no longer do they need to hang around outside the school gates, or their homes – they now have 24/7, and almost unfettered, access to their victims via text messages, emails and social media accounts.

2.153 The PCC for West Mercia reacted to the NSPCC report, committing to ensuring WMP has the resources required to tackle the emerging trends around the methods of child grooming:

"*We all have a responsibility to protect children and young people from harm, and with social media continually evolving there is a particular onus on tech companies to do more… I am committed to ensuring the police have the resources to tackle these emerging trends and that victims of online grooming are supported through the specialist services I fund.*

123 [redacted]
124 [redacted] pg 28
125 Grooming 'epidemic' as almost 19,000 children identified as sexual exploitation victims in England | The Independent | The Independent
126 Record high number of recorded grooming crimes lead to calls for stronger online safety legislation | NSPCC

There is however always more that can be done… and I call upon everyone with a duty and responsibility to protect children to ensure they are taking this seriously."[127]

Conclusions

2.154 Sadly, it is clear to anyone that reads the national press that the crime of CSE still exists today, and is prevalent across the country as a whole. The same models and patterns of exploitation persist; with children being lavished with gifts and attention on one day, and then raped and threatened the next. I have read very recent press reports, detailing stories of children from other cities such as Hull,[128] who continue to exhibit the same warning signs to their families and professionals - such as regularly going missing; appearing home with bruising and minor injuries; dropping out of school; and being subjected to threats that they will be killed, or that their family members will be.

2.155 In Telford, 2019 saw the most recent CSE convictions as part of Operation Epsilon – and other convictions have followed suit elsewhere: 2020 saw three men sent to jail in Oxford for a total of 35 CSE-related offences; and, until it was wound down in 2021, Operation Marksman involved Humberside police looking at a further 34 suspects involved in CSE, following an initial prosecution of a number of men in 2018. In 2021, Greater Manchester Police announced it had set up a dedicated CSE Unit, tasked with looking into fresh allegations of CSE across Greater Manchester, including new victims/survivors and perpetrators in Rochdale since Operation Span – and over 300 victims and 500 offenders have already been identified.[129]

2.156 This goes to show that this dreadful, life-altering crime has not gone away – in Telford, or elsewhere – and it must remain high on the radar of police forces; safeguarding authorities; health authorities; education providers, and all agencies that have a role to play in ensuring the safety and protection of children.

2.157 It seems to me that the following quote sums up the essential nature of sexual exploitation, and in particular, the coercion that leads to the prevalent misapprehension that victims and survivors willingly 'consent' to such activity:

"*Consent needs to be freely given, it needs to be true consent. It doesn't come with threats to kill your parents. It doesn't come with threats to be waiting outside your school.*"[130]

2.158 For CSE to be properly addressed, a number of things need to happen:

2.158.1 First, children need to be able to recognise exploitation;

2.158.2 Second, victims and survivors of any age need to be confident that their voices will be heard if they complain; and

[127] PCC Calls for More to be Done to Tackle Online Grooming - West Mercia Police Crime Commissioner (westmercia-pcc.gov.uk)
[128] 'Terrified' victim of Hull grooming gang beaten and burned during violent rape | UK News | Sky News
[129] GMP identify 809 members of child sex grooming gangs as new unit is launched - Manchester Evening News
[130] Jim Gamble, former Head of CEOPS, quoted in above Sky News article, 25.11.21.

2.158.3 Third, there needs to be accurate monitoring and reporting of the incidence of CSE within Telford, so that resources may be appropriately directed.

2.159 It has been difficult for this Inquiry to confirm by way of any tangible data the scale of 'CSE' within Telford historically, given the lack of understanding around the criminality in the 1980s/early 1990s; the attitudes towards 'child prostitution' and the fact that many children were considered (in line with the law, at that time) to be 'borderline' in terms of their teen age and proximity to the age of consent – which, I believe, led to a very subjective view being taken by professionals across the board as to whether or not the child was consensually engaging in such activity, rather than being subjected to it under some form of grooming, coercion or duress. This, in my view, is a result of cultures and attitudes that prevailed at that time, which I discuss in more detail in Chapter 9: Attitudes and Impact of this report.

2.160 I agree with WMP's assessment, in its Corporate Submission to the Inquiry, that:

"… *the pattern of CSE must also be seen alongside wider criminal exploitation, Organised Crime Groups, County Lines and lone acting criminals who use both cyber and physical contact to groom and exploit vulnerable children*".[131]

2.161 I also agree that organisations operating online communication platforms share a responsibility for ensuring the highest levels of protection are afforded to children having access to those platforms. This is a matter which has of course been long debated in Parliament, and which has led to the recently published Online Safety Bill – and to that extent I do not feel the need to comment further on this aspect of exploitation, save to say that online methods of CSE clearly are as prevalent in Telford as elsewhere, and need to be addressed urgently.

2.162 However, I also echo the much earlier guidance set out in the '*Safeguarding Children and Young People from Sexual Exploitation Supplementary Guidance to Working Together to Safeguard Children 2009'* – which stated that all LSCBs (and, I would broaden this to say all authorities):

"… *should assume that sexual exploitation occurs within its area unless there is clear evidence to the contrary, and should put in place systems to monitor prevalence and responses*".[132]

2.163 Finally, as to the true extent and prevalence of CSE in Telford, the detailed statistical information to which I have referred of course only deals with the relatively recent past, when published data has been made available; furthermore, that information is agency-specific and not based on shared data. It does not provide a retrospective analysis or confirmation of estimates of victim/survivor and perpetrator numbers dating back to the 1980s, 1990s, or early 2000s; and, of course, those who have chosen not to complain can never be counted.

131 [redacted] pg 222
132 [redacted] pg 193

2.164 It follows that I simply cannot determine the number of children abused by sexual exploitation within Telford during the time covered by my Terms of Reference. However, taking the witness evidence and all the available data into account, the extent of CSE in Telford has plainly been very significant: I certainly cannot say that the Sunday Mirror's figure is "*patently untrue*" as quoted above; sadly, I regard it as a measured, reasonable and non-sensational assessment.

2.165 For all of the above reasons, I have sought to make a number of recommendations that seek to address issues of data collection and analysis, in order to ensure that more reliable and accurate information can be published in relation to the nature, patterns and prevalence of CSE in Telford. Those recommendations feature in the overarching Recommendations at the beginning of this Report.

Victim/Survivor Voice

"I had sex with my boyfriend for the first time today, I didn't really want to do it as I'm young and don't feel ready. I'm not sure I can hide it from my parents.

I'm really upset that he is looking at other girls including my friends. My friends are as young as me so maybe he just likes schoolgirls.

He has a group of friends that I hang out with too. I stayed with them and everyone was looking for me, but I didn't want to come back. I was having the best time. They bought me clothes and made me feel special.

I had a bad night. We were just hanging out and my boyfriend's relative gave me a lift home. But he locked the door and he grabbed my head trying to get me to give him a blow job. I said no but he hit me. I managed to get away but he said he's going to kill me next time. He will ask again and I will be too scared to say no.

They often call and ask to meet in the same places where no one is around. We were all drinking together and having a laugh. Next thing I know they were grabbing me. I was screaming for help but no one stopped. When I told my boyfriend he said it was my own fault. He didn't use a condom so I need to go to the doctors again and get another lecture about sleeping around.

I'm frightened as I get picked up in cars with men I don't know. I don't want to make a fool of myself in front of them. They bought me lots of things that made me feel wanted.

I feel so down I want to kill myself and keep being threatened by people unless I have sex with them and give them blow jobs. I am scared to refuse because they threaten me. Some of the men I have to shag make me feel sick and are much, much older than me.

When I am out they keep getting me very drunk and trying to shag me. I try to shout at them to tell them to stop but they ignore me. They say I belong to them and they will look after me.

My boyfriend keeps making me have sex with other men and when I do he just says thank you and he loves me. They all shag me and he does nothing. I try to resist but they are so much older and stronger than me. They come from nowhere so he must tell them where we are.

My Mum and Dad don't understand and shout at me for going out with them. Just because I am young doesn't mean they can tell me what to do. Whatever they do, I will still see them as they give me things and I'll do anything to be with my boyfriend because I love him so much.

I cry at night when I am by myself as my life is so fucked up and I want to run away. I will not survive if I stay here. I seem to end up miles from home and can't get back unless I agree to shag them or give them blow jobs.

The men get angry and scare me. I shag them but I don't want to. They say they have paid for me so I have no choice. I keep getting calls from men, I don't know who gave them my number. I get passed around and want to be dead so I won't feel like this anymore. I just want people to listen to me and want out of this mess. I don't feel like I can speak to my Mum and Dad.

The men make me feel so important and loved when I'm there, but I feel like shit when they have gone. They have hold of me and I don't know what to do, they threaten me and my family if I don't do what they want. They are all I have got right now.

I need to get away from all this as I don't know want to do. I've been through so much I can't take it anymore. I have even said things to the police but they don't care. I wish I was dead. Then the pain would go away."[1]

1 [redacted]